STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING ______ B. WING ______	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted 11-13-18 through 11-16-18. Immediate Jeopardy was identified at CFR 483.12 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 7-22-18 and was removed on 11-16-18. An extended survey was conducted.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review, the facility failed to place a breath activated call light within reach of a resident with quadriplegia to allow for him to request assistance for one of one residents (Resident #71) reviewed for accommodation of needs. The findings included: Resident #71 was initially admitted to the facility on 5/9/17 and was most recently readmitted on 8/22/18 with diagnoses that included quadriplegia.	F 558	Bethany Woods Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Bethany Woods Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any	12/16/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/07/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Continued From page 1

The quarterly Minimum Data Set (MDS) assessment dated 10/1/18 indicated Resident #71 ' s cognition was fully intact. Resident #71 was dependent for all Activities of Daily Living (ADLs).

Resident 71 ' s plan of care, last reviewed 10/9/18, indicated he was totally dependent on staff for assistance with all ADLs.

The Resident Care Guide for Resident #71 indicated a mouth blowing call system was in place since 5/19/17.

An observation and interview were conducted with Resident #71 on 11/13/18 at 3:20 PM. Resident #71 was lying on his back in bed. His breath activated call light was about a foot above his head. Resident #71 stated that he had quadriplegia and he was not able to reach the breath activated call light to request assistance. He indicated that when this occurred he had to ask his roommate to press his call light if he needed assistance.

An observation and interview were conducted with Resident #71 on 11/14/18 at 9:00 AM. Resident #71 was lying on his back in bed and his breath activated call light was over a foot above his head. He reported that he was unable to reach his breath activated call light.

An observation was conducted of Resident #71 on 11/16/18 at 6:50 AM. Resident #71 was lying on his back in bed sleeping and his breath activated call light was over a foot above his head and was inaccessible to the resident.

An interview was conducted with Nursing

F 558

deficiency is accurate. Further, Bethany Woods Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings.

F 558

How corrective action will be accomplished for those residents found to have been affected by the deficient practice

On 11/16/18 resident□s call light was placed within reach by the hall nurse. Visual observations are performed during daily compliance rounds monitoring.

How the facility will identify other residents having the potential to be affected by the same deficient practice

On 11/16/18 an observation audit was completed by a nursing staff member to ensure that all call lights were properly placed within residents□ reach.
The audit revealed that 89% of the call lights were within reach of the resident. All call lights not in reach during the audit were placed appropriately immediately.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

Beginning 11/17/18 re-education was initiated by the RN Staff Development

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F 558	Continued From page 2 Assistant (NA) #9 on 11/16/18 at 7:45 AM. NA #9 stated she was assigned to Resident #71. She stated that Resident #71 utilized his breath activated call light frequently to request assistance. She stated that the breath activated call light was to be placed within reach of Resident #71 ' s mouth so it was accessible to him. NA #9 was asked where Resident #71 ' s breath activated call light was placed at this time. She indicated she had not went into Resident #71 ' s room yet so she had not known where it was placed. An observation was conducted of Resident #71 with NA #9 on 11/16/18 at 7:45 AM. His breath activated call light was over a foot above his head. NA #9 stated that the breath activated call light was not within Resident #71 ' s reach. An interview was conducted with Nurse #3 on 11/16/18 at 7:50 AM. She stated that Resident #71 ' s breath activated call light was to be placed within reach of his mouth as he was unable to reposition it himself. A phone interview was conducted with NA #16 on 11/16/18 at 8:17 AM. She stated that she had worked with Resident #71 the previous night during the third shift (11/15/18 11:00 PM to 11/16/18 7:00 AM). NA #16 indicated that Resident #71 ' s breath activated call light was supposed to be placed within reach of his mouth as he was not able to reposition it himself. She was asked where Resident 71 ' s breath activated call light was placed at the end of her shift that morning (11/16/18). She stated that she had not recalled where it was it. NA #16 indicated that if Resident #71 required assistance and his breath activated call light was out of his reach he would	F 558	Coordinator (SDC)for all staff regarding all call lights to be placed within reach of the resident. Re-education will be completed by 12/16/18. Any staff members not receiving re-education by 12/16/18 will not be allowed to work until education is completed. New hires and agency staff will receive this education during orientation to the facility. The assigned department heads (will include but not limited to nurse supervisors, Social workers, Quality Improvement (QI) nurse, Assistant Director of Nursing (ADON)) will be responsible for compliance round monitoring that includes the placement of call lights on a daily basis at various times including weekends. The assigned department heads will report to the Interdisciplinary Team any negative findings and corrective actions taken. How the facility plans to monitor its performance to make sure that solutions are sustained The results of these daily compliance rounds will be given to the QI Nurse to track and trend. Findings will be reported at the monthly Quality Improvement (QI) meeting for 3 months and quarterly thereafter. The Administrator or Director of Nursing (DON) will monitor the completed compliance rounds to identify any concerns expressed by residents related to call bell placement. The Administrator or DON will immediately validate any identified concerns are resolved in a	

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F 558	Continued From page 3 have asked his roommate to call for assistance or he would have yelled out when he saw a staff member pass the doorway to his room. An interview was conducted with the Administrator and Director of Nursing on 11/6/18 at 8:00 AM regarding Resident #71 ' s breath activated call light not being placed within his reach. They both indicated their expectations were for staff to place Resident #71 ' s breath activated call light within reach of his mouth at all times.	F 558	timely manner. The QI Nurse will present Interdisciplinary Team (IDT) corrective actions and resident concern corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the Executive QI committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of Reasonable Accommodations Needs/Preferences related to call lights. The administrator consulted with the medical director and the nurse practitioner regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		12/16/18

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F 584	Continued From page 4 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to keep the in-room packaged terminal air conditioner (PTAC) units clean, walls clean and free of damage/holes, and bathroom floors clean and free from soil damage in the resident ' s rooms for 5 of 6 Halls observed. Findings included: On 11/16/18 starting at 10:00 am to 12:15 pm, 32 resident rooms that were available for	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 11/19/18, the maintenance director and housekeeping supervisor cleaned the Packaged Terminal Air Conditioner (PTAC) Units in rooms 103, 105, 206,	

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F 584

Continued From page 5

observation on facility halls 100 through 800 were observed for the following concerns:

1. The PTAC units in rooms 103, 105, 206, 210, 305, 310, 313 were observed to appear dirty with grey dust in the lower air intake vent, and grey dust and white matter in the air output.

On 11/16/18 at 11:30 am an interview with observation of the PTAC units was conducted with the Maintenance Director who stated that the PTAC units were cleaned once a year by maintenance staff which started in March 2018. Halls 100 and 200 were all completed and a few rooms on Hall 400. The Maintenance Director stated that during interview he observed a dirty PTAC unit on Hall 200 with dust, food and paper particles in the air output vent and commented that when they (PTAC) are "really dirty" the unit would be removed and taken apart to be cleaned in the shop.

On 11/16/18 at 11:55 am interview was conducted with a maintenance staff person who stated that the PTAC units were cleaned once a year and provided a map of the facility depicting the resident ' s rooms which were documented as cleaned by highlighting.

2. The metal wall trim in rooms 200, 202, 203 was missing paint and was rusted and rotted through which created a hole approximately 2-inches.

In room 211, there was approximately a 4-inch hole in the wall and bathroom door.

Room 301 had multiple brown soil splatter spots on the wall surrounding the bathroom door.

F 584

210, 305, 310, and 313.
By 12/16/18, the maintenance director will repair and paint the metal wall trim in rooms 200, 202, and 203.
By 12/16/18, the maintenance director will repair damage to the walls in rooms 211, 301, 304, 606, 607, and 801A.
By 12/16/18, the maintenance director and housekeeping supervisor will work collaboratively to clean, repair and/or replace linoleum flooring in rooms 103, 200, 205, 206, 210, 211, 309, 313, 408, and 607.
How the facility will identify other residents having the potential to be affected by the same deficient practice
On 11/20/18 the Maintenance director and housekeeping supervisor performed an observation audit of all rooms in the facility to determine any other rooms needing some type of wall repair, PTAC cleaning, and/or cleaning/repair of bathroom floors. There were 74 rooms noted to need some type of wall repair, PTAC cleaning and/or repair and or cleaning of bathroom floors.
By 12/16/18 the maintenance director will formulate a prioritized repair calendar. On 11/17/18, the maintenance director and maintenance assistant began completing the repairs and maintenance tasks in order of priority. The cited room repairs will be completed by 12/16/18.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

Beginning on 11/17/18 with completion by

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In room 304, there was approximately a 6-inch hole in the wall.

In rooms 606 and 607, there was approximately a 2-inch hole/damage in the bathroom wall each.

In room 801A, the wall lateral to the bed was missing paint and had approximately 15-inch wall damage with a depression of 1-inch.

On 11/16/18 at 11:30 am an interview with observation of walls, and bathroom condition on Halls 100 and 200 was conducted with the Maintenance Director who made no comment about the rusting metal trim in the resident ' s bathrooms.

3. Rooms 103, 200, 205, 206, 210, 211, 309, 313, 408, and 607 all had bathroom floor brown stain/soil ring around the toilet base in the linoleum flooring. There was a gap at the base of the toilet where it met the floor and water could migrate. The linoleum appeared dry and damaged as if it had not been cleaned.

Room 211 bathroom had strong odor that resembled urine and the stain ring at the base of the toilet floor was the darkest and largest area compared to the other 9 observed bathrooms floors.

On 11/16/18 at 10:15 am an interview was conducted with house keeper #3 on hall 200 who stated the caulk was missing from the base of the toilet and the floor had become soiled and hard to clean. The linoleum around the base of the toilet was damaged and had more odor. House keeper #3 commented she had not created a work order

F 584

12/16/18, the Director of Nursing (DON) and/or Staff Development Coordinator (SDC) initiated an in-service with licensed nurses, nursing assistants, geriatric care assistants, and agency staff. The in-service reviewed the process for completing and submitting work orders for repairs to include PTAC Units, metal wall trims, and damage to the walls.
After 12/16/18, the Staff Development Coordinator will educate all newly hired licensed nurse, nursing assistant, geriatric care assistant, and agency staff on the work order process, during orientation to the facility.
By 12/16/18 the maintenance director will formulate a prioritized repair calendar. On 11/17/18, the maintenance director and maintenance assistant began completing the repairs and maintenance tasks in order of priority. The cited room repairs will be completed by 12/16/18.

How the facility plans to monitor its performance to make sure that solutions are sustained
On 12 /10 /18, the department heads (administrator, director of nursing, unit managers, social services director, activities director, bookkeepers, payroll, maintenance, housekeeping, and dietary manager) began weekly compliance monitoring rounds to ensure a clean and functional environment. The department heads will document findings on the Compliance Monitoring rounds tool for 12 weeks. Identified issues will be

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F 584	Continued From page 7 for maintenance to repair the soiled, stained floors in rooms 200, 202, 203, 206, 210, and 211. She further commented the floor was especially hard to clean in room 211. On 11/16/18 at 10:35 am an interview was conducted with house keeper #4 who stated she was aware of the brown soil at the base of the toilet and commented that it does not come off and was harder to clean. House keeper #4 was not aware of any plan to replace the floor around the toilet. On 11/16/18 at 11:30 am an interview with observation of walls, and bathroom condition on Halls 100 and 200 was conducted with the Maintenance Director who made no comment about the brown floor stain at the base of the toilet in the resident ' s bathrooms. On 11/16/18 at 11:55 am interview was conducted with a maintenance staff person who stated that the resident bathroom wall metal trim which had rusted from moisture was from washing the floor. The maintenance staff person further stated the toilet base is not caulked at the floor because water builds up under the toilet and can cause damage. The floor's brown ring at the base of the toilet was soil that staff pushed underneath the toilet when cleaning and damaged the tile underneath. The tile was sealed but broke down from soil and the tile needed to be replaced. There was no current plan to replace the tile. The maintenance staff person provided no comment about missing paint or damaged walls. On 11/16/18 at 2:30 pm an interview was conducted with the Administrator who commented she was informed by the	F 584	immediately addressed by the department head and reported to the administrator, maintenance director, and/or housekeeping supervisor. The maintenance director and housekeeping supervisor will present any issues related to a safe, clean, comfortable, and homelike environment to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The maintenance director, housekeeping supervisor, and/or administrator will present trends and QI committee recommendations to the executive QI committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of the facility maintaining a safe, clean, comfortable, and homelike environment for the residents.	

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F 584	Continued From page 8 Maintenance Director of the PTAC, walls, and bathroom floor condition and that "they would be taken care of." The Administrator provided no other comments. On 11/16/18 at 4:15 pm an interview was conducted with the Director of Nursing who stated she expected maintenance to keep the PTAC units clean and to repair the walls and bathroom floors when damaged and/or soiled.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the	F 585		12/16/18

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F 585	Continued From page 9 provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source,	F 585		

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F 585	Continued From page 10 and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews, the facility failed to provide a written grievance response summary (Residents #48 and #71) for 2 of 2 residents reviewed for grievance. Findings included: 1. Resident #48 was admitted to the facility 3/12/18 with the diagnoses chronic kidney disease and	F 585	F 585 Grievances How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 12/6/18, the administrator mailed a written grievance summary to Residents #48s resident representative and hand delivered a written grievance summary to resident #71.	

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	345146	A. BUILDING ______ B. WING ______	11/16/2018

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F 585

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activities of daily living (ADL) self-care deficit.

The resident' s physician note dated 9/7/18 revealed the resident complained of increased urination especially during the night secondary to increased Lasix for edema.

The care plan dated 9/18/18 revealed the resident complained of increased urination with diuretic dose increase, the resident required ADL personal hygiene little or no help to include: supplies for grooming within easy reach, dressing independent, and toileting supervision and reminders. Care plan updated on 11/18 revealed resident ADL remained highly, physically functional.

The quarterly Minimum Data Set dated 10/30/18 revealed the resident had a moderately impaired cognition. The resident required supervision with set up for ADLs and was independent with set up for meals. The active diagnoses were CKD stage 3 and activities of daily living (ADL) self-care deficit. The resident received a diuretic (water pill).

On 11/16/18 at 11:45 am an interview was conducted with the resident who stated that in September he was planned for and picked up by a church minister to go to church. The resident was changed and dressed prior to being picked up by the minister but had urine incontinence again. The resident stated that he had a new increase in his Lasix due to edema and was urinating frequently and felt it was out of control. The resident stated he filed a grievance that he needed incontinence care again immediately to leave for church, but it was not provided when the minister needed to leave. The resident decided

F 585

How the facility will identify other residents having the potential to be affected by the same deficient practice

On 11/17 /18, the administrator reviewed the grievance concern log for completion of the resolution process. The administrator audited grievances filed from 11/1/18 through 11/16/18. The audit revealed five grievances closed without providing a written grievance summary follow-up to the resident/resident representative. Grievance follow ups for those residents were mailed or hand delivered by 12/16/18. To protect other residents having the potential to be affected, the facility will provide a written grievance summary for all resident grievances filed after 11/16/18.
What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

On 12/7/18, the corporate consultant in-serviced the social workers, director of nursing and administrator on the Resident Concerns and Grievance Guidelines process. The in-service included the facility will provide written response to the resident/resident representative speaking on behalf of the resident who file a grievance; a request for a written response is not required. The written response will include the date the grievance was received, a brief description of the grievance, a brief description of findings of investigation and any corrective action.
On 11/16/18, the social workers and/or

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F 585	Continued From page 12 to leave with the minister and felt he had urine odor in church. The resident stated a grievance was filed, and he received an in-person response from staff to address his grievance. The resident stated he did not receive a written grievance resolution from the facility. An interview was conducted with the Administrator on 11/14/18 at 3:00 PM. She indicated that prior to August of 2018 written grievance summaries were provided to the reporting party for all grievances. She revealed that beginning in August 2018 a corporate policy was changed and they were instructed to only provide grievance summaries if requested by the reporting party. She acknowledged that no written grievance summary was provided to Resident #48 or to the reporting party for the grievance dated 9/3/18. The Administrator indicated that she expected the regulations related to grievances to be followed. 2. Resident #71 was initially admitted to the facility on 5/9/17 and was most recently readmitted on 8/22/18 with diagnoses that included quadriplegia. The quarterly Minimum Data Set (MDS) assessment indicated Resident #71 ' s cognition was fully intact. A Facility Concern/Grievance Form with a date received of 10/31/18 for Resident #71 had been initiated by a family member. Review of the Concern/Grievance Form revealed the investigation findings were reported to the family member voicing the concern as well as to Resident #71 in person. The form indicated written notification of the grievance investigation	F 585	the administrator began reviewing grievances during the morning interdisciplinary team (IDT) meeting to ensure resolutions and actions taken will be communicated to the resident and/or resident representative, including a written grievance response. On 11/16/18, the administrator began reviewing the grievance concern log weekly and will ensure all grievances completed include written responses to the resident/resident representative. How the facility plans to monitor its performance to make sure that solutions are sustained On 11/16/18, the social workers and/or administrator will begin presenting any issues related resident grievances to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The social workers and/or administrator will present trends and QI committee recommendations to the executive QI committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of the grievances.	

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F 585	Continued From page 13 findings/summary of the grievance had not been provided to Resident #71 or to his family member. Further review revealed the Administrator had signed the Concern/Grievance Form as having been complete on 11/9/18. An interview was conducted with Resident #71 on 11/13/18 at 3:20 PM. He stated that his family member filed a grievance a couple of weeks ago related to an appointment he missed due to a lack of transportation. He indicated neither he nor his family member had received a written grievance summary reporting the findings of the investigation. An interview was conducted with the Administrator on 11/14/18 at 3:00 PM. She indicated that prior to August of 2018 written grievance summaries were provided to the reporting party for all grievances. She revealed that beginning in August 2018 a corporate policy was changed and they were instructed to only provide grievance summaries if requested by the reporting party. She acknowledged that no written grievance summary was provided to Resident #71 or to the reporting party for the grievance dated 10/31/18. The Administrator indicated that she expected the regulations related to grievances to be followed.	F 585		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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	F 600		12/16/18

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F 600	Continued From page 14 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff, Nurse Practitioner (NP) and Medical Director (MD) interviews and record review, the facility neglected to assess, evaluate, monitor and treat a resident with continued complaints of left rib pain following a fall on 10/17/18. A diagnostic x-ray dated 10/30/18 revealed fractures to the 3rd through 7th ribs on the left side. This was for 1 (Resident #30) or 1 residents reviewed for neglect. The findings included: Resident #30 was admitted on 5/15/18 with cumulative diagnoses of Atrial Fibrillation, Congestive Heart Failure, Osteoarthritis, Restless Leg Syndrome and Delusional Disorder. Resident #30's quarterly Minimum Data Set (MDS) dated 8/15/18 indicated moderate cognitive impairment with a Brief Mental Status (BIMS) score of 12. She was coded with no behaviors and limited assistance with ambulation. Resident #30 was coded with no impairments to her upper or lower extremities. She was coded for scheduled and as needed (PRN) pain medications. Resident #30 was coded as reporting no pain and as having no falls since previous MDS assessment.	F 600	F 600 Free From Abuse and Neglect How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #30 has had decreased complaints of left side rib pain and is receiving scheduled pain medication along with an additional order for PRN pain management. How the facility will identify other residents having the potential to be affected by the same deficient practice The DON and QI nurse reviewed incidents for the two weeks prior to November 16 to determine if any other incidents resulted in complaints of pain that were untreated. The audit revealed no other residents with untreated pain. The Interdisciplinary Team(IDT) will review all residents with incidents, including falls and changes of condition, in morning IDT meeting beginning 11/19/18. The review will include completion of assessment, evaluation, monitoring, and treatment of complaints of pain. The administrator consulted with the medical	

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Continued From page 15

Review of the nursing 24 Hour Report dated 10/16/18 read Resident #30 slid to the floor on first shift with the Physician and Responsible Party (RP) notified. The 24-Hour Report indicated Resident #30 received Tylenol 2 tablets on second shift.

Review of an incident report and nursing note dated 10/17/18 at 10:43 AM read Resident #30 had an unwitnessed fall in her room. She was ambulating on her own from her wheelchair to her closet when she fell. The report and nursing note read no injury, but Resident #30 complained of left rib pain. The nursing note read a correspondence was left for the NP and Medical Director. The intervention was a therapy screen.

Review of a Physician Fax Communication sheet dated 10/17/18 read Resident #30 did not fall but sat on the floor and caught herself using her walker and recliner. Resident #30 complained of left rib pain. The Nurse Practitioner (NP) wrote the word "monitor" with her initials. The NP documentation was undated.

Review of the nursing 24 Hour Report dated 10/17/18 read Resident #30 received Tylenol 2 tablets at 6:00 PM.

Review of the October 2018 Physician Orders and Medication Administration Record (MAR) read Resident #30 was receiving Neurontin (treats nerve pain) three times daily scheduled and Ultram (synthetic opioid used to treat pain) twice daily scheduled. There were also orders for Norco (opioid used to treat pain) 1 tablet as needed for pain.

Review of the October 2018 MAR read Resident

F 600

director/attending physician and the nurse practitioner regarding the plan of correction on 12/11/18 with no changes or recommendations noted.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

Beginning 11/19/18, the Nursing staff will be re-educated by the director of nursing (DON) and/or RN staff development coordinator (SDC) on assessment, evaluation, monitoring, and physician notification of residents with continued complaints of pain. The re-education will be completed by 12/16/18. Any staff members not receiving re-education by 12/16/18 will not be allowed to work until education is completed. New hires and agency staff will receive this education during orientation to the facility.
Facility staff will receive annual training on Abuse, Neglect, and Misappropriation of Property that includes assessment, evaluation, monitoring, and notification of physician of residents with continued complaints of pain. Training will be provided by the Staff Development Coordinator or the Director of Nursing.
Residents exhibiting complaints of pain will be discussed in the daily IDT meeting after the occurrence. Discussion will include notification of attending physician, Resident Representative, and whether interventions implemented are effective.
How the facility plans to monitor its performance to make sure that solutions are sustained

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F 600	Continued From page 16 #30 received no as needed doses of her Norco. Review of the October 2018 MAR read a standing order for Tylenol 325 milligrams (mg) 2 tablets by mouth every 4 hours as needed for pain for 48 hours. The MAR indicated Resident #30 received Tylenol 650 mg on 10/17/18, 10/23/18, 10/24/18 and 10/26/18. Review of the Rehabilitation screen dated 10/18/18 read Resident #30 was not interested in participating in therapy. Review of the nursing 24 Hour Report dated 10/22/18 read Resident #30 complained of rib pain and received Tylenol on third shift. Review of a nursing 24 Hour Report dated 10/23/18 read Resident #30 went out of the facility with her RP on first shift. Review of a Physician Fax Communication dated 10/23/18 read Resident #30 continues to complain of left upper rib pain and stated she was going to have her RP drop her off at the hospital for evaluation if something was not done. The NP documented per Nurse #4, "no complaints" with the date 10/24/18 and her initials. Review of the electronic medical record revealed no nursing notes regarding Resident #30's continued complaints of left rib pain from 10/17/18 until 10/29/18. Review of a nursing note dated 10/29/18 at 4:56 PM read Resident #30 was complaining of soreness to her left side and left arm. Resident #30 requested an x-ray and the NP was notified.	F 600	The QI Nurse will review the IDT form for pain for trending and tracking of residents with repeat complaints of pain on a weekly basis for 12 weeks. The QI Nurse will present IDT corrective actions and reported abuse/neglect actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the executive QI committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of Abuse/Neglect. The administrator consulted with the medical director and the nurse practitioner regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	

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F 600	Continued From page 17	F 600		

Review of an x-ray report dated 10/30/18 read as follows: Minimal displaced fractures of the third through seventh posterior lateral ribs left side suggested. The x-ray was undated but initialed by the NP.

Review of Resident #30's MAR read an order dated 10/30/18 for Biofreeze (topical pain reliever) four times daily to her neck.

Review of a NP note dated 10/30/18 at 2:11 PM, read in part as follows: Resident #30 had a fall approximately 2 weeks ago and continues to have left lower rib cage pain that worsens with coughing, deep breaths or with repositioning in bed. Resident #30 stated her pain medications do help alleviate the pain somewhat, but she is still very concerned since it is ongoing. Resident #30 stated otherwise, she is doing okay and has no complaints.

Review of the November 2018 MAR read Resident #30 received no as needed doses of her Norco or Tylenol.

In an interview on 11/13/18 at 4:49 PM, Resident #30 reported she fell in October and immediately experienced left side pain. She stated she broke her ribs and she received no x-ray and saw no NP or MD until two weeks after the fall. She stated the pain was bad but has improved. She stated she continues to have pain with movement in bed and on transfers. She reached to guard her left side with facial grimacing.

Resident #30's care plan last revised on 11/14/18 indicated she was at risk for pain related to complaints of soreness and discomfort to her left side and left arm on 10/29/18. The care plan

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F 600	Continued From page 18 revised 11/14/18 also read her x-ray dated 10/30/18 indicated fractures of her left 3rd through 7th ribs. Interventions included listening to her complaints of pain, medications as ordered, documenting verbal and non-verbal indicators of pain and notification of the physician if pain management was not effective. In an interview on 11/14/18 at 2:35 PM, Nurse #4 stated she was assigned Resident #30 most days and assigned to her the day she fell. She stated the NP was in the building that day and spoke to the NP about Resident #30's complaints of left side pain. Nurse #4 stated to her knowledge, the NP did not assess Resident #30 on 10/17/18. She stated the NP told her to monitor Resident #30 and administer the prn Tylenol if she needed it for pain. Nurse #4 stated about a week later, Resident #30 was still complaining of pain to her left side so Nurse Supervisor #3 requested an x-ray order from the NP. Nurse #4 stated to her knowledge, the NP did not assess Resident #30 because she had left the facility the with her RP on 10/23/18. Nurse #4 confirmed she neglected to report Resident #30's continued complaints of pain until another Physician Fax Communication form dated 10/23/18 was faxed to the NP. In an interview on 11/14/18 at 2:45 PM, Nursing Assistant (NA) #10 stated Resident #30 complained of left side pain after the fall and she reported it to Nurse #4. She confirmed Resident #30 continues to complain of occasional pain with transfers. In an interview on 11/14/18 at 3:05 PM, Nurse Supervisor #3 stated she was aware that Resident #30 had a fall and was experiencing left side pain. She stated the NP wanted nursing staff	F 600		

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F 600	Continued From page 19 to monitor her for continued or worsening of the pain but confirmed there was little documentation to suggest the nurses were monitoring Resident #30's continued complaints of pain to her left side. She stated she contacted the NP on 10/29/18 and requested an x-ray because Resident #30 requested it. In an interview on 11/15/18 at 8:50 AM, NA #11 stated Resident #30 has complained of pain to her left side with care. NA #11 stated when Resident #30 complained of pain, she would report it to her assigned nurse. In an interview on 11/15/18 at 9:00 AM, the NP stated it was her expectation that when she directed the nursing staff to monitor Resident #30, they would have contacted her if she got worse, but she was likely going to be sore from the fall. The NP stated staff reported to her that Resident #30 was going out with her RP and she was able to function at her baseline, but the nurse neglected to report continued complaints of pain. The NP stated when the Nurse #4 faxed her on 10/23/18, she stopped in to see Resident #30, but she was out of the facility with her RP and she was not notified again until 10/29/18 by Nurse Supervisor #3. The NP stated that was when she ordered the x-ray. The NP confirmed the x-ray results of 5 fractured left side ribs. The NP confirmed she did not assess Resident #30 until 10/30/18. She stated there was no need for additional treatment and that Resident #30 was already taking Ultram twice daily for pain and Tylenol as needed. The NP stated she did not routinely review the nursing notes but rather relied on the staff calling her for sending her a Physician Communication Fax form. The NP confirmed she was at the facility daily Monday	F 600		

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through Friday and available by phone when she was not at the facility.

In a second interview on 11/15/18 at 10:40 AM, Resident #30 was sitting up in her wheelchair with NA #11 present in the room. Resident #30 complained of left side pain where she broke her ribs. She was guarded of her left side with facial grimacing. NA #11 heard Resident #30's complaint of pain and stated she would notify her nurse.

In an interview on 11/15/18 at 5:40 PM, Nurse #6 confirmed she was assigned Resident #30 and had cared for her since beginning her shift at 7:00 AM on 11/15/18. She stated NA #11 neglected to inform her that Resident #30 voiced left side pain earlier today after breakfast and that Resident #30 had not complained of pain to her, but she was due her scheduled Ultram and would assess Resident #30.

A telephone call was made to Resident #30's RP at both phone numbers listed with messages left to call surveyor. At time of exit, there had been no return call from RP.

In an interview on 11/16/18 at 8:20 AM, Resident #30 stated she was feeling better today. She stated her RP told her to take it easy and rest.

In a second interview on 11/16/18 at 10:20 AM, the NP stated it was her expectation that when NA #11 heard Resident #30 complain of left side pain on 11/15/18, she would have reported it to Resident #30's nurse.

A telephone call was made to NA #11 on 11/16/18 at 11:18 AM with a message left to call the

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F 600	Continued From page 21 surveyor regarding not reporting Resident #30's complaints of pain on 11/15/18. At the time of exit, there had been no return phone call. In a telephone call on 11/16/18 at 11:35 AM, NA #12 confirmed she was assigned Resident #30 on 10/19/18 and 10/22/18 for second shift. She stated she recalled Resident #30 complaining of left rib pain especially when toileting and that she could not use her left arm to reach due to the pain. NA #12 stated she reported the pain the Resident #30's nurse on both days. In a telephone call on 11/16/18 a 11:42 AM, NA #13 confirmed she was assigned Resident #30 on 10/18/18 for third shift. She stated she recalled Resident #30 stated she was sore from the fall, but NA #13 could not recall if she reported anything to the nurse. In a second interview on 11/16/18 at 11:55 AM, NA #10 confirmed she was assigned Resident #30 first shift on 10/17/18, 10/18/18, 10/19/18, 10/20/18, 10/21/18, 10/23/18, 10/24/18, 10/26/18 and 10/30/18. NA #10 stated Resident #30 did complain of left side pain on occasion, but she always reported the complaints to the nurse. In an interview on 11/16/18 at 12:30 PM, Nurse #7 confirmed he was assigned Resident #30 on 10/19/18, 10/26/18, 10/27/18 and 10/28. He stated he worked those days from 7:00 AM to 7:00 PM. Nurse #7 stated he received no notification that Resident #30 complained of pain and that she never complained of pain when he went in to give her medications. In a telephone interview on 11/16/18 at 5:00 PM, the MD stated it was his expectation that there	F 600		

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	345146	A. BUILDING ______ B. WING ______	11/16/2018

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F 600	Continued From page 22 would have been assessment completed by the NP at the time when Resident #30 first complained of pain on 10/17/18 and x-ray would have been ordered at that time to rule out injury. He further stated if Resident #30 reported continued pain and the NP did not assess her to rule out injury, it was expectation that the nursing staff would have contacted him for orders. Review of the medical record indicated new orders dated 11/16/18 for Resident #30 to have a pain assessment completed three times daily while awake for 2 weeks and to administer the prn Norco for pain as ordered.	F 600		
F 604 SS=E	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-	F 604		12/16/18

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F 604	Continued From page 23 §483.12(a)(2) Ensure that the resident is free 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 record review, observation, and staff interviews, the facility failed to recognize that utilizing bilateral side rails with padding was a restraint which required a medical symptom to justify their use (Residents #53 and #118) for 2 of 2 residents reviewed for restraints. Findings included: 1. A review of a partially completed side rail evaluation for Resident #53 dated 11/27/17 by the Quality Improvement (QI) Nurse revealed the resident was oriented to person only with short-term and long-term memory impairment and severely impaired decision making. The risks included the increased potential for injuries. The evaluation determined that the side rails were not warranted. The evaluation asked if risks and benefits, alternatives were explained to the resident and the answer indicated they had not been due to a comprehension deficit. This form was not signed as complete. A review of the resident ' s quarterly Minimum Data Set dated 9/20/18 revealed the resident was severely cognitively impaired and required extensive assistance for all activities of daily	F 604	F604 Right to be Free from Physical Restraints How corrective action will be accomplished for those residents found to have been affected by the deficient practice Residents #53 and #118 were reassessed 11/15/18 for the need for side rails with padding using the Physical Device Evaluation form. As a result of the re-assessment the padding was removed. How the facility will identify other residents having the potential to be affected by the same deficient practice An audit was initiated on 11/19/18 by the QI nurse to determine other residents with side rails with padding. The audit revealed one other resident with side rails and padding. As a result of the re-assessment the padding was removed. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Beginning on 11/19/18 and completed by 12/16/18, all licensed nurses were re-educated regarding the assessment of	

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F 604	Continued From page 24 living. The resident was unable to make her needs known. "Physical restraints bed rail not used" was coded. A review of the resident ' s care plan updated 10/4/18 revealed a problem for skin tears which had an intervention of padded side rails to prevent skin tears. Padded side rails and winged mattress initiated on 1/11/17. Repetitive movement prevention of skin tears initiated on 1/13/17. On 11/13/18 at 9:30 am an observation was done of the resident ' s room and bilateral padded side rails were noted. The resident was observed in a reclining wheel chair with frequent movement of her extremities that appeared to be non-purposeful. On 11/14/18 at 2:20 pm an observation was done of the resident ' s room and bilateral padded side rails were noted. On 11/14/18 at 2:15 pm An interview was conducted with Treatment Nurse (TN) who was assigned to Resident #53 and stated that the side rails were placed to prevent the resident from falling out of bed. TN commented that the resident cannot get out of bed on her own at this time. The pads were added to the side rails to prevent skin tears. TN stated she was not aware that the side rails for safety were considered a restraint. An interview was conducted with the QI Nurse on 11/14/18 at 3:20 pm. The Bed Rail Evaluation for Resident #53 dated 11/27/17 that was partially complete was reviewed with the QI Nurse. She confirmed that she partially completed this	F 604	the need for side rails with padding, and/or restraints. Assessments for the need for side rails, padding, and/or restraints will be completed by a licensed nurse quarterly in conjunction with the MDS assessment. Re-education regarding physical devices and their use and purpose was provided by the Staff Development nurse for all nursing staff including nursing assistants, This education was completed by December 16, 2018 Any staff not receiving education by 12/16/18 will not be allowed to work until education is completed. All new hires including agency staff will education regarding restraints upon orientation. How the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing (DON) will perform a 10% audit for assessment and risk versus benefits education in the areas of physical restraints for 12 weeks; then quarterly thereafter on the assessment and risk versus benefits education. The DON and or RN QI nurse will share the results of the Audits with the interdisciplinary team (IDT) at least weekly for 12 weeks. The DON and/or QI RN will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement	

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F 604	Continued From page 25 assessment and confirmed that it was never fully completed. The QI Nurse further revealed she had not provided any education on any of the bed rail evaluations she completed, and this was why none of the assessments were marked as complete. The QI Nurse indicated this Bed Rail Evaluation form was no longer in use as of February 2018. She stated that since that time no bed rail evaluations and/or re-evaluations had been conducted. She reported that the facility did have a restraint assessment, but that she had not done any restraint assessments because the facility had no restraints in use. The interview with the QI Nurse continued and she was asked why Resident #53 had bilateral side rails used in conjunction with bilateral padding and if these interventions had been assessed to determine if they met the definition of a physical restraint. She stated that padded side rails were implemented after Resident #53 sustained a skin tear to her arm (12/17). It was believed the skin tear came from the resident hitting her arms against the side rail from repetitive movement. A Physical Device Use Evaluation dated 11/15/18 for Resident #53 was completed by the QI Nurse who indicated the device currently in use was padded side rails. The specific medical symptom which led to consideration of device use was unsafe movement of extremities. Resident #53 was noted to use the padded side rails daily with the benefit of the prevention of injury and the risks noted as none. The resident was not able to remove the padded side rails independently. The form indicated, "This device does not impede resident' s movement in bed. This resident has physical limitations that prevent her from	F 604	(QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of assessment of physical restraints. The administrator consulted with the medical director and the nurse practitioner regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	

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voluntarily getting out of bed therefore this device does not meet the classifications of a restraint".

A follow-up interview was conducted with the QI Nurse on 11/15/18 at 12:00 pm. The Physical Device Use Evaluation dated 11/15/18 for Resident #53 was reviewed with the QI Nurse. She confirmed she completed this evaluation. She stated she spoke with the Facility Nurse Consultant last evening (11/14/18) and she was directed to complete this assessment. She indicated she went through the form this morning and reviewed it with the Facility Nurse Consultant. The QI Nurse indicated that because Resident #53 was unable to safely get out of bed without assistance it was determined the padded side rails were not a restraint. She stated that the padded side rails were preventing Resident #53 from falling out of bed and that the padding specifically prevented the resident from injuring her body on the side rails related to the resident moving around in bed.

An interview was conducted with the Administrator on 11/14/18 at 4:15 PM. She stated that education of the risks and benefits should have been explained to the resident and/or RP at the time of side rail assessments and that reassessments should have been done upon any change in condition or change in interventions. Resident #53' s bilateral side rail usage in conjunction with bilateral padding was reviewed with the Administrator. She additionally revealed that no assessment was done to determine if the bilateral side rails used in conjunction with the bilateral padding met the definition of a physical restraint. She indicated that she expected the regulations related to physical restraints to be followed

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F 604	Continued From page 27 2. Resident #118 was admitted to the facility on 3/4/17 with diagnoses that included Alzheimer ' s disease, dementia with behavioral disturbance, anxiety, schizophrenia, and insomnia. The quarterly Minimum Data Set (MDS) assessment dated 11/9/17 indicated Resident #118 ' s cognition was severely impaired. She had delusions during the MDS review period. Resident #118 was assessed with physical behaviors on 1 to 3 days, verbal behaviors on 4 to 6 days, and rejection of care on 1 to 3 days. Resident #118 required extensive assistance of 1 for bed mobility, transfers, locomotion on the unit and personal hygiene. She required extensive assistance of 2 or more with dressing and toileting. Resident #118 was not steady and was only able to stabilize with staff assistance. She had no functional limitations with range of motion and she utilized a wheelchair. Resident #118 was always incontinent of bladder and bowel and she had one fall with no injury. The assessment indicated Resident #118 had no physical restraints (defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily which restricts freedom of movement or normal access to one ' s body). A partially completed Bed Rail Evaluation for Resident #118 dated 11/28/17 was conducted by the Quality Improvement (QI) Nurse. This evaluation indicated that Resident #118 was oriented to person only with short-term and long-term memory impairment and severely	F 604		

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impaired decision making. Her functional abilities were assessed as grasp strength within normal perimeters, range of motion/dexterity adequate, muscle weakness, and impaired balance. She had a history of falls. Resident #118 had not expressed a desire to have side rails raised while in bed for her own safety or comfort. The benefits of side rail use were noted as enabling Resident #118 to position self in bed, enabling Resident #118 to rise from a supine (lying) to a sitting and/or standing position, Resident #118 used side rails for care with staff cueing, and enabled Resident #118 to maintain physical functional abilities. The risks included the increased potential for injuries. This assessment indicated that an alternative intervention that was attempted was physical and/or occupational therapy initiated on 7/6/17. No other alternatives or interventions were noted. The recommendations of this evaluation indicated bilateral half rails to serve as an enabler to promote independence. The evaluation asked if risks and benefits, alternatives were explained to Resident #118 and the answer indicated they had not been due to a comprehension deficit. The evaluation asked if risks and benefits, alternatives were explained to the Resident #118 ' s representative and the answer indicated they had not been as the resident ' s family member had previously been aware of bed rail usage and was in agreement. This form was not signed as complete.

An incident report dated 7/3/18 indicated Resident #118 had an injury of unknown origin identified as a bruise to her left eyelid. The Facility Reported Incident (FRI) investigation was reviewed. It indicated a bruise to Resident #118 ' s eyelid was discovered during morning care.

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The area was assessed as not swollen and appeared to be more pressure related rather than trauma. Bruising had not spread and was resolving. Resident #118 was observed during the investigation and noted to lay against the side rail on her bed. The bruised area corresponded to the where Resident #118 laid her head on the side rail. The witness statements indicated no specific incident, but they had noted Resident #118 laid on that side often with her head against the rail.

The quarterly MDS assessment dated 10/11/18 indicated Resident #118 ' s cognition was severely impaired. She had other behaviors on 1 to 3 days. She required extensive assistance of 2 or more with bed mobility and transfers and the extensive assistance of 1 with locomotion on/off the unit. Resident #118 was dependent on 1 staff with toileting and person hygiene. Resident #118 was not steady on her feet and she was only able to stabilize with staff assistance. She had no functional limitations with range of motion and she utilized a wheelchair. Resident #118 had no falls and was always incontinent of bladder and bowel. The assessment indicated Resident #118 had no physical restraints.

The plan of care for Resident #118 included the focus area of potential for skin integrity impairment with bruise noted on 7/3/18 to her left eyelid. This area was initiated on 7/5/18 and most recently revised on 10/15/18. This plan of care also included the focus of area of assistance required for transferring. The interventions indicated Resident #118 was able to weight bear. This focus area was initiated on 3/27/18 and most recently revised on 10/25/18. This care plan had not included any mention of Resident #118 ' s

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F 604	Continued From page 30 side rails. An observation was conducted of Resident #118 on 11/13/18 at 12:30 PM. Resident #118 was in bed being assisted with eating by Nursing Assistant (NA) #7. Resident #118 was alert but was not interviewable. She had bilateral side rails, approximately 30 ¾ inches in length, as well as padding covering each of the side rails. An interview was conducted with NA #7 on 11/13/18 at 12:35 PM. NA #7 was asked why Resident #118 had the bilateral side rails with padding. She stated that they were for protection as Resident #118 moved around in bed and tended to roll over to the side of the bed and place her head on the side rail. She stated that Resident #118 was not able to get out of bed on her own safely and that she was a fall risk. NA #7 was asked if the bilateral side rails had prevented Resident #118 from falling out of the bed and she indicated that they had. An interview was conducted with Nurse #1 on 11/14/18 at 11:15 AM. Nurse #1 indicated she was familiar with Resident #118. She was asked why Resident #118 had bilateral side rails with padding. She stated that she wasn ' t sure, but she believed the padding was implemented because Resident #118 moved around in bed and she was able to lean on the side rails. She reported she thought the pads were added to the side rails so Resident #118 ' s head and arms didn ' t get caught in the rails. Nurse #1 was asked when the pads were implemented. She indicated that she needed to review the record to find the answer. She reviewed the care plan and stated that the side rails and/or the padding were not noted in the care plan. She further reviewed	F 604		

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the record and indicated she believed the pads were added following an incident on 7/3/18 in which Resident #118 obtained a bruise on her eyelid believed to be caused by the side rails.

An interview was conducted with the QI Nurse on 11/14/18 at 3:10 PM. The Bed Rail Evaluation for Resident #118 dated 11/28/17 that was partially complete was reviewed with the QI Nurse. She confirmed that she partially completed this assessment and confirmed that it was never fully completed. She explained that she was directed by her management and the corporate office to complete bed rail evaluations of every resident in the facility in November 2017. She reported that as she began completing the assessments she saw the question on each assessment that asked if education had been providing to the resident and/or Responsible Party (RP) on the risks and benefits of side rail usage. The QI Nurse revealed she was not sure what was supposed to be included in this education, so she asked the Administrator. She stated that the Administrator had contacted the Facility Consultant, but that she never received any direction of what type of education she was supposed to provide. She further revealed she had not provided any education on any of the bed rail evaluations she completed, and this was why none of the assessments were marked as complete. The QI Nurse indicated this Bed Rail Evaluation form was no longer in place in the electronic medical records system as of February 2018. She stated that since that time no bed rail evaluations and/or re-evaluations had been conducted. She reported that the facility did have a restraint assessment, but that she had not done any restraint assessments because the facility had no restraints in use.

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This interview with the QI Nurse continued. She was asked why Resident #118 had bilateral side rails used in conjunction with bilateral padding and if these interventions had been assessed to determine if they met the definition of a physical restraint. She stated that the padding was implemented after Resident #118 sustained a bruise to her eyelid (7/3/18) that they believed came from the resident placing her head against the side rail. The QI Nurse revealed she had not completed a restraint assessment on Resident #118 ' s bilateral side rails with padding.

A Physical Device Use Evaluation dated 11/15/18 for Resident #118 completed by the QI Nurse indicated the device currently in use was padded side rails. The specific medical symptom which led to consideration of device use was unsafe movement of leaning on side rails. Resident #118 was noted to use the padded side rails daily with the benefit of the prevention of injury and the risks noted as none. The resident was not able to remove the padded side rails independently. The form indicated, "This device does not impede resident ' s movement in bed. This resident has physical limitations that prevent her from voluntarily getting out of bed therefore this device does not meet the classifications of a restraint".

A follow up interview was conducted with the QI Nurse on 11/15/18 at 12:00 PM. The 11/15/18 Physical Device Use Evaluation dated 11/15/18 for Resident #118 was reviewed with the QI Nurse. She confirmed she completed this evaluation. She stated she spoke with the Facility Nurse Consultant last evening (11/14/18) and she was told to complete this assessment. She indicated she went through the form this morning

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F 604	Continued From page 33 and reviewed it with the Facility Nurse Consultant. The QI Nurse indicated that because Resident #118 was unable to safely get out of bed without assistance it was determined the padded side rails were not a restraint. She stated that the padded side rails were preventing Resident #118 from falling out of bed and that the padding specifically was preventing her from injuring her body on the side rails related to the resident moving around in bed. An interview was conducted with the Administrator on 11/14/18 at 4:15 PM. The Administrator confirmed she was aware that the QI Nurse had partially completed all residents ' side rail evaluations in November 2017. She confirmed she was aware these were not fully completed as education was not provided to the resident and/or the RP. She stated that education of the risks and benefits should have been explained to the resident and/or RP at the time of the side rail assessments and that reassessments should have been done upon any change in condition or change in interventions. Resident #118 ' s bilateral side rail usage in conjunction with bilateral padding was reviewed with the Administrator. She indicated that the padding was added after Resident #118 sustained a bruise to her eyelid believed to have been caused by the side rails. She explained that Resident #118 moved around in bed and the padding was to stop her from hitting her head on the side rails and causing an injury. The Administrator revealed that no assessment was done prior to the addition of the padding to determine if the side rails were still being utilized by Resident #118. She additionally revealed that no assessment was done to determine if the bilateral side rails used in conjunction with the	F 604		

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	345146	A. BUILDING ______ B. WING ______	11/16/2018

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F 604	Continued From page 34 bilateral padding met the definition of a physical restraint. She indicated that she expected the regulations related to physical restraints to be followed.	F 604		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F 636		12/16/18

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F 636	Continued From page 35 regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete comprehensive Minimum Data Set (MDS) assessments for 3 of 56 residents reviewed for completion of MDS assessments (Resident #417, #416 and #6). Findings: 1.Resident #417 was admitted to the facility on 10/24/2018. A review of Resident #417's MDS assessments revealed the admission	F 636	F636 Comprehensive Assessments and Timing How corrective action will be accomplished for those residents found to have been affected by the deficient practice The RN Minimum Data Set (MDS) nurse completed the Minimum Data Set (MDS) for residents #417, #416, and #6. The assessments were submitted and accepted by 11/19/18.	

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F 636	Continued From page 36 assessment was not completed by 11/15/2018. An interview on 11/16/2018 at 10:40 AM with MDS Nurse #2 revealed Resident #417's admission MDS assessment was due for submission on 11/6/2018. The MDS Nurse #2 further revealed she used the MDS in Progress List, generated from the electronic software, to assist her with keeping up with the MDS assessment due dates. She reported that she was the only MDS staff working between 11/5/2018 through 11/6/2018. The MDS Nurse further reported that she worked over during this period to complete nine pending assessments but failed to complete Resident #417's admission MDS assessment. An interview on 11/16/2018 at 6:13 PM with the Administrator revealed that she was made aware of the late MDS assessments during the Quality Improvement meeting held five days ago. The Administrator further revealed that she had reached out to the corporate consultant to assist with securing additional help to complete MDS assessment on time. Additionally, the Administrator reported she expected the MDS Nurses to complete and submit all the MDS assessments by the date due. 2.Resident #416 was admitted to the facility on 10/24/2018. A review of Resident #416's MDS assessments revealed the admission assessment was not completed by 11/15/2018. An interview on 11/16/2018 at 10:52 AM with MDS Nurse #2 revealed Resident #416's admission MDS assessment was due for submission on 11/6/2018. The MDS Nurse #2 further revealed she used the MDS in Progress	F 636	How the facility will identify other residents having the potential to be affected by the same deficient practice Beginning on 11/19/18 the MDS RN Nurse Consultant conducted a 100% audit of the current residents□ most recent Omnibus Budget Reconciliation Act (OBRA) Minimum Data Set (MDS) submitted for the current residents for timeliness. The audit was completed on 12/11/18 and revealed all other assessments had been completed and submitted in a timely manner. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 12/7/18- 12/16/18 The MDS nurses and Interdisciplinary Team (IDT) were re-educated regarding the importance of timely completion and submission of MDS assessments by the MDS Consultant/RN nurse consultant. The schedule for MDS completion dates will be reviewed daily in the morning IDT meeting. How the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing (DON) and/or RN Quality Improvement (QI) nurse will perform a 10% audit of completed Minimum Data Set (MDS)Comprehensive assessments submitted for the week for review of timely completion and submission of MDS assessments each week for 12 weeks; then quarterly thereafter.The DON and or RN QI nurse will share the results of MDS Audits with	

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F 636	Continued From page 37	F 636		

List, generated from the electronic software, to assist her with keeping up with the MDS assessment due dates. She further reported that she was the only MDS staff working between 11/5/2018 through 11/6/2018. The MDS Nurse further reported that she worked over during this period to complete nine pending assessments but failed to complete Resident #416's admission MDS assessment.

An interview on 11/16/2018 at 6:13 PM with the Administrator revealed that she was made aware of the late MDS assessments during the Quality Improvement meeting held five days ago. The Administrator further revealed that she had reached out to the corporate consultant to assist with securing additional help to complete MDS assessment on time. Additionally, the Administrator reported she expected the MDS Nurses to complete and submit all the MDS assessments by the date due.

3.Resident #6 was admitted to the facility on 1/6/2018. A review of Resident #6's MDS assessments revealed the quarterly assessment for October 2018 was not completed by 11/15/2018.

An interview on 11/16/2018 at 11:15 AM with MDS Nurse #1 revealed both she and MDS Nurse #2 completed Sections A, B, G, GG, H, I, J, L, M, N, O and P. MDS Nurse #2 further revealed she was responsible for submitting the completed MDS assessments. She reported she made a list of when the residents assessments were due and checked the list daily. MDS Nurse #1 further reported Resident #6's October 2018 quarterly MDS assessment just had not been done. She acknowledged that Resident 6's

the interdisciplinary team (IDT) at least weekly for 12 weeks. Any errors noted will be corrected by the MDS RN according to the procedures outlined in the Resident Assessment Instrument (RAI) Manual and re-education will provided as needed by the MDS RN consultant.
The DON and/or MDS RN will present IDT corrective actions to the monthly quality improvement (QI) committee for 12 months for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations for four quarters to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of accuracy of assessments.
The administrator consulted with the medical director and the nurse practitioner regarding the plan of correction on 12/11/18 with no changes or recommendations noted.

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F 636	Continued From page 38 assessment should have been done. Additionally, MDS Nurse #1 revealed that as of 11/15/2018, there were 3 quarterly assessments and 3 comprehensive assessments overdue for submission. An interview on 11/16/2018 at 6:13 PM with the Administrator revealed that she was made aware of the late MDS assessments during the Quality Improvement meeting held five days ago. The Administrator further revealed that she had reached out to the corporate consultant to assist with securing additional help to complete MDS assessment on time. Additionally, the Administrator reported she expected the MDS Nurses to complete and submit all the MDS assessments by the date due.	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to complete a significant change in condition Minimum Data Set	F 637	F637 Comprehensive Assessment after Significant Change How corrective action will be	12/16/18

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F 637	Continued From page 39 (MDS) for a resident with two areas of decline (weight loss and skin) for 1of 1 resident (Resident #165) with identified changes. The findings included: Resident #165 was 3/12/14 with cumulative diagnoses of Cerebral Palsy and Dysphasia. Review of Resident #165 electronic medical record revealed her weight was 91 pounds in June 2018 with no weight obtained in July 2018 and August 2018. Review of Resident #165's quarterly MDS dated 7/10/18 indicated her weight was 91 pounds and her skin intact. Review of the clinical record revealed Resident #165's diet (ordered 6/29/18) was upgraded from mechanical soft with nectar thick liquid, to a regular diet with chopped meats with thin liquids on 7/30/18. Review of the Wound Ulcer Flowsheet dated 9/29/18 indicated Resident #165 had a Suspected Deep Tissue Injury to her left hip. Review of Resident #165 electronic medical record revealed her weight was 72 pounds in September 2018 and her weight was 76 pounds October 2018. Resident #165 was transferred to the hospital on 10/1/18 and discharged back to the facility on 10/5/18 with a new diagnosis of Sepsis. Review of Resident #165's readmission orders indicated a diet downgraded to mechanical soft diet with thin liquids on 10/6/18 and orders for	F 637	accomplished for those residents found to have been affected by the deficient practice The Minimum Data Set (MDS) for residents #165 was completed for a significant change on 11/16 /18. How the facility will identify other residents having the potential to be affected by the same deficient practice Beginning on 11/19/18 the MDS (Minimum Data Set) RN consultant conducted a 100% audit of the current residents□ conditions for the past 30 days to determine if significant change MDS assessments were appropriately completed for those residents having decline in the areas of weight loss and skin integrity. The audit was completed on 12/11/18 and revealed that no other significant change assessments were needed. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Beginning on 12/7/18 and completed by 12/16 /18, The MDS nurses and Interdisciplinary Team (IDT) were re-educated by the MDS consultant/RN consultant regarding the importance of completing a significant change of condition Minimum Data Set (MDS) assessment for a resident with two areas of decline. Residents with significant changes in condition will be reviewed daily in the morning IDT meeting with recommendations to the MDS nurse for the need for a significant change assessment.	

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F 637	Continued From page 40 Speech Therapy. Review of Resident #165's quarterly MDS dated 10/12/18 indicated her weight at 72 pounds and as having an unstageable pressure ulcer. Review of Resident #165 last revised care plan dated 10/19/18 indicated her at risk for weight loss and care planned for the presence of an actual pressure ulcer. Interventions were appropriate. Review of Resident #165's Wound Ulcer Flowsheet dated 10/5/18 indicated the area to her left hip was described as unstageable. Review of Resident #165's Wound Ulcer Flowsheet dated 10/31/18 indicated the area to her left hip was resolved. In an observation on 11/14/18 at 10:30 AM with the Treatment Nurse, the area to Resident #165 left hip was resolved. The Treatment Nurse stated she had a history of the area to her left hip opening but she has had and overall gradual decline in the last 6 months and she was not eating well. In an observation on 11/16/18 at 8:40 AM, Resident #165 ate approximately 25% of her breakfast. Nursing Assistant (NA) #10 stated she does not eat very much and had a gradual decline in her condition in recent months. In an interview on 11/16/18 at 9:30 AM, the Nurse Practitioner (NP) stated Resident #165 had an overall decline and she was in talks with the Responsible Party about Hospice Services.	F 637	How the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing (DON) and or RN QI nurse will perform a 10% audit for significant changes and completion of MDS significant change assessments each week for 12 weeks in the IDT meeting; then quarterly thereafter on resident significant changes and the completion of significant change MDS assessments. The DON will share the results of MDS Audits with the interdisciplinary team (IDT) at least weekly for 12 weeks. The DON and/or MDS RN will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of accuracy of assessments. The administrator consulted with the medical director and the nurse practitioner regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	

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F 637	Continued From page 41 In an interview on 11/16/18 at 4:50 PM, the Director of Nursing (DON) stated it was her expectation that a significant change MDS be completed when there were two areas of functional or medical decline that were not considered self-limiting. In an interview on 11/16/18 at 6:10 PM, MDS Nurse #1 stated she did not feel a significant change MDS was indicated when the quarterly MDS was completed on 10/12/18. She stated her reason as Resident #165's weight had gone up and the pressure ulcer had healed.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview the facility failed to complete the Minimum Data Set (MDS) assessment accurately for the areas of physical restraints (Residents #53 and #118), discharge status (Resident #80), and tube feed (Resident #168) for 4 of 38 residents reviewed for MDS assessments. Findings included: 1. The resident was admitted to the facility on 12/5/16 with the diagnosis of non-Alzheimer' s dementia. A review of Resident #53 ' s quarterly Minimum Data Set dated 9/20/18 revealed the resident was	F 641	F641 Accuracy of Assessments How corrective action will be accomplished for those residents found to have been affected by the deficient practice The Minimum Data Set (MDS) for residents #53, #118, #80 and #168 were assessed for accuracy by the MDS nurse and corrections were resubmitted on 11/16/18 and 12/4/18 by RN MDS nurse. How the facility will identify other residents having the potential to be affected by the same deficient practice Beginning on 11/19/18 the MDS (Minimum Data Set) RN Consultant conducted a 100% audit of the current residents□ most recent Omnibus Budget Reconciliation Act	12/16/18

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F 641 Continued From page 42
severely cognitively impaired and required extensive assistance for all activities of daily living. The resident was unable to make her needs known. "Physical restraints bed rail not used" was coded.

A review of the resident ' s care plan updated 10/4/18 revealed a problem for skin tears which had an intervention of padding added to the side rails to prevent skin tears. Padded side rails and winged mattress was initiated on 1/11/17.

On 11/13/18 at 9:30 am an observation was done of the resident ' s room and bilateral padded side rails were noted on the resident ' s bed.

An interview was conducted with the Quality Improvement (QI) Nurse on 11/14/18 at 3:20 pm and she was asked why Resident #53 had bilateral side rails used in conjunction with bilateral padding and if these interventions had been assessed to determine if they met the definition of a physical restraint. She stated that padded side rails were implemented after Resident #53 sustained a skin tear to her arm (December 2017). The QI Nurse revealed she had not completed a restraint assessment on Resident #53' s bilateral side rails with padding.

An interview was conducted with MDS Nurse #1 on 11/14/18 at 3:30 PM. MDS Nurse #1 was asked what information was utilized to code the MDS for physical restraints. She stated that record review, staff interview, and observation were utilized to code the MDS for physical restraints. She reported that there was a Restraint Assessment that was completed by the QI Nurse if there was a physical restraint in use, but that no physical restraints were currently used

F 641

(OBRA) Minimum Data Set (MDS) submitted for the current residents for accuracy related to physical restraints, discharge status, and tube feeding. The audit was completed on 12/11/18 and revealed no further negative findings.
What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

On 12/7/18 the MDS nurses and Interdisciplinary Team (IDT) were re-educated regarding the importance of accurate submission of MDS assessments by the MDS Consultant.
How the facility plans to monitor its performance to make sure that solutions are sustained
The Director of Nursing (DON) and /or the QI RN will perform a 10% audit for accuracy in the areas of physical restraints, discharge status, and tube feedings each week for 12 weeks; then quarterly thereafter on the accuracy of submitted assessments.
The DON will share the results of MDS Audits with the interdisciplinary team (IDT) at least weekly for 12 weeks.
The DON and/or MDS RN will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations.
The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the

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F 641	Continued From page 43 in the building. The quarterly MDS dated 9/20/18 that indicated Resident #53 had no physical restraints was reviewed with MDS Nurse #1. The observations of Resident #53 as well as staff interviews that indicated Resident #53 had bilateral side rails in place in conjunction with bilateral padding to the rails since 12/17/17 was reviewed with MDS Nurse #1. MDS Nurse #1 revealed she had not known bilateral padding was in place on the bilateral rails. She stated that no one had informed her that the padding had been implemented. MDS Nurse #1 was asked if she had observed Resident #53 when she completed the 9/20/18 MDS assessment and she stated that she had, but that the resident may have been out of bed at that time, so she had not noticed the bilateral side rails with bilateral padding. An interview was conducted with the Administrator on 11/14/18 at 4:15 pm who stated that she expected the regulations related to physical restraints to be followed and for the MDS to be accurately coded. 2. Resident #168 was admitted to the facility on 6/30/17 with the diagnoses dysphagia and cerebral vascular accident (CVA). A review of the resident ' s Speech Therapy note dated 4/18/18 revealed the resident was status post CVA with dysphagia (swallow deficit) that had improved. Tube feeding (TF) continued during this assessment period and weight loss had resolved. A review of the resident ' s physician order dated 7/27/18 revealed an order for Isosource 1.5 to run	F 641	need for continued monitoring to ensure continued compliance in the area of accuracy of assessments. The administrator consulted with the medical director/attending physician and the nurse practitioner regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	

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BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

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at 85 millimeters per hour for 11 hours on at 6 pm and off at 5 am.

The resident ' s quarterly Minimum Data Set (MDS) dated 10/2/18 revealed the resident had an intact cognition. The resident required total assistance for all ADLs. Active diagnoses were dysphagia, CVA without residual deficits, and gastrostomy. The resident required a mechanically altered diet. Tube feeding was coded "no."

A review of the resident ' s care plan dated 10/2/18 revealed plan for gastrostomy tube feeding to assist the resident in maintaining or improving nutritional status characterized by weight loss secondary to dysphagia. Start January 2018 tube feeding at night and eats by mouth during the day.

A review of the resident ' s October 2018 medication administration record (MAR) revealed documentation that the resident received her tube feeding as ordered each night shift.

On 11/13/18 at 10:00 am an observation was done of the resident ' s tube feeding (TF) bag and pump that was infused on the night shift. The bag was dated for 10/12/18 from night shift and was not discarded yet.

On 11/14/18 at 9:00 am an observation was done of the resident ' s TF bag and pump which was discarded by night shift when the feeding was completed. No TF during the day to give the resident the opportunity to attend activities and to eat meals.

On 11/15/18 at 10:25 am an interview was

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conducted with MDS Nurse #1 who stated that if the TF was documented on the MAR as resident received, the quarterly MDS dated 10/2/18 for Resident #168 was inaccurately coded for tube feeding and would be corrected.

An interview was conducted with the Administrator on 11/14/18 at 4:15 PM who stated that she expected the MDS to be accurately coded accordingly to the resident ' s plan of care and orders.

3. Resident #118 was admitted to the facility on 3/4/17 with diagnoses that included Alzheimer ' s disease, dementia with behavioral disturbance, anxiety, schizophrenia, and insomnia.

The quarterly Minimum Data Set (MDS) assessment dated 10/11/18 indicated Resident #118 ' s cognition was severely impaired. She had other behaviors on 1 to 3 days. She required extensive assistance of 2 or more with bed mobility and transfers. The assessment indicated Resident #118 had no physical restraints (defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily which restricts freedom of movement or normal access to one ' s body).

An observation was conducted of Resident #118 on 11/13/18 at 12:30 PM. Resident #118 was in bed being assisted with eating by Nursing Assistant (NA) #7. Resident #118 was alert but was not interviewable. She had bilateral side rails, approximately 30 ¾ inches in length, as well as padding covering each of the side rails.

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F 641	Continued From page 46 An interview was conducted with NA #7 on 11/13/18 at 12:35 PM. NA #7 was asked why Resident #118 had the bilateral side rails with padding. She stated that they were for protection as Resident #118 moved around in bed and tended to roll over to the side of the bed and place her head on the side rail. She stated that Resident #118 was not able to get out of bed on her own safely and that she was a fall risk. NA #7 was asked if the bilateral side rails had prevented Resident #118 from falling out of the bed and she indicated that they had. An interview was conducted with Nurse #1 on 11/14/18 at 11:15 AM. Nurse #1 indicated she was familiar with Resident #118. She was asked why Resident #118 had bilateral side rails with padding. She stated that she wasn ' t sure, but she believed the padding was implemented because Resident #118 moved around in bed and she was able to lean on the side rails. She reported she thought the pads were added to the side rails so Resident #118 ' s head and arms didn ' t get caught in the rails. Nurse #1 was asked when the pads were implemented. She reviewed the record and indicated she believed the pads were added following an incident on 7/3/18 in which Resident #118 obtained a bruise on her eyelid believed to be caused by the side rails. An interview was conducted with the Quality Improvement (QI) Nurse on 11/14/18 at 3:10 PM. She was asked why Resident #118 had bilateral side rails used in conjunction with bilateral padding and if these interventions had been assessed to determine if they met the definition of a physical restraint. She stated that the padding was implemented after Resident #118 sustained	F 641		

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a bruise to her eyelid (7/3/18) that they believed came from the resident placing her head against the side rail. The QI Nurse revealed she had not completed a restraint assessment on Resident #118 ' s bilateral side rails with padding.

An interview was conducted with MDS Nurse #1 on 11/14/18 at 3:30 PM. MDS Nurse #1 was asked what information was utilized to code the MDS for physical restraints. She stated that record review, staff interview, and observation were utilized to code the MDS for physical restraints. She reported that there was a Restraint Assessment that was completed by the QI Nurse if there was a physical restraint in use, but that no physical restraints were currently used in the building. The quarterly MDS dated 10/11/18 that indicated Resident #118 had no physical restraints was reviewed with MDS Nurse #1. The observations of Resident #1 as well as staff interviews that indicated Resident #118 had bilateral side rails in place in conjunction with bilateral padding to the rails since 7/3/18 was reviewed with MDS Nurse #1. MDS Nurse #1 revealed she had not known bilateral padding was in place on the bilateral rails. She stated that no one had informed her that the padding had been implemented. MDS Nurse #1 was asked if she had observed Resident #118 when she completed the 10/11/18 MDS assessment and she stated that she had, but that the resident may have been out of bed at that time, so she had not noticed the bilateral side rails with bilateral padding.

An interview was conducted with the Administrator on 11/14/18 at 4:15 PM. Resident #118 ' s bilateral side rail usage in conjunction with bilateral padding was reviewed with the

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Administrator. She indicated that the padding was added after Resident #118 sustained a bruise to her eyelid believed to have been caused by the side rails. She explained that Resident #118 moved around in bed and the padding was to stop her from hitting her head on the side rails and causing an injury. She indicated that she expected the regulations related to physical restraints to be followed and for the MDS to be coded accurately.

4. Resident #168 was admitted to the facility on 8/17/18 with diagnoses that included pulmonary embolism, anemia, left hip pain and diabetes mellitus. She was discharged home on 8/23/18.

A comprehensive MDS (Minimum Data Set) was in progress at the time of her discharge.

Review of the Discharge MDS dated 8/23/18 revealed the resident was coded as discharged to acute care hospital.

A review of the resident's baseline care plan dated 8/19/18 revealed she was care planned for a desire to return home.

Review of a physician order dated 8/22/18 revealed an order to discharge home on 8/23/18.

On 11/16/18 at 4:35 pm an interview was completed with the MDS Coordinator who stated that the Resident Locater slip that was provided by the Social Worker at the time of the resident's discharge indicated she was discharged home.

On 11/16/18 at 4:40 pm an interview was completed with the MDS nurse who was able to confirm that the resident was marked as

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F 641	Continued From page 49 discharged to the hospital instead of the home setting. She stated that it was a typing error. On 11/16/18 at 4:45 pm an interview was conducted with the Director of Nursing who stated it was her expectation for all Discharge MDS's to be coded correctly.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to refer a resident with newly evident diagnoses of serious mental illnesses for Pre-Admission Screening and Annual Resident Review (PASARR) Level II screen for 1 of 3 residents reviewed for PASARR (Resident #106).	F 644	F644 Coordination of PASAAR and Assessments How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #106 was referred for a Level II	12/16/18

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The findings included:

Resident #106 was admitted to the facility on 4/8/16. Resident #106 ' s only mental health diagnosis at the time of admission was depression and she had a level I Pre-Admission Screening and Annual Resident Review (PASARR).

The quarterly Minimum Data Set (MDS) assessment dated 10/3/18 indicated Resident #106 ' s cognition was severely impaired. She was administered antipsychotic medication, antianxiety medication, and antidepressant medication on 7 of 7 days. Her active diagnoses included schizophrenia, psychotic disorder, and depression.

An observation was conducted of Resident #106 on 11/13/18 at 3:30 PM. There were no observed behavioral issues noted.

An interview was conducted with Social Worker (SW) #2 on 11/14/18 at 4:40 PM. She stated she was aware that when a resident was newly diagnosed with a serious mental illness that was not present on admission that the resident needed to be referred for evaluation for level II PASARR. SW #2 was asked who was responsible for making this referral. She indicated that she was not sure if it would have been herself or the Admissions Director. She revealed there was no clear process in place for this issue.

This interview with SW #2 continued. She confirmed that Resident #106 had a level I PASARR. Resident #106 ' s admission

F 644

Pre-admission screening and annual resident review (PASARR) screening by the Admissions Coordinator on 12/3/18.
How the facility will identify other residents having the potential to be affected by the same deficient practice
Beginning on 11/19/18 and completed on 11/20/18the MDS (Minimum Data Set) License Nurses conducted a 100% audit of any new psychiatric diagnosis for residents for the past 30 days to determine if referrals for Level II PASARR screening are indicated. No other residents were identified as needing Level II screenings.
What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

Beginning on 12/7/18 and completed by 12/16/18, the care plan team including the facility MDS nurse, Social Workers (SW) and Admissions Coordinator were re-educated by the RN facility consultant regarding the process for identifying residents for the need for a Level II Pre-admission screening and annual resident review (PASARR)screening. Residents with new psychiatric diagnoses will be reviewed daily in the morning IDT meeting with recommendations to the assigned SW to make appropriate referrals for Level II PASARR screenings.
How the facility plans to monitor its performance to make sure that solutions are sustained
The RN Quality Improvement (QI) nurse will perform a 10% audit for new psychiatric diagnoses and the need for

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F 644	Continued From page 51 diagnoses that included depression and no other mental health related diagnoses were reviewed with SW #2. Resident #106 ' s 10/3/18 MDS assessment that indicated the active diagnoses of schizophrenia and psychotic disorder were reviewed with SW #2. SW #2 confirmed Resident #106 was not admitted to the facility with the diagnoses of schizophrenia and psychotic disorder. She revealed she had not referred Resident #106 to the PASARR authority for a re-evaluation related to these new diagnoses. An interview was conducted with the Admissions Director (AD) on 11/15/18 at 6:44 PM. She stated that she was aware that when a resident was newly diagnosed with a serious mental illness that was not present on admission that the resident needed to be referred for evaluation for level II PASARR. The AD was asked who was responsible for making this referral. She indicated that she was not sure if it would have been herself or SW #2. She revealed there was no clear process in place for this issue. This interview with the AD continued. She confirmed that Resident #106 had a level I PASARR. Resident #106 ' s admission diagnoses that included depression and no other mental health related diagnoses were reviewed with the AD. Resident #106 ' s 10/3/18 MDS assessment that indicated the active diagnoses of schizophrenia and psychotic disorder were reviewed with the AD. The AD stated that she had not been aware that Resident #106 ' s diagnoses of schizophrenia and psychotic disorder were not present on admission. She revealed she had not referred Resident #106 to the PASARR authority for a re-evaluation related	F 644	follow up PASAAR screenings each week for 12 weeks; then quarterly thereafter on the need for follow up for Level II PASAAR screenings. The QI nurse will share the results of the PASAAR Audits with the interdisciplinary team (IDT) at least weekly for 12 weeks. The QI nurse will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of accuracy of assessments. The administrator consulted with the medical director/attending physician and the nurse practitioner regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	

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F 644	Continued From page 52 to these new diagnoses. An interview was conducted with the Director of Nursing on 11/16/18 at 4:43 PM. She stated that she was not very familiar with the regulations related to PASARR, but that she expected the regulations to be followed.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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)-	F 656		12/16/18

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F 656	Continued From page 53 (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 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 observation, record review, and staff interview, the facility failed to have comprehensive care plans in the areas of wandering (Resident #163) for 1 of 2 residents reviewed for wandering and physical restraints (Residents #118, #53) for 2 of 2 residents reviewed for physical restraints. The findings included: 1. Resident #163 was admitted to the facility on 6/12/18 with diagnoses that included dementia without behaviors, chronic obstructive pulmonary disease (COPD), alcoholic abuse, metabolic encephalopathy, and anxiety. A Nursing Admission Evaluation dated 6/12/18 for Resident #163 indicated he was independent with no help required for bed mobility and transfers. He ambulated independently with supervision. Resident #163 was assessed with wandering behaviors. A wander risk evaluation dated 6/13/18 indicated Resident #163 was at risk for wandering. He was noted with cognitive loss, occasional problems remembering where he was at, and had some	F 656	F 656 Develop/Implement Comprehensive Care Plan How corrective action will be accomplished for those residents found to have been affected by the deficient practice The comprehensive care plans for resident #163 was reviewed and revised for accuracy on 7/23/18 Care plans for residents #118, and #53 were reviewed and revised for accuracy by the RN Minimum Data Set (MDS) nurse on 12/11/18 with #163's care plan also reviewed by the MDS nurse at that time. How the facility will identify other residents having the potential to be affected by the same deficient practice An audit of the comprehensive care plans was assessed by the Quality Improvement (QI) nurse on 12/12/18 for all residents assessed to be at risk for wandering and those residents assessed to have physical restraints. Any adverse findings will be corrected. What measures will be put into place or	

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F 656	Continued From page 54 difficulty in new situations. The assessment indicated Resident #163 had made verbal statements of desire or intent to leave the facility. Follow up interventions were for Resident #163 to reside on the locked memory care unit and for a wanderguard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) to be placed on his person. The "Resident Care Guide" indicated an alarm bracelet (wanderguard) was initiated for Resident #163 on 6/14/18. The Resident Care Guide had not indicated that Resident #163 had wandering behaviors. The Admission Minimum Data Set (MDS) assessment dated 6/19/18 indicated Resident #163' s cognition was moderately impaired. The quarterly MDS assessment dated 7/2/18 indicated Resident #163 ' s cognition was severely impaired. A nursing note dated 7/12/18 indicated Resident #163 opened the fire exit door on the 100 hall (the hall he resided on). Staff were present at that time and Resident #163 had not exited the building. A behavior note dated 7/21/18 indicated Resident #163 was observed wandering in and out of other residents ' rooms. An incident report dated 7/22/18 indicated Resident #163 had an unsupervised exit from the facility. He was found by two staff members sitting outside of the facility unsupervised around 12:00 PM (7/22/18). Resident #163 had been	F 656	systemic changes made to ensure that the deficient practice will not recur MDS nurse was re-educated 12/7/18 by the MDS/RN consultant regarding accuracy and completion of comprehensive care plans in the areas of wandering and physical restraints. The education included the importance of accuracy to ensure that information is available to provide appropriate care and interventions. The Interdisciplinary Team (IDT) team will review comprehensive care plans in the areas of wandering and physical restraints for completion and accuracy in the daily IDT meeting. How the facility plans to monitor its performance to make sure that solutions are sustained The QI nurse will review the IDT tools for wandering and restraints weekly for 4 weeks to track and trend results for inclusion in comprehensive care plans. The audits will be performed weekly for 4 weeks, then bi-weekly for 2 months, then quarterly thereafter. The results of the audits will be communicated to the DON. The QI nurse will share the results of audits with the interdisciplinary team (IDT) weekly for 12 weeks. The DON and/QI nurse will present IDT findings to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement	

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F 656	Continued From page 55 seated at the picnic area adjacent to rear parking lot of the facility. Resident #163 ' s care plan was updated on 7/23/18 with the initiation of the focus area, "Problematic manner in which resident acts characterized by ineffective coping: Wandering and at risk for unsupervised exits from facility related to: cognitive impairment. Unsupervised exit from facility 7/22/18." Prior to 7/23/18, there was no care plan related to wandering for Resident #163. An interview was conducted with MDS Nurse #2 on 11/16/18 at 8:38 AM. She indicated she completed Resident #163 ' s care plan. She revealed she made an error and had not added wandering to Resident #163 ' s care plan until after his 7/22/18 unsupervised exit from the facility. An interview was conducted with the Director of Nursing (DON) on 11/16/18 at 4:43 PM. She stated that she expected care plans to be comprehensive based on the resident ' s assessed needs. She indicated that Resident #163 had been assessed as a wander risk based on his 6/13/18 wander risk evaluation and that a wandering care plan should have been put into place at that time. 2. Resident #118 was admitted to the facility on 3/4/17 with diagnoses that included Alzheimer ' s disease, dementia with behavioral disturbance, anxiety, schizophrenia, and insomnia. A Bed Rail Evaluation for Resident #118 dated 11/28/17 indicated bilateral half rails to serve as	F 656	(QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of developing and implementing comprehensive care plans. The Administrator consulted with the Medical Director and nurse practitioner regarding the plan of correction with no changes or recommendations noted.	

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BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

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F 656	Continued From page 56	F 656		

an enabler to promote independence.

An incident report dated 7/3/18 indicated Resident #118 had an injury of unknown origin identified as a bruise to her left eyelid. The Facility Reported Incident (FRI) investigation was reviewed. It indicated a bruise to Resident #118 ' s eyelid was discovered during morning care. Resident #118 was observed during the investigation and noted to lay against the side rail on her bed. The bruised area corresponded to the where Resident #118 laid her head on the side rail.

The plan of care for Resident #118 included the focus area of potential for skin integrity impairment with bruise noted on 7/3/18 to her left eyelid. This area was initiated on 7/5/18 and most recently revised on 10/15/18. Resident #118 ' s care plan included no mention of side rails.

The quarterly Minimum Data Set (MDS) assessment dated 10/11/18 indicated Resident #118 ' s cognition was severely impaired. The assessment indicated Resident #118 had no physical restraints (defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily which restricts freedom of movement or normal access to one ' s body).

An observation was conducted of Resident #118 on 11/13/18 at 12:30 PM. Resident #118 was in bed being assisted with eating by Nursing Assistant (NA) #7. Resident #118 was alert but was not interviewable. She had bilateral side rails, approximately 30 ¾ inches in length, as well

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F 656	Continued From page 57 as padding covering each of the side rails. An interview was conducted with NA #7 on 11/13/18 at 12:35 PM. NA #7 was asked why Resident #118 had the bilateral side rails with padding. She stated that they were for protection as Resident #118 moved around in bed and tended to roll over to the side of the bed and place her head on the side rail. An interview was conducted with Nurse #1 on 11/14/18 at 11:15 AM. Nurse #1 indicated she was familiar with Resident #118. She was asked why Resident #118 had bilateral side rails with padding. She stated that she wasn ' t sure, but she believed the padding was implemented because Resident #118 moved around in bed and she was able to lean on the side rails. She reported she thought the pads were added to the side rails so Resident #118 ' s head and arms didn ' t get caught in the rails. Nurse #1 was asked when the pads were implemented. She indicated that she needed to review the record to find the answer. She reviewed the care plan and revealed that the side rails and/or the padding were not noted in the care plan. She further reviewed the record and indicated she believed the pads were added following an incident on 7/3/18 in which Resident #118 obtained a bruise on her eyelid believed to be caused by the side rails. The care plan related to skin integrity for Resident #118 was updated on 11/14/18 by MDS Nurse #1 with the intervention of padding to the side rails. An interview was conducted with MDS Nurse #1 on 11/14/18 at 3:30 PM. She revealed that prior to 11/14/18 she had been unaware Resident #118	F 656		

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F 656	Continued From page 58	F 656		

had bilateral side rails used in conjunction with bilateral padding. She reported she expected bilateral side rails used in conjunction with bilateral padding to be care planned. She stated she revised Resident #118 ' s care plan on 11/14/18 after staff informed her that the padding was in use.

An interview was conducted with the Administrator on 11/14/18 at 4:15 PM. Resident #118 ' s bilateral side rail usage in conjunction with bilateral padding was reviewed with the Administrator. She indicated that the padding was added after Resident #118 sustained a bruise to her eyelid on 7/3/18 believed to have been caused by the side rails. She explained that Resident #118 moved around in bed and the padding was to stop her from hitting her head on the side rails and causing an injury. The Administrator indicated that she expected care plans to be comprehensive based on the resident ' s assessed needs.

3.

The resident was admitted to the facility on 12/5/16 with the diagnosis of non-Alzheimer ' s

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F 656	Continued From page 59 dementia. A review of Resident #53 ' s quarterly Minimum Data Set (MDS) dated 9/20/18 revealed the resident was severely cognitively impaired and required extensive assistance for all activities of daily living. The resident was unable to make her needs known. "Physical restraints bed rail not used" was coded. A review of the resident ' s care plan updated 10/4/18 revealed a problem for skin tears which had an intervention of padded side rails to prevent skin tears. Padded side rails and winged mattress was initiated on 1/11/17. On 11/13/18 at 9:30 am an observation was done of the resident ' s room and bilateral padded side rails were noted. On 11/14/18 at 2:15 pm an interview was conducted with the Treatment Nurse (TN) who was assigned to Resident #53 and stated that the side rails were placed to prevent the resident from falling out of bed. TN commented that the resident cannot get out of bed on her own at this time. The pads were added to the side rails to prevent skin tears. TN stated she was not aware that the side rails for safety were considered a restraint. An interview was conducted with the Quality Improvement (QI) Nurse on 11/14/18 at 3:20 pm and she was asked why Resident #53 had bilateral side rails used in conjunction with bilateral padding. The QI Nurse stated that the side rails were placed as a safety measure after the resident fell out of bed. The QI Nurse was not aware that the side rails were not in the care plan.	F 656		

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F 656	Continued From page 60 An interview was conducted with MDS Nurse #1 on 11/14/18 at 3:30 PM. MDS Nurse #1 was asked about Resident #53 ' s bilateral padded side rails. MDS Nurse #1 stated that she coded for side rails when instructed by nursing when they were a restraint and the resident ' s side rails were not considered a restraint. The side rails were for safety to prevent falling out of bed. MDS Nurse #1 revealed she had not known bilateral padding were in place on the bilateral rails. She further stated that if there was no focus or goal for the side rail ' s need, it was missed. An interview was conducted with the Administrator on 11/14/18 at 4:15 PM. Resident #53 ' s bilateral padded side rail usage and that these interventions were not care planned was reviewed with the Administrator. The Administrator indicated that she expected the MDS Nurse to care plan for any care or interventions provided for the resident.	F 656		
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 record reviews, observations and staff interviews, the facility failed to provide nail care for 2 of 2 dependent residents reviewed for Activities of Daily Living (Residents #123 and #20). The findings included:	F 677	F 677 ADL Care Provided for Dependent Residents How corrective action will be accomplished for those residents found to have been affected by the deficient practice The resident #123 and #20 were provided	12/16/18

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Continued From page 61

1. Resident #123 was admitted to the facility 10/8/18 with diagnoses that included Rheumatoid Arthritis.

The most recent MDS (Minimum Data Set) coded as an admission assessment and dated 10/16/18 assessed the resident as being alert and oriented, able to make her needs known and understood others. The assessment had documentation that she required total assistance from 1 to 2 staff members for all her Activities of Daily Living (ADL's).

Review of the resident's active care plan dated 10/19/18 revealed Resident #123 was dependent on others for ADL's and personal care.

Review of the nursing notes revealed no refusals of nail care documented.

Review of a nursing note dated 10/18/18 revealed the resident with bilateral hand contractures due to Rheumatoid Arthritis and was dependent on staff for all ADL's.

During observations for 4 days (11/13/18, 11/14/18, 11/15/18 and 11/16/18) the resident was observed with long nails to both of her contracted hands and a dark substance under both thumb nails.

On 11/14/18 at 2:30pm an interview was completed Resident #123. She stated that she was not able to use her hands due to severe Rheumatoid Arthritis and had not been asked about cleaning under or cutting her nails.

On 11/14/18 at 4:05pm an interview was

F 677

with nail care immediately on 11/16/18 by a Certified Nursing Assistant (CNA).
How the facility will identify other residents having the potential to be affected by the same deficient practice
All residents that require assistance have the potential to be affected. On 11/17/18 the nursing supervisor initiated an audit of resident requiring assistance with nail care. The audit was completed on 11/20/18 with 36 residents requiring follow up nail care. Any issues with resident nails were resolved immediately by the hall nurse and/or certified nursing assistant.
What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
Re-education for all CNA□s to include fulltime, part time, and agency staff was initiated on 11/19/18 to be completed by 12/16/18 regarding following the Resident Care Guide to include nail care.
Re-education was conducted by the Staff development coordinator and/or the DON (Director of Nursing). For staff not re-educated by 12/16/2018 they will be in-serviced prior to working on the floor.
New hires and agency staff will receive this education during orientation to the facility.
The RN supervisors and assigned Department Heads will continue to perform Compliance Monitoring Rounds 3 (three) times per week. The rounds will be performed at random times, and days including weekends.
How the facility plans to monitor its performance to make sure that solutions

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F 677	Continued From page 62 completed with the facility's Treatment Nurse. She stated that the aides, nurses and administrative nurses completed nail care as needed. She stated that there was not a formal schedule to do nail care on a routine basis. She added that the aides would alert a nurse of the need for nail care if the resident was a diabetic. On 11/15/18 at 9:50am an interview was conducted with NA #1 who stated that both the aides and nurses complete nail care as needed. She explained that the aides observe nails during personal care and would provide the needed assistance or alert a nurse if the resident was a diabetic. NA #1 stated that there was not a routine schedule for nail care. On 11/15/18 at 10:05am an interview was completed with LPN #1 who stated that she provided nail care when she saw a need, but the aides provided nail care during personal care unless the resident was a diabetic. She added that diabetic residents have nail care provided by the treatment or floor nurse. She stated that there was not a routine schedule for nail care. On 11/15/18 at 11:15 am an interview was conducted with the Director of Nursing. She stated that the aides could clean under all resident's nails and could cut fingernails for all residents except those with diabetes. Diabetic residents had their fingernails cut by the nurse. She stated that there was not a routine schedule for nail care. The DON stated that it was her expectation for the aides to monitor, clean and trim nails during daily personal care, retrieving a nurse for any diabetic nail care that would be needed.	F 677	are sustained The RN supervisor will perform observation of 5 residents with daily audits 5 times a week for 1 week, then 3 times a week for 3 weeks and then weekly thereafter for Activities of Daily Living (ADL) care to include nail care. The results of the ADL observation audits will be shared with the QI nurse and DON. The Director of Nursing (DON) will track and trend the results and re-educate or initiate counseling for nursing staff as indicated. The DON will share the results of audits with the interdisciplinary team (IDT) weekly for 12 weeks. The DON and/or QI nurse will present Interdisciplinary Team (IDT) corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of providing ADL care. The Administrator consulted with the Medical Director and nurse practitioner regarding the plan of correction with no changes or recommendations noted.	

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F 677	Continued From page 63 On 11/16/18 at 9:35am an interview was conducted with NA #2 who confirmed that she was aware Resident #123's nails were long and dirty and that she had not cleaned under the resident's nails or alert a nurse to the need for care. She denied any refusals from the resident for nail care. She stated that there was not a routine schedule for nail care. 2. Resident #20 was admitted on 7/11/11 with cumulative diagnoses of Cerebral Vascular Accident (CVA) and Hemiplegia. Resident #20's quarterly Minimum Data Set (MDS) dated 8/8/18 indicated moderate cognitive impairment and he was coded as exhibiting no behaviors. He was also coded for extensive assistance of one staff person for hygiene. Review of Resident #20 last revised care plan dated 8/22/18 for personal hygiene read he required staff assistance due to his CVA and Hemiplegia. There were care plans for his refusal of showers, turning, repositioning and for incontinence care. In an observation and interview on 11/13/18 at 9:40 AM, Resident #20 was lying in bed with his right arm under his sheet. He was alert and cooperative. He removed his right hand from under the sheet to allow visitation of his finger nails. They appeared long, jagged and had a dark brown substance under them. He stated the staff cut his nails but had not been done in "a long time." It was noted that his Hemiplegia affected his right hand, but he was able to open his hand	F 677		

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F 677	Continued From page 64	F 677		

upon request.

In another observation on 11/14/18 at 8:30 AM, Resident #20 was again lying in bed. He was sitting up eating breakfast. Observation of both hands reveals long, jagged finger nails with a dark brown substance under them.

In an interview on 11/14/18 at 4:05 PM, the Treatment Nurse stated that the nursing assistants, nurses and administrative nurses provided nail care as needed.

In another observation on 11/15/18 at 8:10 AM, Resident #20 was sitting up in bed. He stated he received a shower this morning. Observation of both hands revealed long, jagged clean finger nails. He stated the staff member cleaned under his nails and stated she would come back later to cut them.

In an interview on 11/15 at 8:20 AM, Nursing Assistant (NA) #15 stated she had not experienced any refusals of care from Resident #20 but she knew he liked to be left alone.

In an interview on 11/15/18 at 8:50 AM, NA #11 stated Resident #20 was cooperative with his activities of daily living (ADL) care.

In an interview on 11/15/18 at 9:50 AM, NA #1 stated the aides and nurses do nail care but added that she looked at nails and trimmed them if needed.

In an interview on 11/15/18 at 10:05 AM, Nurse #1 stated she completed nail care when she saw a need but that aides provided nail care during personal care

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F 677	Continued From page 65 In an interview on 11/15/18 at 11:15 AM, the Director of Nursing stated that diabetic nail care was provided by nurses. The aides trim and clean nails as needed during personal care. She stated that there is no formal schedule for nail care but that it was her expectation for the aides to monitor and clean nails during daily personal care.	F 677		
F 684 SS=G	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, resident, staff, Nurse Practitioner (NP) and Medical Director (MD) interviews and record review, the facility failed to provide timely evaluation of a report of immediate pain following a fall on 10/17/18 and continued complaints of pain. The facility also failed to obtain a diagnostic x-ray until the resident requested one on 10/29/18. The x-ray results dated 10/30/18 revealed fractures to the 3rd through 7th ribs on the left side. This was for Resident #30. The facility also failed to promptly address a resident's expression of passive suicidal ideations and known depressive symptoms for 52 days after reported to the Social Worker (SW). This was for Resident #163. This	F 684	F684 Quality of Care How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #30 has had decreased complaints of left side rib pain and is receiving scheduled pain medication along with an additional order for PRN pain management. Resident #163 received a psychiatric review on 11/8/18 which revealed no suicidal ideations. He continues to receive psychiatric services as needed. How the facility will identify other residents	12/16/18

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F 684	Continued From page 66 deficient practice was for 2 of 2 residents reviewed for wellbeing. The findings included: 1. Resident #30 was admitted on 5/15/18 with cumulative diagnoses of Atrial Fibrillation, Congestive Heart Failure, Osteoarthritis, Restless Leg Syndrome and Delusional Disorder. Resident #30's quarterly Minimum Data Set (MDS) dated 8/15/18 indicated moderate cognitive impairment with a Brief Mental Status (BIMS) score of 12. She was coded with no behaviors and limited assistance with ambulation. Resident #30 was coded with no impairments to her upper or lower extremities. She was coded for scheduled and as needed (PRN) pain medications. Resident #30 was coded as reporting no pain and as having no falls since previous MDS assessment. Review of the nursing 24 Hour Report dated 10/16/18 read Resident #30 slid to the floor on first shift with the Physician and Responsible Party (RP) notified. The 24-Hour Report indicated Resident #30 received Tylenol 2 tablets on second shift. Review of an incident report and nursing note dated 10/17/18 at 10:43 AM read Resident #30 had an unwitnessed fall in her room. She was ambulating on her own from her wheelchair to her closet when she fell. The report and nursing note read no injury, but Resident #30 complained of left rib pain. The nursing note read a correspondence was left for the NP and Medical Director. The intervention was a therapy screen. Review of a Physician Fax Communication sheet dated 10/17/18 read Resident #30 did not fall but	F 684	having the potential to be affected by the same deficient practice An audit was conducted by the RN Quality Improvement (QI)nurse all incident reports from November from 11/1/18 through 11/16/18 for any unresolved complaints of pain or expressions of suicidal ideations. A review of progress notes was completed for any expressions of suicidal ideations not resolved with no negative findings noted. The Interdisciplinary Team will review all residents with incidents, including falls and changes of condition, and any behavior notes indicating suicidal ideations in morning IDT meeting. The review will include completion of assessment, evaluation, monitoring, and treatment of complaints of pain; and assessment, evaluation, completion of psychiatric referrals, and monitoring of follow up for suicidal ideations. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The Nursing staff will be re-educated beginning 11/20/18 by the DON and/or SDC on assessment, evaluation, monitoring, and physician notification of residents with continued complaints of pain and/or suicidal ideations. Re-education will be completed by 12/16/18. Any staff members not receiving re-education by 12/16/18 will not be allowed to work until education is completed. New hires and agency staff will receive this education during orientation to the facility.	

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F 684	Continued From page 67 sat on the floor and caught herself using her walker and recliner. Resident #30 complained of left rib pain. The Nurse Practitioner (NP) wrote the word "monitor" with her initials. The NP documentation was undated. Review of the nursing 24 Hour Report dated 10/17/18 read Resident #30 received Tylenol 2 tablets at 6:00 PM. Review of the October 2018 Physician Orders and Medication Administration Record (MAR) read Resident #30 was receiving Neurontin (treats nerve pain) three times daily scheduled and Ultram (synthetic opioid used to treat pain) twice daily scheduled. There were also orders for Norco (opioid used to treat pain) 1 tablet as needed for pain. Review of the October 2018 MAR read Resident #30 received no as needed doses of her Norco. Review of the October 2018 MAR read a standing order for Tylenol 325 milligrams (mg) 2 tablets by mouth every 4 hours as needed for pain for 48 hours. The MAR indicated Resident #30 received Tylenol 650 mg on 10/17/18, 10/23/18, 10/24/18 and 10/26/18. Review of the Rehabilitation screen dated 10/18/18 read Resident #30 was not interested in participating in therapy. Review of the nursing 24 Hour Report dated 10/22/18 read Resident #30 complained of rib pain and received Tylenol on third shift. Review of a nursing 24 Hour Report dated	F 684	Facility staff will receive annual training on Abuse, Neglect, and Misappropriation of Property that includes assessment, evaluation, monitoring, and notification of physician of residents with continued complaints of pain and/or suicidal ideations. Training will be provided by the Staff Development Coordinator or the Director of Nursing. Residents exhibiting complaints of pain and/or suicidal ideations will be discussed in the daily interdisciplinary team (IDT) meeting after the occurrence. Discussion will include notification of attending physician, Resident Representative and whether interventions implemented are effective. How the facility plans to monitor its performance to make sure that solutions are sustained The QI Nurse will review the IDT form for pain and/or behaviors for trending and tracking of residents with repeat complaints of pain and/or suicidal ideations on a weekly basis for 12 weeks. The QI Nurse will present IDT corrective actions and reported abuse/neglect, suicidal actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the executive QI committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of Abuse/Neglect and/or suicidal ideations.	

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F 684	Continued From page 68 10/23/18 read Resident #30 went out of the facility with her RP on first shift. Review of a Physician Fax Communication dated 10/23/18 read Resident #30 continues to complain of left upper rib pain and stated she was going to have her RP drop her off at the hospital for evaluation if something was not done. The NP documented per Nurse #4, "no complaints" with the date 10/24/18 and her initials. Review of a nursing note dated 10/29/18 at 4:56 PM read Resident #30 was complaining of soreness to her left side and left arm. Resident #30 requested an x-ray and the NP was notified. Review of an x-ray report dated 10/30/18 read as follows: Minimal displaced fractures of the third through seventh posterior lateral ribs left side suggested. The x-ray was undated but initialed by the NP. Review of Resident #30's MAR read an order dated 10/30/18 for Biofreeze (topical pain reliever) four times daily to her neck. Review of a NP note dated 10/30/18 at 2:11 PM, read in part as follows: Resident #30 had a fall approximately 2 weeks ago and continues to have left lower rib cage pain that worsens with coughing, deep breaths or with repositioning in bed. Resident #30 stated her pain medications do help alleviate the pain somewhat, but she is still very concerned since it is ongoing. Resident #30 stated otherwise, she is doing okay and has no complaints. Review of the November 2018 MAR read Resident #30 received no as needed doses of her	F 684	The Administrator consulted with the Medical Director and nurse practitioner regarding the plan of correction with no changes or recommendations noted.	

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Norco or Tylenol.

In an interview on 11/13/18 at 4:49 PM, Resident #30 reported she fell in October and immediately experienced left side pain. She stated she broke her ribs and she received no x-ray and saw no NP or MD until two weeks after the fall. She stated the pain was bad but has improved. She stated she continues to have pain with movement in bed and on transfers. She reached to guard her left side with facial grimacing.

Resident #30's care plan last revised on 11/14/18 indicated she was at risk for pain related to complaints of soreness and discomfort to her left side and left arm on 10/29/18. The care plan revised 11/14/18 also read her x-ray dated 10/30/18 indicated fractures of her left 3rd through 7th ribs. Interventions included listening to her complaints of pain, medications as ordered, documenting verbal and non-verbal indicators of pain and notification of the physician if pain management was not effective.

In an interview on 11/14/18 at 2:35 PM, Nurse #4 stated she was assigned Resident #30 most days and assigned to her the day she fell. She stated the NP was in the building that day and spoke to the NP about Resident #30's complaints of left side pain. She stated she did not recall if the NP assess Resident #30 on 10/17/18 but the NP told her to monitor Resident #30 and administer the prn Tylenol if she needed it for pain. Nurse #4 stated about a week later, Resident #30 was still complaining of pain to her left side so Nurse Supervisor #3 requested an x-ray order from the NP. Nurse #4 confirmed she did not report Resident #30's continued complaints of pain until she sent the NP the Physician Fax

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F 684	Continued From page 70 Communication form dated 10/23/18. In an interview on 11/14/18 at 2:45 PM, Nursing Assistant (NA) #10 stated Resident #30 complained of left side pain after the fall and she reported it to Nurse #4. She confirmed Resident #30 continues to complain of occasional pain with transfers. In an interview on 11/14/18 at 3:05 PM, Nurse Supervisor #3 stated she was aware that Resident #30 had a fall and was experiencing left side pain. She stated the NP wanted nursing staff to monitor her for continued or worsening of the pain. She stated she contacted the NP on 10/29/19 and requested an x-ray because Resident #30 requested it. In an interview on 11/15/18 at 8:50 AM, NA #11 stated Resident #30 has complained of pain to her left side with care. NA #11 stated when Resident #30 complained of pain, she would report it to her assigned nurse. In an interview on 11/15/18 at 9:00 AM, the NP stated it was her expectation that when she directed the nursing staff to monitor Resident #30, they would have contacted her if she got worse, but she was likely going to be sore from the fall. The NP confirmed she did not assess Resident #30 until 10/30/18. The NP stated staff reported to her that Resident #30 was going out with her RP and she was able to function at her baseline. The NP stated when the Nurse #4 faxed her on 10/23/18, she stopped in to see Resident #30, but she was out of the facility with her RP and she was not notified again until 10/29/18 by Nurse Supervisor #3. The NP stated that was when she ordered the x-ray. The NP confirmed	F 684		

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the x-ray results of 5 fractured left side ribs. The NP confirmed she did not assess Resident #30 until 10/30/18. She stated there was no need for additional treatment and that Resident #30 was already taking Ultram twice daily for pain and Tylenol as needed. The NP stated she did not routinely review the nursing notes but rather relied on the staff calling her for sending her a Physician Communication Fax form. The NP confirmed she was at the facility daily Monday through Friday and available by phone when she was not at the facility.

In a second interview on 11/15/18 at 10:40 AM, Resident #30 was sitting up in her wheelchair with NA #11 present in the room. Resident #30 complained of left side pain where she broke her ribs. She was guarded of her left side with facial grimacing. NA #11 heard Resident #30's complaint of pain and stated she would notify her nurse.

In an interview on 11/15/18 at 5:40 PM, Nurse #6 confirmed she was assigned Resident #30 and had cared for her since beginning her shift at 7:00 AM on 11/15/18. She stated NA #11 did not inform her that Resident #30 voiced left side pain earlier today after breakfast and that Resident #30 had not complained of pain to her, but she was due her scheduled Ultram and would assess Resident #30.

A telephone call was made to Resident #30's RP at both phone numbers listed with messages left to call surveyor. At time of exit, there had been no return call from RP.

In an interview on 11/16/18 at 8:20 AM, Resident #30 stated she was feeling better today. She

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stated her RP told her to take it easy and rest.

In a second interview on 11/16/18 at 10:20 AM, the NP stated it was her expectation that when NA #11 heard Resident #30 complain of left side pain on 11/15/18, she would have reported it to Resident #30's nurse.

A telephone call was made to NA #11 on 11/16/18 at 11:18 AM with a message left to call the surveyor regarding not reporting Resident #30's complaints of pain on 11/15/18. At the time of exit, there had been no return phone call.

In a telephone call on 11/16/18 at 11:35 AM, NA #12 confirmed she was assigned Resident #30 on 10/19/18 and 10/22/18 for second shift. She stated she recalled Resident #30 complaining of left rib pain especially when toileting and that she could not use her left arm to reach due to the pain. NA #12 stated she reported the pain the Resident #30's nurse on both days.

In a telephone call on 11/16/18 a 11:42 AM, NA #13 confirmed she was assigned Resident #30 on 10/18/18 for third shift. She stated she recalled Resident #30 stated she was sore from the fall, but NA #13 could not recall if she reported anything to the nurse.

In a second interview on 11/16/18 at 11:55 AM, NA #10 confirmed she was assigned Resident #30 first shift on 10/17/18, 10/18/18, 10/19/18, 10/20/18, 10/21/18, 10/23/18, 10/24/18, 10/26/18 and 10/30/18. NA #10 stated Resident #30 did complain of left side pain on occasion, but she always reported the complaints to the nurse.

In an interview on 11/16/18 at 12:30 PM, Nurse

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#7 confirmed he was assigned Resident #30 on 10/19/18, 10/26/18, 10/27/18 and 10/28. He stated he worked those days from 7:00 AM to 7:00 PM. Nurse #7 stated he received no notification that Resident #30 complained of pain and that she never complained of pain when he went in to give her medications.

In a telephone interview on 11/16/18 at 5:00 PM, the MD stated it was his expectation that there would have been assessment completed by the NP at the time when Resident #30 first complained of pain on 10/17/18 and x-ray would have been ordered at that time to rule out injury. He further stated if Resident #30 reported continued pain and the NP did not assess her to rule out injury, it was expectation that the nursing staff would have contacted him for orders.

Review of the medical record indicated new orders dated 11/16/18 for Resident #30 to have a pain assessment completed three times daily while awake for 2 weeks and to administer the prn Norco for pain as ordered.

2. Resident #163 was admitted to the facility on 6/12/18 with diagnoses that included dementia without behaviors, alcohol abuse, metabolic encephalopathy, anxiety, Chronic Obstructive Pulmonary Disease (COPD).

A review of the medical record indicated Resident #163 was initially admitted to an unlocked unit of the facility (700 hall) on 6/12/18 but was relocated to the locked memory care unit on the 500 hall the same day (6/12/18).

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F 684	Continued From page 74 A Nurse Practitioner (NP) note dated 6/13/18 indicated Resident #163 had a significant history of COPD, alcohol abuse, metabolic encephalopathy, and dementia. He was admitted to the locked memory care unit of the facility. The NP indicated that Resident #163 was oriented to person and year, but he was not certain where he was and stated that he was quite anxious about being at the "here". The Admission Minimum Data Set (MDS) assessment dated 6/19/18 indicated Resident #163 ' s cognition was moderately impaired. The resident ' s mood interview revealed he felt down/depressed/hopeless 12-14 days, had trouble falling asleep/staying asleep/or sleeping too much 12-14 days, feeling tired or having little energy 12-14 days, feeling bad about himself 7-11 days, and trouble concentrating on things 12-14 days. He was assessed with no behaviors. Resident #163 was administered antidepressant medication on 7 of 7 days. The plan of care for Resident #163 indicated the focus area of feelings of sadness, emptiness, anxiety, uneasiness, depression characterized by; ineffective coping, low self-esteem, tearfulness, motor agitation, withdrawal from care/activities related to: admission to facility, loss of independence/change in lifestyle. This focus area was initiated on 6/22/18. The interventions included: convey acceptance of resident and provide repeated honest appraisals of resident ' s strengths, discuss feelings about placement with resident, encourage loved ones to keep in contact/visit, medication as ordered, offer activities that resident has shown interest in, and provide emotional support to resident/family as needed regarding resident ' s alcoholism and	F 684		

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lifestyle prior to admission. These interventions were all initiated on 6/22/18.

A Social Work (SW) note dated 7/2/18 completed by SW #2 indicated a mini-mental status assessment was conducted for Resident #163 and he reported "thoughts he ' d be better off dead but no thoughts of harming himself". SW #2 indicated she asked Resident #163 what made him feel that way and he stated that he wanted a beer and was unable to get it and also that he had not liked being on the locked memory care unit as he was, "not like the other crazy people back there".

The quarterly MDS assessment dated 7/2/18 indicated Resident #163 ' s cognition was severely impaired. The resident mood interview revealed he had felt down/depressed/hopeless 12-14 days, trouble falling asleep/staying asleep/or sleeping too much 12-14 days, feeling tired or having little energy 12-14 days, and had thoughts that he would have been better off dead or thoughts of hurting himself in some way on 2-6 days. He had no behaviors. Resident #163 was administered antidepressant medication on 7 of 7 days.

The plan of care related to feelings of sadness (initiated 6/22/18) was updated in July 2018 (no specific date noted) to indicate Resident #163 reported feeling down and depressed, trouble sleeping, feeling tired without energy, and having thoughts he ' d be better off dead with no thoughts of harming himself. The interventions initiated on 6/22/18 continued with no additions or revisions.

An Admissions Director note dated 7/10/18

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indicated that she had spoken with Resident #163 ' s family member several times about whether to keep Resident #163 on the locked memory care unit or to move him to one of the unsecured units. This was noted to have been discussed with Resident #163 and he reported that he wanted to move off of the locked unit. Resident #163 was noted to be moved out of the locked memory care unit and onto the 100 hall (unlocked) on this date (7/10/18).

An NP note dated 7/12/18 indicated Resident #163 was evaluated and stated that he was somewhat upset because he believed people were touching his things and stealing his things but otherwise he had no complaints and was pleased to be moved off of the locked unit. The NP indicated Resident #163 needed close monitoring in case he was developing paranoia since leaving the locked unit.

On 7/22/18 Resident #163 had an unsupervised exit from the facility. He was moved from the 100 hall unlocked unit to the 500 hall locked memory care unit on this same date (7/22/18).

A behavior note dated 7/28/18 indicated Resident #163 was more anxious since returning to the 500 hall locked unit. He was unable to hold his body still for any period of time, and he had difficulty concentrating on one task.

A physician ' s order by the NP dated 8/1/18 indicated a psychiatric consultation was ordered for Resident #163. This 8/1/18 order was 30 days after Resident #163 ' s report of passive thoughts of suicide on 7/2/18.

A Psychiatric Nurse Practitioner (PNP) note dated

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F 684	Continued From page 77 8/23/18 indicated Resident #163 was seen for his initial psychiatric evaluation and medication management. Staff reported Resident #163 had intermittent confusion, difficulty redirecting, increased anxiety, and some combativeness with care. He was noted with agitation, elevated/expansive/irritable mood, poor concentration, restlessness, physical aggression, combativeness, and resistance to care. No suicidality was noted on this PNPs assessment. This 8/23/18 PNP initial psychiatric evaluation was 52 days after Resident #163 ' s report of passive thoughts of suicide on 7/2/18. An observation was conducted, and an interview was attempted with Resident #163 on 11/16/18 at 7:45 AM. Resident #163 was alert and oriented to self only. He was not interviewable. An interview was conducted with SW #2 on 11/16/18 at 9:33 AM. The note dated 7/2/18 that indicated Resident #163 reported passive thoughts of suicide with no plan in place was reviewed with SW #2. She recalled Resident #163 reporting this information to her. She stated that Resident #163 was alcohol seeking and he wanted to leave the facility to drink. She indicated she had not completed any type of suicide assessment for Resident #163, but she had confirmed he had no active plan in place for harming himself. SW #2 was asked what she had done after Resident #163 reported this information to her. She stated she thought she informed one of the hall nurses and the Director of Nursing (DON) of this information verbally. She reported that this was the normal process for her when an issue came up that was related to mental health/psychiatric care. She indicated she was not supposed to independently contact the	F 684		

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F 684	Continued From page 78	F 684		

physician or the NP to request a psychiatric consultation. She stated that her responsibility was to pass the information off to nursing. SW #2 indicated that Resident #163 reported no suicidal thoughts to her since 7/2/18.

An interview was conducted with the DON on 11/16/18 at 9:41 AM. The note dated 7/2/18 in which Resident #163 reported passive suicidal thoughts to SW #2 was reviewed with the DON. She stated she was unable to recall with any certainty if she had been told this information by SW #2. She reported that there was a lot going on with Resident #163 in July 2018. She stated that on 7/10/18 Resident #163 was moved from the locked memory care unit to an unlocked unit, on 7/22/18 Resident #163 had an unsupervised exit from the facility, and on that same date he was moved back to the locked unit. The DON confirmed SW #2 ' s statement that she was not supposed to independently contact the physician or the NP to request a psychiatric consultation and that her responsibility was to pass the information to the nursing staff. She indicated the nursing staff had a notebook at the nurse ' s station where they kept a list for the PNP of whom she was supposed to see when she came to the facility. The DON reviewed this notebook and stated that there was not any information in the notebook related to Resident #163 ' s report of suicidal ideations on 7/2/18.

This interview with the DON continued. She was asked what her expectation was related to a timely psychiatric consultation for a resident who reported multiple depressive symptoms as well as passive suicidal thoughts. The DON indicated she expected a resident with voiced passive suicidal thoughts and multiple depressive

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F 684	Continued From page 79 symptoms to be referred for a psychiatric consultation and to be documented in the PNP notebook to alert her to see the resident on her next scheduled visit to the facility. She stated that the PNP came to the facility about once every 2 weeks. An interview was conducted with the NP on 11/16/18 at 10:00 AM. The note dated 7/2/18 in which Resident #163 reported passive suicidal thoughts to SW #2 was reviewed with the NP. She stated she was unable to recall with certainty if she had been informed of Resident #163 ' s self-reported suicidal thoughts, but she felt he was not sincere stating that she believed, "he just said that like I would say ' oh I ' d rather be dead than have to do this today ' ." She indicated that when she wrote the order dated 8/1/18 for a psychiatric consultation that it wasn ' t even related to Resident #163 ' s depressive symptoms or suicidal thoughts. She indicated this was related to Resident #163 ' s increased agitation and behaviors. A phone interview was conducted with Resident #163 ' s physician/the facility ' s Medical Director on 11/16/18 at 6:10 PM. The note dated 7/2/18 in which Resident #163 reported passive suicidal thoughts to SW #2 was reviewed with the physician. He stated that he was unable to recall if he had been informed of this information related to Resident #163. He indicated that his expectation was for any statement of suicidal thoughts to be taken seriously and for a psychiatrist to be consulted to make their own determination of the sincerity of the resident ' s expressed thoughts as this was their specialty.	F 684		
F 689	Free of Accident Hazards/Supervision/Devices	F 689		12/16/18

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F 689 SS=J	Continued From page 80 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 record review, staff interview, and observation, the facility failed to provide supervision to prevent 1 of 2 sampled cognitively impaired residents who displayed wandering behaviors from exiting the facility while unsupervised (Resident #163). Resident #163 was found unsupervised outside of the facility by facility staff and returned inside with no injuries. Immediate Jeopardy began on 7/22/18 when Resident #163 was found outside of the facility without supervision by Housekeeper #1 and Housekeeper #2. Resident #163 was seated on a picnic bench under a covered shelter adjacent to the rear parking of the facility at approximately 12:00 PM. Immediate Jeopardy was removed on 11/16/18 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. The findings included:	F 689	F 689 Free of Accidents Hazards/Supervision/Devices How corrective action will be accomplished for those residents found to have been affected by the deficient practice " On 7/22/18, Resident #163 was found, by two members of housekeeping staff, sitting outside in the picnic area adjacent to the rear parking lot. The resident was assisted back into the facility by the two members of housekeeping staff at 12:00pm. " On 7/22/18, the Hall Nurse confirmed Resident #163s wander guard was in place. The wander guard bracelet was not changed. " On 7/22/18 at 12:05 pm, Resident #163 was assessed by the Hall nurse with no injury noted. " 07/22/18 at 12:10 pm the RN supervisor notified the Director of Nursing (DON) of the unsupervised exit of Res #163 and Resident was transferred to the SPARKS (Secured Dementia) unit. The resident is currently wearing a Wander guard. The Wander guard was checked	

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Resident #163 was admitted to the facility on 6/12/18 with diagnoses that included dementia without behaviors, chronic obstructive pulmonary disease (COPD), alcoholic abuse, metabolic encephalopathy, and anxiety.

A review of the medical record indicated Resident #163 was initially admitted to an unlocked unit of the facility (700 hall) on 6/12/18 but was relocated to the locked memory care unit on the 500 hall the same day (6/12/18).

A Nursing Admission Evaluation dated 6/12/18 for Resident #163 indicated he was independent with no help required for bed mobility and transfers. He ambulated independently with supervision. Resident #163 was assessed with wandering behaviors.

A nursing note dated 6/12/18 indicated Resident #163 was alert and oriented to situation with some confusion and was observed wandering about the facility. He was noted to have a history of sun-downing and increased wandering in the evenings.

A Nurse Practitioner (NP) note dated 6/13/18 indicated Resident #163 had a significant history of COPD, alcohol abuse, metabolic encephalopathy, and dementia. He was noted to be a poor historian. Resident #163 was admitted to the locked memory care unit of the facility and he continued on Namenda (cognition enhancing medication) related to dementia which was felt to be alcohol induced. The NP indicated that Resident #163 was oriented to person and year, but he was not certain where he was.

A wander risk evaluation dated 6/13/18 indicated

F 689

for functionality 11/7/18 by the QI Nurse and re-checked by the DON for functionality on 11/15/18.
" On 7 /22 /18 at 12:16pm, Resident #1s physician was notified by the administrator of the residents unsupervised exit.
" On 7/22 /18, at 12:16pm Resident #163s Resident Representative (RR) was notified by the staff nurse of the unsupervised exit.
" On 7/24 /18, the Minimum Data Set (MDS) nurse confirmed Resident #163 was already assessed for At Risk of Wandering, wander guard was on and functional when checked by the admissions director 6/13/18. The resident was admitted to the facility on 6/12/18, the resident was assessed for risk for wandering on 6/13/18, the assessment revealed a score of 6 out of 21 total points. The Wandering Risk evaluation assessment was completed by the Registered Nurse QI Nurse.
" On 7/24 /18, Resident #163s wandering assessment was re-assessed on by the QI nurse and resulted in a score of 10 out of 21 total points. Resident #163s care plan and care guide were reviewed and updated as appropriate on 7/23/18 by the MDS nurse.
" On 7/22/18 at 12:10 pm the RN Staff Nurse documented the Wander guard was intact to right lower leg.
" On 7/22/18 at 12:05 pm The RN Supervisor on duty conducted 100% observation audit of all exit doors, the result of this audit showed no negative findings. The audit included checking all

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F 689	Continued From page 82 Resident #163 was at risk for wandering. He was noted with cognitive loss, occasional problems remembering where he was at, and had some difficulty in new situations. The assessment indicated Resident #163 had made verbal statements of desire or intent to leave the facility. Follow up interventions were for Resident #163 to reside on the locked memory care unit and for a wanderguard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) to be placed on his person. The "Resident Care Guide" indicated an alarm bracelet (wanderguard) was initiated for Resident #163 on 6/14/18. The Resident Care Guide had not indicated that Resident #163 had wandering behaviors. The plan of care for Resident #163 indicated the focus area of the potential for/actual ineffective breathing pattern related to COPD was initiated on 6/14/18. There was no initiated focus area related to Resident #163 ' s wandering behaviors or his wanderguard at that time. The Admission Minimum Data Set (MDS) assessment dated 6/19/18 indicated Resident #163 ' s cognition was moderately impaired. He was assessed with no behaviors, no rejection of care, and no wandering. Resident #163 required the supervision of 1 for bed mobility, transfers, and locomotion on/off the unit. He required supervision with no set up help for walking in room and corridor. Resident #163 ' s balance was assessed as unsteady but able to stabilize without staff assistance. He had no functional limitations with range of motion and utilized no mobility devices.	F 689	exit doors for functionality of alarms and / or locks. The RN Supervisor verbally reported the completion and results of the door audit to the Director of Nursing on 7/22/18. The RN Supervisor documented the audit in the written statement on 11/15/18. " The Maintenance Director checks weekly the functionality of the locking system on all exit doors. The Maintenance Director documents the results of all weekly checks in the TELS computer system. On 11/16/18 the Assistant Administrator printed from the TELS computer system of the Logbook Report of the Resident Monitoring Systems from 6/2/18 through 11/10/18. The Report reveals that weekly door checks have occurred since 6/2/18. " On 11/7/18 the QI nurse checked the functionality of Res # 163s Wander guard. On 11/15/18 at 8:55 pm the DON performed an observation audit on Res # 163s Wander guard for functionality and the Wander guard was properly functioning with an expiration date of 10/2020. The wanderguard had not expired and was functional. " During the investigation of the unsupervised exit that was initiated on 7/22/18, witness statements were obtained from two housekeepers that observed the resident in the outside picnic area and the RN Staff Nurse. Res # 163 was interviewed and was unable to verbalize the exit path that was taken. The RN supervisor interviewed other staff members and communicated to the DON the inability to determine that actual exit	

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The Care Area Assessment (CAA) related to Cognitive Loss/Dementia was triggered for Resident #163 ' s 6/19/18 Admission MDS related to a diagnosis of dementia associated with alcohol abuse. He was noted with cognitive deficits requiring reorientation until he was familiar with his surroundings. Resident #163 had a history of alcohol abuse which he was approximately 2 months post ceasing alcohol use. He had diagnoses of COPD, alcohol abuse, dementia without behavioral disturbance, and metabolic encephalopathy. Resident #163 required very minimal assistance, mainly supervision and cueing to complete tasks. He was noted as essentially homeless prior to admission with noted stays in hotels and sometimes sleeping in the woods of a local park.

A Care Plan Return to Community note dated 6/19/18 completed by Social Worker (SW) #2 indicated Resident #163 wanted to return to the community but that he had been living in the woods up until his hospitalization that resulted in his admission to the facility.

A Care Plan General Note dated 6/27/18 indicated an initial care plan meeting was conducted for Resident #163. Two of his family members were noted to be in attendance. Resident #163 had not attended the meeting. The family reported that Resident #163 had a history of leaving the hospital Against Medical Advice (AMA) and they wished for him to remain at the facility for long term care as they felt he would leave an assisted living facility AMA if he was transferred to a lower level of care.

A SW note dated 7/2/18 completed by SW #2

F 689

path of Res #163. Res #163 was placed in the secured dementia unit at 12:10 pm by the RN supervisor. The RN Staff Nurse notified the Resident Representative and MD of placement in the Secured Dementia Unit. The resident has remained in the Secured Dementia Unit since 7/22/18 without any further unsupervised exits.

" On 11/15/18 at 8:30 pm the Quality Improvement Action Team met to perform a further detailed Root Cause Analysis (RCA) of the Unsupervised Exit of Resident # 163 on 7/22/18. The QI Action team consisted of the Regional Vice President, Administrator, Director of Nursing, Social Services, Admissions Director, Nursing Supervisor, MDS Nurses, Payroll and Accounts Receivable Bookkeepers, Assistant Administrator and Facility RN Consultant. As a results of the RCA, the QI Action Team determined that there were only three probable exit paths that Res #163 could have taken on 7/22/18. Those paths included the exit door from the dining room into the courtyard, the exit door for the service hall to the back parking lot, and the exit door from the 700 hall to the back parking lot. The Areas of Concern were discussed and possible solutions were determined and goals date were set for action items.

CORRECTIVE ACTION FOR RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED

" On 7/22/18, the RN Supervisor completed a 100% head count audit to ensure all other residents were accounted for: no negative findings, all present.

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F 689 Continued From page 84

indicated a mini-mental status assessment was conducted for Resident #163 and expressed passive thoughts of death with no active thoughts or reported desire to harm himself. SW #2 indicated she asked Resident #163 what made him feel that way and he stated that wanted a beer and was unable to get it and also that he had not liked being on the locked memory care unit as he was, "not like the other crazy people back there".

The quarterly MDS assessment dated 7/2/18 indicated Resident #163 ' s cognition was severely impaired. Resident #163 was assessed with no behaviors, wandering, or rejection of care. He required supervision with set up help only for bed mobility and locomotion off the unit. Resident #163 required supervision with no set up or physical help from staff for transfers, locomotion on the unit, and walking in room and corridor. Resident #163 was steady on his feet at all times. He had no functional limitations with range of motion and utilized no mobility devices.

An Admissions Director note dated 7/10/18 indicated that she had spoken with Resident #163 ' s family member several times about whether to keep Resident #163 on the locked memory care unit or to move him to one of the unsecured units. This was noted to have been discussed with Resident #163 and he reported that he wanted to move off of the locked unit. Resident #163 moved out of the locked memory care unit and onto the 100 hall (unlocked) on this date (7/10/18).

A behavior note dated 7/12/18 at 4:18 AM indicated Resident #163 was observed standing up in his bed feeling the walls. He was easily

F 689

" On 11/15/18 at 6:55 pm the Director of Nursing completed a 100% audit of placement and functionality, utilizing the Secure Care Products 707 Tester, of all wander guards currently in use and documented the expiration dates of each wander guard currently in use. Results of the audit determined that all wander guards were in place and functional for the 37 residents identified at risk for wandering. Wanderguards are placed on residents that are identified at risk for elopement. These 37 residents were identified as wanderers by results of the completion of the Wandering Risk Evaluation.

" On 11/15/18 the Nursing Supervisor was in-serviced by the Administrator and Director of Nursing that when initiating the investigation for an unsupervised exit, to promptly check the resident wander guard for placement and functionality as well as checking all exit doors for functionality. The in-service included the use of the Action Checklist for Unsupervised Exit form.

" On 11/15/18 at 5:45 pm the administrator in-serviced the department heads regarding the Action Checklist for Unsupervised Exit, processes for notification of Administrator and Director of Nursing. The Action Checklist for Unsupervised Exits is a guideline that directs actions to be taken by facility staff and administration when an incident of Unsupervised Exits occurs including checking the functionality of the wander guard and all doors for functionality.

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F 689	Continued From page 85 redirected but was seen shortly after ambulating out of another resident ' s room. A nursing note dated 7/12/18 at 11:30 AM completed by Nurse #2 indicated Resident #163 opened the fire exit door on the 100 hall (the hall he resided on). Staff were present at that time and Resident #163 had not exited the building. An NP note dated 7/12/18 indicated Resident #163 was evaluated and stated that he was somewhat upset because he believed people were touching his things and stealing his things but otherwise he had no complaints and was pleased to be moved off of the locked unit. The NP indicated Resident #163 needed close monitoring in case he was developing paranoia since leaving the locked unit. A behavior note dated 7/21/18 at 1:28 PM completed by Nurse #2 indicated Resident #163 was observed wandering in and out of other residents ' rooms all throughout the first shift (7:00 AM - 3:00 PM) An incident report dated 7/22/18 completed by Nurse #2 (the nurse assigned to Resident #163 during the first shift on 7/22/18) was informed by the 200 hall nurse (Nurse #3) that two housekeeping staff (Housekeeper #1 and Housekeeper #2) found Resident #163 sitting outside of the facility unsupervised around 12:00 PM at the picnic area adjacent to rear parking lot of the facility. He was brought back into the facility by Housekeeper #1 and Housekeeper #2. Resident #163 ' s wanderguard was noted to be intact to his right lower leg. (There was no mention as to whether or not the wanderguard was functioning.) Resident #163 was alert but	F 689	" On 11/15/18 at 6:15pm the RN Supervisor #1 and RN #2 began in-services to all nursing staff members on duty regarding the Action Checklist for Unsupervised Exits for Nursing Staff. The facility will utilize the current personnel roster to ensure that all staff members are in serviced by the RN Staff Development Coordinator on actions to be taken when an Unsupervised Exit occurs. The Action Checklist for Unsupervised Exits for Nursing Staff is a guideline of tasks for staff to perform when a door alarm is sounding, if a resident is missing or exits without supervision. " 100% of staff members from all departments will be in serviced starting 11/15/18 to determine the exit door that is sounding, and the appropriate response to the alarm including, going outside and check the area to include the perimeter to assure that a resident has not exited unsupervised, notification of Nursing Supervisor or Unit Nurse of resident□s unsupervised exit if resident is observed outside, completion of a 100% head count of all current residents. If a resident is observed outside staff member should remain with resident and escort resident back into the facility. All staff were made aware of their responsibility to follow the care plan and care guide for residents at risk for wandering, including heightened awareness of those resident□s' location. The inservice will be completed for all facility staff by 12/16/18. " Any staff who have not been re-educated by 12/16/18 must receive education prior to working their assigned	

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F 689	Continued From page 86 was disoriented times three (person, place, and time). There were no injuries, pain, or shortness of breath noted. A predisposing factor to the incident was noted to be Resident #163 ' s recent move into the facility. A behavior note dated 7/22/18 completed by Nurse #2 indicated she was informed by Nurse #3 that Resident #163 was found sitting outside at the picnic area by Housekeeper #1 and Housekeeper #2. Nurse Supervisor #1 was notified, and she reported to the Director of Nursing (DON) via text message. Resident #163 was moved back to the 500 hall locked memory care unit. Resident #163 ' s family member was contacted as well as the NP. A review of the weather conditions per Weather Underground ' s website (www.wanderground.com) for Albemarle ' s weather history indicated the temperature on 7/22/18 at 11:55 AM was 78 degrees Fahrenheit, 76 percent humidity, and there was no precipitation. A Quality Assurance Wandering Review dated 7/26/18 completed by the Quality Improvement (QI) Nurse indicated Resident #163 had an unsupervised exit from the facility on 7/22/18 at 12:00 PM. Resident #163 was noted to be found by staff at the covered picnic area by the staff parking lot. Resident #163 was assisted back into the building. Resident #163 ' s wanderguard placement was noted to be confirmed when he was returned into the building. (The wanderguard ' s functioning was not noted to be confirmed.) Resident #163 was relocated to the 500 hall locked memory care unit.	F 689	shift. All new hires including agency staff will be educated during their facility orientation. " On 11/15/18 at 7:35 pm the Maintenance Director and Maintenance Assistant completed 100% audit of all exit doors for functionality, 100 % of doors were functional. The facility has 10 exit doors that are all equipped with a Secure Care automatic locking / alarming system. The Maintenance Director and the Maintenance Assistant visually and manually checked the functionality of all exit doors. " As a result of the RCA completed on 11/15/18, it was determined that there are three doors that if the security code is entered the wander guard does not trigger the alarm. These three doors are used by visitors, staff and vendors. The door automatically resets each time the door is closed requiring the code to be re-entered to open the door again. The Door codes are only communicated to staff members. The solution implemented by the facility included written signage at all exit doors that states For our residents safety, please do not assist resident outside the door without notify staff first. Additionally the facility mailed a letter on 11/16/18 to all Families and Resident Representatives. " On 11/15/18 at 7:00 pm the MDS nurse #1 completed a 100% audit of residents that have been identified as a risk for unsupervised exits, have a current Wandering Risk Evaluation and documentation on the care plan and resident care guide. Results of the audit	

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An observation was conducted on 11/15/18 at 12:45 PM of the area where Resident #163 was found outside of the building unsupervised on 7/22/18. This area had a concrete pad, picnic tables, and a covering that provided shade and was utilized as a smoking area for residents and staff. It was adjacent to the rear parking lot that was utilized primarily by staff. The area Resident #163 was located was approximately 167 feet away from the nearest facility exit.

An observation was conducted, and an interview was attempted with Resident #163 on 11/16/18 at 7:45 AM. Resident #163 ambulated independently and was alert and oriented to self only. When asked about his unsupervised exit from the building on 7/22/18 he reported that he "goes outside everyday". He was unable to provide any information related to the 7/22/18 incident.

An undated handwritten statement completed by Housekeeper #1 indicated he had exited the facility around 12:00 PM to go to his car that was parked in the facility ' s rear parking lot to eat his lunch. He wrote that he saw Resident #163 get up from the picnic tables underneath the shelter and walk toward his car. Housekeeper #1 noted that he saw Housekeeper #2 coming outside and he asked her if Resident #163 was supposed to be outside unsupervised and she said he was not. Housekeeper #1 indicated he took Resident #163 back inside of the facility.

A phone interview was conducted with Housekeeper #1 on 11/15/18 at 1:04 PM. Housekeeper #1 stated he had exited the building from the 700 hall door to eat his lunch in his car that was parked in the rear parking lot. He

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identified 13 residents with evaluation assessments dates older than 3 months.
" On 11/15/18 at 8:51 pm The QI nurse completed the Wandering Risk Evaluations on those residents identified from the MDS Nurse #1 audit.
" On 11/15/18 at 7 pm the MDS nurse #2 completed a 100% Audit of current pictures in the Wander guard Notebook for residents that have been identified at risk for Unsupervised Exits and require a wander guard monitor. The audit revealed 2 residents did not have current photos. The Social Worker #1 obtained and printed photos for these 2 residents and placed them in the appropriate notebook.

WHAT MEASURES WERE PUT INTO PLACE OF SYSTEMIC CHANGES MADE
" To prevent reoccurrence, starting 11/15/18 the bracelet placement of the wander guard will be documented daily by the licensed nurse on 11-7 shift assigned to the resident. The licensed nurses on 11 -7 shift will be educated by the Director of Nurses starting 11/15/18 and completed by 12/16/18 on the process of checking the placement and documenting the placement on the MAR (Medication Administration record).
" Beginning 11/15/18, the QI nurse will be responsible for documenting weekly the functionality of the wander guards. The QI nurse will document the functionality on the Transmitter Tester Log form. Each resident will have an individual Transmitter Form. The QI nurse will be responsible for tracking the expiration dates of individual wander guards and

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explained that this was the parking lot the staff used and that the 700 hall door required a numerical security code to unlock. Housekeeper #1 indicated he was moving his car from an unshaded spot in the lot to a shaded spot as it was hot outside. He stated that this was when he saw Resident #163 sitting at the picnic tables under the shelter. He revealed that Resident #163 was unsupervised. He stated that he thought Resident #163 "looked tired and was breathing hard". Housekeeper #1 reported that at that time he saw Housekeeper #2 exiting the building through the 700 hall door. He stated that he asked her if Resident #163 was supposed to be outside by himself and she told him that he was not supposed to be outside unsupervised. Housekeeper #1 indicated he and Housekeeper #2 walked Resident #163 back to the 700 hall door, entered the security code, and brought him back into the building. He reported that as he was coming back in with Resident #163 when he saw Nurse #3 and she took the resident from there.

This interview with Housekeeper #1 continued. He was asked how Resident #163 got out of the building. He stated that he did not know how Resident #163 had gotten out. He was asked if any changes had been made to the utilization of the exit doors that required a numerical security code. He indicated that the numerical code was changed regularly, but that the new code was given out department heads and then distributed to staff. He revealed staff still utilized these exit doors.

An undated handwritten statement completed by Housekeeper #2 indicated she had exited the facility on 7/22/18 around 12:00 PM and was

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replacing the wander guard prior to the expiration date. On 11/15/18, the DON will educate the QI nurse on the process to document the weekly functionality of wander guard and tracking the expiration date and replacing the wander guards prior to expiration.

" The Maintenance Director will be responsible for weekly checking of the functionality of the Secure Care door system. The documentation will be uploaded into the TELS computer system. The TELS computer system is a Maintenance Communication Tracking system for work orders and Preventative Maintenance. The QI Nurse will print monthly the weekly door check reports from the TELS computer system and share it with the QI Committee.

" On 11/15/18 the Social Worker completed education with the residents that are currently unsupervised smokers on the importance of not assisting other residents through the locked doors.

" On 11/16/18, the administrator will hold an adhoc QI meeting, participants will include the medical director/resident□s physician, to review the unsupervised exit, root cause analysis, identified issues, in-services, and systematic changes.

HOW THE FACILITY PLANS TO MONITOR MEASURES TO MAKE SURE SOLUTIONS ARE SUSTAINABLE

" The Administrator and/or DON will review new behaviors, incident accident reports in the morning Interdisciplinary Team (IDT) meeting to ensure all unsupervised exits have an associated

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F 689	Continued From page 89 walking to her car. She noted that she saw Housekeeper #1 get out of his car and he asked her if Resident #163 was supposed to be outside of the building and she told him he was not. She indicated she and Housekeeper #1 took Resident #163 back inside the building. A phone interview was conducted with Housekeeper #2 on 11/15/18 at 1:20 PM. Housekeeper #2 stated that she had exited the building through the 700 hall door to get something from her car in the staff parking lot/rear parking lot. She reported that she entered the numerical security code to exit the door. She indicated that she couldn ' t recall much about the incident. She stated she saw Resident #163 outside at the picnic tables unsupervised and she knew he was not supposed to be outside without staff supervision. Housekeeper #2 reported she ran into Housekeeper #1 while she was outside. She stated that she went back into the building through 700 hall door by pressing the numerical security code and she reported to nursing staff that Resident #163 was outside unsupervised. She indicated that Housekeeper #1 walked the resident back inside through the 700 hall door. This interview with Housekeeper #2 continued. She was asked how Resident #163 got out of the building. She stated that she did not know how Resident #163 had gotten out. She was asked if any changes had been made to the utilization of the exit doors that required a numerical security code. She indicated that the numerical code was changed regularly, but that the new code was given out department heads and then distributed to staff. She revealed staff still utilized these exit doors.	F 689	incident report with a root cause analysis and care plans are updated accordingly. " The Administrator and/or DON will report their findings and subsequent corrective actions to the monthly Quality Improvement Committee for any recommendations, recommended actions and monitoring for continued compliance in this area. " The Administrator will monitor the weekly door checks through the TELS program bi-weekly for completion for 3 months then monthly thereafter. The QI Nurse will monitor the documentation of checking placement of wander guards weekly for 3 months then monthly thereafter. " The Administrator will be responsible for implementation of this plan. The Director of Nursing will monitor the documentation of functionality checks bi-weekly for 3 months then monthly thereafter. The results of the findings will be reported to the QI committee monthly by the Administrator, QI Nurse and DON respectively. The administrator consulted with the medical director and the nurse practitioner regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	

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An interview was conducted with Nurse #2 on 11/15/18 at 12:39 PM. She confirmed she was assigned to Resident #163 on 7/22/18 at the time of his unsupervised exit. She additionally confirmed Resident #163 was wearing a wanderguard, had been an identified wanderer, and was cognitively impaired. She reported that she was unable to recall very many specifics about the incident. Nurse #2 stated that she was on her lunchbreak at the time Resident #163 was found outside unsupervised by two housekeepers (Housekeeper #1 and Housekeeper #2). She indicated that Nurse #3 was the person who informed her that Resident #163 had been found outside. She stated that she was unable to recall when she had last seen Resident #163 prior to the time he was found outside unsupervised. She indicated that once she was informed of the incident she checked Resident #163 ' s wanderguard for placement, but she could not recall if she had checked it for functioning. Nurse #2 stated she changed Resident #163 ' s wanderguard as a precaution. She reported she informed Nurse Supervisor #1 verbally and then she called the Director of Nursing (DON). She indicated that Resident #163 was moved to the locked memory care unit about 10 minutes after the incident.

This interview with Nurse #2 continued. She was asked how Resident #163 got out of the building. She stated that it was never determined how Resident #163 exited the building. She was asked if any changes had been made to the utilization of the exit doors that required a numerical security code. She indicated that the numerical code was changed regularly, but that the new code was given out department heads,

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distributed to staff, and was sometimes given to visitors. Nurse #2 revealed staff and visitors still utilized these exit doors.

An interview was conducted with Nurse Supervisor #1 on 11/15/18 3:23 PM. She confirmed she was working at the time of Resident #163 ' s unsupervised exit from the building on 7/22/18. She additionally confirmed that Resident #163 was an identified wanderer, he was wearing a wanderguard, and he was cognitively impaired. She stated that he wandered into other residents ' rooms and all throughout the facility during the time when he was on the unlocked unit. Nurse Supervisor #1 spoke about the incident on 7/22/18. She stated that Housekeeper #1 found Resident #163 outside of the building at the picnic tables adjacent to the rear parking lot. She reported that he was disoriented times 3 when he was brought inside the building. She indicated that a 100% head count was conducted to ensure all residents were in the building. Resident #163 ' s wanderguard was checked for placement. She stated she had not recalled if his wanderguard was checked for functioning. Nurse Supervisor #1 indicated that all of the exit doors were checked to ensure they were locked and they found no problems. She reported that Resident #163 was moved to the locked memory care unit that same afternoon. She stated she asked Nurse #2 when she had last seen Resident #163 and she thought it was about 10 minutes prior to her lunchbreak. She indicated it was estimated Resident #163 was outside unsupervised for about 15 minutes.

This interview with Nurse Supervisor #1 continued. Nurse Supervisor #1 revealed it was

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F 689	Continued From page 92 never determined how Resident #163 had gotten out of the building. She stated that they didn ' t know if he slipped out behind a staff member or a visitor when they exited the building. She reported that Resident #163 ambulated independently, he walked fast, and he also looked like he could have been a visitor at the building rather than a resident. Nurse Supervisor #1 stated that another possibility was for Resident #163 to have exited the building behind a resident who was deemed as a safe smoker and had knowledge of the numerical security code to unlock the dining room exit door. She explained that safe smokers were given the security code so that they could enter and exit the building through the dining room exit door to access the smoking area independently. She reported that the numerical security code was changed regularly, but that the new code was given out to staff, visitors, and the safe smokers. Nurse Supervisor #1 revealed that there had been no changes with the security code being provided to staff, visitors, or the safe smoking residents since the incident. She stated that these exit doors continued to be utilized. An interview was conducted with Nurse #3 on 11/16/18 at 10:25 AM. She confirmed she was working at the time of Resident #163 ' s unsupervised exit from the building on 7/22/18. She additionally confirmed that Resident #163 was an identified wanderer, he was wearing a wanderguard, and he was cognitively impaired. She indicated that on 7/22/18 Housekeeper #2 came in and told her that Resident #163 was found outside unsupervised and that Housekeeper #1 was bringing him inside. She stated that she informed Nurse #2, Resident #163 ' s assigned nurse at that time, because she	F 689		

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was on her lunchbreak. She then informed Nurse Supervisor #1 verbally. She reported that Resident #163 was moved to the locked memory care unit shortly after being brought back inside.

This interview with Nurse #3 continued. She was asked how Resident #163 got out of the building. She stated that it was never determined how Resident #163 exited the building. She was asked if any changes had been made to the utilization of the exit doors that required a numerical security code. She indicated that the numerical code was changed regularly, but that the new code was given out department heads, distributed to staff, and was sometimes given to visitors. Nurse #3 revealed staff and visitors still utilized these exit doors.

A phone interview was attempted with Nursing Assistant (NA) #3 on 11/15/18 at 1:57 PM and 11/16/18 at 8:56 AM. She was unable to be reached for interview. NA #3 was assigned to Resident #163 at the time of his unsupervised exit on 7/22/18.

A phone interview was conducted with NA #4 on 11/15/18 at 2:30 PM. She confirmed she was working on Resident #163 ' s unit (100 hall) at the time of his unsupervised exit on 7/22/18. She was not able to recall any specific details of the incident. NA #4 stated that Resident #163 was a known wanderer and that the staff had to keep an eye on him at all times. She reported he wandered in and out of other residents ' rooms throughout the day as well as throughout the halls of the facility.

An interview was conducted with the Maintenance Director on 11/15/18 at 4:10 PM. He stated that

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F 689	Continued From page 94 he was not working at the time of Resident #163 ' s unsupervised exit from the building on 7/22/18 and he had not been involved in the investigation of the incident. He revealed he had no knowledge that a resident had exited the building unsupervised. The Maintenance Director provided information on all of the buildings exits. He reported that there were 10 exits, all equipped for the wanderguard system, that Resident #163 could have potentially exited the building from. The distances from the 10 exits to the picnic shelter area where Resident #163 was found ranged from 167 feet to 954 feet. He stated that he changed the numerical security codes for the exit doors about once a week. He stated that the codes were provided to staff each time they were changed as the staff members exited the building through a variety of the exit doors. He indicated that there had been no changes made with the usage of any of these exit doors. The Maintenance Director was asked if any monitoring was conducted on the exit doors to ensure they were functioning properly. He reported he checked the functionality of the exit doors locking systems weekly using the computer system TELS (The Equipment Lifecycle System) to electronically log the monitoring. The Maintenance Director provided documentation from the TELS log to verify this weekly monitoring from July 2018 through present (11/15/18). An interview was conducted with the Quality Improvement (QI) Nurse on 11/15/18 at 3:20 PM. She was responsible for oversight of the wanderguard function and placement monitoring. She stated that the third shift nursing staff was supposed to be checking wanderguards daily for function and placement. She revealed that about a week ago she identified that this task was not	F 689		

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F 689	Continued From page 95 being done for any of the residents with wanderguards. The QI Nurse was unable to recall how she identified this lapse in monitoring, but she acknowledged that it was her responsibility for ensuring this task was completed and that as of this date (11/15/18) the wanderguard monitoring was re-initiated for all residents with wanderguards. An interview was conducted with the DON on 11/15/18 at 4:20 PM. She stated that she was aware the QI Nurse discovered that the third shift nursing staff were not checking wanderguards daily for function and placement. The DON was unable to offer an explanation as to how this system failure related to wanderguard monitoring had occurred. On 11/16/18 at 9:20 AM the Assistant Administrator provided a wanderguard monitoring log dated June 2018 that indicated Resident #163 ' s wanderguard had been checked for function and placement on 11 of 29 days. There were 8 days in June that had not indicated Resident #163 ' s wanderguard was checked for function and placement (6/17/18, 6/22/18 through 6/25/18, and 6/28/18 through 6/30/18). An interview was conducted with the Assistant Administrator on 11/16/18 at 9:21 AM. She was asked where the monitoring for Resident #163 ' s monitoring was for July 2018 through 11/14/18. She stated that there was no evidence of function and placement monitoring for Resident #163 ' s wanderguard from July 2018 through 11/14/18. She revealed the facility identified a system failure with wanderguard monitoring and had re-initiated the monitoring as of 11/15/18 by placing the wanderguard monitoring for function	F 689		

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and placement on the Medication Administration Records (MARs). The Assistant Administrator explained that wanderguard monitoring had not been documented in the medical record prior to 11/15/18. She further explained that this monitoring had been documented on a separate form that was kept at the nursing stations and that each nursing station had a list of residents who resided on that unit with wanderguards in place.

An interview was conducted with the Administrator on 11/15/18 at 12:20 PM. She confirmed Resident #163 had an unsupervised exit from the facility on 7/22/18 around 12:00 PM. She additionally confirmed Resident #163 had been identified as wanderer, he had exit seeking behavior, and he had a wanderguard in place prior to the unsupervised exit (7/22/18). She reported that Resident #163 was initially admitted to the locked memory care unit (500 hall) related to fluctuating confusion, dementia related to alcohol abuse, and his family ' s request to place him on the locked unit as Resident #163 was alcohol seeking. She revealed he was moved off of the locked unit on 7/10/18. The Administrator was asked what precipitated Resident #163 ' s move to an unlocked unit. She stated that Resident #163 had reported he was not happy being on the locked unit and in an effort to promote his dignity he was moved to an unlocked unit.

This interview with the Administrator continued. She stated that when Resident #163 was brought back in the building on 7/22/18 after his unsupervised exit, his wanderguard was checked for placement, the wanderguard was replaced as a precaution, and he was moved to the locked

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memory care unit. The Administrator was asked if Resident #163 ' s wanderguard had been checked on 7/22/18 after his unsupervised exit to ensure it was properly functioning at the time of his exit to rule out improper wanderguard functioning as a root cause of the unsupervised exit. She stated she had not known if the wanderguard Resident #163 was wearing at the time of his unsupervised exit had been checked for functioning. The Administrator stated that there were 9 exit doors, that all doors were equipped for the wanderguard system, and that each door had a numerical security code that was required to be entered to unlock the door. She revealed that it had never been determined which exit Resident #163 used to get out of the building. She additionally revealed there had been no changes made with the usage of any of the exit doors since Resident #163 ' s unsupervised exit from the facility on 7/22/18. She stated that staff, visitors, and safe smokers continued to utilize the numerical security code to exit through a variety of the doors. The Administrator was asked how a future incident was going to be prevented if they had not determined how Resident #163 got out of the building. She stated that she believed the problem had been addressed when Resident #163 was moved to the locked memory care unit. She was asked if there were other residents with wanderguards who resided on the unlocked units. She revealed that there were several residents with wanderguards on the unlocked units. The Administrator was unable to explain how these other residents with wanderguards who resided on the unlocked units had been addressed to ensure their wanderguards were functioning properly.

The Administrator and DON were notified of the

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Immediate Jeopardy on 11/15/18 at 5:00 PM.

On 11/16/18 at 5:37 PM the facility provided the following credible allegation of Immediate Jeopardy removal:

CORRECTIVE ACTION FOR THE AFFECTED RESIDENT
· On 7/22/18, Resident #163 was found, by two members of housekeeping staff, sitting outside in the picnic area adjacent to the rear parking lot. The resident was assisted back into the facility by the two members of housekeeping staff at 12:00.
· On 7/22/18, the Hall Nurse confirmed Resident #163 ' s wander guard was in place. The wander guard bracelet was not changed.
· On 7/22/18 at 12:05 pm, Resident #163 was assessed by the Hall nurse with no injury noted.
· On 07/22/18 at 12:10 pm the RN supervisor notified the Director of Nursing (DON) of the Unsupervised exit of Res #163 and Resident was transferred to the SPARKS (Secured Dementia) unit. The resident is currently wearing a Wanderguard. The Wanderguard was checked for functionality 11/7/18 by the QI Nurse and re-checked by the DON for functionality on 11/15/18.
· On 7 /22 /18 at 12:16pm, Resident #1 ' s physician was notified by the administrator of the resident ' s unsupervised exit.
· On 7/22 /18, at 12:16pm Resident #163 ' s Resident Representative (RR) was notified by the staff nurse of the unsupervised exit.
· On 7/24 /18, the Minimum Data Set (MDS) nurse confirmed Resident #163 was already assessed for At Risk of Wandering, wander guard was on and functional when checked by the admissions director 6/13/18. The resident was admitted to the facility on 6/12/18, the resident

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F 689	Continued From page 99 was assessed for risk for wandering on 6/13/18, the assessment revealed a score of 6 out of 21 total points. The Wandering Risk evaluation assessment was completed by the Registered Nurse QI Nurse. · On 7/24 /18, Resident #163 ' s wandering assessment was re-assessed on by the QI nurse and resulted in a score of 10 out of 21 total points. Resident #163 ' s care plan and care guide were reviewed and updated as appropriate on 7/23/18 by the MDS nurse. · On 7/22/18 at 12:10 pm the RN Staff Nurse documented the Wanderguard was intact to right lower leg. · On 7/22/18 at 12:05 pm The RN Supervisor on duty conducted 100% observation audit of all exit doors, the result of this audit showed no negative findings. The audit included checking all exit doors for functionality of alarms and / or locks. The RN Supervisor verbally reported the completion and results of the door audit to the Director of Nursing on 7/22/18. The RN Supervisor documented the audit in the written statement on 11/15/18. · The Maintenance Director checks weekly the functionality of the locking system on all exit doors. The Maintenance Director documents the results of all weekly checks in the TELS computer system. On 11/16/18 the Assistant Administrator printed from the TELS computer system of the Logbook Report of the Resident Monitoring Systems from 6/2/18 through 11/10/18. The Report reveals that weekly door checks have occurred since 6/2/18. · On 11/7/18 the QI nurse checked the functionality of Res # 163 ' s Wanderguard. On 11/15/18 at 8:55 pm the DON performed an observation audit on Res # 163 ' s Wanderguard for functionality and the Wanderguard was	F 689		

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F 689	Continued From page 100 properly functioning with an expiration date of 10/2020. · During the investigation of the unsupervised exit that was initiated on 7/22/18, witness statements were obtained from two housekeepers that observed the resident in the outside picnic area and the RN Staff Nurse. Res # 163 was interviewed and was unable to verbalize the exit path that was taken. The RN supervisor interviewed other staff members and communicated to the DON the inability to determine that actual exit path of Res #163. Res #163 was placed in the secured dementia unit at 12:10 pm by the RN supervisor. The RN Staff Nurse notified the Resident Representative and MD of placement in the Secured Dementia Unit. The resident has remained in the Secured Dementia Unit since 7/22/18 without any further unsupervised exits. · On 11/15/18 at 8:30 pm the Quality Improvement Action Team met to perform a further detailed Root Cause Analysis (RCA) of the Unsupervised Exit of Resident # 163 on 7/22/18. The QI Action team consisted of the Regional Vice President, Administrator, Director of Nursing, Social Services, Admissions Director, Nursing Supervisor, MDS Nurses, Payroll and Accounts Receivable Bookkeepers, Assistant Administrator and Facility RN Consultant. As a result of the RCA, the QI Action Team determined that there were only three probable exit paths that Res #163 could have taken on 7/22/18. The Areas of Concern were discussed, and possible solutions were determined, and goals date were set for action items. CORRECTIVE ACTION FOR RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED · On 7/22/18, the RN Supervisor completed a	F 689		

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F 689	Continued From page 101 100% head count audit to ensure all other residents were accounted for: no negative findings, all present. · On 11/15/18 at 6:55 pm the Director of Nursing completed a 100% audit of placement and functionality, utilizing the Secure Care Products 707 Tester, of all wanderguards currently in use and documented the expiration dates of each wanderguard currently in use. Results of the audit determined that all wanderguards were in place and functional for the 37 residents identified at risk for wandering. Wanderguards are placed on residents that are identified at risk for elopement. These 37 residents were identified as wanderers by results of the completion of the Wandering Risk Evaluation. · On 11/15/18 the Nursing Supervisor was in-serviced by the Administrator and Director of Nursing that when initiating the investigation for an unsupervised exit, to promptly check the resident wanderguard for placement and functionality as well as checking all exit doors for functionality. The in-service included the use of the Action Checklist for Unsupervised Exit form. · On 11/15/18 at 5:45 pm the administrator in-serviced the department heads regarding the Action Checklist for Unsupervised Exit, processes for notification of Administrator and Director of Nursing. The Action Checklist for Unsupervised Exits is a guideline that directs actions to be taken by facility staff and administration when an incident of Unsupervised Exits occurs including checking the functionality of the wanderguard and all doors for functionality. · On 11/15/18 at 6:15pm the RN Supervisor #1 and RN #2 began inservices to all staff members on duty regarding the Action Checklist for Unsupervised Exits for Nursing Staff. The facility will utilize the current personnel roster to ensure	F 689		

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F 689	Continued From page 102 that all staff members are inserviced on actions to be taken when an Unsupervised Exit occurs. The Action Checklist for Unsupervised Exits for Nursing Staff is a guideline of tasks for staff to perform when a door alarm is sounding, if a resident is missing or exits without supervision. · The staff members will be inserviced starting 11/15/18 to determine the exit door that is sounding, and the appropriate response to the alarm including, going outside and check the area to include the perimeter to assure that a resident has not exited unsupervised, notification of Nursing Supervisor or Unit Nurse of resident ' s unsupervised exit if resident is observed outside, complete a 100% head count of all current residents. If a resident is observed outside staff member should remain with resident and escort resident back into the facility. Staff were made aware of their responsibility to follow the care plan and care guide for residents at risk for wandering, including heightened awareness of those resident ' s location. · The facility staff will be inserviced prior to working their next assigned shift. · On 11/15/18 at 7:35 pm the Maintenance Director and Maintenance Assistant completed 100% audit of all exit doors for functionality, 100 % of doors were functional. The facility has 10 exit doors that are all equipped with a Secure Care automatic locking / alarming system. The Maintenance Director and the Maintenance Assistant visually and manually checked the functionality of all exit doors. · As a result of the RCA completed on 11/15/18, it was determined that there are three doors that if the security code is entered the wanderguard does not trigger the alarm. These three doors are used by visitors, staff and vendors. The door automatically resets each time the door is closed	F 689		

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requiring the code to be re-entered to open the door again. The Door codes are only communicated to staff members. The solution implemented by the facility included written signage at all exit doors that states "For our residents ' safety, please do not assist resident outside the door without notify staff first". Additionally, the facility mailed a letter on 11/16/18 to all Families and Resident Representatives.
· On 11/15/18 at 7:00 pm the MDS nurse #1 completed a 100% audit of residents that have been identified as a risk for unsupervised exits, have a current Wandering Risk Evaluation and documentation on the care plan and resident care guide. Results of the audit identified 13 residents with evaluation assessments dates older than 3 months.
· On 11/15/18 at 8:51 pm The QI nurse completed the Wandering Risk Evaluations on those residents identified from the MDS Nurse #1 audit.
· On 11/15/18 at 7 pm the MDS nurse #2 completed a 100% Audit of current pictures in the Wanderguard Notebook for residents that have been identified at risk for Unsupervised Exits and require a wanderguard monitor. The audit revealed 2 residents did not have current photos. The Social Worker #1 obtained and printed photos for these 2 residents and placed them in the appropriate notebook.

WHAT MEASURES WERE PUT INTO PLACE OF SYSTEMIC CHANGES MADE
· Starting 11/15/18 the bracelet placement of the wanderguard will be documented daily by the licensed nurse on 11-7 shift assigned to the resident. The licensed nurses on 11-7 shift will be educated by the Director of Nurses starting 11/15/18 on the process of checking the

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F 689	Continued From page 104 placement and documenting the placement on the MAR (Medication Administration record). · Beginning 11/15/18, the QI nurse will be responsible for documenting weekly the functionality of the wanderguards. The QI nurse will document the functionality on the Transmitter Tester Log form. Each resident will have an individual Transmitter Form. The QI nurse will be responsible for tracking the expiration dates of individual wanderguards and replacing the wanderguard prior to the expiration date. On 11/15/18, the DON will educate the QI nurse on the process to document the weekly functionality of wanderguard and tracking the expiration date and replacing the wanderguards prior to expiration. · The Maintenance Director will be responsible for weekly checking of the functionality of the SecureCare door system. The documentation will be uploaded into the TELS computer system. The TELS computer system is a Maintenance Communication Tracking system for work orders and Preventative Maintenance. The QI Nurse will print monthly the weekly door check reports from the TELS computer system and share it with the QI Committee. · On 11/15/18 the Social Worker completed education with the residents that are currently unsupervised smokers on the importance of not assisting other residents through the locked doors. · On 11/16/18, the administrator will hold an adhoc QI meeting, participants will include the medical director/resident ' s physician, to review the unsupervised exit, root cause analysis, identified issues, in-services, and systematic changes. HOW THE FACILITY PLANS TO MONITOR	F 689		

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F 689	Continued From page 105 MEASURES TO MAKE SURE SOLUTIONS ARE SUSTAINABLE · The Administrator and/or DON will review new behaviors, incident accident reports in the am IDT meeting to ensure all unsupervised exits have an associated incident report with a root cause analysis and care plans are updated accordingly. · The Administrator and/or DON will report their findings and subsequent corrective actions to the monthly Quality Improvement Committee for any recommendations, recommended actions and monitoring for continued compliance in this area. · The Administrator will monitor the weekly door checks through the TELS program bi-weekly for completion for 3 months then monthly thereafter. The QI Nurse will monitor the documentation of checking placement of wanderguards weekly for 3 months then monthly thereafter. · The Administrator will be responsible for implementation of this plan. The Director of Nursing will monitor the documentation of functionality checks bi-weekly for 3 months then monthly thereafter. The results of the findings will be reported to the QI committee monthly by the Administrator, QI Nurse and DON respectively. The credible allegation of Immediate Jeopardy removal was validated on 11/16/18 at 6:10 PM. Record review indicated there were 37 residents identified as wander risks. Each of the 37 residents had updated care plans, care guides, elopement risk assessments, documentation of wanderguard expiration dates, pictures in the wanderguard notebook, and wanderguard function and placement monitoring had been added to their Medication Administration Records. The revised Action Checklist was reviewed, and letters mailed to family members were verified.	F 689		

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F 689	Continued From page 106 Observations confirmed the exit doors were in proper working condition and the numerical codes were changed. The three doors noted as the wanderguard not triggering the alarm when the security code was entered were observed to lock immediately once closed. A review of inservice sign in sheets as well as staff interviews verified education was provided on 11/15/18 and 11/16/18 on investigating unsupervised exits and the revised action checklist. A phone interview conducted with the Medical Director on 11/16/18 at 6:10 PM confirmed his communication with the Administrator on 11/16/18.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff, Nurse Practitioner (NP) and Medical Director (MD) interviews and record review, the facility failed to clarify and implement Pulmonologist and hospital orders for oxygen with oxygen saturation monitoring for a resident with a diagnosis of respiratory failure for 1 (Resident#113) of 1 residents reviewed for respiratory care. The finding included: Resident #113 was admitted 7/10/14 with	F 695	F695 Respiratory, Tracheotomy Care, and Suctioning How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #113'□s orders were clarified by the RN supervisor with the attending physician/medical director and implemented in regard to oxygen with oxygen saturation monitoring on 11/16/18.	12/16/18

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F 695	Continued From page 107 cumulative diagnoses of Chronic Obstructive Pulmonary Disease (COPD), sleep apnea and respiratory failure. Review of Resident #113's August 2018 Physician Orders read she was ordered oxygen at 4 liters per minute via nasal cannula (NC) at bed time and for the nurse to check her oxygen saturation level on every shift. Review of Resident #113's August 2018 Medication Administration Record (MAR) read the nursing initials verifying the use of oxygen at 4 liters via NC at bed time and monitoring her oxygen saturation levels every shift. Review of a Pulmonology Visit Note dated 8/20/18 read due to her chronic respiratory failure the plan was to continue her oxygen at 3 liters at rest and 5 liters at night. Review of Resident #113's oxygen saturation monitoring record stopped on 8/30/18 when she was hospitalized. Each oxygen saturation level documented was with Resident #113 wearing oxygen. After 8/30/18, there was no evidence of oxygen saturation monitoring every shift. Review of a nursing note dated 8/30/18 at 10:46 AM read Resident #113 was sent to the emergency room for a change in her mental status She was admitted to the hospital with a ventriculoperitoneal (VP) shunt failure with replacement and pneumonia. A VP shunt is a device that relieve excessive pressure on the brain. She was discharged back to the facility on 9/13/18. The discharge summary read Resident #133 was to receive oxygen at 3 liters and then wean off as tolerated.	F 695	How the facility will identify other residents having the potential to be affected by the same deficient practice Beginning on 11/19/18 the RN QI nurse conducted a 100% audit of all residents currently receiving oxygen therapy to determine that orders were clarified and implemented as written by the physician. There were no adverse findings. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur All residents with new oxygen orders will be reviewed daily in the interdisciplinary team (IDT) meeting to ensure that orders are clarified and implemented. How the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing (DON) and/or RN QI nurse will perform a 10% audit for residents with orders for oxygen saturation levels monthly times three months then quarterly thereafter. The DON and/or QI nurse will share the results of oxygen audits with the interdisciplinary team (IDT) monthly for three months and then quarterly thereafter. The DON and/or RN QI nurse will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement	

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F 695	Continued From page 108 Review of Resident #113's readmission orders dated 9/13/18 did not include any orders for oxygen except for the standing order of oxygen at 2-3 liters per minute via NC for shortness of breath and there were no orders to resume oxygen saturation monitoring. Review of Resident #113's September 2018 MAR from 9/13/18 to 9/30/18 did not include any mention of oxygen or oxygen saturation monitoring. Review of a NP note dated 9/14/18 at 2:41 PM, read Resident #113 had chronic hypoxic respiratory failure and was worsened by pneumonia. The note read she was placed on a higher oxygen concentration of 3 liters when readmitted on 9/13/18. Review of a NP note dated 9/19/18 at 9:02 AM read Resident #113 oxygen saturation was 92% on room air. The note read she chronically wore oxygen however at the time, Resident #113 had removed her oxygen. She was encouraged to wear per prescribed oxygen. Review of Resident #113's quarterly/5-day Minimum Data Set (MDS) dated 9/20/18 indicated she was cognitively intact and exhibited no behaviors. She was coded for receiving oxygen therapy. Review of Resident #113's October 2018 orders did not include any orders for oxygen or oxygen saturation monitoring. Review of Resident #113's October 2018 MAR did not include any mention of oxygen or oxygen	F 695	(QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of accuracy of assessments. The administrator consulted with the medical director/attending physician and the nurse practitioner regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	

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F 695	Continued From page 109 saturation monitoring. Review of a NP note dated 10/8/18 at 9:17 AM read Resident #113's oxygen saturation was 97% wearing oxygen via NC. There was no documentation of the liter rate in the note. The note read there was no changes in her oxygen orders. Review of Resident #113's last revised care plan dated 10/18/18 read she was at risk for ineffective breathing due to her obstruction, sleep apnea and her taking off her oxygen. The interventions included administration of her oxygen as ordered. Review of a NP note dated 10/31/18 at 12:39 PM read Resident #113's oxygen saturation was 94% on 3 liters per minute via NC. The note reference Resident #113's Pulmonology Visit Note dated 8/20/18 which read the recommendation for her to have oxygen at 3 liters per minute at rest with 5 liters per minute with any exertion. Review of Resident #113's November 2018 orders did not include any orders for oxygen or oxygen saturation monitoring. Review of Resident #113's November 2018 MAR did not include any mention of oxygen or oxygen saturation monitoring. In an observation and interview on 11/13/18 at 4:33 PM, Resident #113 was wearing her oxygen via NC. The oxygen concentrator was running at 1.5 liters per minute. She stated she wore her oxygen all the time due to her poor respiratory status. She was absent of signs of air hunger or respiratory distress and voiced no shortness of breath.	F 695		

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	345146	A. BUILDING ______ B. WING ______	11/16/2018

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F 695	Continued From page 110	F 695		

In a second observation on 11/14/18 at 8:20 AM, Resident #113 was in bed eating breakfast. She was wearing her oxygen via NC and the oxygen concentrator was running at 1.5 liters per minute. She was absent of signs of air hunger or respiratory distress and voiced no shortness of breath.

In an interview on 11/14/18 at 3:02 PM, the Quality Assurance (QA) Nurse confirmed she signed off the readmission orders dated 9/13/18 when Resident #113 returned from the hospital. She stated she only verified the orders were transcribed correctly and did not verify all medications and treatments were on readmission MAR. The QA Nurse stated Resident #113 had no orders for oxygen or for oxygen saturation monitoring when she returned from the hospital because the NP and MD did not order oxygen of oxygen saturation monitoring. The QA Nurse stated there were standing orders for all residents for oxygen at 2-3 liters per minutes via NC for shortness of breath and that was what was likely initiated.

In another observation on 11/15/18 at 8:15 AM, Resident #113 was observed wearing oxygen via NC with the concentrator running at 3 liters per minute. In an interview with Nursing Assistant (NA) #15 stated Resident #113 always wears oxygen.

In a telephone call on 11/15/18 at 8:55 AM, Nurse #5 confirmed she wrote the readmission nursing note dated 9/13/18 at 3:40 PM that read Resident #113 was admitted wearing oxygen at 3 liters per minute via NC but that she only wore the oxygen

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F 695	Continued From page 111 if she needed it. In an interview on 11/15/18 at 9:00 AM, the NP stated she had no expectation for the facility staff to be monitoring Resident #113's oxygen saturation because she assessed her oxygen saturation when she went in the see her. The NP further stated the new orders for Resident #113 to have oxygen at 3 liters per minutes when she was discharged from the hospital on 9/13/18 was an oversight. The NP further stated Resident #113 was being followed by a Pulmonologist routinely who made her oxygen recommendation. The NP was unable to explain why the Pulmonologist recommendation of oxygen at 5 liters per minute via NC were not implemented in August 2018. In an observation on 11/15/18 at 10:40 AM, Resident #113 was observed in the rehabilitation room wearing oxygen at 3 liters per minute via NC with a portable tank attached to her wheelchair. A review of Resident #113's medical record revealed the NP saw Resident #113 on 11/16/18 and made no recommendations for oxygen or oxygen saturation monitoring. In a telephone interview on 11/16/18 at 5:00 PM, the MD stated it was his expectation that when Resident #113 returned from her Pulmonology visit in August 2018 that the recommendations for her oxygen would have been implemented. He stated it was his expectation that on her readmission to the facility on 9/13/18, the facility would have contacted him for clarification of her oxygen orders and obtained orders to have her oxygen saturation level assessed every shift.	F 695		

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F 695	Continued From page 112 Review of Resident #113's medical record revealed new orders dated 11/16/18 for Resident #113 to have oxygen at 3 liters per minute via NC during rest as needed and oxygen at 5 liters per minute via NC during exertion as needed. The orders also included oxygen saturation monitoring twice daily.	F 695		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff, Nurse Practitioner (NP) and Medical Director (MD) interviews and record review, the facility failed to evaluate and treat a resident with continued complaints of left rib pain following a fall on 10/17/18. A diagnostic x-ray dated 10/30/18 revealed fractures to the 3rd through 7th ribs on the left side. This was for 1 (Resident #30) or 1 residents reviewed for pain management. The findings included: Resident #30 was admitted on 5/15/18 with cumulative diagnoses of Atrial Fibrillation, Congestive Heart Failure, Osteoarthritis, Restless Leg Syndrome and Delusional Disorder. Resident #30's quarterly Minimum Data Set (MDS) dated 8/15/18 indicated moderate cognitive impairment with a Brief Mental Status (BIMS) score of 12. She was coded with no	F 697	F697 Pain Management How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #30 has had decreased complaints of left side rib pain and is receiving scheduled pain medication along with an additional order for PRN pain management. How the facility will identify other residents having the potential to be affected by the same deficient practice The Interdisciplinary Team reviewed all residents with reports of pain beginning 11/16/18. The review included completion of assessment, evaluation, monitoring, and treatment of complaints of pain. Three residents reported pain with	12/16/18

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F 697	Continued From page 113 behaviors and limited assistance with ambulation. Resident #30 was coded with no impairments to her upper or lower extremities. She was coded for scheduled and as needed (PRN) pain medications. Resident #30 was coded as reporting no pain and as having no falls since previous MDS assessment. Review of the nursing 24 Hour Report dated 10/16/18 read Resident #30 slid to the floor on first shift with the Physician and Responsible Party (RP) notified. The 24-Hour Report indicated Resident #30 received Tylenol 2 tablets on second shift. Review of an incident report and nursing note dated 10/17/18 at 10:43 AM read Resident #30 had an unwitnessed fall in her room. She was ambulating on her own from her wheelchair to her closet when she fell. The report and nursing note read no injury, but Resident #30 complained of left rib pain. The nursing note read a correspondence was left for the NP and Medical Director. The intervention was a therapy screen. Review of a Physician Fax Communication sheet dated 10/17/18 read Resident #30 did not fall but sat on the floor and caught herself using her walker and recliner. Resident #30 complained of left rib pain. The Nurse Practitioner (NP) wrote the word "monitor" with her initials. The NP documentation was undated. Review of the nursing 24 Hour Report dated 10/17/18 read Resident #30 received Tylenol 2 tablets at 6:00 PM. Review of the October 2018 Physician Orders and Medication Administration Record (MAR)	F 697	appropriate assessment, evaluation, monitoring and treatment administered. All reported improvement in pain levels. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The Nursing staff will be re-educated beginning 11/20/18 by the DON and/or SDC on assessment, evaluation, monitoring, and physician notification of residents with continued complaints of pain. Re-education will be completed by 12/16/18. Any staff not completing education by 12/16/18 will not be allowed to work until education completed. New hires and agency staff will receive this education during orientation to the facility. Residents exhibiting complaints of pain will be discussed in the next morning IDT meeting following the initial report of pain. Discussion will include confirmation of the notification of the attending physician, Resident Representative, interventions, and whether interventions implemented are effective. The Medical Director and nurse practitioner were made aware of the Plan of Correction and the monitoring tools in place by the administrator on 12/11/18. Neither suggested any changes to the plan. How the facility plans to monitor its performance to make sure that solutions are sustained The QI Nurse will review the IDT form for pain and/or behaviors for trending and tracking of residents with repeat complaints of pain on a weekly basis for 12 weeks.	

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F 697	Continued From page 114 read Resident #30 was receiving Neurontin (treats nerve pain) three times daily scheduled and Ultram (synthetic opioid used to treat pain) twice daily scheduled. There were also orders for Norco (opioid used to treat pain) 1 tablet as needed for pain. Review of the October 2018 MAR read Resident #30 received no as needed doses of her Norco. Review of the October 2018 MAR read a standing order for Tylenol 325 milligrams (mg) 2 tablets by mouth every 4 hours as needed for pain for 48 hours. The MAR indicated Resident #30 received Tylenol 650 mg on 10/17/18, 10/23/18, 10/24/18 and 10/26/18. Review of the Rehabilitation screen dated 10/18/18 read Resident #30 was not interested in participating in therapy. Review of the nursing 24 Hour Report dated 10/22/18 read Resident #30 complained of rib pain and received Tylenol on third shift. Review of a nursing 24 Hour Report dated 10/23/18 read Resident #30 went out of the facility with her RP on first shift. Review of a Physician Fax Communication dated 10/23/18 read Resident #30 continues to complain of left upper rib pain and stated she was going to have her RP drop her off at the hospital for evaluation if something was not done. The NP documented per Nurse #4, "no complaints" with the date 10/24/18 and her initials. Review of a nursing note dated 10/29/18 at 4:56	F 697	The QI Nurse will present IDT corrective actions and reported abuse/neglect, suicidal actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the executive QI committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area pain management. The administrator consulted with the medical director/attending physician and the nurse practitioner regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	

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F 697	Continued From page 115 PM read Resident #30 was complaining of soreness to her left side and left arm. Resident #30 requested an x-ray and the NP was notified. Review of an x-ray report dated 10/30/18 read as follows: Minimal displaced fractures of the third through seventh posterior lateral ribs left side suggested. The x-ray was undated but initialed by the NP. Review of Resident #30's MAR read an order dated 10/30/18 for Biofreeze (topical pain reliever) four times daily to her neck. Review of a NP note dated 10/30/18 at 2:11 PM, read in part as follows: Resident #30 had a fall approximately 2 weeks ago and continues to have left lower rib cage pain that worsens with coughing, deep breaths or with repositioning in bed. Resident #30 stated her pain medications do help alleviate the pain somewhat, but she is still very concerned since it is ongoing. Resident #30 stated otherwise, she is doing okay and has no complaints. Review of the November 2018 MAR read Resident #30 received no as needed doses of her Norco or Tylenol. In an interview on 11/13/18 at 4:49 PM, Resident #30 reported she fell in October and immediately experienced left side pain. She stated she broke her ribs and she received no x-ray and saw no NP or MD until two weeks after the fall. She stated the pain was bad but has improved. She stated she continues to have pain with movement in bed and on transfers. She reached to guard her left side with facial grimacing.	F 697		

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F 697	Continued From page 116	F 697		

Resident #30's care plan last revised on 11/14/18 indicated she was at risk for pain related to complaints of soreness and discomfort to her left side and left arm on 10/29/18. The care plan revised 11/14/18 also read her x-ray dated 10/30/18 indicated fractures of her left 3rd through 7th ribs. Interventions included listening to her complaints of pain, medications as ordered, documenting verbal and non-verbal indicators of pain and notification of the physician if pain management was not effective.

In an interview on 11/14/18 at 2:35 PM, Nurse #4 stated she was assigned Resident #30 most days and assigned to her the day she fell. She stated the NP was in the building that day and spoke to the NP about Resident #30's complaints of left side pain. She stated the NP told her to monitor Resident #30 and administer the prn Tylenol if she needed it for pain. Nurse #4 stated about a week later, Resident #30 was still complaining of pain to her left side so Nurse Supervisor #3 requested an x-ray order from the NP. Nurse #4 confirmed she did not report Resident #30's continued complaints of pain until she sent the NP the Physician Fax Communication form dated 10/23/18.

In an interview on 11/14/18 at 2:45 PM, Nursing Assistant (NA) #10 stated Resident #30 complained of left side pain after the fall and she reported it to Nurse #4. She confirmed Resident #30 continues to complain of occasional pain with transfers.

In an interview on 11/14/18 at 3:05 PM, Nurse Supervisor #3 stated she was aware that Resident #30 had a fall and was experiencing left side pain. She stated the NP wanted nursing staff

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F 697	Continued From page 117	F 697		

to monitor her for continued or worsening of the pain. She stated the NP wanted nursing staff to monitor her for continued or worsening of the pain but confirmed there was little documentation to suggest the nurses were monitoring Resident #30's continued complaints of pain to her left side. She stated she contacted the NP on 10/29/18 and requested an x-ray because Resident #30 requested it.

In an interview on 11/15/18 at 8:50 AM, NA #11 stated Resident #30 has complained of pain to her left side with care. NA #11 stated when Resident #30 complained of pain, she would report it to her assigned nurse.

In an interview on 11/15/18 at 9:00 AM, the NP stated it was her expectation that when she directed the nursing staff to monitor Resident #30, they would have contacted her if she got worse, but she was likely going to be sore from the fall. The NP stated staff reported to her that Resident #30 was going out with her RP and she was able to function at her baseline. The NP stated when the Nurse #4 faxed her on 10/23/18, she stopped in to see Resident #30, but she was out of the facility with her RP and she was not notified again until 10/29/18 by Nurse Supervisor #3. The NP stated that was when she ordered the x-ray. The NP confirmed the x-ray results of 5 fractured left side ribs. She stated there was no need for additional treatment and that Resident #30 was already taking Ultram twice daily for pain and Tylenol as needed. The NP stated she did not routinely review the nursing notes but rather relied on the staff calling her for sending her a Physician Communication Fax form. The NP confirmed she was at the facility daily Monday through Friday and available by phone when she

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F 697	Continued From page 118 was not at the facility. In a second interview on 11/15/18 at 10:40 AM, Resident #30 was sitting up in her wheelchair with NA #11 present in the room. Resident #30 complained of left side pain where she broke her ribs. She was guarded of her left side with facial grimacing. NA #11 heard Resident #30's complaint of pain and stated she would notify her nurse. In an interview on 11/15/18 at 5:40 PM, Nurse #6 confirmed she was assigned Resident #30 and had cared for her since beginning her shift at 7:00 AM on 11/15/18. She stated NA #11 did not inform her that Resident #30 voiced left side pain earlier today after breakfast and that Resident #30 had not complained of pain to her, but she was due her scheduled Ultram and would assess Resident #30. A telephone call was made to Resident #30's RP at both phone numbers listed with messages left to call surveyor. At time of exit, there had been no return call from RP. In an interview on 11/16/18 at 8:20 AM, Resident #30 stated she was feeling better today. She stated her RP told her to take it easy and rest. In a second interview on 11/16/18 at 10:20 AM, the NP stated it was her expectation that when NA #11 heard Resident #30 complain of left side pain on 11/15/18, she would have reported it to Resident #30's nurse. A telephone call was made to NA #11 on 11/16/18 at 11:18 AM with a message left to call the surveyor regarding not reporting Resident #30's	F 697		

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F 697	Continued From page 119 complaints of pain on 11/15/18. At the time of exit, there had been no return phone call. In a telephone call on 11/16/18 at 11:35 AM, NA #12 confirmed she was assigned Resident #30 on 10/19/18 and 10/22/18 for second shift. She stated she recalled Resident #30 complaining of left rib pain especially when toileting and that she could not use her left arm to reach due to the pain. NA #12 stated she reported the pain the Resident #30's nurse on both days. In a telephone call on 11/16/18 a 11:42 AM, NA #13 confirmed she was assigned Resident #30 on 10/18/18 for third shift. She stated she recalled Resident #30 stated she was sore from the fall, but NA #13 could not recall if she reported anything to the nurse. In a second interview on 11/16/18 at 11:55 AM, NA #10 confirmed she was assigned Resident #30 first shift on 10/17/18, 10/18/18, 10/19/18, 10/20/18, 10/21/18, 10/23/18, 10/24/18, 10/26/18 and 10/30/18. NA #10 stated Resident #30 did complain of left side pain on occasion, but she always reported the complaints to the nurse. In an interview on 11/16/18 at 12:30 PM, Nurse #7 confirmed he was assigned Resident #30 on 10/19/18, 10/26/18, 10/27/18 and 10/28. He stated he worked those days from 7:00 AM to 7:00 PM. Nurse #7 stated he received no notification that Resident #30 complained of pain and that she never complained of pain when he went in to give her medications. In a telephone interview on 11/16/18 at 5:00 PM, the MD stated it was his expectation that there would have been assessment completed by the	F 697		

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F 697	Continued From page 120 NP at the time when Resident #30 first complained of pain on 10/17/18 and x-ray would have been ordered at that time to rule out injury. He further stated it was his expectation there were timely interventions for pain management. Review of the medical record indicated new orders dated 11/16/18 for Resident #30 to have a pain assessment completed three times daily while awake for 2 weeks and to administer the prn Norco for pain as ordered.	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to follow the physician ' s order for fluid restriction (Resident #61) for 1 of 1 residents reviewed for dialysis. Findings included: Resident #61 was re-admitted to the facility on 7/11/08 with the diagnosis of end-stage renal disease (ESRD). A review of the last Registered Dietician (RD) progress note dated 11/10/16 revealed the resident had a 1500 milliliter per day fluid restriction.	F 698	698 Dialysis How corrective action will be accomplished for those residents found to have been affected by the deficient practice Orders for resident #61 were reviewed by the registered dietician 11/19/18. The resident was educated regarding risk versus benefits of unrestricted fluid intake while receiving dialysis. The dietician adjusted the daily fluid intake offered in his diet to reflect the fluid restriction orders. The water pitcher was removed from the resident room. How the facility will identify other residents having the potential to be affected by the	12/16/18

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BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(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 698	Continued From page 121 A review of the resident ' s annual Minimum Data Set dated 9/24/18 revealed the resident had an intact cognition. The resident required supervision with set up only for his activities of daily living. Active diagnoses were ESRD and diabetes. The resident received dialysis three times a week. A review of the resident ' s care plan dated 9/24/18 revealed fluid restriction of 1500 milliliters per day and dialysis on Monday, Wednesday, and Friday. A review of the resident ' s physician monthly order dated 11/1/18 revealed fluid restriction of 1500 milliliters in a 24-hour period. Four ounces of nutritional supplement were ordered twice a day A review of the resident ' s October and November medication administration record (MAR) revealed the resident received his 4 ounces of nutritional supplement each day. A review of the resident's fluid intake documentation by the nursing assistant for the past 30 days revealed fluid intake varied from 240 to 840 milliliters each day. Nurse's note look-back for the past 90 days did not have the total daily fluid intake documented in the record. On 11/15/18 at 12:15 pm an interview was conducted with Nurse #8 who was assigned to Resident #61. Nurse #8 reviewed the MAR and stated she provided 480 milliliters of fluids for medication on day shift and was not aware of the amount of fluid the resident consumed during	F 698	same deficient practice To protect residents in similar situations, beginning on 11/19/18 the RN QI Nurse conducted a 100% audit of the residents on dialysis including resident #61. No other fluid restriction orders are in place. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Any residents with new orders for dialysis or fluid restrictions will be reviewed in the morning IDT meeting to ensure that orders are carried out and communicated to staff. Beginning on 11/17/18 all licensed nurses were re-educated by the staff development RN on the need to monitor fluid intake for those residents with fluid restriction orders and to provide risk versus benefits education to those residents who are non-compliant with physician orders for fluid restriction. Re-education will be completed by 12/16/18. No nurses will be allowed to work after 12/16/18 until education is received. Education on fluid restriction will be included in new hire education for all licensed nurses including any agency staff. Certified Nursing Assistants (CNA)'s will be instructed to review care guides for any residents with fluid restrictions and appropriate actions for those residents. Geriatric Care Assistants (GCA)'s will be educated regarding appropriate measures for residents with fluid restrictions. All new CNAs and GCA's will be educated on fluid restriction during orientation. CNA's and GCA's will receive education before working their assigned shift.	

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F 698 Continued From page 122

other shifts or the amount of fluid provided by dietary on the 3 meal trays for Resident #61. Nurse #8 stated that she did not document Resident #61's fluid intake for her shift. Nurse #8 stated the nursing assistant documented what they provided to each resident. Nurse #8 indicated that Resident #61 received a full pitcher of ice this shift, and all residents have their pitcher refilled with ice each shift. Nurse #8 did not know how many total milliliters were in a pitcher.

On 11/15/18 at 12:15 pm an interview was conducted with Nursing Assistant (NA) #9 who stated that she was aware of Resident #61's fluid restriction. NA #9 stated that Resident #61 would ask for fluids and the NA would ask the nurse first and then provided the requested drink. Nurse #9 stated that the GCA (geriatric care aide) provided the pitcher of ice to each resident each shift which was not documented in the daily intake amount. The NAs were not responsible to provide the ice and had not documented this intake.

On 11/15/18 at 12:20 pm an interview was conducted with Resident #61 who stated that he was not aware he was on a fluid restriction and had drank at least half of his water pitcher when filled each shift. The resident stated he drank the melted ice directly from his pitcher.

On 11/15/18 at 12:20 pm an observation was done of Resident #61 ' s room and a white Styrofoam pitcher half-full of ice and melted ice was on the bed-side table.

On 11/15/18 at 12:27 pm an interview was conducted with the Administrator who stated that

F 698

How the facility plans to monitor its performance to make sure that solutions are sustained
The RN QI nurse will perform an audit monthly for three months for all dialysis residents to determine if fluid restriction orders are in place and followed as ordered; then quarterly thereafter on resident on all dialysis residents thereafter.
The RN QI nurse will share the results of audits with the interdisciplinary team (IDT) at least monthly for 3 months.
The DON and/or QI RN will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations.
The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of accuracy of assessments.
The administrator consulted with the medical director and the nurse practitioner regarding the plan of correction on 12/11/18 with no changes or recommendations noted.

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the nurse or NA would document fluid intake, and the GCA would provide residents ice each shift.

On 11/15/18 12:48 pm an observation was done of Resident #61 ' s dietary ticket that documented "Thursday lunch 1500 cc per day fluid restriction give only what is on the tray."

On 11/15/18 at 12:48 pm an interview was conducted with Nurse #8 who stated that she did not provide the resident ' s fluid intake amount she administered for the NA to document.

On 11/15/18 at 4:25 pm an interview was conducted with the Dietary Manager (DM) who stated the Styrofoam pitcher holds 600 milliliters of fluid. The DM stated she was aware of Resident #61 ' s fluid restriction and all of the daily allowance was provided by dietary on the resident ' s three meal trays. The DM further stated that she was not in communication with nursing regarding the amount of fluid the resident required to take medication, amount given for his nutritional supplement, or from the ice pitcher.

On 11/16/18 at 12:09 pm an interview was conducted with the RD who stated that Resident #61 was on a 1500 milliliter per day fluid restriction which was managed between nursing and the dietary manager. The RD was not aware of how the total amount of fluid intake was provided between the two departments or by shift.

On 11/16/18 at 4:15 pm an interview was conducted with the Director of Nursing who stated she expected staff to follow the physician ' s order for fluid restriction and to coordinate that between departments accordingly.

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F 700	Continued From page 124	F 700		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to comprehensively assess the need for side rails for 4 of 4 residents (Residents #53, #88, #118, and #148) reviewed for bilateral side rails. The findings included: 1. Resident #148 was initially admitted to the facility on 10/13/17 and most recently readmitted on 12/22/17 with diagnoses that included hemiplegia (paralysis of one side of the body)	F 700	F700 Bed Rails How corrective action will be accomplished for those residents found to have been affected by the deficient practice Residents #53, #148, #88 and #118 were reassessed beginning 11/15/18 and ending 12/7/18 for the need for side rails using the Physical Device Use Evaluation form. The assessment revealed that the side rails for #53 and #118 are used by nursing staff for bed mobility while	12/16/18

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hemiparesis (weakness of one side of the body) affecting right dominant side, cognitive communication deficit and muscle weakness.

A Bed Rail Evaluation dated 11/28/17 initiated by the Quality Improvement (QI) Nurse for Resident #148 revealed a blank evaluation. There were no additional evaluations related to side rails in Resident #148 ' s record.

The 10/15/18 Annual Minimum Data Set (MDS) assessment indicated Resident #148 ' s cognition was moderately impaired. He required the extensive assistance of 2 or more for bed mobility. Transfers were indicated not to have occurred during the MDS review period.

An observation was conducted of Resident #148 on 11/16/18 at 1:45 PM. He was in bed sleeping. Resident #148 had bilateral side rails approximately 30 inches in length in place.

An interview was conducted with Resident #148 ' s family member on 11/16/18 at 1:45 PM. She stated that Resident #148 had bilateral side rails on the bed since his admission. She stated that he may have utilized the bed rails in the past, but she believed he had not used them much now. She stated that she had not recalled being provided with any education related to the risks and/or benefits of side rail usage.

An Interview was conducted with Nursing Assistant (NA) #9 on 11/16/18 at 1:50 PM. She was asked why Resident #148 had bilateral side rails. She stated that she was not sure and that he rarely utilized the side rails.

An interview was conducted with the QI Nurse on

F 700

providing care. Beginning 12/13/18 a weighted blanket was used for residents #53 and #118 when nursing staff are not providing direct care. The weighted blanket will be trialed for five days beginning 12/13/18. Should the blanket not be effective, a perimeter mattress will be trialed. The side rails were removed for resident #88 as a result of the assessment. Resident #148 was assessed to use the rail for bed mobility and positioning. The Resident Representatives for residents #53, #88, #148 and #118 were educated by 12/16/18 on risks vs. benefits for the side rails.

How the facility will identify other residents having the potential to be affected by the same deficient practice

An audit was initiated on 11/19/18 and completed 11/21/18 by the Assistant Director of Nursing (ADON)of 100% of the resident census from 11/19/18-11/21/18 to determine all residents with side rails in use. Assessments for those residents identified as having side rails in use will be completed by 12/16/18 by the Director of Nursing (DON), ADON, Quality Improvement(QI)nurse, and/or the RN Nurse Supervisors. New assessments were completed for any resident who had side rails in place but did not have a previous assessment. Any residents requiring extensive assistance with ADL's and determined to lack independent bed mobility will have alternative measures trialed for at least five days including but not limited to weighted blankets, pillows for positioning, and/or perimeter

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F 700	Continued From page 126 11/14/18 at 3:10 PM. The QI Nurse was asked about the normal process for completion of Bed Rail Evaluations. She stated that she was responsible for Bed Rail Evaluations. She explained that she was directed by her management and the corporate office to complete bed rail evaluations for every resident in the facility in November 2017. She reported that as she began completing the assessments she saw the question on each assessment that asked if education had been provided to the resident and/or Responsible Party (RP) on the risks and benefits of side rail usage. The QI Nurse revealed she was not sure what was supposed to be included in this education, so she asked the Administrator. She stated that the Administrator had contacted the Facility Nurse Consultant, but that she never received any direction of what type of education she was supposed to provide. She revealed she had not provided any education for any of the bed rail evaluations she completed. The QI Nurse indicated this Bed Rail Evaluation form was no longer in place in the electronic medical records system as of February 2018. She stated that since that time no bed rail evaluations and/or re-evaluations had been conducted. A follow up interview was conducted with the QI Nurse on 11/16/18 at 4:40 PM. The blank bed rail evaluation for Resident #148 dated 11/28/17 was reviewed with the QI Nurse. She stated that she was not sure why this assessment was completely blank as she thought she had partially filled it out. She confirmed this was one of the assessments that she had not provided education on the risks and benefits of side rail usage to the resident and/or RP. She additionally confirmed no further assessments or re-evaluations had	F 700	mattresses beginning prior to 12/16/18. Quarterly Re-assessments will be completed for all residents with side rails in use by the Director of Nursing (DON), ADON, Quality Improvement(QI)nurse, and/or the RN Nurse Supervisors. Re-education for residents with side rails in use will be provided to the residents and/or their representatives by 12/16/18 by the nurses assessing the residents and through written material provided by the administrator. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Beginning on 11/19/18 and completed by 12/16/18, all licensed nurses were re-educated regarding the assessment of the need for side rails. Education will be offered to all new nurses upon orientation and no nurses will be allowed to work until they are reeducated. Assessments for the need for side rails will be completed by a licensed nurse quarterly in conjunction with the MDS assessment. How the facility plans to monitor its performance to make sure that solutions are sustained TO monitor performance to make sure that solutions are sustained, The Director of Nursing (DON) will perform a 10% audit of all residents with side rails in use for assessment and risk versus benefits education in the areas of side rail useage for 12 weeks; then quarterly thereafter on the assessment of the need for side rail use and risk versus benefits education. The DON and or RN QI nurse will share	

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F 700	Continued From page 127 been conducted for Resident #148 ' s side rail usage. An interview was conducted with the Administrator on 11/14/18 at 4:15 PM. The Administrator confirmed she was aware that the QI Nurse had partially completed all residents ' side rail evaluations in November 2017. She additionally confirmed she was aware these were not fully completed as education was not provided to the resident and/or the RP. She stated that education on the risks and benefits should have been explained to the resident and/or RP at the time of the side rail evaluations and that re-evaluations should have been done upon any change in condition or change in interventions to determine the continued need of the side rails. 2. Resident #118 was admitted to the facility on 3/4/17 with diagnoses that included Alzheimer ' s disease, dementia with behavioral disturbance, anxiety, schizophrenia, and insomnia. A partially completed Bed Rail Evaluation for Resident #118 dated 11/28/17 was conducted by the Quality Improvement (QI) Nurse. This evaluation indicated that Resident #118 was oriented to person only with short-term and long-term memory impairment and severely impaired decision making. Her functional abilities were assessed as grasp strength within normal perimeters, range of motion/dexterity adequate, muscle weakness, and impaired balance. She had a history of falls. Resident #118 had not expressed a desire to have side rails raised while in bed for her own safety or comfort. The benefits of side rail use were noted as enabling the resident to position self in bed, enabling the	F 700	the results of the audits with the interdisciplinary team (IDT) at least weekly for 12 weeks. Any adverse findings related to side rail useage or lack of assessment will be corrected and re-education given as needed by the RN Staff Development Coordinator (SDC). The DON and/or QI RN will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of assessment of physical restraints. The administrator consulted with the medical director and the nurse practitioner regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	

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F 700	Continued From page 128 resident to rise from a supine (lying) to a sitting and/or standing position, the resident using side rails for care with staff cueing, and enabling the resident to maintain physical functional abilities. The risks included the increased potential for injuries. This assessment indicated that an alternative intervention that was attempted was physical and/or occupational therapy initiated on 7/6/17. No other alternatives or interventions were noted. The recommendations of this evaluation indicated bilateral half rails to serve as an enabler to promote independence. The evaluation asked if risks and benefits, alternatives were explained to Resident #118 and the answer indicated they had not been due to the resident ' s comprehension deficit. The evaluation asked if risks and benefits, alternatives were explained to Resident #118 ' s representative and the answer indicated they had not been as the resident ' s family member had previously been aware of bed rail usage and was in agreement. This form was not signed as complete. The quarterly MDS assessment dated 10/11/18 indicated Resident #118 ' s cognition was severely impaired. She required extensive assistance of 2 or more with bed mobility and transfers. There were no additional bed rail evaluations conducted for Resident #118 after the 11/28/17 assessment that was not fully completed. An observation was conducted of Resident #118 on 11/13/18 at 12:30 PM. Resident #118 was in bed being assisted with eating by Nursing Assistant (NA) #7. Resident #118 was alert but was not interviewable. She had bilateral side rails, approximately 30 ¾ inches in length.	F 700		

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An interview was conducted with NA #7 on 11/13/18 at 12:35 PM. She stated that Resident #118 moved around in bed, was not able to get out of bed on her own safely, and that she was a fall risk. NA #7 was asked if the bilateral side rails had prevented Resident #118 from falling out of the bed and she indicated that they had.

An interview was conducted with the QI Nurse on 11/14/18 at 3:10 PM. The Bed Rail Evaluation for Resident #118 dated 11/28/17 that was partially complete was reviewed with the QI Nurse. She confirmed that she partially completed this assessment and that it was never fully completed. She explained that she was directed by her management and the corporate office to complete bed rail evaluations for every resident in the facility in November 2017. She reported that as she began completing the assessments she saw the question on each assessment that asked if education had been provided to the resident and/or Responsible Party (RP) on the risks and benefits of side rail usage. The QI Nurse revealed she was not sure what was supposed to be included in this education, so she asked the Administrator. She stated that the Administrator had contacted the Facility Nurse Consultant, but that she never received any direction for the type of education she was supposed to provide. She stated she had not provided any education for any of the bed rail evaluations she completed, and this was why none of the assessments were marked as complete. The QI Nurse indicated this Bed Rail Evaluation form was no longer in place in the electronic medical records system as of February 2018. She stated that since that time no bed rail evaluations and/or re-evaluations had been conducted.

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An interview was conducted with the Administrator on 11/14/18 at 4:15 PM. The Administrator confirmed she was aware that the QI Nurse had partially completed all residents ' side rail evaluations in November 2017. She additionally confirmed she was aware these were not fully completed as education was not provided to the resident and/or the RP. She stated that education on the risks and benefits should have been explained to the resident and/or RP at the time of the side rail evaluations and that re-evaluations should have been done upon any change in condition or change in interventions to determine the continued need of the side rails.
3. Resident #88 was admitted to the facility 4/26/17 with diagnoses that included: Dementia with behavioral disturbance, Schizophrenia, Alzheimer's disease and osteoarthritis.

The most recent MDS (Minimum Data Set) coded as a quarterly assessment and dated 10/5/18, assessed the resident as having impaired long and short-term memory. The assessment had documentation that she required extensive assistance of 1 staff member for bed mobility and transfers and supervision for ambulation. No falls were coded during the look back period. The bed rails were not coded as a restraint.

Review of the resident's active care plan dated 10/16/18 revealed no mention of the use of bed rails.

Review of the Bed Rail Assessment dated 11/28/17 revealed the resident was to have bilateral half rails as an enabler for positioning in bed. The person who completed the bed rail assessment did not notify resident representative

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F 700	Continued From page 131	F 700		

or sign and date the assessment.

An interview was conducted on 11/14/18 at 3:10pm with the QI (Quality Improvement) nurse. She stated that she started the bed rail assessments in November 2017 when the new regulations were put into place but as of February 2018 the Bed Rail Assessments were removed from the EHR (Electronic Health Record) system by corporate. She added that since then no bed rail assessments or reevaluations have been done.

During an interview on 11/14/18 at 3:30pm with the MDS Coordinator/MDS Nurse #1 and MDS Nurse #2 they stated that the QI nurse completed the bed rail assessments. They indicated the process for bed rail assessments had changed at some point as directed by corporate, but they weren't sure of the process changes since they were not responsible for completing the assessments. They further added that bed rail use is care planned sometimes but not always.

During an interview on 11/14/18 at 4:15pm with the Administrator she stated that there was a change in the bed rail process by corporate when then new regulations were put into place. Stated that bed rail assessments were done facility wide by the QI nurse. She acknowledged that they were not given any specific direction from corporate as to what type of education should be provided so she was aware that the QI nurse did not know what type of education to provide. She stated that education of the risks and benefits should have been explained to the resident or responsible party at the time of the assessments and reassessments should have been done on any change in condition or change in

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BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

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interventions. She acknowledged the assessment was incomplete.

During an observation on 11/16/18 at 8:50am to Resident #88's bed, half rails were observed down on the left and right side of the bed. Resident was not in the bed at the time of the observation.

An interview was conducted on 11/16/18 at 1:50pm with NA #7 who stated that she had not observed the resident using the half bed rails. She stated that the resident was able to turn and reposition in bed and sit and stand independently to the bed.

An interview was conducted on 11/16/18 at 2:30pm with NA #8 who stated that Resident #88 was independent with turning and repositioning in bed without the use of siderails but that she had seen the resident use the half bed rails to push up to a standing position from the bed.

During an interview on 11/16/18 at 4:40pm with the QI nurse she stated that she did not recall speaking with Resident #88's responsible party to explain benefits, risks and alternatives when the assessment was started. She confirmed that she did not sign or date the assessment.

An interview was conducted on 11/16/18 at 4:45pm with the Director of Nursing who stated that it was her expectation for bed rail assessments to have been completed and reassessed.

4.

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F 700	Continued From page 133 A review of a partially completed side rail evaluation for Resident #53 dated 11/27/17 by the Quality Improvement (QI) Nurse revealed the resident was oriented to person only with short-term and long-term memory impairment and severely impaired decision making. The risks included the increased potential for injuries. The evaluation determined that the side rails were not warranted. The evaluation asked if risks and benefits, alternatives were explained to the resident and the answer indicated they had not been due to a comprehension deficit. This form was not signed as complete. A review of the resident ' s quarterly Minimum Data Set dated 9/20/18 revealed the resident was severely cognitively impaired and required extensive assistance for all activities of daily living. The resident was unable to make her needs known. "Physical restraints bed rail not used" was coded. A review of the resident ' s care plan updated 10/4/18 revealed a problem for skin tears which had an intervention of padded side rails to prevent skin tears. Padded side rails and winged mattress initiated on 1/11/17. On 11/13/18 at 9:30 am an observation was done of the resident ' s room and bilateral padded side rails were noted. The resident was observed in a reclining wheel chair with frequent movement of her extremities that appeared to be non-purposeful. On 11/14/18 at 2:15 pm an interview was conducted with Treatment Nurse (TN) who was assigned to Resident #53 and stated that the side rails were placed to prevent the resident from	F 700		

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F 700	Continued From page 134 falling out of bed. TN commented that the resident cannot get out of bed on her own at this time. The pads were added to the side rails to prevent skin tears. TN stated she was not aware that the side rails were required to be periodically assessed. On 11/14/18 at 2:20 pm an observation was done of the resident ' s room and bilateral padded side rails were noted. An interview was conducted with the QI Nurse on 11/14/18 at 3:20 pm. The Bed Rail Evaluation for Resident #53 dated 11/27/17 that was partially complete was reviewed with the QI Nurse. She confirmed that she partially completed this assessment and confirmed that it was never fully completed. She explained that she was directed by her management and the corporate office to complete bed rail evaluations for every resident in the facility in November 2017. She reported that as she completed the assessments she noted the question on each assessment asked if education had been provided to the resident and/or Responsible Party (RP) on the risks and benefits of side rail usage. The QI Nurse revealed she was not sure what was to be included in this education, so she asked the Administrator. She stated that the Administrator had contacted the Facility Consultant, but that she never received any direction type of education to provide. The QI Nurse further revealed she had not provided any education on any of the bed rail evaluations she completed, and this was why none of the assessments were marked as complete. The QI Nurse indicated this Bed Rail Evaluation form was no longer in use as of February 2018. She stated that since that time no bed rail evaluations and/or re-evaluations had been conducted. She	F 700		

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F 700	Continued From page 135 reported that the facility did have a restraint assessment, but that she had not done any restraint assessments because the facility had no restraints in use. The interview with the QI Nurse continued and she was asked why Resident #53 had bilateral side rails used in conjunction with bilateral padding and if these interventions had been assessed to determine if they met the definition of a physical restraint. She stated that padded side rails were implemented after Resident #53 sustained a skin tear to her arm (12/17). It was believed the skin tear came from the resident hitting her arms against the side rail from repetitive movement. An interview was conducted with the Administrator on 11/14/18 at 4:15 PM. The Administrator confirmed she was aware that the QI Nurse had partially completed all residents' side rail evaluations in November 2017. She confirmed she was aware these were not fully completed because education was not provided to the resident and/or the RP. She stated that education of the risks and benefits should have been explained to the resident and/or RP at the time of side rail assessments and that reassessments should have been done upon any change in condition or change in interventions. Resident #53' s bilateral side rail usage in conjunction with bilateral padding was reviewed with the Administrator. She indicated that the padding was added after Resident #53 sustained a skin tear believed to have been caused by the side rails. She explained that Resident #53 moved her extremities around in bed and the padding was to stop her from hitting the side rails and causing an injury. She additionally revealed	F 700		

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F 700	Continued From page 136 that no assessment was done to determine if the bilateral side rails used in conjunction with the bilateral padding met the definition of a physical restraint. She indicated that she expected the regulations related to physical restraints to be followed A Physical Device Use Evaluation dated 11/15/18 for Resident #53 was completed by the QI Nurse who indicated the device currently in use was padded side rails. The specific medical symptom which led to consideration of device use was unsafe movement of extremities. Resident #53 was noted to use the padded side rails daily with the benefit of the prevention of injury and the risks noted as none. The resident was not able to remove the padded side rails independently. The form indicated, "This device does not impede resident' s movement in bed. This resident has physical limitations that prevent her from voluntarily getting out of bed therefore this device does not meet the classifications of a restraint". A follow-up interview was conducted with the QI Nurse on 11/15/18 at 12:00 pm. The Physical Device Use Evaluation dated 11/15/18 for Resident #53 was reviewed with the QI Nurse. She confirmed she completed this evaluation. She stated she spoke with the Facility Nurse Consultant last evening (11/14/18) and she was directed to complete this assessment. She indicated she went through the form this morning and reviewed it with the Facility Nurse Consultant. The QI Nurse indicated that because Resident #53 was unable to safely get out of bed without assistance it was determined the padded side rails were not a restraint. She stated that the padded side rails were preventing Resident #53 from falling out of bed and that the padding	F 700		

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F 700	Continued From page 137 specifically prevented the resident from injuring her body on the side rails related to the resident moving around in bed. An interview was conducted with the Administrator on 11/16/18 at 4:15 PM. The Administrator confirmed she was aware that the QI Nurse had partially completed all residents' side rail evaluations in November 2017. She additionally confirmed she was aware these were not fully completed as education was not provided to the resident and/or the RP. She stated that education on the risks and benefits should have been explained to the resident and/or RP at the time of the side rail evaluations and that re-evaluations should have been done upon any change in condition or change in interventions to determine the continued need of the side rails.	F 700		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		12/16/18

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F 761	Continued From page 138 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to discard three expired insulins, failed to date when opened two inhalers and failed to store one inhaler in foil pouch when opened in 1 (300 hall cart) of 4 meds carts reviewed for medication storage. The findings included: Review of the undated policy titled Medication Expiration Dates read in part that medications dispensed whose label does not include an expiration date are considered expired 1 year from dispensing with reference of a list of included exceptions dated revised 7/2012 which read as follows: Novolog Insulin Pen-discard 28 days after opening Basaglar Kwik Insulin Pen-discard 28 days after opening On 11/16/18 at 3:12 PM, an observation of the medication cart 300 hall was conducted with Nurse #1. Items discovered included:	F 761	F 761 Label /Store Drugs and Biologicals How corrective action will be accomplished for those residents found to have been affected by the deficient practice The expired medications and undated inhalers identified during the survey were discarded on 11/16/18 by the hall nurse. How the facility will identify other residents having the potential to be affected by the same deficient practice All resident have the potential to be affected. All medication carts were audited by the Nurse Supervisors and/or DON. There were no other adverse findings. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur All licensed nurses will be re-educated by the Director of Nursing and/or staff development RN regarding the process for checking medication carts for expired medications and dating and proper storage of inhalers by 12/16/2018. Any nurses not receiving re-education by 12/16/18 will not be allowed to work until education is received. New hires and	

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F 761	Continued From page 139 *Novolog Insulin Pen for Resident #90 dated as opened 10/10/18. *Basaglar Kwik Insulin Pen for Resident #122 dated as opened 10/10/18. In an interview on 11/16/18 at 3:12 PM, Nurse #1 stated she was not aware that Levemir in the vial, the Novolog Pen and the Basaglar Kwik Insulin Pen was to be discarded after 28 days once opened. Nurse #1 stated she was not sure who was responsible to checking the medication carts for expired medications. In an interview on 11/16/18 at 4:50 PM, the Director of Nursing (DON) stated it was her expectation that expired insulins be removed by any nurse who discovers the expired medication and that the carts are audited monthly by the pharmacy for expired medications.	F 761	agency staff will receive this education during orientation to the facility. How the facility plans to monitor its performance to make sure that solutions are sustained The RN supervisors will perform observation audits for expired meds and undated or improperly stored inhalers weekly. The QI nurse and/or RN supervisors will ensure all medication carts and medication rooms are audited monthly. The results of the audits will be communicated to the DON. The DON will share the results of audits with the interdisciplinary team (IDT) weekly for 12 weeks. The DON and/or nursing unit manager will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance. The administrator consulted with the medical director and the nurse practitioner regarding the plan of correction on 12/11/18 with no changes or recommendations noted.	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		12/16/18

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F 804	Continued From page 140 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interviews, and staff interviews, the facility failed to ensure food was served at an appetizing temperature for 4 of 4 interviewable residents reviewed for food palatability (Residents #45, #71, #113 and #154). The findings included: 1. Resident #45 was most recently readmitted to the facility on 7/22/17. His quarterly Minimum Data Set (MDS) assessment dated 9/5/18 indicated his cognition was fully intact. An interview was conducted with Resident #45 on 11/14/18 at 2:15 PM. He reported that "cold food" being served at meals continued to be an issue at the facility. He explained that this has been an ongoing concern for this entire year (2018). Resident #45 indicated that this was primarily an issue for food served on the halls. An interview was conducted with the Administrator on 11/14/18 at 4:15 PM. She revealed she was aware that "cold food" was a continued issue. She reported that this issue was primarily concerning food served on the halls and	F 804	F804 Nutritive value/Appearance, Palatable/Preferred Temperature How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 11/20/18, residents #45, #71, #113, and #154 were interviewed by the facility Social Workers regarding meal temperatures. Residents were re-educated regarding requesting that meals be reheated or a replacement tray be given when food temperatures are not palatable. A root cause analysis revealed that tray delivery was not efficient once the trays were taken to the hall. How the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be effected. On 11/20/18 the facility Social Workers interviewed all interviewable residents (determined by a BIM score of 13 or above) to determine if food is served at a palatable temperature. Two of 34	

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tended to be a larger issue with breakfast. She stated that the facility had been looking into a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature. She revealed that the current meal tray delivery system was not working well enough. The Administrator stated she was unsure when a new system was going to be implemented.

An interview was conducted with the Dietary Manager (DM) on 11/15/18 at 4:00 PM. She stated that she was unaware "cold food" was a current issue at the facility. She acknowledged that she had known staff reheated items for some of the residents. She reported that the facility had discussed implementing a new meal tray delivery system since she began working as the DM in 2016. She stated she was unaware of when a new system was going to be implemented.

2. Resident #71 was most recently readmitted on 8/22/18. His quarterly Minimum Data Set (MDS) assessment dated 10/1/18 indicated Resident #71's cognition was fully intact.

An interview was conducted with Resident #71 on 11/13/18 at 3:20 PM. He stated that his breakfast meal was never warm. He reported that he was normally served eggs, grits, sausage, a banana, and cereal. Resident #71 indicated that he frequently only ate the banana and cereal because the eggs, grits, and sausage were cold and not appetizing.

An interview was conducted with the Administrator on 11/14/18 at 4:15 PM. She revealed she was aware that "cold food" was a

F 804

residents indicated that there are times when the food temperature does not meet their personal preference. All residents, including the two with concerns, were re-educated that a request can be made to hall staff for a replacement tray or for food to be reheated. A root cause analysis revealed again that tray delivery is not always efficient once the trays are taken to the hall.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

Beginning on 11/19/18, re-education was given to all nursing and dietary staff by the Staff Development Coordinator (SDC) nurse regarding resident preferences for food temperatures and the need to accommodate requests for food to be reheated or a replacement tray given. Re-education will be completed 12/16/18. Any staff not completing education by 12/16/18 will not be allowed to work until the education is completed. New hires and agency staff will receive this education during orientation to the facility. Beginning 12/12/18, the dietary manager will begin sending test trays weekly at random times to include all three meals to each hall. Temperatures will be taken when the last meal tray is delivered to the residents on that hall to ensure that temperatures meet regulatory requirements. A record of the temperatures will be maintained to determine any trends or adverse findings.

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continued issue. She reported that this issue was primarily concerning food served on the halls and tended to be a larger issue with breakfast. She stated that the facility had been looking into a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature. She revealed that the current meal tray delivery system was not working well enough. The Administrator stated she was unsure when a new system was going to be implemented.

An interview was conducted with the Dietary Manager (DM) on 11/15/18 at 4:00 PM. She stated that she was unaware "cold food" was a current issue at the facility. She acknowledged that she had known staff reheated items for some of the residents. She reported that the facility had discussed implementing a new meal tray delivery system since she began working as the DM in 2016. She stated she was unaware of when a new system was going to be implemented.

3. Resident #154 was admitted on 2/12/15. His quarterly Minimum Data Set (MDS) assessment indicated his cognition was intact.

An observation and interview were conducted for Resident #154 on 11/16/18 at 7:50 AM. Resident #154 had been served his breakfast in his room and he was eating independently. He stated that he would have preferred his food to be "warmer" at breakfast.

An interview was conducted with the Administrator on 11/14/18 at 4:15 PM. She revealed she was aware that "cold food" was a continued issue. She reported that this issue was

F 804

How the facility plans to monitor its performance to make sure that solutions are sustained

Facility social workers will interview residents weekly x12 weeks regarding food temperature palatability and report to the Interdisciplinary Team (IDT) committee and trends or concerns for additional interventions.
The Facility social workers will share the results of Compliance Rounds Audits with the interdisciplinary team (IDT) at least weekly for 12 weeks.
The dietary manager will continue to monitor test tray temperatures weekly for two weeks and bi weekly for two weeks.
The results of the test tray temperature audits will be taken to the Quality Improvement (QI) Committee for review identification of trends, additional corrective actions, and recommendations.
The Social workers and/or MDS RN will present IDT corrective actions related to resident interviews to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations.
The administrator and/or RN QI nurse will present trends and QI committee recommendations to the quarterly executive QI committee for review, additional recommendations, and to determine the need for continued monitoring to ensure the continued compliance of palatable food.
The administrator consulted with the medical director and the nurse practitioner regarding the plan of correction on

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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 804	Continued From page 143	F 804		

primarily concerning food served on the halls and tended to be a larger issue with breakfast. She stated that the facility had been looking into a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature. She revealed that the current meal tray delivery system was not working well enough. The Administrator stated she was unsure when a new system was going to be implemented.

An interview was conducted with the Dietary Manager (DM) on 11/15/18 at 4:00 PM. She stated that she was unaware "cold food" was a current issue at the facility. She acknowledged that she had known staff reheated items for some of the residents. She reported that the facility had discussed implementing a new meal tray delivery system since she began working as the DM in 2016. She stated she was unaware of when a new system was going to be implemented.

4. Resident #113 was most recently readmitted to the facility on 9/13/18. Her quarterly Minimum Data Set (MDS) assessment dated 9/20/18 indicated her cognition was intact.

An interview was conducted with Resident #113 on 11/14/18 at 2:10 PM. She reported that "cold food" being served at meals continued to be an issue at the facility. She indicated that this was primarily an issue for food served on the halls.

An interview was conducted with the Administrator on 11/14/18 at 4:15 PM. She revealed she was aware that "cold food" was a continued issue. She reported that this issue was primarily concerning food served on the halls and

12/11/18 with no changes or recommendations noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING ______ B. WING ______	11/16/2018

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F 804	Continued From page 144 tended to be a larger issue with breakfast. She stated that the facility had been looking into a new meal tray delivery system that would help sustain the temperature of the food, so it was served at a more appetizing temperature. She revealed that the current meal tray delivery system was not working well enough. The Administrator stated she was unsure when a new system was going to be implemented. An interview was conducted with the Dietary Manager (DM) on 11/15/18 at 4:00 PM. She stated that she was unaware "cold food" was a current issue at the facility. She acknowledged that she had known staff reheated items for some of the residents. She reported that the facility had discussed implementing a new meal tray delivery system since she began working as the DM in 2016. She stated she was unaware of when a new system was going to be implemented.	F 804		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		12/16/18

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F 812	Continued From page 145 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard expired food items and date food items when stored in the resident nourishment refrigerators for 2 of 2 refrigerators observed. (100/200 hall and 600 hall nourishment room refrigerators) Findings included: 1. Observations of items stored in the facility ' s 100/200 hall and 600 hall nourishment room refrigerators revealed the following: a. On 11/14/18 at 3:30 pm it was observed there was a disposable food container with a sandwich in the hall 100/200 nourishment refrigerator that was not dated. b. On 11/15/18 10:49 am observation of hall 100/200 ' s nourishment room refrigerator with the Assistant Director of Nursing (ADON) revealed an undated food item (sandwich with plastic wrap that was no longer intact) in a disposable container, several undated sandwiches wrapped in plastic, and a blue colored drink that was half full was undated. There was also a sandwich with an expired expiration date of 11/12/18. The ADON observed and agreed the food and drink was not dated or was expired and discarded them. On 11/15/18 at 12:30 pm an interview was conducted with housekeeper #3 who stated	F 812	F812 □ Food Procurement, Store/Prepare/Serve-Sanitary How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 11/15/18, the Assistant Director of Nursing (ADON) discarded the undated/expired food and drink identified in the 100/200 and 600 hall nourishment rooms. How the facility will identify other residents having the potential to be affected by the same deficient practice On 11/19 /18, an audit was completed for all of the nourishment rooms by the Dietary Manager (DM) to determine if there were any other expired and/or undated foods. No expired or undated foods were found. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Dietary staff will monitor refrigerators daily as nourishments are delivered using the Expired Foods in Nourishment Rooms Audit tool. Any expired or undated foods will be discarded at that time. Dietary staff was re-educated by the Dietary Manager (DM) regarding this process beginning on 11/20/18 and completed on 11/21/18.	

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F 812	Continued From page 146 housekeeping was not responsible to discard or check food stored in nourishment room refrigerators that came from the kitchen. Housekeeper #3 also commented that housekeeping was only responsible to discard resident food items that were brought in from the outside. Housekeeper #3 agreed that the disposable food container that was undated on hall 100/200 could have been brought in from the outside c. On 11/15/18 at 11:05 am an observation with the ADON of hall 600 ' s nourishment room refrigerator revealed multiple food items that were either expired or not dated which included; a gallon of milk with an expired expiration date of 11/9/18 and a disposable food container which contained a sandwich. The ADON stated that housekeeping was responsible to discard expired foods and undated open food items daily from the nourishment room refrigerator. On 11/15/18 at 11:22 am an interview was conducted with the Dietary Manager (DM) who stated that the Dietary Department does not have the responsibility to check the resident hall nourishment room refrigerators for expired food. The DM commented that she did not know who was responsible and would find out. On 11/16/18 at 1:30 pm an interview was conducted with the DM who stated she was informed by the Administrator that housekeeping was responsible to check the nourishment room refrigerators daily for expired and undated food items.	F 812	How the facility plans to monitor its performance to make sure that solutions are sustained The Dietary Manager (DM) will perform audits of the Expired Foods in Nourishment Room monitoring tool weekly for 12 weeks. The DM will share the results of the Compliance Audits with the interdisciplinary team (IDT) at least weekly for 12 weeks. The QI nurse will present IDT corrective actions to the monthly quality improvement (QI) committee for review, identification of trends, additional corrective actions, and recommendations. The administrator and/or DON will present trends and QI committee recommendations to the quarterly executive QI committee for review, additional recommendations, and to determine the need for continued monitoring to ensure continued compliance in the area of food storage.	