

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/18/2016
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NAME OF PROVIDER OR SUPPLIER AVANTE AT WILKESBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 COLLEGE STREET WILKESBORO, NC 28697
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F 156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal</p>	F 156	<p>Deficiency corrected</p> <p>Corrective action has been accomplished for the alleged deficient practice in regards to posting of the state complaint intake phone number. The Administrator corrected the phone number on the posting on 8/17/16 when it was brought to his attention by the surveyor.</p> <p>Current facility residents have the potential to be affected by the alleged deficient practice. The corrected phone number was posted in the front lobby and in hallway on 8/17/16, which is easily accessible for residents and family members.</p> <p>Measures put into place to ensure the alleged deficient practice does not recur include: The Activity Director and/or the Social Service director will observe the posting at least monthly and update as necessary and will review with residents the state contact information during monthly resident council meeting. The Admissions director and/or social service director will review and provide State contact information to family and/or resident during admission and/or readmission.</p> <p>The Social Service director and/or the Activity director will analyze observations for patterns/trends and report in the Quality Assurance committee meeting monthly for three months to evaluate the effectiveness of</p>	09/16/16



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John P. Walder TITLE: Administrator (X6) DATE: 9/8/16

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

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F 156	<p>Continued From page 1</p> <p>funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p>	F 156		

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews, the facility failed to post the correct telephone number for the complaint intake unit for 1 of 2 families interviewed. The findings included: On 08/17/16 at 3:20 PM a family member asked to be interviewed. During the interview the family expressed concerns and stated that she had attempted to contact the State agency to file a complaint. The family member could not recall the exact date but stated it had been "a while." She added that she obtained the complaint number from a posting in the facility, dialed the number, but the telephone number posted was incorrect. On 08/17/16 at 5:00 PM the posted information was observed. The telephone number posted to file a complaint was incorrect. The Administrator was present for the observation and stated he was unaware the wrong information had been posted and removed the documents.	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to Resident #7. The Administrator and Director of Nursing (DON) offered to move resident back to room 116 after the room was remodeled. On 8/22/16 resident declined to move rooms. The offer was presented on three separate occasions. The Administrator and	

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F 241	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review a facility staff member spoke to a resident in a manner that upset the resident for 1 of 1 sampled residents (Resident #7).</p> <p>The findings included:</p> <p>Resident #7 was admitted to the facility on 02/06/12 and re-admitted to the facility on 01/17/16 with diagnoses that included muscle weakness and others. The most recent Minimum Data Set (MDS) dated 07/19/16 specified the resident's cognition was intact. Review of Resident #7's room assignment revealed she had been in room 116 since 2012.</p> <p>On 08/17/16 at 9:15 AM Resident #7 was in the doorway of her room. She reported that she had to change rooms and described the move as "awful" and so upsetting she cried and became sick causing her to vomit. A follow-up interview was conducted with Resident #7 on 08/18/16 at 1:30 PM about the room move. Resident #7 stated the Social Worker (SW) told the resident she would have to "move rooms or move to another facility." Resident #7 stated she was scared and felt sick from that thought of having to change rooms and the thought of having to leave the facility. Resident #7 said she cried. Resident #7 explained that she agreed to move rooms because she did not want to leave the facility but she wanted to move back to room 116.</p> <p>On 08/18/16 at 11:37 AM a staff member was interviewed on the telephone. The staff member reported an observation that upset Resident #7. The staff member reported the facility Social</p>	F 241	<p>DON provided in service education to the Social Service Director (SSD) on 8/18/16, regarding dignity and respect particularly regarding room change procedure to accommodate needs of residents, techniques to reduce anxiety that changes may cause and follow up with resident daily for at least a week after room change.</p> <p>Current facility residents that may need to make room changes within the facility have the potential to be affected by the alleged deficient practice. The Administrator and/or DON provided in service education for the SSD and Admission staff beginning on 8/19/16, regarding dignity and respect particularly regarding the procedure for room change to accommodate the needs of the residents, techniques to reduce anxiety that changes may cause and follow up with resident daily for at least a week after room change. The SSD and/or the Admission staff identified current facility residents that have had a room change in the last 30 days (through August 2016); to validate room changes were discussed with dignity and respect for the resident and the room change remains appropriate and resident is satisfied. No concerns were identified.</p> <p>Measures put into place to ensure the alleged deficient practice does not recur include: . The Administrator and/or DON provided in service education for the SSD and Admission staff beginning on 8/18/16, regarding dignity and respect particularly regarding the procedure for room change to accommodate the needs of the residents, techniques to reduce anxiety that changes may cause and follow up with resident daily for at least a week after room change.</p>	

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F 241	Continued From page 4 Worker approached Resident #7 and told Resident #7, "She had 2 options, option 1 move to another room or option 2 move to another facility." The staff member said that Resident #7 instantly became upset and cried. On 08/18/16 at 1:06 PM the Social Worker was interviewed and stated she had told Resident #7 she needed to move rooms and if she didn't agree to the room move, she would have to move to another facility. The SW reported that it was not appropriate to tell Resident #7 she would have to move to another facility but that she had "consulted" with someone who told her it was okay to say that. On 08/18/16 at 2:50 PM the Director of Nursing (DON) was interviewed and was aware Resident #7 had been asked to change rooms. The DON stated the Social Worker should not have told the resident she would have to move to another facility.	F 241	The IDT will discuss potential room changes during daily morning meeting at least 5 days a week. The SSD and/or the Admission staff will discuss room change with the resident and/or responsible party prior to the change, allowing the resident and/or responsible party to agree on the move. In emergency situations, the resident and/or responsible party will be notified of the move and the Administrator and/or DON will meet with the resident and/or family to discuss other options as necessary. The Administrator and/or the DON will visit with the resident at least 5 days following the move, to assure the resident remains satisfied with the room change. The Director of Nursing will analyze audits/reviews/interviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	09/16/16	
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	F 279	Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to Resident #6 & 7. The MDS coordinator developed a care on 9/9/16 for Resident # 6 for Restorative services of active ROM and walking to include goals and interventions. The MDS coordinator developed a care plan on 9/9/16, for Resident #7 for restorative services of active ROM and walking to include goals and interventions.		

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F 279	<p>Continued From page 5</p> <p>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 under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop care plans for residents receiving restorative nursing services for 2 of 2 sampled residents (Resident #6 and #7).</p> <p>The findings included:</p> <p>1. Resident #6 was admitted to the facility on 03/01/16 with diagnoses that included muscle weakness and difficulty walking. The most recent Minimum Data Set (MDS) dated 06/07/16 specified the resident had intact cognition and received 1 day of restorative nursing for active range of motion and 1 day of restorative nursing for walking.</p> <p>Review of Resident #6's care plan revealed there was no indication the resident received restorative nursing services.</p> <p>On 08/18/16 at 10:40 AM the MDS Coordinator was interviewed and explained she oversaw the restorative nursing program. She added that residents receiving restorative nursing services did not have care plans that identified the service and/or the treatment plan or goals. She stated that she used "logs" to record when the service was provided and included goals on the log. The</p>	F 279	<p>Current facility residents receiving restorative services have the potential to be affected by the alleged deficient practice: Beginning 9/9/16, the MDS coordinator and/or the Director of Nursing (DON) identified current facility residents that receive restorative services and developed care plans for the service that is provided to include goals and approaches.</p> <p>Measures put into place to ensure the alleged deficient practice does not recur include: The Region clinical nurse provided in service education on 8/17/16, for the MDS coordinator and the DON regarding implementation of care plans for residents on a restorative program. The MDS coordinator, the Restorative nurse, and/or the Rehab program manager will assess residents that are referred to restorative services and will develop an appropriate program for the resident and implement a care plan that will</p> <p>include resident specific goals and approaches. The Restorative aide will document residents participation in the program on the daily grid and will document a weekly summary, and the Restorative nurse will review documentation weekly to validate continuation of program or implement changes to program as necessary to maintain residents functional ability. The Restorative nurse, Rehab Program manager, DON and Restorative aides will review the residents restorative program and care plan monthly to validate continuation of program and update care plan as necessary to maintain residents functional ability.</p>		

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F 279	Continued From page 6 MDS Coordinator added that the "log" was considered an "extension of the care plan." 2. Resident #7 was admitted to the facility on 01/17/16 with diagnoses that included muscle weakness. The most recent Minimum Data Set (MDS) dated 07/19/16 specified the resident's cognition was intact and she had received 7 days of restorative nursing program for active range of motion and walking. Further review of the medical record revealed the resident's care plan did not specify the restorative nursing program services, goals or interventions. On 08/18/16 at 10:40 AM the MDS Coordinator was interviewed and explained she oversaw the restorative nursing program. She added that residents receiving restorative nursing services did not have care plans that identified the service and/or the treatment plan or goals. She stated that she used "logs" to record when the service was provided and included goals on the log. The MDS Coordinator added that the "log" was considered an "extension of the care plan."	F 279	The Restorative nurse and/or the MDS coordinator will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	09/16/16	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, resident, family and staff interviews and record review, the facility failed to provide restorative nursing services to 2 of 2	F 311	Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to Residents #6 & #7. On 9/9/16, the Director of Nursing (DON) and the MDS coordinator reviewed the restorative programs for Residents #6 & #7 and identified the programs remain appropriate for Residents#6 & #7. Beginning on 9/9/16 care plans were developed on each restorative program. The DON and MDS coordinator will review the program at least monthly to validate the need for the continuation of the restorative program for Residents #6 & #7.		

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F 311	<p>Continued From page 7</p> <p>residents referred by therapy for a maintenance program (Resident #6 and #7).</p> <p>The findings included:</p> <p>1. Resident #6 was admitted to the facility on 03/01/16 with diagnoses that included muscle weakness and difficulty walking. The most recent Minimum Data Set (MDS) dated 06/07/16 specified the resident had intact cognition, did not reject care and received 1 day of restorative nursing for active range of motion and 1 day of restorative nursing for walking.</p> <p>Resident #6 did not have a care plan that addressed her restorative nursing program.</p> <p>Resident #6 had a document titled "Restorative Nursing Log" dated May 2016. The document specified Resident #6 was to receive 3 restorative programs daily beginning on 05/18/16 (ambulation, daily exercises and range of motion). Review of the log revealed the Resident only received restorative nursing services 6 days in the month of May.</p> <p>Resident #6's "Restorative Nursing Log" dated June 2016 was reviewed and specified the resident was to continue to receive daily restorative services for ambulation, range of motion and daily exercises. Resident #6 only received restorative nursing services 7 days in the month of June.</p> <p>Resident #6's "Restorative Nursing Log" dated July 2016 was reviewed and specified the resident was to continue to receive daily restorative services for ambulation, range of motion and daily exercises. Resident #6 only</p>	F 311	<p>Current facility residents that are on a restorative program have the potential to be affected by the alleged deficient practice. Beginning 9/9/16, the DON and the MDS coordinator identified residents that are on a restorative program and validated if the program was appropriate for each resident identified. On 9/12/16, the MDS coordinator and/or the DON developed a care plan for each resident on a restorative program and communicated with the restorative aides regarding each individual restorative program.</p> <p>Measures put into place to ensure the alleged deficient practice does not recur include: On 9/8/16, the Region clinical director provided in service education for the DON and the Rehab program manager regarding the Restorative program. Beginning on 9/12/16, the DON and Rehab program manager provided in service education for the restorative aides and MDS coordinator regarding the Restorative program, which includes provision of services identified for each individual resident on the restorative program, documentation guidelines and monthly review of the program. The DON and/or the MDS coordinator will monitor/observe the documentation for the program weekly for four weeks then monthly ongoing, to assure the residents on the program are receiving services according to the care plan.</p> <p>The Director of Nursing will analyze audits/reviews/observations for patterns/trends and report in the Quality Assurance committee meeting monthly for three months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.</p>	09/16/16

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F 311	<p>Continued From page 8</p> <p>received restorative services 15 days for the month of July.</p> <p>On 08/17/16 at 1:40 PM Resident #6 was in her room with a family member. The Resident was observed ambulating independently. The family member stated that Resident #6 was still able to walk and she tried to encourage the resident to ambulate because there was not enough staff to assist the resident with ambulation. Resident #6 stated staff were not always available to walk her daily as she would like. The family member stated she was aware Resident #6 did not get to walk every day.</p> <p>On 08/18/16 at 9:35 AM the restorative aides were interviewed. Restorative aide #1 stated she had been pulled that day from providing restorative nursing services to give residents showers to cover a nurse aide shortage. The aide reported that she got pulled often to the floor and that it prevented restorative services from being provided to the residents. Restorative aide #2 reported that she could not get to all the residents by herself to provide all the restorative services. The aides stated that due to staffing limitations and being pulled to cover call-offs the services were not provided daily as scheduled. The aides stated staffing had gotten better in the month of August.</p> <p>On 08/18/16 at 12:45 PM the MDS Coordinator was interviewed and explained she oversaw the restorative nursing program. The MDS Coordinator reported that daily services were not being provided because the restorative aides got pulled to cover staffing shortages. She added that she kept a calendar to document that dates the aides were pulled and services were not</p>	F 311			

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F 311	<p>Continued From page 9</p> <p>provided. The MDS Coordinator reported the Director of Nursing and Administrator were aware the restorative nursing program was not being offered daily because of staffing.</p> <p>On 08/18/16 at 2:28 PM the scheduling coordinator was interviewed and explained that staffing was a challenge. She explained the facility had taken efforts to recruit and hire nurse aides but there were still openings. The scheduling coordinator reported that call-offs and vacancies were filled with volunteers and in some cases restorative aides were pulled to the floor. The scheduler stated even the Director of Nursing got pulled to work as a nurse aide.</p> <p>On 08/18/16 at 2:50 PM the Director of Nursing was interviewed and explained the restorative program was not working because of staffing limitations. She stated one of the restorative aides would get pulled to the floor every other weekend. The DON stated that she expected the restorative aides to get pulled as last resort but it was still a frequent occurrence.</p> <p>2. Resident #7 was admitted to the facility on 02/06/12 and re-admitted on 01/17/16 with diagnoses that included muscle weakness. The most recent Minimum Data Set (MDS) dated 07/19/16 specified the resident's cognition was intact, she did not reject care and she had received 7 days of restorative nursing program for active range of motion and walking.</p> <p>Resident #7 did not have a care plan that addressed her restorative nursing program.</p> <p>Review of Resident #7's medical record revealed there was no physician order for a restorative</p>	F 311			

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F 311	<p>Continued From page 10 nursing program.</p> <p>Resident #7 had a document titled "Restorative Nursing Log" dated May 2016. The document specified Resident #7 was to receive 2 restorative programs daily beginning on 02/16/16 (ambulation and upper body strengthening). Review of the log revealed the Resident only received restorative nursing services 16 days in the month of May.</p> <p>Resident #7's "Restorative Nursing Log" dated June 2016 was reviewed and specified the resident was to continue to receive daily restorative services for ambulation and upper body strengthening. Resident #7 only received restorative nursing services 14 days in the month of June.</p> <p>Resident #7's "Restorative Nursing Log" dated July 2016 was reviewed and specified the resident was to continue to receive daily restorative services for ambulation and upper body strengthening. Resident #7 only received restorative services 25 days for the month of July.</p> <p>On 08/18/16 at 1:30 PM Resident #7 was interviewed. She reported that she loved to walk and looked forward to staff walking her daily. She added that some days there wasn't staff available to walk her which made her sad. The resident reported the facility struggled with short staffing and had gone days without having anyone to walk her. Resident #7 stated she looked forward to her daily walks around the facility.</p> <p>On 08/18/16 at 9:35 AM the restorative aides were interviewed. Restorative aide #1 stated she had been pulled that day from providing</p>	F 311			

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F 311	<p>Continued From page 11</p> <p>restorative nursing services to give residents showers to cover a nurse aide shortage. The aide reported that she got pulled often to the floor and that it prevented restorative services from being provided to the residents. Restorative aide #2 reported that she could not get to all the residents by herself to provide all the restorative services. The aides stated that due to staffing limitations and being pulled to cover call-offs the services were not provided daily as scheduled. The aides stated staffing had gotten better in the month of August.</p> <p>On 08/18/16 at 12:45 PM the MDS Coordinator was interviewed and explained she oversaw the restorative nursing program. The MDS Coordinator reported that daily services were not being provided because the restorative aides got pulled to cover staffing shortages. She added that she kept a calendar to document that dates the aides were pulled and services were not provided. The MDS Coordinator reported the Director of Nursing and Administrator were aware the restorative nursing program was not being offered daily because of staffing.</p> <p>On 08/18/16 at 2:28 PM the scheduling coordinator was interviewed and explained that staffing was a challenge. She explained the facility had taken efforts to recruit and hire nurse aides but there were still openings. The scheduling coordinator reported that call-offs and vacancies were filled with volunteers and in some cases restorative aides were pulled to the floor. The scheduler stated even the Director of Nursing got pulled to work as a nurse aide.</p> <p>On 08/18/16 at 2:50 PM the Director of Nursing was interviewed and explained the restorative</p>	F 311		

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F 311	Continued From page 12 program was not working because of staffing limitations. She stated one of the restorative aides would get pulled to the floor every other weekend. The DON stated that she expected the restorative aides to get pulled as last resort but it was still a frequent occurrence.	F 311			
F 323 SS=G	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 record reviews and resident and staff interviews the facility failed to secure a side rail during incontinence care to prevent a resident who used side rails for turning and positioning from falling from bed and resulted in fractures of the femurs (thigh bones) on both legs for 1 of 3 sampled residents for supervision to prevent accidents (Resident #3). The findings included: Resident #3 was re-admitted to the facility on 01/19/16 with diagnoses which included chronic pain, muscle weakness, chronic lung disease, chronic kidney disease and weakness, stiffness and numbness in the neck. A review of an annual Minimum Data Set (MDS)	F 323	Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to Resident #3. Resident #3 was assessed following the incident on 6/08/16 by the licensed nurse and the physician was notified with orders received to send to hospital for evaluation. Resident #3 returned to facility on 6/8/16, with bilateral lower extremity immobilizers and orders for bed rest. The side rails were present on bed and staff were educated regarding use of side rails during turning and repositioning and use with air mattress for safety. The immobilizers were discontinued on 8/8/16, and resident #3 was able to get out of bed into regular wheel chair on 6/8/16. On 8/9/16, the resident was able to transition to a electric wheelchair. The DON and/or unit managers began in service education on 6/8/16 for the nursing staff regarding use of side rails for residents on an air mattress and to assist residents with turning in bed. Current facility residents on an air mattress and/or residents that use rails for self-positioning/turning have the potential to be affected by the alleged deficient practice. Beginning on 9/9/16 the DON and unit managers and identified current residents on an air mattress and/or that uses rails to position and/or turn in bed to validate that rails are intact on bed and residents ability use safely.		

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F 323	<p>Continued From page 13</p> <p>dated 05/06/16 indicated Resident #3 was cognitively intact for daily decision making. The MDS also indicated Resident #3 required extensive assistance for bed mobility and was totally dependent on staff for toileting, hygiene and bathing and was always incontinent of bladder and bowel.</p> <p>A review of a care plan which was updated on 06/08/16 indicated Resident #3 was at risk for falls related to deconditioning and incontinence and a goal revealed Resident #3 would not have a fall with injury through next review date. The interventions were listed in part for padded half side rails on the bed to use for positioning, bed mobility and activities of daily living (ADL). The care plan revealed Resident #3 had a fall from bed on 06/08/16 which resulted in femur fractures on both legs. The care plan also revealed Resident #3 was sent to the emergency room and was ordered knee immobilizers for both legs and a consult with an Orthopedic Physician.</p> <p>A review of a nurse's note dated 06/08/16 at 8:02 AM revealed Resident #3 had a fall from bed in the high position. The note indicated Resident #3 complained of pain in both knees, left hip pain and there was a large abrasion to her left hip. The notes further indicated the physician was notified and orders were received to send Resident #3 to the emergency room.</p> <p>A review of a nurse's note dated 06/08/16 at 8:26 AM revealed Resident #3 was transferred to the emergency room by emergency medical services (EMS).</p> <p>A review of a facility document titled "Unusual Occurrence Report & Investigation for Resident</p>	F 323	<p>In service education began on 6/8/16, for nursing staff regarding use of rails for residents on an air mattress and/or for residents that use rails to turn/position themselves in bed.</p> <p>Measures put into place to ensure the alleged deficient practice does not recur include: In service education began on 6/8/16, for nursing staff regarding use of rails for residents on an air mattress and/or for residents that use rails to turn/position themselves in bed. This information will be included during the new hire process. The DON, Unit Managers and/or the will observe at least 5 residents weekly for four weeks, then 5 monthly for 3 months, while in bed receiving care/assistance to validate rails are in place and used appropriately according to resident needs and safety. The IDT will review incident reports and investigations during daily morning meeting at least 5 times a week, to identify potential cause of incident and implement appropriate interventions to reduce/prevent further incidents.</p> <p>The Director of Nursing will analyze audits/reviews/observations for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.</p>	09/16/16

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F 323	<p>Continued From page 14</p> <p>Fall" dated 06/08/16 at 9:50 AM revealed factors observed at the time of the fall was bed height was not appropriate and an air mattress was on the bed. The report indicated Resident #3's bed in high position and a side rail was not engaged in the horizontal position and Resident #3 was in a puddle of urine and urine was on the floor.</p> <p>A review of a nurse's note dated 06/08/16 at 12:36 PM revealed Resident #3 arrived back to the facility by EMS transport and had knee immobilizers in place on both knees.</p> <p>A review of a therapy note dated 06/09/16 at 11:49 AM by the Director of Rehabilitation revealed Resident #3 had a fall from bed on 06/08/16 while being cleaned by staff and Resident #3 reported she was told to roll and when she rolled her legs slid off the bed and hit the floor. The therapy notes indicated a review of xrays revealed Resident #3 had a displaced fracture of her right femur and had a non-displaced fracture of her left femur and had knee immobilizers in place on both legs. The notes further indicated Resident #3 had an appointment with an Orthopedic Physician on 06/10/16.</p> <p>A review of a care plan titled ADL self care deficit revised on 06/28/16 indicated Resident #3 required extensive to total assistance for incontinence care.</p> <p>During an interview on 08/17/16 at 5:08 PM with Resident #3 she confirmed she fell out of bed on 06/08/16 and it shouldn't have happened. She explained she was in bed and was wet and needed to be cleaned and NA #1 came in to clean her up. She stated the side rail on the left</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>side of the bed was in the up position and was not engaged in it's normal horizontal position and when she turned to her left side she reached for the side rail like she usually did and nothing was there for her to grab onto and she fell out of bed. She explained usually the side rail was down in the horizontal position so she could reach for it and turn herself and hold onto it while staff cleaned her. She stated she felt the fall could have been prevented if the side rail had been engaged in the horizontal position like it usually was. She explained when she fell out of bed, she hit her knees on the floor and broke her legs. She stated she wanted the side rails on her bed because they gave her the ability to turn herself in bed and she felt safer when the side rails were engaged.</p> <p>During an interview on 08/18/16 at 10:15 AM with NA #1 she explained she was assigned to care for Resident #3 on 06/08/16 and when she made her first round around 7:30 AM Resident #3 was in bed and was in a mess and urine was puddled on the bed and was dripping off the side of the bed onto the floor. She stated she left the room to get clean linens and when she returned she asked Resident #3 roll to her right side and Resident #3 grabbed the right side rail which was engaged and was in the horizontal position for her to hold onto. She explained she cleaned Resident #3 and started to put clean linens on the bed and asked Resident to turn onto her back. She stated she then realized a tray table was too close at her left side and was in her way so she walked and pushed the tray table to the foot of the bed and turned her back to Resident #3. NA #1 stated when she turned around Resident #3 was turning to her left side and she saw the left side rail was pointed up in a vertical position and</p>	F 323			

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F 323	<p>Continued From page 16</p> <p>was not engaged in its usual horizontal position. She further stated Resident #3 kept rolling and slid out of bed and down the left side rail and onto her knees on the floor. She explained Resident #3 was stuck in a squatting position on her knees on the floor and she couldn't leave her in that position so she laid Resident #3 on the floor and went and got the nurse who came to the room and assessed her. She explained Resident #3 complained of pain in her legs and she had a long scrape on her left hip and complained it hurt too. She stated she did not know why the left side rail had been left up and was not engaged and she did not know who had left it in that position. She explained usually 1 NA provided incontinence care when Resident #3 was in bed because the resident could assist staff and turn herself with the help of side rails. She stated she realized now she should have put the left side rail in the horizontal positron so that it was engaged for Resident #3 to use it to turn herself. She stated it did not register with her when she first entered Resident #3's room that morning that the left rail was not engaged since it usually was because Resident #3 needed the side rails to turn herself in bed. She explained when Resident #3 had the immobilizers placed on her legs she needed more assistance with turning in bed but now that the immobilizers had been removed Resident #3 could assist with turning herself in bed.</p> <p>During an interview on 08/18/16 at 11:00 AM with Unit Manager #1 she stated she arrived at work at 8:00 AM on 06/08/16 and was told Resident #3 had fallen out of bed. She explained Resident #3 had an air mattress on her bed and she would have expected for both of the side rails to be engaged when Resident #3 turned for safety. She further explained the air fluctuated inside the</p>	F 323			

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F 323	Continued From page 17 air mattress and the side rails should have been engaged to provide Resident a rail to hold onto. She stated Nurse #1 who assessed Resident #3 after her fall was away on vacation and was not available for interview. During an interview on 08/18/16 at 1:54 PM with Unit Manager #2 she explained it was reported to her after Resident #3 fell out of bed on 06/08/16 that NA #1 was providing incontinence care to Resident #3 and NA #1 had turned her back and the resident fell out of bed. She stated NA #1 had reported the left side rail was not engaged. She explained when the side rails were engaged in a horizontal position they kept the resident from falling out of bed as the air in the air mattress shifted. She stated it was her expectation that residents who had air mattresses should have side rails so when the air in the mattress shifted the resident could hold onto the side rail to prevent a fall out of bed. During an interview on 08/18/16 at 2:48 PM with the Director of Nursing she stated it was her expectation for Nurse Aides (NAs) to make sure the side rails were engaged when the NAs provided care to Resident #3 when she was in bed. She confirmed Resident #3 had an air mattress on her bed and she expected the NA would ensure the side rails were engaged before they provided care to Resident #3.	F 323			
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as	F 353	F 353 Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to Residents #6 & #7. The Director of Nursing (DON) and the MDS coordinator reviewed the restorative programs for Residents #6 & #7 on 9/9/16 and identified that the programs remain appropriate for Residents#6 . A care plan was developed on 9/9/16 for each program.		

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F 353	<p>Continued From page 18 determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, resident, family and staff interviews and record review, the facility failed to provide sufficient quantity of staff to provide restorative nursing services to 2 of 2 residents referred by therapy for a maintenance program (Resident #6 and #7).</p> <p>The findings included:</p> <p>Cross refer F 311. Based on observations, resident, family and staff interviews and record review, the facility failed to provide restorative nursing services to 2 of 2 residents referred by therapy for a maintenance program (Resident #6 and #7).</p>	F 353	<p>The DON and MDS coordinator will review the program at least monthly to validate the need for the continuation of the restorative program for Residents #6 & #7.</p> <p>Current facility residents that are on a restorative program have the potential to be affected by the alleged deficient practice. On 9/9/16-, the DON and the MDS coordinator identified residents that are on a restorative program and validated if the program was appropriate for each resident identified. On 9/12/16, the MDS coordinator and/or the DON developed a care plan for each resident on a restorative program and communicated with the restorative aides regarding each individual restorative program.</p> <p>Measures put into place to ensure the alleged deficient practice does not recur include: On 9/8/16, the Region clinical director provided in service education for the DON and the Rehab program manager regarding the Restorative program. Beginning on 9/13/16, the DON and Rehab program manager provided in service education for the restorative aides and MDS coordinator regarding the Restorative program, which includes provision of services identified for each individual resident on the restorative program, documentation guidelines and monthly review of the program. The DON and/or the MDS coordinator will monitor/observe the documentation for the program weekly for four weeks then monthly ongoing, to assure the residents on the program are receiving services according the care plan. The DON and/or unit managers will review staffing daily to assure restorative aides are in place and providing restorative services as indicated for residents on a restorative program.</p> <p>The Director of Nursing will analyze audits/reviews/observations for patterns/trends and report in the Quality Assurance committee meeting monthly for three months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.</p>	09/16/16
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“ Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.”