STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

(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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to identify functional range of motion (ROM) limitation for a resident (Resident #39) with bilateral upper extremity contractures on a comprehensive assessment. The facility also failed to accurately	F 278	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	7/27/16

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

Electronically Signed | 07/18/2016

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F 278	Continued From page 1 code active diagnoses of neurogenic bladder (Resident #74) and urinary obstruction with urinary catheter for 2 of 25 Minimum Data Set (MDS) assessments reviewed for accuracy. Findings included: 1. Resident # 39 was originally admitted on 8/16/14 with a diagnosis of cerebral vascular accident (CVA). The significant change MDS dated 6/15/16 indicated severe cognitive impairment and total assistance with all activities of daily living no impairment to upper or lower functional ROM. Resident #39 was not coded as receiving passive or active ROM to his upper extremities. The Care Assessment Area (CAA) for this MDS assessment for Resident #39 ' s risk for falls mentioned contractures to all extremities as his usual condition. The care plan with the last revision date 6/23/16 included for identified focus related to contractures. A review of the Bedside Kardex Report used by the nursing assistants (NA) dated 2/1/16 and no revision date included contractures of ROM and a functional limitation requiring any ROM. A nursing quarterly review dated 5/12/16 identified Resident #39 as having contractures. In an observation on 6/27/16 at 2:20pm, Resident #39 was observed lying in bed. He was nonverbal and appeared to be sleeping. He did open his eyes when addressed. He was observed clean and well groomed with his bilateral elbows flexed across his chest and his bilateral hand contracted. There was no wash cloth, splint or positioning devise observed to Resident #39 ' s upper extremity contractures. There was no observed splinting devices observed lying in his room. In an interview on 6/28/16 at 9:38 AM, the MDS nurse stated Resident #9 and bilateral hand	F 278	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 date or dates indicated. F278 Corrective Action for Resident Affected: For Resident #39 MDS assessment was modified to include the assessed functional limitations in range of motion and resubmitted by the MDS Coordinator. For resident #74, the annual assessment was completed including the diagnosis neurogenic bladder and submitted. This was completed by 07/05/2016 Corrective Action for Resident Potentially Affected All current residents have the potential to be affected by this practice. On 07/18/2016, the MDS Coordinator began an audit of all current residents contracture status as well as auditing all current residents chart for the diagnosis of Neurogenic Bladder and Obstructive Uropathy. Once the audit is completed, the findings will be compared to the residents most recent MDS assessment to assess for accurate coding. If incorrect coding was noted, a modification assessment will submitted by 07/27/2016 and the plan of care updated if indicated by the MDS Coordinator.	

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F 278	Continued From page 2 contractures and he was receiving passive ROM. In an observation on 6/28/16 at 10:40AM, Resident #39 was observed lying in bed with his bilateral arms flexed over his chest and his hands contracted. There was no wash cloth or splinting device observed in use or observed lying in his room. In an observation on 6/29/16 at 11:50 AM, Resident #39 was observed lying in bed with his bilateral arms flexed over his chest and his hand contracted. There was no wash cloth or splinting device observed in use or observed lying in his room. His nails were trimmed and there was no odor noted from his left hand. In an interview on 6/29/16 at 11:55 AM, NA #1 stated she had worked at the facility for 26 years and worked with Resident #39 since his admission. She stated at no time had he ever had any splints for his bilateral upper extremities and at no time was he ever on a restorative program. NA #1 stated she always did passive ROM when she bathing Resident #39 because she knew it was important. NA #1 stated she was never instructed to keep a washcloth rolled up and placed inside Resident #39 ' s left hand. She stated the aides look at the Bedside Kardex Report in the computer for each resident to know what each resident ' s needs were. She verified there was no mention of ROM of the Bedside Kardex Report for #39. In another interview with the MDS nurse on 6/29/16 at 12:00PM, she stated was over the restorative program, Resident #39 was not on the restorative program and she was not aware of the use of any splints. In another observation on 6/30/16 at 9:05 PM, Resident #39 was observed lying in bed with his bilateral arms flexed over his chest and his ands	F 278	Systemic changes: On 07/18/2016, the MDS Coordinator was in-serviced by the MDS Consultant on accurate coding of MDS item Sections G, and section I, care planning requirements, and updating care plans. This information has been integrated into the standard orientation training for MDS Coordinators and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The DON will audit 5 residents for MDS accuracy of section G and I. This will be completed weekly times 4 weeks then monthly for two months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by theAdministrator or DON to ensure correctiveaction initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QAMeeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 278	Continued From page 3	F 278		

contracted. There was no wash cloth or splinting device observed in use or observed lying in his room. In an interview with NA #2 stated she had worked at facility for 2 years and she had never seen a splint or restorative working with Resident #39. She verified there was no ROM listed on the Bedside Kardex Report for Resident #39.
In an interview on 6/30/16 at 11:20 AM, the Restorative Aide (RA) stated she never had Resident #39 on her caseload for splinting or ROM. She stated her supervisor was the MDS nurse and it was the MDS nurse who assigned her resident ' s for restorative nursing.

In an interview on 6/30/16 at 11:41 AM, the MDS nurse stated should have coded for contractures and care planned for contractures on Resident #39 ' s comprehensive MDS. Assessment dated 6/15/16. The MDS nurse also stated the Bedside Kardex Report the aides follow should have included passive ROM with ADLs because she was not aware that Resident #39 should have left hand resting splint at present.

In an interview on 6/30/16 at 1:30 PM, the Administrator stated it was her expectation that the MDS reflect Resident #39 ' s current condition and the care be planned according to the accurate MDS assessment.

2. Resident #74 was admitted to the facility on 07/10/2015. His admission diagnoses included retention of urine, history of urinary tract infections, and enlarged prostate with lower urinary tract symptoms.

A review of a Urology Consultation Notes dated 12/15/2015 included the resident was seen on the last visit because of the neurogenic bladder. He

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F 278	Continued From page 4 was using long-term urinary catheter for drainage. A record review of physician progress notes dated 01/09/2016 revealed medical history of urinary retention, neurogenic bladder with benign prostatic hyperplasia and urinary obstruction with chronic urinary catheter, and obstructive uropathy. It included current assessments of other neuromuscular dysfunction of bladder dated 10/26/2015; unspecified abnormal findings in urine dated 11/14/2015; and enlarged prostate with lower urinary tract symptoms dated 10/26/2015. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/31/2016 for Resident #74 did not include the active diagnoses of neurogenic bladder with benign prostatic hyperplasia and urinary obstruction with chronic urinary catheter in Section I Active Diagnosis. Section H Bladder and Bowel of this quarterly assessment revealed the Resident having an indwelling catheter and coded as always incontinent for urine. On 6/28/2016 at 3:35 PM, the Resident was observed with indwelling urinary catheter in place. On 6/28/2016 at 4:14 PM, the Resident was interviewed about his care for his indwelling catheter. He stated he had a catheter because of his prostate. He stated, " It (the catheter) helps but I want to go home. " During an interview on 6/29/2016 at 11:57 AM with the Minimum Data Set Nurse she revealed the diagnosis of neurogenic bladder was not included in section I of the MDS. She stated it was because the change from ICD 9 to ICD 10 coding caused it to be missed. She stated when	F 278		

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F 278	Continued From page 5 the coding sequence changed she did not think neurogenic bladder was still on the form. On review of the MDS for Resident #74 with the MDS Nurse, she stated it was omitted. Neurogenic bladder and obstructive uropathy was still on the MDS form. An interview on 6/29/2016 at 4:20 PM with the Director of Nursing revealed the diagnosis of neurogenic bladder was on the Urology Consult for Resident #74. An interview on 5/30/2016 at 10:10 AM with the Administrator revealed her expectation was the MDS assessment should be properly coded in section I of the quarterly MDS assessment.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		7/27/16

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F 279	Continued From page 6 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to care plan functional range of motion (ROM) limitations for a resident (Resident #39) with bilateral upper extremity contractures 1 of 25 residents reviewed for accurate care planning needs. Findings included: Resident # 39 was originally admitted on 8/16/14 with a diagnosis of cerebral vascular accident (CVA). The significant change Minimum Data Set (MDS) dated 6/15/16 indicated severe cognitive impairment and total assistance with all activities of daily living no impairment to upper or lower functional ROM. Resident #39 was not coded as receiving passive or active ROM to his upper extremities. The Care Assessment Area (CAA) for this MDS assessment for Resident #39 ' s risk for falls mentioned contractures to all extremities as his usual condition. The care plan with the last revision date 6/23/16 included no identified focus related to contractures. A review of the Bedside Kardex Report used by the nursing assistants (NA) dated 2/1/16 with no revision date included nothing related to contractures or a functional limitation requiring any ROM. A review of the occupational therapy note dated 1/13/16 indicated Resident #39 was being treated for bilateral upper extremity contractures using stretching in preparation for splinting. The nursing staff were educated in passive ROM to his bilateral upper extremities and placing a rolled wash cloth in Resident #39 ' s left hand until his splint was available. A nursing quarterly review dated 5/12/16	F 279	F 279 A corrective action for affected resident: For resident # 39, the MDS Coordinator updated the residents care plan on 07/04/2016 to reflect his current contracture status. Interventions were initiated as indicated. All current residents have the potential to be affected by the alleged deficient practice. On 07/18/2016, the Nurse Mangement Team assessed all current resident for contractures. If contractures are identified, the MDS Coordinator will audit the care plan to ensure the contractures are care planned and interventions included as indicated. This process will be completed by 07/27/2016. Systemic changes made were: On 07/18/2016, the MDS Coordinator was in-serviced by the MDS Consultant on accurate coding of MDS item Sections G, and section I, care planning requirements, and updating care plans. This information has been integrated into the standard orientation training for MDS Coordinators and will be reviewed by the Quality Assurance Process to verify that the	

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F 279	Continued From page 7 identified Resident #39 as having contractures. In an observation on 6/27/16 at 2:20 PM, Resident #39 was lying in bed. He was nonverbal and appeared to be sleeping. He did open his eyes when addressed. He was observed clean and well groomed with his bilateral elbows flexed across his chest and his bilateral hand contracted. There was no wash cloth, splint or positioning devise observed to Resident #39 ' s upper extremity contractures. There was no observed splinting devices lying in his room. In an interview on 6/28/16 at 9:38 AM, the MDS nurse stated Resident #39 had bilateral hand contractures and he was receiving passive ROM. In an observation on 6/28/16 at 10:40 AM, Resident #39 was observed lying in bed with his bilateral arms flexed over his chest and his hands contracted. There was no wash cloth or splinting device observed in use or observed lying in his room. In an observation on 6/29/16 at 11:50 AM, Resident #39 was lying in bed with his bilateral arms flexed over his chest and his hand contracted. There was no wash cloth or splinting device observed in use or observed lying in his room. His nails were trimmed and there was no odor noted from his hands. In an interview on 6/29/16 at 11:55 AM, NA #1 stated she had worked at the facility for 26 years and worked with Resident #39 since his admission. She stated at no time had he ever had any splints for his bilateral upper extremities and at no time was he ever on a restorative program to the best of her knowledge. NA #1 stated she always did passive ROM when she bathing Resident #39 because she knew it was important. NA #1 stated she was never instructed to keep a washcloth rolled up and placed inside Resident #39 ' s left hand. She stated the aides looked at	F 279	change has been sustained. The facility plans to monitor its performance by: The Director of Nursing will monitor this issue using the Care Plan Quality Assurance Tool for monitoring care planning for contractures . This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by theAdministrator or DON to ensure correctiveaction initiated as appropriate. Compliancewill be monitored and ongoing auditing program reviewed at the weekly QAMeeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 279	Continued From page 8	F 279		

the Bedside Kardex Report in the computer for each resident to know what each residents needs were. She verified there was no mention of ROM on the Bedside Kardex Report for #39.
In another interview with the MDS nurse on 6/29/16 at 12:00 PM, she confirmed she was over the restorative program, Resident #39 was not on the restorative program and she was not aware of the use of any splints.

In another observation on 6/30/16 at 9:05 AM, Resident #39 was observed lying in bed with his bilateral arms flexed over his chest and his hands contracted. There was no wash cloth or splinting device observed in use or lying in his room. In an interview with NA #2 stated she had worked at facility for 2 years and she had never seen a splint or restorative working with Resident #39. She verified there was no ROM listed on the Bedside Kardex Report for Resident #39.
In an interview on 6/30/16 at 11:20 AM, the Restorative Aide (RA) stated she had not ever had Resident #39 on her caseload for splints or ROM. She stated she got her resident assignment from the MDS nurse.

In an interview on 6/30/16 at 11:41 AM, the MDS nurse stated she should have coded for contractures and care planned for contractures on Resident #39 ' s comprehensive MDS assessment dated 6/15/16. The MDS nurse stated The Bedside Kardex Report the aides follow should have included passive ROM with ADLs because she was not aware that Resident #39 should have left hand resting splint at present.

In an interview on 6/30/16 at 1:30 PM, the Administrator stated it was her expectation that

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F 279	Continued From page 9 the care plan be accurate and the Bedside Kardex Report be accurate in order for the nursing staff to know how to care for Resident #39.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to update the care plan, investigate and implement interventions for a resident who sustained a fall due to staff error (Resident #103) for 1 of 1 residents reviewed for accidents. Findings included:	F 280	F 280 A corrective action for affected resident: For resident #103, the care plan was updated with fall interventions bariatric bed and two person assist with bed	7/27/16

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F 280	Continued From page 10 Resident #103 was admitted 12/3/15 with cumulative diagnoses of cerebral vascular accidents and left sided hemiplegia. The Significant Change Day Minimum Data Set (MDS) dated 3/15/16, the 5-day MDS dated 5/6/16, the 14-Day MDS dated 5/11/16 and the quarterly MDS dated 6/9/16 indicated Resident #103 had moderate cognitive impairment, no behaviors and required extensive assistance with bed mobility using two persons. Resident #103 was care planned for falls with initiated dated of 2/10/16, revised 5/2/16, 5/16/16 and again on 6/22/16. Interventions included staff anticipating Resident #103 ' s needs as much as possible, encouraging him to call for assistance before reaching, therapy to evaluate as needed, keeping frequently used items in Resident #103 ' s reach and keeping his call light in reach. On 6/22/16, the intervention to ensure the bed was in the lowest position was initiated. A review of the incident report dated 6/22/16 at 6:26 AM stated the nurse was called to Resident #103 ' s room by staff. Resident #103 was on floor beside the bed. Resident #103 stated he rolled out of the bed. There was a gash to Resident #103 ' s head. The responsible party and physician were contacted and Resident #103 was sent to the hospital for an evaluation. He returned to the facility with a laceration to the left side of his forehead. A review of the hospital emergency room physician record dated 6/22/16 at 7:00 AM, indicated Resident #103 fell from the bed while changing his brief. The draw sheet was pulled out from underneath Resident #103 and he fell out of the bed. There was no change in his level of	F 280	mobility on 07/05/2016 by the MDS Coordinator. All current residents have the potential to be affected by the alleged deficient practice. Beginning 07/18/2016, the Nurse Management Team began reviewing all current residents who have had a fall in the last 3 months. Each fall was reviewed for incident investigation and implementation of interventions specific to the investigation. When the audit is complete, the MDS Coordinator will then review the interventions to ensure that the they are care planned and in place. This process will be completed by 07/27/2016. Systemic changes made were: On 07/18/2016, the MDS Coordinator was in-serviced by the MDS Consultant on accurate coding of MDS item Sections G, and section I, care planning requirements, and updating care plans. This information has been integrated into the standard orientation training for MDS Coordinators and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing will monitor this issue using the Care Plan Quality Assurance Tool for monitoring careplan updates. This will be completed weekly for	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 11 consciousness but a laceration was noted to the left side of his head. In an interview and observation on 6/27/16 at 11:30 AM, Resident #103 was sitting up in a reclining chair. There was noted a laceration to the left side of his forehead near his left eye. He stated he received the laceration last week while the aide was changing his brief. Resident #103 stated the bed was in the high position and the aide rolled him over onto his right side to remove the old brief and draw sheet. He stated he tried to stop from rolling out of the bed by grabbing onto the night stand but he could not stop. Resident #103 stated he rolled out of the right side of the bed and thought he bumped his head on the night stand. Resident #103 stated he did not want to get anyone in trouble because it was an accident. In an observation on 6/29/16 at 11:25 AM, Resident #103 was observed lying in bed. NA #4 was completing personal care and stated Resident #103 was one person assistance for his activities of daily living (ADLs) as far as she was aware. NA #4 stated she followed the Bedside Kardex Report to know how to care for Resident #103. In an interview on 6/29/16 at 11:40 AM, the Director of Nursing (DON) stated the MDS was in charge during her absence last week and the MDS nurse conducted the investigation on Resident #103 ' s fall on 6/22/16. The DON stated she did not look any further into the fall herself and she had not seen the hospital records related to the fall. In an observation on 6/29/16 at 4:30 PM, NA #5	F 280	4 weeks monitoring 5 residents then monthly times 2 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by theAdministrator or DON to ensure correctiveaction initiated as appropriate. Compliancewill be monitored and ongoing auditing program reviewed at the weekly QAMeeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 280	Continued From page 12	F 280		

entered the room and repositioned Resident #103 into the center of the bed. She stated she followed the Bedside Kardex Report and he was a one person assistance for all of his ADLs.

In another telephone interview on 6/30/16 at 10:10 AM, NA # 3 stated she was changing Resident #103 and had rolled him over toward the window and he reached to grab onto the night stand to stabilize himself when he fell. NA #4 stated Resident #103 was a one person assistance for all of his ADLs according to the Bedside Kardex Report.

In an interview on 6/30/16 at 11:41 AM, the MDS nurse stated she was acting as the DON last 6/22/16, 6/23/16 and 6/24/16 while she was on vacation. The MDS nurse stated she received the incident report on Resident #103 and they discussed the fall in their morning meeting on 6/22/16. She stated she updated the care plan to keep his bed in the low position at that time. The MDS nurse stated she did not investigate or interview the Resident #103 or staff regarding the circumstances of the fall to determine the root cause. The MDS nurse also stated just because the MDS was coded as a two person assistance for bed mobility, it did not necessarily mean he required two person assistance all the time.

In an interview on 6/30/16 at 1:30 PM, the Administrator stated it was her expectation that all falls be investigated for the root cause and then proper interventions be care planned and conveyed to the staff. The Administrator stated her expectation was if Resident #103 was coded consistently as a two person assistance for bed mobility, he should have been care planned that way and his care be provided using two person

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F 280	Continued From page 13 assistance as indicated on the MDS.	F 280		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to provide evidence of passive range of motion (PROM) or splinting for a resident (Resident #39) with bilateral upper extremity contractures for 1 of 3 residents reviewed for contractures. Findings included: Resident # 39 was originally admitted on 8/16/14 with a diagnosis of cerebral vascular accident (CVA). The significant change Minimum Data Set (MDS) dated 6/15/16 indicated severe cognitive impairment and total assistance with all activities of daily living no impairment to upper or lower functional ROM. Resident #39 was not coded as receiving passive or active ROM to his upper extremities. The Care Assessment Area (CAA) for this MDS assessment for Resident #39 ' s risk for falls mentioned contractures to all extremities as his usual condition. The care plan with the last revision date 6/23/16 included for identified focus related to contractures. A review of the Bedside Kardex Report used by the nursing assistants (NA) dated 2/1/16 with no revision date included contractures or a functional limitation requiring	F 318	F 318 A corrective action for affected resident: For resident #39, the MDS Coordinator updated the residents care plan to include contractures and interventions for ROM daily with care. This was completed on 07/05/2016. In addition to this, on 7/7/2016 the resident was evaluated by OT for contracture interventions and picked up on case load. All current residents have the potential to be affected by the alleged deficient practice. On 07/18/2016, the Nurse Management Team assessed all current resident for contractures. If contractures are identified, the MDS Coordinator will audit the care plan to ensure the contractures are care planned and interventions included as	7/27/16

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F 318	Continued From page 14 any ROM. A review of the occupational therapy note dated 1/13/16 indicated Resident #39 was being treated for bilateral upper extremity contractures using stretching in preparation for splinting. The nursing staff were educated in passive ROM to his bilateral upper extremities and placing a rolled wash cloth in Resident #39 ' s left hand until his resting hand splint was available. A review of Resident #39 ' s medical record indicated he was discharged to the hospital on 1/23/16 and returned to the facility on 2/1/16 on a hospice benefit. Prior to his hospitalization on 1/23/16, Resident #39 was receiving therapy for his contractures. Once Resident #39 returned from the hospital on 2/1/16, hospice did not order the continuation of therapy. A review of the Therapy Services Screening form dated 5/5/16 completed by the occupational therapist (OT) indicated Resident #39 ' s hand splint was still pending insurance approval. A nursing quarterly review dated 5/12/16 identified Resident #39 as having contractures. In an observation on 6/27/16 at 2:20 PM Resident #39 was observed lying in bed. He was nonverbal and appeared to be sleeping. He did open his eyes when addressed. He was clean and well groomed with his bilateral elbows flexed across his chest and his bilateral hand contracted. There was no wash cloth, splint or positioning devise observed to Resident #39 ' s upper extremity contractures. There was no observed splinting devices lying in his room. In an interview on 6/28/16 at 9:38 AM, the MDS nurse stated Resident #39 had bilateral hand contractures and he was receiving passive ROM. In an observation on 6/28/16 at 10:40 AM, Resident #39 was lying in bed with his bilateral	F 318	indicated. In addition to this, each resident identified with contractures will be screened by OT for the need of additional interventions. This process will be completed by 07/27/2016. Systemic changes made were: On 07/18/2016, the MDS Coordinator was in-serviced by the MDS Consultant on accurate coding of MDS item Sections G, and section I, care planning requirements, and updating care plans. On 07/20/2016, the Administrator will in-service the Rehab Director on the procedure for screening all new and readmitted residents for the need of therapy services including residents who were on active caseload upon discharge from the facility. This information has been integrated into the standard orientation training for MDS Coordinators and Rehab Directors and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing will monitor this issue using the Contracture Care Quality Assurance Tool for monitoring residents with contractures for appropriate interventions. This will be completed weekly for 4 weeks monitoring 5 residents then monthly times 2 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the	

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F 318	Continued From page 15 arms flexed over his chest and his hands contracted. There was no wash cloth or splinting device observed in use or lying in his room. In an interview on 6/28/16 at 11:50 AM, the Rehabilitation Manager stated hospice would not pay for the splint and did not resume his therapy. She stated she would follow up on why Resident #39 was not receiving and sort of passive ROM or re-evaluated since coming off of hospice earlier this month. In an observation on 6/29/16 at 11:50 AM, Resident #39 was lying in bed with his bilateral arms flexed over his chest and his hand contracted. There was no wash cloth or splinting device observed in use or lying in his room. His nails were trimmed and there was no odor noted from his hands. In an interview on 6/29/16 at 11:55 AM, NA #1 stated she had worked at the facility for 26 years and worked with Resident #39 since his admission. She stated at no time had he ever had any splints for his bilateral upper extremities and at no time was he ever on a restorative program to the best of her knowledge. NA #1 stated she always did passive ROM when she bathing Resident #39 because she knew it was important. NA #1 stated she was never instructed to keep a washcloth rolled up and placed inside Resident #39 ' s left hand. She stated the aides look at the Bedside Kardex Report in the computer for each resident to know what each resident ' s needs were. She verified there was no mention of ROM on the Bedside Kardex Report for #39. In another interview with the MDS nurse on 6/29/16 at 12:00 PM, she confirmed she was over the restorative program, Resident #39 was not on the restorative program and she was not aware of	F 318	Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 318	Continued From page 16 the use of any splints. In an interview on 6/29/16 at 3:40 PM with the Rehabilitation Manager and OT stated they did a trial on Resident #39 with a resting hand splint but he was not able to tolerate the splint originally ordered. The OT verified teaching was done with the nursing staff on gentle stretching to try and increase Resident #39 ' s ability to wear the new splint once it arrived. The OT stated she had no documentation other than the note dated 1/13/16 regarding the nursing staff education. A trial resting hand splint was provided to the staff and Resident #39 was able to tolerated the resting hand splint for two or three hours and bilaterally upper extremity passive ROM was to be performed daily. The Rehabilitation Manager was unable to say what happened to the trial splint but stated any of the nursing staff could have put a wash cloth in Resident #39 ' s hand and nursing could have ordered a restorative program without a therapy. In another observation on 6/30/16 at 9:05 PM, Resident #39 was lying in bed with his bilateral arms flexed over his chest and his ands contracted. There was no wash cloth or splinting device observed in use or lying in his room. In an interview with NA #2 stated she had worked at facility for 2 years and she had never seen a splint or restorative working with Resident #39. She verified there was no ROM listed on the Bedside Kardex Report for Resident #39. In an interview on 6/30/16 at 11:20 AM, the Restorative Aide (RA) stated she had not ever had Resident #39 on her caseload for splinting or ROM. She stated she got her resident assignment from the MDS nurse.	F 318		

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F 318	Continued From page 17 In an interview on 6/30/16 at 1:30 PM, the Administrator stated it was her expectation that Resident #39 receive any necessary services and devices to prevent further decline in his ROM.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and records review, the facility failed to prevent a resident fall from the bed while in the highest position with one staff present providing care for a resident identified as a two person assistance for bed mobility resulting in a laceration to the head for (Resident #103) for 1 of 1 residents reviewed for accidents. Findings included: Resident #103 was admitted 12/3/15 with cumulative diagnoses of cerebral vascular accidents and left sided hemiplegia. The Significant Change Day Minimum Data Set (MDS) dated 3/15/16, the 5-day MDS dated 5/6/16, the 14-Day MDS dated 5/11/16 and the quarterly MDS dated 6/9/16 indicated Resident #103 had moderate cognitive impairment, no behaviors and required extensive assistance with bed mobility using two persons.	F 323	F 323 A corrective action for affected resident: For resident #103, the care plan was updated with fall interventions bariatric bed and two person assist with bed mobility on 07/05/2016 by the MDS Coordinator. All current residents who require assistance with incontinence have the potential to be affected by the alleged deficient practice. Beginning 07/18/2016, the Nurse Management Team began reviewing all current residents who have had a fall in the last 3 months. Each fall was reviewed for incident investigation and	7/27/16

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F 323	Continued From page 18 Resident #103 was care planned for falls with initiated dated of 2/10/16, revised 5/2/16, 5/16/16 and again on 6/22/16. Interventions included staff anticipating Resident #103 ' s needs as much as possible, encouraging him to call for assistance before reaching, therapy to evaluate as needed, keeping frequently used items in Resident #103 ' s reach and keeping his call light in reach. On 6/22/16, the intervention to ensure the bed was in the lowest position was initiated. A review of the incident report dated 6/22/16 at 6:26 AM stated the nurse was called to Resident #103 ' s room by staff. Resident #103 was on floor beside the bed. Resident #103 stated he rolled out of the bed. There was a gash to Resident #103 ' s head. The responsible party and physician were contacted and Resident #103 was sent to the hospital for an evaluation. He returned to the facility with a laceration to the left side of his forehead. A review of the hospital emergency room physician record dated 6/22/16 at 7:00 AM, indicated Resident #103 fell from the bed while changing his brief. The draw sheet was pulled out from underneath Resident #103 and he fell out of the bed. There was no change in his level of consciousness but a laceration was noted to the left side of his head. In an interview and observation on 6/27/16 at 11:30 AM, Resident #103 was sitting up in a reclining chair. There was noted a laceration to the left side of his forehead near his left eye. He stated he received the laceration last week while the aide was changing his brief. Resident #103 stated the bed was in the high position and the aide rolled him over onto his right side to remove	F 323	implementation of interventions specific to the investigation. When the audit is complete, the MDS Coordinator will then review the interventions to ensure that the they are care planned and in place. This process will be completed by 07/27/2016. Systemic changes made were: Inservice education on maintaining resident safety when providing care in the bed and skills check for providing care to a resident while in bed will be completed by the Director of Nursing and Staff Development Coordinator by 07/27/2016. All full time, part time and PRN Nurses and CNA's will be required to attend this education. The facility specific in-service was sent to each Hospice Provider and Agency Provider whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Staff Development Coordinator will monitor this issue using the Providing Bed Care Quality Assurance Tool for monitoring bed care for safety practices. This will be completed weekly for 4 weeks monitoring 5 residents weekly then	

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F 323	Continued From page 19 the old brief and draw sheet. He stated he tried to stop from rolling out of the bed by grabbing onto the night stand but he could not stop. Resident #103 stated he rolled out of the right side of the bed and thought he bumped his head on the night stand. Resident #103 stated he did not want to get anyone in trouble because it was an accident. In an observation on 6/29/16 at 11:25 AM, Resident #103 was observed lying in bed. NA #4 was completing personal care and stated Resident #103 was one person assistance for his activities of daily living (ADLs) as far as she was aware. NA #4 stated she followed the Bedside Kardex Report to know how to care for Resident #103. In an interview on 6/29/16 at 11:40 AM, the Director of Nursing (DON) stated she was not at work last week from Wednesday through Friday but recalled being told the investigation concluded that Resident #103 ' s fall was not due to staff error but rather she was told Resident #103 had maneuvered himself to the side of the bed and before the aide to get around to the other side of the bed, Resident #103 fell from the right side of the bed. The DON stated the MDS nurse conducted the investigation on Resident #103 ' s fall on 6/22/16 in her absence and she did not look any further into the fall and had not seen the hospital records related to the fall. In a telephone interview on 6/29/16 at 1:00 PM, NA #3 stated on 6/22/16 around 6:30 AM, Resident #103 put on his call light. NA #3 stated Resident #103 was cognitively intact and put on his call light for assistance as needed. NA #3 stated she was proving care standing on the left side of the bed and Resident #103 rolled himself	F 323	monthly times 2 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by theAdministrator or DON to ensure correctiveaction initiated as appropriate. Compliancewill be monitored and ongoing auditing program reviewed at the weekly QAMeeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 323	Continued From page 20	F 323		

over to the right side. She stated he rolled too far and before she could get around to the other side of the bed, Resident #103 rolled onto the floor. He sustained a laceration from the night stand and went to the emergency room. She confirmed the bed was in the high position at the time of the fall.

In a telephone interview on 6/29/16 at 1:30 PM, Nurse #4, recalled working the night of the fall when NA #3 called him to the room. Nurse #4 stated NA #3 was in Resident #103 ' s room providing care and she told him Resident #103 turned too quickly and fell onto the floor before she could catch him. Nurse #4 stated he thought the bed was in the high position when Resident #103 fell and NA #3 was the only staff member in the room at the time of the fall.

In an observation on 6/29/16 at 4:30 PM, NA #5 entered the room and repositioned Resident #103 into the center of the bed. She stated she followed the Bedside Kardex Report and he was a one person assistance for all of his ADLs.

In another telephone interview on 6/30/16 at 10:10 AM, NA # 3 stated she was changing Resident #103 and had rolled him over toward the window and he reached to grab onto the night stand to stabilize himself when he fell. NA #4 stated Resident #103 was a one person assistance for all of his ADLs according to the Bedside Kardex Report.

In an interview on 6/30/16 at 11:41 AM, the MDS nurse stated she was acting as the DON last 6/22/16, 6/23/16 and 6/24/16 while she was on vacation. The MDS nurse stated she received the incident report on Resident #103 and they

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F 323	Continued From page 21 discussed the fall in their morning meeting on 6/22/16. She stated she updated the care plan to keep his bed in the low position at that time. The MDS nurse stated she did not investigate or interview the Resident #103 or staff regarding the circumstances of the fall to determine the root cause. The MDS nurse also stated just because the MDS was coded as a two person assistance for bed mobility, it did not necessarily mean he required two person assistance all the time. In an interview on 6/30/16 at 1:30 PM, the Administrator stated her expectation was if Resident #103 was coded consistently as a two person assistance for bed mobility, his care should have been provided using two person assistance for bed mobility for safety as indicated on the MDS.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to discard enteral tube feeding formulas from 1 of 1 central supply room and the facility failed to label and date stored food	F 371	F 371 A corrective action for affected resident:	7/27/16

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F 371	Continued From page 22 products. Findings included: Review of facility policy for Durable Medical Supply Storage that includes enteral formulas; issued date June 2007. Policy # CSP-131 provided by the administrator on 6/30/2016 stated "Expired products will be stored in a separate location in the supply room and will be clearly marked so they will not be used". Review of facility policy for Food Safety, Date Marking; issuing date 12/15; Policy # DIP-115 provided by the dietary manager on 6/30/2016 stated " All ready-to-eat, potentially hazardous foods prepared on site and held in refrigeration for more than 24 hours must be marked with the date of preparation or with the date that indicates when the food shall be consumed or discarded". 1. On 06/29/2016 at 11:15 am observation of the 300/400 hall medication room revealed the following: a. 12 - 8 ounce cans of Glucerna 1.5 with an expiration date of 6/1/2016; b. 24 - 8 ounce cans of Glucerna 1.5 with an expiration date of 3/1/2016; c. 24 - 8 ounce cans of Glucerna 1.5 with an expiration date of 5/1/2016; d. 24 - 8 ounce cans of Osmolite 1.2 with an expiration date of 3/1/2016 and e. 27 - 8 ounce cartons of Boost Plus with an expiration date of 5/31/2016. These products were stored with other enteral tube feeding formulas. They were not stored in a separate area for expired products and there was no sign indicating that these products were expired and should not be used. Review of	F 371	No residents were identified as affected. The Dietary Manager properly labeled and dated food items in dietary storage immediately on 6/27/16. The applesauce and pudding cups were removed from the Medication Room Refrigerator and discarded on 6/29/16 by the Dietary Manager. On 06/29/2016, the expired cans of tube feeding were promptly removed and discarded by the Director of Nursing. All current residents have the potential to be affected by the alleged deficient practice. On 06/27/2016, the Dietary Manager properly labeled and dated food items in dietary storage immediately. On 06/292016, the Medication Room on 300/400 was audited for any other expired tube feeding and none was noted. This was completed by the Director of Nursing. Systemic changes made were: Inservice education on stock rotation was provided to the Central Supply clerk for the rotation of tube feeding and prompt removal of expired items. This was completed by the Director of Nursing on 06/29/2016. On 7/1/16 an In-Service was initiated for all Dietary Staff on Labeling and Dating Practices by the Dietary Manager. The in-servicing continued through 7/5/2016. An additional in-service prepared by Corporate Dietitian (Senior Nutrition Services Coordinator for Liberty	

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F 371	Continued From page 23 physician orders revealed that the facility currently has 13 residents receiving tube feeding. Five of the 13 residents have physician orders to receive Glucerna 1.5. Two of the 13 residents have physician orders to receive Jevity 1.2. On 06/29/2016 at 2:15 PM observation of the 300/400 hall medication room with the dietary manager to show her the expired enteral tube feeding products. She acknowledged the expired products. She stated that central supply was in charge of this area. She stated that there were no residents currently using the cans of the expired formulas and that they were using the RTH (ready to hang) tube feeding products. On 06/29/2016 at 3:20 PM interview with LPN #2 and LPN #3. They stated that they used RTH (ready to hang) products for those residents on continuous feedings via pump. They used canned products for those residents on bolus feedings. They stated that in the case of an emergency such as being out of a product in the RTH (ready to hang) version they would use the canned product and a bag/pump set to administer the tube feeding. On 06/29/2016 at 3:26 PM an interview with LPN #4 an agency nurse who has been working 2nd shift here since March 2016. Stated he has 6 residents in his area receiving tube feeding. He stated that they typically use RTH (ready to hang) products for continuous feedings via pump; but today they are out of Glucerna 1.5 in the RTH (ready to hang) containers so he was going to have to use the cans of Glucerna 1.5 and a bag/pump set to administer the tube feeding. On 06/29/2016 at 3:35 PM interview with the	F 371	Healthcare & Rehabilitation Services) was conducted by facility Dietary Manager starting on 7/18/2016 and will be completed with all dietary staff by 7/22/2016. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all central supply clerks and dietary staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Dietary Manager will monitor this issue using the "Dietary QA Audit" tool which evaluates Food storage practices in all Food Storage Areas including Nourishment Kitchens (Refer to attached monitoring tool). This audit will be completed 5 days/week for four weeks and then weekly times four months or until resolved by QOL/QA committee. The Staff Development Coordinator will monitor tube feeding storage using the expired tube feeding Quality Assurance Tool for monitoring for rotation of and removal of expired tube feedings. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly	

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Central Supply Clerk. She stated that she has been in this position for several weeks and is learning the process. She stated that expired products should be thrown away. She also stated that they were out of Glucerna 1.5 in the RTH (ready to hang) containers. The nurses would need to use the Glucerna 1.5 in cans and the pump/bag sets until the RTH (ready to hang) product was received. She was not aware of a specific policy related to storage of enteral tube feeding products.

2. On 06/27/2016 at 10:07 AM observation of the dietary dry storage room revealed one open and undated package of corn flakes. Observation of the walk-In freezer revealed one unlabeled package of pancakes and one unlabeled package of vegetable blend. Observation of the walk-in refrigerator revealed 2 bag lunches that were not labeled or dated.

On 06/29/2016 at 12:20 PM observation of the nourishment refrigerator in the 500 hall medication room revealed one cup of applesauce and two cups of chocolate pudding that were not labeled or dated. Both were in disposable clear plastic cups with lids.

On 06/29/2016 at 12:25 PM interview with LPN #1. She stated the applesauce and pudding are obtained from the kitchen each morning for med pass. She also stated they do not label and date the cups.

On 06/29/2016 at 4:59 PM interview with the dietary manager. She stated that nurses come and get the pudding and applesauce. The kitchen provides pre-packaged applesauce and pudding in disposable clear plastic cups with lids.

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F 371	Continued From page 25 The pudding should be labelled and dated when removed from the original container and the applesauce should be labeled and dated when the original package is opened. On 06/30/2016 at 9:14 AM interview with the dietary manager. She stated that her expectation for labeling and dating was that items such as the frozen vegetables and pancakes that are taken out of the original container should be labeled with the name of item and the date received. The cereal should have been re-labeled and dated after it had been used at the breakfast meal. On 06/30/16 at 10:45 AM interview with dietary aide. She stated that foods should be labeled and dated. Cooked foods are held for 3 days. Ready to eat foods can be held for 7 days. Items should be labeled and dated with delivery and open dates. On 06/29/2016 at 3:02 PM interview with the administrator. She stated it was her expectation that there were no expired products in the facility	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		7/27/16

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F 431	Continued From page 26 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to record the date of opening for 1 opened insulin pen and failed to maintain proper labeling of medications for 4 insulin pens contained within the medication cart on the 200 hall in 1 of 3 medication carts reviewed for medication storage. Findings included: The review of manufacturer specifications revealed Novolog FlexPen should be discarded 28 days after opening.	F 431	F 431 A corrective action for affected resident: On 06/30/2016, the insulin pen not dated and the insulin pen without a label were discarded and new pens obtained from the back up pharmacy immediately. All current residents who recieve insulin via pens have the potential to be affected by the alleged deficient practice.	

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F 431	Continued From page 27 The review of the undated policy provided by Director of Nursing (DON) on 6/30/2016 for Medication Labels revealed partly included the following: a) Each prescription medication label includes: 1. Resident ' s name. 2. Specific directions for use, including route of administration. 5. Physician ' s name. 6. Date medication is dispensed. 7. Quantity. 8. Expiration Date. 9. Name, address, and telephone number of provider pharmacy. 11. Accessory labels indicating storage requirements and special procedures. Example: " Shake well " " Take on empty stomach, one hour before or 2 hours after meals. " 1. On 6/30/16 at 11:30 AM an observation of the medication cart for the 200 hall revealed a Novolog FlexPen with a broken seal was not marked with the date of opening. Interview with Nurse # 1 on 6/30/16 at 11:33 AM revealed that she was not sure what happened to the resident ID label because the night shift nurse put the pen on the cart. Nurse stated that names are handwritten on the cap of insulin pen as a method of identification. Nurse stated this is her first week and she is not sure why the resident ID labels are missing. 2. On 6/30/16 at 11:30 AM an observation of the medication cart for the 200 hall revealed 4 insulin pens stored within the medication cart did not have resident Identification (ID) label.	F 431	On 07/19/2016, all insulin pens were audited by the Nurse Mangement Team for missing labels and missing open dates. Corrections will be made as needed. Systemic changes made were: On 07/19/2016, the pharmacy began a new labeling process for insulin pens. Inservice education will begin on 07/19/2016 by the Staff Development Coordinator and will be completed by 07/27/2016. All full time, part time and PRN Nurses will be educated. Topics included labeling all insulin pens with the date opened when the pen is put into use. In addition to this, the nurses were educated on what to do when a label comes off an insulin pen. The facility specific in-service was sent to each Agency Provider whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Staff Development Coordinator will monitor this issue using the Insulin Pen	

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F 431	Continued From page 28 On 6/30/16 at 11:33 AM an observation of the medication cart for the 200 hall revealed that there were loose insulin pens stored in the top drawer of the medication cart creating the potential for insulin pen caps be interchanged. Interview with Unit Manager (UM) on 6/30/2016 at 11:37 AM revealed that her expectations are for insulin pens to be labeled with resident ID label. UM also stated that sometimes the resident ID label sometimes comes off of the insulin pen. UM stated if this happens she would expect the resident name to be written on the actual insulin pen itself, not the cap to the insulin pen. Interview with Pharmacy Representative on 6/30/2016 at 11:43 AM revealed that the expectation of the pharmacy is for the insulin pen to be stored in the plastic bag from the pharmacy with the resident ID label. It is not appropriate for the insulin pen to be stored outside the plastic bag without the resident ID label. Interview with DON on 6/30/2016 at 11:48 AM revealed that her expectation is for insulin pens to be labeled with resident name and date opened. When asked if she thinks it is appropriate for the resident name to be written on the cap of the insulin pen in place of the resident ID label she responded, " A prudent nurse would ensure the caps are not mixed up. "	F 431	Quality Assurance Tool for monitoring for open dates and labels. This will be completed weekly for 4 weeks monitoring 5 residents with insulin orders then monthly times 2 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by theAdministrator or DON to ensure correctiveaction initiated as appropriate. Compliancewill be monitored and ongoing auditing program reviewed at the weekly QAMeeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of	F 520		7/27/16

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F 520	Continued From page 29 nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in February 2016 to correct a deficiency for failing to update a care plan and implement interventions for accident (F280) cited during a compliant survey on 1/12/16 and a recertification survey on 6/30/16. The continued failure of the facility during another Federal survey of record dated 6/30/16 shows a pattern of the facility ' s inability to sustain an effective Quality Assurance Program.	F 520	F 520 A corrective action for affected resident: F280-D For resident #103, the care plan was updated with fall interventions bariatric bed and two person assist with bed mobility on 07/05/2016 by the MDS Coordinator. F323-D For resident #103, the care plan was updated with fall interventions bariatric bed and two person assist with bed mobility on 07/05/2016 by the MDS Coordinator.	

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F 520	Continued From page 30 The facility's Quality Assessment and Assurance Committee also failed to maintain implemented procedures and monitor the interventions the committee put into place in February and May 2016 at accidents (F323) cited during a complaint investigation dated 1/12/16, 5/4/16 and a recertification survey on 6/30/16. The continued failure of the facility during another Federal survey of record dated 6/30/16 shows a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. Findings included: This tags is cross referenced to: F280-D: Based on observations, staff interviews and record review, the facility failed to update the care plan, investigate and implement interventions for a resident who sustained a fall due to staff error (Resident #103) for 1 of 1 reviewed for accidents. F323-D: Based on observation, staff interviews and records review, the facility failed to prevent a resident fall from the bed while in the highest position with one staff present providing care for a resident identified as a two person assistance for bed mobility resulting in a laceration to the head for (Resident #103) for 1 of 1 residents reviewed for accidents. In an interview on 6/30/16 2:00 PM, the Administrator acknowledged understanding of reciting of F280 and F323 during recertification survey of 06/30/16. The Administrator stated there has been a restructuring of management to include a new Director of Nursing and a change	F 520	All current residents who require assistance with incontinence have the potential to be affected by the alleged deficient practice. F280-D Beginning 07/18/2016, the Nurse Management Team began reviewing all current residents who have had a fall in the last 3 months. Each fall was reviewed for incident investigation and implementation of interventions specific to the investigation. When the audit is complete, the MDS Coordinator will then review the interventions to ensure that the they are care planned and in place. This process will be completed by 07/27/2016. F323-D Beginning 07/18/2016, the Nurse Management Team began reviewing all current residents who have had a fall in the last 3 months. Each fall was reviewed for incident investigation and implementation of interventions specific to the investigation. When the audit is complete, the MDS Coordinator will then review the interventions to ensure that the they are care planned and in place. This process will be completed by 07/27/2016. Systemic changes made were: Inservice education was provided to the Director of Nursing and Administrator on 07/18/2016 by the Corporate Clinical Consultant. Topics included the importance of maintaining implemented procedures and monitoring interventions identified in the facilities plan of correction for survey that began on 06/27/2016 and ended on 06/30/2016. This information	

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F 520	Continued From page 31 in the Administrator as of 6/22/16. She stated progress had been made in the area of accidents but she want not aware of the lack of an accident investigation to determine the root case in order to prevent another fall for Resident #103.	F 520	has been integrated into the standard orientation training and in the required in-service refresher courses for all Administrators and Director of Nursing and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Corporate Clincal Consultant will monitor this issue using the Quality Assurance Sustained Quality Assurance Tool for monitoring facility practices including fall investigation, implementing interventions and updating care plans with fall interventions as well as providing safety to residents during bed cares. This will be completed monthly for 12 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by theAdministrator or DON to ensure correctiveaction initiated as appropriate. Compliancewill be monitored and ongoing auditing program reviewed at the weekly QAMeeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	