STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345284	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey with complaints was conducted from 5/21/17 through 5/25/17. Immediate Jeopardy was identified at: CFR 483.25 at tag F309 at a scope and severity (J) CFR 483.25 at tag F323 at a scope and severity (J) CFR 483.75 at tags F490 at a scope and severity (J) The tags F309 and F323 constituted Substandard Quality of Care. Immediate Jeopardy began on 9/30/16 and was removed on 5/25/17. An extended survey was conducted.	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to promote resident dignity by placing a wander-guard ankle bracelet on one of one alert and oriented residents (Resident #35). The findings included: Resident #35 was admitted to the facility on 12/28/16 with diagnoses of diabetes, fracture of	F 241	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged	6/19/17

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

Electronically Signed | 06/16/2017

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F 241	Continued From page 1 the pelvis, and depression. Review of the most recent Minimum Data Set (MDS), a quarterly, dated 3/29/17 indicated Resident #35 had long and short term memory intact, had no behaviors exhibited, which included wandering, verbal and physical aggressive behaviors. The MDS indicated Resident #35 was not ambulatory, required supervision with bed mobility, transfers and locomotion on the unit and limited assistance for locomotion off the unit. Resident #35 used a wheelchair for mobility and had no physical limitations of her extremities. Review of the care plan dated 12/29/16 included a problem of depression with use of an antidepressant.. Behaviors of elopement were not included on the current care plan. A physician's progress note dated 5/19/17 indicated Resident #35 had a severe episode of recurrent major depressive disorder, without psychotic features. Current treatment for depression was with a medication Cymbalta. The resident was in agreement to see the psychiatrist or psychologist. The physician included she had no active wish to die and is requesting help. Resident #35 admitted to lifelong psychiatric illness. The physician indicated Resident #35 had problems sleeping, likely due related to severe depression with possible bipolar. Record review of a nurse's note on 5/21/17 revealed Resident #35 had become angry and attempted to hit the nurse. There was no information in the medical record of exit seeking behaviors. Observations were made on 5/22/17, at 9:30 AM,	F 241	deficiencies cited have been or will be corrected by the date or dates indicated. F241 DIGNITY AND RESPECT OF INDIVIDUALITY. Corrective Action: Resident #35. Risk assessment completed on 5/26/2017. Resident scored high for wandering. Resident is alert and oriented X 3. Resident scored a 15 on the most recent BIMs. Resident is their own responsible party. Resident is able to make her own needs known. MD notified. Care plan updated and wander guard care plan resolved. Wander guard removed. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On 5/26/2017 to 6/14/2017 the Director of nursing, MDS nurse coordinators, Unit manager completed risk assessments on all current resident. A wander guard risk review was completed by the Director of Nursing, MDS nurse coordinators, Unit manager, Administrator, Social worker on 6/16/2017 during the weekly Quality of life meeting. No other alert and oriented residents were noted to have a wander guard's bracelet placed. Systemic Changes: Director of Nursing and /or Designee In serviced all staff (full time, part time, and PRN) to inform them that, the facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement	

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F 241	Continued From page 2 5/23/17 at 11:00 and 5/24/17 at 4:00 PM and revealed Resident #35 did not leave her room, slept late in the morning and ate her breakfast close to 11:00 AM. No behaviors were observed during the observations and no attempts to leave Interview with Nurse #5 on 5/23/17 at 10:13 AM revealed the resident had a wander-guard on her ankle due to exit seeking behavior. The resident would go to the doors and say she was going home. The nurse was asked if those behaviors would be documented and she explained it would be in the nurse's notes. An interview with the social worker was conducted on 05/23/17 at 12:33 PM During the interview the social worker explained he did not know Resident #35 had a wander-guard on her ankle. Interview revealed he was familiar with the resident, she was able to make her own decisions, did not try to leave and was not physical with anyone. Further interview revealed Resident #35 would become angry at times if there was something she didn't want to do. He gave an example that she had refused to wear clothes, and wore a hospital gown. But that was her choice. He was asked again if she was incompetent, unable to make safe decisions, had behaviors and he stated "no." The social worker further explained he was looking for placement in an assisted living facility close to her family. Resident #35 was interviewed on 5/23/17 at 3:24 PM revealed she wore a bracelet on her leg "because I told them I wanted to leave and they were afraid I would leave, but I won't." Interview with the MDS nurse on 05/25/17 at 11:25 AM revealed she was not aware the	F 241	of his or her quality of life recognizing each resident's individuality. The facility must protect and promote all the rights of the resident. The facility should promote care for residents in manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This in service was completed by June 16th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Administrator or Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by interviewing 5 alert and oriented residents weekly to ensure that a wander guard bracelet was not in place. This is will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and	

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F 241	Continued From page 3 wander-guard was placed on the resident. She further explained the resident says she wants to leave "all the time." A risk assessment would be completed that included behaviors of wandering/elopement. The electronic chart was reviewed with the MDS nurse which revealed the last risk assessment was completed on 3/27/17. That assessment indicated she was assessed as having no behaviors of exit seeking. Continued interview with the MDS nurse revealed a care plan would need to include the use of the wander-guard. The care plan had not been updated because she did not know about the placement on 5/15/17. Interview with the Administrator on 5/25/17 at 1:00 PM revealed she had put the wander-guard bracelet on the resident's chair. On 5/10/17 Resident #35 was in a verbal altercation with her roommate and the roommate's family. The Administrator explained she attempted to calm Resident #35 and moved her to another room. After Resident #35 had been moved, she remained angry and made a comment she would leave and the Administrator would never find her. During the interview, the Administrator commented the resident should be re-assessed in the next week. Interview with Nurse #5 on 5/25/17 at 2:39 PM revealed she had been asked by the Director of Nursing to check Resident #35's wheelchair for the wander-guard. She explained she could not find the one on her wheelchair, so she placed one on her leg on 5/15/17. Interview with the Unit Manager on 5/25/17 at 3:15 PM revealed she did a risk assessment on 5/23/17. The Unit Manager explained she was	F 241	ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.	

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F 241	Continued From page 4 asked to re-assess Resident # 35 for the need of the continued use of the wander-guard. During interview, she explained the resident was upset with a room change, was angry, and threatened to leave. When asked if there was any other intervention they could have done, the Unit Manager explained she could not think of any. The Unit Manager further explained usual practice included completing a risk assessment at the time the wander-guard was placed. Interview with the Treatment Nurse on 5/25/17 at 2:45 PM revealed Resident #35 had requested to see the psychiatrist because she was depressed. Further interview revealed Resident #35 wanted to be in a facility close to family. The primary physician had seen her on 5/19/17 and ordered the psychiatric consult and started another medication for depression. During the interview the treatment nurse was asked what other interventions were attempted before a wander-guard was placed on the resident's wheelchair. The treatment nurse was not aware of anything else that was attempted.	F 241		
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence	F 248		6/19/17

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F 248	Continued From page 5 and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide ongoing activities for 2 of 3 sampled residents reviewed for activities (Resident #78 and Resident #149). The findings included: 1) Resident #78 was admitted to the facility on 6/30/16 with a diagnosis of non-Alzheimer ' s dementia. An Activity Review was completed for Resident #78 on 11/15/16. The review indicated Resident #78's current interests included pets, music, puzzles, movies, gardening, television, reading, and outdoor activities. The resident was noted to prefer active participation in activities and wished to be invited to out of room activities. Information for the review was provided by the resident. A review of the Interdisciplinary Progress Notes included the following notation dated 11/16/16 at 10:50 AM by the Activity Department: "(Resident #78) enjoys watching TV, listening to music, flowers, having others around, going outside when the weather is nice and religious services. We will encourage her to attend different activities of choice." An Activity Review was completed for Resident #78 on 2/9/17. The review indicated Resident #78 ' s current interests included pets, music, BINGO, movies, gardening, television, reading, and outdoor activities. The review indicated Resident #78 felt it was very important to her to do things with groups of people and to do her	F 248	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F248 ACTIVITIES MEET INTEREST OF EACH RES Corrective Action: Resident #78: Preferences reevaluated by completing a Staff assessment of Daily and Activity preferences on 6/15/2017 as resident is not interview able (severely impaired cognitive skills for daily decision making). Care plan updated appropriately. Resident # 149: Preferences reevaluated by completing a resident interview of Daily and Activity preference on 6/15/2017 Care plan updated appropriately. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On 5/24/2017 to 6/16/2017, preferences reevaluated by completing a staff assessment of Daily and Activities preferences for all current non-interviewable residents and by completing	

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F 248	Continued From page 6 favorite activities. Information for the review was provided by the resident. A review of Resident #78's April 2017 Activity Log revealed the resident participated in three activities during the month. Activity involvement noted on the Activity Log included Games and Puzzles on 4/5/17, participation in a 1:1 Program on 4/19/17 and a Religious Service on 4/26/17. An Activity Review was completed for Resident #78 on 5/4/17. The review indicated Resident #78 ' s current interests included arts and crafts, pets, music, BINGO, movies, gardening, television, reading, and outdoor activities. The review indicated Resident #78 felt it was very important to her to do things with groups of people and to do her favorite activities. The resident was noted to prefer active participation in activities and wished to be invited to out of room activities. Information for the review was provided by the resident. A review of Resident #78's most recent quarterly Minimum Data Set (MDS) dated 5/4/17 revealed the resident was assessed by staff to have severely impaired cognitive skills for daily decision making. She required extensive assistance from staff for all of her Activities of Daily Living (ADLs), with the exception of being totally dependent on staff for transfers and eating. A review of the resident's most recent Care Plan (last revised 5/16/17) included the following areas of focus: --"I like to participate in most activities that are offered in the facility." (Initiated on 8/4/15; Revised on 8/4/15) The planned interventions/tasks for this area of	F 248	a resident interview for Daily and Activity preferences for all current interviewable residents by the Activities Director .Care plans updated appropriately. All Activities assessments that include residents daily and activity preferences were placed in the Activities book at each nursing station. Systemic Changes: Director of Nursing and /or Designee In serviced the Activities Director and all Nursing staff (full time, part time, and PRN) to inform them that, the facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choices of activities , both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Activities assessments for each resident will be placed in the activities book at each nursing station. The assessments include residents daily and activity preference in which the staff can refer too. Activities for dependent and debilitated patients who are bed or room bound will be carried out by the activities department and nursing staff daily as needed. Visual and tactile stimulating items will be placed in a plastic bin at the nurse station and will be accessible to all staff at all times. Staff will be encouraged and reminded to	

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F 248	Continued From page 7 focus included: --"Provide activities that are meaningful to me." (Initiated 8/4/15) --"Provide me with a calendar of activities each month." (Initiated 8/4/15) --"The activity director to document on my activity participation daily." (Initiated 8/4/15) A review of Resident #78's May 2017 Activity Log to date revealed the resident participated in 5 activities during the month. Activity involvement noted on the Activity Log included a Spa Service on 5/2/17, a Religious Service on 5/4/17, a Social on 5/4/17, a Communication Activity on 5/8/17, and Group Events on 5/12/17. An observation was made on 5/22/17 at 10:00 AM as Resident #78 was lying on her bed. She appeared to be asleep. An observation was made on 5/23/17 at 11:45 AM as Resident #78 was lying on her bed. The resident was awake and alert. No activities were observed. An interview was conducted on 5/23/17 at 3:17 PM with the facility ' s Activities Director. During the interview, Resident #78's participation in activities was discussed. The Activities Director reported the resident used to get up and come to BINGO on occasions, but noted the resident had not gotten up as much lately. Upon review of Resident #78's Activity Log, the Activity Director was asked if the log reflected resident participation in as many activities as she would like it to. The Activity Director reported it did not. An observation was made on 5/24/17 at 9:30 AM as Resident #78 sat in a wheelchair in her room.	F 248	disperse these items to the appropriate residents throughout the day by Activities Director and Unit Manager. Television and CD/music player will be utilized for patient enjoyment. Books on tape will be made available for the staff to utilize for those patients identified for the need or at the request of the patient. Televisions will be turned on by staff members periodically throughout the day for those patients who may not do so without assistance. Resident family members will be contacted by the activities department and/or nursing staff to inquire about patient's preferences, for those patient's unable to voice their choices of entertainment / stimulus on Admission. Activities Director will monitor and instruct staff on the appropriate choice of activities for the patient as the need arises. Activity Director and nursing staff will document in the medical record resident participation in activities. This in service was completed by June 16th, 2017. Any Activities Department staff member and Nursing Staff (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Administrator or Director of Nursing or designee will	

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F 248	Continued From page 8 The resident was awake and alert (but not verbal). Resident #78 did not have a television or radio on in the room. No activities were observed. An observation was made on 5/24/17 at 2:50 PM as Resident #78 sat in a wheelchair in her room with her eyes closed. Resident #78 did not have a television or radio on in the room. No activities were observed. An observation was made on 5/24/17 at 3:50 PM as Resident #78 sat in a wheelchair in her room. Her eyes were closed. Resident #78 did not have a television or radio on in the room. No activities were observed to be within reach of the resident. An observation was made on 5/25/17 at 10:45 AM as Resident #78 was lying in bed in her room. The resident was awake. The resident was not observed to be engaged in an activity. An interview was conducted on 5/25/17 at 10:47 AM with Nurse #3. Nurse #3 was assigned to care for Resident #78 on 1st shift. Upon inquiry, the nurse reported she did not recall the resident being involved in activities. An interview was conducted on 5/25/17 at 11:20 AM with Nursing Assistant (NA) #2. NA #2 was assigned to care for Resident #78. Upon inquiry regarding the resident ' s involvement in activities, NA #2 reported Activities came and assisted the resident to attend a Sing-along earlier that morning. An interview was conducted on 5/25/17 at 12:38 PM with the facility's Director of Nursing (DON). During the interview, the DON stated nursing staff	F 248	monitor this issue using the QA survey tool. Facility will monitor compliance by observing 5 residents weekly to ensure that they are participating in activities of choice per their preferences. Facility will also monitor compliance by reviewing documentation of resident participation in activities per their preferences in the medical record. This is will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.	

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needed to work with the Activities Department to incorporate some of the things the resident enjoyed into her day.

2) Resident #149 was admitted to the facility on 12/28/16 with a diagnosis of dementia.

An Activity Review was completed for Resident #149 on 12/28/16. The review indicated Resident #149 ' s current interests included arts and crafts, pets, music, puzzles, BINGO, movies, gardening, television, reading, and outdoor activities. The resident was noted to prefer active participation in activities and wished to be invited to out of room activities. Information for the review was provided by the resident.

A review of the Interdisciplinary Progress Notes included a note dated 1/4/17 by the Activity Department. The notation revealed Resident #149 enjoyed listening to music, watching TV, working with flowers, reading, going outside when the weather is nice, having family around, and attending religious services. The Activity Department reported staff would encourage the resident to attend different activities of her choice.

An Activity Review was completed for Resident #149 on 3/28/17. The review indicated Resident #149's current interests included cooking, arts and crafts, music, BINGO, gardening, television, and outdoor activities. The resident was noted to prefer active participation in activities and wished to be invited to out of room activities. Information for the review was provided by the resident.

A review of Resident #149's most recent quarterly Minimum Data Set (MDS) dated 3/29/17 revealed the resident was assessed by staff to have

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moderately impaired cognitive skills for daily decision making. She required extensive assistance from staff for all of her Activities of Daily Living (ADLs), with the exception of being totally dependent on staff for locomotion, dressing, and personal hygiene.

A review of the resident's most recent Care Plan revised on 1/30/17 included the following area of focus:
--"I am increased risk for falls related to confusion, gait/balance problems." (Initiated 1/9/17)
The planned interventions/tasks for this area of focus included, in part:
--"Encourage me to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as: (Specify)." No activities were specified. (Initiated 1/30/17)
Resident #149's Care Plan did not include an area of focus specifically related to Activities.

A review of Resident #149's March 2017 Activity Log revealed the resident participated in 2 activities during the month. Activity involvement noted on the Activity Log included participation in a Group Event on 3/22/17 and a 1:1 Program on 3/23/17.

A review of Resident #149's April 2017 Activity Log revealed there was no documentation of resident participation in activities for the month.

A review of Resident #149's May 2017 Activity Log to date revealed the resident participated in 10 activities during the month to date. Activity involvement noted on the Activity Log included a Group Event on 5/1/17, a Spa Service on 5/2/17,

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a Religious Service and a Social on 5/4/17, a Group Event on 5/9/17, an Exercise Activity on 5/10/17, a Group Event on 5/12/17, a Social on 5/16/17 and 5/18/17, and an Exercise Activity on 5/18/17.

An observation was made on 5/22/17 at 11:45 AM as Resident #149 sat in a wheelchair in her room. The resident was awake and alert but did not respond to questions posed. Resident #149 did not have a television or radio on in the room. No activities were observed.

An observation was made on 5/22/17 at 2:50 PM as Resident #149 sat in a wheelchair in her room. The resident was awake and alert. Resident #149 did not have a television or radio on in the room. No activities were observed.

An observation was made on 5/23/17 at 11:43 AM as Resident #149 sat in a wheelchair in her room. The resident was awake and alert. Resident #149 did not have a television or radio on in the room. No activities were observed.

An interview was conducted on 5/23/17 at 3:17 PM with the facility ' s Activities Director. During the interview, Resident #149's participation in activities was discussed. The Activities Director reported the resident enjoyed getting her nails done, looking at magazines and watching television. Upon inquiry, the Activities Director confirmed the resident did not have a television but would sometimes come to the lounge area to watch TV. Upon review of the April 2017 Activity Log, the Activities Director stated she thought she had done "some things" with the resident but could not recall specifics and acknowledged no activities were documented on the log. When the

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Activity Director was asked if the log reflected resident participation in as many activities as she would like it to, she reported it did not.

An observation was made on 5/24/17 at 9:30 AM as Resident #149 sat in a wheelchair in her room. The resident was awake and alert. Resident #149 did not have a television or radio on in the room. No activities were observed.

An observation was made on 5/24/17 at 2:50 PM as Resident #149 was lying on the bed in her room. The resident was awake with her eyes open. Resident #149 did not have a television or radio on in the room. No activities were observed.

An observation was made on 5/24/17 at 3:50 PM as Resident #149 was lying on the bed in her room. Her eyes were open. Resident #149 did not have a television or radio on in the room. No activities were observed.

An interview was conducted on 5/25/17 at 10:47 AM with Nurse #3. Nurse #3 was the 1st shift nurse assigned to care for Resident #149. Upon inquiry regarding the resident's activities, the nurse stated Resident #149 did go out in hallway in her wheelchair today. However, the nurse stated that as far as she knew, the resident didn't go to activities.

An interview was conducted on 5/25/17 at 12:31 PM with the facility's Director of Nursing (DON). During the interview, the DON reported the nursing staff did engage Resident #149 in activities on occasions. The DON stated her expectation would be for nursing staff to document any activities they engaged the

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F 248	Continued From page 13 resident in to better reflect her participation.	F 248		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct	F 272		6/19/17

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F 272	Continued From page 14 observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to comprehensively assess the dental needs for 1 of 3 sampled residents (Resident #77) reviewed for dental status and services. The findings included: Resident #77 was initially admitted to the facility on 9/4/13. The resident re-entered the facility on 7/15/16 with a cumulative diagnoses which included diabetes, dysphagia, and malnutrition. A review of Resident #77 ' s Nursing Quarterly Reviews dated 3/29/16 and 6/20/16 revealed the resident had, "Some/all natural teeth lost - does not have or does not use denture (or partial plates)." The resident ' s last annual, comprehensive Minimum Data Set (MDS) assessment was completed on 6/23/16. Section K of the annual MDS revealed the resident received a therapeutic and mechanically-altered diet. She weighed 202 pounds (#). Section L of the MDS indicated no dental concerns were present. The resident was	F 272	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F272 COMPREHENSIVE ASSESSMENT Corrective Action: Resident #77: Oral assessment completed on 5/26/2017. An OBRA Comprehensive assessment, with assessment reference date of 5/23/2017 was completed on 6/6/2017, Care Areas completed on 6/6/2017 and Care Plan decisions completed on 6/8/2017. Assessment was submitted and accepted to the QIES ASAP system on 6/9/2017. Care plan updated	

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F 272	Continued From page 15 not reported as being edentulous (no natural teeth). The Care Area Assessment (CAA) Summary in Section V of the MDS revealed the care area related to Dental Care did not trigger for review or potential care planning. A review of the Nursing Admission / Readmission Review form dated 7/15/16 indicated Resident #77 had, "Some/all natural teeth lost - does not have or does not use denture (or partial plates)." A Speech Therapy screen dated 7/15/16 was reviewed. The screen noted no skilled speech therapy was warranted at that time. The resident received a Level 2 National Dysphagia Diet (NDD) with thin liquids. A Level 2 NDD diet consisted of foods that were moist, soft-textured, and included ground or minced meats. A review of the Nursing Quarterly Reviews dated 9/13/16 and 12/16/16 revealed the resident had, "Some/all natural teeth lost - does not have or does not use denture (or partial plates)." However, a review of the Nursing Quarterly Review dated 2/24/17 indicated the resident did not have any dental concerns (such as dentures, missing, broken, loose or carious teeth, or inflamed gums). A review of Resident #77 ' s most recent quarterly MDS assessment dated 2/28/17 indicated the resident had intact cognitive skills for daily decision making. Resident #77 was totally dependent on staff for dressing and locomotion on the unit; she required extensive assistance for bed mobility, transfers, toileting, and personal hygiene; and, needed supervision only for eating. Section K of the MDS revealed the resident received a therapeutic and mechanically-altered	F 272	appropriately. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On 5/24/2017 to 6/16/2017 comprehensive oral assessments were completed on all current residents. Care plan updated appropriately. All Comprehensive OBRA assessments within the last 6 months were reviewed on 6/16/2017 for accuracy for Section L-Oral-Dental Status by the RN MDS coordinators and modifications completed respectively. Systemic Changes: On 5/24/2017 The RN MDS Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the Corporate MDS Nurse Consultant. Section L: Oral /Dental status is intended to record any dental problems present in the 7day look back period. Poor oral health has a negative impact on quality of life, overall health and nutritional status. Oral assessment can identify periodontal disease that can contribute to or cause systemic diseases and conditions such as aspiration, malnutrition, pneumonia, endocarditis and poor control of diabetes. Oral assessments will be completed on each resident to help identify residents who may be at risk for aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes. Referral for dental consult will be done when warranted.	

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F 272	Continued From page 16 diet. She weighed 185#. A review of the resident ' s Care Plan included the following area of focus, in part: --I have a potential nutritional problem related to receiving mechanically altered and therapeutic diets, fair intake and weight loss (initiated 7/23/15 and revised on 5/22/17). A review of Resident #77 ' s May 2017 Physician ' s Order Summary revealed her current diet prescription was a No Added Salt, Level 2 NDD with thin liquids. The resident was on a 1500 milliliter (ml) per day fluid restriction. She received fortified foods with meals (which included a fortified cereal, potato, or pudding at each meal) and 120 ml of Med Pass 2.0 (a high calorie, high protein liquid nutritional supplement) three times daily due to weight loss. A review of the resident ' s paper and electronic medical records revealed there was no documentation of a dental consult for Resident #77. An observation and interview were conducted on 5/22/17 at 12:13 PM with Resident #77. The observation revealed the resident was edentulous. During the interview, Resident #77 reported her dentures did not fit well so she chose not to wear them. She did not report any problems at that time. An interview was conducted on 5/23/17 at 4:50 PM with MDS Nurse #1. During the interview, the MDS nurse indicated she did not think Resident #77 was edentulous. Accompanied by MDS Nurse #1, Resident #77	F 272	The education focused on the Federal regulations at 42 CFR 483.20(b)(1)(xviii),(g), and (h) require that: The assessment accurately reflects the residents status. A registered Nurse conducts or coordinates each assessment with the appropriate participation of health professionals. The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. The information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during the observation period) the interdisciplinary team completing the assessment. The Observation (Look Back) Period is the time period over which the resident's condition or status is captured by the MDS assessment. The observation period for a particular assessment for a particular resident will be chosen based upon the regulatory requirements concerning timing and the ARDs of previous assessment. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59	

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F 272	Continued From page 17 was observed on 5/23/17 at 4:51 PM as she laid on the bed in her room. The resident was awake and alert. When the MDS nurse asked the resident to open her mouth and let her see her teeth, Resident #77 stated, "I ain't got no teeth." The resident then told the nurse that her dentures had not fit for a long time and they were just sitting in her drawer. When asked how long she has gone without wearing her dentures, the resident stated, "a long time." Upon further inquiry, the resident was a bit uncertain but indicated it had likely been a year or so since she last wore her dentures. An interview was conducted on 5/23/17 at 4:55 PM with MDS Nurse #1. Upon inquiry, the MDS nurse stated the resident may have stopped wearing her dentures after the last annual assessment was completed in June 2016. When the MDS nurse was asked how she would have known about a change in the resident's dentition, she stated she would have expected to find out about any changes with the 24-hour report (a weekday clinical meeting attended by Department Managers). The MDS nurse reported if she had known about Resident #77 ' s change in dentition, she would likely have initiated a significant change MDS to assess the resident. Additionally, MDS Nurse #1 stated she thought a referral would have been made for the resident to see a dentist, a referral made for a Speech Therapy evaluation, and a message sent to the Dietary Department to make them aware of a change in dentition. Upon inquiry as to whether or not an edentulous resident would be care planned as such, the MDS nurse stated she would expect the resident to be care planned for this type of change in dentition.	F 272	p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look back period will be captured. If it did not occur during the look back period, it is not coded on the MDS. The Director of Nursing or RN Designee will review OBRA assessments to ensure accurate coding for Section L-Oral /Dental status. Any issues will be reported to the Director of Nursing or Administrator for appropriate action. During the daily Clinical Meeting (Monday through Friday), the RN MDS Coordinator or Designee will review assessment reference dates for OBRA assessments. The Daily Clinical Meeting is attended by the Director of Nursing, Unit Managers, MDS Coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Social Worker, The Administrator and others as needed. This in service was completed by June 16th, 2017. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, the Director of Nursing or Designee will conduct a review using the QA Assessment Accuracy Tool.	

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F 272	Continued From page 18 An interview was conducted on 5/23/17 at 5:00 PM with Nurse #1. Upon inquiry, Nurse #1 stated she had worked at the facility for more than 10 years. The nurse noted she was normally assigned to work on Resident #77 ' s hall. When asked how long Resident #77 had gone without wearing her dentures, the nurse stated it had been a long time. The nurse reported she did not actually recall a time when the resident wore dentures. Upon further inquiry, Nurse #1 stated the resident had been edentulous for at least one year. An interview was conducted on 5/23/17 at 5:05 PM with Nursing Assistant (NA) #1. NA #1 reported she had worked at the facility for 6 or 7 years and was typically assigned to Resident #77 ' s hall. Upon inquiry, NA #1 reported the resident had been without her dentures for at least a year. A follow-up interview was conducted on 5/25/17 at 10:27 AM MDS Nurse #1. During the interview, MDS Nurse #1 reported she would normally look in a resident ' s mouth when she did the annual MDS assessment. However, the MDS nurse reported she did not look in Resident #77 ' s mouth in June of 2016 because she felt she knew the resident. The MDS nurse stated she spoke to Resident #77 ' s family member and it was confirmed the resident had not been wearing her dentures for a long time. MDS Nurse #1 stated, "I missed it." An interview was conducted on 5/25/17 at 12:45 PM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON stated her expectation was for the MDS personnel to assess the resident accurately and to code the MDS as correctly as possible.	F 272	Five residents OBRA assessments will be reviewed weekly for 4 weeks, and then monthly for three months. The items reviewed on the QA Assessment Accuracy Tool will include: Section L-Oral/Dental Status. Identified issues will be reported immediately to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, and the Administrator.	

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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 observation, resident and staff interviews and record review the facility failed to	F 278	The statements made on this Plan of Correction are not an admission to and do	6/19/17

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F 278	Continued From page 20 accurately code on the comprehensive Minimum Data Set (MDS) assessment a level two PASRR (Preadmission Screening and Resident Review) for 1 of 1 resident (Resident #9) reviewed for PASRR; failed to accurately complete section L of the Admission Minimum Data Set (MDS) for 1 of 3 sampled residents reviewed for dental status (Resident #105) and failed to accurately code the Minimum Data Set (MDS) assessment to indicate the reason why an influenza vaccination was not provided for 1 of 5 sampled residents reviewed for vaccination status (Resident #240). Findings included: 1. Resident #9 was admitted to the facility on 4/27/17 with diagnoses that included anxiety disorder and depression. A review of the PASRR Level II Determination Notification dated 4/30/17 revealed that Resident #9 was determined to be a PASRR level two (The purpose of the Level II screening is to assure that individuals with serious mental illness entering or residing in Medicaid-certified nursing facilities receive appropriate placement and services). A review of the comprehensive MDS assessment dated 5/4/17 indicated Resident #9 was not coded as a level two PASRR. An interview was completed with MDS Nurse #1 on 5/24/17 at 10:00 AM. She stated the resident did not come with a PASRR number from the hospital and that it took 3-4 days to get the number so she did not have the correct information to put on the MDS. MDS Nurse #1 stated she had completed a significant correction on 5/23/17.	F 278	not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F278 ASSESSMENT ACCURACY/COORDINATION/CERTIFIED Corrective Action: Resident #9 Prior Comprehensive Assessment: Dated 5/4/2017. LEVEL TWO PASRR A Significant Correction to Prior Comprehensive Assessment (SCPA) was opened with an Assessment Reference Date of 5/23/2017. The Assessment Reference Date was set within 14days after the determination that a significant error in the prior comprehensive assessment occurred (ARD= Determination date 5/23/2017 + 14 calendar days). The Significant Correction to Prior Comprehensive Assessment completion date (item Z0500B) was 6/5/2017. (No later than 14days from ARD). The CAA(s) completion date (itemV0200B2) was 6/5/2017. (No later than 14days from ARD).The Care Plan completion date (Item V0200C2) was 6/5/2017. (No later than 7days after the CAA(s) completion date (item V0200B2) Resident #105 OBRA Comprehensive assessment ARD 5/4/2017 Section L- Oral/Dental Status	

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F 278	Continued From page 21 An interview with the Director of Nursing on 5/25/17 at 8:38 AM revealed her expectation that the MDS assessments would be coded accurately on the PASRR section. 2. Resident #105 was admitted to the facility on 4/27/17 with diagnoses which included: diabetes mellitus, dysphagia, iron deficiency anemia, and vitamin B deficiency. Review of the Admission Nursing Assessment dated 4/27/17 documented Resident #105 had no missing or broken teeth or dentures. Review of the Admission MDS dated 5/04/17 indicated Resident #105 was cognitively intact, had no dental issues, no swallowing or chewing problems, received a therapeutic, mechanical soft diet, and had no weight loss. During an observation and interview on 5/22/17 at 2:50 p.m., Resident #105 was noted to have one visible tooth located in front of his lower gum area. The resident revealed he only had three teeth, but had no problems chewing food and no problems with his gums. On 5/23/17 at 12:43 p.m., Resident #105 was observed in his room finishing his lunch. The resident consumed approximately 98% of a meal consisting of chicken pot pie, green peas, apple pie, unsweetened iced tea, and water. During an interview on 5/23/17 at 3:50 p.m., MDS Nurse#1 stated the MDS nurse who completed the resident's MDS may have relied on the Nursing Admission assessment when he completed Resident #105's Admission MDS.	F 278	Item set L0200Z coded Yes. Resident # 240 A Modification Request was created for the OBRA Admission Assessment with the Assessment Reference Date of 3/7/2017. This corrected record has all items included, not just the items in error. The Correction Request Section X items were completed on 6/12/2017 and includes the corrected record. Item O0250C has a value of 2, indicating a modification request. The Modification Request was submitted to the QIES ASAP system on 6/13/2017 Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All OBRA comprehensive assessments within the last 6 months were reviewed for accuracy for Item Set O0250C (Reason why an influenza vaccination was not provided), Section L Oral/Dental Status, and assessment of level two PASRR (Preadmission Screening and Resident Review) by 6/16/2017 by the RN MDS coordinators. Systemic Changes: On 5/24/2017 The RN MDS Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the Corporate MDS Nurse Consultant. The education focused on the Federal regulations at 42 CFR 483.20(b)(1)(xviii),(g), and (h) require that: The assessment accurately reflects the residents status. A registered Nurse	

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F 278	Continued From page 22 MDS Nurse#1 stated that the normal protocol was to perform a physical observation of a resident when assessing him or her to ensure accuracy of the MDS. She stated that Resident #105's MDS would be modified to reflect accuracy of section L of the MDS. 3. Resident #240 was admitted to the facility on 2/28/17 from another nursing home or swing bed. Her cumulative diagnoses included diabetes and renal insufficiency. A review of Resident #240's admission Minimum Data Set (MDS) assessment dated 3/7/17 was completed. Section O of the MDS indicated the resident did not receive the influenza vaccine in the facility. The MDS reported the reason the resident did not receive the vaccination was, "Resident not in this facility during this year's influenza vaccination season." An interview was conducted on 5/24/17 at 10:30 AM with the facility ' s Director of Nursing (DON). During the interview, Resident #240's immunization status was reviewed. The DON reported this year's influenza vaccination was declined by the resident. An interview was conducted on 5/25/17 at 10:17 AM with MDS Nurse #1. Upon inquiry, the MDS nurse reviewed Section O of Resident #240's MDS dated 3/7/17. The MDS nurse reported the reason why Resident #240 did not receive an influenza vaccination at this facility was coded incorrectly. She stated the MDS should have indicated Resident #240 received the vaccination at a previous facility. Upon further inquiry as to how this information would have been obtained, the MDS nurse stated a negative response (which indicated a resident did not get the	F 278	conducts or coordinates each assessment with the appropriate participation of health professionals. The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident□s medical record, physician, and family, guardian, or significant other as appropriate or acceptable. The information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident□s actual status was during the observation period) the interdisciplinary team completing the assessment. The Observation (Look Back) Period is the time period over which the resident□s condition or status is captured by the MDS assessment. The observation period for a particular assessment for a particular resident will be chosen based upon the regulatory requirements concerning timing and the ARDs of previous assessment. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look back period will be captured. If it did not occur during the look back period,	

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F 278	Continued From page 23 influenza vaccination in this facility) carried over from what the admission staff put into the electronic record. After that, the MDS nurse reported she needed to talk with the admission staff member, resident, or family to determine the reason why the resident did not receive the vaccination at the facility. A follow-up interview was conducted on 5/25/17 at 12:43 PM with the DON. Upon inquiry, the DON reiterated that based on the records she had reviewed, the resident and/or responsible party actually declined the flu vaccination upon admission to the facility. The DON stated her expectation was, "We code the MDS as accurately as possible."	F 278	it is not coded on the MDS. The Director of Nursing or RN Designee will review OBRA assessments to ensure accurate coding for Item Set O0250C (Reason why an influenza vaccination was not provided), Section L Oral/Dental Status, and assessment of level two PASRR (Preadmission Screening and Resident Review) Any issues will be reported to the Director of Nursing or Administrator for appropriate action. During the daily Clinical Meeting (Monday through Friday), the RN MDS Coordinator or Designee will review assessment reference dates for OBRA assessments. The Daily Clinical Meeting is attended by the Director of Nursing, Unit Managers, MDS Coordinators, Support Nurse, Therapy, Health Information Manager, Dietary Manager, Social Worker, The Administrator and others as needed. This in service was completed by June 16th, 2017. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, the Director of Nursing or Designee will conduct a review using the QA Assessment Accuracy Tool.	

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F 278	Continued From page 24	F 278	Five residents OBRA assessments will be reviewed weekly for 4 weeks, and then monthly for three months. The items reviewed on the QA Assessment Accuracy Tool will include: for Item Set O0250C (Reason why an influenza vaccination was not provided), Section L Oral/Dental Status, and assessment of level two PASRR (Preadmission Screening and Resident Review) Identified issues will be reported immediately to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager, Administrator, and Medical Director.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the	F 280		6/19/17

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F 280	Continued From page 25	F 280		

plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

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F 280	Continued From page 26 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to update a care plan for falls for one of two sampled residents with falls. Resident # 190 Findings included: Resident # 190 was admitted to the facility on 7/28/16 with diagnosis of a stroke. Review of the Minimum Data Set (MDS) dated 3/6/17 indicated Resident #190 had an intact long and short term memory, required supervision for transfers and ambulation. The MDS included he had two falls without injury.	F 280	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	

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F 280	Continued From page 27 Review of the updated care plan on 3/6/17 included a problem of at risk for falls. Interventions for this problem included the use of a fall mat to be placed beside his bed. Observation on 5/23/17 at 9:30 AM revealed no mat on the floor beside the bed. . Interview with the Nurse #5 on 05/25/17 at 11:40 AM revealed Resident #190 had not had a mat for some time. Nurse #5 explained the fall mat had been discontinued. Interview with the MDS nurse on 5/25/17 at 11:45 AM revealed the fall mat should have been removed from the care plan. The MDS nurse explained she was not aware the mat had been discontinued. Resident #190 had a room change and it may not have moved with him. Further interview revealed the MDS nurse stated it was not appropriate anymore due to the resident was up and ambulating. The MDS nurse was not sure how they missed updating the care plan.	F 280	Corrective Action: Resident #190 Resident Care plan was reviewed and updated. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On 6/16/2017 a falls review meeting was held in the Weekly Quality of Life meeting. Risk assessments were completed on all current residents by 6/16/2017. In this meeting all residents were reviewed for high falls risk and current interventions in place to prevent falls and the need for additional interventions for residents with poor safety awareness. This was completed on 6/16/2017. In addition to this, any new interventions put in place were added to the individual residents care plan by the MDS Coordinator and were reflected on the Kardex and Care plan respectively. Systemic Changes: On 5/25/2017 The RN MDS Coordinator and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the QA nurse consultant. The education focused on the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	

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F 280	Continued From page 28	F 280		

interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the residents care plan. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
Good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan.
The resident has a right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, he right to request meetings and the right to request revisions to the person-centered plan of care. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. The right to receive the services and/or items

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F 280	Continued From page 29	F 280	included in the plan of care. The right to see the care plan, including the right to sign after significant changes to the plan of care. The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must facilitate the inclusion of the resident and/or resident representative. The facility must include an assessment of the resident's strengths and needs. The facility must incorporate the resident's personal and cultural preferences in developing goals of care. A comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment. The Director of Nursing or RN Designee will review comprehensive assessments to ensure that a comprehensive care plan is completed for each resident per the RAI requirements as listed above. Any issues will be reported to the Director of Nursing or Administrator for appropriate action. During the daily Clinical Meeting (Monday through Friday), the RN MDS Coordinator or Designee will review assessment reference dates for OBRA assessments. The Daily Clinical Meeting is attended by the Director of Nursing, Unit Managers, MDS Coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Social Worker, The Administrator and others as needed. This in service was completed by June 16th, 2017. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive	

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F 280	Continued From page 30	F 280	in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Administrator or Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by completing a daily falls (Monday through Friday) review during daily clinical Quality of life meeting to ensure a complete investigation of the fall, root cause , and interventions are initiated and care planned. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.	
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		6/19/17

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F 281	Continued From page 31 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility: 1) Failed to implement a pre-operative physician order to ensure a resident did not eat or drink anything after midnight the day before a scheduled surgery for 1 of 1 resident (Resident #191) reviewed with preoperative physician orders; and, 2) Failed to give a supplement as ordered by the physician for 1 of 7 residents (Resident #21) reviewed for nutrition. The findings included: 1) Resident #191 was admitted to the facility on 11/3/16 from a hospital. His cumulative diagnoses included an inguinal hernia (a condition which occurs when tissue protrudes through a weak spot in the lower abdominal wall). A review of the resident's most recent Care Plan (last revised 2/16/17) included the following area of focus: -- (Resident #191) may have acute pain around the inguinal (groin) area (Date initiated: 11/4/16; Date revised: 11/4/16). A review of Resident #191's most recent quarterly Minimum Data Set (MDS) dated 5/2/17 revealed the resident was assessed to have moderately impaired cognitive skills for daily decision making.	F 281	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Corrective Action: Resident #191 Physician was notified on 5/25/2017. New physician orders obtained and initiated. Resident representative notified on 5/25/2017. Resident #21 Physician was notified on 5/25/2017. New physician orders obtained and initiated. Resident representative notified on 5/25/2017. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On	

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F 281	Continued From page 32 He was totally dependent on staff for transfers; required extensive assistance for bed mobility, locomotion, dressing, and toileting; required limited assistance with eating; and, needed supervision only for personal hygiene. A review of the resident's medical record revealed a surgical consultation was completed on 5/19/17. The consultation report recommended surgical repair of the right inguinal hernia and hydrocele (a fluid-filled sac surrounding a testicle). Further review of Resident #191's medical record included a fax received from a Preoperative Anesthesia Department dated 5/24/17 at 2:00 PM. The fax outlined pre-operative instructions, which noted Resident #191 should not eat or drink anything after midnight the night before the scheduled surgery. A review of Resident #191 ' s medical record revealed a verbal physician's order was received on 5/24/17 to keep the resident "NPO (nothing by mouth) after midnight; one time only for 1 Day." The order was noted to be in effect at midnight on 5/24/17. An interview was conducted with Resident #191 on 5/25/17 at 3:00 PM. During the interview, the resident stated he understood his surgery was scheduled for today (5/25/17), but had to be rescheduled to 6/1/17. The resident reported he was not upset by the delay and stated, "June 1st isn't so far away." An interview was conducted on 5/25/17 at 3:05 PM with Nurse #2. Nurse #2 was assigned to care for Resident #191. Upon inquiry, Nurse #2	F 281	5/24/2017 to 6/16/2017 2017 a chart audit was initiated for all current residents in the facilities to ensure that all physician orders were followed and initiated. The audit was also initiated to ensure that all NPO orders were initiated as ordered by the physician and communicated to the Dietary Department to ensure continual of service. The audit was also initiated to ensure that all dietary supplement orders were followed and initiated per physician orders. The chart audit was completed by the Nurse Management Team (Director of Nursing, Unit Manager and Support Nurse). All physician orders were followed and initiated as ordered. Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time, part time, and PRN) and the interdisplinary care planning team on the fact that the services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality. All Nurses (RNs, LPNs, full time, part time, and PRN) were also educated on the fact that it is the nurse's responsibility to notify physician, follow and initiate Physician orders. All NPO physician orders will be initiated and followed as ordered and communicated to the Dietary Department to ensure continual of service. NPO orders received from the physician will be communicated to the Dietary Department by using the dietary communication slip. The dietary communication slip will be filled by nursing, the white original slip will go to the Dietary department and the	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 33 reported she knew the resident was scheduled for surgery earlier this morning (5/25/17). The nurse reported after she began to work on the medication cart this morning, she saw the breakfast trays had been delivered to the floor. Nurse #2 stated she went into Resident #191's room and discovered he had been served his breakfast tray and had already eaten his eggs. The nurse stated she told the resident's Responsible Party (RP) about this when she came in to see him. The nurse also reported she called the surgical service to inform them the resident had eaten breakfast and was told he needed to be NPO for at least 8 hours prior to surgery. Nurse #2 indicated she would have expected the Dietary Department to have received the NPO order written on 5/24/17 for this resident so he would not have gotten a breakfast tray the morning of 5/25/17. An interview was conducted on 5/25/17 at 3:10 PM with the Unit Manager working on Resident #191's hall. During the interview, the Unit Manager explained Resident #191's surgery was originally scheduled for 5/26/17. However, the surgical service called the facility yesterday afternoon (5/24/17) around 2:30 or 3:00 PM and reported his surgery had been moved up by one day to 5/25/17. The Unit Manager reported she put the resident ' s pre-operative orders into the computer on 5/24/17, including an order for the resident to be NPO after midnight on 5/24/17. The Unit Manager stated all of the nurses (1st shift, 2nd shift, and 3rd shift) knew about the resident ' s surgery scheduled for 5/25/17 and the order for him to be NPO after midnight on 5/24/17. However, she reported the nursing assistants did not know Resident #191 wasn't supposed to eat so when the resident's breakfast	F 281	yellow copy will be kept in the residents medical record. Supplement orders received from the physician will be entered into the residents electronical medical record. The nurses will initiate the supplemental orders as ordered by the physician and document in the resident electronical medication administration record. The nurses will administer the supplements per physician orders. All Dietary Supplements ordered will be initiated and followed as ordered per physician orders. If resident refuses to take Dietary Supplements, documentation of refusal will be indicated in the Electronic Medication Administration. Physician and Resident representative will be notified. Physician should be called 24 hours a day and 7 days a week. This process does not change due to time or day of the week. Physician phone numbers orders are located at each nurse's station in the notebook. If you are unable to reach the attending physician or the physician on call, call the facility medical director within 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate response or does not call back within 30 minutes then the nurse is to contact the DON immediately for further instructions. This in service was completed by June 16th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed.	

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	345284	A. BUILDING _____ B. WING _____	C 05/25/2017

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F 281	Continued From page 34 tray was on the cart this morning, it was delivered to him. When asked if the Dietary Department knew about the 5/24/17 NPO order, the Unit Manager stated, "It should." The Unit Manager stated she would have expected the Dietary Department to hold the resident ' s breakfast tray since the NPO order had been put into the computer system the day before. The Unit Manager reported Resident #191's surgery needed to be rescheduled for 6/1/17. A telephone interview was conducted on 5/25/17 at 3:30 PM with the resident ' s physician. The rescheduling of Resident #191's surgery was discussed during the interview. Upon inquiry as to how the delay may potentially impact the resident, the physician reported the surgery was an elective surgery. The physician also stated while the rescheduling of the surgery was, "frustrating and an unfortunate circumstance," it would not cause harm to the resident. An interview was conducted on 5/25/17 at 3:45 PM with the facility ' s Food Services Director. During the interview, the Food Services Director was asked what the facility ' s process was to change a diet order for a resident. The Food Services Director reported when nursing staff received an order for a diet change, they would give her a Dietary Communication Slip. From that point, she would enter the diet change into the Dietary Department ' s electronic system. Upon further inquiry, the Food Services Director stated a change in Resident #191 ' s diet order to NPO would be communicated from Nursing to Dietary by use of a Dietary Communication Slip (not via computer). The Food Services Director stated she would need to check her records to see whether or not the Dietary Department had	F 281	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by reviewing 5 residents' charts with NPO physician orders to ensure that physician orders were followed, initiated and communicated to the Dietary department to ensure continual of services. The facility will also monitor compliance by reviewing 5 residents' charts with Dietary supplements ordered to ensure that physician orders are followed and initiated as ordered. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Director of Nursing, Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager, Social Services.	

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F 281	Continued From page 35	F 281		

been informed that Resident #191 was supposed to be NPO after midnight on 5/24/17.

A follow-up interview was conducted on 5/25/17 at 4:00 PM with the Food Services Director. At that time, the Food Services Director reported the Dietary Department did not receive an order to make Resident #191 NPO after midnight on 5/24/17. The Food Services Director indicated she would have expected the resident's NPO order to be communicated to the Dietary Department so he would not have been sent a breakfast tray the morning of 5/25/17.

2) Resident #21 was admitted to the facility on 1/15/16 with diagnoses that included dysphagia and non-Alzheimer's dementia.

A review of the comprehensive Minimum Data Set (MDS) assessment dated 12/21/16 revealed Resident #21 had impaired cognition and decision making skills, and needed extensive assistance with one person for eating. The resident's weight was 114 pounds.

A review of care plan problems included nutrition. A care plan intervention dated 7/8/16 revealed "provide and serve supplements as ordered." The care plan further revealed the discipline responsible for the task was a nurse's aide.

A review of the physician's order dated 3/11/16 revealed "Magic cup with meals for anorexia."

An observation of Resident #21 on 5/23/17 at 1:13 PM revealed nurse aide #4 (NA #4) had fed the resident. NA #4 stated the resident was "a

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good eater" if the food on her tray was something she liked to eat. NA #4 reported if Resident #21 didn't eat well she offered her an alternative, such as a peanut butter and jelly sandwich. NA #4 stated, at times, she encouraged the resident to eat more by rewarding her with a "chocolate shake" but did not mention there was an order for Magic Cup.

An observation of Resident #21 was completed 5/23/17 at 6:48 PM. The Magic Cup was not on the meal tray.

An interview was completed with the Dietary Manager on 5/24/17 at 9:37 AM. She stated the Magic Cups were given by the nursing staff and they were not placed on the meal trays by the dietary department. The kitchen staff brought the supplement to the nourishment room and nurses gave them out.

An interview was completed with Nurse #2 on 5/24/17 at 9:45 AM. She stated the Magic Cups came out on the meal trays or "we went up to the kitchen and got them."

An interview with NA #5 on 5/24/17 at 11:18 AM revealed he had fed the resident a couple of times and fed her whatever was on the tray. He reported he had not fed her a Magic Cup with her meals.

An interview was completed with the Registered Dietician (RD) on 5/24/17 at 2:00 PM. She stated the kitchen delivered all Magic Cups and stocked them in the nourishment rooms, and the nursing staff passed the supplements. "We (dietary) don't put any supplements on the residents' trays. It was listed on the electronic medication

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F 281	Continued From page 37 administration record that they be passed and signed off by the nurse." A review of the May 2017 Medication Administration Record showed the Magic Cups were signed off as given, however, Nurse #2 stated in her interview on 5/24/17 at 9:45 AM that the Magic Cups came on the residents' trays. A second interview was completed with NA #4 on 5/24/17 at 4:45 PM. She reported she did not give the Magic Cup to Resident #21 every time she was fed. She stated in the past, at times, she gave the supplement to the resident at lunch or dinner. "I saw what she did with her meal. If she asked for something else I gave it to her." NA #4 stated during meal time she would not get a Magic Cup unless the resident wanted something more or had not eaten enough. She reported if she gave a Magic Cup she went to the nurse and requested it for the resident. An interview was completed with the Director of Nursing (DON) on 5/25/17 at 8:43 AM. She stated the facility had changed dietary managers and they would be trying a different system to ensure supplements were placed on the meal trays. Her current expectation was that the nurse would place the supplements on the meal trays from the nourishment room and nurse aides were expected to give the supplement to the resident.	F 281		
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-	F 282		6/19/17

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F 282	Continued From page 38 (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to follow care plan interventions for one of one sampled residents with an indwelling urinary catheter, Resident #258. The findings included: Resident #258 was admitted to the facility on 4/10/17 with diagnoses of neuromuscular dysfunction of the bladder. Review of the admission Minimum Data Set (MDS) dated 4/10/17 indicated Resident #258 had an indwelling urinary catheter. Review of the care plan dated 4/19/17 included a problem for use of an indwelling urinary catheter. The stated goals indicated the resident would be free from catheter related trauma and to have no signs or symptoms of an infection. The interventions included for staff to keep the urinary catheter bag covered adequately to promote dignity, use a leg band to secure the catheter, and position the urinary catheter bag and tubing below the level of the bladder and away from the entrance room door. Observations on 5/23/17 at 10:10 AM revealed Resident #258 was in bed, with a urinary catheter bag hanging from the bottom of the bedframe. The catheter bag had no privacy covering and was facing the open door to the hallway. A	F 282	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Corrective Action: Resident #258 Indwelling catheter: Physician notified, orders initiated and implemented per physician orders. Care plan updated on 5/24/2017 by MDS Coordinator. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by this practice. On 6/15/2017 the Director of Nursing initiated a chart audit on all current residents to ensure that all residents with indwelling catheters had orders initiated, implemented as ordered and care planed initiated and followed. 4# of residents have indwelling catheters. All physician Orders initiated, implemented as per physician orders, care plan up to	

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F 282	Continued From page 39 securing device was not in place to prevent pulling or tension on the catheter tubing. Interview with Nurse Aide #6 (NA #6) on 5/23/17 at 10:27 AM revealed she had looked for a securing device and said he did not have one. NA #6 explained someone put tape on the tubing to secure it and it came loose from his leg. At the time of the interview, NA #6 was observed to press the tape against the resident's leg to secure the tubing. An observation on 5/24/17 at 8:07 AM were made with the Treatment Nurse. The observation revealed a securing device was not in place to secure the catheter tubing. The tape was no longer on the tubing. Interview with the Treatment Nurse on 5/24/17 during the observation at 8:07 AM revealed a catheter strap should be used to secure the urinary catheter tubing. She further explained some residents do prefer the strap. The Treatment Nurse asked Resident #258 if he would object to use of the strap. The resident replied "no" and the Treatment Nurse applied the strap to secure the urinary tubing. The Treatment Nurse explained she would get a privacy bag for the urinary catheter drainage bag. An interview was conducted on 5/24/17 at 11:42 AM, with Nurse #5 who was the charge nurse for Resident #258 on 5/23/1. Interview revealed she was not notified yesterday that Resident #258 did not have a leg strap to secure the urinary catheter tubing. Interview with the Director of Nursing on 5/24/17 at 3:00 PM revealed she would expect the	F 282	date. Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time, part time, and PRN) and the interdisplinary care planning team on the fact that the services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality. All Nurses (RNs, LPNs, full time, part time, and PRN) were also educated on the fact that it is the nurse's responsibility to notify physician, follow and initiate Physician orders. All residents who are admitted or readmitted to the facility with an indwelling catheter, nurse must ensure that there is written order for the use of the catheter, appropriate diagnosis to support the use of the catheter, treatment and care of the catheter, presence of a revised and updated care plan with focus goals and interventions as appropriate. Physician should be called 24 hours a day and 7 days a week. This process does not change due to time or day of the week. Physician phone numbers orders are located at each nurse's station in the notebook. If you are unable to reach the attending physician or the physician on call, call the facility medical director within 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate response or does not call back within 30 minutes then the nurse is to contact the DON immediately for further instructions. This in service was completed by June	

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F 282	Continued From page 40 resident to have a leg strap to secure the catheter and a privacy cover on the drainage bag per the care plan.	F 282	16th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by reviewing 5 residents' charts with indwelling catheter to ensure that care plans are updated and followed. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Director of Nursing, Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services.	
F 309 SS=J	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		6/19/17

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F 309	Continued From page 41 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility Transportation Aide failed to secure the wheelchair to the floor of the facility van according	F 309	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the	

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F 309	Continued From page 42 to manufacturer's instructions before transporting one of one resident reviewed for van transportation, Resident #54. During transport the wheelchair with Resident #54 fell backwards with the resident landing on her back and hitting her head on the van floor. Resident #54 complained of right shoulder pain after the incident. The Transportation Aide failed to call 911 and the facility after the incident and moved the resident back to a sitting position in the wheelchair after the incident. Resident #54 complained of right shoulder pain after the incident. This was for one of one residents transported in the facility van Resident #54. Immediate jeopardy began on 9/30/16 at 5:00 PM when facility van driver #1 failed to secure the wheelchair to the facility van floor according to manufacturer's recommendation. Immediate jeopardy was lifted on 5/25/17 when the facility's acceptable credible allegation of compliance was verified. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedures for securing wheelchairs in the facility van for resident transport. The findings included: Review of the manufacturer's recommendations "Q'Straint" provided the following instructions to secure the wheelchair: 1. Place wheelchair facing forward in securement area; apply wheel locks or turn power off. 2. Attach tie-downs into floor anchorages and ensure they are locked in.	F 309	alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Corrective Action: Resident #54 Discharged from facility. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On 5/25/2017, the nurse managers assessed all 6 current patients for signs/symptoms of injuries related to possible transport injuries such as unexplained bruising, swelling or pain to extremities for those who had been transported via the facility owned van from 10/6/2016 to 10/25/2016. No injuries were identified. No residents were transported via the facility owned van from 10/26/2016 to 6/16/2017 . Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time, part time, and PRN) on the fact that Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest	

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F 309	Continued From page 43 3. Attach the four tie-down hooks to solid frame members or weldments, near seat level. Ensure tie-downs are fixed at approximately 45 degrees, and are within angles shown. Do not attach hooks to wheels, plastic, or removable parts of wheelchair. 4. Ensure all tie-downs are locked and properly tensioned. If necessary, rock wheelchair back and forth or manually tension retractor knobs to take up additional webbing slack. Review of the facility policy and procedure for resident transportation, with a revision date of 6/09 included in part: on page 4 of 8, "Transportation Policy: 1. Resident transportation should be completed by employees who have been trained to do so. Transportation aides must be current Nursing Assistants or Emergency Medication Technicians. The must also have valid CPR training ... 5. In the event of an emergency, call 911. Provide basic first aid. Implement CPR if it is indicated such as no heartbeat or breathing. Do not move patient if injury is suspected or unless life is threatened ..." Resident #54 was admitted to the facility on 8/3/15 with diagnoses of dementia without behaviors, cerebral infarction and polyneuropathy. The Minimum Data Set (MDS), a significant change, dated 7/12/16 indicated Resident #54 had no impairment with long or short memory and she exhibited no behaviors. The MDS indicated she required extensive assistance of two staff for bed mobility, dressing and transfer. She was not ambulatory, and required extensive assistance of one staff member for personal hygiene.	F 309	practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident choices, including but not limited to the following: Pain Management and Dialysis. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. On 5/24/2017, the Director of Nursing educated all nurses (FT, PT, PRN RN OR LPN) in reference to incidents reports. Investigation of incident: When a resident has an incident, the person discovering the resident reassures the resident and immediately alerts the primary nurse. The nurse assesses the resident for injuries after notification of incident. If the resident refuses to be assessed after notification of incident notify Director of nursing and physician. With suspected fractures of	

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THE OAKS	901 BETHESDA ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 44 Review of Transportation Aide (TA) #1's safety training for use of the van dated 8/24/16 revealed a check list that included "Secure Resident Safely for Lift Operation" and "Secure resident for transport with approved system safety device which includes using seat belts to secure the person and using approved safety straps, belts and hooks to secure the chair." Both of these were "checked" indicating she had been observed and was able to perform the tasks. Review of an incident report dated 9/30/16 at 6:43 PM indicated Resident #54 was observed during a facility van transport, while in-route, to have her legs up in the air when viewed by the TA #1 in her rear view mirror. TA #1 stopped the van, found Resident #54 lying on her back in the wheelchair. The incident report indicated the whole wheelchair fell backwards. Resident #54 informed the van driver her wheelchair fell backwards while the bus was turning. Review of the nurse's note dated 9/30/16 at 7:34 PM indicated the nurse was informed of the incident after Resident #54 was in the dining room eating dinner. After the resident finished her meal, the nurse took her to her room for an assessment. The resident had no "bumps or bruises" on her head and no bruises or red areas noted on her body. Full range of motion of her extremities was checked with no #1 after Resident #54 was in the dining room eating dinner. After the resident finished her meal, the nurse took her to her room for an assessment. The resident had no "bumps or bruises" on her head and no bruises or red areas noted on her body. Full range of motion of her extremities was checked with no limitations. Resident #54 complained of pain of the right shoulder when her	F 309	limbs, the limbs in question are immobilized. When other fractures are suspected the resident is kept immobilized and put in place and an order to send to the ER is obtained. Vital Signs are obtained. The attending physician is notified immediately of the incident if injury is apparent. If no injury is apparent the physician is notified. Notify the family or legal representative. Initial documentation in the nurse's notes needs to be complete and through. The resident is to be thoroughly assessed every shift after the incident with complete vital signs for 72 hrs. A neuro assessment is done every shift for 72 hours or according to MD orders. Incident Reporting: A Quality Assurance Incident Report is to be completed in detail and all spaces completed. The Director of nursing or designee should make sure that the resident has been thoroughly assessed, the physician and the family have been notified, and the incident report has been fully completed. Then the incident report should be investigated as follows. All resident who have a van incident should be referred to the Quality Assurance Committee. This in service was completed by May 25th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the	

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F 309	Continued From page 45 arm was raised. Nurse #1 documented the family and the on call Physician's Assistant were notified of the incident. An order was obtained to X-Ray the resident's right shoulder. Review of the nurses' note dated 10/1/16 revealed an X-Ray report indicated negative results for a fracture or dislocation of the right shoulder. The X-Ray indicated Resident #54 had chronic rotator cuff tear, moderate osteoporosis and osteopenia. Review of a self-report by the facility dated 10/7/16 revealed a report of an allegation of neglect that occurred on 9/30/16 at 5:00 PM. The report indicated Resident #54 had tipped backward in the wheelchair during transport. Part of the investigation included a statement by the TA#1. TA #1's statement included she arrived at a doctor's office around 4:26 PM on 9/30/16, to pick the resident up for transport back to the facility. She "secured all four bases of the wheelchair with safety straps. She placed the seatbelt strap around the resident's waist and through the right side of the resident's arm rest, securing both straps in place. As the driver made a left turn onto (Street Name) road, the resident informed her the wheelchair had fallen over. She looked into the rearview mirror and realized the resident's foot was upright. She proceeded to drive until she was able to find a safe and secure place to park. She kept in verbal contact with the resident to ensure she was conscious. She was about 2 blocks from the facility when she stopped the van. She asked the resident if she was alright and/or hurt. The resident informed her that she had hit the right side of her head against the van floor. The resident had no apparent injuries so she	F 309	Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. A quality review will be implemented when transports are started back once we start using the facility owned van. The director of nursing will also review incident reports during daily clinical meeting for accidents that may involve the van. If an event is identified the chart will be checked by the Director of Nursing to ensure that the patient was assessed promptly by the nurse. Chart evidence will also be validated by interviewing the patient and the nurse to ensure that assessments were conducted promptly. If errors are the Quality Assurance Committee will review the event for appropriate corrective actions. This will be done for 4 weeks, and then monthly for three months. The Director of Nursing will review all incidents reports daily during daily clinical quality of life meeting (Monday through Friday). Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager,	

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proceeded to "secure the seatbelt strap to release and move the resident and secure the wheelchair upright." After the wheelchair was secured with all four straps in place, she lifted the resident and placed her into the wheelchair. Again, she checked to see if the resident had any open wounds or bruises. She then secured her with the seatbelt and proceeded back to the facility while talking to the resident. Upon arrival to the facility, she unloaded the resident and brought her into the building. She notified the administrator of the incident.

Resident #54 had been discharged from the facility to an assisted living facility in a neighboring state. She was not available for interview.

Interview on 5/23/17 at 8:46 AM with the Administrator revealed she had TA #1 do a return demonstration of how she tied down the wheelchair in the van. After the demonstration, it was determined TA#1had not placed the securing device correctly to lock it and had not pulled it tight to secure it. The van driver was the "back up" driver. It was determined in the facility investigation TA #1 did not follow protocol after the incident. The Administrator would expect the driver to call 911, not move the resident and not proceed to the facility. The van driver had her own personal cell phone when the incident occurred. The administrator explained the van had not been used by the facility since 9/30/16. A "sister" facility had the van until yesterday (5/23/17). The keys to the van are in the administrator's office and secured by the administrator. Further interview revealed TA#1 had been terminated on 10/7/16. The main TA#2 would be in-serviced by the corporate Social Services.

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management staff before using the van again. The administrator did express the facility would be using the van after the training was completed. At present, there was not a date certain as to when the van would be used. No other incidents had occurred during transport with the facility van prior to 9/30/16.
Interview with the Director of Nursing (DON) on 5/23/17 at 11:10 AM revealed she received a call an incident had occurred with Resident #54 in the van. The resident tilted backwards during transport from a doctor's visit to the facility. Further interview revealed she did not remember who called her. The Administrator had completed an investigation of the event. A return demonstration was performed by TA#1 in the presence of the Administrator. The TA #1 was suspended pending the outcome of the investigation and all transports using the facility van was suspended on 9/30/17.

Interview with the Nurse #1 on 5/23/17 at 1:02 PM revealed the TA #1 had not informed her of the incident. Nurse #1 was the charge nurse for Resident #54. The Administrator had approached her and asked her to complete an incident report on the occurrence. She had not observed the resident before she was brought into the facility and was not sure when Resident #54 had returned to the facility. The resident returned to the facility approximately 5:00 PM and the nurse was informed about two hours later. She completed the incident report and assessed the resident after Resident #54 had finished eating supper. Nurse #1 clarified there were no injuries observed during her assessment.
An attempt to call the van driver #1 on 5/23/17 at 3:00 PM was made with no answer at the phone number provided.

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Follow up interview with the Administrator on 5/24/17 at 4:40 PM revealed the facility van had been in use from October 6, 2016 to October 25, 2016. Review of the re-training of TA's #2 and #3 indicated it was completed on 10/5/16 by a corporate staff member.

On 5/24/17 the Administrator was informed at 3:45 PM of immediate jeopardy.

The facility provided the following Credible Allegation of Compliance on 5/25/17 at 2:22 PM:

Credible Allegation for 309
Corrective Action for Affected Residents
The facility immediately began investigating the incident involving resident #54 occurring on 9/30/2016 in which resident was being transported back to the facility after a medical appointment. In route to the facility resident #54 informed the van transportation aide that her wheelchair had fallen over. The van transportation aide then looked into the rearview mirror and realized the patient's foot was upright. The van transportation aide then proceeded to drive until she was able to find a safe and secure place to park, while talking to the patient to make sure patient remained conscious. The van transportation aide was about two blocks from the facility when she stopped the van. The van transportation aide then asked resident if she was alright and or hurt. The patient per the van transportation aide had no apparent injuries so she proceeded to secure the seatbelt strap to release and move patient so she could secure the wheelchair upright. Once the wheelchair was upright and secured with all four straps in place, the van transportation aide lifted the patient

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placing her into the wheelchair. The van transportation aide then checked to make sure the patient did not have any open wounds and or bruises. The van transportation aide then secured patient with seatbelt and proceeded back to the facility while continuing to talk to patient. Upon arriving to the facility, the van transportation aide unloaded the resident and brought her into the facility dining room. The van transportation aide informed Administrator of the incident. The administrator then notified the nurse on the hall that resident was on the facility van coming from a doctor's appointment when the van transportation aide said she looked in her rear view mirror and saw resident's legs up in the air. The administrator continued to inform the nurse that the van transportation aide then stopped the bus and found resident lying on her back in her wheelchair on the floor. At that time, when administrator was notifying the nurse, the resident was in the dining room. When the administrator finished notifying the nurse of the incident, the nurse went into the dining room to find the resident was eating her dinner independently and was talking with other residents. Nurse informed resident that she needed to complete an assessment due to the incident that happened in the van. Resident then told the nurse that she wanted to finish dinner and asked if the nurse could wait until she was done with dinner. Resident did not show any signs of distress, no apparent or obvious signs of injury were noted. Once the resident completed her dinner, the nurse then proceed to take resident back to the room and transferred her to the bed. The nurse completed a full body assessment. The nurse assessed residents head with a flash light and observed no bumps or discolorations. Full range of motion was done to her extremities. Nurse

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noted that resident moved all extremities well but did complain about her right shoulder hurting when she raised her arm up. Neurochecks were initiated and were all within normal limit. Vital signs were obtained and were Temperature 98.7, P-87, and R -20 B/P 125 /72. Resident #54 Daughter and Physicians Elder Care were called and informed of the incident. Order obtained for a right shoulder x ray Physician Assistant.
X -Ray to right shoulder was completed on 9/30/2016. Impression: No radiographic evidence of acute fracture or dislocation, findings compatible with chronic rotator cuff tear, moderate osteoporosis demonstrated, moderate osteopenia.
On 9/30/2016, the facility van was taken out of operation through 10/5/2016. A 24 hour report was completed on 9/30/2016 and a 5 day report was completed on 10/7/2016. Outside transportation company was used to scheduled necessary transports for the facility. The involved employee #1 was suspended on 9/30/2016 and subsequently terminated on 10/7/2016.
On 5/24/2017, it was determined the root cause for the resident not being assessed promptly was the van transportation aide did not stop, call 911 and also moved resident without having a professional medical personnel assess resident. The facility owned van was taken out of operation from 9/30/2016 through 10/5/2016. On 10/5/2016, 2 facility staff designated to aide in facility transportations were checked off by the corporate van trainer utilizing the skills checklist and Q' Straint manufacturer guidelines. The corporate van trainer has received training directly from Q' Straint/Surelock National Training Seminar products in September 2016. The corporate van trainer utilizes the training he received, Q' Straint manufacturer guidelines, and a skills checklist to

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educate van transporters. A skills validation is also completed where the staff member must demonstrate the skills appropriately. This also included educating the new team members on the need to stop and call 911 for any accident that occurs during transports. Training was completed by the corporate van trainer on 10/5/2016 prior to the transportation aide completing any van transports. The facility owned van was placed back in service from 10/6/2016 through 10/25/2016. On 10/26/2016 facility owned van was then utilized by sister facility through 5/23/2017. The facility has not utilized the facility owned van since 10/26/2016 and the facility owned van keys are with the Administrator and no one has access to the keys. The facility owned van will be out of service until new facility staff are designated and trained by the corporate van trainer.

Corrective Action for Potentially Affected Residents

On 5/25/2017, the nurse managers verified that no patients have been transported by our facility van since 10/25/16. Six current patients were transported using the facility owned van from 10/6/2016 to 10/25/2016. On 5/25/2017, the nurse managers assessed all 6 patients for signs/symptoms of injuries related to possible transport injuries such as unexplained bruising, swelling or pain to extremities. No injuries were identified. On 5/25/17, the nurse managers also reviewed the incident reports to verify that there were no van related injuries or accidents that should have been assessed by emergency medical services during the time frame of 10/6/2017 to 10/25/2016.

Systemic changes

On 10/5/2016, corporate van trainer educated 2

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F 309	Continued From page 52 facility staff designated to aide in facility transportations; Education included; Investigation of incident: Prior to transporting any patient on the company owned van, the employee conducting the transport must be trained by our corporate van trainer .This training will included the policy statement that: In the event of an emergency, STOP and call 911. Provide basic first aid. Implement CPR if it in indicated such as no heartbeat or breathing. Do not move patient if injury is suspected or unless life is threatened. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees who operate the facility van and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff member designated to aide in facility transportation or any in-house staff involved with the facility transportation, who did not receive in-service training will not be allowed to work or participate in facility transportation using the facility owned van until training is completed. Validation of the credible allegation of compliance included review of the training information on safety and emergency procedures, interviews of the two TAs to verify their understanding of the safety training, verification the TA was CPR certified, review of the van audits completed by the corporate staff member and visualizing the van keys kept in the administrator's office. Immediate jeopardy was lifted on 5/25/17 at 7:00 PM.	F 309		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS	F 322		6/19/17

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F 322	Continued From page 53 (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide tube feeding as ordered by the physician for 1 of 1 resident (Resident #102) reviewed for tube feeding. Findings included: 1. Resident #102 was admitted to the facility on 6/20/16 with diagnoses that included dysphagia following cerebral infarction and gastrostomy. A review of the comprehensive Minimum Data Set (MDS) assessment dated 1/31/17 revealed Resident #102 had impaired cognition and severely impaired decision making skills. She was non-verbal. Resident #102 received her	F 322	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F322 NG TREATMENT/SERVICES RESTORE EATING SKILLS Corrective Action: Resident #102	

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F 322	Continued From page 54 nutrition through tube feeding. A review of care plan problems included Resident #102 required tube feeding to assist in maintaining nutritional status due to dysphagia from a stroke (dated 9/11/14) and that she could not have anything by mouth (dated 8/23/16). A care plan intervention dated 9/11/14 revealed "administer tube feeding formula and water flushes as ordered by physician." A review of the physician's order dated 6/20/16 revealed "Glucerna 1.5 at 55 cubic centimeters (cc's) per hour times 18 hours. On at 14:00 (2 PM), off at 08:00 (8 AM)." An observation of Resident #102's room was completed on 5/23/17 at 2:49 PM. Resident #102 was in her bed and the tube feeding was not administered or running as ordered for Glucerna 1.5 at 55 cc per hour. The pump was off and tube was disconnected. An observation of Resident #102's room was completed on 5/23/17 at 3:39 PM. Resident #102 was in her bed and the tube feeding was not administered or running as ordered. The pump was off and tube was disconnected. An observation of Resident #102's room was completed on 5/23/17 at 4:02 PM. Resident #102 was in her bed and the tube feeding was not administered or running as ordered. The pump was off and tube was disconnected. An observation of Resident #102's room was completed on 5/23/17 at 4:55 PM. Resident #102 was in her bed and the tube feeding was not administered or running as ordered. The pump	F 322	Physician notified on 5/24/2017. Physician orders initiated, implemented and followed as ordered and care plan updated. Identification of other residents who may be involved with this practice: All residents who are on tube feeding have the potential to be affected by this practice. All G-tube residents were identified and assessed for appropriate orders. Also facility ensured that all enteral feeding orders were initiated, implemented and followed as per physician orders. The review was completed on 5/26/2017 by Director of Nursing and/or designee. Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time, part time, and PRN) on the fact that an assisted nutrition and hydration.(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the residents clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and	

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F 322	Continued From page 55 was off and tube was disconnected. An observation of Resident #102's room was completed on 5/23/17 at 5:57 PM. Resident #102 was in her bed and the tube feeding was not administered or running as ordered. The pump was off and tube was disconnected. An observation of Resident #102's room was completed on 5/23/17 at 6:26 PM. Resident #102 was in her bed and the tube feeding was not administered or running as ordered. The pump was off and tube was disconnected. An observation of Resident #102's room was completed on 5/23/17 at 6:51 PM. Nurse #4 was in the room and upon interview stated she would begin the tube feeding "after I stop flushing her." An observation of Resident #102's room was completed on 5/23/17 at 6:55 PM. The tube feeding was running as ordered by the physician. An observation of Resident #102's room was completed on 5/24/17 at 7:58 AM. Resident #102 was in her bed and the tube feeding was running as ordered. An observation of Resident #102's room was completed on 5/24/17 at 8:24 M. Resident #102 was in her bed and the tube feeding was being administered. An observation of Resident #102's room was completed on 5/24/17 at 8:55 AM. Resident #102 was in her bed and the tube feeding was being administered. An observation of Resident #102's room was	F 322	nasal-pharyngeal ulcers. Also educated regarding appropriate G-tube orders at admission/re-admission. In-service included education of notification to Registered Dietician of needed G-tube evaluation. All enteral feeding physician orders should be implemented and followed as ordered. This in service was completed by June 16th , 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by observing 5 residents with enteral tube feeding orders to ensure that each resident is receiving tube feeding per physician orders. These observation will ensure that enteral tube feeding orders are started and stopped per physician order. This will be done for 4 weeks, and then monthly for three months. The Director of Nursing will review all incidents reports daily during daily clinical quality of life meeting (Monday through Friday). Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate.	

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F 322	Continued From page 56 completed on 5/24/17 at 9:05 AM. Resident #102 was in her bed and the tube feeding was being administered. An observation of Resident #102's room was completed on 5/24/17 at 9:35 AM. Resident #102 was in her bed and the tube feeding had been stopped. The pump was off and tube was disconnected. An interview was completed with Nurse #2 on 5/24/17 at 9:40 AM and she stated she stopped the tube feeding at 8:15 that morning. An interview was completed with the Medical Director on 5/24/17 at 12:05 PM. He stated he would be concerned if the tube feeding was not running for the ordered full amount of time. He stated he expected that if there was a reason it was not running for the full amount of time that the physician would be notified. "It would be expected to run at 18 hours unless there is an issue." An interview was completed with Nurse #4 on 5/24/17 at 3:09 PM. Nurse #4 stated when she went in to Resident #102's room on 5/23/17 at around 6:45 PM to flush the tube she observed the tube feeding was not running. She stated she gave the resident the 5:00 PM medications then started the tube feeding. She stated she did not document that the tube feeding started late. An interview was completed with Nurse #2 on 5/24/17 at 3:12 PM. Nurse #2 stated she started the tube feeding on 5/23/17 at 2:00 PM. When told the tube feeding was observed off until 6:55 PM she stated the tube was clogged and that she was not good at unclogging the tube. Nurse #2	F 322	Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager, Social Services.	

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F 322	Continued From page 57 stated she told the second shift nurse (Nurse #4) that the tube was clogged. Nurse #2 stated when a tube is clogged an attempt is made to flush the tube with lukewarm water and if it is still clogged, the physician would be called. Nurse #2 stated she did not call the physician and did not document that the tube was clogged. A review of nurses' notes from 5/21/17-5/24/17 revealed no documentation in the clinical record that Resident's #102 feeding tube was clogged, nor that the physician was contacted regarding any issues with the tube being clogged. A second interview with Nurse #4 on 5/24/17 at 3:15 PM revealed she was not notified by Nurse #2 on 05/23/17 that the tube was clogged. Nurse #4 stated when she went in to Resident #102's room about 6:45 PM she saw the feeding tube was clogged and unclogged it. An interview was completed with the Director of Nursing on 5/25/17 at 8:46 AM. She stated she was not aware the tube feeding didn't start until 6:55 PM. She stated her expectation was that staff would follow the physician's order so that resident received the adequate amount of tube feeding.	F 322		
F 323 SS=J	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	F 323		6/19/17

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F 323	Continued From page 58 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility Transportation Aide failed to secure the wheelchair to the floor of the facility van according to manufacturer's instructions before transporting one of one resident reviewed for van transportation, Resident #54. During transport the wheelchair with Resident #54 fell backwards with the resident landing on her back and hitting her head on the van floor. Resident #54 complained of right shoulder pain after the incident. Immediate jeopardy began on 9/30/16 at 5:00 PM when facility Transportation Aide #1 failed to secure the wheelchair to the facility van floor according to manufacturer's recommendation. During transport the wheelchair tipped backwards with Resident #54 landing on her back and hitting her head on the van floor. Transportation Aide#1	F 323	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Corrective Action: Resident #54 Discharged from facility. Identification of other residents who may	

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F 323	Continued From page 59 pulled over and asked Resident #54 if she was alright, and checked for cuts and bruises. Transportation Aide#1 proceeded to lift Resident #54 and place her back into the wheelchair and proceed back to the facility. Immediate jeopardy was lifted on 5/25/17 when the facility's acceptable credible allegation of compliance was verified. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedures for securing wheelchairs in the facility van for resident transport. The findings included: Review of the manufacturer's instructions "Q'Straint" provided the following: 1. Place wheelchair facing forward in securement area; apply wheel locks or turn power off. 2. Attach tie-downs into floor anchorages and ensure they are locked in. 3. Attach the four tie-down hooks to solid frame members or weldments, near seat level. Ensure tie-downs are fixed at approximately 45 degrees, and are within angles shown. Do not attach hooks to wheels, plastic, or removable parts of wheelchair. 4. Ensure all tie-downs are locked and properly tensioned. If necessary, rock wheelchair back and forth or manually tension retractor knobs to take up additional webbing slack. Review of the facility policy and procedure for resident transportation, with a revision date of June 2009 included in part: on page 4 of 8, "Transportation Policy: 1. Resident transportation should be completed by employees who have been trained to do so. Transportation aides must	F 323	be involved with this practice: All residents have the potential to be affected by the alleged practice. On 9/30/2016, the facility van was taken out of operation through 10/5/2016. On 10/5/2017, the corporate van trainer completed the Vehicle Inspection: Safety Inspection check list for the one facility owned van. No concerns were identified.On 10/1/2016 the administrator began interviewing all alert and oriented residents that were transported on the facility owned van to ensure they were secured by the shoulder and lap seatbelt and front and back floor retractors according to facility policy and Q' Straint manufacturer guidelines. This audit was conducted weekly for 4 weeks. No concerns were identified. Employee #1 was terminated on 10/7/2016. Current residents that were transported on the facility owned van from 10/6/2016 to 10/25/2016 have the potential to be affected by this alleged practice. An audit was completed on 05/24/2017 by the Administrator to determine which residents were transported by the facility van from 10/6/2016 to 10/25/2016. 6 Current residents were identified. On 05/24/2017, the Director of Nursing interviewed the identified 6 alert and oriented residents that were transported 10/6/2016 to 10/25/2016 for any safety concerns during transports and to validate that the following technique was used to secure their wheelchair during transportations: all 4 floor retractors are hooked to the wheelchair, the seat belt is attached across the residents lap and	

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F 323	Continued From page 60 be current Nursing Assistants ... must also have valid CPR training ... 5. In the event of an emergency, call 911. Provide basic first aid. Implement CPR if it is indicated such as no heartbeat or breathing. Do not move patient if injury is suspected or unless life is threatened ..." Resident #54 was admitted to the facility on 8/3/15 with diagnoses of dementia without behaviors, cerebral infarction and polyneuropathy. The Minimum Data Set (MDS), a significant change, dated 7/12/16 indicated Resident #54 had no impairment with long or short memory and she exhibited no behaviors. The MDS indicated she required extensive assistance of two staff for bed mobility, dressing and transfer. She was not ambulatory, and required extensive assistance of one staff member for personal hygiene. Review of the Transportation Aide (TA) #1"s safety training for use of the van dated 8/24/16 revealed a check list that included "Secure Resident Safely for Lift Operation" and "Secure resident for transport with approved system safety device which includes using seat belts to secure the person and using approved safety straps, belts and hooks to secure the chair." Both of these items were "checked" indicating she had been observed and was able to perform the tasks. Review of an incident report dated 9/30/16 at 6:43 PM indicated Resident #54 was observed during a facility van transport, while in-route, to have her legs up in the air when viewed by TA #1 in her rear view mirror. TA #1 stopped the van, found Resident #54 lying on her back in the wheelchair. The incident report indicated the whole	F 323	secured to floor restraints, and the shoulder strap is positioned across the shoulder and secured to the lap belt. All 6 alert and oriented residents stated the above procedures have been followed for their transports occurring from 10/6/2016 to 10/25/2016 and they did not have any safety concerns. Systemic Changes: Director of Nursing and /or Designee in serviced all staff (full time, part time, and PRN) to inform that the facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. On 10/5/2016, 2 facility staff designated to aide in facility transportations were checked off by the corporate van trainer utilizing the skills checklist and Q' Straint manufacturer guidelines. The corporate van trainer has received training directly from Q' Straint/Surelock National Training Seminar products in September 2016. The corporate van trainer utilizes the training he received, Q' Straint manufacturer guidelines, and a skills checklist to educate van transporters. A skills validation is also completed where the staff member must demonstrate the skills appropriately. This also included educating the team members on the need to stop and call 911 for any accident that occurs during transports. On 10/5/2016, training was completed by the corporate van trainer for facility staff designated to transport prior to completing any van	

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F 323	Continued From page 61 wheelchair fell backwards. Resident #54 informed the van driver her wheelchair fell backwards while the bus (van) was turning. Review of the nurse's note dated 9/30/16 at 7:34 PM and signed by Nurse #1, indicated Nurse #1 was informed of the incident after Resident #54 was in the dining room eating dinner. After the resident finished her meal, the nurse took her to her room for an assessment. The resident had no "bumps or bruises" on her head and no bruises or red areas noted on her body. Full range of motion of her extremities was checked with no limitations. Resident #54 complained of pain of the right shoulder when her arm was raised. Review of the medical record revealed neurological assessments were initiated on 9/30/16 at 7:34 PM as part of the nurses' assessments. Resident #54 had no symptoms of a head injury per the assessments. Review of the nurses' note dated 10/1/16 revealed an X-Ray was ordered of the right shoulder with negative results for a fracture or dislocation. The X-Ray indicated Resident #54 had chronic rotator cuff tear, moderate osteoporosis and osteopenia. Review of the nurse practitioner's progress note dated 10/3/16 indicated the resident was seen due to a fall from the wheelchair while inside the van. Resident #54 was assessed and found to have limited range of motion of bilateral shoulders which was chronic. The X-Ray report and findings were reviewed with no fracture or dislocation noted. The progress note listed diagnoses as chronic	F 323	transports. A quality review will also be implemented when transports are started back on 10/6/2016. The review includes the administrator or maintenance director in their absence will observe facility van transports weekly for 2 weeks to ensure residents and the chair are secured to the vehicle by visualizing that all 4 floor retractors are hooked to the wheelchair, that the seat belt is attached across the residents lap and secured to floor restraints, shoulder strap is positioned across the shoulder and secured to the lap belt. The administrator will be responsible for ensuring safe transportation of residents. In addition to this, alert and oriented residents will be interviewed asking if their wheelchairs were secured and seat belts applied according to Q'Straint manufacturer instructions. If errors are identified the employee will be suspended pending an investigation of the allegations. This in service was completed by June 16th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using	

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F 323	Continued From page 62 torn rotator cuff, osteoporosis and osteopenia. Review of self-report by the facility dated 10/7/16 revealed a report of an allegation of neglect that occurred on 9/30/16 at 5:00 PM. The report indicated Resident #54 had tipped backward in the wheelchair during transport. Part of the investigation included a statement by TA #1 indicated she arrived at a doctor's office around 4:26 PM on 9/30/16, to pick the resident up for transport back to the facility. She "secured all four bases of the wheelchair with safety straps. She placed the seatbelt strap around the resident's waist and through the right side of the resident's arm rest, securing both straps in place. As the driver made a left turn onto [Street Name] road, the resident informed her the wheelchair had fallen over. She looked into the rearview mirror and realized the resident's foot was upright. She proceeded to drive until she was able to find a safe and secure place to park. She kept in verbal contact with the resident to ensure she was conscious. She was about 2 blocks from the facility when she stopped the van. She asked the resident if she was alright and/or hurt. The resident informed her that she had hit the right side of her head against the van floor. The resident had no apparent injuries so she proceeded to "secure the seatbelt strap to release and move the resident and secure the wheelchair upright." After the wheelchair was secured with all four straps in place, she lifted the resident and placed her into the wheelchair. Again, she checked to see if the resident had any open wounds or bruises. She then secured her with the seatbelt and proceeded back to the facility while talking to the resident. Upon arrival to the facility, she unloaded the resident and brought her into the building. She notified the	F 323	the QA survey tool. A quality review will be implemented when transports are started back once we start using the facility owned van. The director of nursing will also review incident reports during daily clinical meeting for accidents that may involve the van. If an event is identified the chart will be checked by the Director of Nursing to ensure that the patient was assessed promptly by the nurse. Chart evidence will also be validated by interviewing the patient and the nurse to ensure that assessments were conducted promptly. If errors are the Quality Assurance Committee will review the event for appropriate corrective actions. This will be done for 4 weeks, and then monthly for three months. The Director of Nursing will review all incidents reports daily during daily clinical quality of life meeting (Monday through Friday). Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services.	

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administrator of the incident.

Resident #54 had been discharged from the facility to an assisted living facility in a neighboring state. She was not available for interview.

Interview on 5/23/17 at 8:46 AM with the Administrator revealed she had the TA#1 do a return demonstration of how she tied down the wheelchair in the van. After the demonstration, it was determined the TA#1 had not placed the securing device correctly to lock it and had not pulled it tight to secure it. TA #1 was the "back up" driver. The administrator explained the van had not been used by the facility since 9/30/16. A "sister" facility had the van until yesterday (5/23/17). The keys to the van were in the administrator's office and secured by the administrator. Further interview revealed TA#1 had been terminated on 10/7/16. The main TA#2 will be in-serviced by the corporate management staff before using the van again. The administrator did express the facility would be using the van after the training was completed. At present, there was not a date certain as to when the van would be used. No other incidents had occurred during transport with the facility van prior to 9/30/16.

Interview with the Director of Nursing (DON) on 5/23/17 at 11:10 AM revealed she received a call an incident had occurred with Resident #54 in the van. The resident tilted backwards during transport from a doctor's visit to the facility. Further interview revealed she did not remember who called her. The administrator had completed an investigation of the event. A return demonstration was performed by the TA#1 in the

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presence of the Administrator. TA#1 was suspended pending the outcome of the investigation and all transports using the facility van was suspended on 9/30/17.

Interview on 5/23/17 at 8:46 AM with the Administrator revealed she had TA#1 do a return demonstration of how she tied down the wheelchair in the van. After the demonstration, it was determined TA #1 had not placed the securing device correctly to lock it and had not pulled it tight to secure it. TA#1 was the "back up" driver. It was determined in the facility investigation TA#1 did not follow protocol after the incident. The Administrator would expect the driver to call 911, not move the resident and not proceed to the facility. The van driver had her own personal cell phone when the incident occurred.

Interview with the Nurse #1 on 5/23/17 at 1:02 PM revealed TA#1 had not informed her of the incident. Nurse #1 stated the Administrator had approached her and asked her to complete an incident report on the occurrence. The nurse explained she had not observed the resident before she was brought into the facility and was not sure when she had returned to the facility. Nurse #1 completed the incident report and assessed the resident after Resident #54 had finished eating supper. She clarified there were no injuries observed during her assessment.

An attempt to call TA#1 on 5/23/17 at 3:00 PM was made with no answer at the phone number provided.

Follow up interview with the Administrator on 5/24/17 at 4:40 PM revealed the facility van had

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been in use from October 6, 2016 to October 25, 2016. Review of the re-training of TA#2 and #3 indicated it was completed on 10/5/16 by a corporate staff member.

On 5/24/17 the Administrator was informed at 3:45 PM of immediate jeopardy.

The facility provided the following Credible Allegation of Compliance on 5/25/17 at 2:22 PM:

Credible Allegation for F323
Corrective Action for Affected Residents
The facility immediately began investigating the incident involving Resident #54 occurring on 9/30/2016 in which resident was being transported back to the facility after a medical appointment. In route to the facility Resident #54 informed the van transportation aide that her wheelchair had fallen over. The van transportation aide then looked into the rearview mirror and realized the patient's foot was upright. The van transportation aide then proceeded to drive until she was able to find a safe and secure place to park, while talking to the patient to make sure patient remained conscious. The van transportation aide was about two blocks from the facility when she stopped the van. The van transportation aide then asked the resident if she was alright and or hurt. The patient per the van transportation aide had no apparent injuries so she proceeded to secure the seatbelt strap to release and move patient so she could secure the wheelchair upright. Once the wheelchair was upright and secured with all four straps in place, the van transportation aide lifted the patient placing her into the wheelchair. The van transportation aide then checked to make sure the patient did not have any open wounds and or

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bruises. The van transportation aide then secured patient with seatbelt and proceeded back to the facility while continuing to talk to patient. Upon arriving to the facility, the van transportation aide unloaded the resident and brought her into the facility dining room. The van transportation aide informed Administrator of the incident. The administrator then notified the nurse on the hall that resident was on the facility van coming from a doctor's appointment when the van transportation aide said she looked in her rear view mirror and saw resident's legs up in the air. The administrator continued to inform the nurse that the van transportation aide then stopped the bus and found resident lying on her back in her wheelchair on the floor. At that time, when Administrator was notifying the nurse, the resident was in the dining room. When the administrator finished notifying the nurse of the incident, the nurse went into the dining room to find the resident was eating her dinner independently and was talking with other residents. Nurse informed resident that she needed to complete an assessment due to the incident that happened in the van. Resident then told the nurse that she wanted to finish dinner and asked if the nurse could wait until she was done with dinner. Resident did not show any signs of distress, no apparent or obvious signs of injury were noted. Once the resident completed her dinner, the nurse then proceed to take resident back to the room and transferred her to the bed. The nurse completed a full body assessment. The nurse assessed residents head with a flash light and observed no bumps or discolorations. Full range of motion was done to her extremities. Nurse noted that resident moved all extremities well but did complain about her right shoulder hurting when she raised her arm

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up. Neurochecks were initiated and were all within normal limit. Vital signs were obtained and were Temperature 98.7, P-87, and R -20 B/P 125 /72. Resident #54's Daughter and Physicians Elder Care were called and informed of the incident. Order obtained for a right shoulder x ray Physician Assistant.
X -Ray to right shoulder was completed on 9/30/2016. Impression: No radiographic evidence of acute fracture or dislocation, findings compatible with chronic rotator cuff tear, moderate osteoporosis demonstrated, moderate osteopenia.
On 9/30/2016, the facility van was taken out of operation through 10/5/2016. A 24 hour report was completed on 9/30/2016 and a 5 day report was completed on 10/7/2016. Outside transportation company was used to schedule necessary transports for the facility from 10/1/2016 to 10/5/2016. The involved employee #1 was suspended on 9/30/2016 and subsequently terminated on 10/7/2016. On 10/5/2016, the corporate van trainer investigated the incident and determined the root cause of this event was the transportation aide failed to secure the front floor retractors to the resident's wheelchair according to Q' Straint manufacturer guidelines.
The facility owned van was taken out of operation from 9/30/2016 through 10/5/2016. On 10/5/2016, 2 facility staff designated to aide in facility transportations were checked off by the corporate van trainer utilizing the skills checklist and Q' Straint manufacturer guidelines. The corporate van trainer has received training directly from Q' Straint/Surelock National Training Seminar products in September 2016. The corporate van trainer utilizes the training he received, Q' Straint manufacturer guidelines, and a skills checklist to

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educate van transporters. A skills validation is also completed where the staff member must demonstrate the skills appropriately. This also included educating the new team members on the need to stop and call 911 for any accident that occurs during transports. Training was completed by the corporate van trainer on 10/5/2016 prior to the transportation aide completing any van transports. The facility owned van was placed back in service from 10/6/2016 through 10/25/2016. On 10/26/2016 facility owned van was then utilized by sister facility through 5/23/2017. The facility has not utilized the facility owned van since 10/26/2016 and the facility owned van keys are with the Administrator and no one has access to the keys. The facility owned van will be out of service until new facility staff are designated and trained by the corporate van trainer.

Resident #54 was not able to reenact the incident and was not able to recall how the straps were placed on her wheelchair.

On 10/3/2016 Employee reenacted the incident to the administrator and stated "I loaded the patient into the van, securing all four bases of the patient's wheelchair with safety straps. I also placed the seatbelt strap around patient's waist and through the right side of patient's armrest, securing both straps in place."

The root cause of the incident is employee #1 did not follow Q' Straint manufacturer guidelines and facility policy in securing the resident and wheelchair prior to completing the transport.

Corrective Action for Potentially Affected Residents

On 9/30/2016, the facility van was taken out of operation through 10/5/2016. On 10/5/2017, the corporate van trainer completed the Vehicle Inspection: Safety Inspection check list for the

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one facility owned van. No concerns were identified.
On 10/1/2016 the administrator began interviewing all alert and oriented residents that were transported on the facility owned van to ensure they were secured by the shoulder and lap seatbelt and front and back floor retractors according to facility policy and Q' Straint manufacturer guidelines. This audit was conducted weekly for 4 weeks. No concerns were identified.
Employee #1 was terminated on 10/7/2016.
Current residents that were transported on the facility owned van from 10/6/2016 to 10/25/2016 have the potential to be affected by this alleged practice. An audit was completed on 05/24/2017 by the Administrator to determine which residents were transported by the facility van from 10/6/2016 to 10/25/2016. 6 Current residents were identified.
On 05/24/2017, the Director of Nursing interviewed the identified 6 alert and oriented residents that were transported 10/6/2016 to 10/25/2016 for any safety concerns during transports and to validate that the following technique was used to secure their wheelchair during transportations: all 4 floor retractors are hooked to the wheelchair, the seat belt is attached across the residents lap and secured to floor restraints, and the shoulder strap is positioned across the shoulder and secured to the lap belt. All 6 alert and oriented residents stated the above procedures have been followed for their transports occurring from 10/6/2016 to 10/25/2016 and they did not have any safety concerns.
Systematic Changes
On 10/5/2016, 2 facility staff designated to aide in facility transportations were checked off by the

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corporate van trainer utilizing the skills checklist and Q' Straint manufacturer guidelines. The corporate van trainer has received training directly from Q' Straint/Surelock National Training Seminar products in September 2016. The corporate van trainer utilizes the training he received, Q' Straint manufacturer guidelines, and a skills checklist to educate van transporters. A skills validation is also completed where the staff member must demonstrate the skills appropriately. This also included educating the new team members on the need to stop and call 911 for any accident that occurs during transports. Training was completed by the corporate van trainer on 10/5/2016 prior to the transportation aide completing any van transports.

A quality review will also be implemented when transports are started back on 10/6/2017. The review includes the administrator or maintenance director in their absence will observe facility van transports weekly for 2 weeks to ensure residents and the chair are secured to the vehicle by visualizing that all 4 floor retractors are hooked to the wheelchair, that the seat belt is attached across the residents lap and secured to floor restraints, shoulder strap is positioned across the shoulder and secured to the lap belt. The administrator will be responsible for ensuring safe transportation of residents. In addition to this, alert and oriented residents will be interviewed asking if their wheelchairs were secured and seat belts applied according to Q'Straint manufacturer instructions. If errors are identified the employee will be suspended pending an investigation of the allegations.

Any staff member designated to aide in facility transportation or any in-house staff involved with the facility transportation, who did not receive

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F 323	Continued From page 71 in-service training will not be allowed to work or participate in facility transportation using the facility owned van until training is completed. Validation of the credible allegation of compliance included review of the training information on safety and emergency procedures, interviews of the two current TA's to verify their understanding of the safety training, verification the van driver was CPR certified, review of the van audits completed by the corporate staff member and visualizing the van keys kept in the administrator's office. Immediate jeopardy was lifted on 5/25/17 at 7:00 PM.	F 323		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or 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.	F 371		6/19/17

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F 371	Continued From page 72 (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 observations and staff interviews, the facility failed to label food items and properly clean 1 of 3 residents' nourishment refrigerators. Nourishment Refrigerator #3. Findings included: During an observation on 5/24/17 at 10:04 a.m., nourishment refrigerator #3 located in the medication room at nursing station #3 contained 4-unopened food items without names of ownership (1-container of ice cream, 1-frozen entree, 1-can soda and 1-bottled soda). The Dietary Manager (DM) indicated these items were not purchased by the facility's dietary services. There were also large yellowed stains throughout the refrigerator and a large red sticky, stain was observed on the bottom shelf and inside one of the bins in the refrigerator. During an interview on 5/24/17 at 1:00 p.m., the DM revealed that the housekeeping staff were responsible for keeping the nourishment refrigerators and the nourishment areas clean. She also stated that the nourishment refrigerators were for the storage of food items belonging to and for the residents of the facility, only. During an interview on 5/25/17 at 10:27 a.m., the Environmental Services Supervisor stated that prior to the hiring of the new DM, there was a	F 371	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 371 Food Procedure Corrective Action for Resident Affected An audit tool was put into place to monitor safe food storage practices and cleanliness of Nourishment areas on a daily basis. Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this alleged deficient practice. The audit tool began on June 5, 2017 to monitor safe food storage practices & cleanliness of Nourishment Areas. Systemic Changes On 5/24/17 items that were not properly labeled and dated for residents were	

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F 371	Continued From page 73 verbal arrangement made between Housekeeping Services and Dietary Services that each of these departments would alternate cleaning the nourishment refrigerators weekly and when needed. The Supervisor revealed there was no written schedule or auditing report maintained to support this arrangement.	F 371	discarded, housekeeping was notified and the refrigerator was cleaned. An in-service was conducted on May 29, 2017, June 3, 2017 and June 5, 2017 by the Dietary Manager. Those who attended were all dietary staff. The in-service topic included maintenance of food storage areas in the nourishment rooms. Any in-house staff member who did not receive in-service training was not be allowed to work until training was completed. Information presented included monitoring of nourishment food storage areas. All monitoring tools/audits will be completed and findings will be reported to the weekly/monthly QA meeting. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Dietary employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Dietary Manager or Consultant Dietitian for Gallins Dining and Nutrition will monitor this issue using the "Dietary Quality Assurance Audit" tool. This will be 5 days/week for four weeks and then weekly times two months or until resolved by Quality Of Life/Quality Assurance committee. Reports will be given to the weekly Quality of Life- Quality Assurance committee and corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and	

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F 371	Continued From page 74	F 371	ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager, Social Services, and Medical Director.	
F 490 SS=J	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's administration failed to operationalize manufacturer's recommendations for transporting a resident in the facility van resulting in a fall with Resident #54 hitting her head on the van floor. The facility administration failed to enforce a policy that would ensure the resident's wheelchair was secured according to manufacturer's instructions and follow emergency procedures when the wheelchair fell backwards with the resident. After the resident fell in the van, the facility staff moved the resident back into the wheelchair and drove her back to the facility without assessment from licensed staff for potential injury. This was evident in 1 (Resident #54) of 1 sampled resident who was transported using the facility's van. Immediate jeopardy began on 9/30/16 at 5:00 PM	F 490	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F490 EFFECTIVE ADMINISTRATION /RESIDENT WELL-BEING Corrective Action: Resident #54 Discharged from facility.	6/19/17

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F 490	Continued From page 75 when facility Transportation Aide #1 failed to secure the wheelchair to the facility van floor according to manufacturer's recommendation. During transport the wheelchair tipped backwards with Resident #54 landing on her back and hitting her head on the van floor. Transportation Aide#1 pulled over and asked Resident #54 if she was alright, and checked for cuts and bruises. Transportation Aide#1 proceeded to lift Resident #54 and place her back into the wheelchair and proceed back to the facility. Immediate jeopardy was removed on 5/25/17 when the facility's acceptable credible allegation of compliance was verified. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedures for securing wheelchairs in the facility van for resident transport. Findings included: 1. Cross refer: F323Based on record review and staff interviews the facility Transportation Aide (TA) #1 failed to secure the wheelchair to the floor of the facility van according to manufacturer's instructions before transporting one of one resident reviewed for van transportation, Resident #54. During transport the wheelchair with Resident #54 fell backwards with the resident landing on her back and hitting her head on the van floor. Resident #54 complained of right shoulder pain after the incident. 2. Cross refer: F309 Based on record review and staff interviews the facility TA#1 failed to secure the wheelchair according to manufacturer's recommendation for Resident #54, to the floor of the facility van before transport. During transport	F 490	Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On 9/30/2016, the facility van was taken out of operation through 10/5/2016. On 10/5/2017, the corporate van trainer completed the Vehicle Inspection: Safety Inspection check list for the one facility owned van. No concerns were identified. On 05/24/2017 the Clinical RN consultant met with the administrator to determine who the facility utilized as facility van drivers and that the designated drivers met the following criteria: Resident transportation should be completed by employees who have been trained to do so. Transportation aides must be current Nursing Assistants or Emergency Medication Technicians. They must also have valid CPR training. All van drivers must hold a valid North Carolina drivers license, have had a drivers license DMV check, and have had documented training on van usage prior to transportation of residents. In addition to this, the administrator was educated on ensuring that staff designated to transport residents on the facility van understand the importance and expectation of the administrator for following Q' Straint manufacturer guidelines when transporting residents. There will be no tolerance of transportation staff not following the manufacturer guidelines or having an attitude of non-compliance.1 Employee was designated as facility van drivers meeting the above criteria. On 05/24/2017 the Clinical RN Consultant	

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F 490	Continued From page 76 the wheelchair with Resident #54 fell backwards with the resident landing on her back and hitting her head on the van floor. The TA#1 failed to call 911 and the facility after the incident and moved the resident back to a sitting position in the wheelchair after the incident. Resident #54 complained of right shoulder pain after the incident. This was for one of one residents transported in the facility van Resident #54. On 5/24/17 at 3:45 PM, the Administrator was informed of the immediate jeopardy. The facility provided an acceptable credible allegation of compliance on 5/25/17 at 2:22 PM. The credible allegation included: Credible Allegation for F490 Corrective Action for Affected Residents The facility immediately began investigating the incident involving resident #54 occurring on 9/30/2016 in which resident was being transported back to the facility after a medical appointment. In route to the facility resident #54 informed the van transportation aide that her wheelchair had fallen over. The van transportation aide then looked into the rearview mirror and realized the patient's foot was upright. The van transportation aide then proceeded to drive until she was able to find a safe and secure place to park, while talking to the patient to make sure patient remained conscious. The van transportation aide was about two blocks from the facility when she stopped the van. The van transportation aide then asked resident if she was alright and or hurt. The patient per the van transportation aide had no apparent injuries so she proceeded to secure the seatbelt strap to release and move patient so she could secure the wheelchair upright. Once the wheelchair was	F 490	reviewed the skills check list for the designated van driver to ensure that the skills check list were completed by the corporate van trainer on 10/5/2016 or sooner. On 9/30/2016, the one facility owned van was removed from operation and outside transportation company was used to scheduled necessary transports for the facility from 10/1/2016 to 10/5/2016. Systemic Changes: On 05/24/2017, the Clinical RN Nurse Consultant educated all current FT, PT and PRN employees who operate the one facility owned van were educated on the following Resident Transportation Policy and Procedure. Transportation Policy: 1. Resident transportation should be completed by employees who have been trained to do so. Transportation aides must be current Nursing Assistants or Emergency Medication Technicians. They must also have valid CPR training. 2. PRIOR to operating a facility transportation vehicle, the TSP-101 DAILY VAN CHECKLIST will be completed. All residents will be properly secured with appropriate strapping of wheelchairs and/or seatbelt placement. Under no circumstances will the van be operated without adequate seatbelts for every resident being transported. If there is an issue identified on the daily checklist, it must be reviewed and corrected prior to the van being used if it is a patient safety issue. 3. The van will also be inspected by the maintenance director or designee on a	

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F 490	Continued From page 77 upright and secured with all four straps in place, the van transportation aide lifted the patient placing her into the wheelchair. The van transportation aide then checked to make sure the patient did not have any open wounds and or bruises. The van transportation aide then secured patient with seatbelt and proceeded back to the facility while continuing to talk to patient. Upon arriving to the facility, the van transportation aide unloaded the resident and brought her into the facility dining room. The van transportation aide informed Administrator of the incident. The administrator then notified the nurse on the hall that resident was on the facility van coming from a doctor's appointment when the van transportation aide said she looked in her rear view mirror and saw resident's legs up in the air. The administrator continued to inform the nurse that the van transportation aide then stopped the bus and found resident lying on her back in her wheelchair on the floor. At that time, when administrator was notifying the nurse, the resident was in the dining room. When the administrator finished notifying the nurse of the incident, the nurse went into the dining room to find the resident was eating her dinner independently and was talking with other residents. Nurse informed resident that she needed to complete an assessment due to the incident that happened in the van. Resident then told the nurse that she wanted to finish dinner and asked if the nurse could wait until she was done with dinner. Resident did not show any signs of distress, no apparent or obvious signs of injury were noted. Once the resident completed her dinner, the nurse then proceed to take resident back to the room and transferred her to the bed. The nurse completed a full body assessment. The nurse assessed residents head with a flash light and	F 490	weekly basis. Results of the inspection will be documented on form TSP-102 WEEKLY CHECKLIST. 4. All van drivers must hold a valid North Carolina drivers license, have had a drivers license DMV check, and have had documented training on van usage prior to transportation of residents. 5. In the event of an emergency, call 911. Provide basic first aid. Implement CPR if it in indicated such as no heartbeat or breathing. Do not move patient if injury is suspected or unless life is threatened. 6. All wheelchairs used for transportation of residents must be approved for transport use. If a personally-owned wheelchair (not a wheelchair provided or arranged by the facility) is to be used for transportation, it must be approved by Liberty Risk Management to determine if it is safe for transport use. 7. Power wheelchairs must be fitted with transportation appropriate straps for correct tie down procedures in order to be ready for use in the transportation van. If they do not have manufacturer installed safety strap attachment points or cannot be fitted with attachment devices from the manufacturer, they cannot be considered safe for transport. 8. All transportation Aids must have completed annual transportation safety training. 9. Training must include the safe procedures for loading and unloading of residents, the safe and proper use of the approved safety restraint system provided by the manufacturer of the transportation van and emergency measures to remove	

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	345284	A. BUILDING _____ B. WING _____	C 05/25/2017

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F 490	Continued From page 78 observed no bumps or discolorations. Full range of motion was done to her extremities. Nurse noted that resident moved all extremities well but did complain about her right shoulder hurting when she raised her arm up. Neurochecks were initiated and were all within normal limit. Vital signs were obtained and were Temperature 98.7, P-87, and R -20 B/P 125 /72. Resident #54 Daughter and Physicians Elder Care were called and informed of the incident. Order obtained for a right shoulder x ray Physician Assistant. X -Ray to right shoulder was completed on 9/30/2016. Impression: No radiographic evidence of acute fracture or dislocation, findings compatible with chronic rotator cuff tear, moderate osteoporosis demonstrated, moderate osteoarthritis. On 9/30/2016, the facility van was taken out of operation through 10/5/2016. A 24 hour report was completed on 9/30/2016 and a 5 day report was completed on 10/7/2016. Outside transportation company was used to schedule necessary transports for the facility. The involved employee #1 was suspended on 9/30/2016 and subsequently terminated on 10/7/2016. On 10/5/2016, the corporate van trainer investigated the incident and determined the root cause of this event was the transportation aide failed to secure the front floor retractors to the resident's wheelchair according to Q' Straint manufacturer guidelines. The facility owned van was taken out of operation from 9/30/2016 through 10/5/2016. On 10/5/2016, 2 facility staff designated to aide in facility transportations were checked off by the corporate van trainer utilizing the skills checklist and Q' Straint manufacturer guidelines. The corporate van trainer has received training directly from Q' Straint/Surelock National Training Seminar	F 490	residents from the safety restraint system. 10. Immediately notify the Administrator when an incident occurs during a van transport regardless of how minor the incident is. This includes resident and non-resident incidents. Incidents include but are not limited to: fall from wheelchair, equipment malfunction, refusal of resident to utilize safety belts, and injury of any nature. Administrator phone number 336-830-1356 The following amendment to the policy is to insure safety of residents during loading and application of the safety restraint system; Item #1: All wheelchairs used in transportation must have foot rests in place (attached to the chair) during loading, transport and unloading of residents. It has been determined that the resident's feet must be on the wheelchair foot rests to prevent feet and toes being caught or pinched in the lift bridge plate during lift operations, resulting in injury. Foot rests can help to keep feet in a position that will not allow toes to slide under the bridge plate. If the chair being used for transportation does not have foot rests attached at the time of transport, appropriate foot rests are to be located and attached to the chair properly or another chair with foot rests is to be used. It is recommended the transportation aids set aside a wheelchair for transportation use ahead of time to void the necessity of locating and fitting another wheelchair. Item #2: All wheelchairs used in transportation	

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F 490	Continued From page 79 products in September 2016. The corporate van trainer utilizes the training he received, Q' Straint manufacturer guidelines, and a skills checklist to educate van transporters. A skills validation is also completed where the staff member must demonstrate the skills appropriately. This also included educating the new team members on the need to stop and call 911 for any accident that occurs during transports. Training was completed by the corporate van trainer on 10/5/2016 prior to the transportation aide completing any van transports. The facility owned van was placed back in service from 10/6/2016 through 10/25/2016. On 10/26/2016 facility owned van was then utilized by sister facility through 5/23/2017. The facility has not utilized the facility owned van since 10/26/2016 and the facility owned van keys are with the Administrator and no one has access to the keys. The facility owned van will be out of service until new facility staff are designated and trained by the corporate van trainer. Resident #54 was not able to reenact the incident and was not able to recall how the straps were placed on her wheelchair. On 10/3/2016 Employee reenacted the incident to the administrator and stated "I loaded the patient into the van, securing all four bases of the patient's wheelchair with safety straps. I also placed the seatbelt strap around patient's waist and through the right side of patient's armrest, securing both straps in place." The root cause of the incident is employee #1 did not follow Q' Straint manufacturer guidelines and facility policy in securing the resident and wheelchair prior to completing the transport. Corrective Action for Potentially Affected Residents On 9/30/2016, the facility van was taken out of	F 490	must be of the types that have removable arm rest. Access to the unrestricted back of the wheelchair seat is required to secure the lap safety belt in place over the resident's lap. Placing the lap belt through the underside of the arm rest does not allow the belt to restrain the resident at the hip. The safety lap belt must cross over the lap from hip to hip to keep the resident from slipping out of the seat. Item #3: Wheelchair Floor restraints are never to be attached to the cross (X) bars of the wheelchair. The cross bars are not part of the frame of the chair and will collapse if the chair is forced on its side as in a hard turn. All floor straps are to be attached to the frame at or above the point where welded joints connect the frame. This is typically found where the wheels or wheel casters are attached. Item #4 Geriatric Chairs can never be used for transport. Gerri Chairs have no way to lock the reclining feature of the chair and may fall into a reclining position during transport. IN the event of a chair reclining during transport the safety harness system will not protect the resident and may result in a serious or fatal event. Item #5 Power Wheelchairs must be approved for transportation before they can be used for transport of a resident. If they are not considered safe for transport, the facility must provide a facility approved chair for the resident transportation needs. Item #6 Unoccupied wheelchairs will no longer be	

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F 490	Continued From page 80 operation through 10/5/2016. On 10/5/2017, the corporate van trainer completed the Vehicle Inspection: Safety Inspection check list for the one facility owned van. No concerns were identified. On 05/24/2017 the Clinical RN consultant met with the administrator to determine who the facility utilized as facility van drivers and that the designated drivers met the following criteria: Resident transportation should be completed by employees who have been trained to do so. Transportation aides must be current Nursing Assistants or Emergency Medication Technicians. They must also have valid CPR training. All van drivers must hold a valid North Carolina drivers' license, have had a drivers' license DMV check, and have had documented training on van usage prior to transportation of residents. In addition to this, the administrator was educated on ensuring that staff designated to transport residents on the facility van understand the importance and expectation of the administrator for following Q' Straint manufacturer guidelines when transporting residents. There will be no tolerance of transportation staff not following the manufacturer guidelines or having an attitude of non-compliance. 1 Employee was designated as facility van drivers meeting the above criteria. On 05/24/2017 the Clinical RN Consultant reviewed the skills check list for the designated van driver to ensure that the skills check list were completed by the corporate van trainer on 10/5/2016 or sooner. On 9/30/2016, the one facility owned van was removed from operation and outside transportation company was used to scheduled necessary transports for the facility from 10/1/2016 to 10/5/2016. The facility owned van was taken out of operation	F 490	transported on the facility van. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees who operate the facility van and will be reviewed by the Quality Assurance process to verify that the change has been sustained. A quality review will also be implemented when transports are started back once we start using facility owned van. The review includes the administrator or maintenance director in their absence will observe facility van transports daily for 2 weeks to ensure residents and the chair are secured to the vehicle by visualizing that all 4 floor retractors are hooked to the wheelchair, that the seat belt is attached across the residents lap and secured to floor restraints, shoulder strap is positioned across the shoulder and secured to the lap belt. The administrator will be responsible for ensuring safe transportation of residents. In addition to this, alert and oriented residents will be interviewed asking if the transporter secured both front and back safety harnesses as well as the wheelchair to the van floor. If errors are identified the employee will be suspended pending an investigation of the allegations. The administrator and director of nursing attended the van training on 10/5/2016 provided by the corporate van trainer to ensure proper knowledge of the safety harness system in order to verify that it is completed correctly. Any staff member designated to aide in facility transportation or any in-house	

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F 490	Continued From page 81 from 9/30/2016 through 10/5/2016. On 10/5/2016, 2 facility staff designated to aide in facility transportations were checked off by the corporate van trainer utilizing the skills checklist and Q' Straint manufacturer guidelines. The corporate van trainer has received training directly from Q' Straint/Surelock National Training Seminar products in September 2016. The corporate van trainer utilizes the training he received, Q' Straint manufacturer guidelines, and a skills checklist to educate van transporters. A skills validation is also completed where the staff member must demonstrate the skills appropriately. This also included educating the new team members on the need to stop and call 911 for any accident that occurs during transports. Training was completed by the corporate van trainer on 10/5/2016 prior to the transportation aide completing any van transports. The facility owned van was placed back in service from 10/6/2016 through 10/25/2016. On 10/26/2016 facility owned van was then utilized by sister facility through 5/23/2017. The facility has not utilized the facility owned van since 10/26/2016 and the facility owned van keys are with the Administrator and no one has access to this keys. The facility owned van will be out of service until facility staff designated to aide in facility transportation have been checked off again. Systematic Changes On 10/5/2016, Corporate van trainer educated 2 facility staff designated to aide in facility transportations; they were educated on the following Resident Transportation Policy and Procedure. Transportation Policy: 1. Resident transportation should be completed by employees who have been trained to do so.	F 490	staff involved with the facility transportation, who did not receive in-service training will not be allowed to work or participate in facility transportation using the facility owned van until training is completed. This in service was completed by May 25th , 2017. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. A quality review will be implemented when transports are started back once we start using the facility owned van. The director of nursing will also review incident reports during daily clinical meeting for accidents that may involve the van. If an event is identified the chart will be checked by the Director of Nursing to ensure that the patient was assessed promptly by the nurse. Chart evidence will also be validated by interviewing the patient and the nurse to ensure that assessments were conducted promptly. If errors are the Quality Assurance Committee will review the event for appropriate corrective actions. This will be done for 4 weeks, and then monthly for three months. The Director of Nursing will review all incidents reports daily during daily clinical quality of life meeting (Monday through Friday). Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and	

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F 490	Continued From page 82 Transportation aides must be current Nursing Assistants or Emergency Medication Technicians. They must also have valid CPR training. 2. PRIOR to operating a facility transportation vehicle, the TSP-101 DAILY VAN CHECKLIST will be completed. All residents will be properly secured with appropriate strapping of wheelchairs and/or seatbelt placement. Under no circumstances will the van be operated without adequate seatbelts for every resident being transported. If there is an issue identified on the daily checklist, it must be reviewed and corrected prior to the van being used if it is a patient safety issue. 3. The van will also be inspected by the maintenance director or designee on a weekly basis. Results of the inspection will be documented on form TSP-102 WEEKLY CHECKLIST. 4. All van drivers must hold a valid North Carolina drivers license, have had a drivers license DMV check, and have had documented training on van usage prior to transportation of residents. 5. In the event of an emergency, STOP and call 911. Provide basic first aid. Implement CPR if it in indicated such as no heartbeat or breathing. Do not move patient if injury is suspected or unless life is threatened. 6. All wheelchairs used for transportation of residents must be approved for transport use. If a personally-owned wheelchair (not a wheelchair provided or arranged by the facility) is to be used for transportation, it must be approved by Liberty Risk Management to determine if it is safe for transport use. 7. Power wheelchairs must be fitted with transportation appropriate straps for correct tie down procedures in order to be ready for use in	F 490	ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services.	

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the transportation van. If they do not have manufacturer installed safety strap attachment points or cannot be fitted with attachment devices from the manufacturer, they cannot be considered safe for transport.
8. All transportation Aids must have completed annual transportation safety training.
9. Training must include the safe procedures for loading and unloading of residents, the safe and proper use of the approved safety restraint system provided by the manufacturer of the transportation van and emergency measures to remove residents from the safety restraint system.
10. Immediately notify the Administrator when an incident occurs during a van transport regardless of how minor the incident is. This includes resident and non-resident incidents. Incidents include but are not limited to: fall from wheelchair, equipment malfunction, refusal of resident to utilize safety belts, and injury of any nature. Administrator phone number 336-830-1356
The following amendment to the policy is to insure safety of residents during loading and application of the safety restraint system;
Item #1:
All wheelchairs used in transportation must have foot rests in place (attached to the chair) during loading, transport and unloading of residents. It has been determined that the resident's feet must be on the wheelchair foot rests to prevent feet and toes being caught or pinched in the lift bridge plate during lift operations, resulting in injury. Foot rests can help to keep feet in a position that will not allow toes to slide under the bridge plate. If the chair being used for transportation does not have foot rests attached at the time of transport, appropriate foot rests are to be located and

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attached to the chair properly or another chair with foot rests is to be used. It is recommended the transportation aids set aside a wheelchair for transportation use ahead of time to void the necessity of locating and fitting another wheelchair.
Item #2:
All wheelchairs used in transportation must be of the types that have removable arm rest. Access to the unrestricted back of the wheelchair seat is required to secure the lap safety belt in place over the resident's lap. Placing the lap belt through the underside of the arm rest does not allow the belt to restrain the resident at the hip. The safety lap belt must cross over the lap from hip to hip to keep the resident from slipping out of the seat.
Item #3:
Wheelchair Floor restraints are never to be attached to the cross (X) bars of the wheelchair. The cross bars are not part of the frame of the chair and will collapse if the chair is forced on its side as in a hard turn. All floor straps are to be attached to the frame at or above the point where welded joints connect the frame. This is typically found where the wheels or wheel casters are attached. Item #4
Geriatric Chairs can never be used for transport. Gerri Chairs have no way to lock the reclining feature of the chair and may fall into a reclining position during transport. IN the event of a chair reclining during transport the safety harness system will not protect the resident and may result in a serious or fatal event.
Item #5
Power Wheelchairs must be approved for transportation before they can be used for transport of a resident. If they are not considered safe for transport, the facility must provide a facility approved chair for the resident

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transportation needs.
Item #6
Unoccupied wheelchairs will no longer be transported on the facility van.
This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees who operate the facility van and will be reviewed by the Quality Assurance process to verify that the change has been sustained.
A quality review will also be implemented when transports are started back once we start using facility owned van. The review includes the administrator or maintenance director in their absence will observe facility van transports daily for 2 weeks to ensure residents and the chair are secured to the vehicle by visualizing that all 4 floor retractors are hooked to the wheelchair, that the seat belt is attached across the residents lap and secured to floor restraints, shoulder strap is positioned across the shoulder and secured to the lap belt. The administrator will be responsible for ensuring safe transportation of residents. In addition to this, alert and oriented residents will be interviewed asking if the transporter secured both front and back safety harnesses as well as the wheelchair to the van floor. If errors are identified the employee will be suspended pending an investigation of the allegations.
The administrator and director of nursing attended the van training on 10/5/2016 provided by the corporate van trainer to ensure proper knowledge of the safety harness system in order to verify that it is completed correctly.
Any staff member designated to aide in facility transportation or any in-house staff involved with the facility transportation, who did not receive in-service training will not be allowed to work or participate in facility transportation using the

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F 490	Continued From page 86 facility owned van until training is completed. Validation of the credible allegation of compliance was conducted on 5/25/17. TA's #2 and #3 were interviewed regarding the training provided on 5/25/17 and safety procedures to follow. Both drivers confirmed training had been provided and were able to explain procedures for securing the van and how to respond in an emergency situation. Review of the audits confirmed both had been observed to correctly secure a resident's wheelchair in the van. Sampled residents were selected for record review that had been transported in the facility van and no incidents had occurred. Facility record review revealed the TA's were nursing assistants with current CPR certification. The Administrator and Director of Nursing received training on 5/25/17. Immediate jeopardy was removed on 5/25/17 at 7:00 PM.	F 490		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (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	F 514		6/19/17

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F 514	Continued From page 87 (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 record reviews and staff interviews, the facility failed to accurately document the time medications were administered for 1 of 1 resident reviewed (Resident #102) who received medications via a gastrostomy tube (a tube inserted into the stomach through an opening in the abdominal wall for the administration of fluids and/or nutrition). The findings included: Resident #102 was admitted to the facility on 6/20/16 with a cumulative diagnosis which included dysphasia (difficulty swallowing) with placement of a gastrostomy tube. A review of Resident #102's May 2017 medication orders revealed medications were scheduled to	F 514	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F514 RES RECORDS-COMPLETE/ACCURATE /ACCESSIBLE Corrective Action: Resident #102. Physician notified. No new	

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be administered each morning at 6:00 AM, 6:30 AM, 8:00 AM, and 9:00 AM. The medications scheduled for 9:00 AM administration included: 30 milligrams (mg) lansoprazole (a medication that inhibits gastric acid secretion) given as 1 dispersible (easily dissolved) tablet sublingually (under the tongue); 100 mg / milliliter (ml) levetiracetam (an anticonvulsant medication) given as 2.5 ml via gastrostomy tube; 50 mg metoprolol tartrate (an antihypertensive medication) given as 1 tablet via gastrostomy tube; and, 2 grams cholestyramine powder (a medication used to decrease lipids or fats in the blood) given via gastrostomy tube.

An interview was conducted on 5/24/17 at 7:55 AM with Nurse #2. Nurse #2 was the 1st shift nurse assigned to care for Resident #102. During the interview, inquiry was made regarding what time the 9:00 AM medications were going to be administered to Resident #102. Nurse #2 reported the 9:00 AM medications had already been given along with the resident's 8:00 AM medications. The nurse estimated the medications were given at approximately 7:45 AM. She reported the hall had a heavy workload and administering medications together (even though they were scheduled at different times) was necessary to expedite the med pass. Nurse #2 reported she was going to talk with the resident's physician to see if the medication times could be changed.

A review of Resident #102's electronic Medication Administration Record (MAR) was conducted with Nurse #2 at 7:58 AM. The electronic MAR indicated Resident #102's 9:00 AM medications were not documented as given. Upon inquiry, Nurse #2 reported the medications scheduled for

orders. Medications administered as per physician orders and documentation of medication administration times was accurate, timely and in accordance with the physician orders.
Identification of other residents who may be involved with this practice:
All residents have the potential to be affected by the alleged practice. Audits were done by the Director of Nursing by 6/15/2017 checking the Medication Administration records ensuring that all medication were administered as prescribed. Random Medication Observations of Several Staff over different shifts and units (RN□s and LPN□s, Full time, Part time and PRN) were completed by the Director of Nursing and Pharmacist to ensure that medication was administered as per physician orders and documentation of medication administration times was accurate, timely and in accordance with the physician orders by 6/19/2017. The Random Medication Observations were of multiple routes of administration (oral, enteral, intravenous, subcutaneous, topical, optical etc.) and a minimum (not maximum) of 25 medication opportunities. All the resident□s medication for each observed medication administration were observed and documented.
Systemic Changes:
Director of Nursing and /or Designee in serviced all staff (full time, part time, and PRN) to inform that the facility must maintain medical records on each resident that are complete, accurately documented, readily accessible and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345284	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 89 9:00 AM could not be recorded in the electronic MAR as given because it was too early to do so. The nurse stated she would document the 9:00 AM medications were given when the electronic MAR allowed her to do so. An interview was conducted on 5/24/17 at 12:18 PM with the facility's Medical Director. During the interview, the discrepancy between when Resident #102 ' s medications were scheduled (9:00 AM) versus when they were administered (7:45 AM) was discussed, along with the nurse ' s delay in documenting the medications administered. The physician reported the providers were always available for consultation if there was a problem or a need to consolidate medication administration times. The physician also indicated that he would expect the documentation of medication administration times to be accurate, timely, and in accordance with the physician's orders.	F 514	systematically organized. The medical record must contain sufficient information to identify the resident, a record of the residents assessments; The comprehensive plan of care and services provided; The results of any preadmission screening and resident review evaluations and determinations conducted by the State; Physician□s, nurse□s, and other licensed professional□s progress notes; and Laboratory, radiology and other diagnostic services reports. All Nurses (RNs, LPNs, full time, part time, and PRN) were also educated on the fact that it is the nurse□s responsibility to notify physician, follow and initiate Physician orders. Medication should be administered as per physician orders and documentation of medication administration times should be accurate, timely and in accordance with the physician orders. This in service was completed by June 16th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by completing 5 Random Medication Observations of Staff over	

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F 514	Continued From page 90	F 514	different shifts and units including weekends (RN□s and LPN□s, Full time, Part time and PRN) weekly. The Random Medication Observations will be of multiple routes of administration (oral, enteral, intravenous, subcutaneous, topical, optical etc.) and a minimum (not maximum) of 25 medication opportunities. All the resident□s medication for each observed medication administration will be observed and documented. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.	