STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	C 06/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

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F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to assess the ability of a resident to self-administer medications that were kept at bedside for 1 of 1 sampled residents (Resident #65) reviewed for self-administration of medications. The findings included: Resident #65 was admitted to the facility on 5/9/16 with diagnoses of hemiplegia following cerebral infarction affecting left dominant side, anxiety disorder and polyneuropathy. A review of the quarterly Minimum Data Set (MDS) assessment dated 5/4/18 revealed the resident was cognitively intact. A record review conducted on 6/19/18 did not reveal an assessment was completed for the resident to self-administer medications. A record review conducted on 6/19/18 of the physician orders for June 2018 revealed no order present for Imodium or Ambesol. An observation on 6/19/18 at 10:54 AM revealed a bottle of Imodium tablets with the lid partially open and a bottle of Ambesol liquid located at the residents bedside.	F 554	Ashton Health & Rehabilitation acknowledges receipt of the Statement of Deficiencies and purpose of this Plan of Correction to the extent the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the survey conducted on June 18-23, 2018. Ashton Health and Rehabilitation response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute and admission that any deficiency is accurate. Furthermore, Ashton Health & Rehabilitation reserves the right to refute any deficiency on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures. F554 1. Facility failed to conduct a	7/27/18

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

Electronically Signed | 07/20/2018

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F 554	Continued From page 1 An interview with the resident on 6/19/18 at 10:54 AM revealed he took those medications when he needed them and his physician told him he could. He revealed he needed them at bedside because he had to take them right away and sometimes the nurses couldn't get to him promptly. Observations on 6/20/18 at 3:31 PM and 6/21/18 at 11:15 AM revealed the medications remained at bedside. An interview with Nurse #1 on 6/22/18 at 8:31 AM revealed she did not have any residents her hall that self-administered medications. She stated residents would have to be assessed first. She was unaware Resident #65 had medications in his room. An interview on 6/22/18 at 8:45 AM with the Director of Nursing revealed the process for self-administering medications was for an assessment to be completed and for the resident to have an order for the medications. She was unable to locate an assessment completed for this resident to self-administer his medications. She would expect the nurses to be aware of the process and follow it.	F 554	self-administration assessment for medications for resident #65. The medications were removed from the bedside for resident #65 on 6/22/18 by Director of Nursing. Licensed nursing staff was not aware to conduct a self-administration of medication assessment upon admission. 2. Audit of all current residents to determine if medications are at the bedside was conducted on 6/20/18 by Director of Nursing, Regional Clinical Manager, Staff Development Manager, and Nurse Manager. Self-medication administration assessments were conducted on those with medications found at bedside by Staff Development Coordinator. Clinically appropriate medication(s) were left at bedside. If practice was determined not to be clinically appropriate, medications were removed from the bedside. Self-administration assessments for those that have been deemed clinically appropriate will be updated quarterly and the care plan updated accordingly. 3. Licensed and certified staff will be re-educated by Director of Nursing and/or Staff Development Coordinator regarding the process for a resident to self-administer medications. Nurse Managers will conduct audits to determine if medications are at the bedside for current residents to ensure medications aren□t kept at the bedside	

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F 554	Continued From page 2	F 554	for those residents not deemed clinically appropriate. This audit will occur weekly x 12 weeks. Opportunities will be corrected as identified. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free	F 604		7/27/18

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F 604	Continued From page 3 from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility to provide an environment free from physical restraints for one of one sampled residents in a chair that prevented her rising and walking. (Resident #118.) The findings included: Resident # 118 was admitted to the facility on 12/7/17 with diagnosis including fracture of the right arm, dementia and hypertension. The Occupational Therapy (OT) discharge summary dated 3/22/18 included therapy was provided for positioning due to falls, her hips slid forward in the wheelchair and discomfort while seated in the wheelchair. On discharge, the chair that was provided was a "rock n go." (This type of chair had a seat that slants back and downward, and rocks back and forth with resident movement. The chair had wheels larger than a regular wheelchair.) The OT discharge summary included use of a pommel cushion. (This was a special type of cushion was placed in the chair to prevent the resident's hips from sliding forward.) Review of the quarterly Minimum Data Set (MDS) dated 4/2/18 revealed Resident #118 had	F 604	F604 1. Facility failed to conduct a restraint assessment for resident #118. Restraint assessment conducted on 7/16/18. Care plan updated on 7/16/18. Licensed staff was not aware that the chair and cushion were a restraint. 2. Restraint assessments will be completed for all current residents. If a restraint identified, the MDS and care plan will be updated accordingly. All residents will be evaluated that are in a chair that has potential to prevent them from rising and walking. Those identified as a potential for a restraint will have a restraint assessment conducted and therapy referral for therapy evaluation. Resident #118 was evaluated by Occupational Therapy for least restrictive device on 6/25/18. 3. Licensed and certified nursing staff will be re-educated by Director of Nursing and/or Staff Development Coordinator on respect and dignity, the right to be free from any physical or chemical restraints	

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F 604	Continued From page 4 impairment with short and long-term memory and was severely impaired in cognitive skills for decision making. This MDS assessed the resident as not being able to walk, required extensive assistance of one person for bed mobility, transfers and toileting. This assessment included one fall with no injuries had occurred since December 2017. The use of a physical restraint, a chair that prevents rising, was not included on the MDS. The Physical Therapy (PT) plan of care dated 5/25/18 included therapy was provided due to recent decrease in ambulation and to re-establish RNP (Restorative Nursing Program). The initial assessment indicated prior level of functioning for mobility "does the resident walk" and the response was "yes." For the "current level" it was "yes" and for the "anticipated" level it was "yes." The "gait, distance" for the "prior level" and "current level" was 100 feet. The "anticipated" level was 200 feet. The underlying impairments (for therapy progress) were the resident's intermittent ability to follow instructions. Review of a quarterly MDS dated 6/1/18 revealed Resident #118 had no changes with her impairment with short and long-term memory, and required extensive assistance with activities of daily living. This MDS assessed the resident as not being able to walk. The use of a physical restraint, a chair that prevents rising, was not included on the MDS. Documentation was not provided that included the medical symptoms being treated, a re-evaluation of the restraint with restraint reduction attempts by nursing or therapy. There was no documentation of a physician's order with	F 604	imposed for purposes of discipline or convenience. Nurse Managers will monitor residents that are in chairs that have potential to prevent them from rising and walking, weekly for 12 weeks, to ensure chair is not a restraint. Opportunities will be corrected as identified. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 604	Continued From page 5	F 604		

the medical symptoms that required the use of the physical restraint.

Review of the current care plan, updated 6/1/18 or a problem of fall risk did not include the use of the "rock n go" wheelchair or the use of the pommel cushion. A "problem" of physical restraints was not included on the care plan.

Review of a telephone order dated 6/7/18 indicated the resident was discharged from PT due to transitioning to restorative nursing.

Observations on 6/19/18 at 3:19 PM revealed Resident #118 was seated in the "rock n go" chair with a pommel cushion underneath her buttocks and thighs. The resident was observed leaning to her right side with her feet dangling and not touching the floor. During this observation the resident made no attempt to get out of the "rock n go."

Interview with Nurse Aide #4 on 6/22/18 at 9:21 AM revealed Resident #118 had a lean back chair, with a pommel cushion and leg rests. NA #4 explained the resident would try to get up out of a regular wheelchair and she would slide down in the wheelchair seat.

Interview with Nurse Aide #2 on 6/22/18 at 9:30 AM revealed the resident had the "rock n go" wheelchair and pommel cushion because she had attempted to stand from the regular wheelchair and had fallen.

Interview with the MDS Nurse # 2 on 6/22/18 at 10:42 AM revealed the "rock n go" and pommel cushion was not a restraint because she did not think the resident could walk. She explained the

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F 604	Continued From page 6 reason for the change in seating was due to the resident having falls from the wheelchair. The "rock n go" was the recommendation by OT after their treatment. Interview with the Physical Therapist #1 (PT) on 6/22/18 at 11:10 AM revealed Resident #118 was able to walk 100 feet. PT #1 explained Resident #118 varied from day to day depending on her cognition. At times the resident needed two people to help her walk, and other times she could walk with stand by assistance. She further explained, the resident was in a regular wheelchair and had fallen due to her attempts to stand without assistance. Interview with the OT on 6/22/18 at 11:15 AM revealed she had the resident on therapy for seating and positioning due to falls from the wheelchair and positioning problems of leaning. She had not reviewed the chair for a restraint. Interview with the Regional MDS Nurse consultant on 6/23/18 at 11:51 AM revealed the resident should have medical symptoms documented for the use of the restraint.	F 604		
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 observations, record review, staff interview, resident interview and observation the facility failed to accurately code the Minimum Data Set assessments for 2 of 48 sampled	F 641	F641 1. Facility failed to accurately code the MDS for resident #118 and #65. MDS	7/27/18

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F 641	Continued From page 7	F 641		

residents. 1. The facility failed to code Resident #118 with physical restraint use and 2. The facility coded Resident #65 as having dialysis which was in error.

The findings included:

1. Resident # 118 was admitted to the facility on 12/7/17 with diagnosis including dementia.

The Occupational Therapy (OT) discharge summary dated 3/22/18 included therapy was provided for positioning due to falls, her hips slid forward in the wheelchair and discomfort while seated in the wheelchair. On discharge, the chair that was provided was a "rock n go." (This type of chair had a seat that slants back and downward, and rocks back and forth with resident movement. The OT discharge summary included use of a pommel cushion. (This was a special type of cushion was placed in the chair to prevent the resident's hips from sliding forward.)

Review of the quarterly Minimum Data Set (MDS) dated 4/2/18 revealed Resident #118 had impairment with short and long-term memory and was severely impaired in cognitive skills for decision making. This MDS assessed the resident as not being able to walk and had one fall without injury. The use of a physical restraint, a chair that prevents rising, was not included on the MDS.

Review of a quarterly MDS dated 6/1/18 revealed Resident #118 had no changes with her impairment with short and long-term memory, and required extensive assistance with activities of daily living. This MDS assessed the resident as not being able to walk. The use of a physical

modified for resident #118 on 7/16/18. MDS modified for resident #65 on 7/16/18. Resident #65 MDS was miscoded due to an oversight. Licensed staff was not aware that the chair and cushion were a restraint.

2. Section O and P of the MDS, for all current residents, for census date 6/23/18 will be audited for accuracy. Opportunities corrected as identified.

3. MDS staff will be re-educated on the importance of accuracy coding the MDS, specifically, physical restraints and hemodialysis by Regional Reimbursement Manager. Regional Reimbursement Manager will audit sections O and P of 5 MDS per week x 12 weeks for accuracy.

4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

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F 641	Continued From page 8	F 641		

restraint, a chair that prevents rising, was not included on the MDS.

Observations on 6/19/18 at 3:19 PM revealed Resident #118 was seated in the "rock n go" chair with a pommel cushion underneath her buttocks and thighs. The resident was observed leaning to her right side with her feet dangling and not touching the floor. During this observation the resident made no attempt to get out of the "rock n go."

Interview with Nurse Aide (NA) #4 on 6/22/18 at 9:21 AM revealed Resident #118 had a lean back chair, with a pommel cushion and leg rests. NA #4 explained the resident would try to get up out of a regular wheelchair and she would slide down in the wheelchair seat.

Interview with the Regional MDS Nurse consultant on 6/23/18 at 11:51 AM revealed the resident should have medical symptoms documented for the use of the restraint and the resident's 4/2/18 and 6/1/18 MDS assessments should have included the use of a chair that prevents rising as a restraint.

2. Resident #65 was admitted to the facility on 5/9/16 with diagnoses of hemiplegia following cerebral infarction affecting left dominant side, anxiety disorder and polyneuropathy.

Record review of the quarterly MDS dated 5/4/18 specified Resident #65 was receiving dialysis.

Review of Resident #65's physician orders revealed no current or prior orders for dialysis.

An interview with the resident on 6/19/18 at 10:54

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F 641	Continued From page 9 AM revealed he does not receive dialysis. An interview with MDS Nurse #1 on 6/22/18 at 9:00 AM revealed she knew the resident was not on dialysis and the dialysis entry on the 5/4/18 MDS was a coding error. An interview with the interim Administrator on 6/23/18 at approximately 11:30 AM revealed her expectation was that the MDS be coded accurately.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F 655		7/27/18

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F 655	Continued From page 10 (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement a baseline care plan within 48 hours of admission for 2 of 6 sampled residents (Resident # 425 and Resident # 332) who were newly admitted to the facility. The findings included: 1. Resident #425 was admitted to the facility on 6/14/18 with diagnoses, in part, of dementia with behavioral disturbance. A review of the admission assessments dated 6/14/18 completed by the nurse on admission indicated the resident was a high risk for falls and was combative at times with care. A record review revealed no baseline care plan	F 655	F655 1. Facility failed to complete baseline care plans for resident #425 and #332. Comprehensive care plan completed on 6/26/18 for resident #332. Comprehensive care plan completed on 6/27/18 for resident #425. Resident #425 and #332 did not receive a baseline care plan due to an oversight. 2. Audit of baseline care plans for new admissions since 6/23/18 to ensure a baseline care plan has been completed Director of Nursing and/or Nurse Managers. 3. Licensed staff will be re-educated by Director of Nursing and/or Staff	

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F 655	Continued From page 11 present. An observation on 6/19/18 at 8:33 AM of Resident #425 in his wheelchair in the dayroom revealed the resident had a tight grip on the nursing assistants hand, she was unsure how to respond and tried to pull her hand away. An observation on 6/19/18 at 2:30 PM revealed Resident #425 in the dayroom trying to get up from his wheelchair. An interview conducted on 6/21/18 at approximately 3:15 PM with Social Worker #1 revealed the nurses complete the baseline care plan. She stated they were in the process of developing a new system for baseline care plans that was going to start this week. An interview conducted on 6/21/18 at 2:25 PM with Nurse #2 who was providing care to the resident revealed she did not complete a baseline care plan for Resident #425 because she never got the chart from the supervisor who was also working on the admission. An interview conducted on 6/23/18 at approximately 11:30 AM with the interim Administrator revealed it was her expectation that baseline care plans be completed within 48 hours of admission. 2. Resident #332 was admitted to the facility on 6/13/18 with diagnoses that included respiratory failure, chronic obstructive pulmonary disease (COPD), atrial fibrillation, diabetes mellitus (DM), and hypothyroidism. Resident #332 was cognitively intact and the	F 655	Development Coordinator on importance of developing and implementing a baseline care plan. New admissions will be reviewed in clinical morning meeting to ensure baseline care plan is completed Director of Nursing and/or Nurse Managers. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 655	Continued From page 12 admission minimum data set (MDS) assessment was still in progress of being completed. Record review revealed no baseline care plan was present in the resident's hard chart or in the computer system. A review of the care plan for Resident #332 initiated on 6/20/18 revealed two care plans with interventions regarding nutritional risk and potential for breathing problems/impaired gas exchange related to need for oxygen, history of respiratory failure, and tracheostomy. No other care areas were addressed. During an observation of resident #332 on 6/19/18 at 11:02 AM she as lying in bed with her gown on, her tracheostomy dressing was clean, dry and intact. During an interview with the medical records director on 6/23/18 at 10:32 AM, when asked if she could provide resident #332's care plan, she provided the care plan initiated on 6/20/18 and stated that was the only one available. During an interview with the MDS Coordinator on 6/23/18 at 1:14 PM, she stated that nurses are supposed to fill out the base line care plans in the first 48 hours and then she would provide a more detailed care plan within 14 days. An interview was conducted with the DON on 6/23/18 at 3:39PM and she stated her expectation was that a baseline care plan be completed within 48 hours.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		7/27/18

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F 656	Continued From page 13	F 656		

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care

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F 656	Continued From page 14 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to develop a care plan that addressed psychotropic medication use for 1 of 7 residents (Resident #73) reviewed for unnecessary medications. The facility also failed to develop a care plan for 1 of 1 resident (Resident #118) reviewed for restraints and 1 of 1 resident (Resident #376) reviewed for accidents. Findings included: 1. Resident #73 was admitted to the facility on 3/3/17 with diagnoses that included, in part, anxiety disorder and psychotic disorder. A review of the medical record revealed a physician order dated 5/3/18 for Nuplazid, (an antipsychotic medication) 17 milligrams (mg) for psychosis. A review of the annual Minimum Data Set (MDS) assessment dated 5/8/18 revealed Resident #73 received an anti-psychotic medication. A review of the Care Area Assessment (CAA) for psychotropic medication use dated 5/22/18 revealed a care plan would be developed since "Resident at risk for complications related to adverse reactions due to daily use of psychotropic medications." A review of the care plan updated 5/22/18 revealed there was no care plan that addressed psychotropic medication use.	F 656	F656 1. Facility failed to develop a care plan that addressed psychotropic medication use, restraints and accidents. Care plan updated to address psychotropic medication use on 6/22/18 for resident #73. Care plan updated to include restraints on 7/16/18 for resident #118. Fall mat is in place for an intervention for resident #376. Resident #73 did not have a care plan that addressed psychotropic medication use due to an oversight. Resident #118 did not have a care plan that addressed restraints due to licensed staff not aware that resident #118 had a restraint. Intervention was not in place for resident #376 due to an oversight. 2. Audit of all active residents comprehensive care plans will occur to ensure accuracy of the care plan. 3. Interdisciplinary Tea re-educated on timeliness and accuracy of care plans by Regional Reimbursement Manager. Licensed and certified staff re-educated by Director of Nursing and/or Staff Development Coordinator on following resident care plan. Telephone orders and clinical information to be reviewed in clinical morning meeting in order to update care	

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F 656	Continued From page 15 On 6/22/18 at 3:54 PM an interview was completed with MDS Nurse #2. She stated when she completed an annual assessment she created a new care plan. She said she typically wrote the care plan after she finished the CAA. She said the care plan for psychotropic medication use for Resident #73 was not in the computer and that she must have missed completing it. On 6/23/18 at 11:27 AM an interview was completed with the Director of Nursing (DON). She stated she expected a care plan be developed if it was indicated in the resident's CAA. 2. Resident # 118 was admitted to the facility on 12/7/17 with diagnosis including dementia. Review of the quarterly Minimum Data Set (MDS) dated 4/2/18 revealed Resident #118 had impairment with short and long-term memory and was severely impaired in cognitive skills for decision making. This MDS assessed the resident as not being able to walk. The use of a physical restraint, a chair that prevents rising, was not included on the MDS. Review of the current care plan, updated 6/1/18 for a problem of fall risk did not include the use of the "rock n go" wheelchair or the use of the pommel cushion. A "problem" of physical restraints was not included on the care plan. Observations on 6/19/18 at 3:19 PM revealed Resident #118 was seated in the "rock n go" chair with a pommel cushion underneath her buttocks and thighs. The resident was observed leaning to	F 656	plans by Director of Nursing/Nurse Managers and/or MDS Nurse. Regional Reimbursement Manager will audit 5 care plans per week x 12 weeks to ensure appropriate care plans are developed. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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her right side with her feet dangling and not touching the floor. During this observation the resident made no attempt to get out of the "rock n go."

Interview with Nurse Aide #4 on 6/22/18 at 9:21 AM revealed Resident #118 had a lean back chair, with a pommel cushion and leg rests. NA #4 explained the resident would try to get up out of a regular wheelchair and she would slide down in the wheelchair seat.

Interview with the MDS Nurse # 2 on 6/22/18 at 10:42 AM revealed the "rock n go" and pommel cushion was not a restraint because she did not think the resident could walk. She explained the reason for the change in seating was due to the resident having falls from the wheelchair. The "rock n go" was the recommendation by Occupational Therapy (OT) after their treatment.

Interview with the Regional MDS Nurse consultant on 6/23/18 at 11:51 AM revealed the resident should have a care plan for the use of the rock n go as a restraint.

3. Resident #376 was admitted to facility on 4/11/18 with diagnoses of a fracture hip that was not operable, fracture of the arm, and dementia.

Review of the Admission Minimum Data Set (MDS) dated 4/18/18 indicated Resident #376 had short and long-term memory impairment, required extensive assistance of one staff member for bed mobility and transfers and he did not walk. This MDS indicated he had a fall prior to admission to the facility.

Review of the care plan dated 4/11/18 included a

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F 656	Continued From page 17 problem of at risk for falls and fall related injuries. The approaches included for the bed to be against the wall, and fall mat placed on the floor at admission. Observations on 6/18/18 at 4:09 PM revealed Resident #376 was in the bed and the fall mat was not beside the bed. Observation on 6/19/18 at 8:45 AM revealed Resident #376 was in bed, with the head of the bed elevated 90 degrees. The fall mat was not on the floor beside the bed. Observations on 6/21/18 at 2:39 PM revealed the fall mat was not on the floor beside the bed. The resident was in the bed during the observation. On 6/21/18 at 2:39 PM an interview with Nurse Aide #5 revealed the resident had a floor mat that is supposed to be on the floor when he is in bed. She further explained the fall mat was picked up each day for housekeeping to mop. The NA located the fall mat in the bathroom against the wall. Interview with MDS Nurse #2 on 6/22/18 at 11:20 AM revealed the fall mat was an intervention for falls and should have been in place beside the bed when the resident was in the bed.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		7/27/18

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F 657	Continued From page 18 (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. (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 interviews the facility failed to update the care plans for 2 of 48 sampled residents. Resident #106's care plan was not updated for suicide prevention and Resident #103 was not updated for range of motion and splint application. The findings included: 1. Resident #106 was admitted to the facility initially on 8/14/17 with diagnosis of anxiety, depression, and psychosis. The care plan dated 8/22/17 for Resident #106 specified the resident had a diagnoses of	F 657	F657 1. Facility failed to update the care plan for resident #106 and #103. Resident #106 discharged from facility on 6/27/18. Care plan updated for resident #103 7/17/18. Resident #106 did not receive an updated care for suicidal ideations due to a communication failure. Resident #103 did not receive an updated care plan for splinting and range of motion due to staffing challenges in restorative nursing. 2. Active residents as of 6/23/18 will have care plans audited to ensure appropriate interventions are in place, active and	

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depression and anxiety with the need for psychotropic medication. The care plan was updated on 1/28/18 also has diagnosis of dementia, psychosis, PTSD (Post Traumatic Stress Disease). The care plan was updated on 4/25/18 for Exhibiting paranoia, and hallucinations.

Review of the nurses' notes dated 5/12/18 revealed the resident had threatened suicide with a table knife held to her throat. The note specified the resident was placed on 1:1 until she was transferred to the hospital.

The Quarterly Minimum Data Set (MDS) dated 5/11/18 indicated the resident did not have any short or long-term memory impairments. The MDS indicated she required supervision or cueing with bed mobility, transfers, and ambulation and did not have psychotic or wandering behaviors exhibited.

Record review revealed the resident returned to the facility from the hospital on 5/16/18 with diagnoses of urinary tract infection and psychosis.

Review of the psychiatric consult dated 5/17/18 revealed in part: "Resident (#106) grabbed a butter knife and threatened to stab herself; paranoid; hearing the voice of her son; attempted to break a window ..." "Each delirium is progressively worse; once the delirium clears, her cognition is not quite as good as before."

There were no Social Worker notes related to the behaviors, paranoia, hallucinations or to the threatened suicide attempt with table knife.

reflect current status.

3. Interdisciplinary Team re-educated on timeliness and accuracy of care plans by Regional Reimbursement Manager.

Telephone orders and clinical information to be reviewed in clinical morning meeting in order to update care plans Director of Nursing/Nurse Managers and/or MDS Nurse.

Regional Reimbursement Manager will audit 5 care plans per week x 12 weeks to ensure care plans are updated.

4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

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Interview on 6/22/18 at 10:00 AM with the Director of Nursing (DON) explained she would have expected the staff to check for any items the resident could hurt herself with when she threatened to kill herself in May. During the interview she explained the resident should have had plastic utensils instead of regular silverware and paper products instead of regular plates, cups etc following her hospitalization. Further interview revealed the resident's care plan did not address her suicide attempt and none of these interventions were in place to protect the resident.

Interview with the MDS Nurse #2 on 6/22/18 at 10:15 AM revealed the care plan should have been updated to address the resident's attempted suicide threats.

2. Resident#103 was re-admitted to the facility on 5/8/18 with diagnosis of encephalopathy acute, left hemiparesis, history of stroke and diabetes.

Review of the summary for occupational therapy (OT) dated 5/9/18 indicated therapy was to provide splint tolerance to the left hand. The summary included "without therapy patient at risk for further contracture development/worsening." The summary indicated the resident would be discharged to Restorative Nursing Program (RNP) for splint application.

Review of a telephone order dated 5/22/18 to discontinue OT and to follow up with RNP for left resting hand splint.

Review of the updated care plan 4/26/18 did not include a problem of hemiplegia with contracture management by RNP.

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F 657	Continued From page 21 Observations on the following dates revealed no splint was on her left hand: - 6/18/18 at 7:00 PM, - 6/19/18 at 7:00 AM, 10:00 AM, - 6/20/18 at 8:00 AM, 11:00 AM and - 6/21/18 at 12 Noon. An interview with the Restorative Nurse on 6/21/18 at 2:00 PM revealed the facility did not have restorative and had not had it for about 3 - 4 weeks. He indicated the Director of Nursing (DON) or the Administrator could give more details. Interview with the MDS Nurse #1 on 6/23/18 at 10:00 AM revealed the care plan should have been updated for application of the splint.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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, record review and staff interviews the facility failed to 1) change the dressing and caps of a peripherally inserted central catheter (PICC) as ordered by the physician for one of one sample residents with a PICC (Resident #333) and 2) provide a frozen nutritional supplement at each meal as ordered by speech therapy for one of one sampled residents reviewed for swallowing problems (Resident #376).	F 658	F658 1. Facility failed to 1) change the dressing and caps of a peripherally inserted central catheter line (PICC) as ordered by the physician and 2) provide a frozen nutritional supplement at each meal as ordered by speech therapy. PICC line dressing and caps were changed for resident #333 on 6/22/18 by Nurse.	7/27/18

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F 658	Continued From page 22 Findings include: 1. Resident #333 was admitted to the facility on 6/4/18 with diagnoses that included hypertension (high blood pressure) and an infection to left knee replacement. The admission Minimum Data Set (MDS) dated 5/21/18 specified the resident had intact cognition, no behaviors or rejection of care, and received an antibiotic six of seven days during that assessment period. Review of physician orders initiated on 6/4/18 revealed orders were placed for PICC line dressing to be changed once a week on Tuesday and to change injection caps after blood draws and weekly. Review of laboratory results revealed that Resident #333 had blood drawn on 6/7/18 and 6/14/18. Review of the resident ' s June 2018 medication administration record (MAR) on 6/19/18 revealed that the PICC dressing and caps were changed on 6/5/18, and there was no other documentation at that time. During an observation and interview on 6/19/18 at 10:34 AM resident #333 ' s PICC dressing was soiled and peeling off. The date written on the dressing was for 6/5/18. When asked how often staff changed her PICC dressing, the resident stated it had only been changed once, right after she arrived to the facility. During an interview with Nurse #4 on 6/22/18 at	F 658	Frozen nutritional supplement was on resident #376 tray on 6/22/18 Dietary Manager. Licensed staff failed to follow a physician order to change the dressing and caps of a PICC line due to an oversight. Dietary staff failed to place the frozen nutritional supplement due to oversight. 2. Audit of all active residents with PICC lines will be completed to ensure the dressing and caps are being changes as ordered Nurse Managers. Audit of all active residents with orders for frozen nutritional supplements will be completed to ensure they are receiving as ordered by Registered Dietician. 3. Licensed staff re-educated by Director of Nursing and/or Staff Development Coordinator on following physician orders for PICC line dressing and cap changes. Nurse managers will monitor residents with PICC lines weekly x 12 weeks to ensure residents with PICC line dressing and caps are changed as ordered. Licensed, certified and dietary staff will re-educated on tray card accuracy by Director of Nursing/Staff Development Coordinator and/or Registered Dietician. 20 resident trays will be audited per week x 12 weeks to ensure tray card accuracy Dietary Manager. Opportunities corrected as identified. 4. Data obtained during the audit process	

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F 658	Continued From page 23 1:32 PM, she stated that the PICC line was flushed daily and that a reminder for what to do with it would pop up on her screen in relevance to the physician orders and care to be completed by her or other nurses per shift. She stated that the resident ' s PICC dressing was supposed to be changed weekly and if soiled, that she did not remember doing it, and that if she had seen the reminder she would have performed the task. Review of the MAR and tasks to complete in the computer system revealed that the task was to be completed every Tuesday during first shift. During an interview with the Director of Nurses (DON) on 6/22/18 at 3:48 PM, she stated that it was her expectation that staff follow physician orders and facility policy for routine care of a PICC line. While reviewing the MAR with the DON, she stated that when she started working at the facility there were so many tasks that had not been documented as completed in the computer system that she had to clear out all over the overdue tasks to be able to see the present tasks that were due. The DON verified that based on the MAR the dressing and caps were not changed based on the physician ' s orders. She stated that it was important for staff to change PICC dressings as ordered to prevent site infections. 2. Resident #376 was admitted to the facility on 4/11/18 with diagnoses of a fracture hip that was not operable, dysphagia and dementia. Review of the Admission Minimum Data Set (MDS) dated 4/18/18 indicated Resident #376 had short and long term memory impairment, and required extensive assistance of one staff	F 658	will be analyzed for patterns and trends and reported to QAPI by Director of Nursing and Dietary Manager monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 658	Continued From page 24	F 658		

member for eating. The MDS indicated he had difficulty with swallowing and was on an altered mechanical diet.

Review of the care plan dated 4/11/18 included a problem of nutritional risk due to history of dysphagia, required assistance with eating, and variable oral intake. One of the approaches included offering supplements as ordered.

Review of the care plan dated 4/11/18 included a problem of nutritional risk due to history of dysphagia, required assistance with eating, and variable oral intake. One of the approaches included offering supplements as ordered.

Review of a telephone order dated 5/30/18, written by the speech therapist, was to provide a frozen nutritional supplement for texture. Observations on 6/18/18 at 4:09 PM revealed the supper tray was provided in the resident's room. The frozen nutritional supplement was not on the tray.

Observations on 6/19/18 at 8:49 AM revealed the breakfast tray was provided in the resident's room. The frozen nutritional supplement was not on the tray.

Interview with the dietician on 6/21/18 at 11:32 AM revealed the supplement was provided to assist the resident with swallowing due to the texture.

Interview with the Dietary Manager on 6/22/18 at 4:27 PM revealed the frozen nutritional supplement may have been removed by the nursing aides on the floor. He explained he had two new staff in dietary and they may have taken

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F 658	Continued From page 25 the supplement to the floor, instead of putting it on the tray. During the interview he explained the resident was supposed to get the frozen supplement on the tray with each meal and it should have been on the tray.	F 658		
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 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide incontinent care for 1 of 8 dependent sampled residents reviewed for ADLs (activities of daily living) Resident #45. Findings included: Resident #45 was admitted to the facility on 2/10/17 with diagnoses which included: congestive heart failure, fibromyalgia, muscle weakness, and chronic pain syndrome. Review of the Physician's Order dated 12/12/17 and the medication administration record for June 2018 revealed Resident #45 received 40 mg (milligrams) of furosemide (diuretic medication) every morning. The quarterly minimum data set dated 4/20/18 indicated Resident #45 was cognitively intact with adequate vision; required extensive assistance with bed mobility, transfers, and toileting; and was always incontinent of bowel and bladder.	F 677	F677 1. Facility failed to provide ADL care for dependent resident. ADL care was provided for resident #45 on 5/25/18. Facility failed to provide ADL care for resident #45 due to staff not being aware of the care plan regarding ADL care. Care plan for resident #45 was updated on 7/16/18. 2. Licensed and certified staff educated regarding providing ADL care for all residents as needed by Director of Nursing and/or Staff Development Coordinator. 3. Weekly audits will be conducted for four weeks, and randomly thereafter, by Director of Nursing and/or Nurse Manager, from a random sampling of residents to ensure proper ADL care is being provided. If any adverse outcomes are identified via the weekly audit,	7/27/18

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F 677	Continued From page 26 The Care Plan dated 4/20/18 revealed Resident #45 had the potential for skin breakdown due to limited mobility and incontinence. Approaches included: remind resident to call for assistance; ask if resident needed to use the bathroom upon rising, before and after meals, before bed, and every two hours during the night, if awake; change the resident promptly after any incontinent episode. Also, use barrier cream to protect the resident's skin. Review of a nurse's note dated 5/26/18, documented Resident #45 informed Supervising Nurse #1 that she (the resident) did not receive incontinence care on Friday night, 5/25/18 during third shift until 5:30 a.m. and at approximately 10:00 a.m. the morning of 5/26/18. The resident reported she received incontinent care only once during the 7:00 a.m.-3:00 p.m. shift this day (5/26/18) and she was "soaked". The resident revealed to the nurse that this has been a problem for approximately two weeks. The Supervising Nurse documented that upon assessment, the resident and the resident's bedding were wet and the resident's inner thighs were red with raised skin due to the increased wetness of her adult brief. Further documentation revealed the Supervising Nurse immediately addressed the nursing assistant and the resident was provided incontinent care as well as cream applied to the resident's inner thighs. The charge nurse was also made aware. During an interview on 6/20/18 at 10:45 a.m., Resident #45 stated she frequently had to wait for call light assistance especially during the 7:00 a.m.-3:00 p.m. shift. The resident revealed she received a diuretic every day and has had to wait	F 677	immediate action will be taken, to include reporting via 24 hour report. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 677	Continued From page 27	F 677		

five to six hours before someone provided incontinent care; by which time she would be soaked with urine and/or bowel movement down her leg. The resident was unable to recall the names of the third and first shift nursing assistants who assisted her during this time period. When questioned about the accuracy of the time she had to wait for assistance, the resident pointed to the clock on the wall across from the head of her bed. The resident stated that less than one month ago, the housekeeper (whose name the resident was unable to recall) observed how uncomfortable she was and reported it to the supervisor who, after interviewing and observing her "soaked in urine" had the nursing assistant assist her in providing incontinent care. She indicated the Supervising nurse only worked on the weekends, but had checked with the resident when on duty.

During an interview on 6/23/18 at 9:04 a.m., Supervising Nurse#1 stated she only worked at the facility on weekends, supervising the 7:00 a.m-11:00 p.m. shifts. She revealed that on 5/25/18 (between 8:00 a.m.-8:30 a.m.), she responded to Resident #45's call light request. She was informed by the resident that she required incontinent care at approximately 6:00 a.m. or 7:00 a.m., the nursing assistant answered her call light request by informing her (resident) that someone would assist her shortly, but no one returned. The Supervising Nurse stated she observed that the resident's adult brief, bed pad, and bed sheet were wet with urine. She indicated there were no brown, dried stains on the pad or sheets. She stated that with the assistance of the nursing assistant (unable to recall which nursing assistant) provided perineal care, applied barrier cream, and changed the resident's bed linen. As

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F 677	Continued From page 28 a result of this incident, Supervising Nurse#1 had a meeting with all of the nursing assistants on duty during first, second, and third shifts concerning residents' call light requests and providing incontinent care. She indicated that she checks with Resident #45 every weekend. During an observation and interview on 6/23/18 at 11:15 a.m., Supervising Nurse#1 removed Resident #45's brief. The resident's brief was wet but the resident stated they had changed her about an hour earlier, and that she was administered furosemide earlier that morning.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide positioning devices for 1 of 8 sampled residents reviewed for positioning. (Resident #118) The findings included: Resident #118 was admitted to the facility on 12/7/17 with diagnosis including fracture of the right arm, left side hemiplegia, and dementia.	F 684	F684 1. Facility failed to provide positioning devices for a resident. Positioning devices are in place for resident #118 as of 6/22/18. Facility failed to provide positioning devices for resident #118 due to staff no communication between therapy and nursing. 2. Licensed and certified staff educated	7/27/18

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F 684	Continued From page 29 Review of the care plan for a problem of at risk for falls and fall related injuries with approaches dated 1/1/18 for therapy to screen and evaluate as needed. Review of the Occupational Therapy (OT) Discharge Summary dated 3/23/18 indicated Resident #118 was to be seated in a rock n go wheelchair. Review of the quarterly Minimum Data Set (MDS) dated 4/2/18 revealed Resident #118 had impairment with short and long-term memory and was severely impaired in cognitive skills for decision making. This MDS assessed the resident as not being able to walk, required extensive assistance of one person for bed mobility, transfers and toileting. This assessment included one fall with no injuries had occurred since December 2017. The care plan was not updated for the use of the rock n go and positioning devices after being discharged from OT 3/23/18. The care plan continued to include the use of the wheelchair and ensure the the wheels were locked before transferring. Observations of Resident #118 on 06/21/18 from 9:16 AM to 11:14 AM revealed she was sitting in a rock n go, leaning to her right side. The rock n go had one foot pedal on the left side, none on the right side. Her feet were dangling unsupported. A Pommel cushion was underneath the resident's buttocks. During the continuous observations, Resident #118 was not repositioned or checked by staff. Interview with OT #1 via phone on 06/22/18 at	F 684	regarding providing positioning devices for residents by Director of Nursing and/or Staff Development Coordinator. 3. Nurse Managers and/or Rehab Manager will monitor all residents with positioning devices to ensure they are in place as ordered 5 times per week x 4 weeks, weekly x 8 weeks. Opportunities corrected as identified. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 684	Continued From page 30 11:11 AM revealed the resident was had a positioning device, like a pommel, seated in a rock n go chair. OT#1 explained the resident was to have a cervical pillow for her neck, foot rests on the chair to support her feet. A lateral support was to be applied to assist her in maintaining an upright position and not lean. The lateral support was not a pillow, like one for your head, but a square type support device. Interview with Nurse Aide (NA)#1 on 6/22/18 at 9:19 AM regarding how Resident #118 should be positioned revealed she was not sure if leg rests were to be used, she had a lean back chair and a cushion. During the interview, she was not aware of any other positioning devices. Interview on 6/22/18 at 9:21 AM with NA #2 revealed the resident had to have a lean back chair, pommel cushion and leg rests. She was not aware of any other positioning devices. Observations on 06/22/18 11:39 AM revealed the left foot pedal was on the chair, the right was not on the chair. The resident was right side leaning without the support device. A neck pillow was not in use. Interview with the Therapy Manager on 6/22/18 at 11:45 AM revealed she observed the resident and would look for the devices that were to be used for positioning.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		7/27/18

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F 686	Continued From page 31 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide the intervention of a positioning device to treat pressure ulcers for one of four sampled residents reviewed for pressure ulcers. (Resident #103) The findings included: Resident #103 was admitted to the facility on 12/13/16 with diagnosis of stroke, hemiplegia and hemiparesis, congestive heart failure, diabetes and dementia. The current Minimum Data Set (MDS) dated 4/13/18, a quarterly, indicated Resident #103 required extensive assistance with all activities of daily living except eating. The MDS assessed the resident as having one unstageable pressure ulcer that had not healed. cognition The care plan with a revised date of 4/26/18 included a problem of an unstageable pressure ulcer on the right heel. Approaches included wound care as ordered by physician, weekly wound evaluation, treatment to right heel as ordered.	F 686	F686 1. Facility failed to provide the intervention of a positioning device to treat pressure ulcers for a resident. Positioning device to treat pressure ulcers were in place for resident #103 on 6/22/18. Facility failed to provide the intervention of a positioning device to treat a pressure ulcer due to staff not being educated to provide said device. 2. Licensed and certified staff educated regarding providing positioning devices for residents by Director of Nursing and/or Staff Development Coordinator. 3. Nurse Managers and/or Therapy Manger will monitor all residents with positioning devices to ensure they are in place as ordered 5 times per week x 4 weeks, weekly x 8 weeks. Opportunities corrected as identified. 4. Data obtained during the audit process will be analyzed for patterns and trends	

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F 686	Continued From page 32 Review of the physician orders dated 5/9/18 included treatment to unstageable pressure ulcer injury right heel to clean with normal saline, Santyl ointment (chemical debriding agent) cover with padded gauze (ABD dressing) and wrap with Kerlix (gauze wrap). Review of the medical record revealed wound assessments dated 5/14/18 with measurements of the right heel as 2 centimeters (cm) by 3 cm with no depth. A Podus boot (positioning device that keeps the heel off the mattress) in place to off load heel as an intervention. Observations on 6/18/18 at 4:41 PM revealed Resident # 103 had her right foot wrapped in gauze wrap and was resting on the mattress. There were positioning devices on the floor in the bathroom and on the shelf above the dresser drawers in the resident's room. Observations on 6/19/18 at 8:52 AM revealed Resident #103 did not have a positioning device on her right foot, with the foot resting on the mattress. Observations on 6/21/18 at 12:28 PM revealed the Temporary Treatment Nurse #1 (TTN) entered the resident's room to perform the dressing change and wound care. The right foot did not have a positioning device in place to prevent the right heel from having pressure due to the mattress. The TTN#1 removed the dressings, completed the wound care per the physician orders. The TTN #1 placed a long round pillow and a regular pillow between the resident's legs. Resident #103 was positioned on her right side. The pillow was under her legs at	F 686	and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 686	Continued From page 33	F 686		

the calves, but her heels remained on the bed. Observations of the right heel revealed it was boggy looking at center, whitish thick with a very small ring area around center that was pink. The area was bigger than quarter in size. Interview with the TTN #1 revealed she was not sure if resident was to wear any type of boot. She looked around the room, and explained the boots on the dresser belonged to the roommate.

The regular treatment nurse (was on vacation during the survey) that documented in the wound assessment form the use of the Podus boots was not available for interview during the survey.

Interview with Nurse Aide (NA) #5 on 6/21/18 at 2:59 PM revealed she was not aware if the resident had any positioning devices. Further interview revealed she would check in the ADL book (resident information for the aides to provide care). During the interview, she did not find the information in the ADL book and she was observed asking Nurse #3 about the boots.

Interview with Nurse #3 on 6/21/18 at 3:05 PM revealed the resident had Podus boots but she had gone to the hospital recently. The NA #5, Nurse #3 and surveyor went to the room, and the boots for Resident #103 were the ones on the chest of drawers. Further interview with Nurse #3 revealed the boots were on the orders prior to the last hospitalization. The order to apply the Podus boots was not re-ordered on readmission. He did not find an order to discontinue the boots.

Interview with the Director of Nursing on 6/22/18 at 10:30 AM revealed the order for the Podus boots was missed. Further interview revealed the system was inconsistent to check for readmission

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F 686	Continued From page 34 orders and what was previously in place for care and treatment.	F 686		
F 688 SS=E	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 observations, record reviews and staff interviews, the facility failed to provide passive range of motion and splinting services to 3 of 7 sampled residents (Residents #18, #61, and #103) reviewed for contracture management. Findings included: 1. Resident #18 was admitted to the facility on 3/1/17 with diagnoses which included: aphasia, dementia, and contractures of the upper extremities.	F 688	F688 1. Facility failed to provide passive range of motion and splinting services for contracture management for residents. Resident #18 was evaluated by Occupational Therapy on 6/22/18 and continues on caseload. Resident #61 was evaluated by Occupational Therapy on 7/10/18 and continues on caseload. Resident #18 and #61 did not receive passive range of motion and splinting services due to staffing challenges in	7/27/18

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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 688	Continued From page 35 Review of the quarterly Minimum Data Set dated 4/2/18 indicated Resident #18 had short and long term memory problems with severely impaired decision-making skills and had range of motion impairments of her bilateral, upper and lower extremities. A review of a Facility Training Log revealed on 4/26/18, one restorative aide received training from the rehabilitative therapist on providing the following services for Resident #18 which were to be initiated on 4/27/18: 1) PROM (passive range of motion) for 2-3 minutes of bilateral elbows and hands, slow and gentle to allow placement of splints. 2) Place blue carrot splints in each hand to line #12 to wear for 6-8 hours each day. 3) Place bean bag splints on each elbow with buckles on outside of arm to wear 6-8 hours each day. Additionally, the restorative aide was instructed to: monitor carefully for skin irritation, redness, and breakdown; provide slow, gentle PROM with verbal reassurance within the resident's pain tolerance; and to use lotion during PROM of hands to assist with resident's comfort and reduce risk of skin shearing. Review of the physician's order dated 4/27/18 documented Resident #18 was to be discharged from skilled occupational therapy services with follow-up with the facility's restorative program. The discharge plans and instructions documented in the Occupational Therapy (OT) Discharge Summary dated 4/27/18 revealed Resident #18 was to receive contracture management/prevention by the facility's RNP (Restorative Nursing Program) and caregiver assistance for proper positioning in a tilt in-space positioning chair.	F 688	restorative nursing Facility restorative nursing program restored on 7/2/18. Restorative aides were trained by Rehab Program Manager. 2. Occupational Therapy will re-assess all residents with current orders for orthopedic devices to determine the need for continued orthopedic devices. The Rehab Manager will coordinate these assessments. 3. Licensed and Certified Nursing Staff will be re-educated by the Director of Nursing and/or Rehab Program Manager on the proper donning and removal of orthopedic devices. Nurse Managers will monitor 5 residents with orthopedic devices to ensure they are in place 5 times per week x 4 weeks, weekly x 8 weeks. Opportunities will be corrected as identified. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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The updated Care Plan (4/30/18) read: Resident #18 would receive restorative nursing PROM prior to splint application to improve muscle tone and to reduce further contractures related to contractures of both hands and elbows, and restorative nursing splint program to reduce further risk of continued contractures. Approaches included: restorative nursing to assist the resident in performing PROM 2-3 minutes of bilateral elbows and hands-slow gentle stretch prior to splints. Restorative nursing would apply blue carrot splints to bilateral hands to line #12 and place bean bag splints to bilateral elbows with buckles to outside-both splints to be worn 6-8 hours daily, 7 times per week for 90 days. Restorative nursing would monitor skin integrity for irritation, redness, pain, or skin breakdown, and report to nurse if needed. Document if resident refuses restorative care.

A review of the RNP Log indicated Resident #18 received 15 minutes of PROM on 4/27/18, 5/2/18, 5/4/18, 33 minutes on 5/27/18, 15 minutes on 6/2/18, 6/3/18, and 30 minutes on 6/10/18. The restorative log also revealed the resident received splinting application for 15 minutes only on 4/27/18 and 5/19/18.

During an observation on 6/20/18 at 9:43 a.m., Resident #18 was in the dining area sitting in a tilt in-space positioning wheelchair. Both of the resident's hands were tightly fisted with both thumbs protruding between her fingers. The resident's arms were bent upward towards her chest. Resident #18 was awake but non-verbal. There were no splints applied to the resident's hands and elbows.

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During an observation on 6/21/18 at 11:53 a.m., Resident #18 was in the dining area with both arms bent toward her chest and both of her hands were tightly fisted with the thumbs protruding between her fingers. There was a piece of gauze protruding between the forefinger and middle finger of the resident's left hand. There were no splints applied to the resident's hands and elbows.

On 6/21/18 at 4:47 p.m., the Rehabilitative Director stated the therapist who worked with Resident #18 no longer worked at facility, but review of the progress notes revealed the resident's splinting device was the blue carrot for both hands. She stated the resident was unable to tolerate the bean bag splints to her elbows.

During an interview on 6/21/18 at 4:52 p.m., the Restorative Nurse stated Resident #18 was to receive restorative PROM and splinting beginning 4/30/18. He revealed the resident wore a blue carrot splint on each hand and a bean bag splint on each elbow. He stated that the restorative nurse aides were able to apply the splints as directed. He revealed the Restorative Program had not been operating consistently since 5/21/18 due to the two restorative aides were frequently requested to work as floor nursing assistants. Whenever the restorative aides worked on a floor where a resident who was in the restorative program resided, the aides were instructed to do as much of the restorative service as possible with splinting as a high priority. The Restorative Nurse also revealed there were currently no consistent restorative aides and confirmed Resident #18 had not received PROM services since 6/10/18 and splinting application since 5/19/18 as documented on the resident's RNP

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log.

On 6/21/18 at 5:45 p.m., an observation of the splinting applications of the blue carrots to Resident#18's hands was conducted by the Rehabilitative Director and a therapy staff in the resident's room. The Administrator, the Director of Nursing, and the Restorative Nurse were also in attendance. The resident was awake, lying on her back in a low bed as the Rehabilitative Director and the therapy staff slowly and carefully applied the blue carrot splints to both of the resident's hands. As the rehabilitative staff separated the resident's fingers from the palms of her hands, the resident's nails were noted to be approximately half an inch in length, but clean. There was no odor emitting from Resident#18's hands or scarring or ulcers in her palms. The therapists only able to be applied to line #6 of the blue carrot splints.

During an interview on 6/21/18 at 5:58 p.m., the Rehabilitative Director stated that the occupational therapy discharge summary of 4/27/18 recommended the carrot splints be applied to line #10 in each of the resident's hands due to fluctuating tone and resistance. She concluded that based on this day's observation (the splints were only able to be applied to line #6), Resident #18 had declined in her range of motion.

2. Resident #103 was admitted to the facility on 12/13/16 with diagnosis of stroke, hemiplegia and hemiparesis, congestive heart failure, diabetes and dementia.

A telephone order dated 3/8/18 indicated Resident #103 was to have restorative nursing for

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application of a hand splint 7 to 8 hours as tolerated.

Review of the care plan, that was updated on 3/15/18 for the problem the resident was to participate in RNP (Restorative Nursing Program) for passive range of motion program, splinting management and prevention related to hemiplegia. The resident was discharged per therapy 4/11/18.

The current Minimum Data Set (MDS) dated 4/13/18, a quarterly, indicated Resident #106 required extensive assistance with all activities of daily living except eating. This MDS indicated there was limitation in functional movement of one side of her body. For that assessment timeframe, the resident was receiving physical therapy and occupational therapy.

Resident#103 was re-admitted to the facility on 5/8/18 with diagnosis of -encephalopathy acute, left hemiparesis, history of stroke and diabetes.

Review of the summary for occupational therapy (OT) dated 5/9/18 indicated therapy would provide splint tolerance to the left hand. The summary included "without therapy patient at risk for further contracture development/worsening." The summary indicated the resident would be discharged to RNP for splint application.

Review of a telephone order dated 5/22/18 to discontinue OT and to follow up with Restorative Nursing Program (RNP) for left resting hand splint.

Review of the updated care plan did not include a problem of hemiplegia with contracture

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management by RNP.

There was no documentation provided for review of application of the splint by the restorative nurse.

Observations on the following dates revealed no splint was on her left hand:
- 6/18/18 at 7:00 PM, her hand was open and not contracted
- 6/19/18 at 7:00 AM and 10:00 AM, her fingers were slightly curved, not contracted
- 6/20/18 at 8:00 AM, 11:00 AM and her hand closed and resident sleeping
- 6/21/18 at 12:00 Noon. her hand was closed and she was sleeping

An interview with the Restorative Nurse on 6/21/18 at 2:00 PM revealed the facility did not have restorative and had not had it for about 3 - 4 weeks. He indicated the Director of Nursing (DON) or the Administrator could give more details.

Interview with the Administrator and DON on 6/22/18 at 10:00 AM revealed they did not have nursing assistants trained in the restorative program currently. They explained they had two RNP aides, one of the RNP aides was on medical leave and the other had quit. The nursing department was in the process of recruiting RNP aides and would train the floor staff in restorative treatment. Further interview revealed the floor staff were not applying splints or performing range of motion.

3. Resident #61 was admitted to the facility on 12/21/15 with diagnosis of osteoarthritis.

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Review of the Occupational Therapy summary (OT) dated 8/9/17 included the resident was discharged to RNP (Restorative Nursing Program) to apply a splint to left hand and provide range of motion to the left hand. The range of motion and splint application was to prevent contractures due to osteoarthritis. The OT Discharge Summary indicated Resident #61 had 76-100% impairment in her left hand. Further review revealed she had no improvement at the time of discharge and the limitation remained 76-100% impairment.

The care plan dated 3/24/18 included a problem for restorative nurse to provide passive range of motion (PROM) program to improve muscle tone prior to splint application related to generalized muscle weakness with risk of contractures. The stated goal included the resident was to receive PROM gentle stretch for 1-2 minutes to left hand prior to splint 7 times a week. The care plan included restorative nursing to apply the splint to manage or reduce risk of contractures. The goal for the splint use was to apply the left hand splint daily for 4-6 hours as tolerated 7 times a week (daily). The approaches included restorative nursing to assist resident in applying left hand splint daily 7 times week.

Review of the April 2018 restorative resident caseload revealed the resident was on the list to apply splint to the left hand. There was no documentation provided that splints were applied in May or June 2018.

The Minimum Data Set (MDS) dated 5/1/18, a quarterly, indicated Resident #61 required extensive assistance of two staff for activities of daily living. The MDS indicated there was

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F 688	Continued From page 42 limitation in functional range of motion on one side of her body. Observations on 6/19/18 at 10:32 AM, and 1:42 PM, and 6/21/18 at 9:00 AM revealed Resident #61 did not have the splint on her left hand. Her hand was in a closed fist during the observations. Interview with the Restorative Nurse on 6/21/18 at 2:53 PM revealed the facility did not have a restorative program as of about 3 or 4 weeks ago. He indicated the Director of Nursing (DON) or the Administrator could give more details. Interview with DON on 06/22/18 10:45 AM revealed they became aware of the problems with restorative not providing the care last month. They have had therapy audit everyone for possible needs for therapy/restorative. The unit managers will be trained as well as the aides on the floor to provide restorative. The plan had not been completed at this time. She explained currently, restorative was not being provided.	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: Based on observations, staff interviews and record reviews the facility failed to provide a safe	F 689	F689	7/27/18

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F 689	Continued From page 43 environment for Resident #106 and failed to complete accident investigations and review interventions after falls for Resident #376. This was for two residents in a sample of five with accidents or incidents. The findings included: 1. Resident #106 was originally admitted to the facility on 8/14/17 with diagnosis of anxiety, depression, and psychosis. Record review revealed nurses' notes dated 5/3/18 and 5/4/18 indicated Resident #106 was exhibiting paranoia behavior. Resident #106's behavior was described as paranoid and hallucinating. The care plan dated 4/25/18 for a problem of increased confusion, hallucinations and paranoid behaviors and a secure alarm bracelet was applied. The stated goal included the resident would not leave the secured area unattended. The approaches included personal secure alarm as ordered, check functioning of the alarm every shift, check placement and the skin underneath the bracelet. The Quarterly Minimum Data Set (MDS) dated 5/11/18 indicated the resident did not have any short or long-term memory impairments. The MDS indicated she required supervision or cueing with bed mobility, transfers, and ambulation and did not have psychotic or wandering behaviors exhibited. Review of the nurses' notes dated 5/12/18 revealed the resident #106 had threatened suicide with a table knife held to her throat. The	F 689	1. Facility failed to 1) provide a safe environment 2) complete accident investigations and review interventions after falls for residents. Secure alarm applied on 6/22/18 for resident #106. Fall mat is in place for resident #376. Facility failed to check placement of secure alarm for resident #106 to ensure it is in place due to an oversight. Fall mat was not in place for resident #376 due to an oversight. 2. Active residents with secure alarms will be audited to ensure secure alarm is in place Nurse Managers. Active residents with fall mats will be audited to ensure they are in place Nurse Managers. 3. Licensed and certified staff educated regarding 1) ensuring secure alarms are in place and checked as ordered 2) fall mats are in place as ordered 3) completion of incident and accident reports by Staff Development Coordinator. Nurse Managers and/or designee will monitor all residents with secure alarms and fall mats to ensure they are in place as ordered 5 times per week x 4 weeks, weekly x 8 weeks. Opportunities corrected as identified. Incident and accident reports will be reviewed in morning clinical meeting for completion Director of Nursing and/or Nurse Managers. 4. Data obtained during the audit process will be analyzed for patterns and trends	

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F 689	Continued From page 44 resident was placed on one on one observation until she was transferred to the hospital. Record review revealed the resident returned to the facility on 5/16/18 with diagnoses of urinary tract infection and psychosis. Review of the "Wandering Assessment" dated 5/17/18 indicated the resident was physically capable of wandering or elopement, had cognitive impairment with poor decision- making skills, had wandered in the last 7 days, did not have a history of elopement, did not have history of standing by facility door, wandered independently about facility oblivious to physical and safety needs, and had increased confusion, disorientation, wandering, agitation, restlessness caused by UTI or other. Review of the psychiatric consult dated 5/17/18 revealed in part: "Resident (#106) grabbed a butter knife and threatened to stab herself; paranoid; hearing the voice of her son; attempted to break a window ..." "Each delirium is progressively worse; once the delirium clears, her cognition is not quite as good as before." Review of a nurse's note dated 6/19/18 at 3:20 PM revealed the secure alarm bracelet was not in place. The resident had made statements of "she needs to get out of here and will call 911 if she had to." Review of the Medication Administration Record (MAR) for the month of June 2018 revealed checks for the placement and function of the secure alarm bracelet were documented with nurses' initials. Interview with Social Worker (SW) #2, on 6/21/18	F 689	and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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at 10:25 AM revealed Resident #106 had frequent urinary tract infections. During the time of the infections, her behaviors increased, with her talking about a family member coming to kill her. Continued interview revealed the resident was usually alert and oriented and she was not aware of anything new in the last few weeks. The SW #2 explained Resident #106's would get fixated on someone trying to harm her.

Interview with Resident #106 on 6/22/18 at 9:00 AM revealed she had a secure alarm bracelet but it was kept in her cloth bag attached to her rolling walker. She explained she did not like it on her ankle because it irritated her skin. Resident #106 searched through her cloth bag and did not find it. She replied, "It's in there somewhere.

Interview with MDS Nurse #2 and the Regional MDS consultant on 6/22/18 at 9:42 AM revealed the resident resided on a regular hall and not in a secure unit. The secure alarm bracelet should be placed on her person.

The resident was observed on 6/22/18 at 11:20 AM to ambulate with a walker and walk in the hallways on and off the unit. She was observed walking to the front lobby and turned around and went back down the hall.

Interview with the Nurse #4 on 6/22/18 at 1:03 PM revealed the assigned med aide or nurse would check for placement of the secure alarm bracelet for Resident #106. Nurse #4 explained the med aide who was working with Resident #106 on 6/22/18 and would have checked it. Interview with Med Aide #1 on 6/22/18 at 1:04 PM revealed the resident did not have the secure alarm bracelet on her body. She explained it was

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in the med cart, because Resident #106 had cut it off. She had talked to the supply person, and was told the resident could not have another secure alarm bracelet because she kept cutting them off and the secure alarm bracelets were expensive. Med Aide #1 pointed to a cut secure alarm bracelet and confirmed it was Resident #106's.

Nurse # 4 was re-interviewed on 6/22/18 at 1:09 PM and she was the charge nurse for Resident #106. Interview with Nurse #4 revealed she was not aware the bracelet was not on the resident.

Interview with the supply staff person on 6/22/18 at 1:15 PM revealed he had given her 7 secure alarm bracelets and they were expensive. The resident kept cutting them off and nursing staff could not always find the monitor. He had more bracelets that could be used in the supply room. He explained the Resident #106's bracelet was tested yesterday before she went to the appointment.

Interview on 6/22/18 at 10:00 AM with the Administrator, Director of Nursing (DON), MDS Nurse #2, Regional Nurse Consultant and SW #2 revealed Resident #106 was at risk for wandering. She had not attempted to exit the facility. Interview revealed the secure alarm bracelet would be checked every shift, by the nurse. Interview revealed they were not aware Resident #106 was removing the secure alarm bracelets and there were no other interventions to prevent the resident from exiting the facility.

During the interview on 6/22/18 at 10:00 AM with the administration staff, they were asked if interventions were in place for suicide prevention

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for Resident #106. The DON explained she would have expected the staff to check for any items the resident could hurt herself with when she threatened to kill herself in May. She should have had plastic utensils instead of regular silverware and paper products instead of regular plates, cups etc. Further interview revealed none of these interventions were in place to protect the resident.

Observations on 6/22/18 at 1:33 PM revealed the resident's room was searched by the DON with the following items in her possession: 2 pair of scissors, without sharp points and a pair of tweezers with sharp points. The DON explained these items should not be in the resident's possession due to her threats to harm herself.

2. Resident #376 admitted to facility on 4/11/18 with diagnoses of fractured hip that was not operable, fracture of the arm, and dementia.

A fall assessment dated 4/12/18 revealed a score of 12, which indicated he was a high risk for falls.

Review of the Admission Minimum Data Set (MDS) dated 4/18/18 indicated Resident #376 had short and long-term memory impairment, required extensive assistance of one staff member for bed mobility and transfers and he did not walk. This MDS indicated he had a fall prior to admission to the facility without injury.

The care plan dated 4/16/18 included a problem of "Resident is at risk for falls and fall related injuries." The stated goal included the resident would not experience any injuries related to falls. The approaches included for call light to be within

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easy reach, the bed to be against the wall and a fall mat that was placed on admission.

Review of the medical record revealed falls occurred on:

- 5/29/18 at 5:31 PM he was noted on floor by staff, slid on floor from wheel chair. There were no apparent no injuries.

- 6/9/18. The nurse's note documented he was found on floor, on his right side, alongside of bed. There were no apparent injuries.

Review of the "Post-Incident Actions" revealed reports of a fall were:

- 5/6/18 at 2:55 PM when the resident was noted on the floor beside the bed. "Immediate Post -Incident Action" taken was the Resident was assisted to wheel chair and was sitting in dining area. The "Immediate Actions Taken" was blank.

- 6/9/18 at 6:15 AM when the resident was found lying on the floor on his right side alongside of his bed. The "Immediate Post-Incident Action was blank. The "Immediate Actions Taken: Assessed resident for injury."

Interview with the Director of Nursing (DON) on 6/22/18 at 8:30 AM revealed she did not have a fall report for the fall that occurred on 5/29/18. She would expect incident reports to be completed for all falls. She was not the DON during that timeframe and could not speak to why one was not done.

Interview with the MDS Nurse #1 on 6/22/18 at

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F 689	Continued From page 49 3:36 PM revealed the Resident # 376 was supposed to have a fall mat at bedside when he was in bed. She did not have any other interventions after each fall. The process to review falls included a fall meeting, but one had not been held since the previous DON had left. She explained the process had not been set up with the new administration to review falls.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		7/27/18

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F 690	Continued From page 50 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to schedule a follow up appointment with the urologist for one of three sampled residents with an indwelling urinary catheter. Resident #106 The findings included: Resident #106 was originally admitted to the facility on 8/14/17 with diagnosis of anxiety, depression, neurogenic bladder and psychosis. The Quarterly Minimum Data Set (MDS) dated 5/11/18 indicated the resident did not have any short or long-term memory impairments. The MDS indicated she had an indwelling urinary catheter. Resident #106 was discharged to the hospital due to increased confusion and suicidal threats on 5/11/18. She was re-admitted to the facility on 5/16/18 with diagnoses of urinary tract infection and psychosis. Review of the the hospital discharge summary dated 5/16/18 included an order to schedule a follow up appointment with the urologist. The hospital summary indicated she had a urinary infection. Review of the nurse's notes revealed the resident was treated for two urinary tract infections after	F 690	F690 1. Facility failed schedule a follow up appointment with the urologist for one resident with an indwelling urinary catheter. Resident #106 discharged from facility on 6/27/18, therefore, no follow up appointment made. Facility failed to schedule a follow up appointment with the urologist for resident #106 due to an oversight. 2. Audit of residents admitted or re-admitted in the past 30 days to assure all recommended follow up appointments/consults were ordered and scheduled. Opportunities corrected as identified. 3. Director of Nursing and/or Staff Development Coordinator educated licensed staff to use the final discharge summary for writing orders with special attention to recommended follow up appointments/consults. Nurse Managers will review all admission/re-admission final Discharge Summaries to assure recommended follow up appointments/consults were	

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F 690	Continued From page 51 readmission to the facility on 5/16/18. Diflucan (an antifungal) was given 5/25/18 to 5/29/18 for a urinary tract infection. In June, Levaquin (an antibiotic) was administered 6/9/18 to 6/17/18 for a urinary tract infection. Review of the nurse's notes revealed she had increased confusion and increased paranoia. A urinalysis was obtained which did indicate she had a urinary tract infection. Review of the nurse's notes dated 6/19/18 at 3:20 PM revealed the nurse discovered the order for the appointment had not been made and she had not been seen by the urologist. Record review revealed no new orders were given by the urologist after the resident saw the urologist on 6/21/18. Interview with the Director of Nursing on 6/22/18 at 10:30 AM revealed the system was inconsistent to check for readmission orders and what was previously in place for care and treatment. The DON explained that the resident's order for the follow up urology appointment was missed on his readmission. The DON stated the admitting nurse was responsible for checking the resident's readmission orders and to start the process to schedule the urology appointment as ordered.	F 690	ordered and scheduled. Review will occur within three days of the admission date to ensure recommended follow up appointments/consults were scheduled. All admissions will be audited x 3 months. Opportunities corrected as identified. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 725		7/27/18

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F 725	Continued From page 52 practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to provide sufficient nursing staffing to ensure passive range of motion and splinting services were provided to 3 of 7 sampled residents (Residents #18, #61, and #103) reviewed for contracture management. The finding included: This tag is cross referenced to: Tag F-688: Based on observations, record reviews and staff interviews, the facility failed to provide passive range of motion and splinting services to 3 of 3 sampled residents (Residents	F 725	F725 1. Facility failed to provide sufficient nursing staffing to ensure passive range of motion and splinting services were provided for residents for contracture management. Restorative nursing services were restored on 7/2/18. Facility failed to provide sufficient nursing staffing due to education regarding the requirement for restorative nursing services. 2. Occupational Therapy will re-assess all residents with current orders for	

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F 725	Continued From page 53 #18, #61, and #103) reviewed for contracture management. Resident #18 did not receive range of motion and splint application and experienced a decline in range of motion of her hands. Interview with DON on 06/22/18 10:45 AM revealed they became aware of the problems with restorative not providing the care last month. They have had therapy audit everyone for possible needs for therapy/restorative. The unit managers will be trained as well as the aides on the floor to provide restorative. The plan had not been completed at this time. She explained currently, restorative was not being provided.	F 725	orthopedic devices to determine the need for continued orthopedic devices. The Rehab Manager will coordinate these assessments. Findings from assessments will be addressed accordingly by Rehab Manager. 3. Licensed and Certified Nursing Staff will be re-educated by the Director of Nursing and/or Rehab Program Manager on the proper donning and doffing of orthopedic devices to include range of motion. Nurse Managers will monitor 5 residents with orthopedic devices to ensure they are in place 5 times per week x 4 weeks, weekly x 8 weeks. Opportunities will be corrected as identified. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		7/27/18

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F 757	Continued From page 54 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to administer a pain medication according to the physician's parameters, failed to clarify an order for the pain medication, and failed to give the medication as ordered for the frequency for one of seven sampled residents reviewed for unnecessary medications. Resident #103. The findings included: Resident #103 was re-admitted to the facility on 05/08/18 with diagnoses including altered mental status, lethargy related to polypharmacy and urinary tract infection. Review of the readmission orders dated 5/08/18 included Oxycodone (Opiate pain medication) 2.5 milligrams (mg) every 8 hours as needed (PRN). A telephone order dated 5/8/18 indicated Oxycodone (no dosage) to be "offered TID" (three	F 757	F757 1. Facility failed to 1) administer a pain medication according to the physician□s parameters 2) clarify an order for the pain medication 3) give the medication as ordered for the frequency. Order for oxycodone (no dosage) to be offered TID (three times a day) was discontinued on 6/19/18 for resident #103. Facility staff failed to follow the six rights of medication administration regarding the medication order for resident #103. 2. Audit of all PRN narcotics to ensure they include all the components of an accurate order Director of Nursing and/or Nurse Managers? Any opportunities will be corrected as identified. 3. Licensed and Certified Nursing Staff will be educated on the six rights of	

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F 757	Continued From page 55 times a day). Review of the June 2018 Medication Administration Record (MAR) revealed the times of administration to "offer Oxycodone" were at 9:00 AM, 1:00 PM and 7:00 PM. There was no dose for the Oxycodone for these times of administration on the MAR. Review of the current June 2018 physician order dated 6/4/18 revealed Oxycodone 2.5 mg was to be given at 6:00 AM, 2:00 PM and 10:00 PM on a scheduled basis and to hold the medication if sedated or confused. The PRN (as needed) Oxycodone was discontinued on 6/4/18. Review of the MAR for June 2018 revealed the medication was charted as being given at 6:00 AM 2:00 PM and 10:00 PM. The June MAR included "offer oxycodone TID" and the times listed for administration were 9 AM, 1 PM and 7 PM. There was no dosage with this order. This was initialed by the nurses/medication aides and checked with a green check for these times indicating the medication was "offered." Review of the physician orders in the electronic chart revealed a discontinue date of 6/19/18 for the order to "offer" the Oxycodone TID. Review of the narcotic count sheet for the times the Oxycodone was administered and were not according to the physician orders were as follows: - 6/14/18 at 6 AM, 2 PM and 8 PM, - 6/15/18 at 6 AM, 12 PM and 10 PM. - 6/16/18 at 6 AM, 9 PM - 6/17/18 at 6 AM, 12 PM with 1:35 PM and 9 PM. The 1:35 PM was documented as being	F 757	medication administration and unnecessary drugs by Staff Development Coordinator. Telephone orders will be reviewed in clinical morning meeting to ensure that any PRN narcotic orders include all the components of an accurate by Director of Nursing and/or Nurse Managers. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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wasted, and not administered.
- 6/18/18 at 5:30 AM, 1 PM, and 10 PM
- 6/19/18 at 6 AM, 12:00 PM, 8 PM and 11 PM.

Observations of Resident #15 on the following dates and times revealed she was sleeping:
-6/19/18 at 8:52 AM, 11:23 AM and 3:00 PM
- 6/21/18 at 10:05 AM, 11:10 AM, 12:28 PM and 2:59 PM.

Interview with Nurse #3 on 6/19/18 at 11:00 AM revealed he had just administered the Oxycodone for her to have prior to the treatment on her pressure ulcer. When interviewed, he explained he could give the medication an hour before or after it was due and he would be in compliance.

Interview with the Director of Nursing on 6/19/18 at 3:00 PM revealed she was not aware of the resident having two different orders for administration of the Oxycodone. Further interview revealed she would check the orders and notes on the MAR for clarification.

Interview with Nurse #4 on 6/23/18 9:43 AM revealed the order was to offer the medication at the 9 AM, 1PM and 7 PM and if she was in pain, she would have given the medication. She explained that would have been in addition to the scheduled times for the pain medication at 6 AM, 2 PM and 10 PM. When asked what dose would she give, she stated the dose listed in the other order.

The physician who ordered the Oxycodone to be offered TID (with no dosage) was no longer seeing residents at the facility. The new physician was not available for interview.

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F 757	Continued From page 57 Interview 06/23/18 10:33 AM with the Director of Nursing (DON) revealed she was not the DON during May 2018 and could not speak to why the resident had two different orders for the same medication. Further interview revealed she had reviewed the June MAR's and discovered no documentation in the "note" section of the MAR regarding administration of the medication at a different time from what was on the MAR. She further explained both orders should not have been on the MAR, the nurse should have clarified the orders and the order was not complete for the Oxycodone TID to be offered. During the interview she explained the resident was at risk for having the Oxycodone administered in double doses.	F 757		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to provide the correct food consistency as ordered by the physician for 1 of 6 sampled residents who were to receive a mechanically altered diet (Resident #332). Findings included: Resident #332 was admitted to the facility on 6/13/18 with diagnoses that included respiratory failure, and chronic obstructive pulmonary	F 805	F805 1. Facility failed to provide the correct food consistency as ordered by the physician for a resident who was to receive a mechanically altered diet. Resident #332 received an alternate meal. Facility failed to provide the correct food consistency for resident #332 due to an oversight. 2. Audit completed of diet orders to	7/27/18

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F 805	Continued From page 58 disease (COPD). Review of the nurse's admission assessment from 6/13/18 revealed Resident #332 was cognitively intact and had a tracheostomy. The admission minimum data set (MDS) assessment was still in progress of being completed. Review of physician orders revealed an order for mechanical soft diet. A review of the care plan initiated on 6/20/18 revealed two care plans with interventions regarding nutritional risk and potential for breathing problems/impaired gas exchange related to need for oxygen, history of respiratory failure, and tracheostomy (trach). During an observation on 6/19/18 at 6:45 PM resident #332 was observed to have a croissant with chicken salad served as part of her lunch meal and her meal ticket stated she was supposed to receive a mechanical soft diet. The resident was observed to have tracheostomy in place and stated that she had been getting foods that she wasn't able to eat since admission because she could not swallow them due to their consistency. She stated that this meal was something she was able to eat. During an observation and interview on 6/21/18 at 10:40 AM the resident was coughing. This surveyor notified Nurse #3 at 10:42 AM about resident #332's cough and statement. Resident #332 stated that she had received a hot dog with chili and coleslaw with french fries for supper the previous night, but she knew she could not eat it.	F 805	ensure that the order matches the meal ticket by Registered Dietician. Any opportunities are corrected as identified. 3. Licensed, certified and dietary staff will re-educated on tray card accuracy by Registered Dietician and/or Dietary Manager. 20 resident trays will be audited per week x 12 weeks to ensure tray card accuracy. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing and Dietary Manager monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 805	Continued From page 59	F 805		

When she asked staff for an alternate and she was offered a peanut butter and jelly sandwich. She stated she cannot eat peanut butter because it hangs in her throat, so she didn't eat any supper.

During an observation on 6/21/18 at 1:06 PM resident #332 received a whole piece of salisbury steak as part of her lunch meal of 6/21/18 and her meal ticket stated mechanical soft diet. She stated that she didn't feel like this should be something served to someone with a mechanically altered diet.

Review of the dietary meal/consistency spreadsheet provided revealed that the resident was supposed to receive the salisbury steak as ground meat during the lunch meal of 6/21/18.

During an interview with Nursing Assistant (NA) #3 on 6/21/18 at 1:08 PM she stated that staff checked the meals versus the meal tickets prior to serving the food. The meal ticket said mechanical soft diet but did not say ground meat so she stated that she felt it was okay to serve. She stated she had asked the resident if she would like her to cut up the meat but she had denied it.

During an interview with the dietary manager on 6/22/18 at 4:19 PM he stated that the resident was on a mechanical soft diet. When asked about the hot dog, peanut butter, and whole salisbury steak he stated that Resident #332 should never have been offered or received these

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	C 06/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

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F 805	Continued From page 60 meal items based on her ordered mechanical soft diet. During an interview with the DON on 6/23/18 at 3:48 PM she stated that it was her expectation that residents receive meals based on the diet/consistency that is ordered by the physician and/or dietician. She also stated that a resident with a mechanical soft diet should not receive a hot dog, peanut butter, or a whole piece of salisbury steak.	F 805		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 7/13/2017 complaint and recertification survey. This was for a recited deficiency in the area of Services Provided Meet Professional Standards (F658). The deficiency was cited again on the current recertification and complaint survey on 6/23/2018. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.	F 867	F867 1. The facility had continued failure during two federal surveys of record which shows a pattern of the facility's inability to sustain an effective QAA program. Facility failed to sustain an effective QAA program to due oversight. Quality Assurance and Performance Improvement Committee to meet monthly, with the purpose of identifying areas of out of compliance and establishing a plan to correct deficient practice and follow up on areas address in Performance	7/27/18

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F 867	Continued From page 61 Findings include: This tag is cross referenced to: Based on observations, record review and staff interviews the facility failed to 1) change the dressing and caps of a peripherally inserted central catheter (PICC) as ordered by the physician for one of one sample residents with a PICC (Resident #333) and 2) provide a frozen nutritional supplement at each meal as ordered by speech therapy for one of one sampled residents reviewed for swallowing problems (Resident #376). During the complaint and recertification survey on 7/13/2017 the facility failed to follow physician orders for 1 of 4 sampled residents. The facility failed to complete admission orders and provide ordered medications that were available for Resident # 293. An Interview was conducted with the facility's Interim Administrator and Director of Nursing (DON) on 6/23/2018 at 12:41 PM. The Administrator stated that the facility had recently undergone a change in management, and that ongoing observations were being completed daily to indicate changes that needed to be made. Once things were identified, interventions were being implemented to correct problem areas put into place from the previous management team. When asked what expectations the facility's administration had for preventing reoccurring problems, she stated that interventions were going to be put into place to prevent this from happening again.	F 867	Improvement plans to ensure practices are being maintained. (Services Provided Meet Professional Standards to be a priority in upcoming meetings. 2. Audit of active residents with PICC lines will be completed to ensure the dressing and caps are changed as ordered by Nurse Managers. Audit of all residents with orders for frozen nutritional supplements will be completed to ensure they are receiving as ordered by Registered Dietician. 3. Administrator and Director of Nursing educated by Regional Clinical Manager on Quality Assurance and Performance Improvement process with focus on establishing and maintaining corrective actions to ensure consistent delivery of care and services. Administrator completed a re-education with the facility QAPI committee related to the facility process and intent of the Quality Assurance and Performance Improvement committee, which included the responsibilities of the QAPI committee to ensure sustainability with identified areas of opportunity. Facility will utilize internal audits and input from facility staff to determine potential areas for improvement on an ongoing basis. ADHOC QAPI meetings will be held should areas be identified prior to scheduled monthly meetings. 4. QAPI meetings to be held monthly,	

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F 867	Continued From page 62	F 867	with minimal attendance of Administrator, Director of Nursing, Social Services and a Nurses' Aid (if possible), with Medical Director input into identified concerns and Performance Improvement Plans. Regional Clinical Manager to randomly review Quality Assurance and Performance Improvement minutes and to attend meetings when possible.	