STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	C 03/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(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 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		3/23/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/19/2018

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F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain clean and sanitary wheel chairs for 9 residents that resided on 2 of 2 nursing stations in the facility. (Residents #27, 31, 45, 84, 2, 44, 19, 58, and 29.) The findings included: On 3/5/2018 at 10:20am, the following residents were in the main dining room and were noted to be in heavily soiled wheel chairs: Residents # 27, 31, 45, and 2. On 3/5/2018 at 2:58pm, Resident #84 was in the hallway of the facility and noted to be in a soiled wheel chair. Resident #19 was observed in his room at 3:10pm and was seated in a soiled wheel chair. On 3/5/2018 at 3:32pm in the Station 1 recreation room, Resident # 58 and #29 were observed sitting in soiled wheel chairs. Resident #44 was observed in his room at 4:15pm on 3/5/2018 and was seated in a soiled wheel chair that had dusty and dirty spokes on the wheels. On 3/6/2018 8:30am Resident # 19 was observed sitting in a soiled wheel chair in his room. On 3/6/2018 9:55am, Resident # 27, 31, and 45 were all in the facility main dining area and each of them were in a dirty wheel chair that had soiled spokes. On 3/6/2018 10:40am, Residents #58 and 29 were observed in the recreation on Station 1 and both were seated in wheel chairs that had soiled spokes. On 3/6/2018 11:15am, Resident # 2 and 84 were observed in the main dining room and were	F 584	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Mount Olive Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. F584 100% of facility wheelchairs and geri-chairs were disinfected and pressure washed between 3/15 and 3/16. Maintenance in conjunction with nursing was to assure wheelchairs were cleaned monthly. The facility experienced changes in the maintenance department and nurse leadership that apparently resulted in a systemic breakdown of the established process. Staff educated by the Center Nurse Executive and/or Assistant Director of Nursing on notifying management of wheel chairs that are in need of cleaning. Education also included night shift nursing staff on weekly wipe down process. The Center Executive Director and Center Nurse Executive are reinforcing the	

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F 584	Continued From page 2 seated in a dirty wheel chairs that had soiled spokes. On 3/7/2018 8:12am, Resident #19 was observed seated in his wheel chair in his room. The wheel chair remained soiled. On 3/7/2018 10:45am, Resident #27, 31, and 45 were observed in the main dining room and each of the residents were seated in dirty wheel chairs. On 3/7/2018 at 3:55pm, Resident # 44 was observed in his room and was seated in a wheel chair that was dusty. On 3/8/2018 at 9:15am, Resident # 19 was observed to be sitting in a dirty wheel chair in his room. On 3/8/2018 at 11:30am, Residents # 45, 31, and 27 were observed to be in the facility dining room and all three of their wheel chairs were heavily soiled. On 3/8/2018 at 2:58pm, Resident #44 Jones was observed in the facility hallway in a dirty wheel chair. On 3/8/2018 at 3:22pm, Resident # 58 and 29 were observed in the recreation room on Station 1 and both of their wheel chairs had dirty spokes on the wheels. On 3/8/2018 3:48pm, Resident # 84 was observed in the facility hallway and was in a wheel chair that had very dusty spokes. On 3/8/2018 at 4:07pm Staff Interview was conducted with a station 1 nurse who reported the maintenance staff cleans resident wheel chairs. She stated they have a schedule when they pressure wash all wheel chairs. Another staff interview was completed on 3/8/2018 at 4:12pm with an administrative nurse. She stated the maintenance staff are responsible for cleaning resident wheel chairs. She stated they	F 584	monthly cleaning schedule. All wheelchairs will be cleaned each month by Maintenance, and weekly wipe down will be completed by the night shift nursing department. Clinical and Administration team will spot check wheelchairs during daily walking rounds. Results of the 5 day a week wheelchair observations will be documented on the Morning Meeting Report and reviewed to assure cleaning was completed. Supervisors and managers are reminded to be observant and report any visibly soiled wheelchairs so they can be spot cleaned as needed. The Center Executive Director (Administrator) is responsible for implementing the Plan of Correction. 3/23/18	

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F 584	Continued From page 3 have a schedule when they clean the wheel chairs and if any wheel chairs need cleaning at other times, there is a form staff can fill out and send to the maintenance department. An additional staff interview was completed on 3/8/2018 at 4:16pm when a station II nurse was interviewed and she reported maintenance is responsible for cleaning resident wheel chairs. On 3/9/2018 at 11:30am a staff interview with the facility administrator was conducted. He stated that the maintenance department is primarily responsible for the cleaning of wheel chairs in the facility. He also reported that human resources department cleaned 5 wheel chairs on the previous night, because one particular resident's wheel chair required immediate cleaning. He stated normally the wheel chairs are cleaned about quarterly. And he confirmed any staff has the opportunity to report wheel chairs that need to be cleaned to the maintenance department by filling out a work order request. The administrator also reported the maintenance director was not in the facility on 3/9/2018.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of physical restraints for 1 of 1 residents reviewed (Resident #76).	F 641	F641 Resident #76 was reassessed and the roll control bolsters have been removed and the MDS has been updated to reflect this change. The MDS was coded incorrectly and was not identified in the quarterly	3/23/18

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F 641	Continued From page 4 The findings included: 1-Resident #76 was admitted to the facility on 6/27/2106 with diagnoses which included Cerebral Infarct (Stroke) and Hemiplegia (Paralysis) affecting the left side. Medical record review of the Quarterly Minimum Data Set (MDS) dated 2/2/2018 revealed Resident #76 was severely cognitively impaired and required total assistance with all activities of daily living (ADLs). The MDS indicated the resident could feed herself independently with tray set up assistance. The MDS revealed the resident had functional impairments to the upper and lower extremities on one side. The MDS indicated there were no restraints used for the resident. Review of Resident #76's Care Plan updated on 2/2/2018 revealed a problem with ADLs and falls which included the intervention of roll control bolsters to the resident's bed. On 3/5/2018 at 12:06 PM, an observation was made of Resident #76. The resident was observed lying in bed, positioned on her left side. There were quarter side rails on both sides of the bed and there were pads on both sides of the bed which were approximately 10 inches high attached with nylon straps secured to the bedframe under the mattress. The pads were positioned inside the quarter rails and extended beyond the quarter rails to half the length of the bed. On 3/7/2018 at 9:51 AM, an observation was made of Resident #76. The resident was observed lying in bed, lying on her back. There	F 641	MDS update. Nursing and MDS Staff will be more attentive to the MDS entries during quarterly or significant change reviews. Nursing Department will assess all residents with roll control bolsters to assure they are appropriate for resident and coded appropriately. Education will be provided by Center Nurse Executive and/or Assistant Director of Nursing to MDS and Nursing staff for coding an assessment correctly and to assure all clinical assessments are completed accurately regarding restraint use, by 3/23/18. Audit was completed by Unit Managers on 3/16/2018 and no other roll control bolsters are in use. Any new interventions will be assessed by the clinical management team to ensure accurate coding. Center Nurse Executive (Director of Nursing) is responsible for implementing the Plan of Correction. 3/23/18	

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F 641	Continued From page 5 were quarter side rails on both sides of the bed and there were pads on both sides of the bed which were approximately 10 inches high attached with nylon straps secured to the bedframe under the mattress. The pads were positioned inside the quarter rails and extended beyond the quarter rails to half the length of the bed. An interview was conducted with the Nurse Unit Manager (UM) on 3/7/2018 at 10:40 AM. The UM stated the roll control bolsters were on Resident #76's bed due to a history of her attempts to slide out of the bed. The UM stated the resident was not able to remove them. The UM further stated the resident was busy at times and the bolsters probably kept her from falling out of bed. The UM further stated the resident was usually up in the wheelchair daily. An interview was conducted with the Director of Nursing on 3/7/2018 at 11:17 AM. The DON reported she was familiar with Resident #76 and was aware of the roll control bolsters on her bed. The DON indicated the resident needed the bolsters due to decreased safety awareness and the was the resident positioned herself in bed. The DON indicated she never considered the bolsters a restraint but they met the definition and should be assessed and coded as a restraint. The DON stated the expectation was for all assessments to be coded accurately.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		3/23/18

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F 677	Continued From page 6 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide nail care to 3 of 3 residents who were dependent on staff for assistance with activities of daily living (Resident #76, Resident #15 and Resident #14). The findings included: 1-Resident #76 was admitted to the facility 06/27/16 with diagnoses which included Cerebral Infarct (Stroke) and Hemiplegia (Paralysis) affecting the left side. Medical record review of the Quarterly Minimum Data Set (MDS) dated 2/2/2018 revealed Resident #76 was severely cognitively impaired and required total assistance with all activities of daily living (ADLs). The MDS indicated the resident could feed herself independently with tray set up assistance. The MDS revealed the resident had functional impairments to the upper and lower extremities on one side. The care plan updated 2/2/2018 indicated Resident #76 required total assistance from staff for all of her personal care needs due to cognitive loss and Hemiplegia. The goal included the resident's care needs would be anticipated and met. Interventions included total assistance from staff for all personal care and hygiene needs. An observation of Resident #76 was conducted on 3/5/2018 at 11:58 AM. The resident was in bed at the time of the observation. The observation revealed the fingernails on her right hand extended ¼ to ½ inch beyond her fingertips. All 5	F 677	F677 Resident□s number 76, 15, and 14 nails were cleaned and trimmed. Unit Managers completed a 100% audit on each unit on 3/12/18 to assure nails are clean and trimmed. Facility failed to assure all nails were clean and trimmed. Process breakdown consisted of failure to follow through and observe that nail care was completed appropriately. Nursing staff were educated by Center Nurse Executive and / or the Assistant Director of Nursing regarding the process and importance of trimming and cleaning nails. Unit Managers will complete audits of nail care weekly for 4 weeks and then monthly for 3 months. Assistant Director of Nursing will complete random audits for 4 weeks and monthly for 3 months. Concerns or noted issues will be addressed immediately and reported to the Center Nurse Executive. Resident□s nails will be monitored weekly for 4 weeks and monthly for 3 months. Results of monitoring will be reviewed at the QAPI meetings for a minimum of 3 months. Center Nurse Executive (Director of Nursing) is responsible for implementing the Plan of Correction. 3/23/18	

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F 677	Continued From page 7	F 677		

nails were observed with brown debris caked under each nail. The left hand was in a contracted position and the fingernails were not visible.
An observation of Resident #76 was conducted on 3/6/2018 at 9:23 AM. The resident was seated in a wheelchair beside her bed. The observation revealed the fingernails on her right hand to be unchanged from the previous observation on 3/5/2018. The left hand was in a contracted position and the fingernails were not visible.

On 3/6/2018 at 10:10 AM an interview was conducted with Nursing Assistant (NA) #5. NA #5 confirmed she was the NA assigned to Resident #76 on 3/5/2018 and 3/6/2018. NA #5 indicated she had completed the resident's bath and morning care. NA #5 reported she did not notice any issues with the resident's nails.

ADL care was observed for Resident #76 on 3/7/2018 at 10:30 AM. The resident was in bed at the time the care was provided. NA #6 completed the resident's bath. NA #7 assisted with the care. NA #7 observed the resident's fingernails and indicated the nails needed to be cleaned and trimmed. The fingernails on the left hand were observed during the bath and were noted to be over ½ inch long, curved inward and were positioned against the resident's palm due to the contracture. The skin was intact in the resident's palm.

The Nurse Unit Manager (UM) observed Resident #76's fingernails on 3/7/2018 during the ADL care. The UM indicated the resident needed her nails cleaned and trimmed. The UM stated the nail care would be completed.

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An interview was conducted with the Director of Nursing (DON) on 3/7/2018 at 11:17 AM. The DON stated the direct care staff was responsible for nail care. The DON indicated some of the independent residents desired to complete their own nail care, but the staff was responsible for the dependent residents. The DON stated the expectation was staff would ensure all residents' nails were trimmed and clean as part of the daily ADL care.

2-Resident #15 was admitted to the facility 03/11/2013 with diagnoses which included Cerebral Infarct (Stroke) and Dementia.

Medical record review of the Minimum Data Set (MDS) dated 12/12/2017 revealed Resident #15 was severely cognitively impaired and required extensive to total assistance with all activities of daily living (ADLs). The MDS revealed the resident had functional impairments to the upper and lower extremities on one side.

The care plan updated 12/12/2017 indicated Resident #15 required extensive to total assistance from staff for all of her personal care needs due to cognitive loss and Hemiplegia. The goal included the resident's care needs would be anticipated and met. Interventions included total assistance from staff for all personal care and hygiene needs.

An observation of Resident #15 was conducted on 3/6/2018 at 10:30 AM. The resident was sitting up in bed at the time of the observation. The observation revealed her fingernails extended ¼ to ½ inch beyond her fingertips. All of her nails were observed with brown debris caked under each nail.

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F 677	Continued From page 9	F 677		

An observation of Resident #15 was conducted on 3/7/2018 at 9:14 AM. The resident was in bed. The observation revealed her fingernails were unchanged from the previous observation on 3/5/2018.

On 3/6/2018 at 10:10 AM an interview was conducted with Nursing Assistant (NA) #5. NA #5 confirmed she was the NA assigned to Resident #15 on 3/5/2018 and 3/6/2018. NA #5 reported she did not notice any issues with the resident's nails.

An interview was conducted with the Director of Nursing (DON) on 3/7/2018 at 11:17 AM. The DON stated the direct care staff was responsible for nail care. The DON indicated some of the independent residents desired to complete their own nail care, but the staff was responsible for the dependent residents. The DON reported Resident #15 was a Hospice resident and the Hospice staff usually provided her ADL care. The DON further stated even though the resident received Hospice services, the facility staff was also responsible for ensuring needed care was provided. The DON stated the expectation was staff would provide care to assure residents' nails were trimmed and clean as part of the daily ADL care and as needed.

3. A review of the medical record revealed Resident #14 was admitted 4/15/2014 with diagnoses of Stroke, dementia with behaviors,

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F 677	Continued From page 10	F 677		

depressive disorder and General Anxiety Disorder.
The Quarterly Minimum Data Set (MDS) dated 12/19/2017 noted Resident #14 to be severely impaired for cognition and needed total assistance for all Activities of Daily Living (ADLs) with the physical assistance of one person.
The car plan dated 5/12/2016 noted a focus of the Resident requires assistance with ADLs due to cognitive loss/dementia. The goal was the resident's care needs will be anticipated and met. Interventions included: Set up for eating, observe for shortness of breath, fatigue and condition change, resident requires total assist with all ADLs.
On 3/6/2018 at 11:15 AM, Resident #14 was observed in bed with her feet at the edge of the bed, uncovered. Resident #14 was noted to have very long toenails on all of her toes except two, which appeared to have been trimmed.
On 3/7/2018 at 3:10 PM Nursing Assistant #1 removed Resident #14's socks while Resident #14 was in bed. The nails appeared as follows: Right foot: The nail on the great toe was more than ½ inch beyond the great toe. The 2nd and 3rd toe nails were trimmed and short. The 4th toe nail was curled completely underneath the toe at an approximate length of ¾ of an inch beyond the toe. The 5th toe nail was also curled and was approximately ¾ inches beyond the 5th toe. Left foot: The nail on the great toe was ½ inch beyond the end of the toe. The 2nd and 3rd toe nails extended more than ¼ inch longer than the end of the toes. The 4th toe nail was curled all the way under the toe and the 5th toe nail was approximately ¼ inch past the end of the toe. NA #1 stated she did not work on Station 2, but was there because someone called out. NA #1 indicated she did nail care when she did a

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F 677	Continued From page 11 resident's bath. The Nurse Unit Manager went into Resident #14's room on 3/7/2018 at 3:20 PM, and removed Resident #14's socks to view her nails. The Unit Manager stated she would take care of the nails. In an interview on 3/7/2018 at 4:10 PM, the Director of Nursing stated her expectation was that resident's nails would be trimmed on a regular basis.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide splinting application per therapy recommendation for 1 of 1 residents which resulted in the possibility of an increased risk of further decreased range of motion/contractures (Resident #76).	F 688	F688 Resident #76 had an immediate therapy screen on 3/08/18 and no decline in Range of Motion but resident had decrease wear tolerance of splint. Occupational Therapy is working with the	3/23/18

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F 688	Continued From page 12 Findings included: Record review revealed Resident #76 was admitted to the facility on 6/27/2016 with diagnoses which included Cerebral Infarct (Stroke), Hemiplegia (paralysis) left side and contractures. Medical record review of the Quarterly Minimum Data Set (MDS) dated 2/2/2018 revealed Resident #76 was severely cognitively impaired and required total assistance with all activities of daily living (ADLs). The MDS revealed the resident had functional impairments to the upper and lower extremities on one side. The care plan updated 2/2/2018 indicated Resident #76 demonstrated loss of range of motion to her left elbow, her left hand and her left lower extremity due to contractures. Interventions included the resident was to wear a left elbow splint for around 6 hours per day. Record review of the Resident Care Guide with a print date of 2/16/2018 indicated Resident #76 was to wear a left elbow splint for around 6 hours a day. A splint application instruction sheet for Resident #76 was observed on 3/5/2018. The sheet was taped to the inside of the resident's closet door in her room. The instruction sheet was dated 8/17/16 and included instructions to complete range of motion to the resident's left elbow and hand prior to the administration of the splint. The instructions indicated the resident would say it hurt but to pull gently and the elbow would extend to about 60 degrees. The instructions further	F 688	resident on stretching and motion. Splint is being worn during Occupational Therapy Sessions for buildup of tolerance. Rolled up wash cloth in resident□s left hand at all times with the exception of ADL care. Process not followed for ensuring splints in place as recommended and ordered. Nursing Department failed to assure all resident□s splints were in place. Nursing staff failed to assure resident # 76 splint was in place for a contracture to her left elbow. Therapy Department will notify Nursing Department of an order for the splint. An updated list of residents with splints will be created and updated weekly. Nursing Department will be educated by the Center Nurse Executive and/or the Assistant Director of Nursing, on the process of ordering, monitoring and the importance of having the splint in place if indicated to be completed by 3/23/18. Unit Manager will audit all residents with a splint to assure compliance 5 X a week for 2 weeks, then 3 times a week for 2 weeks and then 1 time a month for 3 months. Assistant Director of Nursing will complete random audits for 5 months. Finding of audits will be reported and discussed at Quality Assurance each month. Center Nurse Executive (Director of Nursing) is responsible for implementing the Plan of Correction. 3/23/18	

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indicated the splint was to be worn during the day and off at night and to place a rolled washcloth in her left hand when the splint was not in use. There were 2 pictures on the instruction sheet of the resident's left elbow and hand with the splint applied. The instruction sheet also included to ask therapy if there were any questions.

In an observation of Resident #76 on 3/5/2018 at 11:55 AM, the resident was lying in bed with no splint in place.
In an observation of Resident #76 on 3/5/2018 at 2:45 PM, the resident was up in her wheelchair with no splint in place.
In an observation of Resident #76 on 3/6/2018 at 9:24 AM, the resident was lying in bed with no splint in place.
In an observation of Resident #76 on 3/6/2018 at 3:38 PM, the resident was up in her wheelchair with no splint in place.

An observation of AM care for Resident #76 was conducted on 3/7/2018 at 10:30 AM. The resident was cooperative during the care. NA #6 opened the resident's contracted left hand to cleanse the palm and fingers, extended the residents left elbow slightly to cleanse and raised the resident's left arm slightly to cleanse under her arm. The resident did not complain when the contracted areas were slightly extended. NA #6 did not attempt to extend the contracted areas beyond the areas resistance.

An interview was conducted with NA #6 on 3/7/2018 at 10:40 AM. NA #6 reported Resident #76 did not wear a splint.

An interview was conducted with NA #7 on 3/7/2018 at 10:42 AM. NA #7 assisted with

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Resident #76's AM care. NA #7 indicated she assisted with the resident often and the resident used to wear a splint to the left arm. NA #7 was unsure if the resident was supposed to still wear a splint. NA #7 reported the information would be in the Care Tracker or inside the resident's closet door. NA #7 indicated the splint application instructions would be inside the closet door and the splint should be in the closet. NA #7 looked in the closet and the instructions were taped on the inside of the door but she was unable to locate the splint. NA #7 stated she would report it to the nurse manager immediately.

An interview was conducted with the Nurse Unit Manager (UM) on 3/7/2018 at 11:00. The UM indicated she was familiar with the care of Resident #76. The UM reported the resident was admitted with contractures to her left arm/hand. The UM indicated the resident fought and screamed when the splints were applied and she would not wear it for more than a couple of minutes. The UM indicated due to the resident's refusal the splint was discontinued. The UM stated she documented the resident's behaviors, splint refusals and discontinuation of the splint in the nursing notes. The UM reviewed the medical record and was unable to locate the documentation. The UM reported she did not know why the splint application instructions were still in the resident's closet and did not know why the application of the splints was on the Care Tracker as the resident did not use the splints anymore. The UM was unable to recall if the resident was screened by the therapy department for the splints to be discontinued.

An interview was conducted with the Physical Therapy (PT) Director on 3/7/2018 at 1:53 PM.

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F 688	Continued From page 15 The PT Director indicated she was familiar with Resident #76 and had worked with her for positioning/contractures. The PT Director stated the resident required a significant amount of time to stretch her elbow for splint application. We instructed the staff on how to apply the splint and how to stretch her. The PT Director indicated the resident would resist at times and yell but she would allow the splint to be applied. The PT Director further indicated the therapy department completed quarterly screens on residents. The PT Director presented a therapy screen dated 2/12/2018 which indicated the resident's needs were unchanged and the splint application was to continue to prevent further decrease in the left arm contractures. An interview was conducted with the Director of Nursing on 3/7/2018 at 3:20 PM. The DON stated the expectation was for contractures to be managed to prevent worsening. The DON further stated refusals for splinting needed to be documented and appropriate follow up completed to ensure alternate measures could be implemented.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		3/23/18

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F 689	Continued From page 16 Based on observation, record review, family and staff interviews the facility failed to provide supervision to prevent accidents and failed to implement appropriate interventions to prevent further accidents which resulted in multiple falls for 1 of 1 residents (Resident #15). Findings included: Record review revealed Resident #15 was admitted to the facility on 3/11/2013 with diagnoses which included Cerebral Infarction (Stroke), Dementia and lack of coordination. Record review of the most recent comprehensive Minimum Data Set (MDS) dated 3/4/018 revealed Resident #15 was severely cognitively impaired and required extensive to total assistance with all of her care. The MDS further revealed the resident had impairments to upper and lower extremities to one side. Review of the Care Area Assessment (CAA) dated 3/4/2018 indicated Resident #15 had a history of falls related to Dementia and decreased safety awareness. The area of falls from the CAA initiated the need for the area to be care planned. Review of the Care Plan for Resident #15 dated 3/4/2018 included a focus of risk for falls related to a history of Cerebral Vascular Accident, impaired mobility, cognitive loss, lack of safety awareness, history of falls and noncompliance with asking for assistance. The goal was the resident would have no falls with injury through the next review date of 3/20/2018. Interventions implemented since 7/25/2017 included to cue resident to ask for assistance, mechanical lift for all transfers, offer bedpan or toilet before and after meals, prior to bedtime and as needed	F 689	F689 Resident # 15 was reassessed for the appropriateness of the current fall interventions. New interventions added were resident to be out of room as resident will allow for increased supervision and increased activities as resident will allow for increased socialization with increased supervision. Nursing Department Clinical Team failed to assure new fall interventions evaluated post each fall. 100% audit will be completed by the Interdisciplinary team of falls in the last 60 days on 3/20/18 to assure interventions were put into place. Education will be provided by the Center Nurse Executive and/or the Assistant Director of Nursing to all nursing staff for implementing fall interventions by 3/23/18. Assistant Director of nursing to complete monthly audit for three months on falls to ensure all falls have received an appropriate intervention. The results of the audits will be reported and reviewed at QAPI each month. Center Nurse Executive (Director of Nursing) is responsible for implementing the Plan of Correction. 3/23/18	

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throughout the night, low bed and non-slip socks.

The following fall investigations for Resident #16 were reviewed with circumstances and interventions listed:

10/2/2017 at 8:00 AM-Resident slid out of wheelchair to the floor on her buttocks. Interventions were to implement non-skid socks while awake and during the night.

10/22/2017 at 12:30 AM-Resident was found lying on the floor beside her bed. No assessed injuries were documented. Neurological checks were completed per the facility policy. No new fall interventions were documented.

12/21/2017 at 6:50 PM-Resident was found on the bathroom floor. No assessed injuries were documented. Neurological checks were completed per the facility policy. No new interventions were documented.

1/9/2018 at 8:30 AM-Resident was found on the floor in her room. No assessed injuries were documented. Neurological checks were completed per the facility policy. The report indicated the resident would not ask for assistance for toileting when she had the urge to go. No new interventions were documented.

2/4/2018 at 3:00 PM-Resident was found lying on the bathroom floor next to the toilet. No assessed injuries were documented. Neurological checks were completed per the facility policy. Interventions for the fall were documented to offer the resident the bedpan or toilet before and after meals, prior to bedtime and as needed throughout the night.

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F 689	Continued From page 18 2/14/2018 at 5:00 AM-Resident was found lying on the floor next to her bed. The resident reported she was trying to get to the bathroom. No assessed injuries were documented. Neurological checks were completed per the facility policy. No new interventions were documented. 2/24/2018 at 6:55 AM-Resident was found in her room on the floor kneeling on her chair. No assessed injuries were documented. Neurological checks were completed per the facility policy. The report indicated there were no new interventions at the time of the fall due to the resident's cognitive deficits and even with staff continuously redirecting the resident, she attempted to get up every chance she got. 2/27/2018 at 8:50 AM-Resident was found sitting upright on the floor beside her bed. No assessed injuries were documented. Neurological checks were completed per the facility policy. The report indicated there were no new interventions at the time of the fall due to the resident's cognitive deficits and even with staff continuously redirecting the resident, she attempted to get up every chance she got. 2/27/2018 at 12:00 PM-Resident was in wheelchair in the hall, used side rail to pull up, lost her balance and sat on the floor. No assessed injuries were documented. Neurological checks were completed per the facility policy. The report indicated there were no new interventions at the time of the fall due to the resident's cognitive deficits and even with staff continuously redirecting the resident, she attempted to get up every chance she got.	F 689		

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An observation of Resident #16 was conducted on 3/6/2018 at 8:55 AM. The resident was lying in bed, the bed was in the low position.

An observation of Resident #16 was conducted on 3/7/2018 at 3:07 PM. The resident was up in the wheelchair and a family member was present. An interview was conducted with the family member who indicated the resident had numerous falls. The family member reported the resident tried to do things independently and fell. The family member reported he was notified when the resident fell and he did not know what the facility needed to do to reduce the falls. The family member reported he did not remember what the facility did when the resident fell, but it did not work because she continued to fall.

An interview was conducted on 3/7/2018 at 3:00 PM with the Nurse Unit Manager (UM). The UM reported she was aware of Resident #16's repeated falls. The UM indicated the falls were reviewed daily by the clinical team and interventions were put into place which were appropriate. The UM further indicated interventions for the resident were difficult due to the fact the resident had decreased safety awareness and attempted to get up independently.

An interview was conducted on 3/7/2018 at 3:20 with Nursing Assistant (NA) #7. NA #7 confirmed she was familiar with Resident #16 and worked with her regularly. NA #7 reported the resident tried to get up and would fall often. NA #7 indicated she did not know what would keep the resident from falling. NA #7 further indicated all the staff on the hall were aware of the resident's numerous falls and would check on her often. NA

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F 689	Continued From page 20 #7 said she checked on the resident at least every hour when she worked. An interview was conducted with the Director of Nursing (DON) on 3/7/2018 at 3:50 PM. The DON revealed the clinical team met every day and discussed each fall. The DON indicated the clinical team tried to find appropriate interventions for all falls. The DON reported she was aware of Resident #16's numerous and repeated falls and since the resident was not cognitively able to follow directions the clinical team did not know what else to offer as interventions. The DON stated she spoke with the resident's responsible party (RP) and offered to move the resident close to the nursing station, but the RP declined because the resident was familiar with her surroundings and her roommate. The DON stated the staff was encouraged to check the resident often but there was not a schedule for visual checks. The DON stated the expectation was for fall interventions to be appropriate and individual and for supervision to be provided to prevent accidents.	F 689		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to	F 865		3/23/18

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F 865	Continued From page 21 the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility's Quality Assessment and Assurance (QA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put in place following the 4/16/2017 recertification survey. This is for two deficiencies originally cited in the 4/16/2017 survey and again cited in the 3/9/2018 survey. The deficiencies were in the areas of accuracy of resident assessment and in the completion of activities of daily living for resident who are dependent on staff for daily care. This continued failure of the facility during the past two recertification surveys represented a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F 641 and F 677. 1. F 641 Accuracy of Assessment: Based on observation, record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) in the area of physical restraints for one resident. During the 4/6/2017 recertification survey, the facility was cited for F 278 for a resident who had a valid PASRR (Preadmission Screening and Resident Review) but the Minimum Data Set for the resident did not indicate the resident had a Level ll PASRR status. In interview with the facility administrator on	F 865	F865 Reference F641 and F677 Above: The facility Standing QAPI consists of: Center Executive Director, Center Nurse Executive, Assistant Center Nurse Executive, Medical Director, Social Services Director, Admission Director, Maintenance Director, Housekeeping Director, Director of Dining Services, Registered Dietitian, and Activity Director. These Team Members attended one hour training session through Genesis HealthCare on the new QAPI requirements on dates listed: 2/7/18 □ Introduction to the QAPI Process; 2/14/18 □ Setting Up Your Annual QAPI Schedule; 2/21/18 □ Excellence Teams and Analysis for Action Pre-Meeting; 2/28/18 □ How to Run Your Steering Committee Meeting; 3/7/18 □ Root Cause Analysis and PI Activity and PI Plans. The Center Executive Director has completed an NAB approved Course Performance Improvement Champion Training □ Part 1 on 3/3/18 and was awarded 1.75 CEU□s. The facility uses a combination of QAPI analytical tools to assess systems and process. These tools include: Plan Do Study Act (PDSA), Process Improvement	

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F 865	Continued From page 22 3/9/2018 at 2:45pm, it was reported the facility had the same staff completing assessments now that were completing assessments in 4/2017. He reported the assessment concerns were addressed and monitored following the last annual recertification survey and he thought the problem of assessment inaccuracies had been corrected. He stated that they must identify the problem that exists when staff fail to accurately assess issues for the residents and correct it. 2. F 677 Activities of Daily Living Care Provided for Dependent Residents: Based on observation, record review and staff interview, the facility failed to provide nail care for 3 residents who were dependent on staff for daily care. During the 4/16/2017 recertification survey, the facility was cited for F 312 for the facility's failure to remove facial hair for 1 resident who was dependent on facility staff for personal hygiene. In interview with the facility administrator on 3/9/2018 at 2:45pm, it was reported that facility staff has been assigned to make rounds daily and he was hopeful the rounds would take care of the activities of daily living that had previously been missed. He stated the activities of daily living had been monitored following the recertification survey in 2017. He also reported they would need to make additional changes to see that needs for dependent residents are being taken care of by facility staff.	F 865	(PI); Improvement Activity (IA); and Process Improvement Plans (PIP). The facility has Excellence Teams in place as follow: Business Excellence; Clinical Excellence; Customer Excellence; Safety Excellence; and Staff Excellence. These teams meet month to review areas covered by their teams and when issues are identified, a decision is made regarding the implementation of the appropriate analytical tool to investigate process factors and to make next step decisions designed to bring about desired changes. A root cause analysis will be conducted by 3/22/18 on F641 □ Assessments to determine the reason for the repeat deficiency of F278 on the 2017 survey and F641 on this survey. Data will be taken from the root cause analysis and a plan for corrective measures will be implemented to test the corrective measures and to assure their effectiveness. A root cause analysis will be conducted by 3/22/18 on F641 □ Assessments to determine the reason for the repeat deficiency of F278 on the 2017 survey and F641 on this survey. Data will be taken from the root cause analysis and a plan for corrective measures will be implemented to test the corrective measures and to assure their effectiveness. A root cause analysis will be conducted by	

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F 865	Continued From page 23	F 865	3/22/18 on F677 □ Assessments to determine the reason for the repeat deficiency of F312 on the 2017 survey and F677 on this survey. Data will be taken from the root cause analysis and a plan for corrective measures will be implemented to test the corrective measures and to assure their effectiveness. The Center Executive Director (Administrator) is responsible for implementing the Plan of Correction. 3/23/18	