| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| MOUNTAIN VIEW MANOR NURSING CE | 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713 |

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| {F 000} | INITIAL COMMENTS<br><br>An onsite revisit was conducted on 08/29/19. Tags F637 and F641 were corrected as of 08/29/19. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance. | {F 000} | | |
| {F 640} SS=E | Encoding/Transmitting Resident Assessments<br>CFR(s): 483.20(f)(1)-(4)<br><br>§483.20(f) Automated data processing requirement-<br>§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:<br>(i) Admission assessment.<br>(ii) Annual assessment updates.<br>(iii) Significant change in status assessments.<br>(iv) Quarterly review assessments.<br>(v) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(vi) Background (face-sheet) information, if there is no admission assessment.<br><br>§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.<br><br>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit | {F 640} | | 9/18/19 |

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

Electronically Signed | 09/20/2019

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| {F 640} | Continued From page 1<br>encoded, accurate, and complete MDS data to the CMS System, including the following:<br>(i)Admission assessment.<br>(ii) Annual assessment.<br>(iii) Significant change in status assessment.<br>(iv) Significant correction of prior full assessment.<br>(v) Significant correction of prior quarterly assessment.<br>(vi) Quarterly review.<br>(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.<br><br>§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to complete one admission, one annual and one quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD) and failed to transmit one entry and 2 death in the facility tracking records within 14 days of the MDS completion date for 6 of 10 residents reviewed for Resident Assessments (Residents #5, #6, #7, #8, #9, and #10).<br><br>Findings included:<br><br>1. Resident #5 was admitted to the facility on 08/01/19.<br><br>Review of Resident #5's electronic medical | {F 640} | Disclaimer: We respectfully request this plan of correction be considered our allegation of substantial compliance. Preparation and/or completion of this plan of correction in general, or any corrective action set forth, herein, in particular, does not constitute an admission of agreement by Mountain View Manor of the conclusions set forth in the Statement of Deficiencies (Form 2567). The Plan of Correction and specific correction action are prepared and/or executed solely as a provision of Federal and/or State law.<br><br>The Minimum Data Set (MDS) of Resident # 5 with the Assessment Reference Date (ARD) date of 8/7/19 was | |

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| {F 640} | Continued From page 2<br>record revealed the last transmitted MDS was coded as an entry tracking record with an ARD of 08/01/19.<br><br>Further review of Resident #5's electronic medical record revealed an admission MDS assessment with an ARD of 08/07/19. The status of this assessment was "in progress" which indicated it had not been completed as of 08/29/19.<br><br>An interview was conducted with the MDS Coordinator on 08/29/19 at 12:20 PM. The MDS Coordinator confirmed she was responsible for completing and transmitting MDS assessments. The MDS Coordinator explained her focus had been on completing and transmitting MDS assessments that were late prior to the facility's annual recertification survey on 06/27/19 but was still behind on completing and transmitting MDS assessments that were due after the recertification date. She acknowledged the MDS assessment dated 08/05/19 for Resident #5 was late and not completed within the regulatory timeframe.<br><br>An interview was conducted with the Administrator on 08/29/19 at 3:51 PM. The Administrator stated after the facility's annual recertification survey on 06/27/19, he was under the impression MDS assessments were being completed and transmitted within the required timeframe based on the results of the facility's compliance audits. The Administrator stated he was unaware there was still an issue and expected MDS assessments to be completed and transmitted within the regulatory timeframe.<br><br>2. Resident #6 was admitted to the facility on | {F 640} | completed in the electronic health record on 9/10/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the Quality Improvement and Evaluation System (QIES) on 9/10/19 by the RN/MDS Coordinator.<br><br>The MDS of Resident # 6 with the ARD date of 8/5/19 was completed in the electronic health record on 9/5/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 9/06/19 by the RN/MDS Coordinator.<br><br>The MDS of Resident # 7 with the ARD date of 8/6/19 was completed in the electronic health record on 8/20/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 9/06/19 by the RN/MDS Coordinator.<br><br>The MDS of Resident# 8 with the ARD date of 8/7/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator.<br><br>The MDS of Resident # 9 with the ARD date of 7/28/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator. | |

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| {F 640} | Continued From page 3<br>08/10/18.<br><br>Review of Resident #6's electronic medical record revealed the last transmitted MDS was coded as a quarterly assessment with an ARD of 05/09/19.<br><br>Further review of Resident #6's electronic medical record revealed an annual MDS assessment with an ARD of 08/05/19. The status of this assessment was "in progress" which indicated it had not been completed as of 08/29/19.<br><br>An interview was conducted with the MDS Coordinator on 08/29/19 at 12:20 PM. The MDS Coordinator confirmed she was responsible for completing and transmitting MDS assessments. The MDS Coordinator explained her focus had been on completing and transmitting MDS assessments that were late prior to the facility's annual recertification survey on 06/27/19 but was still behind on completing and transmitting MDS assessments that were due after the recertification date. She acknowledged the MDS assessment dated 08/05/19 for Resident #6 was late and not completed within the regulatory timeframe.<br><br>An interview was conducted with the Administrator on 08/29/19 at 3:51 PM. The Administrator stated after the facility's annual recertification survey on 06/27/19, he was under the impression MDS assessments were being completed and transmitted within the required timeframe based on the results of the facility's compliance audits. The Administrator stated he was unaware there was still an issue and expected MDS assessments to be completed and | {F 640} | The MDS of Resident # 10 with the ARD date of 8/11/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator.<br><br>Residents # 5, #6, #7, #8, #9, and # 10 will continue to have timely assessments completed in the electronic health record by the Interdisciplinary Team (IDT) and transmitted by the MDS Coordinator into the QIES system per Resident Assessment Instrument (RAI) guidelines.<br>All residents have the potential to be affected by the same practice. An MDS audit will be completed by an RN to review current residents and the timeliness of MDS assessments. Any resident who has not had an MDS completed or transmitted in a timely manner will have corrective action taken by the MDS Coordinator.<br>The audits were completed on 09/16/19 and corrective action was taken by the MDS Coordinator for any discrepancies identified.<br>The Director of Nursing provided inservice education to all MDS Coordinators on 09/05/2019 on timely completion and transmission of the MDS Assessments. A posttest was given to access learning and promote competency. The MDS Coordinators all successfully passed the posttest with a score of 100.<br>A copy of the RAI guidelines related to the timelines of completion and transmission of MDS assessments was posted in the | |

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| {F 640} | Continued From page 4<br>transmitted within the regulatory timeframe.<br><br>3. Resident #7 was admitted to the facility on 12/01/17.<br><br>Review of Resident #7's electronic medical record revealed the last transmitted MDS was coded as a quarterly assessment with an ARD of 05/13/19.<br><br>Further review of Resident #7's electronic medical record revealed a quarterly MDS assessment with an ARD of 08/06/19. The status of this assessment was "in progress" which indicated it had not been completed as of 08/29/19.<br><br>An interview was conducted with the MDS Coordinator on 08/29/19 at 12:20 PM. The MDS Coordinator confirmed she was responsible for completing and transmitting MDS assessments. The MDS Coordinator explained her focus had been on completing and transmitting MDS assessments that were late prior to the facility's annual recertification survey on 06/27/19 but was still behind on completing and transmitting MDS assessments that were due after the facility's annual recertification date. She acknowledged the MDS assessment dated 08/06/19 for Resident #7 was late and not completed within the regulatory timeframe.<br><br>An interview was conducted with the Administrator on 08/29/19 at 3:51 PM. The Administrator stated after the facility's annual recertification survey on 06/27/19, he was under the impression MDS assessments were being completed and transmitted within the required timeframe based on the results of the facility's | {F 640} | MDS office by the Director of Nursing on 9/16/19 as a reference guide for the MDS Coordinator.<br>An RN will complete weekly audits of the MDS assessments reviewing completion and transmission dates. The audits began on 09/05/19 and will continue at a minimum of four weeks or until the QAPI committee has deemed substantial compliance has been reached and the system has been deemed effective.<br>The MDS Coordinator will meet with the Administrator and/or Assistant Administrator at a minimum of two times a week to review completion and transmission of the MDS assessments in the electronic health record. These meetings were initiated on 08/30/19. The Administrator may choose to decrease the frequency of the meetings to weekly after one month, based on the recommendations of the QAPI committee, if timely completion and transmission of the MDS assessments are occurring per RAI guidelines.<br>The Administrator will review the results of the audits and the weekly compliance meetings with MDS Coordinator for timeliness of completion and submission for any trends or patterns and report to the Quality Assurance Performance Improvement Committee. The QAPI Committee consists of the Administrator, Director of Nursing, Medical Director, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI Committee will review the results of the weekly reviews of MDS timeliness of completion and submissions and direct | |

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| {F 640} | Continued From page 5<br>compliance audits. The Administrator stated he was unaware there was still an issue and expected MDS assessments to be completed and transmitted within the regulatory timeframe.<br><br>4. Resident #8 was readmitted to the facility on 08/07/19.<br><br>Review of Resident #8's electronic medical record revealed an entry tracking record with an ARD of 08/07/19. The status of this assessment was "exported" with a transmission date of 08/28/19.<br><br>An interview was conducted with the MDS Coordinator on 08/29/19 at 12:20 PM. The MDS Coordinator confirmed she was responsible for completing and transmitting MDS assessments. The MDS Coordinator explained her focus had been on completing and transmitting MDS assessments that were late prior to the facility's annual recertification survey on 06/27/19 but was still behind on completing and transmitting MDS assessments that were due after the recertification date. She acknowledged the MDS assessment dated 08/07/19 for Resident #8 was late and not transmitted within the regulatory timeframe.<br><br>An interview was conducted with the Administrator on 08/29/19 at 3:51 PM. The Administrator stated after the facility's annual recertification survey on 06/27/19, he was under the impression MDS assessments were being completed and transmitted within the required timeframe based on the results of the facility's compliance audits. The Administrator stated he was unaware there was still an issue and expected MDS assessments to be completed and | {F 640} | corrective action as necessary. The QAPI Committee may approve changes in the frequency of the audits and/or discontinue the audits once the new system has been deemed effective to maintain substantial compliance.<br>Completion date 09/18/19 | |

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| {F 640} | Continued From page 6 | {F 640} | | |

transmitted within the regulatory timeframe.

5. Resident #9 was admitted to the facility on 06/15/18.

Review of Resident #9's electronic medical record revealed a death in facility tracking record with an ARD of 07/28/19. The status of this assessment was "exported" with a transmission date of 08/28/19.

An interview was conducted with the MDS Coordinator on 08/29/19 at 12:20 PM. The MDS Coordinator confirmed she was responsible for completing and transmitting MDS assessments. The MDS Coordinator explained her focus had been on completing and transmitting MDS assessments that were late prior to the facility's annual recertification survey on 06/27/19 but was still behind on completing and transmitting MDS assessments that were due after the recertification date. She acknowledged the MDS tracking record dated 07/28/19 for Resident #9 was late and not transmitted within the regulatory timeframe.

An interview was conducted with the Administrator on 08/29/19 at 3:51 PM. The Administrator stated after the facility's annual recertification survey on 06/27/19, he was under the impression MDS assessments were being completed and transmitted within the required timeframe based on the results of the facility's compliance audits. The Administrator stated he was unaware there was still an issue and expected MDS assessments to be completed and transmitted within the regulatory timeframe.

6. Resident #10 was readmitted to the facility on

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| {F 640} | Continued From page 7<br>07/04/19.<br><br>Review of Resident #10's electronic medical record revealed a death in facility tracking record with an ARD of 08/11/19. The status of this assessment was "exported" with a transmission date of 08/28/19.<br><br>An interview was conducted with the MDS Coordinator on 08/29/19 at 12:20 PM. The MDS Coordinator confirmed she was responsible for completing and transmitting MDS assessments. The MDS Coordinator explained her focus had been on completing and transmitting MDS assessments that were late prior to the facility's annual recertification survey on 06/27/19 but was still behind on completing and transmitting MDS assessments that were due after the recertification date. She acknowledged the MDS tracking record dated 08/11/19 for Resident #10 was late and not transmitted within the regulatory timeframe.<br><br>An interview was conducted with the Administrator on 08/29/19 at 3:51 PM. The Administrator stated after the facility's annual recertification survey on 06/27/19, he was under the impression MDS assessments were being completed and transmitted within the required timeframe based on the results of the facility's compliance audits. The Administrator stated he was unaware there was still an issue and expected MDS assessments to be completed and transmitted within the regulatory timeframe. | {F 640} | | |

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| F 000 | INITIAL COMMENTS<br><br>An onsite revisit and complaint investigation survey was conducted on 08/28/19 through 08/29/19. Two of the four allegations were substantiated. | F 000 | | |
| F 604 SS=D | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§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).<br><br>§483.12<br>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.<br><br>§483.12(a) The facility must-<br><br>§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. | F 604 | | 9/18/19 |

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| F 604 | Continued From page 1<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to maintain an environment free of physical restraints for 1 of 2 residents (Resident #1) reviewed for restraint usage by placing a sheet around Resident #1's waist and tying it to the back of her wheelchair to prevent rising.<br><br>Findings included:<br><br>Resident #1 was admitted to the facility on 10/10/16 with multiple diagnoses that included Alzheimer's disease, anxiety and history of falls.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 07/01/19 indicated Resident #1 had moderate impairment in cognition, required extensive to total assistance with all activities of daily living and displayed no behaviors during the 7-day assessment period. The MDS noted Resident #1 had no falls and no use of physical restraints during the assessment period.<br><br>Review of Resident #1's fall care plan, with a review date of 07/01/19, revealed she had the potential for falls related to an unsteady gait, wheelchair use, and cognitive impairment. Interventions included for staff to observe and monitor Resident #1's attempts to get up unassisted and provide reminders as needed.<br><br>Review of the facility's abuse investigations revealed an allegation was reported on 06/29/19 at 7:00 PM that Resident #1 had been restrained to her wheelchair with a sheet by Nurse #1.<br><br>Review of Resident #1's medical record revealed no nursing progress note or incident report | F 604 | Disclaimer: We respectfully request this plan of correction be considered our allegation of substantial compliance. Preparation and/or completion of this plan of correction in general, or any corrective action set forth, herein, in particular, does not constitute an admission of agreement by Mountain View Manor of the conclusions set forth in the Statement of Deficiencies (Form 2567). The Plan of Correction and specific correction action are prepared and/or executed solely as a provision of Federal and/or State law.<br><br>Resident #1 removed the sheet that had been tied around her wheelchair by taking the sheet over her head according to staff interviews conducted by the Social Service Director (SSD) on 06/30/2019. The sheet was not reapplied to the resident by the nursing staff. Resident #1 displayed no signs or symptoms of distress or discomfort per staff interview conducted by the SSD on 06/30/2019. Resident # 1 will continue to use a wheelchair when out of bed and will not have a restraint applied without a medical symptom as assessed by a Registered Nurse (RN) and with a physician□s order for use.<br>All residents are at risk to be affected by the same practice. Nursing staff interviews will be conducted by the SSD, Assistant Administrator (AA) and/or designated Registered Nurse (RN) across all shifts as a means of helping to identify | |

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| F 604 | Continued From page 2<br>related to the incident that occurred on 06/29/19.<br><br>Review of Resident #1's skin assessment completed on 06/30/19 revealed no new bruising or injuries related to the incident on 06/29/19.<br><br>Resident #1 was unable to be interviewed due to cognition.<br><br>During a telephone interview on 08/28/19 at 11:07 AM, Personal Care Assistant (PCA) #1 confirmed she was assigned to Resident #1's hall on 06/29/19 but did not provide direct care. PCA #1 recalled as she walked by Resident #1's room, she noticed her sitting in the wheelchair with a sheet around her waist and tied to the back of the wheelchair. She stated Resident #1 did not appear distressed but was trying to get up out of the wheelchair. PCA #1 was unable to recall the exact time this had occurred but stated it was approximately 10:00 AM and did not feel that she had been left that way for very long because Resident #1 "wiggled her way right out of it."<br><br>During telephone interviews on 08/28/19 at 12:39 PM and 5:40 PM, NA #5 verified she was one of the NAs assigned to Resident #1's hall on 06/29/19 when she had observed Resident #1 seated in her room with a sheet wrapped around her waist and tied to the back of her wheelchair. NA #5 could not recall the exact time of her observation but stated it was "around lunchtime." She added PCA #1 was already in the room when she entered and told her Nurse #1 had placed the sheet around Resident #1. NA #5 stated prior to providing Resident #1 with assistance both she and PCA #1 left the room to discuss their observation with the other NAs on the hall. She added when they had returned to the room, | F 604 | if any other residents were affected by the same practice of using a sheet as a restraint. Any deficient practice identified during the interviews related to restraints and/or improper use of restraints will be reported to the Administrator and Director of Nursing (DON) for corrective action. The interviews will be completed by 09/18/19.<br>The facility□s guidelines on restraints were updated by a RN on 9/3/19 to include more specific examples of what can be considered a restraint, as well as guidelines for use of a restraint if needed to treat a medical symptom. Copies of the revised and approved guidelines will be maintained in the nursing office and the DON will place copies on each nurses□ station in a manual for reference by the nursing staff.<br>The Director of Nursing (DON) provided inservice education to the licensed and non-licensed nursing staff on 09/10/19. The training reviewed the updated restraint guidelines. A posttest to access learning and promote competency was given. Mandatory make-up inservices will be provided by 09/18/19. Any licensed staff and non-licensed staff on leave will be required to make-up the inservice prior to return to duty.<br>New nursing employee orientation will be updated to include training on restraints and the updated restraint policy.<br>Weekly staff interviews related to use of a sheet as a restraints will be completed by the SSD, AA, and/or designated RN for a total of four weeks at a minimum or longer until substantial compliance is achieved | |

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| F 604 | Continued From page 3<br>Resident #1 had already "halfway wiggled out of the restraint" and ended up removing it the rest of the way by pulling the sheet up over her head.<br><br>During telephone interviews on 08/28/19 at 1:45 PM and 5:37 PM, NA #6 confirmed she was one of the NAs assigned to Resident #1's hall on 06/29/19. NA #6 explained Resident #1 had very poor safety awareness and frequently attempted to stand unassisted from her wheelchair. She added the NAs all worked together to keep her in visual site and provided redirection whenever she attempted to stand up from her wheelchair so she would not fall and get hurt. NA #6 stated it was around lunchtime when she was informed by NA #7 that Resident #1 had been tied to her wheelchair by Nurse #1 and when she walked into her room, she noticed a sheet was wrapped around her waist and tied to the back of the wheelchair. She added as she walked into the room, Resident #1 pulled the sheet up over her head and removed it before she was able to assist her. She recalled Resident #1 displayed no signs of distress while attempting to remove the sheet or the remainder of the afternoon.<br><br>During an interview on 08/29/19 at 10:03 AM, NA #7 confirmed she was one of the NAs assigned to Resident #1's hall on 06/29/19. NA #7 stated Resident #1 had her "good and bad days" where some days she would be calm and the other days she would be very "fidgety." She added they usually kept her in visual site due to her poor safety awareness and to prevent her from falling. NA #7 recalled Resident #1 was restless on 06/29/19 and making frequent attempts to stand up unassisted from her wheelchair. NA #7 further recalled when she did not see Resident #1 sitting out in the hall, she went into her room to check on | F 604 | and maintained as determined by the Quality Assurance Performance Improvement (QAPI) Committee. The weekly staff interviews were initiated on 09/04/19. Weekly rounds will be conducted randomly by the DON and/or RN Supervisor on all shifts to identify if a resident is inappropriately restrained for four weeks or longer until substantial compliance is achieved and maintained as determined by the QAPI Committee. The weekly rounds by the DON and/or RN supervisor were initiated on 09/06/19. Any discrepancies will receive immediate corrective action by a licensed nurse. The DON will review the results of the weekly interviews and rounds for any trends or patterns and report to the QAPI Committee. The QAPI Committee consists of the Administrator, DON, Medical Director, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI Committee will review the results of the interviews and resident observation audits and direct corrective action as necessary. The QAPI Committee may approve changes in the frequency of the audits and/or discontinue the audits once the new system has been deemed effective to maintain substantial compliance.<br><br>Completion date 09/18/19 | |

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| F 604 | Continued From page 4 | F 604 | | |

her and found her with a sheet wrapped around her waist and tied to the back of the wheelchair. NA #7 stated Resident #1 displayed no signs of distress and before providing any assistance, she left the room to get another NA as a witness. She indicated as she, NA #5 and NA #6 walked back into the room, Resident #1 was "halfway out of the restraint" by pulling the sheet up over her head and removing it from around her waist. She added Nurse #1 came into the room while they were all standing in the doorway and asked who had taken the sheet off the wheelchair. NA #7 stated they told Nurse #1 that Resident #1 had removed it herself.

During a telephone interview on 08/28/19 at 2:25 PM, Nurse #1 confirmed that on 06/29/19 she had used a sheet to wrap around Resident #1's waist to keep her seated in the wheelchair but stressed that it was not done to harm her, just keep her safe while she finished the 12:00 PM blood glucose monitoring for other residents. Nurse #1 explained Resident #1 was a fall risk and the Receptionist had assisted with supervising Resident #1 that morning to keep her safe. She added when the Receptionist went to lunch and Resident #1 was brought back to the hall, she was unable to find any of the NAs to supervise Resident #1. Nurse #1 recalled Resident #1 had been "extremely agitated" all morning, constantly getting up and down out of her wheelchair, would not sit still, and it had "pushed her to her wits end." Nurse #1 indicated it was a rather "hectic day" and she only needed "10 minutes or so" to get the 12:00 PM blood glucose monitoring completed, so at approximately 11:30 AM she took Resident #1 to her room, placed a sheet around her waist and "loosely" tied the sheet to the back of the

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| F 604 | Continued From page 5 | F 604 | | |

wheelchair. She stated it only took Resident #1 approximately 10 minutes to remove the sheet by pulling it up over her head, throw it behind her, stand up and attempt to push her wheelchair. Nurse #1 stressed she was not trying to restrain Resident #1, she was just fearful she would fall and get hurt and only put the sheet around her waist to keep her safe. Nurse #1 confirmed it was facility policy never to physically restrain a resident and restated the loosely tied sheet did not bind, harm or restrain Resident #1 from moving. Nurse #1 restated she did not and would not intentionally cause Resident #1 any harm, she was only trying to ensure her safety and looking back, should have found someone to sit with Resident #1 instead of making the bad judgement of placing a sheet around her waist.

During a telephone interview on 08/29/19 at 9:06 AM, the Receptionist indicated she worked every Saturday and Sunday during the hours of 8:00 AM to 6:30 PM and verified she worked on 06/29/19. The Receptionist confirmed Resident #1 often sat out in the lobby whenever she worked and needed constant redirection to sit back down in her wheelchair to keep from falling. The Receptionist stated she typically took her lunch around 11:30 AM but was unable to recall if Resident #1 was present in the reception area when she had left for lunch on 06/29/19. The Receptionist was unable to recall anything unusual about Resident #1's behavior and stated on 06/29/19 she never observed Resident #1 restrained to her wheelchair with a sheet.

During an interview on 08/29/19 at 3:51 PM, the Administrator confirmed he was notified of the incident involving Resident #1 on 06/30/19. The Administrator explained prior to utilizing a

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| F 604 | Continued From page 6<br>restraint on a resident, a nurse was expected to complete an assessment that verified the need for the restraint and evaluate how the resident would respond and benefit from the use of the restraint. The Administrator stated he felt Nurse #1 made a bad judgement call and added while a restraint might be necessary in some circumstances for a resident's safety, using a sheet to wrap around a resident's waist and tying it to the back of the wheelchair would never be an appropriate or acceptable restraint to use. | F 604 | | |
| F 640 SS=E | Encoding/Transmitting Resident Assessments<br>CFR(s): 483.20(f)(1)-(4)<br><br>§483.20(f) Automated data processing requirement-<br>§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:<br>(i) Admission assessment.<br>(ii) Annual assessment updates.<br>(iii) Significant change in status assessments.<br>(iv) Quarterly review assessments.<br>(v) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(vi) Background (face-sheet) information, if there is no admission assessment.<br><br>§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. | F 640 | | 9/18/19 |

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| F 640 | Continued From page 7<br>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:<br>(i)Admission assessment.<br>(ii) Annual assessment.<br>(iii) Significant change in status assessment.<br>(iv) Significant correction of prior full assessment.<br>(v) Significant correction of prior quarterly assessment.<br>(vi) Quarterly review.<br>(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.<br><br>§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to complete one admission, one annual and one quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD) and failed to transmit one entry and 2 death in the facility tracking records within 14 days of the MDS completion date for 6 of 10 residents reviewed for Resident Assessments (Residents #5, #6, #7, #8, #9, and #10).<br><br>Findings included:<br><br>1. Resident #5 was admitted to the facility on | F 640 | The Minimum Data Set (MDS) of Resident # 5 with the Assessment Reference Date (ARD) date of 8/7/19 was completed in the electronic health record on 9/10/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the Quality Improvement and Evaluation System (QIES) on 9/10/19 by the RN/MDS Coordinator.<br><br>The MDS of Resident # 6 with the ARD date of 8/5/19 was completed in the electronic health record on 9/5/19 by the | |

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| F 640 | Continued From page 8<br>08/01/19.<br><br>Review of Resident #5's electronic medical record revealed the last transmitted MDS was coded as an entry tracking record with an ARD of 08/01/19.<br><br>Further review of Resident #5's electronic medical record revealed an admission MDS assessment with an ARD of 08/07/19. The status of this assessment was "in progress" which indicated it had not been completed as of 08/29/19.<br><br>An interview was conducted with the MDS Coordinator on 08/29/19 at 12:20 PM. The MDS Coordinator confirmed she was responsible for completing and transmitting MDS assessments. The MDS Coordinator explained her focus had been on completing and transmitting MDS assessments that were late prior to the facility's annual recertification survey on 06/27/19 but was still behind on completing and transmitting MDS assessments that were due after the recertification date. She acknowledged the MDS assessment dated 08/05/19 for Resident #5 was late and not completed within the regulatory timeframe.<br><br>An interview was conducted with the Administrator on 08/29/19 at 3:51 PM. The Administrator stated after the facility's annual recertification survey on 06/27/19, he was under the impression MDS assessments were being completed and transmitted within the required timeframe based on the results of the facility's compliance audits. The Administrator stated he was unaware there was still an issue and expected MDS assessments to be completed and | F 640 | RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 9/06/19 by the RN/MDS Coordinator.<br><br>The MDS of Resident # 7 with the ARD date of 8/6/19 was completed in the electronic health record on 8/20/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 9/06/19 by the RN/MDS Coordinator.<br><br>The MDS of Resident# 8 with the ARD date of 8/7/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator.<br><br>The MDS of Resident # 9 with the ARD date of 7/28/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator.<br><br>The MDS of Resident # 10 with the ARD date of 8/11/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator.<br><br>Residents # 5, #6, #7, #8, #9, and # 10 will continue to have timely assessments | |

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| F 640 | Continued From page 9<br>transmitted within the regulatory timeframe.<br><br>2. Resident #6 was admitted to the facility on 08/10/18.<br><br>Review of Resident #6's electronic medical record revealed the last transmitted MDS was coded as a quarterly assessment with an ARD of 05/09/19.<br><br>Further review of Resident #6's electronic medical record revealed an annual MDS assessment with an ARD of 08/05/19. The status of this assessment was "in progress" which indicated it had not been completed as of 08/29/19.<br><br>An interview was conducted with the MDS Coordinator on 08/29/19 at 12:20 PM. The MDS Coordinator confirmed she was responsible for completing and transmitting MDS assessments. The MDS Coordinator explained her focus had been on completing and transmitting MDS assessments that were late prior to the facility's annual recertification survey on 06/27/19 but was still behind on completing and transmitting MDS assessments that were due after the recertification date. She acknowledged the MDS assessment dated 08/05/19 for Resident #6 was late and not completed within the regulatory timeframe.<br><br>An interview was conducted with the Administrator on 08/29/19 at 3:51 PM. The Administrator stated after the facility's annual recertification survey on 06/27/19, he was under the impression MDS assessments were being completed and transmitted within the required timeframe based on the results of the facility's | F 640 | completed in the electronic health record by the Interdisciplinary Team (IDT) and transmitted by the MDS Coordinator into the QIES system per Resident Assessment Instrument (RAI) guidelines.<br>All residents have the potential to be affected by the same practice. An MDS audit will be completed by an RN to review current residents and the timeliness of MDS assessments. Any resident who has not had an MDS completed or transmitted in a timely manner will have corrective action taken by the MDS Coordinator.<br>The audits were completed on 09/16/19 and corrective action was taken by the MDS Coordinator for any discrepancies identified.<br>The Director of Nursing provided inservice education to all MDS Coordinators on 09/05/2019 on timely completion and transmission of the MDS Assessments. A posttest was given to access learning and promote competency. The MDS Coordinators all successfully passed the posttest with a score of 100.<br>A copy of the RAI guidelines related to the timelines of completion and transmission of MDS assessments was posted in the MDS office by the Director of Nursing on 9/16/19 as a reference guide for the MDS Coordinator.<br>An RN will complete weekly audits of the MDS assessments reviewing completion and transmission dates. The audits began on 09/05/19 and will continue at a minimum of four weeks or until the QAPI committee has deemed substantial compliance has been reached and the system has been deemed effective. | |

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| F 640 | Continued From page 10<br>compliance audits. The Administrator stated he was unaware there was still an issue and expected MDS assessments to be completed and transmitted within the regulatory timeframe.<br><br>3. Resident #7 was admitted to the facility on 12/01/17.<br><br>Review of Resident #7's electronic medical record revealed the last transmitted MDS was coded as a quarterly assessment with an ARD of 05/13/19.<br><br>Further review of Resident #7's electronic medical record revealed a quarterly MDS assessment with an ARD of 08/06/19. The status of this assessment was "in progress" which indicated it had not been completed as of 08/29/19.<br><br>An interview was conducted with the MDS Coordinator on 08/29/19 at 12:20 PM. The MDS Coordinator confirmed she was responsible for completing and transmitting MDS assessments. The MDS Coordinator explained her focus had been on completing and transmitting MDS assessments that were late prior to the facility's annual recertification survey on 06/27/19 but was still behind on completing and transmitting MDS assessments that were due after the facility's annual recertification date. She acknowledged the MDS assessment dated 08/06/19 for Resident #7 was late and not completed within the regulatory timeframe.<br><br>An interview was conducted with the Administrator on 08/29/19 at 3:51 PM. The Administrator stated after the facility's annual recertification survey on 06/27/19, he was under | F 640 | The MDS Coordinator will meet with the Administrator and/or Assistant Administrator at a minimum of two times a week to review completion and transmission of the MDS assessments in the electronic health record. These meetings were initiated on 08/30/19. The Administrator may choose to decrease the frequency of the meetings to weekly after one month, based on the recommendations of the QAPI committee, if timely completion and transmission of the MDS assessments are occurring per RAI guidelines.<br>The Administrator will review the results of the audits and the weekly compliance meetings with MDS Coordinator for timeliness of completion and submission for any trends or patterns and report to the Quality Assurance Performance Improvement Committee. The QAPI Committee consists of the Administrator, Director of Nursing, Medical Director, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI Committee will review the results of the weekly reviews of MDS timeliness of completion and submissions and direct corrective action as necessary. The QAPI Committee may approve changes in the frequency of the audits and/or discontinue the audits once the new system has been deemed effective to maintain substantial compliance.<br>Completion date 09/18/19 | |

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the impression MDS assessments were being completed and transmitted within the required timeframe based on the results of the facility's compliance audits. The Administrator stated he was unaware there was still an issue and expected MDS assessments to be completed and transmitted within the regulatory timeframe.

4. Resident #8 was readmitted to the facility on 08/07/19.

Review of Resident #8's electronic medical record revealed an entry tracking record with an ARD of 08/07/19. The status of this assessment was "exported" with a transmission date of 08/28/19.

An interview was conducted with the MDS Coordinator on 08/29/19 at 12:20 PM. The MDS Coordinator confirmed she was responsible for completing and transmitting MDS assessments. The MDS Coordinator explained her focus had been on completing and transmitting MDS assessments that were late prior to the facility's annual recertification survey on 06/27/19 but was still behind on completing and transmitting MDS assessments that were due after the recertification date. She acknowledged the MDS assessment dated 08/07/19 for Resident #8 was late and not transmitted within the regulatory timeframe.

An interview was conducted with the Administrator on 08/29/19 at 3:51 PM. The Administrator stated after the facility's annual recertification survey on 06/27/19, he was under the impression MDS assessments were being completed and transmitted within the required timeframe based on the results of the facility's

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| F 640 | Continued From page 12 | F 640 | | |

compliance audits. The Administrator stated he was unaware there was still an issue and expected MDS assessments to be completed and transmitted within the regulatory timeframe.

5. Resident #9 was admitted to the facility on 06/15/18.

Review of Resident #9's electronic medical record revealed a death in facility tracking record with an ARD of 07/28/19. The status of this assessment was "exported" with a transmission date of 08/28/19.

An interview was conducted with the MDS Coordinator on 08/29/19 at 12:20 PM. The MDS Coordinator confirmed she was responsible for completing and transmitting MDS assessments. The MDS Coordinator explained her focus had been on completing and transmitting MDS assessments that were late prior to the facility's annual recertification survey on 06/27/19 but was still behind on completing and transmitting MDS assessments that were due after the recertification date. She acknowledged the MDS tracking record dated 07/28/19 for Resident #9 was late and not transmitted within the regulatory timeframe.

An interview was conducted with the Administrator on 08/29/19 at 3:51 PM. The Administrator stated after the facility's annual recertification survey on 06/27/19, he was under the impression MDS assessments were being completed and transmitted within the required timeframe based on the results of the facility's compliance audits. The Administrator stated he was unaware there was still an issue and expected MDS assessments to be completed and

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| F 640 | Continued From page 13<br>transmitted within the regulatory timeframe.<br><br>6. Resident #10 was readmitted to the facility on 07/04/19.<br><br>Review of Resident #10's electronic medical record revealed a death in facility tracking record with an ARD of 08/11/19. The status of this assessment was "exported" with a transmission date of 08/28/19.<br><br>An interview was conducted with the MDS Coordinator on 08/29/19 at 12:20 PM. The MDS Coordinator confirmed she was responsible for completing and transmitting MDS assessments. The MDS Coordinator explained her focus had been on completing and transmitting MDS assessments that were late prior to the facility's annual recertification survey on 06/27/19 but was still behind on completing and transmitting MDS assessments that were due after the recertification date. She acknowledged the MDS tracking record dated 08/11/19 for Resident #10 was late and not transmitted within the regulatory timeframe.<br><br>An interview was conducted with the Administrator on 08/29/19 at 3:51 PM. The Administrator stated after the facility's annual recertification survey on 06/27/19, he was under the impression MDS assessments were being completed and transmitted within the required timeframe based on the results of the facility's compliance audits. The Administrator stated he was unaware there was still an issue and expected MDS assessments to be completed and transmitted within the regulatory timeframe. | F 640 | | |
| F 656 | Develop/Implement Comprehensive Care Plan | F 656 | | 9/18/19 |

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| F 656 SS=D | Continued From page 14<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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. | F 656 | | |

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| F 656 | Continued From page 15<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews, record reviews, and observations the facility failed to develop a comprehensive care plan for falls to include the intervention of a lap belt for 2 of 2 residents reviewed for restraints (Resident #1 and #4).<br><br>The findings included:<br><br>1. Resident #1 was admitted to the facility on 03/16/2018 with an admitting diagnosis of Alzheimer's, dementia, anxiety disorder, muscle weakness, rheumatoid arthritis, and a history of Falls.<br><br>The quarterly Minimum Data Set (MDS) dated 07/01/2019 revealed that Resident #1 had moderate impairment in cognition, she also had a short-term and long-term memory deficit extensive assistance of 1 staff with bed mobility and transfers. Resident #1 used a wheelchair for mobility. The MDS also revealed she had no falls coded for this assessment.<br><br>A review of Resident #1 care plans revealed that her fall care plan was initiated on 10/10/16 and was last reviewed on 07/01/2019 with a notation of no falls and to continue goals and interventions. The interventions in place for falls included: keep bed in the lowest position, remind her as needed to not get up without assistance, when out of bed she will be in wheelchair, fall mats next to bed, Left side of bed up against the wall, call light within reach, back wheels on the | F 656 | The care plan of Resident # 1 and Resident # 4 was updated on 08/29/19 by the MDS Coordinator. Resident # 1 and Resident # 4 will continue to have a care plan that reflects the use of a lap belt as long as the physician□s order for the lap belt is in place.<br>All residents who use a lap belt in a wheelchair are at risk to be affected by the same practice. A care plan audit will be completed by an RN for those residents who use a lap belt in the wheelchair to verify that care plan is in place for use of the lap belt. The care plan audit will be completed by 09/18/19. Corrective action will be taken by the RN completing the audit for any resident who does not have a care plan in place for the use of a lap belt.<br>The DON provided education to the care plan team which consists of the MDS Coordinator, the Activities Director, the Director of Social Services, and the Dietary Manager on 08/29/19 on the need to include a lap belt on the resident□s comprehensive plan of care.<br>A licensed nurse receiving a physician□s order for a lap belt will update the resident□s care plan to reflect the use of a lap belt. The MDS Coordinator or designated RN will review telephone orders weekly for newly ordered lap belts and verify that the lap belt has been | |

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| F 656 | Continued From page 16<br>wheelchair are lowered by occupational staff to assist with positioning, and bolsters on mattress. There was no care plan intervention for a lap belt.<br><br>An observation on 08/28/2019 at 09:07 AM revealed Resident #1 sitting in her wheelchair in the front lobby common area with a lap belt around her waist.<br><br>An interview was conducted on 08/28/2019 at 1:55 PM with Nursing Assistant (NA) # 3 revealed Resident #1 has always had a lap belt on her while she was in her wheelchair, and that she could unfasten it herself.<br><br>An interview was conducted on 08/29/2019 at 2:32 PM with the MDS Nurse revealed that a lap belt needed and order and should have been on the care plan. The MDS Nurse stated that Resident #1 needed the lap belt to deter her from getting up unassisted to avoid injury. The interview further revealed she was responsible for updating care plans.<br><br>An interview was conducted on 08/29/2019 at 1:45 PM with the Director of Nursing (DON) revealed that a lap belt required a doctor's order and it should be on the resident's care plan. She further revealed that she had no idea why Resident #1 did not have a doctor's order or why it was not on the care plan. The DON revealed that she is new in her position and does not know if there was a system in place for lap belts.<br><br>An interview on 08/29/2019 at 3:51 PM with the Administrator revealed that he had no idea that the residents with lap belts did not have a doctor's order for use. He also revealed that it was his expectation that the MDS nurse would have | F 656 | added to the plan of care. If the lap belt has not been added to the plan of care, the MDS Coordinator or designated RN will update the plan of care at that time to reflect the use of the lap belt. This process was implemented on 08/29/19.<br>Care plan audits will be completed weekly beginning on 08/29/19 by an RN to verify that residents who utilize lap belts have a care plan to address the use of the lap belt for four weeks at a minimum or longer until substantial compliance is achieved and maintained as determined by the QAPI Committee. Corrective action will be taken by the MDS Coordinator and/or RN for any resident who uses a lap belt that does not have a care plan in place to address the use of the belt.<br>The Director of Nursing (DON) provided inservice education to the licensed and non-licensed nursing staff on 09/10/19. The training reviewed the updated restraint guidelines. A posttest to access learning and promote competency was given. Mandatory make-up inservices will be provided by 09/18/19. Any licensed staff and non-licensed staff on leave will be required to make-up the inservice prior to return to duty.<br>Care plan audits will be completed weekly beginning 08/29/19 by an RN to verify that residents who utilize lap belts have a care plan to address the use of the lap belt for four weeks at a minimum or longer until substantial compliance is achieved and maintained as determined by the QAPI Committee. Corrective action will be taken by the MDS Coordinator and/or RN for any resident who uses a lap belt that does | |

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| F 656 | Continued From page 17<br>included the lap belt on the resident's care plan.<br><br>2. Resident #4 was admitted to the facility on 11/02/2019 with an admitting diagnosis of vascular dementia, abnormal posture, and a history of falls.<br><br>A review of a quarterly MDS dated 06/18/2019 revealed that Resident #4 had moderately impaired cognition and deficits with her long-term and short-term memory. She was a total assist for all activities of daily living with 1-2 staff assistance. The MDS revealed no falls coded for this assessment.<br><br>A review of Resident #4 fall care plan initiated on 11/02/2015 and last updated 06/18/2019 revealed a notation of no falls, and to continue with goals and interventions. The interventions in place for falls included: keep bed in the lowest position, remind her as needed to not get up without assistance, when out of bed she will be in wheelchair, fall mats next to bed, Left side of bed up against the wall, and the call light within reach. There was no care plan intervention for a lap belt.<br><br>An observation of Resident #4 on 08/29/2019 at 2:30 PM revealed she was sitting in her wheelchair and had a lap belt around her waist.<br><br>An interview was conducted on 08/29/2019 at 2:35 PM with NA #4 revealed that Resident #2 had always had a lap belt since her admission, and when she was up in her wheelchair it was always on. She further revealed that Resident #4 could unfasten the lap belt.<br><br>An interview was conducted on 08/29/2019 at 2:35 PM with NA #1 revealed that Resident #4 | F 656 | not have a care plan in place to address the use of the belt.<br>The DON will review the results of the weekly care plan audits for any trends or patterns and report to the QAPI Committee. The QAPI Committee consists of the Administrator, Director of Nursing, Medical Director, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI Committee will review the results of the audits and direct corrective action as necessary. The QAPI Committee may approve changes in the frequency of the audits and/or discontinue the audits once the new system has been deemed effective to maintain substantial compliance.<br>Completion date 09/18/19 | |

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| F 656 | Continued From page 18<br>had always had a lap belt since her admission, and when she was up in her wheelchair it was always on. She further revealed that Resident #4 could unfasten the lap belt.<br><br>An interview was conducted on 08/29/2019 at 2:32 PM with the MDS Nurse revealed that a lap belt needed and order and should have been on the care plan. The MDS Nurse stated that Resident #4 needed the lap belt to deter her from getting up unassisted to avoid injury. The interview further revealed she was responsible for updating care plans.<br><br>An interview was conducted on 08/29/2019 at 1:45 PM with the Director of Nursing (DON) revealed that a lap belt required a doctor's order and it should be on the resident's care plan. She further revealed that she had no idea why Resident #1 did not have a doctor's order or why it was not on the care plan. The DON revealed that she was new in her position and did not know if there was a system in place for lap belts.<br><br>An interview on 08/29/2019 at 03:51 PM with the Administrator revealed that he had no idea that the residents with lap belts did not have a doctor's order for use. He also revealed that it was his expectations that the MDS nurse would have included the lap belt on the resident's care plan. | F 656 | | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(g)(2)(ii)<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(ii) Develop and implement appropriate plans of | F 867 | | 9/18/19 |

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| F 867 | Continued From page 19<br>action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the annual recertification survey of 06/27/19. This was for one recited deficiency that was originally cited in June of 2019 and subsequently recited on the current revisit and complaint investigation of 08/29/19. The recited deficiency was in the area of Encoding/Transmitting Resident Assessments. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.<br><br>Findings included:<br><br>This tag is cross referenced to:<br><br>F-640 Encoding/Transmitting Resident Assessments: Based on record review and staff interviews, the facility failed to complete one admission, one annual and one quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD) and failed to transmit one entry and 2 death in the facility tracking records within 14 days of the MDS completion date for 6 of 10 residents reviewed for Resident Assessments (Residents #5, #6, #7, #8, #9, and #10).<br><br>During the annual recertification survey of 06/27/19 the facility was cited for failure to complete and transmit discharge, significant change and annual MDS assessments within the | F 867 | Resident #1 removed the sheet that had been tied around her wheelchair by taking the sheet over her head according to staff interviews conducted by the Social Service Director (SSD) on 06/30/2019. The sheet was not reapplied to the resident by the nursing staff. Resident #1 displayed no signs or symptoms of distress or discomfort per staff interview conducted by the SSD on 06/30/2019. Resident # 1 will continue to use a wheelchair when out of bed and will not have a restraint applied to her without a medical symptom as assessed by a Registered Nurse (RN) and a physician□s order for use.<br>The Minimum Data Set (MDS) of Resident # 5 with the Assessment Reference Date (ARD) date of 8/7/19 was completed in the electronic health record on 9/10/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the Quality Improvement and Evaluation System (QIES) on 9/10/19 by the RN/MDS Coordinator.<br><br>The MDS of Resident # 6 with the ARD date of 8/5/19 was completed in the electronic health record on 9/5/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 9/06/19 by the RN/MDS Coordinator.<br><br>The MDS of Resident # 7 with the ARD | |

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| F 867 | Continued From page 20<br>regulatory timeframe.<br><br>During an interview on 08/29/19 at 3:51 PM, the Administrator explained that after the facility's annual recertification survey on 06/27/19, the Quality Assessment and Assurance (QAA) committee met to review the identified areas of concern and systems were put into place to correct the deficiencies cited. The Administrator stated he was under the impression MDS assessments were being completed and transmitted within the required timeframe based on the results of the facility's compliance audits. The Administrator further stated he was unaware there was still an issue and the repeated area of concern would be reviewed by the QA committee to discuss and develop a sustainable plan of correction. | F 867 | date of 8/6/19 was completed in the electronic health record on 8/20/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 9/06/19 by the RN/MDS Coordinator.<br><br>The MDS of Resident# 8 with the ARD date of 8/7/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator.<br><br>The MDS of Resident # 9 with the ARD date of 7/28/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator.<br><br>The MDS of Resident # 10 with the ARD date of 8/11/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator.<br><br>Residents # 5, #6, #7, #8, #9, and # 10 will continue to have timely assessments completed in the electronic health record by the Interdisciplinary Team (IDT) and transmitted by the MDS Coordinator into the QIES system per Resident Assessment Instrument (RAI) guidelines. The care plan of Resident # 1 and | |

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| F 867 | Continued From page 21 | F 867 | Resident # 4 was updated on 08/29/19 by the MDS Coordinator. Resident # 1 and Resident # 4 will continue to have a care plan that reflects the use of a lap belt as long as the order for the lap belt is in place.<br>All residents are at risk to be affected by the same practice. Nursing staff interviews will be conducted by the Social Services Director (SSD), Assistant Administrator (AA) and/or designated RN across all shifts as a means of helping to identify if any other residents were affected by the same practice of using a sheet as a restraint. Any deficient practice identified during the interviews related to restraints and/or improper use of restraints will be reported to the Administrator and Director of Nursing for corrective action. The interviews will be completed by 09/18/19.<br>An MDS audit will be completed by an RN to review current residents and the MDS assessments. Any resident who has not had an MDS completed or transmitted in a timely manner will have corrective action taken by the MDS Coordinator. The audits will be completed by 09/18/19.<br>A care plan audit will be completed by an RN for those residents who use a lap belt in the wheelchair to verify that care plan is in place for use of the lap belt. The care plan audit will be completed by 09/18/19.<br>The Administrator provided education to the QAPI team on 09/04/19. A pre and posttest was given to assess learning. New members that are added to the QAPI team will have education provided by the Administrator or DON during their | |

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| F 867 | Continued From page 22 | F 867 | orientation period.<br>Weekly staff interviews related to use of a sheet as a restraints will be completed by the SSD, AA, or designated RN for a total of four weeks. The weekly staff interviews will be initiated on 09/05/19 and run through 09/26/19. Weekly rounds will be conducted randomly by the DON and/or RN Supervisor on all shifts to identify if a resident is inappropriately restrained for four weeks or longer until substantial compliance is achieved and maintained as determined by the QAPI Committee. The weekly rounds by the DON and/or RN Supervisor were initiated on 09/06/19. Any discrepancies will receive immediate corrective action by a licensed nurse.<br>An RN will complete weekly audits of the MDS assessments reviewing completion and transmission dates. The audits began on 09/05/19 and will continue at a minimum of four weeks or until the QAPI committee has deemed substantial compliance has been reached and the system has been deemed effective. The MDS Coordinator will meet with the Administrator and/or Assistant Administrator at a minimum of two times a week to review completion and transmission of the MDS assessments in the electronic health record. The meetings were initiated on 08/30/19. The Administrator may choose to decrease the frequency of the meetings to weekly after one month, based on the recommendations of the QA committee, if timely completion and transmission of the MDS assessments are occurring per RAI guidelines. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345193 | A. BUILDING _____ B. WING _____ | C 08/29/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOUNTAIN VIEW MANOR NURSING CE | 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713 |

| (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 867 | Continued From page 23 | F 867 | The MDS Coordinator will meet with the Administrator and/or Assistant Administrator at a minimum of two times a week beginning 08/30/19 to review completion and transmission of the MDS assessments in the electronic health record. The Administrator may choose to decrease the frequency of the meetings to weekly after one month, based on the recommendations of the QAPI committee, if timely completion and transmission of the MDS assessments are occurring per RAI guidelines.<br>The MDS Coordinator will prepare a report for the QAPI committee on the timeliness of completion and transmission of the MDS assessments in the electronic health record for the QAPI reporting period.<br>Care plan audits will be completed weekly by an RN for a total of four weeks to verify that residents who utilize lap belts have a care plan to address the use of the lap belt. The care plan audits will begin on 08/29/19 and run thru 09/19/19.<br>Corrective action will be taken by the RN for any resident who uses a lap belt that does not have a care plan in place to address the use of the belt.<br>The Administrator, AA, SSD, or DON will review the results of their audits, rounds and/or interviews for any trends or patterns and report to the Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee consists of the Administrator, Director of Nursing, Medical Director, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 867 | Continued From page 24 | F 867 | Committee will review the results of the audits and direct correct action as necessary. The QAPI Committee may approve changes in the frequency of the audits and/or discontinue the audits/interviews once the new system has been deemed effective to maintain substantial compliance.<br>Completion date 09/18/19 | |