STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. BUILDING _____ B. WING _____	09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HILLS A PERSONAL CARE	864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589

(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 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to have a medical justification for the use of a lap tray for 2 of 7 residents reviewed with restraints (Resident #87, Resident #137). The findings included: 1. Resident #87 was admitted to the facility on 5/16/14. Diagnoses included Cerebrovascular Accident, Chronic Kidney Disease, Osteoarthritis and Muscle Weakness. The most recent Quarterly Minimum Data Set (MDS) Assessment dated 6/29/16 assessed Resident #87 as cognitively intact with a Brief Interview for Mental Status score of 13. Resident #87 had no behaviors, required extensive two person assistance with bed mobility and transferring, required limited one person assistance with walking in his room and the hallway and extensive one person assistance with toileting. He had range of motion limitations on one side of his upper extremities and limitations on both sides of his lower extremities. Resident #87 was frequently incontinent of bowel and bladder, his balance was unsteady and he had a history of falls. Resident #87 was assessed as having a trunk restraint that was used daily when in the chair or out of bed. The Care Area Assessment (CAAs) Summary dated 11/4/15 triggered in the area of restraints	F 221	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F221 RIGHT TO BE FREE FROM PHYSICAL RESTRIANTS. Corrective Action: Resident #87. Resident #87 was physically assessed. No injuries, or marks or bruises were noted at that time. The care plan team completed a device evaluation related to the device on 10/5/2016.The patient will be screened by therapy to see if alternative seating arrangements can be made. Therapy screened the patient on 10/6/2016 and decided to discontinue use of lap tray. Additionally on 10/6/2016 the care plan team evaluated the use of the lap tray. The team decided to discontinue	10/11/16

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

Electronically Signed | 10/07/2016

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F 221	Continued From page 1 because Resident #87 used a trunk restraint daily. The care planning decision box was checked. The care plan, last updated 7/12/16, revealed a problem/focus of risk for falls. Interventions included lap tray to wheelchair when out of bed due to unsteady gait, attempting unassisted ambulation/transfers and safety awareness. Restraints were not listed in the care plan as a problem/focus. Review of the Restraint Evaluations, dated 11/5/15, 2/1/16, 4/15/16 and 7/12/16 documented the medical reason for restraint use as multiple falls with major injury. The Summary Evaluation documented that Resident #87 did have at one time a TLC cushion (often referred to as a lap buddy) and would remove it, get up unassisted and fall. After a fall with a laceration the lap tray was initiated. Review of the Physician ' s order, dated 10/8/15 documented discontinuing the TLC cushion to the wheelchair due to unsteady gait and ambulating unassisted. A lap tray to the wheelchair was ordered due to attempting to ambulate without assistance and poor safety awareness. Review of the Incident Report dated 3/6/16 documented Resident #87 attempted to transfer self to the toilet without asking for assistance after removing his lap tray. He had a fall. The intervention listed included encouraging the resident to ask for assistance when he needed to go to the bathroom and asking maintenance to check lap tray to be sure it latched/strapped in place. Review of the Incident Report dated 4/8/16 documented Resident #87 removed his lap tray and attempted to toilet self. He was found on the floor near the bathroom. The root cause was	F 221	the use of the lap tray after therapy recommendation. Lap tray discontinued on 10/6/2016 as a result of the screen and after care plan team review of recommendations. New interventions are to toilet resident upon rising, before and after meals and at bedtime. Resident wheelchair cushion changed. Resident #137 Therapy screened the patient on 9/15/2016. Lap tray was discontinued after therapy screen. The team updated her care plan with new intervention to place resident at nursing station while up on wheelchair and offer Activities. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by this alleged deficient practice. On 10/4/2016 to 10/6/2016 the nurse managers completed device evaluation forms on all current residents. This was accomplished by going into every resident's room and determining what type of side rails, hi low or other potentially restraining devices were being used. This included bed rails, hi-low mattresses, Geri chairs, and other cushions that might be considered restraints. Once a device was determined to be attached or adjacent to the resident's body it was evaluated by the nurse to identify if it restricted the patients freedom of movement or normal access to the patient's body. Devices that were considered a restraint were then reviewed for medical necessity by the evaluating nurse. If the device was identified as a	

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F 221	Continued From page 2 listed as removing his lap tray and attempting to go to the bathroom. The intervention listed, in part, was to ensure buckle for the lap tray was not in resident reach. On 9/14/16 at 11:40AM, Resident #87 was observed sitting in his wheelchair in his room with the lap tray in place. The seat belt was latched behind the wheelchair seat. The seat belt straps were noted to be loose. The resident made no attempt to remove the device when asked if he could do so. On 9/14/16 at 2:50PM, Resident #87 was sitting in his wheelchair with the lap tray attached. The seat belt was fastened behind the wheelchair. On 9/15/16 at 10:24AM, Resident #87 was observed sitting in his wheelchair with the lap tray in place. The seat belt was latched behind the wheelchair. The seat belt was not tightened firmly. On 9/15/2016 at 11:53AM, Resident #87 was observed sitting in his wheelchair in his room with the lap tray in place. The seat belt was attached to the lap tray and buckled behind the wheelchair back. On 09/15/2016 at 3:41PM, Resident #87 was observed in his wheelchair with the lap tray attached. The seat belt was attached behind the wheelchair hanging loosely, draping towards the lower portion of the wheelchair back. During an interview with Nurse #2 on 9/14/16 at 9:02AM she stated Resident #87 was at risk for falls and had a lap tray because of safety awareness. She stated he had had falls with injuries and this was just a reminder for him to ask for help. During an interview with Nursing Assistant #2 on	F 221	restraint and not medically indicated a reduction plan was established by the care planning team. This review was completed by 10/6/2016. As of 10/6/2016 all patients have been evaluated and all restraining devices without medical necessity have been discontinued or have active reduction plans with specified time frames to accomplish the reduction. As a result of this review, 7 patients had changes in bedrail utilization, 3 residents have Restraints with a medical necessity and will be reviewed weekly. 34 patients that utilize either Geri chairs, hi low mattresses or other devices are being screened by therapy as the first step of their restraint reduction plan. The care plan team will review each resident on the restraint reduction plan on the weekly QA meeting. Systemic Changes: On 10/4/2016, the QA Nurse Consultant, in-serviced all nurses managers (unit managers, MDS, SDC and DON) on restraints. Topics included: • Many devices can be a restraint for a patient. For something to be a restraint it depends on why and how we use it. We typically think of a restraint being a vest restraint or wrist restraints but restraints can be anything that limits a patient's ability to move. • The official definition of a physical restraint is according to the State Operation Manual is was reviewed with staff. Emphasis was put on the fact that bedrails, hi-low mattresses and Geri chairs can be considered restraints.	

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F 221	Continued From page 3 9/14/16 at 11:20AM she stated Resident #87 had a tray for safety awareness. She further stated if the resident needed to use the bathroom he would call out and say, " take this off " , referring to the lap tray. During an interview with Resident #87 on 9/14/16 at 11:53AM he stated he did not remove the tray but the staff would remove it when he needed to use the toilet. During a follow up interview with Resident #87 on 9/14/16 at 2:50PM he stated he could not remove his tray. During an interview with Nurse #3 on 09/15/2016 12:48PM she stated that Resident #87 usually hollered out when he needed to use the bathroom. She stated he was toileted every two hours and sometimes in between. She stated the facility started out with a TLC cushion but he would remove it and so the facility began using a lap tray which had a seat belt in the back of the wheelchair. She stated she believed he could reach behind the chair and remove the tray. During an observation and interview on 09/15/2016 3:41 PM with Nurse #3 and Resident #87 the nurse asked the resident to remove his lap tray. Resident #87 was sitting in his wheelchair in his room. Resident #87 stated that he could not remove the seat belt. Resident #87 stated he did not like the lap tray because he couldn't get up to use the bathroom. During an interview with the Director of Nursing on 09/15/2016 at 2:57PM she stated Resident #87 originally had a TLC cushion and he would remove the cushion and fall. The facility then began using the hard lap tray. She stated the facility attempted to remove the lap tray and the	F 221	• Device evaluation forms must be completed on all patients on admission, readmission, every 6 months and with significant changes. Additionally any time a resident has fall where a device was utilized the device must be evaluated to ensure that the device does not pose a hazard to the patient. A device evaluation form should be completed to document this review in the medical record. The device evaluations should look at all devices that the patient uses that may meet the definition of a restraint listed above. If the device is considered a restraint then the medical necessity of the device is reviewed. If the device is medically necessary then the interdisciplinary care plan team should review the device to try and reduce or eliminate the use of the restraint. Reduction plans should be reviewed every week during the daily clinical meeting to ensure that the restraint is being reduced. This must continue until the restraint is discontinued. On 10/4/2016 the nurse managers began in-servicing all current nursing staff (RN, LPN, NA both full time, part time and PRN regarding the use of devices and side rails. The Director of Nursing will ensure that any employee who has not received this training by 10/11/2016 will not be allowed to work until the training is completed. This in-service included the following topics: • There are lots of reason why we should not use a restraint. Studies have shown that restraints do not prevent falls	

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F 221	Continued From page 4 resident would fall. She stated after falling and hitting his head, the facility attempted to use a helmet, but the resident would remove it and throw it across the room. She stated it was then the lap tray was put back on his wheelchair. She further stated that the seat belt was higher on the chair at one time and tighter; however, the resident was able to wiggle his elbows on the tray loosening the belt and moving the tray sideways until the seat belt latch was reachable. She stated the facility had now lowered the seat belt on the back of the wheelchair where the resident could not reach the latch. During an interview with the Administrator on 09/16/2016 2:23PM she stated it was her expectation there be a medical justification for the use of a restraint. 2. Resident #137 was admitted to the facility on 6/6/16 and had a diagnosis of cerebrovascular accident with hemiplegia and hemiparesis and diabetic retinopathy. The Admission Minimum Data Set (MDS) Assessment dated 6/13/16 revealed the resident had moderate cognitive impairment and no behaviors. The MDS revealed the resident required the extensive assistance of 2 persons for transfers and extensive to total assistance for activities of daily living. The Care Area Assessment (CAA) for Cognitive Loss dated 6/17/16 noted the resident responded slowly and some days were better than others. The CAA for Activities of Daily Living (ADLs) dated 6/17/16 noted the resident required up to total assistance and would fluctuate between 1-2 staff members. The CAA for Falls dated 6/17/16	F 221	and can actually cause harm to a patient. This harm can include fractures, skin injuries, or even death by strangulation. The survey guidelines that regulate skilled nursing facilities also include regulations that protect the resident's right against being restrained. • Restraints can include a physical restraint or chemical restraint (medications). For something to be a restraint it depends on why and how we use it. We typically think of a restraint being a vest restraint or wrist restraints but restraints can be anything that limits a patient's ability to move. The official definition of a physical restraint was reviewed during the inservice. • If a patient uses one of those devices we need to ensure that the device is not a hazard for the patient. If you notice the patient throwing their legs over the rails or gerichair, notify the charge nurse immediately. The charge nurse should ensure that the nurse manager is notified. The nurse manager will need to complete a device or side rail evaluation to ensure that the device is still medically necessary or they will need to make efforts to remove the device. • The survey manual says: Restraints may not be used for staff convenience. However, if the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility has a notice indicating that the resident has previously made a valid refusal of the treatment in question. If a resident's unanticipated violent or aggressive behavior places	

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F 221	Continued From page 5 noted the resident required up to total assist with transfers and would fluctuate between 1-2 staff members for transfers and had a history of falls with poor vision. There was a physician ' s order dated 7/3/16 for a lap tray to the wheel chair due to attempting to ambulate without assistance and poor safety awareness. The Care Plan was updated on 7/3/16 that read: Lap tray to wheelchair due to attempting to ambulate without assistance and multiple falls. Interventions included to ensure correct positioning with proper body alignment while device in use and to report to nurse any episodes of sliding down in the chair when in use. On 9/13/16 at 2:55PM, Resident #137 was observed sitting in her room in a wheelchair with a tray table that rested on the arms of the wheelchair in front of the resident and secured with straps that wrapped around the back of the wheelchair where the straps were hooked together. The resident was observed to rest her arms on the tray table and her eyes were closed. On 9/13/16 at 2:58 PM, Nurse #5 stated in an interview that the reason the resident had the lap tray was because the resident was blind and would get up without assistance and fall. On 9/15/16 at 9:34 AM the Director of Nursing (DON) stated in an interview they put a tray on the resident ' s wheelchair and the resident would remove it and get up and fall so they put a tray on the wheelchair that fastened in the back of the wheelchair so she could not remove it. On 9/15/16 at 2:36 PM an interview was conducted with the Administrator and the MDS Coordinator. The MDS Coordinator stated in August of 2016 they identified restraints as a problem and had written a plan of correction that was still in progress and not complete.	F 221	him/her or others in imminent danger, the resident does not have the right to refuse the use of restraints. • As you can see there are very few situations where restraints should be used. • In general when dealing with a patient who is agitated there are some basic steps you can follow to try and reduce the agitation. They include active listening, provide reassurance, provide activities, modify the environment, find other outlets for the patient and check yourself ensuring your approach is calm and reassuring. • Each patient is unique and interventions to minimize the risk of falling may range from offering favorite foods to playing music or a TV program that they may like. The patient's care plan will include interventions that should be used to try to calm the patient. The physician should also be notified so that medical interventions can be explored if the care plan interventions do not work or if the agitation is more severe than usual. If interventions listed in the care plan do not work and the physician cannot provide additional directions, then notify the DON or nurse manager on call. • Anytime a patient is actively trying to get up unassisted or if they are trying to get out of a Geri chair unassisted or throwing their legs over a side rail, one on one supervision must be implemented. Staffing should be reallocated to cover all patients until additional assistance can be called in to cover the one on one supervision. Your charge nurse should	

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F 221	Continued From page 6 On 9/15/16 at 2:40 PM, Nurse #4 stated in an interview the resident had a lap tray for safety. The Nurse stated the resident was blind and would get up and wander around. The Nurse stated the tray table was removed today and they were keeping her in the hall so they could watch her.	F 221	contact the administrator and DON immediately if a patient meets this criteria and to get assistance in coordinating the staffing needs. The administrators and DON phone numbers are listed at the nursing station. One on one supervision should be continued until the patient is reviewed by the Quality Assurance team and alternative safety interventions are identified and implemented. The QA team should ensure that the complete a device evaluation or a siderail evaluation is completed. Also make sure to document the restlessness and any fall in the electronic health record. To assist in fall prevention make sure to include any devices (gerichair, bedrail. Bolster mattress or restraint) that was in use. • Restraints do not provide safety for our patients and should only be used in extreme emergencies. Restraints can be both physical and chemical. Physician restraints may be items not typically thought of as a restraint such as a sheet or chairs. It depends on how the device is used and why we are using it. If you are caring for an agitated patient who is trying to get up unassisted please refer to the care plan for interventions to minimize the agitation. If they do not work contact the physician. One on one supervision may also be necessary for patient safety. • If you have questions please contact your DON or Nurse Supervisor for clarifications. This information has been integrated into the standard orientation training and in the required in-service refresher courses for	

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F 221	Continued From page 7	F 221	all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Administrator or Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by reviewing 5 residents each week that have any devices. They will ensure that the devices have been evaluated by the nurse to identify if it restricts the patients freedom of movement or normal access to the patient's body. They will ensure that devices which are considered a restraint have a medical necessity. If a device that is identified as a restraint and is not medically indicated, they will ensure that the reduction plan is established by the care planning team. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 10/11/2016	
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		10/11/16

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F 279 SS=D	Continued From page 8 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 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to develop a care plan for 1 of 7 sampled residents (Resident # 87) reviewed for restraints and failed to develop a care plan for 1 of 1 resident (Resident #123) on an antidepressant medication. The findings included: 1. Resident #87 was admitted to the facility on 5/16/14. Diagnoses included Cerebrovascular Accident, Chronic Kidney Disease, Osteoarthritis and Muscle Weakness.	F 279	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	

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F 279	Continued From page 9 The Care Area Assessment (CAAs) Summary dated 11/4/15 triggered in the area of restraints because Resident #87 used a trunk restraint daily. The most recent Quarterly Minimum Data Set (MDS) Assessment dated 6/29/16 assessed Resident #87 as cognitively intact with a Brief Interview for Mental Status score of 13. Resident #87 was assessed as having a trunk restraint that was used daily when in the chair or out of bed. The resident was assessed as having two falls without injury and two falls with injury. The care plan, last updated 7/12/16, revealed a problem/focus of risk for falls. Interventions included lap tray to wheelchair when out of bed due to unsteady gait, attempting unassisted ambulation/transfers and safety awareness, check the placement of the lap tray every shift, remove lap tray to ambulate resident with assistance as needed and use the FWW (front wheel walker) on 1st and 2nd shifts daily and for prompted toileting every two hours. Restraints were not listed in the care plan as a problem/focus. During an interview with the Occupational Therapist on 09/16/2016 10:12 AM she stated that Resident #87 was at his baseline and he could no longer stand and support his weight and he no longer ambulated with the rolling walker. During an interview with the Director of Nursing on 9/16/16 at 1:20 PM she stated that the facility had always put the restraint under the fall care plan as an intervention to falls. She stated Resident #87 was no longer on a toileting program. During an interview with the Administrator on 09/16/2016 2:23 PM she stated it would be her	F 279	F279 DEVELOP COMPREHENSIVE CARE PLANS Corrective Action: Resident #87: Resident Care plan was reviewed and updated. Resident #126 Resident Care plan was reviewed and updated Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All comprehensive assessments (most recent) within the last 6 months were reviewed: a review of each Care Area Assessment (CAA) for each respective comprehensive assessment was reviewed to ensure that each Care Area Assessment triggered that had a Care Plan Consideration checked “YES” has a care plan addressed with interventions in place. This was done by 10/7/2016 by the QA Nurse Consultant. Systemic Changes: On 10/5/2016 The RN MDS Coordinator and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the QA Nurse Consultant. The education focused on Facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident’s needs (42 CFR 483.20(b)). The Facility uses the CAAs in identifying and clarifying areas of concern that are triggered based on how specific MDS items are coded on the MDS. The process focuses on evaluating	

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	345240	A. BUILDING _____ B. WING _____	09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HILLS A PERSONAL CARE	864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589

(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 279	Continued From page 10 expectation that a care plan be developed to address a restraint as the focus and be updated as needed. 2. Resident #126 was originally admitted to the facility on 4/17/15 and was readmitted on 6/1/15 with diagnoses including Anxiety Disorders, Psychosis and Depression. Review of Resident #126's Care Area Assessment Summary (CAA) dated 3/31/16 revealed Psychotropic Drug Use triggered for further review due to the resident receiving an antidepressant medication. Resident #126's CAA of 3/31/16 also specified a care plan would be developed for the area of Psychotropic Drug Use. According to Resident #126's most recent Quarterly Minimum Data Set (MDS) dated 6/15/16, Resident #126 required extensive assistance in most areas of activities of daily living, except in the area of eating, she fed herself independently and she required limited assistance with walking from one location to another in her room. Resident # 126 had a Brief Interview for Mental Status (BIMS) score of 11 which meant she had limited cognitive deficits. The MDS also specified Resident #126 received antidepressant medication for the last seven (7) days. Review of Resident #126's updated Care Plan dated 9/12/16, revealed antidepressant medication was not care planned. Review of Resident #126's September, 2016 Physician's orders revealed the resident had an order to receive 10 milligrams of Lexapro (an	F 279	these triggered care areas using the CAAs, but does not provide exact detail on how to select pertinent interventions for care planning. Interventions must be individualized and based on applying effective problem solving and decision making approaches to all of the information available for each resident. Care Area Triggers (CATs) identify conditions that may require further evaluation because they may have an impact on specific issues and/or conditions, or the risk of issues and/or conditions for the resident. Each triggered item must be assessed further through the use of the CAA process to facilitate care plan decision making, but it may or may not represent a condition that should or will be addressed in the care plan. The significance and causes of any given trigger may vary for different residents or in different situations for the same resident. Different CATs may have common causes, or various items associated with several CATs may be connected. CATs provide a “flag” for the IDT members, indicating that the triggered care area needs to be assessed more completely prior to making care planning decisions. Further assessment of a triggered care area may identify causes, risk factors, and complications associated with the care area condition. The plan of care then addresses these factors with the goal of promoting the resident’s highest practicable level of functioning: (1) improvement where possible or (2) maintenance and prevention of avoidable	

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F 279	Continued From page 11 antidepressant medication) at bedtime every night. Further review of Resident #126's Physician's orders revealed the resident had orders to receive Lexapro nightly since 11/24/15. During an interview 09/15/2016 at 3:10 PM, the Corporate MDS Coordinator and the facility MDS Coordinator revealed they could not find the care plan for antidepressant medication for Resident #126. The Corporate MDS Coordinator stated nurses were documenting any visible side effects on the Medication Administration Record (MAR) daily. During an interview on 09/16/2016 at 11:41 AM, Nursing Assistant (NA) #3 stated she informed the nurse if Resident #126 exhibited any behaviors. She revealed if she had questions about Resident # 126's care she would ask other nursing assistants and review Resident #126's care guide. She further stated she did not know what to look for in reference to side effects of Resident #126's medications. During an interview on 9/16/16 at 1:29 PM, the Director of Nursing (DON) revealed Resident #126 should have a Care Plan for antidepressant medication use or it could have been combined together with other issues. She stated the Pharmacist monitored Resident # 126's medications and Nursing Assistants let the nurses know about behaviors and side effects of medication. During an interview on 09/16/2016 at 3:20 PM the Administrator revealed if the resident's CAA assessment specified the use of an antidepressant medication would be care planned, it was her expectation that staff would	F 279	declines. The CAA process may help the IDT: Identify and address associated causes and effects; Determine whether and how multiple triggered conditions are related; Identify a need to obtain additional medical, functional, psychosocial, financial, or other information about a resident's condition that may be obtained from sources such as the resident, the resident's family or other responsible party, the attending physician, direct care staff, rehabilitative staff, or that requires laboratory and diagnostic tests; Identify whether and how a triggered condition actually affects the resident's function and quality of life, or whether the resident is at particular risk of developing the conditions; Review the resident's situation with a health care practitioner (e.g., attending physician, medical director, or nurse practitioner), to try to identify links among causes and between causes and consequences, and to identify pertinent tests, consultations, and interventions; Determine whether a resident could potentially benefit from rehabilitative interventions; Begin to develop an individualized care plan with measurable objectives and timetables to meet a resident's medical, functional, mental and psychosocial needs as identified through the comprehensive assessment. Good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan. The CAAs provide a link between the MDS and care planning. The	

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F 279	Continued From page 12 develop a care plan for the use of this medication.	F 279	care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving (see.42 CFR 483.20(k), Comprehensive Care Plans). The RN coordinator is required to sign and date the Care Area Assessment (CAA) Summary after all triggered CAAs have been reviewed to certify completion of the comprehensive assessment (CAAs Completion Date, V0200B2). Facilities have 7 days after completing the RAI assessment to develop or revise the resident's care plan. Facilities should use the date at V0200B2 to determine the date at V0200C2 by which the care plan must be completed (V0200B2 + 7 days). The 7-day requirement for completion or modification of the care plan applies to the Admission, SCSA, SCPA, and/or Annual RAI assessments. A new care plan does not need to be developed after each SCSA, SCPA, or Annual reassessment. Instead, the nursing home may revise an existing care plan using the results of the latest comprehensive assessment. Facilities should also evaluate the appropriateness of the care plan at all times including after Quarterly assessments, modifying as needed. The Director of Nursing or RN Designee will review comprehensive assessments to ensure that a comprehensive care plan is completed for each resident per the RAI requirements as listed above. Any issues will be reported to the Director of Nursing or Administrator for appropriate action. During the daily Clinical Meeting (Monday	

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F 279	Continued From page 13	F 279	through Friday), the RN MDS Coordinator or Designee will review assessment reference dates for OBRA assessments. The Daily Clinical Meeting is attended by the Director of Nursing, Unit Managers, MDS Coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Social Worker, The Administrator and others as needed. Monitoring: To ensure compliance, the Director of Nursing or Designee will conduct a review using the QA Tool. Five residents comprehensive OBRA assessments will be reviewed weekly for 4 weeks, and then monthly for three months. The items reviewed on the QA Care plan Tool will include: CAAs triggered reviewed, Care plan considerations reviewed, Comprehensive care plan for antipsychotic medication and restraint use is completed, Identified issues will be reported immediately to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, and the Administrator. Date of Compliance: 10/11/2016	
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	F 280		10/11/16

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F 280	Continued From page 14 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 record review and staff interviews the facility failed to revise a care plan for 1 of 22 sampled residents (Resident #87). The findings included: Resident #87 was admitted to the facility on 5/16/14. Diagnoses included Cerebrovascular Accident, Chronic Kidney Disease, Osteoarthritis and Muscle Weakness. The most recent Quarterly Minimum Data Set (MDS) Assessment dated 6/29/16 assessed Resident #87 as cognitively intact with a Brief Interview for Mental Status score of 13. Resident #87 was assessed as having a trunk restraint that was used daily when in the chair or out of bed. The resident was assessed as having two falls without injury and two falls with injury. The Care Area Assessment (CAAs) Summary	F 280	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP Corrective Action: Resident #87:	

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F 280	Continued From page 15 dated 11/4/15 triggered in the area of falls related to Resident #87 having balance problems during transitioning, unsteady gait, having at least one fall and he used a trunk restraint daily. The care plan, last updated 7/12/16, revealed a problem/focus of risk for falls. Interventions included lap tray to wheelchair when out of bed due to unsteady gait, attempting unassisted ambulation/transfers and safety awareness, check the placement of the lap tray every shift, remove lap tray to ambulate resident with assistance as needed and use the FWW (front wheel walker) on 1st and 2nd shifts daily and for prompted toileting every two hours. During an interview with the Occupational Therapist on 09/16/2016 10:12 AM she stated that Resident #87 was at his baseline and he could no longer stand and support his weight and he no longer ambulated with the rolling walker. During an interview with the Director of Nursing on 9/16/16 at 1:20 PM she stated that Resident #87 was no longer on a toileting program. During an interview with the Administrator on 09/16/2016 2:23 PM she stated it would be her expectation that a care plan would be updated as needed.	F 280	Resident Care plan was reviewed and updated. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All comprehensive assessments (most recent)within the last 6 months were reviewed: a review of each Care Area Assessment (CAA) for each respective comprehensive assessment was reviewed to ensure that each Care Area Assessment triggered that had a Care Plan Consideration checked “YES” has a care plan addressed with interventions in place. This was done by 10/7/2016 by the QA Nurse consultant. Systemic Changes: On 10/5/2016 The RN MDS Coordinator and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the QA nurse consultant. The education focused on 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	

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F 280	Continued From page 16	F 280		

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.
Facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident's needs (42 CFR 483.20(b)). The Facility uses the CAAs in identifying and clarifying areas of concern that are triggered based on how specific MDS items are coded on the MDS. The process focuses on evaluating these triggered care areas using the CAAs, but does not provide exact detail on how to select pertinent interventions for care planning. Interventions must be individualized and based on applying effective problem solving and decision making approaches to all of the information available for each resident. Care Area Triggers (CATs) identify conditions that may require further evaluation because they may have an impact on specific issues and/or conditions, or the risk of issues and/or conditions for the resident. Each triggered item must be assessed further through the use of the CAA process to facilitate care plan decision making, but it may or may not represent a condition that should or will be addressed in the care plan. The significance and causes of any given trigger may vary for different residents or in different situations for the same resident. Different CATs may have common causes, or various items associated with several CATs may be

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F 280	Continued From page 17	F 280	connected. CATs provide a “flag” for the IDT members, indicating that the triggered care area needs to be assessed more completely prior to making care planning decisions. Further assessment of a triggered care area may identify causes, risk factors, and complications associated with the care area condition. The plan of care then addresses these factors with the goal of promoting the resident’s highest practicable level of functioning: (1) improvement where possible or (2) maintenance and prevention of avoidable declines. The CAA process may help the IDT: Identify and address associated causes and effects; Determine whether and how multiple triggered conditions are related; Identify a need to obtain additional medical, functional, psychosocial, financial, or other information about a resident’s condition that may be obtained from sources such as the resident, the resident’s family or other responsible party, the attending physician, direct care staff, rehabilitative staff, or that requires laboratory and diagnostic tests; Identify whether and how a triggered condition actually affects the resident’s function and quality of life, or whether the resident is at particular risk of developing the conditions; Review the resident’s situation with a health care practitioner (e.g., attending physician, medical director, or nurse practitioner), to try to identify links among causes and between causes and consequences, and to identify pertinent tests, consultations, and	

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interventions; Determine whether a resident could potentially benefit from rehabilitative interventions; Begin to develop an individualized care plan with measurable objectives and timetables to meet a resident's medical, functional, mental and psychosocial needs as identified through the comprehensive assessment.
Good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan. The CAAs provide a link between the MDS and care planning. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving (see.42 CFR 483.20(k), Comprehensive Care Plans).
The RN coordinator is required to sign and date the Care Area Assessment (CAA) Summary after all triggered CAAs have been reviewed to certify completion of the comprehensive assessment (CAAs Completion Date, V0200B2). Facilities have 7 days after completing the RAI assessment to develop or revise the resident's care plan. Facilities should use the date at V0200B2 to determine the date at V0200C2 by which the care plan must be completed (V0200B2 + 7 days). The 7-day requirement for completion or modification of the care plan applies to the Admission, SCSA, SCPA, and/or Annual RAI assessments. A new care plan does not need to be developed after each SCSA, SCPA, or Annual reassessment. Instead, the nursing home may revise an existing care plan using the results of the

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F 280	Continued From page 19	F 280	latest comprehensive assessment. Facilities should also evaluate the appropriateness of the care plan at all times including after Quarterly assessments, modifying as needed. The Director of Nursing or RN Designee will review comprehensive assessments to ensure that a comprehensive care plan is completed for each resident per the RAI requirements as listed above. Any issues will be reported to the Director of Nursing or Administrator for appropriate action. During the daily Clinical Meeting (Monday through Friday), the RN MDS Coordinator or Designee will review assessment reference dates for OBRA assessments. The Daily Clinical Meeting is attended by the Director of Nursing, Unit Managers, MDS Coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Social Worker, The Administrator and others as needed. Monitoring: To ensure compliance, the Director of Nursing or Designee will conduct a review using the QA Tool. Five residents comprehensive OBRA assessments will be reviewed weekly for 4 weeks, and then monthly for three months. The items reviewed on the QA Care plan Tool will include: CAAs triggered reviewed, Care plan considerations reviewed, Comprehensive care plan for antipsychotic medication and restraint use is completed, Identified issues will be reported immediately to the Director of Nursing or Administrator for appropriate	

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F 280	Continued From page 20	F 280	action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, and the Administrator. Date of Compliance: 10/11/2017	
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, record review and staff interviews, the facility failed to correctly apply a restraint for 2 of 7 residents reviewed having restraints (Resident #87, Resident #137). The findings included: 1. Resident #87 was admitted to the facility on 5/16/14. Diagnoses included Cerebrovascular Accident, Chronic Kidney Disease, Osteoarthritis and Muscle Weakness. The most recent Quarterly Minimum Data Set (MDS) Assessment dated 6/29/16 assessed Resident #87 as cognitively intact with a Brief Interview for Mental Status score of 13. Resident #87 was assessed as having a trunk restraint that was used daily when in the chair or out of bed. The Care Area Assessment (CAAs) Summary	F 323	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Corrective Action:	10/11/16

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F 323	Continued From page 21 dated 11/4/15 triggered in the area of restraints because Resident #87 used a trunk restraint daily. The care plan, last updated 7/12/16, revealed a problem/focus of risk for falls. Interventions included lap tray to wheelchair when out of bed due to unsteady gait, attempting unassisted ambulation/transfers and safety awareness, check the placement of the lap tray every shift, remove lap tray to ambulate resident with assistance as needed and use the FWW (front wheel walker) on 1st and 2nd shifts daily and for prompted toileting every two hours. Restraints were not listed in the care plan as a problem/focus. Review of the Physician ' s order, dated 10/8/15 documented discontinuing the TLC cushion (commonly referred to as a lap buddy) to the wheelchair due to unsteady gait and ambulating unassisted. A lap tray to the wheelchair was ordered due to attempting to ambulate without assistance and poor safety awareness. Review of the Incident Report dated 3/6/16 documented Resident #87 attempted to transfer self to the toilet without asking for assistance after removing his lap tray. He had a fall. The intervention listed included encouraging the resident to ask for assistance when he needed to go to the bathroom and asking maintenance to check lap tray to be sure it latched/strapped in place. Review of the Incident Report dated 4/8/16 documented Resident #87 removed his lap tray and attempted to toilet self. He was found on the floor near the bathroom. The root cause was listed as removing his lap tray and attempting to go to the bathroom. The intervention listed, in part, was to ensure buckle for the lap tray was not	F 323	Resident #87 Resident #87 was physically assessed. No injuries, or marks or bruises were noted at that time. The care plan team completed a device evaluation related to the device on 10/5/2016.The patient will be screened by therapy to see if alternative seating arrangements can be made. Therapy screened the patient on 10/6/2016 and decided to discontinue use of lap tray. Additionally on 10/6/2016 the care plan team evaluated the use of the lap tray. The team decided to discontinue the use of the lap tray after therapy recommendation. Lap tray discontinued on 10/6/2016 as a result of the screen and after care plan team review of recommendations. New interventions are to toilet resident upon rising, before and after meals and at bedtime. Resident wheelchair cushion changed. Resident #137 Therapy screened the patient on 9/15/2016. Lap tray was discontinued after therapy screen. The team updated her care plan with new intervention to place resident at nursing station while up on wheelchair and offer Activities. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All resident with devices were assessed by the Director of Nursing or Unit support nurse or MDS Coordinators from 10/4/2016 to 10/6/2016 to ensure that the devices used were applied correctly and functioning properly.	

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F 323	Continued From page 22 in resident reach. On 9/14/16 at 11:40AM, Resident #87 was observed sitting in his wheelchair in his room with the lap tray in place. The seat belt was latched behind the wheelchair seat. The seat belt straps were noted to be loose. The resident made no attempt to remove the device when asked if he could do so. On 9/14/16 at 2:50PM, Resident #87 was sitting in his wheelchair with the lap tray attached. The seat belt was fastened behind the wheelchair. On 9/15/16 at 10:24AM, Resident #87 was observed sitting in his wheelchair with the lap tray in place. The seat belt was latched behind the wheelchair. The seat belt was not tightened firmly. On 9/15/2016 at 11:53 AM, Resident #87 was observed sitting in his wheelchair in his room with the lap tray in place. The seat belt was attached to the lap tray and buckled behind the wheelchair back. On 09/15/2016 at 3:41 PM, Resident #87 was observed in his wheelchair with the lap tray attached. The seat belt was attached behind the wheelchair hanging loosely, draping towards the lower portion of the wheelchair back. During an interview with Nurse #2 on 9/14/16 at 9:02AM she stated Resident #87 was at risk for falls and had a lap tray because of safety awareness. She stated he had had falls with injuries and this was just a reminder for him to ask for help. During an interview with Nursing Assistant #2 on 9/14/16 at 11:20AM she stated Resident #87 had a tray for safety awareness. She further stated if	F 323	Systemic Changes: Director of Nursing and /or Designee in serviced all staff (full time, part time, and PRN) to inform that 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. Any time a device is not functioning properly staff will take the device out of order and fill out a work order for the maintenance director. Staff will also notify the Director of nursing or designee for a replacement or an alternative intervention if needed. Any staff member (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. 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. Monitoring: To ensure compliance, Administrator or Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by completing safety checklists on devices used by 5 residents to ensure that the devices are correctly applied and functioning properly. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure	

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F 323	Continued From page 23 the resident needed to use the bathroom he would call out and say, " take this off " , referring to the lap tray. During an interview with Nurse #3 on 09/15/2016 12:48 PM she stated that Resident #87 usually hollered out when he needed to use the bathroom. She stated he was toileted every two hours and sometimes in between. She stated the facility started out with a the TLC cushion but Resident #87 would remove it and so the facility began using a lap tray which had a seat belt in the back of the wheelchair. She stated she believed he could reach behind the chair and remove the tray. During an observation and interview on 09/15/2016 3:41 PM with Nurse #3 and Resident #87 the nurse asked the resident to remove his lap tray. Resident #87 was sitting in his wheelchair in his room. Resident #87 stated that he could not remove the seat belt. Resident #87 stated he did not like the lap tray because he couldn't get up to use the bathroom. During an interview with the Director of Nursing (DON) on 09/15/2016 at 2:57 PM she stated Resident #87 originally had a TLC tray and he would remove the tray and fall. The facility then began using the hard lap tray. She stated the facility attempted to remove the tray and the resident would fall. She stated it was then the lap tray put back on his wheelchair. She further stated that the seat belt was higher on the chair at one time and tighter; however, the resident was able to wiggle his elbows on the tray loosening the belt and moving the tray sideways until the seat belt latch was reachable. She stated the facility had now lowered the seat belt on the back of the wheelchair where the resident could	F 323	corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 10/11/2016	

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F 323	Continued From page 24 not reach the latch. During an observation and interview with the DON on 09/16/2016 at 1:55 PM Resident #87 was observed sitting in his wheelchair in the hall. The seat belt was loosely hanging in the back of the wheelchair back. The DON was observed to pull the tray forward and there was an approximate gap of 5 inches between the resident's chest and the tray. The DON then stated if we move the belt up where it should be in the back of the wheelchair and tighten the belt, Resident #87 would move the tray back and forth until he could reach the latch and undo the belt. She then stated she realized that the gap could be a potential hazard and tightened the belt where it was correctly applied. During an interview with the Administrator on 09/16/2016 2:23 PM she stated it was her expectation that any restraint be applied correctly. 2. Resident #137 was admitted to the facility on 6/6/16 and had a diagnosis of cerebrovascular accident with hemiplegia and hemiparesis and diabetic retinopathy. The Admission Minimum Data Set (MDS) Assessment dated 6/13/16 revealed the resident had moderate cognitive impairment and no behaviors. The MDS revealed the resident required the extensive assistance of 2 persons for transfers and extensive to total assistance for activities of daily living. The Care Area Assessment (CAA) for Cognitive Loss dated 6/17/16 noted the resident responded	F 323		

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slowly and some days were better than others.
The CAA for Activities of Daily Living (ADLs) dated 6/17/16 noted the resident required up to total assistance and would fluctuate between 1-2 staff members. The CAA for Falls dated 6/17/16 noted the resident required up to total assist with transfers and would fluctuate between 1-2 staff members for transfers and had a history of falls with poor vision.
There was a physician ' s order dated 7/3/16 for a lap tray to the wheel chair due to attempting to ambulate without assistance and poor safety awareness.
The Care Plan was updated on 7/3/16 with the following: Lap tray to wheelchair due to attempting to ambulate without assistance and multiple falls. Interventions included to ensure correct positioning with proper body alignment while device in use and to report to nurse any episodes of sliding down in the chair when in use.
On 9/13/16 at 2:55PM, Resident #137 was observed sitting in her room in a wheelchair with a tray table that rested on the arms of the wheelchair in front of the resident with straps that wrapped around the back of the wheelchair where the straps were hooked together to secure the tray table. The resident was observed to rest her arms on the tray table that was flat and stable with the resident leaning on the table.
On 9/15/16 at 10:20 AM the resident was observed sitting in her room in a wheelchair with the tray table secured in the same way, however, the tray table was not flat and the front of the tray table was leaning downward with the resident resting her arms on the tray table and leaning forward.
On 9/15/16 at 10:25 AM an observation of the wheelchair and tray table was made with the Administrator. The Administrator stated the tray

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table was not applied correctly. The Administrator asked the Director of Nursing (DON) to look at the wheelchair with the tray table and the DON stated it looked like the arms of the wheelchair were not long enough to support the front of the tray table and would have therapy evaluate the device.
On 9/15/16 at 2:33 PM, Resident #137 was observed sitting in the hall without the tray table.
On 9/15/16 at 2:35 PM, Nurse #4 stated the tray table was removed today and they were keeping her in the hall so they could watch her.
On 9/16/16 at 9:08 AM, Nurse #1 stated in an interview that several weeks ago there was a bolt on the resident ' s tray table that was loose and caused the tray table to lean forward. The Nurse stated she had to tighten the bolt to keep this from happening and she reported the problem to maintenance but could not say exactly when this occurred.
On 9/16/16 at 9:12 AM the Maintenance Director stated in an interview that he received a work order that a bolt was missing from the tray table on Resident #137 ' s wheelchair but could not remember when. The Maintenance Director stated the tray table was not stable and would twist and when he checked the tray table a bolt was missing and he replaced the bolt to stabilize the tray table. The Maintenance Director was unable to provide a date when he replaced the bolt and stated the work orders had been removed from the facility when the facility was bought by another company in August of 2016.
On 9/16/16 at 9:33 AM the tray table used on the resident ' s wheelchair was observed with the Maintenance Director. There was a plastic piece with grooves on the bottom of the left and right side of the tray table that fit over the arms of the wheelchair. There was a bolt that attached the

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F 323	Continued From page 27 front of the plastic groove to the tray table and a bolt that attached the back of the plastic groove to the tray table on each side. The bolt on the left rear groove was missing and caused the table top to separate from the grooved section causing the front of the tray table to lean downward On 9/16/16 at 11:09 AM an interview was conducted with NA #5 who was assigned to Resident #137 on 9/14-15/16. The NA stated she had not worked with the resident for about a week until 9/14/16 and 9/15/16. The NA stated when she saw the tray table leaning on 9/14-15/16 she thought there was a piece missing on the bottom where the table fit over the arm of the wheelchair. The NA stated she did not report the problem to anyone.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 errors out of 26 opportunities resulting in a medication error rate of 7.6% for 2 of 5 residents observed during medication pass (Resident #82 and Resident #74). The findings included: 1. Resident #82 was admitted to the facility on 6/11/16 and had a diagnosis of chronic obstructive pulmonary disease (COPD). Review of the clinical record revealed an order	F 332	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	10/11/16

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F 332	Continued From page 28 dated 9/7/16 for Symbicort 160 inhaler, 2 puffs twice a day. On 9/14/16 at 3:46 PM, Nurse #6 was observed to administer 2 inhalations of Symbicort to Resident #82. Symbicort contains a corticosteroid medication and used to treat COPD. The manufacturer ' s package insert for Symbicort gave instructions to have the patient rinse the mouth with water after the inhalation of Symbicort to prevent a fungal infection. The Nurse did not instruct the resident to rinse her mouth after the Symbicort was administered. On 9/14/16 at 3:50 PM Nurse #6 stated in an interview that she had worked at a place where they were supposed to have the resident rinse their mouth after the use of Symbicort but she had not been told to do it at this facility. On 9/16/16 at 3:09 PM, the Administrator stated in an interview she would expect the nurse to follow the manufacturer ' s instructions for administering the medication. 2. Resident #74 was admitted to the hospital on 12/9/10 and had a diagnosis of Dry Eyes. Review of the clinical record revealed a physician ' s order dated 8/29/16 for Systane Ultra Solution 0.4-0.3%, instill 1 drop in both eyes four times a day for dry eyes. On 9/15/16 at 8:37 AM, Nurse #5 was observed to prepare and administer medications to Resident #74. The nurse did not administer the Systane eye drops. On 9/15/16 at 9:00 AM, Nurse #5 stated she overlooked the Systane eye drops for Resident #74 and administered the eye drops to the resident. On 9/16/16 the Administrator stated in an interview that she expected medications to be given as ordered.	F 332	F332 FREE OF MEDICATION ERROR RATES OF 5% OR MORE Corrective Action: Resident #82 Medications administered as ordered. Manufacturer's instructions followed. Resident #74 Medications administered as ordered. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. Audits were done by the Director of Nursing by 10/6/2016 checking the Medication Administration records ensuring that all medication were administered as prescribed. Audits were done by Director of Nursing by 10/6/2016 to ensure that all oral inhalations medication are administered and also following manufacturer's instructions. Systemic Changes: Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, full time, part time, and PRN) that the facility must ensure that it is free of medication error rates of five percent or greater. Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Medications are prepared only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to prepare	

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F 332	Continued From page 29	F 332	medications. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the provider pharmacy contacts the physician for clarification. This interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate. Medications are administered at the time they are prepared. Medications are not pre-poured. The person who prepares the dose for administration is the person who administers the dose. Hand hygiene should be performed before and after administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications. The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate. The individual who	

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administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Signature will be found on master signature sheet. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (for example, the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), (the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is on the reverse side of the record provided for PRN documentation). If (two consecutive doses) of a vital medication are withheld or refused, the physician is notified.
When administering Oral Inhalation medications, determine that an adequate amount of medication is remaining in the aerosol canister. Remove the cap and hold the inhaler upright. Shake the inhaler. Instruct the resident to tilt his/her head back slightly, stand or sit up as straight as possible, and breathe out through mouth. Place inhaler into mouth. Instruct resident

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F 332	Continued From page 31	F 332	to inhale slowly as you depress the canister to release the medication. Breathe in and out normally for one (1) minute, keeping inhaler in place in the mouth. Have resident rinse his/her mouth and spit out the rinse water. Rinse and dry the inhaler mouthpiece .Wash your hands. This in service was completed by 10/11/2016. Any nursing staff member (RNs, LPNs, full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. 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. Monitoring: To ensure compliance, Administrator or Maintenance Director or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by auditing 5 residents medication Administration record on a weekly basis to ensure that medications are administered as prescribed .The audit will also review 5 residents with oral inhalations medication orders weekly to ensure that the manufacturer's instructions are being followed. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to	

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F 332	Continued From page 32	F 332	the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 10/11/2016	
F 371 SS=E	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 interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean the tray steam table under shelf for one of one steam tables observed. The findings included: Review of the Sanitation, Manual Cleaning & Sanitizing of Stationary Equipment and Work Stations revision date of 9/11. Reads as follow: " Policy: Equipment, work stations and all food contact surfaces must be cleaned and sanitized.	F 371	F371 SS=E Corrective Action for Resident Affected No specific resident is identified. Corrective Action for Resident Potentially Affected All residents residing in the facility have potential to be affected. The facility is to maintain kitchen equipment in a sanitary condition to prevent cross contamination.	10/11/16

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F 371	Continued From page 33 Stationary Equipment. *Turn off and unplug equipment before cleaning. *Remove food and soil from under and around the equipment. " Review of the cleaning list for the week of 9/11/16 to 9/17/16 under AM Aide 2 listed cleaning duties as " Steamtable, toaster, cook refrigerator, walk-In cooler, floor, meal carts, meal cards, check label and date all foods items. " The cleaning list was initialed on Sunday 9/11/16 indicating the steamtable had been cleaned on that date. During an observation on 9/14/16 at 11:26 AM the 5 well steam table was observed. The 5 ½ foot underside of the steam table shelf was observed to be covered with dark dried food particles. A second observation on 9/15/16 at 9:17 AM the 5 ½ foot underside of the steam table shelf was observed to be covered with dark dried food particles. During a third observation on 9/16/16 at 10:12 AM the 5 ½ foot underside of the steam table shelf was observed to be covered with dark dried food particles. In an interview with the Food Service Manager on 9/16/16 at 10:12 AM she stated that when the AM and PM dietary aide clean the steam table wells they should also clean the underside of the steam shelf. On 9/16/16 at 10:18 AM the dietary staff stated that the steam table shelf should be cleaned every day, but that she just did not get to it today. In an interview with the Administrator on 9/16/16 she stated that she would expect dietary staff to follow the cleaning schedule.	F 371	Cleaning schedules are to be followed and completed cleaning assignments will be monitored to ensure satisfactory completion. Compliance will be monitored by Dietary Management. Systemic Changes Thorough cleaning of the steam table area including under the steam table shelf was completed _9-15-16_____. An audit tool will be put in place to monitor cleaning of the steam table area. Staff was in-serviced by the Dietary Manager on ___10-7-16_____ regarding completion of all cleaning assignments. Quality Assurance The Dietary Services Director will monitor this issue using the Dietary QA Audit Tool. This will be done 3 days per week for three months or until resolved by QOL/QA committee. Reports will be given to the weekly QOL/QA committee and Corrective Action initiated as appropriate. The QOL/QA committee is the main Quality Assurance Committee. This regularly scheduled weekly meeting is attended by The Administrator, Director of Nursing, Dietary Services Director, and__MDS_____. The Medical Director will review during the Quarterly QA Meeting.	
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY	F 372		10/11/16

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F 372	Continued From page 34 The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain the area surrounding the dumpster free of debris for 1 of 1 dumpsters observed. The findings included: Review of the Sanitation, Disposal of Garbage and Refuse policy last revised on 9/11, reads as follows: " Sanitation, Disposal of Garbage & Refuse. Policy *Outdoor trash receptacles should be kept covered at all times, with their drain plugs in place. The outside area is to be kept clean at all times. " During an observation of the dumpster on 9/16/16 at 8:38 AM a clear plastic bag of trash and one disposable glove were observed on the ground beside the dumpster. A second observation on 9/16/16 at 9:42 AM revealed a clear plastic bag of trash and one disposable glove were observed on the ground beside the dumpster. An observation of the dumpster was conducted with the Food Service Manager on 9/16/16 at 10:15 AM. A clear plastic bag of trash and one disposable glove were observed on the ground beside the dumpster. On 9/16/16 at 10:24 AM the Food Service Manager stated that she had checked the dumpster area once that morning and another department had left their trash on the ground. On 9/16/16 at 1:53 PM the Administrator stated that she would expect all staff to pick up around the dumpster.	F 372	F372 SS=D Corrective Action for Resident Affected No specific resident is identified. Corrective Action for Resident Potentially Affected All residents residing in the facility have potential to be affected. The facility is to dispose of garbage & refuse properly. Compliance will be monitored by Dietary & Facility Maintenance Management. Systemic Changes The Dumpster area was cleaned of all trash on__9-14-16_____. An audit tool will be put in place to monitor the cleanliness of the area. Quality Assurance The Dietary Services Director & Maintenance Director will monitor this issue using the Dietary QA Audit Tool. This will be done 3 days per week for three months or until resolved by QOL/QA committee. Reports will be given to the weekly QOL/QA committee and Corrective Action initiated as appropriate. The QOL/QA committee is the main Quality Assurance Committee. This regularly scheduled weekly meeting is attended by The Administrator, Director of Nursing, Dietary Services Director,	

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F 372	Continued From page 35	F 372	and__Maintenance_____. The Medical Director will review during the Quarterly QA Meeting.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		10/11/16

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F 441	Continued From page 36 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, a facility nurse failed to sanitize her hands between residents for 3 of 5 residents observed during a medication pass (Resident #74, Resident #141 and Resident #8). The findings included: The facility policy titled Handwashing dated 1/2010 listed the purpose was to prevent the spread of germs and cross-contamination. The section Alcohol Based Handrubs read: " Use Alcohol Based Hand Rubs: Before having direct contact with resident. After having direct contact with resident. " 1a On 9/15/16 at 8:37 AM, Nurse #5 was observed to prepare medications for Resident #74. The nurse was observed to punch out one pill from each of 3 blister pack punch cards and used her fingers to remove each pill from the pack and place in a plastic medication cup. During the observation, the Nurse stated she had a hard time punching out the pill from the card into the cup and had to use her fingers to ensure the pill got into the medication cup. The nurse was observed to administer the medications to Resident #74. b. The nurse exited the room and was observed to apply a brace to the right foot and leg of Resident #8 who was sitting in a wheelchair in the hall near the medication cart. c. The nurse was observed to return to the medication cart to prepare medications for Resident #141. The nurse was observed to punch out one pill from each of 3 blister pack cards and	F 441	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F441 INFECTION CONTROL, PREVENT SPREAD, LINENS Corrective Action: Resident # 74 Medication was administered as ordered maintaining standard precautions during medication administration. Resident #141 Medication was administered as ordered maintaining standard precautions during medication administration. Resident #8 Medication was administered as ordered maintaining standard precautions during medication administration. Facility immediately in serviced all Nurses staff and Med Techs (RN, LPN and Med Techs: Full time, Part Time and PRN) about infection control, preventing spread	

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F 441	Continued From page 37 used her fingers to remove each pill from the pack and place in a plastic cup. During the medication pass, the nurse did not wash her hands or use a hand sanitizer between the 3 residents. On 9/15/16 at 9:20 AM, Nurse #5 stated in an interview that she was nervous and forgot to wash her hands and was observed to open a drawer of the medication cart and used a bottle of hand sanitizer to sanitize her hands. On 9/16/16 at 3:08 PM, the Administrator stated in an interview it would be her expectation for the nurse to wash or sanitize her hands between residents.	F 441	of infection during medication administration. To ALWAYS maintain standard precautions during medication administration and to always wash their hands when resident contact is made. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. Director of Nursing observed Medication Administration Passes on Nurses (RN, LPN and Med Techs) All residents medications administered as ordered maintaining standard precautions during medication administration. Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses staff and Med Techs (RN, LPN and Med Techs: full time, part time, and PRN) about infection control, preventing spread of infection during medication administration. The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;(2) Decides what procedures, such as isolation, should be applied to an individual resident; and(3) Maintains a record of incidents and corrective actions related to infections.(b) Preventing Spread of Infection(1) When the Infection Control Program determines that a resident needs isolation to prevent	

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F 441	Continued From page 38	F 441		

the spread of infection, the facility must isolate the resident.(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

Medications are administered at the time they are prepared. Medications are not pre-poured. The person who prepares the dose for administration is the person who administers the dose. Hand hygiene should be performed before and after administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications.

Always observe Standard Precaution during any medication administration. Wash hands if resident contact is made. Standard Precautions should be used with all procedures involving blood or other potentially infectious body fluids.

Ointments and drops should be kept in separate containers labeled with the resident's name. Liquid and PO medications should be stored separately in the medication carts. No medications used for treatments such as creams should be kept in the medication cart. These items should be kept in the treatment cart. Any medication used for the treatment of a resident who is on

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F 441	Continued From page 39	F 441	isolation precautions should be stored separately from other resident's treatment supplies and should be locked to prevent unauthorized access. Medication carts shall be cleaned when visibly soiled. Food and utensils shall be handled in a sanitary manner. Unused medication cups shall be kept covered or inverted. Sharps containers on medication carts shall be affixed or secured to prevent spillage. When administering oral medications, never touch pills or tablets with bare hands. If blister pack medications are prepared by pharmacy, punch the medication directly into a medication cup for dispensing. If tablets are in a bottle, then pour the medication into the lid and then transfer ordered dose into the medication cup. Clean any spilled liquid medication immediately. When administering eye drops, Always wear gloves. Wash hands after administration. Ensure that eye medication dispensers/containers do not touch the resident's eyes. If eye secretions are present, cleanse the lid with saline. Always wipe from the inner canthus outward. Always use separate tissue wipes or cotton balls for each eye to prevent cross contamination. When administering injections, Always wear gloves. Wash hands after administration. Use sterile technique when preparing the medication for injection. Cleanse the site with an antiseptic prior to administration of the injection. Dispose of the sharp in an appropriate container immediately following administration. Monitor the	

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F 441	Continued From page 40	F 441	injection site for sign and symptoms of infection. When administering medications via syringe, the syringe should be used for one resident only. Syringe shall be changed at least every 24 hours. Syringe shall be rinsed thoroughly, separated and dried thoroughly after each use and placed in cover by bedside or in a plastic bag, which is attached to feeding pole ready for next use. This in services were completed on 10/11/2016. Any nursing staff member (RNs, LPNs, full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. 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. Monitoring: To ensure compliance, Director of nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by observing 5 different medication administration passes done by an RN or LPN or Med tech during any shift. This will be done to ensure that standard precautions are maintained during medication administration and that hands are washed if resident contact is made. This will be done on a weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the	

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F 441	Continued From page 41	F 441	Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 10/11/2016.	
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 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	F 520		10/11/16

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F 520	Continued From page 42 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility ' s Quality Assurance (QA) Committee Failed to maintain implemented procedures and effective monitoring practices to develop comprehensive care plans and assess restraints to ensure compliance as sustained. The facility had a pattern of two re-cited deficiencies. The first which was originally cited in October 2015 on a recertification survey, and now on the current recertification survey. The second, which was originally cited in October 2015 on a recertification survey, and the current recertification survey. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance program. The findings included: This tag was cross referenced to: 1. F279 -Based on record review and staff interviews the facility failed to develop a care plan for 1 of 7 sampled residents (Resident # 87) reviewed for restraints and failed to develop a care plan for 1 of 1 resident (Resident #123) on an antidepressant medication. During the recertification survey of October 2015 the facility failed to develop a care plan for dialysis and fluid restriction for 1 of 1 resident on dialysis and failed to care plan a restraint for 1 of 1 resident reviewed for restraint use. 2. F221 - Based on observation, resident and staff interviews and record review, the facility	F 520	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F520 QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS Corrective Action: Cross reference Tag F520 to Tag F279 Resident #87, Resident #126 Resident #87 and #126. Residents Care plans were reviewed and updated. Cross Reference Tag F520 to Tag F221 Resident #87, Resident #137 Resident #87. Resident #87 was physically assessed. No injuries, or marks or bruises were noted at that time. The care plan team completed a device evaluation related to the device on 10/5/2016.The patient will be screened by therapy to see if alternative seating arrangements can be made. Therapy screened the patient on 10/6/2016 and decided to discontinue use	

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F 520	Continued From page 43 failed to have a medical justification for the use of a lap tray for 2 of 7 residents reviewed with restraints (Resident #87, Resident #137). During the recertification survey of October 2015 the facility failed to have a medical justification for a lap buddy restraint for 1 of 1 resident and failed to assess for the less restrictive device for 1 of 1 resident reviewed for restraint use. During an interview with the Director of Nursing (DON) on 9/16/16 at 1:40pm she stated the Quality Assurance (QA) Performance Improvement Committee met monthly and any staff members could bring a problem to the QA meeting to be evaluated. The DON indicated that all the charts and care plans were reviewed after the last survey and all corrections were made for the deficiencies that were cited. She stated that she was unaware that restraints needed to be removed during meal times. She further stated that the facility had always listed restraint use under the care plan for falls as an intervention. She stated this was a work in progress.	F 520	of lap tray. Additionally on 10/6/2016 the care plan team evaluated the use of the lap tray. The team decided to discontinue the use of the lap tray after therapy recommendation. Lap tray discontinued on 10/6/2016 as a result of the screen and after care plan team review of recommendations. New interventions are to toilet resident upon rising, before and after meals and at bedtime. Resident wheelchair cushion changed. Resident #137 Therapy screened the patient on 9/15/2016. Lap tray was discontinued after therapy screen. The team updated her care plan with new intervention to place resident at nursing station while up on wheelchair and offer Activities. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. Cross Reference Tag F520 to Tag F279 All residents have the potential to be affected by the alleged practice. All comprehensive assessments (most recent) within the last 6 months were reviewed: a review of each Care Area Assessment (CAA) for each respective comprehensive assessment was reviewed to ensure that each Care Area Assessment triggered that had a Care Plan Consideration checked “YES” has a care plan addressed with interventions in place. This was done by 10/7/2016 by the QA Nurse Consultant. Cross Reference Tag F520 to Tag F221 All residents have the potential to be	

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F 520	Continued From page 44	F 520	affected by this alleged deficient practice. On 10/4/2016 to 10/6/2016 the nurse managers completed device evaluation forms on all current residents. This was accomplished by going into every resident's room and determining what type of side rails, hi low or other potentially restraining devices were being used. This included bed rails, hi-low mattresses, Geri chairs, and other cushions that might be considered restraints. Once a device was determined to be attached or adjacent to the resident's body it was evaluated by the nurse to identify if it restricted the patients freedom of movement or normal access to the patient's body. Devices that were considered a restraint were then reviewed for medical necessity by the evaluating nurse. If the device was identified as a restraint and not medically indicated a reduction plan was established by the care planning team. This review was completed by 10/6/2016. As of 10/6/2016 all patients have been evaluated and all restraining devices without medical necessity have been discontinued or have active reduction plans with specified time frames to accomplish the reduction. As a result of this review, 7 patients had changes in bedrail utilization, 3 residents have Restraints with a medical necessity and will be reviewed weekly. 34 patients that utilize either Geri chairs, hi low mattresses or other devices are being screened by therapy as the first step of their restraint reduction plan. The care plan team will review each resident on the restraint reduction plan on the weekly QA	

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	345240	A. BUILDING _____ B. WING _____	09/16/2016

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F 520	Continued From page 45	F 520	meeting. Systemic Changes: Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, Medication Aides, CNAs full time, part time, and PRN) that : Cross reference Tag F520 to Tag F279 Resident #87, Resident #126. Cross Reference Tag F520 to Tag F221 Resident #87, Resident #137 A facility must maintain a quality assessment and assurance committee consisting of them director of 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 in service was completed by 10/5/2016.Any Quality assessment and assurance committee team member (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the	

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F 520	Continued From page 46	F 520	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. Monitoring: To ensure compliance, Administrator or Director of Nursing will monitor this issue using the QA survey tool. Facility will monitor compliance of QA for F 279 and F279. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 10/11/2016	