STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING _____ B. WING _____	C 05/11/2017

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey. Event ID # ADYO11.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 157		6/8/17

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

Electronically Signed | 06/03/2017

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F 157	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and nurse practitioner interview, the facility failed to inform the Physician or Nurse Practitioner that a resident with a history of congestive heart failure experienced increased edema and weight gain for 1 of 1 sampled residents (Resident #18). Findings included: A review of Resident #18 ' s admission minimum data set assessment dated 4/9/17 revealed that the resident required assistance by one staff member for personal care, activities of daily living and mobility in the wheel chair. The resident had an intact cognition. According to Resident #18 ' s face sheet, she was re-admitted on 4/19/17 from the hospital for congestive heart failure and heart attack. According to the physician ' s progress note dated 4/19/17, Resident #18 ' s diagnoses were congestive heart failure (CHF), hypertension,	F 157	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. 1.Resident affected a.Resident # 18 was assessed by Nurse and sent to the ER for treatment on 5/8/17 b. Nurse #1 was re-educated by the Director of Health Services on assessments and signs and symptoms of acute on chronic onset of CHF on 5/9/17. 2.Residents with potential to be affected a.All residents in the facility with chronic	

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pulmonary hypertension, anxiety, heart attack, anemia, and chronic renal failure stage III.

A review of the nurses ' notes revealed there was no documentation of the presence of lower extremity edema for Resident #18 from 4/20/17 until the day of the resident ' s hospitalization on 5/8/17.

A review of the medication administration daily weight record revealed Resident #18 weighed 137 pounds on 5/5/17, weighed 137.8 pounds on 5/6/17, refused to be weighed on 5/7/17, and weighed 141 pounds on 5/8/17. This represented a four-pound weight gain in two days.

Observations on 5/8/17 at 11:10 am revealed Nurse #1 entered Resident #18 ' s room and stated the resident was diagnosed with pneumonia. Nurse #1 stated the resident was on Doxycycline and was then switched to Augmentin yesterday because Doxycycline was not working. Nurse #1 stated that the resident was anxious and she exhibited this type of behavior before. Nurse #1 also stated that the resident had asked to go to the hospital earlier this morning. Nurse #1 stated she was trying to calm the resident down and was to continue with Augmentin and give the antibiotic a chance to work. Nurse #1 stated that she had not called the physician. Nurse #1 stated that Resident #18 ' s shaking was from anxiety.

A review of Resident #18 ' s hospital history and physical report for the 5/8/17 admission revealed that the resident was not feeling well on 5/7/17 and had increased swelling in her lower legs and feet. Throughout the day on 5/7/18 the shortness of breath became worse and the resident

and acute onset of cardiac and respiratory issues had the potential to be impacted.

b. On 5/30/17 100% review of resident with a diagnosis of CHF were assessed by the Nurse Management team for any weight gains and edema, with any abnormal findings communicated to the physician. There were no negative findings.

3. Systemic Change/Interventions

a. Education began on 5/10-5/11/17 conducted by the Clinical Competency Coordinator and the Director of Health Services for the licensed nurses on completing cardiac assessments, completing respiratory assessments and completing an SBAR Interact tool so that all necessary information is available to provide to physicians and/or nurse practitioners when communicating a change in condition. All newly hired licensed nurses will also receive the same education and will receive a competency evaluation in orientation. PRN and weekend staff were educated to this policy. No nurses will be allowed to work a scheduled shift without completion of this training. Additional training was conducted for employees who were on vacation on 5/30/17. All nurses on payroll have been educated.

b. All new admission and readmissions with a diagnosis of CHF will be placed on weight schedule determined by the physician. The Nurse Management team

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F 157	Continued From page 3 informed the nurse. On the morning of 5/8/17 the resident informed the nurse that she was unable to sleep all night due to shortness of breath. Physician ' s evaluation of lower leg and feet edema was +3 (range 0 to +4) Physician ' s evaluation for admission was "if the patient is not admitted to the hospital, she is at risk for death, heart attack, shock, sepsis, and/or respiratory distress." Admitting diagnosis was acute on chronic CHF. On 5/10/17 at 10:48 am an interview was conducted with the Nurse Practitioner (NP). The NP stated that Nurse #1 called her on Monday 5/8/17 around noon. The NP stated Nurse #1 informed her the resident ' s oxygen saturation was 99% and did not indicate whether the resident was on room air or oxygen. The NP stated that Nurse #1 did not provide an assessment of the resident ' s respiratory effort. The NP stated that Nurse #1 informed her the resident requested to go to the hospital. The NP stated she ordered an additional dose of Xanax 0.25 milligrams to be given immediately. The NP stated she gave an order for the nurse to decide with the resident if the resident needed to go to the hospital. The NP stated the last time the she saw the resident her left lower extremity was +1 edema. The NP stated she would expect staff to inform her of edema and weight gain to make an accurate presentation of the resident ' s condition and a correct plan of treatment instead of leaving the decision to go to the hospital up to the resident. The NP stated if she knew the resident had increased edema and weight gain she would have ordered intramuscular Lasix 40 milligrams to be given immediately before sending the resident to the hospital. The NP stated it was important and expected that the staff provide a	F 157	will audit the weights obtained to ensure compliance with MD orders or resident specific disease protocols, and the charts of the residents with CHF 5 times weekly x 1 weeks, then weekly x 3 weeks, then monthly X 3 months until compliance is achieved to ensure exacerbation of symptoms is being monitored and MDs are being notified. 4. Plan to Monitor a.The Director of Health Service will review and trend the findings from the admission and readmission audits of residents with the diagnosis of CHF. The Director of Health Services will bring results to the Monthly Quality Assurance Performance Improvement Committee meetings x 3 months or until substantial compliance is achieved to ensure monitoring for exacerbation of symptoms and MD notification. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action.	

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F 157	Continued From page 4 complete and accurate assessment for her to create an effective plan of treatment. On 5/10/17 12:20 pm an interview was conducted with the Director of Nursing (DON). DON stated that she expected staff to assess a resident according to their plan if there was a change condition and notify the physician. The DON stated that she was not aware that the resident had asked to be transferred to the hospital on 5/8/17 before 11:00 am. The DON stated that she would expect to be informed if the resident was being sent to the hospital and if an assessment needed to be conducted for a resident change in status.	F 157		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and record review, the facility failed to place a resident's call light (Resident #52) within reach to allow for the resident to request staff assistance if needed for one of one resident reviewed for accommodation of needs. The findings included: Resident #52 was admitted to the facility on	F 246	1.Resident affected a. Resident # 52 was witnessed with the call bell not positioned in the center of her chest as per the care plan. The call bell was noted in position on 5/10/17 by the surveyor. The resident suffered no ill effects.	6/8/17

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F 246	Continued From page 5 6/4/12 and most recently readmitted on 1/28/15 with diagnoses that included hemiplegia (paralysis of one side of the body) following cerebrovascular disease affecting the left dominant side and morbid obesity. The annual Minimum Data Set (MDS) assessment dated 2/9/17 indicated Resident #52's cognition was intact. She was dependent on the assistance of 2 or more staff for bed mobility, toileting, and personal hygiene. She was dependent on the assistance of 1 staff for dressing and bathing. Resident #52 was noted with impairment on one side of her upper and lower extremities due to the diagnosis of hemiplegia. She was assessed as always incontinent of bladder of bowel. The Care Area Assessment (CAA) related to Activities of Daily Living (ADLs) for the 2/9/17 MDS indicated Resident #52 required the assistance of one to two staff with ADLs due to contracture of left arm and limited mobility in left leg due to hemiplegia. She was noted as incontinent of bowel and bladder. Resident #52 was assessed as able to clearly voice needs and wants. Resident #52's plan of care dated 2/21/17 included, in part, the problem/need areas of ADLs, fall risk, and incontinence. Resident #52 was indicated to require assistance with ADLs due to functional limitation with left side hemiplegia from old cerebrovascular accident (CVA) and impaired mobility due to a contracture of left upper extremity. She was noted as at risk for falls due to impaired mobility from left side hemiplegia. Resident #52 was also indicated as incontinent of bowel and bladder. The	F 246	2.Residents with potential to be affected a. All residents in the facility with accommodation needs could be impacted by this practice b. On 5/21/17 □ 5/23/17 100% review of residents with an accommodation need for call bell placement was conducted by the restorative CNA. There were no other negative findings. 3. Systemic Change/Interventions a. Education began on 5/26/17, 5/29/17 and 5/30/17 conducted by the Clinical Competency Coordinator and the Director of Health Services for the licensed nurses and certified staff (Nursing Assistants) to follow accommodations of needs found in the care plans for call bell placement. b. Care Flow Guides were updated in Smart Charting electronic documentation system for CNAs on 5/22/17 to ensure effective communication of needs. This will alert the CNAs to be aware of call bell placement related to specific needs. c. All newly hired licensed and certified staff will receive the same education in their orientation going forward. All PRN and weekend certified staff have also been educated. No employees were allowed to work a shift prior to completion of this training. d. All daily compliance round team members will receive a list of required	

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F 246	Continued From page 6 interventions for Resident #52's risk of falls and incontinence included keeping Resident #52's call light within reach when she was in bed. An observation and interview was conducted with Resident #52 on 5/8/17 at 10:36 AM. Resident #52 was lying on her back in bed and her call light was attached by a clip to her clothing above her left shoulder area. Resident #52 revealed she was unable to reach her call light at its present position. She indicated she had left side hemiplegia and was dependent on staff for bed mobility. She demonstrated her inability to reach her call light by extending her right arm toward her left shoulder and being unable to touch the call light. Resident #52 indicated she was unable to roll or turn toward her left side which would have allowed her to reach the call light. She reported her call light was normally placed in the center of her chest area attached by a clip to her clothing and within her reach. An observation and interview was conducted with Resident #52 on 5/8/17 at 4:00 PM. Resident #52 was lying on her back in bed with her pillow behind her head and her call light attached to the left upper corner of the pillowcase. She revealed she was unable to reach her call light. It was observed Resident #52 was unable to extend her right arm to reach the call light. An observation and interview was conducted with Resident #52 5/9/17 at 9:05 AM. Resident #52 was lying on her back in bed and her call light was attached by a clip to her clothing in the center of her chest area. Resident #52 demonstrated her ability to reach her call light. She stated this position was where she preferred her call light to be placed.	F 246	placement of call bells by 6/7/17 as per specific resident needs in order to validate placement during 5X weekly compliance rounds. Week-end manager will complete compliance rounds to validate placement of call bells. 4. Plan to Monitor a. Individuals in charge of compliance rounds (Administrator, DHS, ADHS, Clinical Competency Coordinator, Case Mix Director, Financial Counselor, Social Worker, Payroll and Personnel Coordinator, Dietary Manager, Transportation CNAs, Restorative CNAs and Medical Records) will complete daily compliance rounds 5 X per week. The IDT will verify placement of call bells as per patient needs. The Compliance Round Team will correct any call bells that are not in proper placement and will report the findings in the Daily Stand Up meeting that occurs 5 X per week. b.The Director of Health Services will bring results to the Monthly Quality Assurance Performance Improvement Committee meetings x 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action.	

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An interview was conducted with the Treatment Nurse on 5/10/17 at 9:10 AM. She indicated she was familiar with Resident #52. She stated Resident #52 was able to use her call light to request staff assistance. She reported Resident #52 had immobility on her left due to the effects of a CVA. She revealed Resident #52's call light was to be placed in the center of her chest area for her to be able to reach it.

An interview was conducted with Nursing Assistant (NA) #7 on 5/10/17 at 10:10 AM. She stated she worked with Resident #52 frequently. She indicated Resident #52 was able to use her call light to request staff assistance. She reported Resident #52 was unable to move the left side of her body. She revealed she placed Resident #52's call light in the center of her chest area so she was able to reach it.

An interview was conducted with NA #8 on 5/10/17 at 3:11 PM. She stated she was familiar with Resident #52. She indicated Resident #52 was able to use her call light to request staff assistance. She reported Resident #52 was immobile on her left side and she was dependent on staff for ADL assistance. She stated Resident #52 was unable to turn or roll over in bed without staff assistance. NA #8 revealed Resident #52's call bell was to be placed near the center of her chest are so she was able to reach it.

An interview was conducted with the Director of Nursing (DON) on 5/10/17 at 3:20 PM regarding Resident #52's call light not being placed within her reach. The DON indicated her expectations were for staff to place resident call lights within the resident's reach at all times.

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F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed remove a broken chair from #86 ' s room on 1 of 4 halls. Findings included: In an observation on 5/9/17 at 5:50 PM, a tour was done on the 100 hall. In Resident #86 ' s room, there was observed a straight back upholster chair with arm rest against the wall opposite the beds. The right arm rest was broken off at the front and still hanging from the back of the chair facing downward toward the floor. There was also observed a shard of wood sticking straight upward from the front piece of wood where the armrest was originally secured. The wood shard measured 4 inches in height, bottom width was 2 inches and narrowed at the top to ½ inch. Resident #86 was up in the wheelchair propelling the in hallway when the Maintenance Supervisor was summoned to the room. In an interview and observation on 5/9/17 at 5:53 PM, NA #2 stated she had not noticed the broken chair in Resident #86 ' s room and that he never sat in a chair like due to his hemiplegia. She stated he only got up to his wheelchair. NA #2 assessed the chair with surveyor and stated, "Someone is going to get hurt if they sit down in that chair. That spike will stab someone. It shouldn ' t be in here." NA #2 stated it was maintenance who removed items like the broken chair from the facility.	F 253	1.Resident affected a.Resident # 86 was not affected, however, a broken guest chair was present in this resident□s room. Due to a hemiplegia diagnosis, the resident was unable to sit in the guest chair. 2. Residents with potential to be affected a.All residents with the ability to self-transfer to a guest chair had the ability to be impacted by this practice. b.On 5/9-5/10/17, a 100% review of all guest chairs was conducted by the Maintenance Director for function and safety with no negative findings. 3.Systemic Change/Interventions a.Education began on 5/26/17, 5/29/17 and 5/30/17 conducted by the Clinical Competency Coordinator and the Director of Health Services for staff members on the facility protocol for their responsibility to remove broken chairs immediately upon identification and the facility protocol for reporting maintenance and housekeeping repair requests. The facility protocol requires that staff members who identify a maintenance or housekeeping	6/8/17

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F 253	Continued From page 9 In an interview and observation on 5/9/17 at 6:00 PM, the Maintenance Supervisor was shown the chair in Resident #86 ' s room. He stated the chair was a hazard to other residents, staff and visitors but stated Resident #86 was physical incapable of sitting in that type of chair. He stated it was his expectation that any broken item like the chair be removed for safety. The Maintenance Supervisor stated the process the facility had in place was any person finding any item in disrepair, that person was to complete a work order and give it to him. He stated in this instance, his expectation would be who noticed the broken chair should have removed it immediately. The Maintenance Supervisor removed the chair from Resident #86 ' s room and from the facility. In an interview on 5/11/17 at 9:10 AM, Nurse #2 stated she worked the 100 hall yesterday. She stated she did not notice a broken chair in Resident #86 ' s room. She stated had she noticed it, she would have reported it the 10 910am Nurse #2 did not notice broken chair would have reported it to the Maintenance Supervisor. In an interview on 5/11/17 at 9:43 AM. The Administrator stated it was her expectation that chair would have been removed immediately when it was first observed in that condition.	F 253	repair concern will place a request in the maintenance log which is located at the nurse□s station. The Maintenance Director will be responsible for reviewing the request daily X 5 days per week, and will complete or delegate all requests. Should there be an urgent request that would affect patient care or safety, the Maintenance Director (or the nursing manager on call) will be called and the issues will be addressed immediately. This education has been added for all newly hired employees and into the orientation process going forward. b.To further ensure compliance, an audit was placed in Building Engines to be conducted by the Maintenance Director on 5/29/17 for a weekly audit of guest chairs for safety and function. Should the Maintenance Director not be available, the Housekeeping Supervisor will be responsible for completing the audit. 4.Plan to Monitor a.The Maintenance Director will review of the results of the Building Engines audit and the reviews of the maintenance logs with the Monthly Quality Assurance Performance Improvement Committee meetings x 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action.	

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F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and	F 278	1. Resident affected	6/8/17

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F 278	Continued From page 11 record review, the facility failed to accurate code the most recent Minimum Data Set (MDS) for restraints (Resident #112 and Resident #56), failed to code a diagnosis of psychosis (Resident #91) and failed to accurately code cognition (Resident #69) for 4 of 19 residents reviewed for MDS accuracy. The findings included: 1. Resident # 112 was admitted to the facility 9/4/15 with cumulative diagnoses of dementia, anxiety and cerebral vascular accident (CVA). A review of Resident #112 ' s Annual Observation for Physical Device Form dated 12/6/16 read Resident #112 was unable to release the self-release seat belt on command 100% of the time due to her dementia. This was communicated to the responsible party (RP) who consented to the continuation of the device. This form was completed by the Assistant Director of Nursing (ADON). A review of the Case Mix Director Observation Form dated 3/8/17 completed by the MDS nurse read Resident #112 utilized a self-release belt to her wheelchair daily. The MDS documented on all attempts multiple times during the day during the 7 day look back, Resident #112 was able to self-release the belt on command. The MDS documented it was not a restraint. The quarterly Minimum Data Set (MDS) dated 3/8/17 indicated Resident #112 had severe cognitive impairments, no behaviors, required extensive assistance with all her activities of daily living (ADLs). She was not coded for a trunk restraint. A review of Resident #112 ' s current care plan last revised by the MDS nurse on 3/8/17 indicated	F 278	a. Residents #112, #56, #91 and #69 were impacted by this practice 2. Residents with potential to be affected a. All residents in the facility have the ability to be impacted by this practice. There were no adverse outcomes related to this concern. b. On 5/24/17, a new MDS assessment was completed for resident #112 with an ARD date of 5/10/17 by the Case Mix Director to ensure proper coding related to restraints as per instructions from the Director of Clinical Reimbursement. c. Resident #56 had a new MDS assessment completed by the Case Mix Director on 5/29/17 with an ARD of 5/22/17 to ensure proper coding related to restraints as per instructions from the Director of Clinical Reimbursement. d. Residents #112 and #56 are the only residents in the facility that are ordered or utilize a soft self-release belt or any other restraint. e. Resident #91 received a clarification order for the diagnosis of psychosis to support the use of the antipsychotic medications on 5/10/17 during annual survey by order of the Nurse Practitioner. A request was submitted to open the assessment on 5/12/17 and the MDS was modified and closed on 5/16/17 by the Case Mix Director.	

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F 278	Continued From page 12 she was at risk for injury related the use of a soft seat belt to her wheelchair. Interventions included teaching Resident #112 about the use of the device, assist with position changes every 30 minutes to 2 hours, checking the device for good condition, and removing the device during supervised activities. The most recent Physical Restraint Elimination Evaluation dated 3/29/17 completed by the ADON read that Resident #112 required the continued use of the soft self-release seatbelt due to poor safety awareness and her leaning forward in her wheelchair. In an observation on 5/9/17 at 8:39 AM, Resident #112 was sitting in a wheelchair in the hallway. She had a light blue seat belt around her trunk held together with Velcro. The seat belt was attached to the back frame of the wheelchair. She was clean, well groomed and absent of any odors to suggest incontinence. In an interview and observation on 5/9/17 at 8:40 AM, Nursing Assistant (NA) #3 stated Resident #112 was not capable of removing her self-release seat belt on command due to her poor cognition. NA #3 asked Resident #112 to remove the self-release seat belt. Resident #112 appeared unsure of request and began to run her finger through her hair and then to her face. She remained nonverbal. NA #3 again asked Resident #112 to remove her self-release seat belt. Resident #112 began to self-propel toward the dining room. In an interview on 5/11/17 at 9:43 AM, the Administrator stated it was her expectation that all MDS assessment be accurate.	F 278	f. A request was sent on 5/11/17 to re-open a closed assessment for Resident #69. The assessment was modified and closed on 5/18/17 with the correct BIM by the Case Mix Director. 3. Systemic Change/Interventions a. A 100% audit of all resident records who are receiving anti-psychotic medications was completed on 5/18/17 by the Case Mix Director to ensure all records contained an accurate diagnosis. This audit was validated by the Director of Health Services. There were no negative findings. b. A 100% audit of all resident records for accuracy of BIMs assessments was completed on 6/2/17 by the Director of Social Services. This audit was validated by the Director of Health Services. There were no negative findings. c. An audit of all residents with most current OBRA assessments will be completed by the Case Mix Director, the Case Mix Coordinator, the Social Services Director, the Dietary Manager and the Director of Health Services for accuracy. The audit will include 25% of all current OBRA assessments weekly (and all new OBRA assessments that come due). The first weekly audits will be completed by 6/8/17 and will occur weekly thereafter until 100% is complete. The findings will be placed on the MDS accuracy audit tool and will be reviewed by the Administrator	

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F 278	Continued From page 13 In an interview on 5/11/17 at 11:45 AM, the MDS nurse stated during the 7 day look back for the most recent quarterly MDS dated 3/8/17, she completed the assessment on both first and second shift for 7 days of whether Resident #112 ' s self-release seat belt was a restraint. She stated she also reviewed the chart for incidents when Resident #112 removed her seat belt. A review of the nursing notes from 3/2/17 to 3/8/17 included no documentation in reference to the self-release seat belt. In a second observation on 5/11/17 at 12:03 PM, resident #112 was in the main dining room. The tray had not come from the kitchen and she was not at a table but rather sitting with a group of resident who had participated in an activity. The MDS nurse asked Resident #112 to remove the self-release seat belt from across her trunk. Resident #112 appeared confused and became tearful. She was not able to remove the self-release seat belt. In an interview on 5/11/17 at 12:27 PM, the Director of Nursing stated it was her expectation that Resident #112 ' s self-release seat belt be coded as a restraint on the quarterly MDS dated 3/8/17. 2. Resident #56 was admitted 11/24/14 with cumulative diagnoses of Alzheimer ' s disease and Chronic Obstructive Pulmonary Disease. A review of the Case Mix Director Observation Form dated 3/3/17 completed by the MDS nurse read Resident #56 utilized a self-release belt to her wheelchair. The MDS documented on all	F 278	monthly and reported to the Quality Assurance and Performance Improvement Committee to ensure compliance. d. Competency education for MDS item coding definitions will be completed by Case Mix Director, the Case Mix Coordinator, the Social Services Director, the Dietary Manager and the Director of Health Services electronically via Assessment Intelligence Systems (AIS) by 6/6/17 on accurate assessment coding. A post-test will serve as proof of competency in this area. e. The Assessment Accuracy process review with Case Mix Director, the Case Mix Coordinator, the Social Services Director, the Dietary Manager and the Director of Health Services was re-educated by the Director of Clinical Reimbursement on utilization of the Data Integrity feedback tool and RUGS analysis worksheet for determining MDS accuracy. The RUGS analysis worksheet is a comparison of the current assessment to the prior completed assessment for MDS items. The Data Integrity Feedback Audit is an electronic real time audit that pulls from Point Right to identify potential issues or areas that require further verification. Point Right is a subscription service that the facility utilizes as a data driven predictive analytics tool to help identify clinical areas that could affect optimal outcomes. f. The RUGs Analysis Worksheet will be	

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attempts multiple times during the day during the 7 day look back, Resident #56 was able to self-release the belt on command. The MDS documented it was not a restraint during the look back.

A review of Resident #112 ' s Annual Observation for Physical Device Form dated 3/14/17 read Resident #56 was unable to release the self-release seat belt at all times. This was communicated to the responsible party (RP) who consented to the continuation of the device. This form was completed by the Assistant Director of Nursing (ADON).

Resident #56 was care planned on 3/17/17 for a risk for injury due to the need for a self-release seat belt to her wheelchair. The interventions included assisting Resident #56 with position changes every 30 minutes to 2 hours, remove the device during supervised activities and provide diversional activities.

The annual MDS dated 3/22/17 indicated Resident #56 had severe cognitive impairment, verbal and physical behaviors and extensive assistance with her ADLs. She was not coded for a trunk restraint.

The most recent Physical Restraint Elimination Evaluation dated 3/22/17 completed by the ADON read that Resident #56 required the continued use of the soft self-release seat belt to assist with positioning and serve as a reminder to call for assistance.

In an observation on 5/9/17 at 4:00 PM, Resident #56 was self-propelling her wheelchair in the hallway. She had a light blue seat belt around her

reviewed by team members completing the MDS (by the Case Mix Director, the Case Mix Coordinator, the Social Services Director, the Dietary Manager and the Director of Health Services) with the completion of each assessment. The Point Right Data Integrity Feedback report for each assessment will be reviewed by the Case Mix Director, the Case Mix Coordinator, the Social Services Director, the Dietary Manager and the Director of Health Services in daily Case Mix Meetings after the completion of each assessment. The Administrator will verify the results of the reviews 1 X weekly for 3 weeks, and then 1 X monthly for 3 months for appropriate follow up. The results will be tracked and trended for quality assurance and performance improvement.

4.Plan to Monitor

a. The Administrator will review and trend the findings from MDS Accuracy Audit Tool monthly and will review the results from the Data Integrity Feedback from the weekly Case Mix Meetings weekly X 4 weeks and monthly for 3 months ensure accurate coding of the MDS. The Administrator will bring results to the Monthly Quality Assurance Performance Improvement Committee meetings x 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action.

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trunk held together with Velcro. The seat belt was attached to the back frame of the wheelchair. She was clean, well groomed and absent of any odors to suggest incontinence.

In an interview and observation on 5/9/17 at 4:02 PM, NA #2 stated Resident #56 was not capable of removing her self-release seat belt on command due to her poor cognition. NA #2 asked Resident #56 to remove the self-release seat belt. Resident #56 appeared agitated and unable to focus on request. . NA #2 again asked Resident #56 to remove her self-release seat belt. Resident #56 again appeared restless and agitated and began self-propelling down the hallway.

In an interview on 5/11/17 at 9:43 AM, the Administrator stated it was her expectation that all MDS assessment be accurate.

In an interview on 5/11/17 at 11:45 AM, the MDS nurse stated during the 7 day look back for the most recent annual MDS dated 3/22/17, she completed the assessment on both first and second shift for 7 days of whether Resident #56 ' s self-release seat belt was a restraint. She stated she also reviewed the chart for incidents when Resident #56 removed her seat belt. A review of the nursing notes from 2/25/17 to 3/3/17 included no documentation in reference to the self-release seat belt.

In a second observation on 5/11/17 at 12:03 PM, resident #112 was in the main dining room. The tray had not come from the kitchen and she was not at a table but rather sitting with a group of resident who had participated in an activity. The MDS nurse asked Resident #112 to remove the

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self-release seat belt from across her trunk. Resident #112 appeared confused and became tearful. She was not able to remove the self-release seat belt.

In an interview on 5/11/17 at 12:27 PM, the Director of Nursing stated it was her expectation that Resident #56 ' s self-release seat belt be coded as a restraint on the annual MDS dated 3/22/17.

3. Resident #91 was admitted 12/30/15 with cumulative diagnoses of, cerebral Vascular Accident (CVA) with vascular dementia, and anxiety.

Resident was diagnosed with psychosis on 1/16/17 and prescribed an antipsychotic.

The quarterly MDS dated 2/21/17 indicated she was cognately intact with no behaviors extensive assistance with her ADLs except for eating. Resident #91 was coded as taking an antipsychotic medication 7 of 7 days during the look back period.

Resident #91 was care planned for a psychotropic medication on 1/16/17 with the last care plan review on 3/31/17. Interventions included monitoring the medications for side effects, psychological services as ordered, Abnormal Involuntary Movement assessment (AIMS) every 6 months and gradual dose reduction as ordered by the physician.

In an observation on 5/10/16 at 10:17 AM, Resident 391 was sitting in the dining room waiting for church services to start. She was well

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groomed and appeared cooperative and with a pleasant affect. She voiced no complaints.

In an interview on 5/11/17at 8:30 AM NA #4 stated Resident #91 was confused at times and would refused ADLs.

In an interview on 5/11/17 at 9:43 AM, the Administrator stated it was her expectation that all MDS assessment be accurate.

In an interview on 5/11/17 at 11:45 AM, the MDS nurse stated when she completed the quarterly MDS on 2/21/17, she failed for coded Resident #91 with the new diagnosis of psychosis supporting the use of the antipsychotic medication.

In an interview on 5/11/17 at 12:27 PM, the Director of Nursing stated it was her expectation that Resident #91 diagnosis of psychosis would have been coded on the quarterly MDS dated 2/21/17.

4. Resident #69 was admitted 3/20/12. Cumulative diagnoses included renal failure and diabetes.

A Quarterly Minimum Data Set (MDS) dated 2/24/17 was reviewed. Section C titled Cognitive Patterns C0100 indicated the resident interview was conducted. The Brief Interview for Mental Status (BIMS) for Resident #69 was coded "0" on a scale of 0-15. This indicated Resident #69 was severely impaired in cognition. The previous annual MDS dated 1/3/17 indicated Resident #69 was cognitively intact.

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F 278	Continued From page 18 A review of the Social Services Assessment form dated 2/24/17 indicated resident #69 was alert, independent with memory recall of current season, staff names/ faces, that she was in a healthcare facility, and knew the location of room. The note indicated the Social Worker had completed the BIMS with Resident #69 and found her to be fully cognitively intact. On 5/8/17 at 4:56 PM, an interview was conducted with Resident #69. Resident #69 was noted to be cognitively intact. On 5/11/17 at 10:10 AM, an interview was conducted with the Social Worker who reviewed the MDS and stated the information on the MDS was wrong and Resident #69 was cognitively intact. She said she did not understand what happened or why the information was incorrect on the MDS. On 5/11/17 at 9:43AM, an interview was conducted with the Administrator who stated it was her expectation that the MDS be coded accurately. On 05/11/2017 at 12:26 PM, an interview was conducted with the Director of Nursing. She stated she expected the MDS to be accurate.	F 278		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in	F 282		6/8/17

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F 282	Continued From page 19 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and record review, the facility failed to follow the plan of care interventions to place a resident's call light (Resident #52) within reach for one of one resident reviewed for accommodation of needs. The findings included: Resident #52 was admitted to the facility on 6/4/12 and most recently readmitted on 1/28/15 with diagnoses that included hemiplegia (paralysis of one side of the body) following cerebrovascular disease affecting the left dominant side and morbid obesity. The annual Minimum Data Set (MDS) assessment dated 2/9/17 indicated Resident #52's cognition was intact. She was dependent on the assistance of 2 or more staff for bed mobility, toileting, and personal hygiene. She was dependent on the assistance of 1 staff for dressing and bathing. Resident #52 was noted with impairment on one side of her upper and lower extremities due to the diagnosis of hemiplegia. She was assessed as always incontinent of bladder of bowel. The Care Area Assessment (CAA) related to Activities of Daily Living (ADLs) for the 2/9/17 MDS indicated Resident #52 required the assistance of one to two staff with ADLs due to contracture of left arm and limited mobility in left leg due to hemiplegia. She was noted as incontinent of bowel and bladder. Resident #52 was assessed as able to clearly voice needs and wants.	F 282	1. Resident affected a. Resident # 52 was witnessed with the call bell not positioned in the center of her chest as per the care plan. The call bell was noted in position on 5/10/17 by the surveyor. The resident suffered no ill effects. 2. Residents with potential to be affected a. All residents in the facility with accommodation needs could be impacted by this practice b. On 5/21/17 □ 5/23/17 100% review of residents with an accommodation need for call bell placement was conducted by the restorative CNA. There were no other negative findings. 3. Systemic Change/Interventions a. Education began on 5/26/17, 5/29/17 and 5/30/17 conducted by the Clinical Competency Coordinator and the Director of Health Services for staff members on the facility protocol for their responsibility to remove broken chairs immediately upon identification and the facility protocol for reporting maintenance and housekeeping repair requests. The facility protocol requires that staff members who identify a maintenance or housekeeping repair concern will place a request in the	

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F 282	Continued From page 20 Resident #52's plan of care dated 2/21/17 included, in part, the problem/need areas of ADLs, fall risk, and incontinence. Resident #52 was indicated to require assistance with ADLs due to functional limitation with left side hemiplegia from old cerebrovascular accident (CVA) and impaired mobility due to a contracture of left upper extremity. She was noted as at risk for falls due to impaired mobility from left side hemiplegia. Resident #52 was also indicated as incontinent of bowel and bladder. The interventions for Resident #52's risk of falls and incontinence included keeping Resident #52's call light within reach when she was in bed. An observation and interview was conducted with Resident #52 on 5/8/17 at 10:36 AM. Resident #52 was lying on her back in bed and her call light was attached by a clip to her clothing above her left shoulder area. Resident #52 revealed she was unable to reach her call light at its present position. She indicated she had left side hemiplegia and was dependent on staff for bed mobility. She demonstrated her inability to reach her call light by extending her right arm toward her left shoulder and being unable to touch the call light. Resident #52 indicated she was unable to roll or turn toward her left side which would have allowed her to reach the call light. She reported her call light was normally placed in the center of her chest area attached by a clip to her clothing and within her reach. An observation and interview was conducted with Resident #52 on 5/8/17 at 4:00 PM. Resident #52 was lying on her back in bed with her pillow behind her head and her call light attached to the left upper corner of the pillowcase. She revealed	F 282	maintenance log which is located at the nurse□s station. The Maintenance Director will be responsible for reviewing the request daily X 5 days per week, and will complete or delegate all requests. Should there be an urgent request that would affect patient care or safety, the Maintenance Director (or the nursing manager on call) will be called and the issues will be addressed immediately. This education has been added for all newly hired employees and into the orientation process going forward. b. To further ensure compliance, an audit was placed in Building Engines to be conducted by the Maintenance Director on 5/29/17 for a weekly audit of guest chairs for safety and function. Should the Maintenance Director not be available, the Housekeeping Supervisor will be responsible for completing the audit. 4. Plan to Monitor a. Individuals in charge of compliance rounds (Administrator, DHS, ADHS, Clinical Competency Coordinator, Case Mix Director, Case Mix Coordinator, Financial Counselor, Social Worker, Payroll and Personnel Coordinator, Dietary Manager, Transportation CNAs, Restorative CNAs, Skin Integrity Coordinator and Medical Records) will complete daily compliance rounds 5 X per week. The IDT will verify placement of call bells as per patient needs. The Compliance Round Team will correct any call bells that are not in proper placement	

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F 282	Continued From page 21 she was unable to reach her call light. It was observed Resident #52 was unable to extend her right arm to reach the call light. An observation and interview was conducted with Resident #52 5/9/17 at 9:05 AM. Resident #52 was lying on her back in bed and her call light was attached by a clip to her clothing in the center of her chest area. Resident #52 demonstrated her ability to reach her call light. She stated this position was where she preferred her call light to be placed. An interview was conducted with the Treatment Nurse on 5/10/17 at 9:10 AM. She indicated she was familiar with Resident #52. She stated Resident #52 was able to use her call light to request staff assistance. She reported Resident #52 had immobility on her left due to the effects of a CVA. She revealed Resident #52's call light was to be placed in the center of her chest area for her to be able to reach it. An interview was conducted with Nursing Assistant (NA) #7 on 5/10/17 at 10:10 AM. She stated she worked with Resident #52 frequently. She indicated Resident #52 was able to use her call light to request staff assistance. She reported Resident #52 was unable to move the left side of her body. She revealed she placed Resident #52's call light in the center of her chest area so she was able to reach it. An interview was conducted with NA #8 on 5/10/17 at 3:11 PM. She stated she was familiar with Resident #52. She indicated Resident #52 was able to use her call light to request staff assistance. She reported Resident #52 was immobile on her left side and she was dependent	F 282	and will report the findings in the Daily Stand Up meeting that occurs 5 X per week. b.The Director of Health Services will bring results to the Monthly Quality Assurance Performance Improvement Committee meetings x 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action.	

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F 282	Continued From page 22 on staff for ADL assistance. She stated Resident #52 was unable to turn or roll over in bed without staff assistance. NA #8 revealed Resident #52's call bell was to be placed near the center of her chest are so she was able to reach it. An interview was conducted with the Director of Nursing (DON) on 5/10/17 at 3:20 PM regarding Resident #52's call light not being placed within her reach as indicated in the interventions in her plan of care. The DON reported her expectations were for the care plan interventions to be followed and for staff to place resident call lights within the resident's reach at all times.	F 282		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff and physician assistant (PA) interviews and record review, the	F 314	1.Resident affected	6/8/17

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F 314	Continued From page 23 facility failed to administrator pressure ulcer treatment as ordered for 1 (Resident #28) of 3 residents reviewed for pressure ulcers. The findings included: Resident #28 was admitted on 2/23/16 with cumulative diagnoses of Parkinson ' s disease and cerebral vascular accident (CVA). A review of the wound care PA note dated 2/9/17 indicated the area to Resident #28 ' s left outer ankle was a chronic pressure ulcer with an original onset date of 2/9/15. Resident #28 ' s last revised care plan dated 2/13/17 indicated a risk for skin breakdown. Interventions included a pressure reducing mattress and floating her heels in bed. Resident #28 was also care planned on 2/20/17 for a pressure ulcer to her left malleolus (outer ankle). Interventions included supplements, medications and treatments as ordered. A review of the wound care PA note dated 2/23/17 read the area to Resident #28 ' s left outer ankle reopened 2/20/17 measuring 1.9 centimeters (cm) length x 1.5 cm width x 0.2 cm depth and was described as a stage three pressure ulcer with thick necrotic (dead) tissue. He ordered the area to be cleaned with normal saline (NS) Collagen (stimulates the development of new cells while debriding dead cells) applied along with Calcium Alginate (fights bacteria and absorbs drainage). The wound was to be covered with a foam dressing and changed every day. A review of the February 2017 treatment administration record (TAR) indicated Resident #28 received the treatment as ordered to her left outer ankle.	F 314	a. On 5/9/17 during survey, Resident #28 was assessed by Registered Nurse and a corrected wound treatment order was obtained for treatment to a left outer ankle pressure ulcer. b. On 5/11/17, Treatment Nurse was re-educated by Director of Health Services in regards to correct transcription of wound orders from QSM wound physician progress note. 2. Residents with potential to be affected a. All residents in the facility with pressure ulcers had the potential to be impacted b. On 5/25/17, the treatment nurse conducted a 100% review of treatment administration records, which was verified by the Director of Health Services, and the prevailing physician orders for care to ensure proper transcription of all orders and accuracy of the treatment administration records. The review indicated that the two affected resident and one additional resident (who expired prior to survey) had treatment orders that were not transcribed properly. For current residents, the treatment orders were clarified. 3. Systemic Change/Interventions a.Education began on 5/26/17, 5/29/17 and 5/30/17 conducted by the Clinical Competency Coordinator and the Director of Health Services for the licensed nurses on the removal of discontinued orders and	

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F 314	Continued From page 24 The wound PA note dated 3/2/17 read the area to Resident #28 ' s left outer ankle measured 2.0 cm x 1.7 cm x 0.2 cm with moderate serous drainage and thick necrotic tissue. He noted the ulcer as improved and continued the Collagen, Calcium Alginate and a foam dressing daily. The wound PA note dated 3/9/17 read the area to Resident #28 ' s left outer ankle measured 1.5 cm x 1.2 cm x 0.2 cm with moderate serous drainage and thick necrotic tissue. He noted the ulcer as improved and continued the Collagen, Calcium Alginate and a foam dressing daily. The wound PA note dated 3/16/17 read the area to Resident #28 ' s left outer ankle measured 1.5 cm x 1.1 cm x 0.1 cm with moderate serous drainage and thick necrotic tissue. He noted the ulcer as improved and continued the Collagen, Calcium Alginate and a foam dressing daily. The wound PA note dated 3/23/17 read the area to Resident #28 ' s left outer ankle measured 1.4 cm x 1.0 cm x 0.1 cm with moderate serous drainage and thick necrotic tissue. He noted the ulcer as improved and continued the Collagen, Calcium Alginate and a foam dressing daily. A review of the March 2017 treatment administration record (TAR) indicated Resident #28 received the treatment as ordered to her left outer ankle. The wound PA note dated 3/30/17 read the area to Resident #28 ' s left outer ankle measured 1.5 cm x 1.5 cm x 0.1 cm with mild serous drainage and thick necrotic tissue. He noted the ulcer as deteriorated and he changed the wound care	F 314	proper transcription of orders onto a patient chart. This education has been added for all newly hired employees into the orientation process going forward. All PRN and weekend staff was also educated and no employee worked a scheduled shift prior to this training being completed. b. In order to ensure this process does not reoccur, a Red-Line process will be implemented as of 6/5/17 in which a double check occurs daily by a 3rd shift licensed nurse to ensure orders transcribed by nurses on earlier shifts were transcribed correctly. This process ensures that a licensed nurse will verify that any change in orders is transcribed accurately by verifying the orders and noting a red mark by the transcription. c. The Director of Health Services or nurse manager will review order changes daily X 5 days and weekly X 3 weeks and monthly for 3 months to ensure proper transcription of new orders and discontinuation of old orders. d. The Director of Health Services or nurse management will review all treatment administration records monthly to ensure orders are accurate. 4. Plan to Monitor a. The Director of Health Service or nurse manager will review and trend the findings from the order review daily X 5 days, weekly X 3 weeks and monthly for 3	

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treatment. The area was to be cleaned with NS, Collagen applied and an oil emulsion gauze (keeps the wound moist and allows for drainage without adhering to the wound) followed by a dry dressing daily.

The wound PA note dated 4/6/17 read the area to Resident #28 ' s left outer ankle measured 1.3 cm x 1.5 cm x 0.1 cm with mild serous drainage and thick necrotic tissue. He noted the ulcer as improved and continued the Collagen, oil emulsion gauze then a dry dressing daily.

The wound PA note dated 4/13/17 read the area to Resident #28 ' s left outer ankle measured 1.2 cm x 1.3 cm x 0.1 cm with mild serous drainage and thick necrotic tissue. He noted the ulcer as improved and continued the Collagen, oil emulsion gauze then a dry dressing daily.

The wound PA note dated 4/20/17 read the area to Resident #28 ' s left outer ankle measured 0.8 cm x 0.7 cm x 0.1 cm with mild serous drainage and thick necrotic tissue. He noted the ulcer as improved and continued the Collagen, oil emulsion gauze then a dry dressing daily.

The wound PA note dated 4/27/17 read the area to Resident #28 ' s left outer ankle measured 0.8 cm x 0.9 cm x 0.1 cm with mild serous drainage and thick necrotic tissue. He noted the ulcer as improved and continued the Collagen, oil emulsion gauze then a dry dressing daily.

A review of the April 2017 treatment administration record (TAR) indicated Resident #28 ' s treatment orders were not updated to include the discontinuation of the Collagen and the initiation of the oil emulsion gauze daily the

months to ensure proper transcription of new orders and discontinuation of old orders. The Director of Health Services will bring results to the Monthly Quality Assurance Performance Improvement Committee meetings x 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action.

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her left outer ankle.

The wound PA note dated 5/4/17 read the area to Resident #28 ' s left outer ankle measured 0.7 cm x 0.6 cm x 0.1 cm with mild serous drainage and thick necrotic tissue. He noted the ulcer as improved and continued the Collagen, oil emulsion gauze then a dry dressing daily.

A review of the May 2017 treatment administration record (TAR) from 5/1/17 through 5/9/17 indicated Resident #28 ' s treatment orders were not updated to include the discontinuation of the Collagen and the initiation of the oil emulsion gauze daily the her left outer ankle.

In a wound care observation on 5/9/17 at 3:10 PM, the treatment nurse stated before initiating the observation, she wanted to verify the physician order since she had been on a leave for five weeks. The treatment nurse returned to the treatment cart and stated the treatment order was apparently changed on 3/30/17 discontinuing the Collagen and the initiation of the oil emulsion gauze. The treatment nurse stated the area to Resident #28 ' s left outer ankle had been treated using the incorrect physician orders since 3/30/17. The treatment nurse proceed to dressing the area to Resident #28 ' s left outer ankle using the correct physician orders using the oil emulsion gauze. There was no observed concerns with the wound care treatment to Resident #28 ' s left outer ankle.

In an interview on 5/9/17 at 4:09 PM, the Director of Nursing stated it was her expectation the correct order would have been taken off the medical record, transcribed to the TAR and that

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F 314	Continued From page 27 Resident #28 would have received the treatment as ordered. In a telephone interview on 5/10/17 at 3:37 PM, the wound care PA stated it was his expectation his orders would be followed. He stated the facility contacted him regarding the treatment error and he gave orders to use the Collagen, Calcium Alginate and the foam dressing and he would reassess the left outer ankle on 5/4/17.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 323		6/8/17

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F 323	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to monitor the function and placement of a Sigma Shield (a device used to monitor exit seeking behaviors for cognitively impaired residents) for a period of 16 days following the date of implementation for a resident (Resident #13) who was identified as a significant risk of wandering to a dangerous place for 1 of 3 residents reviewed for accidents. The findings included: Resident #13 was admitted to the facility on 4/17/17 with diagnoses that included dementia, anxiety, and depression. An Elopement Risk Observation form dated 4/17/17 indicated Resident #13 had a score of 17 which corresponded to a categorization of high risk for elopement (a score of 11 or greater was identified as high risk). A nursing note written by Nurse #4 dated 4/21/17 indicated a Sigma Shield was applied to Resident #13 ' s left ankle due to exit seeking behaviors. A physician's order dated 4/21/17 indicated a Sigma Shield was applied to Resident #13 ' s left ankle due to exit seeking behaviors. This order was obtained by Nurse #4. A nursing note dated 4/22/17 assessed Resident #13 with wandering behaviors, restless/fidgeting/anxious mood, disorganized thinking, and disorientation to place and time. An admission Minimum Data Set (MDS) assessment dated 4/24/17 indicated Resident	F 323	1. Resident affected a. Resident #13 was not adversely affected by this incident as the Sigma Shield device was functioning properly, although was not being monitored as ordered. The correct monitoring was placed on the medical record on 5/8/17 and the order was clarified on 5/9/17. b. Nurse #4 was re-educated by the Director of Health Services on 5/9/17 on proper transcription of Sigma Shield alarms to denote monitoring for intactness and function every shift to promote an environment free of hazards. 2.Residents with potential to be affected a. All cognitively impaired residents with exit seeking behaviors had the potential to be impacted b. On 5/9/17, the Director or Health Services and nurse managers conducted a 100% review of all resident records with orders for a Sigma Shield to ensure monitoring was transcribed to the MAR. There were no other negative findings. 3. Systemic Change/Interventions a. Education began on 5/9/17 conducted by the Clinical Competency Coordinator and the Director of Health Services for the licensed nurses on the proper transcription of orders onto a patient	

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F 323	Continued From page 29 #13 ' s cognition was significantly impaired. She had physical behaviors and verbal behaviors on 1 to 3 days during the 7 day MDS look back period. These behaviors were indicated to put Resident #13 and others at significant risk for physical injury and also significantly interfered with her care. Resident #13 rejected care and had wandering behaviors on 1 to 3 days during the 7 day MDS review period. The wandering behaviors were noted to place Resident #13 at significant risk of getting to a dangerous place and also significantly intruded on the privacy of others. Resident #13 required limited assistance with bed mobility, walking in room, walking in corridor, and locomotion off unit. She required extensive assistance with transfers and locomotion on unit. Resident #13 was not steady on her feet and was only able to stabilize with staff assistance. She utilized a walker and wheelchair. She had one fall without injury since her admission. Resident #13 had received antidepressant medication on 7 of 7 days during the MDS look back period. The Care Area Assessment (CAA) for behavioral symptoms for the 4/24/17 MDS indicated Resident #13 had behaviors and a Sigma Shield was in place. A nursing note dated 4/27/17 assessed Resident #13 with wandering behaviors, at risk for physical injury, abnormal sleep patterns, restless/fidgeting/anxious mood, disorganized thinking, and disorientation to place and time. A review of the April 2017 Medication Administration Record (MAR) had no documentation to indicate Resident #13 ' s Sigma Shield had been monitored for function and	F 323	chart. This education has been added for all newly hired employees into the orientation process going forward. This training was provided to all PRN and weekend staff and no employee was allowed to work a scheduled shift until the training was complete. b. A Red-Line process was implemented as of 6/5/17 in which a double check occurs daily by a 3rd shift licensed nurse to ensure orders transcribed by nurses on earlier shifts were transcribed correctly. This process ensures that a licensed nurse will verify that any change in orders is transcribed accurately by verifying the orders and noting a red mark by the transcription. c. The Director of Health Services or nurse manager will review order changes daily X 5 days and weekly X 3 weeks and monthly for 3 months ensure proper transcription of new orders and discontinuation of old orders. d. The Director of Health Services or nurse management will review all medication administration records monthly to ensure orders are accurate. 4. Plan to Monitor a. The Director of Health Service or nurse manager will review and trend the findings from the order review daily X 5 days, weekly X 3 weeks and monthly for 3 months ensure proper transcription of new orders and discontinuation of old orders.	

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F 323	Continued From page 30 placement after its implementation on 4/21/17 through 4/30/17 (a nine day period following the implementation of the Sigma Shield). The plan of care initiated on 5/1/17 included, in part, the problem/need area of wandering for Resident #13. The interventions included a monitoring device on Resident #13 that sounded an alarm if she left the building. A review of the May 2017 MAR indicated on 5/8/17 monitoring the Sigma Shield ' s placement three times daily for Resident #13 was added to the MAR and was completed by nursing staff as indicated. Additionally, on 5/8/17 monitoring the Sigma Shield's function once daily for Resident #13 was added to the MAR and was completed by nursing staff as indicated. There was no documentation of monitoring the Sigma Shield's placement three times daily and function once daily for Resident #13 on 5/1/17 through 5/7/17 (a seven day period.) A physician's order dated 5/9/17 for Resident #13 indicated a clarification to check Sigma Shield every shift for intactness and function. An interview was conducted with Nurse #5 on 5/10/17 at 11:00 AM. She indicated the facility utilized Sigma Shields to monitor residents who had exit seeking behaviors and were at risk for elopement. She stated when a Sigma Shield was ordered by the physician the nurse who obtained the order then added monitoring for function and placement to the resident's MAR. She indicated placement of the Sigma Shield was monitored three times daily and function of the Sigma Shield was monitored once daily to ensure it was on the resident and that it was working properly.	F 323	The Director of Health Services will bring results to the Monthly Quality Assurance Performance Improvement Committee meetings x 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action.	

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The interview with Nurse #5 continued on 5/10/17 at 11:05 AM. She stated she was familiar with Resident #13. She reported Resident #13 had wandering behaviors. The physician's order dated 4/21/17 that indicated the implementation of a Sigma Shield for Resident #13 was reviewed with Nurse #5. The April 2017 and May 2017 MARs that indicated no monitoring for placement three times daily or function once daily was completed for a period of 16 days following the implementation of Resident #13's Sigma Shield was reviewed with Nurse #5. She reported she worked on the first shift (7:00 AM to 3:00 PM) on 5/8/17 and identified that monitoring for placement three times daily and function once daily of Resident #13's Sigma Shield had not been added to the MAR. Nurse #5 stated she verified with the facility's Clinical Coordinator that Resident #13 was supposed to have a Sigma Shield and she then added the monitoring for placement three times daily and function once daily to Resident #13's MAR. Nurse #5 revealed that prior to 5/8/17 there was no monitoring for function or placement of Resident #13's Sigma Shield since its implementation on 4/21/17.

An interview was conducted with the Assistant Director of Nursing (ADON) on 5/10/17 at 11:10 AM. She indicated when a Sigma Shield was ordered by the physician the nurse who obtained the order then added monitoring for function and placement to the resident's MAR. The physician's order dated 4/21/17 that indicated the implementation of a Sigma Shield for Resident #13 was reviewed with the ADON. The April 2017 and May 2017 MARs that indicated no monitoring for placement three times daily or function once daily was completed for a period of 16 days

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following the implementation of Resident #13's Sigma Shield was reviewed with the ADON. The ADON revealed Nurse #4 obtained the order for the Sigma Shield on 4/21/17 and had failed to add monitoring for function and placement to Resident #13's MAR. She additionally revealed that prior to 5/8/17 there was no monitoring for function or placement of Resident #13's Sigma Shield since its implementation on 4/21/17. The ADON indicated her expectation was for monitoring for function and placement of the Sigma Shield to be added to the MAR on the day of its implementation to ensure it was on the resident and that it was working properly.

An interview was conducted with the Director of Nursing (DON) on 5/10/17 at 3:20 PM. She verified that the normal procedure for Sigma Shield orders was for the nurse who obtained the order to add monitoring for function and placement to the resident's MAR. The physician's order dated 4/21/17 that indicated the implementation of a Sigma Shield for Resident #13 was reviewed with the DON. The April 2017 and May 2017 MARs that indicated no monitoring for placement three times daily or function once daily was completed for a period of 16 days following the implementation of Resident #13's Sigma Shield was reviewed with the DON. She revealed the nurses were the only staff who monitored for function and placement of the Sigma Shield and if it was not added to the MAR then it had not been monitored. The DON indicated her expectation was for monitoring for function and placement of the Sigma Shield to be added to the MAR on the day of its implementation to ensure it was on the resident and that it was working properly.

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F 323	Continued From page 33 An interview was conducted with Nurse #4 on 5/10/17 at 3:37 PM. She indicated the facility utilized Sigma Shields to monitor residents who had exit seeking behaviors and were at risk for elopement. She verified the normal procedure for Sigma Shield orders was for the nurse who obtained the order to add monitoring for function and placement to the resident's MAR. She indicated placement of the Sigma Shield was monitored each shift and function of the Sigma Shield was monitored once daily to ensure it was on the resident and that it was working properly. The interview with Nurse #4 continued on 5/10/17 at 3:40 PM. She stated she was familiar with Resident #13. She reported Resident #13 had wandering behaviors. The physician's order dated 4/21/17 that indicated the implementation of a Sigma Shield for Resident #13 was reviewed with Nurse #4. She confirmed she had obtained this physician's order on 4/21/17. The April 2017 and May 2017 MARs that indicated no monitoring for placement three times daily or function once daily was completed for a period of 16 days following the implementation of Resident #13's Sigma Shield was reviewed with Nurse #4. She revealed she made an error by not adding monitoring for function and placement of the Sigma Shield to Resident #13's MAR on 4/21/17 when she obtained the order. Nurse #4 additionally revealed that prior to 5/8/17 there was no monitoring for function or placement of Resident #13's Sigma Shield since its implementation on 4/21/17.	F 323		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or	F 371		6/8/17

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F 371	Continued From page 34 considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to label and date opened items in one of one refrigerators located in the kitchen (the reach in refrigerator). The findings included: Facility policy titled "Labeling, Dating and Storage" revised 6/14/16 stated, in part, "1. Food and/or beverage items will be properly labeled with the name of the item, an open date and a discard date." On 5/8/17 at 9:00 AM, an initial tour of the kitchen was conducted with the Dietary Manager. An	F 371	1. Resident affected a. No residents were negatively impacted by this concern 2. Residents with potential to be affected a. Any resident who received thickened liquids or supplemental shakes had the ability to be impacted by this concern b. On 5/8/17, the Certified Dietary Manager conducted a full audit of the contents of the reach in refrigerator. All	

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F 371	Continued From page 35 observation of the reach-in refrigerator in the kitchen revealed the following: 8 strawberry shakes thawed and undated, 1 container of thickened cranberry juice opened and undated, one container of thickened orange juice opened and undated, one container of thickened milk opened and undated and 1 container of thickened lemon flavored water opened and undated. On 5/8/17 at 9:00 AM, an interview was conducted with the Dietary Manager. She stated the dietary aide should have labeled and dated all the items when they were opened.	F 371	items that were thawed and/or opened and undated were immediately discarded. There were no other negative findings. 3. Systemic Change/Interventions a. Education began on 5/8/17 and 5/11/17 conducted by the Certified Dietary Manager for all dietary staff on the company□s policy for labeling and dating of thawed and/or opened food items. b. Additional training was added to the orientation of new dietary staff to ensure their knowledge of this policy ongoing. c. The Certified Dietary Manager will audit the contents of the reach in refrigerator daily X 5 days, weekly for 3 weeks, and monthly for 3 months (to include both weekend and weekday monitoring). Should the Dietary Manager not be available, a dietary aide will complete the audit. 4. Plan to Monitor a. The Certified Dietary Manager will audit the contents of the reach in refrigerator daily X 5 days, weekly for 3 weeks, and monthly for 3 months. The Certified Dietary Manager will bring results to the Monthly Quality Assurance Performance Improvement Committee meetings x 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate	

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F 371	Continued From page 36	F 371	corrective action.	
F 456 SS=D	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure proper function of a prescribed pressure reducing mattress (PRM) on 1 (Resident #8) of 4 halls reviewed resident equipment. The facility also failed to maintain the kitchen freezer in good working order as evidenced by a buildup of ice on the lower door frame of the freezer and on the lower part of the freezer door causing water to be present on the cooler floor. The findings included: 1. Resident #8 was admitted 9/8/14 with cumulative diagnoses of diabetes and peripheral vascular disease (PVD). The annual Minimum data Set dated 2/8/17 indicated Resident #8 was cognitively intact and required extensive assistance with her activities of daily living (ADLs). She was coded for two vascular ulcers and coded for a pressure reducing mattress (PRM) to the bed. Resident #8 was care planned on 2/8/17 for a risk of pressure ulcer related to her immobility and	F 456	1. Resident affected a. No residents were adversely impacted by this concern. 2. Residents with potential to be affected a. All residents in the facility on a pressure relieving mattress had the potential to be affected with the concern related to mattresses. b. No resident had the ability to be impacted by the concern related to ice build-up outside of the freezer doors as the freezers and coolers are located in an area to which no resident has access. c. On 5/9/17-5/10/17 a 100% audit was completed by the Maintenance Director and Treatment Nurse of all pressure relieving mattress for function and safety. No other concerns were identified.	6/8/17

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F 456	Continued From page 37 incontinence. The intervention included a PRM to the bed. In an observation on 5/8/17 at 10:32 AM, outside in the hallway near Resident #8 ' s room there was an audible hissing noise coming from her room. On entry to Resident 38 ' s room, a PRM was observed to the bed with a clear tubing attached the mattress pump. The PRM appeared to be leaking air from an area on the clear tubing because the hose had been taped with yellow tape to prevent air loss. The mattress was determined to be inflated and functioning but Resident #8 stated the hissing sound was annoying. Resident #8 stated PRM was placed on her bed several months ago. She did not recall who placed the mattress on her bed and stated she did not observed a staff member attempting to stop the leaking by using yellow tape. In an interview and observation on 5/9/17at 5:05 PM, the Maintenance Supervisor was asked to stand in the hallway outside of Resident #8 ' s room. He stated he heard a "hissing" sound coming from her room. On entering Resident #8 ' s room, the Maintenance Supervisor noted the PRM leaking from where the tubing was taped. He stated someone taped the leak using floor tape in an attempt to stop an air leak. He stated the floor tape was kept in his office but on occasion, the housekeeping floor technician staff used the tape to tape areas staff and visitor were not to walk on. The Maintenance Supervisor stated he was not aware of issue concerning Resident #8 ' s PRM and any attempt to repair the mattress. He stated he would have expected the nurse, aides or the treatment nurse to have reported the leaning mattress so another	F 456	d. On 5/10/17, after interview with the Administrator, the Administrator notified the Maintenance Director who immediately removed ice from lower outside portion of the door of the walk in freezer. The Maintenance Director removed the ice build-up with warm water and a towel when it was identified. 3. Systemic Change/Interventions a. Education began on 5/26/17, 5/29/17 and 5/30/17 conducted by the Clinical Competency Coordinator and Director of Health Services for all staff related to their responsibility to report defective equipment immediately to include furniture, pressure relieving mattresses and kitchen equipment to make appropriate housekeeping and maintenance repair requests. b. Additional training was added to the orientation of staff to ensure their knowledge of this policy ongoing. All weekend and PRN staff were re-educated. No employee will work a scheduled shift without completion of this education. c. The Certified Dietary Manager will educate all dietary staff who is responsible for checking food temperatures daily to verify that no ice build-up has occurred on the freezer door by 6/7/17. Should ice build-up be present, the dietary staff member who identifies this will remove the build-up with warm water and a towel at that time.	

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mattress could be placed on Resident #8 ' s bed. The Maintenance Supervisor took a photo of the attempted at repair of the tubing and stated he would see that another mattress was ordered today.
In an observation on 5/9/17 at 6:00 PM, a new PRM was placed on Resident #8 ' s bed.

In an interview on 5/10/17 at 8:30 AM, Nurse #3 stated she had not noticed the PRM leaking or seen the tape on the tubing.

In an interview on 5/10/17 at 8:55 AM, Nursing assistant (NA) #5 and NA #5 stated they had not noticed the PRM leaking or observed the yellow tape on the tubing until 5/8/17. The stated had they noticed it, they would have reported it to the Maintenance Supervisor.

In an interview on 5/11/17 at 8:43 AM, the treatment nurse stated several month ago, Resident #8 had a sacral pressure ulcer. That was when the PRM was ordered and placed on her bed. The treatment nurse stated the Environmental Supervisor retrieved the mattress from the storage building. The treatment nurse stated the PRM that was on Resident #8 ' s bed had a fabric waterproof sleeve that extended over the length of the tubing for appearance and comfort. She stated the sleeve had been pushed back on 5/8/17 revealing the tubing leak along with the attempted repair with the floor tape. The treatment nurse stated that was why nobody noticed it
Until the surveyor pointed it out. She recalled the defective mattress had been removed and someone placed it in the storage shed until the mattress provided came to pick it up. The treatment nurse stated when the defective

d. On 5/19/17, the Director of Health Services and Nursing Management added additional documentation to the MAR for licensed nurses to check the function and safety of pressure relieving mattresses each shift. This was also entered into Smart Charting for the CNAs.

e. To further ensure ongoing compliance, an audit was placed in Building Engines on 5/29/17 for the Maintenance Director to complete a weekly inspection of pressure relieving mattresses, coolers and freezers for safety and function. Should the Maintenance Director not be available, this audit will be completed by the Housekeeping Supervisor.

4. Plan to Monitor

a. The Director of Maintenance will bring results of the audits to the Monthly Quality Assurance Performance Improvement Committee meetings x 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action.

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mattress was removed from the facility, there was no tape covering the tubing where the air leak was noted. The treatment nurse stated the Environmental Supervisor was the person who retrieved the defective mattress from the storage shed and placed it on Resident #8 ' s bed.

In an interview on 5/11/17 at 9:37 AM, the Environmental Supervisor stated the defective mattress was a rental and they wanted it returned to the providing company. She recalled placing the mattress in the storage shed but did not recall placing the defective mattress on Resident #8 ' s bed nor did she recall wrapping the leaking tubing with floor tape. She stated she completed compliance rounds daily and the 400 hall was her hall to check. The Environmental Supervisor stated she heard something making a "strange" sound coming from Resident #8 ' s room but she thought it was the mattress pump. She confirmed only she and the Maintenance Supervisor had keys to access the storage shed.

In an interview on 5/11/17 at 9:43 AM, the Administrator stated it was her expectation that the mattress would have been replaced once it was identified as having a leak and since it was defective, it was her expectation that it would not be used for a resident to begin with.

2. On 5/10/17 at 9:45 AM, a tour of the walk in cooler and freezer was conducted with the Dietary Manager. An observation of the walk in cooler and freezer revealed a buildup of ice on the freezer door frame (approximately 6 inches from the base of the door on each side) and a buildup of ice on the bottom of the door frame

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F 456	Continued From page 40 from the hinge to halfway on the door at the base of the door. Water was noted on the floor of the walk in cooler and outside of the freezer door. When coming out of the freezer to the walk in cooler area, the floor was observed to be wet and slippery. On 5/10/17 at 10:00 AM, an interview was conducted with the Maintenance Director who stated the ice buildup was a chronic problem due to the fact that there were heat coils around the top and side of the door but they could not install a heat coil at the bottom of the door. He said he scrapes the ice from the door on a regular basis but he had been out of the facility for two weeks and probably no one had cleaned the ice from the door during the time he was out of the facility. On 5/10/17 at 12:55 PM, an interview was conducted with the Administrator who stated she knew the freezer would frost up at the bottom of the door but was not aware that there was a buildup of water on the bottom of the door or water getting on the floor. She said she would have to see if a heating coil could be put on the bottom of the door or if the door would have to be replaced and she was going to check with corporate immediately. On 5/10/17 at 2:15 PM, an observation of the freezer door was conducted with the Administrator and there was buildup of ice on the lower frame of the freezer. The buildup of ice had been removed from the lower outside of the door.	F 456		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		6/8/17

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F 514	Continued From page 41 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to write a physician order for change in treatment of a right and left ischium pressure ulcer and to write the	F 514	1. Resident affected a. Residents #57, 59 and 72 had an inaccurate medical record due to this	

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F 514	Continued From page 42 order for the treatment of the sacral pressure ulcer for 6 months (Resident #59), failed to have accurate physician orders for code status (Resident #57) and failed to have accurate medication administration records for antipsychotic medication (Resident #72) for three of 19 sampled residents. The findings included: 1. Resident #59 was admitted to the facility on 7/13/12. Cumulative diagnoses included: pressure ulcer of the sacral region, pressure ulcer of right buttock and pressure ulcer of left buttocks. A wound physician note dated 11/17/16 stated Resident #59 was seen for multiple wounds. Plan to continue silver alginate (antimicrobial wound dressing) dressing to sacrum and add collagen (protein) every three days and as needed. Will also change left ischial dressing to Santyl (debriding medication) and mupirocin 2% (antibiotic ointment) and calcium alginate (absorbent microbial wound dressing) daily and as needed. Right ischial wound had improved in size. Plan to continue current treatment. A review of the Treatment Administration Record for November 2016 revealed the following treatments dated 11/17/16: sacrum-cleanse with silver alginate. Apply silver alginate, collagen and adhesive dressing. Change every 3 days and as needed. Left and right ischium-cleanse with normal saline. Apply santyl, mupirocin and calcium alginate. Change daily and as needed. A review of the December 2016, January 2017 and February 2017 physician orders revealed a treatment order for the right and left ischium: Cleanse right and left gluteal (ischium) with	F 514	concern but suffered no adverse event related to this finding. b. On 5/11/17, Nurse #5 and #6 received education from the Director of Health Services in regards to correct transcription, documentation of administering medications in the medical record and MAR/POF. Specific education was provided on accurately documenting the rationale for any circled medications. c. On 5/10/17, the order related to treatment of resident #59s treatment for a sacral pressure ulcer was clarified by the Treatment Nurse. The Treatment nurse was educated on 5/11/17 for accurate transcription of wound care orders from QSM wound physician by the Director of Health Services. d. On 5/9/17, the code status of Resident #57 was clarified and accurately transcribed by a licensed nurse during survey. e. On 5/11/17, the licensed nurse identified to have made the transcription error for code status was re-educated by the Director of Health Services on proper transcription of code status onto the MAR. 2.Residents with potential to be affected a. All residents in the facility had the ability to ability to be impacted by this practice b.. On 5/25/17 a 100% audit was completed by the Treatment Nurse for all	

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normal saline. Apply santyl, 2 x 2 gauze and foam dressing once daily. Cleanse right and left gluteal with normal saline. Apply santyl, 2 x 2 gauze and foam dressing once daily as needed. There was no order for the sacral pressure ulcer and no order for the change in treatment for the right and left ischium.

A review of the care plan revealed the following: 2/23/17-- trauma to right buttocks. Approaches included, in part, to provide treatment per order. Encourage / assist with turning and repositioning during care rounds and as resident allowed. Ensure proper placement of lift sling when transferring resident to wheelchair. Promptly provide incontinent care.

A review of the March 2017 physician orders revealed a treatment order for the right and left ischium: Cleanse right and left gluteal (ischium) with normal saline. Apply santyl, 2 x 2 gauze and foam dressing once daily. Cleanse right and left gluteal with normal saline. Apply santyl, 2 x 2 gauze and foam dressing once daily as needed. There was no order for the sacral pressure ulcer and no order for the change in treatment for the right and left ischium.

A wound physician note dated 3/30/17 stated Resident #59 was seen for multiple wounds. Continue silver alginate. Right ischial wound is improved in size with increased size noted to the left ischial wound. Continue current treatment to right ischium and plan to dress left ischium with mupirocin 2% and calcium alginate. Bilateral buttock wounds have reopened and present with dermal tissue in both wound beds. Plan to continue hydrocolloid dressing every 3 days and as needed. Follow up on all wounds in one week.

treatment administration records to ensure accuracy of transcription of orders. This audit was verified by the DHS. All orders in error were clarified by the Treatment Nurse. No resident suffered an adverse effect.

c. On 5/29/17, a 100% audit was completed on all residents to ensure proper code status was recorded in the medication administration record by the Director of Health Services and nursing management. 22 residents received clarification orders for code status transcription errors.

3. Systemic Change/Interventions

a. Education began on 5/26/17, 5/29/17 and 5/30/17 conducted by the Clinical Competency Coordinator and the Director of Health Services for the licensed nurses on the proper transcription of orders and medications onto a patient chart. This education has been added for all newly hired employees into the orientation process going forward

b. In order to ensure this process does not reoccur, a Red-Line process will be implemented as of 6/5/17 in which a double check occurs daily by a licensed nurse to ensure orders transcribed by nurses on earlier shifts were transcribed correctly. This process ensures that a licensed nurse will verify that any change in orders is transcribed accurately by verifying the orders and noting a red mark

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F 514	Continued From page 44 A review of the April 2017 physician orders revealed a treatment order for the right and left ischium: Cleanse right and left gluteal (ischium) with normal saline. Apply santyl, 2 x 2 gauze and foam dressing once daily. Cleanse right and left gluteal with normal saline. Apply santyl, 2 x 2 gauze and foam dressing once daily as needed. There was no order for the sacral pressure ulcer and no order for the change in treatment for the right and left ischium. A review of the April 2017 Treatment Administration Record revealed the following treatments: left ischium-cleanse with normal saline, apply mupirocin, calcium alginate and dry dressing. Change daily. Right ischium-cleanse with normal saline, apply mupirocin 2%, collagen, dry dressing. Change daily and as needed. Sacrum-cleanse with normal saline. Apply silver alginate and adhesive dressing. Change daily and as needed. A review of the May 2017 physician orders revealed a treatment order for the right and left ischium: Cleanse right and left gluteal (ischium) with normal saline. Apply santyl, 2 x 2 gauze and foam dressing once daily. Cleanse right and left gluteal with normal saline. Apply santyl, 2 x 2 gauze and foam dressing once daily as needed. There was no order for the sacral pressure ulcer and no order for the change in treatment for the right and left ischium. A review of the May 2017 Treatment Administration Record revealed the following treatments: left ischium-cleanse with normal saline, apply mupirocin, calcium alginate and dry dressing. Change daily. Right ischium-cleanse	F 514	by the transcription. c. The Director of Health Services or nurse manager will review order changes daily X 5 days and weekly X 3 weeks and monthly for 3 months ensure proper transcription of new orders and discontinuation of old orders. d. The Director of Health Services or nurse management will review all medication administration records monthly to ensure orders are accurate. 4.Plan to Monitor a.The Director of Health Service or nurse manager will review and trend the findings from the order review daily X 5 days, weekly X 3 weeks and monthly for 3 months ensure proper transcription of new orders and discontinuation of old orders. The Director of Health Services will bring results to the Monthly Quality Assurance Performance Improvement Committee meetings x 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action.	

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with normal saline, apply mupirocin 2%, collagen, dry dressing. Change daily and as needed. Sacrum-cleanse with normal saline. Apply silver alginate and adhesive dressing. Change daily and as needed.

A wound physician note dated 5/4/17 stated sacral and bilateral ischial wounds were all improved in size compared to last assessment. No signs of deterioration noted to all wounds with continued minimal SP drainage noted to sacral wound. Intact periwound skin and granulation tissue noted in the wound bed. Plan to continue current treatment to all wounds and follow up in one week.

On 5/10/17 at 9:50 AM, wound care for Resident #59 was observed with the Wound Care nurse. Resident #59 had pressure ulcers present on the right and left ischium and the sacrum. All three pressure ulcer areas were cleansed with normal saline. The Wound Care nurse applied mupirocin 2% ointment, collagen and a dry dressing to the right ischium. She applied calcium alginate, mupirocin 2% ointment and foam dressing to the left ischium and silver alginate and a foam dressing to the sacrum.

On 5/10/17 at 11:02 AM, an interview was conducted with the Wound Care nurse. She reviewed Resident #59 ' s medical record and stated she was not aware the wound care orders had not been transcribed to the physician order sheet. She stated she was out on leave at the time the wound care orders were changed. The Wound Care nurse said she should have checked the physician orders for the wound care orders.

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On 5/10/17 at 12:16 PM, an interview was conducted with the Director of Nursing who stated her expectation was for the nurse to write the treatments orders on the physician order sheet as per the wound physician at the time the orders were given and follow his orders for wound care.

On 5/10/17 at 3:45 PM, an interview was conducted with the Wound Care physician assistant who stated the process was to communicate his orders verbally to the nurse and he expected the nurses to write the orders at that time.

On 5/11/2017 at 8:46 AM, the Wound Care nurse was re-interviewed and she stated the wound care orders were changed on 11/16/16 and there was not a physician order written for the changes in treatment. She did not know why the wound care orders had not been transcribed to the physician orders.

2. Resident #57 was admitted to the facility on 6/18/16.

A review of Resident #57 ' s care plan dated 7/26/16 revealed an advance directive of "do not resuscitate" (DNR). There were related goals and interventions present to address the resident ' s code status.

A review of a Hospice intake revealed Resident #57 was admitted to Hospice on 2/26/17 and the code status was "DNR."

A review of the code status record for Resident #57 revealed a "DNR" form dated 2/28/17 and signed by the physician.

A review of the quarterly minimum data set dated 4/10/17 revealed Resident #57 had significant impaired cognition. The resident ' s diagnoses were non-Alzheimer ' s dementia.

A review of the monthly physician ' s orders for

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the month of May 2017 revealed the code status was "full code."
A review of the May 2017 physician ' s monthly orders for Resident #57 revealed the orders were reviewed and signed by nursing staff. The code status on the order reflected "full code." The monthly summary of orders for May 2017 was the only month of physician orders that had the "full code" error.
On 5/10/17 at 3:28 pm an interview was conducted with the Director of Nursing (DON). The DON stated that the nurse who reviewed the monthly physician ' s order was expected to review the orders for accuracy before signing. The DON expected the nurses to sign the orders when accurate and make corrections as necessary.
On 5/10/17 at 4:09 pm an interview was conducted with Nurse #1. Nurse #1 stated the May 2017 physician orders were signed by nursing as being accurate, which included the code status of full code. Nurse #1 reviewed the record and stated she agreed that the May 2017 physician orders should have been "do not resuscitate" and proceeded to correct the physician order and medication administration record.

3. Resident #72 was initially admitted to the facility on 6/30/12 and most recently readmitted on 4/3/17 with diagnoses that included schizophrenia.

Resident #72's April 2017 physician's orders included Risperdal (antipsychotic medication) 0.5 milligrams (mg) once daily at bedtime.

The 5 day Minimum Data Set (MDS) assessment

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dated 4/10/17 indicated Resident #72's cognition was intact. He was indicated to have received antipsychotic medication on 4 of 7 days during the MDS look back period.

A review of Resident #72's April Medication Administration Record (MAR) showed no documentation that Risperdal was administered on 4/4/17, 4/7/17, 4/9/17, 4/14/17, 4/16/17, and 4/21/17.

An interview was conducted with the Assistant Director of Nursing (ADON) on 5/11/17 at 11:48 AM. The April 2017 MAR for Resident #72 that showed no documentation that Risperdal was administered on 6 days (4/4/17, 4/7/17, 4/9/17, 4/14/17, 4/16/17, and 4/21/17) was reviewed with the ADON. She reported if a medication was not administered, the reason was supposed to be documented on the back of the MAR. She stated there was no documentation on Resident #72's April MAR to indicate why the Risperdal was not documented as administered on 6 days. The ADON indicated Nurse #5 worked with Resident #72 on the evenings of 4/7/17, 4/9/17, 4/16/17, and 4/21/17. She additionally indicated Nurse #6 worked with Resident #72 on the evening of 4/14/17.

A phone interview was conducted on 5/11/17 at 12:00 PM with Nurse #5. She stated she worked with Resident #72 on the evenings of 4/7/17, 4/9/17, 4/16/17 and 4/21/17. The documentation from the April 2017 MAR for Resident #72 that showed no indication Risperdal was administered on 4/7/17, 4/9/17, 4/16/17, and 4/21/17 was reviewed with Nurse #5 by phone. She revealed she forgot to document the administrations of the Risperdal on the MAR.

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F 514	Continued From page 49 She stated this was an error and she had administered Risperdal to Resident #72 on all 4 dates in question. Nurse #5 indicated the MAR was inaccurate because of the error. A phone interview was conducted on 5/11/17 at 12:20 PM with Nurse #6. She stated she worked with Resident #72 on the evening of 4/14/17. The documentation from the April 2017 MAR for Resident #72 that showed no indication Risperdal was administered on 4/14/17 was reviewed with Nurse #6 by phone. She revealed she forgot to document the administration of the Risperdal on the MAR. She stated this was an error and she had administered the Risperdal to Resident #72 on the date in question. Nurse #6 indicated the MAR was inaccurate because of the error. An interview was conducted on 5/11/17 at 12:26 PM with the Director of Nursing (DON). She indicated she expected medications that were administered to be documented on the MAR accurately and completely.	F 514		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 520		6/8/17

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F 520	Continued From page 50 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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 interviews, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 6/16/16 recertification survey. The recited deficiency was in the area of assessment accuracy (F278). This deficiency was cited again on the current recertification survey of 5/11/17. The continued	F 520	1.Resident affected a.No resident was negatively impacted by this concern. 2.Residents with potential to be affected a.All residents in the facility have the ability to be impacted by this practice.	

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F 520	Continued From page 51 failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F278 - Assessment Accuracy: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of cognition (Resident #69), restraints (Residents #112 and #56), diagnosis (Resident #91), and antipsychotic medication (Resident #91) for 4 of 19 sampled residents. During the recertification survey of 6/16/16, the facility was cited F278 for failing to accurately code the MDS assessment in the areas of Preadmission Screening and Resident Review and behavioral and wandering symptoms. On the current recertification survey of 5/11/17 the facility failed to code the MDS accurately in the areas of cognition, restraints, diagnosis, and antipsychotic medication. An interview was conducted with the Administrator on 5/11/17 at 11:00 AM. The Administrator stated she was the head of the facility ' s Quality Assurance Committee. The Administrator indicated the committee consisted of the Administrator, Director of Nursing (DON), Medical Director, Minimum Data Set (MDS) Coordinator, Admissions Director, Social Worker, and Pharmacist. She stated the committee met monthly with the exception of the pharmacist who attended quarterly. The Administrator indicated she was aware assessment accuracy was a	F 520	There were no adverse outcomes related to this concern. b.On 6/5/17, the Administrator was re-educated by the Area Vice President of Operations on the quality assurance process. 3.Systemic Change/Interventions a. The Administrator will provide re-education to all members of the Quality Assurance and Performance Improvement (QAPI) Committee, which is comprised of the Director of Health Services, Assistant Director of Health Services, Clinical Competency Coordinator, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Financial Counselor, Payroll and Personnel Coordinator, Social Services Director, Admissions Director and Medical Records Coordinator on 6/6/17. All employees that are on the QAPI committee are full time. There are no PRN or weekend staff on this committee. b. The Area Vice President of Operations will designate a member of the Regional Leadership team to participate in the Quality Assurance/Performance Improvement meetings for the facility monthly X 12 months. c. The Regional Leadership team will review performance improvement plans for the facility monthly X 12 months to ensure effectiveness. Any negative	

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F 520	Continued From page 52 repeat citation from the 6/16/16 recertification survey. She stated the previous plan of correction included audits of 30% of the MDS assessments for a period of about 3 months. The Administrator stated that in April 2017 inaccuracy of the MDS was again identified and an audit was initiated and education provided. The Administrator stated the reason there was continued inaccuracy of the MDS were the Medicare coding changes and the MDS Coordinator was auditing inaccurately. Also, there is currently more critique of the MDS going forward. The Administrator stated that the admission MDSs were being audited, not the existing MDS.	F 520	findings will be reviewed at the Regional Leadership team at the quarterly Quality Assurance/Performance Improvement meeting for opportunities for re-education or correction. 4. Plan to Monitor a. The Administrator will bring results of all open PI Plans to the Monthly Quality Assurance Performance Improvement Committee meetings x 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action b. The Regional Leadership team will review performance improvement plans for the facility monthly X 12 months to ensure effectiveness. Any negative findings will be reviewed at the Regional Leadership team at the quarterly Quality Assurance/Performance Improvement meeting for opportunities for re-education or correction.	