STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345216	A. BUILDING _____ B. WING _____	C 04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD REHABILITATION AND HEALTH CENTER	**3100 TRAMWAY ROAD SANFORD, NC 27330**

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E 000	Initial Comments An unannounced Recertification survey was conducted on 04/15/19 through 04/18/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #M7MY11.	E 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		5/15/19

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

Electronically Signed | 05/04/2019

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F 623	Continued From page 1	F 623		

be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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F 623	Continued From page 2 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the responsible party (RP) in writing of the reason for hospital discharge for 4 of 4 sampled residents reviewed for hospitalization (Residents # 25, #46, #8 and #39). Findings included: 1. Resident #46 was originally admitted to the facility on 3/21/19. Review of Resident #46 nurse's note written by	F 623	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F623	

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F 623	Continued From page 3 Nurse #2 revealed that he was discharged to the hospital on 3/30/19 due to low oxygen saturation and labored breathing. The note did not indicate that the RP was notified in writing of the reason for the discharge. On 4/17/19 at 10:58 AM, Nurse #2 was interviewed. The Nurse stated that he normally notified the RP by phone when a resident was discharged to the hospital. He added that he had been sending a copy of the bed hold policy but not a written discharge summary to the RP. On 4/17/19 at 2:50 PM, Nurse #3 was interviewed. The Nurse stated that if the RP was not present during the discharge, she called her/him by phone and notify him/her that the resident was discharged to the hospital. The Nurse reported that she had not sent the RP a notice of discharge in writing. On 4/17/19 at 3:15 PM, the Nurse Consultant was interviewed. The Nurse Consultant stated that she was not aware of the regulation that facility had to notify the RP in writing of the reason for hospital discharge On 4/18/19 at 8:34 AM, the Director of Nursing (DON) was interviewed. The DON also stated that she was not aware of the regulation that facility had to notify the RP in writing of the reason for the hospital discharge. The DON reported that she expected the regulation for notification to be followed. 2. Resident #25 was originally admitted to the facility on 8/3/17.	F 623	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to notify the responsible party in writing of the reason for hospital discharge. 1.Corrective action for resident(s) affected by the alleged deficient practice: On 5/3/19 the responsible parties of residents #25, 46, 8 and 39 were mailed written notice of the reason for discharge to the hospital by the Support Nurse. 2.Corrective action for residents with the potential to be affected by the alleged deficient practice. On 5/3/19 the Director of Nurses audited all discharges for the last 7 days to monitor that the responsible party had been notified in writing of the reason for discharge to the hospital. 3.Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 4/17/19, the Director of Nurses and Nurse Consultant began education of all full time, part time and as needed nurses, social worker, administrator, admissions, business and office manager on facility policy on notifying the responsible party in writing of the reason for a resident□s discharge to the hospital. Education will be completed by 5/15/19 at which time all of the above must be in-serviced prior to working. 4.Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.	

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F 623	Continued From page 4 Review of the nurse's note written by Nurse #2 revealed that Resident #25 was discharged to the hospital on 9/2/18 due to confusion and abnormal laboratory reports. The RP was present during the discharge and was notified. The note did not indicate that a written discharge summary/notice was sent or given to the RP when the resident was discharged to the hospital. On 4/17/19 at 10:58 AM, Nurse #2 was interviewed. The Nurse stated that he normally notified the RP by phone when a resident was discharged to the hospital. He added that he had been sending a copy of the bed hold policy but not a written discharge summary to the RP. On 4/17/19 at 2:50 PM, Nurse #3 was interviewed. The Nurse stated that if the RP was not present during the discharge, she called her/him by phone and notify him/her that the resident was discharged to the hospital. The Nurse reported that she had not sent the RP a notice of discharge in writing. On 4/17/19 at 3:15 PM, the Nurse Consultant was interviewed. The Nurse Consultant stated that she was not aware of the regulation that facility had to notify the RP in writing of the reason for hospital discharge On 4/18/19 at 8:34 AM, the Director of Nursing (DON) was interviewed. The DON also stated that she was not aware of the regulation that facility had to notify the RP in writing of the reason for the hospital discharge. The DON reported that she expected the regulation for notification to be followed. 3. Resident #8 was originally admitted to the facility on 2/19/11.	F 623	The Director of Nurses will monitor compliance utilizing the Written Notification of RP Hospital Discharge Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor all nursing assistants for compliance with the completion of annual Dementia training. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 5/15/19	

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F 623	Continued From page 5	F 623		

Review of Resident #8 nurse's note revealed that he was discharged to the hospital on 2/10/19 due to vomiting brown emesis. The note did not indicate that the RP was notified in writing of the reason for the discharge.

On 4/17/19 at 10:58 AM, Nurse #2 was interviewed. He stated that he had been sending a copy of the bed hold policy but not a written discharge summary to the RP.

On 4/17/19 at 3:15 PM, the Nurse Consultant was interviewed. The Nurse Consultant stated that she was not aware of the regulation that facility had to notify the RP in writing of the reason for hospital discharge.

On 4/18/19 at 8:34 AM, the Director of Nursing (DON) was interviewed. The DON also stated that she was not aware of the regulation that facility had to notify the RP in writing of the reason for the hospital discharge. The DON reported that she expected the regulation for notification to be followed.

4. Resident #39 was admitted to the facility on 4/26/17 with diagnoses that included chronic kidney disease and aphasia.

The annual Minimum Data Set (MDS) assessment dated 3/18/19 indicated Resident #39 ' s cognition was severely impaired.

A medical record review revealed Resident #39

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F 623	Continued From page 6 was transferred to the hospital on 3/26/19. There was no documentation that a written notice of hospital discharge was provided to Resident #39 ' s Responsible Party (RP). Resident #39 was readmitted to the facility on 3/28/19. On 4/17/19 at 10:58 AM, Nurse #2 was interviewed. Nurse #2 stated that he normally notified the RP by phone when a resident was discharged to the hospital. He added that he had been sending a copy of the bed hold policy, but not a written discharge summary to the RP. On 4/17/19 at 2:50 PM, Nurse #3 was interviewed. Nurse #3 stated that if the RP was not present during the discharge, she called the RP by phone and notified them that the resident was discharged to the hospital. Nurse #3 reported that she had not sent the RP a notice of discharge in writing. On 4/17/19 at 3:15 PM, the Nurse Consultant was interviewed. The Nurse Consultant stated that she was not aware of the regulation that indicated the facility had to notify the RP in writing of the reason for the hospital discharge. On 4/18/19 at 8:34 AM, the Director of Nursing (DON) was interviewed. The DON also stated that she was not aware of the regulation that indicated the facility had to notify the RP in writing of the reason for the hospital discharge. The DON reported that she expected the regulation for notification to be followed.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		5/15/19

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F 641	Continued From page 7 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of discharge status (Resident #66), active diagnoses (Residents #116 and #20) and rejection of care (Resident #15) for 4 of 17 sampled residents reviewed. Findings included: 1. Resident 66 was admitted to the facility on 1/30/19. Review of the discharge Minimum Data Set (MDS) assessment dated 2/17/19 revealed that Resident #66 was discharged to the hospital on 2/17/19. Review of Resident #66's nurse's notes revealed that the resident was discharged to home on 2/17/19. On 4/16/19 at 3:10 PM, MDS Nurse #1 was interviewed. The MDS Nurse reviewed the nurse's notes and verified that Resident #66 was discharged to the community instead of the hospital. The MDS Nurse indicated that the discharge MDS assessment dated 2/17/19 was coded incorrectly under the discharge status. On 4/18/19 at 8:34 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.	F 641	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F641 Accuracy of Assessments For resident #66, a corrective action was obtained on 05/04/19. "The specific deficiency was corrected on 05/04/19 by modifying the Minimum Data Set assessment with an ARD of 02/17/19 in order to correct resident□s discharge disposition in Section A to accurately reflect their discharge to home. This was completed by the Regional Minimum Data Set Consultant. Corrected Minimum Data Set assessment was re-submitted to State Database in Batch #1278 on 05/04/19. For resident #116, a corrective action was obtained on 05/04/19. "The specific deficiency was corrected on 05/04/19 by modifying the Minimum Data Set assessment with an ARD of 01/29/19 in order to code the presence of active diagnosis of Peripheral Vascular Disease	

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F 641	Continued From page 8 2. Resident # 116 was admitted to the facility on 1/22/19 with multiple diagnoses including Peripheral Vascular Disease (PVD). Resident #116's admission Minimum Data Set (MDS) assessment dated 1/29/19 was reviewed. The assessment did not indicate that Resident #116 had a diagnoses of PVD. Resident #116's care plan was reviewed. The care plan problems dated 1/29/19 included "I am at risk for acute pain related to PVD" and "I have PVD". On 4/17/19 at 2:35 PM, MDS Nurse #2 was interviewed. The MDS Nurse reviewed the resident's medical records and verified that Resident #116 had a diagnoses of PVD. The MDS Nurse indicated that the admission MDS assessment dated 1/29/19 was coded incorrectly under the active diagnoses. On 4/18/19 at 8:34 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately. 3. Resident #15 was admitted to the facility on 11/6/15 with diagnoses that included visual loss in right eye and dry eye syndrome. A review of nursing notes dated 1/27/19 indicated Resident #15 frequently refused medications and eye drops.	F 641	in Section I. This was completed by the Minimum Data Set Consultant. Corrected Minimum Data Set assessment was re-submitted to State Database in Batch #1278 on 05/04/19. For resident #15, a corrective action was obtained on 05/04/19. "The specific deficiency was corrected on 05/04/19 by modifying the Minimum Data Set assessment with an ARD of 02/01/19 in order to accurately code Section E to reflect resident□s rejection of care that occurred during the assessment reference timeframe. This was completed by Minimum Data Set Consultant. Corrected Minimum Data Set assessment was re-submitted to State Database in Batch #1278 on 05/04/19. For resident #20, a corrective action was obtained on 05/07/19. :The specific deficiency was corrected on 05/07/19 by modifying the Minimum Data Set assessment with an ARD of 02/06/19 in order to accurately code Section I to reflect active diagnosis of Malnutrition. This was completed by Minimum Data Set Consultant. Corrected Minimum Data Set assessment was re-submitted to State Database in Batch #1279 on 05/07/19. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. In order to validate accurate coding of Section A □ Discharge Status, Section I □	

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F 641	Continued From page 9 A review of Resident #15' s Medication Administration Records (MARs) from 1/26/19 through 2/1/19 indicated she refused medications and/or eye drops on 7 of 7 days. The annual Minimum Data Set (MDS) assessment dated 2/1/19 indicated Resident #15 ' s cognition was intact, and she had no rejection of care. The Behavior Section of the 2/1/19 MDS for Resident #15 was completed by the Social Worker (SW). A review of Resident #15 ' s active care plan was conducted on 4/16/19. This care plan had not addressed Resident #15 ' s rejections of medications and/or eye drops. An interview was conducted with the SW on 4/17/19 at 2:30 PM. She stated that she completed the Behavior Section of the MDS by reviewing nursing notes. She reported there also was a section on the electronic medical record that showed her any Nursing Assistant (NA) documentation related to behaviors and/or rejection of care. She reported that she had not reviewed the MARs to when she completed the Behavior Section of the MDS assessments. The nursing notes dated 1/27/19 and the MARs from 1/26/19 through 2/1/19 (the 7-day look back period for the 2/1/19 MDS) for Resident #15 were reviewed with the SW. The 2/1/19 MDS that indicated Resident #15 had no rejection of care was reviewed with the SW. She revealed that she must have missed the 1/27/19 nursing notes and that she had not reviewed Resident #15 ' s MARs. She further revealed she was unaware Resident #15 had frequent refusals of medications and/or eye drops. The SW indicated the 2/1/19 MDS for Resident #15 was coded	F 641	Active Diagnoses, and Section E □ Behaviors, the following audits were completed. #1. 100% audit of Discharge assessments completed during timeframe of 02/01/19 □ 05/01/19 was completed to ensure that the discharge status in Section A2100 was accurately coded. This audit was completed by the Regional Minimum Data Set Nurse Consultant on 05/07/19. "Audit Results: 76 of 76 Discharge assessments reviewed had A2100 (Discharge Status) coded accurately. #2. 100% audit of Minimum Data Set assessments completed during timeframe of 02/01/19 □ 05/01/19 was completed to ensure that any resident with active diagnoses of either Malnutrition or Peripheral Vascular Disease has been accurately coded in Section I. This audit was completed by the Regional Minimum Data Set Consultant on 05/07/19. " Audit Results:2 of 2 residents with diagnosis of malnutrition had accurate coding of malnutrition in Section I. * Audit Results:7 of 7 residents with diagnosis of peripheral vascular disease had accurate coding of peripheral vascular disease in Section I. #3.100% audit of Minimum Data Set assessments completed during timeframe of 02/01/19 □ 05/01/19 was completed in order to ensure accurate coding of the presence of resident behaviors in Section E. This audit was completed by the Regional Minimum Data Set Consultant	

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F 641	Continued From page 10 inaccurately for rejection of care. An interview was conducted with the Director of Nursing (DON) on 4/17/19 at 11:40 AM. She verified Resident #15 had no care plan that addressed rejection of care. A follow up interview was conducted with the DON on 4/18/19 at 8:27 AM. She indicated she expected the MDS to be coded accurately. 4. Resident #20 was admitted to the facility on 12/29/17 with diagnoses that included atrial fibrillation and adult failure to thrive. A review of the medical record indicated Resident #20 was admitted to hospice services on 1/24/19 with a primary hospice diagnosis of protein-calorie malnutrition. The significant change Minimum Data Set (MDS) assessment dated 2/6/19 indicated Resident #20 ' s cognition was moderately impaired, and she was receiving hospice services. Resident #20 ' s active diagnoses had not included malnutrition. The Active Diagnoses Section of the 2/6/19 MDS for Resident #20 was completed by MDS Nurse #1. An interview was conducted with MDS Nurse #1 on 4/17/19 at 2:25 PM. She stated that she coded the 2/6/19 MDS for Resident #20 in the area of Active Diagnoses. The 2/6/19 MDS for Resident #20 that included no diagnosis of malnutrition was reviewed with MDS Nurse #1. The hospice documentation that indicated Resident #20 was admitted to hospice services on 1/24/19 with a primary hospice diagnosis of	F 641	on 05/07/19. "Audit Results: 77 of 77 residents reviewed had accurate coding of Section E (behaviors). Systemic Changes On 05/06/19, the Regional Minimum Data Set Consultant completed an in service training for the facility Social Services Director and Minimum Data Set Coordinators that included the following: the importance of thoroughly reviewing the medical record prior to completion of Section E of the Minimum Data Set assessment in order to ensure accurate coding of the presence of any behaviors during the assessment reference lookback window. The education also included the importance of and instruction on reviewing the resident□s medical record thoroughly prior to coding Section A (Discharge Status) for Discharge Assessments in order to ensure accurate coding of where resident was discharged to. The education also contained information on how to and the importance of reviewing the resident□s medical record thoroughly prior to coding Section I (Active Diagnoses) in order to ensure accurately coding this section. This information has been integrated into the standard orientation training for new Social Services Directors and Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that	

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F 641	Continued From page 11 protein-calorie malnutrition was reviewed with MDS Nurse #1. MDS Nurse #1 confirmed malnutrition was an active diagnosis for Resident #20 at the time of her 2/6/19 MDS and that this MDS was coded inaccurately. An interview was conducted with the Director of Nursing (DON) on 4/18/19 at 8:27 AM. She indicated she expected the MDS to be coded accurately.	F 641	specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. On 05/06/19, the Director of Nursing or designated Nurse Manager will begin auditing Minimum Data Set assessments that have been completed in order to ensure that they have been accurately coded for Section A (Discharge Status); Section E (Behaviors) and Section I (Active Diagnoses). These audits will be completed using the quality assurance survey tools entitled: Accurate Diagnoses Coding on MDS Audit Tool; Accurate Coding of Discharge MDS (Section A □ Discharge Status) Audit Tool, and Accurate Coding of MDS Section E (Behaviors) Audit Tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction;	

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F 641	Continued From page 12	F 641	Administrator and /or Director of Nursing. Date of Compliance: 05/07/19	
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)- (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	F 656		5/15/19

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F 656	Continued From page 13 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, resident interview, and staff interview, the facility failed develop a comprehensive care plan in the area of refusals of care (Resident #15) and failed to implement care plans related to Activity of Daily Living (ADL) assistance (Resident #39), the use of a gait belt (Resident #7), and the use of a splint (Resident #25) for 4 of 17 sampled residents. The findings included: 1. Resident #15 was admitted to the facility on 11/6/15 with diagnoses that included dry eye syndrome and respiratory disease. The annual Minimum Data Set (MDS) assessment dated 2/1/19 indicated Resident #15's cognition was intact. A review of Resident #15's Medication Administration Records (MARs) from 3/16/19 through 4/16/19 revealed the following refusals: - Artificial Tears Solution (eye drop) was refused on 28 of 49 administration opportunities - Restasis Emulsion (eye drop) was refused on 19 of 64 administration opportunities - DuoNeb Solution (inhaler) was refused on 26 of 64 administration opportunities - Mucinex was refused on 5 of 64 administration opportunities	F 656	Plan of Correction The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the F 656 Develop/Implement Comprehensive Care Plan Corrective Actions for Resident #15. A corrective action was taken to correct the care plan for Resident #15 on 04/17/19. The Minimum Data Set nurse revised resident□s care plan in order that it may accurately reflect episodes of refusal/rejection of care. This was completed on 04/17/19. Corrective Action for Resident # 39. A corrective action was taken to correct the care plan for Resident #39 on 05/02/19. The Minimum Data Set nurse revised resident□s care plan by firing tasks to the CNA□s stating that resident	

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F 656	Continued From page 14 A review of Resident #15's Nursing Assistant (NA) personal care documentation from 3/16/19 through 4/16/19 indicated she had refused a shower and/or bed bath on 9 of 32 days (3/25/19, 3/27/19, 4/1/19 - 4/4/19, 4/7/19, 4/8/19, and 4/12/19). A review of Resident #15's active care plan was conducted on 4/16/19. This care plan had not addressed Resident #15's refusals of care. An interview was conducted with the Director of Nursing (DON) on 4/17/19 at 11:40 AM. She verified Resident #15 had no care plan in place that addressed rejection of care. She stated that this was one of the MDS Nurses' responsibility to develop a care plan to address rejection of care. She indicated that if a resident rejected care once or twice, she would not have expected a care plan to be in place to address this issue. The DON reported that since Resident #15 had a pattern of care and medication refusals that she expected a care plan to be in place that addressed these refusals. An interview was conducted with MDS Nurse #1 on 4/17/19 at 11:44 AM. She verified Resident #15 had no care plan that addressed rejection of care. She stated that she had been unaware Resident #15 had a pattern of refusals of medications and of personal care. She reported that she was going to develop a care plan to address Resident #15's refusals of care. 2. Resident #39 was admitted to the facility on 4/26/17 with diagnoses that included chronic	F 656	requires 2 staff members for transfers. This was done to ensure adequate communication of this intervention to staff so that this intervention may be fully implemented. This was completed on 05/02/19. Corrective Action for Resident # 7. A corrective action was taken to correct the care plan for Resident #7 on 05/02/19. The Minimum Data Set nurse revised resident□s care plan by firing tasks to the CNA□s stating that resident requires use of a gait belt for transfers. This was done to ensure adequate communication of this intervention to staff so that this intervention may be fully implemented. This was completed on 05/02/19. Corrective Action for Resident # 25. A corrective action was taken to correct the care plan for Resident #25 on 05/02/19. The Minimum Data Set nurse revised resident□s care plan by firing tasks to the CNA□s to give instruction on use of splint. This was done to ensure adequate communication of this intervention to staff so that this intervention may be fully implemented. This was completed on 05/02/19. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents□ care plans was completed on 05/07/19 by the Regional Minimum Data Set Consultant. This audit included ensuring that each resident has a comprehensive	

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F 656	Continued From page 15 kidney disease, aphasia, history of cerebral infarction, history of falling, and unspecified convulsions. The quarterly Minimum Data Set (MDS) assessment dated 12/18/18 indicated Resident #39 ' s cognition was moderately impaired. She required the extensive assistance of 2 for transfers. Resident #39 ' s care plan included the focus area of an Activity of Daily Living (ADL) self-care performance deficit related to activity intolerance (initiated on 5/24/17). The interventions included, in part, the extensive assistance of 2 people for transfers (initiated on 1/10/19). An incident report dated 3/2/19 completed by Nurse #4 indicated Resident #39 had a witnessed fall with no injury on 3/2/19 at 4:39 PM. Nursing Assistant (NA) #7 notified Nurse #4 that Resident #39 was on the floor. NA #7 reported that she was transferring Resident #39, her bed was unlocked, and the bed rolled causing her to be unable to support the resident. Resident #39 was lowered to the floor by NA #7. A review of the fall investigation dated 3/4/19 completed by the Director of Nursing (DON) indicated this fall was reviewed and it was noted that the bed was not locked prior to transferring Resident #39 from chair to bed. Staff were to ensure that the bed was locked prior to transferring Resident #39 with a 2 person assist. A phone interview was attempted with NA #7 on 4/16/19 at 1:32 PM and on 4/17/19 at 8:32 AM. She was unable to be reached.	F 656	care plan that addresses his/her needs, risks, goals, and appropriate interventions. " Audit results: 7 of 77 residents identified with incomplete care plans. These 7 resident care plans were updated to include all required items. This was completed on 05/07/19 by the Regional Minimum Data Set Consultant. Systemic Changes On 05/06/19 the Regional Minimum Data Set Nurse Consultant provided in-service education to the facility Minimum Data Set Nurses on Comprehensive Care Plans. This education included the importance of ensuring that each resident□s care plan addressed actual problems, risk factors, resident strengths and preferences. The education emphasized that the care plan must communicate the resident□s current condition, needs, and preferences to the staff. Therefore, the care plan must have ongoing revisions and updates as the resident□s condition changes. The educational material included the importance of ensuring that care plan interventions are communicated to CNAs and other appropriate staff as needed in order to ensure that these interventions are implemented timely and appropriately. Also on 05/03/19, education for all Nurses, CNAs and Med. Tech□s/Med. Aides was initiated in order to ensure their understanding of how to and the importance of reviewing each resident□s Kardex and Tasks prior to providing care. It emphasized the importance of ensuring that the care plan is followed and that interventions are carried out as	

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F 656	Continued From page 16 A phone interview was conducted with Nurse #4 on 4/16/19 at 4:35 PM. The 3/2/19 incident report for Resident #39 was reviewed with Nurse #4. She indicated that NA #7 was in Resident #39 ' s room without another NA present on 3/2/19 when she was notified of the assisted fall that occurred during a transfer. An interview was conducted with the DON on 4/17/19 at 12:05 PM. The 3/2/19 incident report for Resident #39 and the investigation dated 3/4/19 were reviewed with the DON. She stated that she was unable to recall with certainty if it had been identified during the investigation that NA #7 was transferring Resident #39 without another staff ' s assistance. She indicated that during the investigation she was so focused on the resident ' s bed being unlocked during the transfer that she may have not realized that the intervention of a 2 person assist for transfers was not implemented. The DON stated that she expected the care plan interventions to be implemented at all times. 3. Resident #7 was admitted 1/16/14 with cumulative diagnoses of Rheumatoid Arthritis, contractures and Kyphosis. Resident #7's annual Minimum Data Set (MDS) dated 1/10/19 indicated she was cognitively intact and exhibited no behaviors. She was coded for extensive assistance with transfers and toileting. Resident #7 was coded as having no falls. Review of Resident #7's fall care plan last revised 1/10/19 indicated the intervention of a gait belt was to be utilized for transfers originally initiated 1/10/14. Review of Resident #7's undated computerized	F 656	prescribed. This education also included instructions on how to view the Kardex as well as how to view Tasks and document on tasks. This education was provided by the Director of Nursing and Nurse Managers and will be completed for all Nurses, CNA□s and Med. Tech□s/Med. Aides no later than 05/09/19. This information has been integrated into the standard orientation training for new Minimum Data Set Nurses, Nurses, CNA□s and Med. Tech□s/Med. Aides. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designated Nurse Manager will conduct audits to ensure that resident care plans are completed, updated/revised as resident conditions change, and that the care plan interventions are being implemented by the appropriate staff members by using the following Quality Assurance Audit Tools: Care Plan Audit Tool and Communication and Implementation of Interventions Audit Tool. These audits will be completed weekly for 4 weeks then monthly for 6 months or until sustained compliance has been achieved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the	

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F 656	Continued From page 17 Kardex the nursing assistants (NA) utilized indicated the required a gait belt for transfers. Review of a facility incident report dated 3/26/19 at 7:30 PM, read NA #8 was transferring Resident #7 to the bathroom when the resident's legs gave out. The Interdisciplinary Team note dated 3/29/19 read the staff were to use a gait belt for ambulation and transferring to the toilet. During an interview on 4/16/19 at 1:40 PM, Resident #7 stated the staff were not using a gait belt during her fall on 3/26/19. Resident #7 stated she was not injured during the fall on 3/26/19. During an interview on 4/16/19 at 1:46 PM, the Director of Nursing (DON) stated she was not aware that the gait belt had been an intervention since 1/10/14. During an interview on 4/16/19 at 3:15 PM, NA #8 stated she was assigned Resident #7 the evening of 3/26/19 and recalled her fall. She stated she was aware that Resident #7 was to be transferred using a gait belt because it was on her computerized Kardex During an interview on 4/17/19 at 2:50 PM, MDS Nurse #1 stated the computerized Kardex automatically populated from the care plan except the use of the gait belt had to be initiated so the aides would know to only transfer Resident #7 with the use of a gait belt. She confirmed the use of a gait belt was initiated and it appeared on the computerized Kardex visible to the aides. During another interview on 4/18/19 at 8:27 AM, the DON stated it was her expectation that the	F 656	Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction. Completion date: 05/09/2019	

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F 656	Continued From page 18	F 656		

aides follow the care plan and Kardex intervention of using a gait belt for Resident #7's transfers.

4. Resident #25 was originally admitted to the facility on 8/3/17 with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. The quarterly Minimum Data Set (MDS) assessment dated 2/24/19 indicated that Resident #25's cognition was intact and he had impairment in range of motion on one side. The assessment further indicated that the resident did not display rejection of care.

Resident #25' care plan dated 3/1/19 was reviewed. One of the care plan problems was Resident #25 had activities of daily living (ADL) self - care deficit and she required extensive assistance of 2 persons for toileting related to right hemiplegia. The approaches included to wear right upper extremity (RUE) modified resting hand splint every morning for up to 6-8 hours (added on 3/8/19). The care plan did not indicate that Resident #25 had refused to wear the splint.

Resident #25 nurse's notes for March and April 2019 were reviewed. The notes did not indicate that Resident #25 had refused to wear the splint.

On 4/15/19 at 3:29 PM, Resident #25 was observed up in wheelchair in her room. Her right wrist was contracted and she was not wearing a splint. She had a hand roll on her right hand when observed. On the wall, there was an instruction on how to apply the RUE resting hand splint.

On 4/16/19 at 10:05 AM and 1:44 PM, Resident #25 was again observed up in wheelchair in her room. Her right wrist was contracted and she

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F 656	Continued From page 19 was not wearing a splint. She was observed to have a hand roll on her right hand. On 4/16/19 at 1:45 PM, Nurse Aide (NA) #1 was interviewed. NA #1 stated that she started working at the facility as a NA in August 2018. She indicated that she was assigned to Resident #25. NA #1 reported that Resident #25 used to wear a splint on her right arm but she thought it was discontinued and was replaced with a hand roll. She added that she didn't know as to when the splint was discontinued. On 4/16/19 at 4:58 PM, Nurse #1 was interviewed. She stated that Resident #25 was supposed to have a splint on her right hand. Nurse #1 reviewed the MAR and verified that Resident #25 was supposed to have a splint applied at 6 AM every morning and it should be removed after 6-8 hours or until the resident tolerated it. Nurse #1 further indicated that the NA was supposed to apply the splint and the nurse to check behind. She stated that she didn't check the splint this morning if it was applied or not. The Nurse did not indicate that Resident #25 was refusing to wear the splint. On 4/18/19 at 8:34 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected nursing to follow the intervention/approach for the application of the splint as care planned.	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited	F 688		5/15/19

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F 688	Continued From page 20 range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interview, the facility failed to apply the splint as ordered for 1 of 4 sampled residents reviewed for limitation in range of motion (Resident #25). Findings included: Resident #25 was originally admitted to the facility on 8/3/17 with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. The quarterly Minimum Data Set (MDS) assessment dated 2/24/19 indicated that Resident #25's cognition was intact and she had impairment in range of motion on one side. The assessment further indicated that the resident did not display rejection of care. The Occupational Therapy (OT) notes were reviewed. The OT note revealed that Resident #25 was treated from 3/20/18 through 4/30/18	F 688	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F688 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to apply splints to residents with contractures as ordered. 1.Corrective action for resident(s) affected by the alleged deficient practice:	

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	345216	A. BUILDING _____ B. WING _____	C 04/18/2019

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F 688	Continued From page 21 due to contracture of the right forearm and right hand. The recommendation upon discharge was for Resident #25 to wear the right upper extremity (RUE) resting hand splint to prevent further contracture and for contracture management. Resident #25 had a physician's order dated 5/2/2018 to wear RUE modified resting hand splint every morning for up to 6-8 hours. Resident #25' care plan dated 3/1/19 was reviewed. One of the care plan problems was Resident #25 had activities of daily living (ADL) self - care deficit and she required extensive assistance of 2 persons for toileting related to right hemiplegia. The approaches included to wear right upper extremity (RUE) modified resting hand splint every morning for up to 6-8 hours (added on 3/8/19). The care plan did not indicate that Resident #25 had refused to wear the splint. Resident #25 Medication Administration Records (MAR) for April, 2019 was reviewed. The MAR revealed that the RUE resting hand splint had been applied every day at 6 AM. Resident #25 nurse's notes for March and April 2019 were reviewed. The notes did not indicate that Resident #25 had refused to wear the splint. On 4/15/19 at 3:29 PM, Resident #25 was observed up in wheelchair in her room. Her right wrist was contracted and she was not wearing a splint. She had a hand roll on her right hand when observed. On the wall, there was an instruction on how to apply the RUE resting hand splint. On 4/16/19 at 10:05 AM and 1:44 PM, Resident	F 688	For resident # 25 corrective action was obtained on 4/18/19. On 4/18/19 the Director of Nurses directed nursing staff to follow the physician□s order for the RUE resting hand splint and audited that the splint had been applied as ordered for resident #25. The MDS Coordinator reviewed the resident□s Kardex on 5/1/19 and audited to assure the application of the splint was in place. 2.Corrective action for residents with the potential to be affected by the alleged deficient practice: On 5/3/19 the Director of Nurses audited all current residents with orders for splints to assure that all ordered splints were being applied as ordered. The MDS Coordinator audited all current residents with ordered splints to ensure that all splints were indicated on the kardex. One other resident was affected and the kardex was corrected to reflect splint application on 5/3/19. 3.Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 4/30/19, the Director of Nurses began education of all full time, part time, as needed nurses and certified nursing assistants on splint application and use of the kardex. The in-servicing will be completed by 5/15/19 at which time all nurses and certified nursing must be in-serviced prior to working.	

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F 688	Continued From page 22 #25 was again observed up in wheelchair in her room. Her right wrist was contracted and she was not wearing a splint. She was observed to have a hand roll on her right hand. On 4/16/19 at 1:45 PM, Nurse Aide (NA) #1 was interviewed. NA #1 stated that she started working at the facility as a NA in August 2018. She indicated that she was assigned to Resident #25. NA #1 reported that Resident #25 used to wear a splint on her right arm but she thought it was discontinued and was replaced with a hand roll. She added that she didn't know as to when it was discontinued. On 4/16/19 at 4:58 PM, Nurse #1 was interviewed. She stated that Resident #25 was supposed to have a splint on her right hand. Nurse #1 reviewed the MAR and verified that Resident #25 was supposed to have a splint applied at 6 AM every morning and it should be removed after 6-8 hours or until the resident tolerated it. Nurse #1 further indicated that the NA was supposed to apply the splint and the nurse to check behind. She stated that she didn't check the splint this morning if it was applied or not. The Nurse did not indicate that Resident #25 was refusing to wear the splint. On 4/17/19 at 8:50 AM, Resident #25 was observed up in wheelchair in her room. She was wearing a RUE resting hand splint at this time. She stated that the staff had not been applying the splint for a while until this morning at 6 AM. On 4/18/19 at 8:34 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected nursing to apply the splint as ordered and to document if the resident was	F 688	4.Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.: The Director of Nurses will monitor compliance utilizing the Splint Application Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor all residents with splint orders to ensure compliance with splint application and documentation of the task. The Director of Nurses or Support Nurse will observe 3 residents weekly on random shifts and random days of the week(to include weekends) to assure compliance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 5/15/19	

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F 688	Continued From page 23 refusing to wear the splint.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to implement the interventions for transfers resulting in falls without injury (Residents #39 and #7) for 2 of 3 residents reviewed for accidents. The findings included: 1. Resident #39 was admitted to the facility on 4/26/17 with diagnoses that included chronic kidney disease, aphasia, history of cerebral infarction, history of falling, and unspecified convulsions. The quarterly Minimum Data Set (MDS) assessment dated 12/18/18 indicated Resident #39 ' s cognition was moderately impaired. She required the extensive assistance of 2 for transfers. Resident #39 ' s care plan included the focus area of an Activity of Daily Living (ADL) self-care performance deficit related to activity intolerance (initiated on 5/24/17). The interventions included,	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F689 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to implement the interventions for transfers resulting in falls without injury. 1.Corrective action for resident(s) affected by the alleged deficient practice:	5/15/19

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F 689	Continued From page 24 in part, the extensive assistance of 2 people for transfers (initiated on 1/10/19). An incident report dated 3/2/19 completed by Nurse #4 indicated Resident #39 had a witnessed fall with no injury on 3/2/19 at 4:39 PM. Nursing Assistant (NA) #7 notified Nurse #4 that Resident #39 was on the floor. NA #7 reported that she was transferring Resident #39, her bed was unlocked, and the bed rolled causing her to be unable to support the resident. Resident #39 was lowered to the floor by NA #7. A review of the fall investigation dated 3/4/19 completed by the Director of Nursing (DON) indicated this 3/2/19 fall was reviewed and it was noted that the resident's bed was not locked prior to transferring Resident #39 from chair to bed. Staff were to ensure that the bed was locked prior to transferring Resident #39 with a 2 person assist. A phone interview was attempted with NA #7 on 4/16/19 at 1:32 PM and on 4/17/19 at 8:32 AM. She was unable to be reached. A phone interview was conducted with Nurse #4 on 4/16/19 at 4:35 PM. The 3/2/19 incident report for Resident #39 was reviewed with Nurse #4. She indicated that NA #7 was in Resident #39 ' s room without another NA present on 3/2/19 when she was notified of the assisted fall that occurred during a transfer. An interview was conducted with the DON on 4/17/19 at 12:05 PM. The 3/2/19 incident report for Resident #39 and the investigation dated 3/4/19 were reviewed with the DON. She stated that she was unable to recall with certainty if it	F 689	For resident # 7 corrective action was obtained on 4/18/19. The Director of Nurses obtained an individual gait belt for resident # 7 that is to be maintained at the resident bedside for use with staff transfers on 4/18/19. On 4/18/19 Nursing Assistant #8 and Nurse # 5 were educated regarding placement of the gait belt at the resident bedside for use with the resident transfers. On 4/8/19 the DON observed a return demonstration of a gait belt transfer by nursing assistant #8. The gait belt transfer was done correctly with Resident #7 For resident #39 corrective action was obtained on 4/18/19. Nursing Assistant # 7 was educated by the Director of Nurses on utilization of the resident kardex to assure that the appropriate resident transfer technique is used and that beds are in locked position prior to initiating a transfer. Nursing assistant #7 was observed by the Director of Nurses and performed a return demonstration for compliance with adherence to the kardex identified transfer technique and locking of the bed prior to initiating a transfer on 04/18/19. 2.Corrective action for residents with the potential to be affected by the alleged deficient practice: On 05/02/19 the MDS Coordinator audited all current residents to ensure that all transfer techniques were accurately reflected on the care plan/kardex. 69 out of 77 had the appropriate intervention in	

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F 689	Continued From page 25 had been identified during the investigation that NA #7 was transferring Resident #39 without another staff ' s assistance. She indicated that during the investigation she was so focused on the resident ' s bed being unlocked during the transfer that she may not have realized that the intervention of a 2 person assist for transfers was not implemented. The DON stated that she expected the care plan interventions to be implemented at all times to reduce the risk of falls. 2. Resident #7 was admitted 1/16/14 with cumulative diagnoses of Rheumatoid Arthritis, contractures and Kyphosis. Resident #7's annual Minimum Data Set dated 1/10/19 indicated she was cognitively intact and exhibited no behaviors. She was coded for extensive assistance with transfers and toileting. Resident #7 was coded as having no falls. Review of Resident #7's fall care plan last revised 1/10/19 indicated the intervention of a gait belt was to be utilized for transfers. Review of Resident #7's undated computerized Kardex the nursing assistants (NA) utilized indicated the required a gait belt for transfers. Review of a facility incident report dated 3/26/19 at 7:30 PM, read NA #8 was transferring Resident #7 to the bathroom when the resident's legs gave out. The Interdisciplinary Team note dated 3/29/19 read the staff were to use a gait belt for ambulation and transferring to the toilet. During an interview on 4/16/19 at 1:40 PM, Resident #7 stated the staff were not using a gait belt during her fall on 3/26/19. She stated earlier	F 689	place on both the care plan and Kardex and the remaining eight residents were corrected on the care plan and karex. on 5/2/19. As of 5/3/19 each nursing assistant began receiving a gait belt from the assigned nurse for use with resident transfers on their shift. The gait belt is to be turned in to the nurse at the end of the assigned shift and documented on the Gait Belt log to assure gait belts are available for use and being utilized by staff. the end of the shift and assigneAll had the appropriate intervention in place on both the care plan and kardex. On 5/1/19 the facility Maintenance Director audited all facility beds to assure that the locking mechanisms on the wheels of each bed was functioning properly. Results: One brake was replaced and all others were properly functioning. 3.Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 5/2/19, the Director of Nurses began education of all full time, part time, as needed nurses and certified nursing assistants on Safe Resident Transfers. The education is to include: accessing the kardex for assessed transfer status, performance of the assessed transfer method, assuring bed is in locked position prior to initiating a transfer, use of gait belts with resident transfers and how/where to obtain a gait belt for use during an assigned shift. The in-service will be completed by 5/15/19 at which time all nurses and certified nursing assistants must be in-serviced prior to working.	

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F 689	Continued From page 26 on 4/16/19, the staff did use the gait belt while taking her to the bathroom, but the staff had not been using one. Resident #7 stated she was not injured during the fall on 3/26/19. During an interview on 4/16/19 at 1:46 PM, the Director of Nursing (DON) stated she was not aware that the gait belt had been an intervention since 1/10/14. She stated she recently took the position of DON and only knew of a few residents who required the use of a gait belt with transfers. She stated she would like those residents to have a gait belt in their rooms, but it was the facility practice was to have a gait belt on the nurse medication cart for staff to use as needed. During an interview on 4/16/19 at 3:15 PM, NA #8 stated she was assigned Resident #7 the evening of 3/26/19 and recalled her fall. She stated she was aware that Resident #7 was to be transferred using a gait belt, but she lost her personal gait belt and could not find one in Resident #7's room or at the nursing station to use. She stated she was not aware that the gait belts were supposed to be keep on the nurse medication cart. During an interview on 4/17/19 at 8:50 AM, NA #5 stated Resident #7 was able to ambulate to the bathroom with one-person assistance and her walker. She stated she did not always use a gait belt when transferring Resident #7 because she could not always locate a gait belt on the nurse medication cart or at the nursing station. NA #5 stated the nurse's and the DON were aware that gait belts were not always readily available. During an interview on 4/17/19 at 8:50 AM, Nurse #5 stated she did not have a gait belt on her medication cart, but they were to be left at the nursing station for the aides to use.	F 689	The Maintenance Director will monitor bed locks on a weekly basis and or as needed basis. Information will be documented in TELS system. 4.Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and or/in compliance with regulatory requirements: The Director of Nurses will monitor compliance utilizing the Safe Transfer Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nurses or Support Nurse will observe 3 residents weekly on random shifts and random days of the week(to include weekends) to assure compliance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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F 689	Continued From page 27 Observation of the nursing station on 4/17/19 at 9:00 AM did not reveal any visible evidence of a gait belt. Observation of Resident #7's room and bathroom in her presence on 4/17/19 at 9:05 AM did not reveal any visible evidence of a gait belt. Resident #7 confirmed she did not have a gait belt anywhere in her room. During another interview on 4/18/19 at 8:27 AM, the DON stated it was her expectation that Resident #7 be transferred using a gait belt. She further stated she would like to see the aide issued a gait belt on hire and if they lost it, it should be replaced at the expense of the employee. The DON stated at present, this was not their policy and the gait belt were supposed to be located on the nurse's medication carts or at the nursing station. The DON further stated during the day, a gait belt could also be found in the therapy room if needed.	F 689		
F 727 SS=B	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	F 727		5/15/19

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F 727	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to staff Registered Nurse (RN) coverage for 8 consecutive hours daily for 7 of 15 days reviewed for RN coverage (4/1/19, 4/3/19, 4/5/19, 4/8/19, 4/10/19, 4/12/19 and 4/15/19). The findings included: Review of the daily staffing sheets revealed no RN coverage on 4/1/19 (census of 69), 4/3/19 (census of 71, 4/5/19 (census of 67), 4/8/19 (census of 68), 4/10/19 (census of 71), 4/12/19 (census of 70) and 4/15/19 (census of 71). During an interview on 4/18/19 at 8:27 AM, the Director of Nursing (DON) stated she was under the impression that she or the Minimum Data Set (MDS) Nurse could serve as the facility's 8 consecutive hour RN coverage on the days in question. She stated she discovered on 4/16/19 that the DON could only serve as coverage for a resident census of 60 residents or below. She stated it was her expectation that there be 8 hours of consecutive daily RN coverage provided by another RN other then herself or the MDS Nurse.	F 727	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F727 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to staff Registered Nurse coverage for 8 consecutive hours daily. 1. Corrective action for resident(s) affected by the alleged deficient practice: At least eight consecutive hours of registered nurse staffing will be maintained daily by 5/16/19. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 5/3/19 staffing sheets were reviewed by the DON from 4/25-5/2/19 to monitor that at least eight consecutive hours of registered nurse staffing was in place daily. 5 of8 days had	

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F 727	Continued From page 29	F 727	at least 8 consecutive hours of registered nurse hours in place. An on call process to maintain At least eight consecutive hours of registered nurse staffing will be maintained daily by 5/16/19 and an on call process to maintain eight consecutive hours of registered nurse staffing daily and use of a contracted agency for registered nurses will be developed and in use by 5/16/19. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 5/3/19, the Nurse Consultant educated the Administrator and DON on the requirement of the facility to staff RN coverage for at least 8 consecutive hours daily. Coverage by a Registered Nurse for at least eight consecutive hours will be maintained by 5/16/19. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON will monitor compliance utilizing the F272 Quality Assurance Tool weekly for staffing of registered nurse hours daily x 2 weeks, then monthly x 3 months. The DON will monitor staffing for compliance with the requirement for at least 8 hours or registered nurse hours daily x 2 weeks, then monthly x 3 months. The DON will monitor staffing for compliance with the requirement for at least 8 hrs. of registered nurse staffing daily. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored	

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F 727	Continued From page 30	F 727	and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Rehab Manager, Health Information Manager and the Dietary Manager.	
F 730 SS=C	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff and facility Nurse Consultant interviews and record review, the facility failed to provide Nursing Assistant (NA) required annual dementia training. This was for 4 (NA #2 hire date 4/27/17, NA #3 hire date 10/4/16, NA #5 hire date 6/15/17 and NA #6 hire date 6/3/14) of 5 sampled NA's reviewed for annual dementia training. The findings included During an interview on 4/17/19 at 1:53 PM, the facility Nurse Consultant stated there was no evidence of any dementia training but for NA #4 who received the training January 2019. She stated the facility recently added dementia training for all staff in January 2019 and that all staff would have the dementia training no later than July 2019. She further stated it was her expectation that staff receive dementia training	F 730	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F730 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to provide nursing assistant annual dementia training.	5/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345216	A. BUILDING _____ B. WING _____	C 04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD REHABILITATION AND HEALTH CENTER	3100 TRAMWAY ROAD SANFORD, NC 27330

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F 730	Continued From page 31 during orientation and annually. During an interview on 4/18/19 at 8:27 AM the Director of Nursing stated it was her expectation that receive annual dementia training.	F 730	1.Corrective action for resident(s) affected by the alleged deficient practice: Nursing Assistants #2, 3, 5 and 6 completed Dementia Training as of 5/3/19. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 5/1/19 the Director of Nurses audited all nursing assistants to monitor for completion of annual Dementia training. 15 of 35 nursing assistants were in compliance. 3.Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 5/1/19, the Director of Nurses began Dementia Training of all full time, part time and as needed nursing assistants. All nursing assistants will complete Dementia training by 5/15/19 at which time all nursing assistants must be in-serviced prior to working. 4.Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses will monitor compliance utilizing the Dementia Training Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor all nursing assistants for compliance with the completion of	

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F 730	Continued From page 32	F 730	annual Dementia training. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	