STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. BUILDING _____ B. WING _____	11/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON REHABILITATION AND HEALTHCARE	1000 TANDALL PLACE KNIGHTDALE, NC 27545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) for contractures and limited range of motion for 1 of 1 sampled resident (Resident #12) reviewed for range of motion. Findings included:	F 278	F278 483.20(g) – (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED Corrective Action or the Resident Affected The comprehensive annual MDS, Section	1/3/17

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

Electronically Signed | 12/15/2016

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F 278	Continued From page 1 Resident #12 was admitted on 7/15/14 with diagnoses that included coronary artery disease, hypertension and dementia. Review of the 8/10/16 Annual MDS indicated Resident #12 was cognitively impaired and required extensive to total assistance for all activities of daily living. Arthritis and contractures were not identified as active diagnoses. The MDS indicated the resident had no impairment in functional range of motion of lower extremities or upper extremities including shoulder, elbow, wrist or hand that interfered with daily functions. Nursing Assistant (NA) #3 was interviewed on 11/17/16 at 10:34 AM. She stated Resident #12 had been unable to open her hands fully for a long time. The NA added at one point, the resident had splints she wore. The Director of Nursing (DON) was interviewed on 11/17/16 at 5:19 PM. She confirmed Resident #12 had contractures in her hands for a long time, including during the assessment period. The DON added she expected the MDS nurse to physically assess the resident before coding range of motion to assure MDS accuracy.	F 278	G for Resident #12 dated 08/10/16 was reviewed and corrected on 12/08/16 by the MDS Coordinator to accurately reflect the resident's functional range of motion of lower extremities, upper extremities including shoulders, elbow, wrist or hand that interfered with daily functions. Corrective Action for the Resident Potentially Affected On 12/12/16 Genesis Rehabilitation Services initiated screening on residents for their functional range of motion of lower extremities, upper extremities, including shoulders, elbows, writs or hands that interfere with daily function. Each comprehensive annual MDS, section G will be reviewed by the DCS, ADCS, Nurse Supervisor and or MDS Coordinator to ensure it accurately reflected the resident's functional range of motion of lower extremities, upper extremities, including shoulders, elbows, wrists or hands that interfere with daily function. Follow up based on findings. Systemic Changes The Regional MDS Coordinator in-serviced the MDS Coordinator on 12/13/16 on accurate coding on section G on the MDS. The DCS, ADCS, and or Nurse Supervisor will randomly review 5 comprehensive annual MDS assessments section G monthly and compare to their functional range of motion of lower extremities, upper extremities including shoulders, elbows, wrists or hands that interfere with daily function for 12 weeks, then quarterly to validate accurate coding on sections G is updated utilizing the QI Monitoring Tool for accurate coding of	

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F 278	Continued From page 2	F 278	MDS, Section G. Opportunities will be corrected by the MDS Coordinator as identified during these reviews. Quality Assurance The results of these reviews will be submitted to the QAPI Committee by the MDS Coordinator for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record	F 279	F279	1/3/17

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F 279	Continued From page 3 review, the facility failed to develop a comprehensive care plan which included the target behaviors staff were to monitor for 1 of 2 sampled residents (Resident #12) who received an antipsychotic medication. Findings included: Resident #12 was admitted on 7/15/14 with diagnoses that included depression and psychotic disorder. Resident #12's care plan, last reviewed on 8/3/16, indicated she was at risk for side effects from the use of an antipsychotic medication. The goal of having no injury related side effect to the medication was to be achieved by observing for side effects and monitoring and recording target behaviors. The care plan did not include what target behaviors were exhibited by Resident #12. Review of her 8/10/16 Annual Minimum Data Set (MDS) indicated the resident was cognitively impaired. During the assessment period, the resident exhibited verbal behaviors directed toward others and other behaviors 4-6 days. Active diagnoses included depression and a psychotic disorder. Review of the November 2016 physician's orders indicated Resident #12 received Seroquel (an antipsychotic medication) 25 milligrams (mgs) at 3:00 PM and 50 mgs at 9:00 PM. The Psychiatric Nurse Practitioner (NP) was interviewed on 11/16/16 at 10:00 AM. She stated she had worked with Resident #12 since 2014. Behaviors exhibited by Resident #12 included bizarre delusions and paranoia.	F 279	483.20(d), 483.20(k)(1) – DEVELOP COMPREHENSIVE CARE PLANS Corrective Action or the Resident Affected On 11/30/16 the Social Services Director reviewed the care plan for resident #12 and corrected with the targeted behaviors associated with the antipsychotic medications. Corrective Action for the Resident Potentially Affected On 11/30/16 the Social Services Director initiated review of all care plans for residents receiving antipsychotic medications to ensure that their targeted behaviors were identified. Any care plans that did not reflect the targeted behaviors were updated by the Social Services Director. Systemic Changes On 12/12/16 the Social Services Director received re-education on care planning in long term care REL-SRC-0-CPLTC through Relias Consulate University. The DCS, ADCS, RN Supervisor, MDS Coordinator and or Social Services Director will randomly observe 5 residents and review the Resident Care Plans weekly for 12 weeks, then quarterly to validate care plans are in place with targeted behaviors for residents on antipsychotic medications as required. The results of this monitoring will be documented on the QI Monitoring Tool for residents on antipsychotic medications with targeted behaviors. Opportunities will be corrected by the MDS Coordinator as identified during these audits. Quality Assurance The results of these reviews will be	

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F 279	Continued From page 4 During observation of care on 11/16/16 at 10:42 AM, the resident repeated over and over not to leave her in the company of the nursing assistant (NA), because the NA would try to kill her. On 11/17/16 at 3:25 PM, Resident #12 was heard yelling. On entering the room, the resident repeated over and over she was scared someone was trying to hurt her. The Director of Nursing (DON) and Administrator were interviewed on 11/17/16 at 5:22 PM. The target behaviors for Resident #12 as described by the DON and Administrator included yelling out, paranoia about people hurting her and visual hallucinations of elephants and cows in her room. The DON and Administrator stated target behaviors should be recorded for staff. The MDS nurse was interviewed on 11/17/16 at 5:27 PM. She stated she was not familiar with the term target behavior. She stated she had been trained to identify behaviors and provide interventions for behaviors including non-pharmacological interventions. The MDS nurse identified the resident's behaviors as yelling out and refusing care. Delusions, hallucinations and paranoia were not identified.	F 279	submitted to the QAPI Committee by the MDS Coordinator for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		1/3/17

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F 280	Continued From page 5 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to revise a care plan for 1 of 1 resident reviewed for activities (Resident #12) and failed to revise the care plan for 1 of 1 resident reviewed for pressure ulcers (Resident #52). Findings included: 1. Resident #12 was admitted on 7/15/14 with diagnoses that included coronary artery disease, hypertension and dementia. Review of the resident's 8/10/16 Annual Minimum Data Set (MDS) indicated the resident was severely cognitively impaired. The MDS indicated it was very important for Resident #12 to have books, newspapers and magazines to read, very important to listen to music she liked, and somewhat important to be around animals. The MDS was also coded to indicate it was somewhat	F 280	F280 483.20(d)(3), 483.10(k)(2) – RIGHT TO PARTICIPATE PLANNING CARE – REVISE CP Corrective Action or the Resident Affected On 11/17/16 the Activities Director reviewed and revised the Activities care plan for resident #12 to include specific activities the resident like to do. On 12/08/16 the MDS Coordinator reviewed and revised the care plan for resident #52 to include the pressure ulcer. Corrective Action for the Resident Potentially Affected On 12-06-16 and 12-07-16 the Activities Directors and RN Supervisor reviewed and updated 100% of all residents' activities care plans individualizing them to the residents likes and dislikes for activities. On 12-08-16 the MDS Coordinator	

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F 280	Continued From page 6 important to Resident #12 to participate in religious services and very important to do things she liked. The primary respondent for the preferences was listed as the resident. The care plan for Activity Programming and Therapeutic Recreation, dated as revised on 11/16/16, indicated the resident was dependent for activities due to disinterest, a wish not to participate and cognitive deficits. A goal of expressing satisfaction with types and level of activities had been established. Interventions included porch sitting, celebrations and parties, coffee hour, hand held games and small group activities. Nursing Assistant (NA) #3 was interviewed on 11/17/16 at 10:34 AM. The NA stated Resident #12 refused to leave her room to participate in any activities. On 11/17/16 at 2:31 PM, Nurse #6 stated she had not observed Resident #12 participating in any activities outside of her room. The nurse added the resident's favorite activities included watching TV and eating snack food. The Nurse Supervisor (NS) was interviewed on 11/17/16 at 2:58 PM. The NS stated Resident #12 refused to go to out of room activities; adding she liked staying in her room and watching TV. The Activity Director (AD) was interviewed on 11/17/16 at 4:18 PM. The AD stated activity preferences were determined by talking with residents and/or their family members. She stated she tried to find activities that corresponded with a resident ' s previous activity preferences. The AD added care plans, including	F 280	reviewed and updated all resident's care plans to include any pressure ulcers. Systemic Changes On 12/14/16 the Activities Director attended re-education with the Regional MDS Coordinator and was in-serviced on how to write and update the activities care plans for individualization. The DCS, ADCS, RN Supervisor, MDS Coordinator and or Activities Director will randomly observe 5 residents and review the Residents Activities Care Plans weekly for 12 weeks, then quarterly to validate care plans are in place with individualized activities for residents. The results of this monitoring will be documented on the QI Monitoring Tool for Activities Care Plans. Opportunities will be corrected by the MDS Coordinator and or Activities Director as identified during these audits. On 12/13/16, the MDS Coordinator was re-educated on care planning in long term care REL-SRC-0-CPLTC through Relias Consulate University. The DCS, ADCS, MDS Coordinator Treatment Nurse and or Nurse Supervisor will randomly observe 5 residents and review their Skin/Wound Care plan weekly for 12 weeks, then quarterly to validate care plans have been updated with for residents with pressure ulcers. The results of this monitoring will be documented on the QI Monitoring Tool for Skin Integrity. Opportunities will be corrected by the MDS Coordinator and or Treatment Nurse as identified during these audits. Quality Assurance The results of these reviews will be submitted to the QAPI Committee by the	

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F 280	Continued From page 7 the activity care plan was reviewed quarterly. The AD confirmed Resident #12 did not go outside of her room for activities. On review of the activity care plan for Resident #12, the AD denied it was the care plan she had written for Resident #12. She was unable to find the care plan she had written for the resident and was unable to explain the 11/16/16 revision date. 2. Resident #52 had been admitted to the facility on 12/21/2015 with diagnoses including pneumonia, anemia, heart failure, cardiovascular accident, chronic obstructive pulmonary disease, hypertension, and dementia. Resident #52 ' s Admission Minimum Data Set (MDS) dated 12/28/2015 indicated she had severe cognitive impairment, required supervision with eating and extensive assistance with all other activities of daily living, and was frequently incontinent of urine. The MDS indicated no pressure ulcers were present upon admission and Resident #52 was at risk for developing pressure ulcers. A Care Area Assessment (CAA) was completed and identified Resident #52 was at risk for developing pressure ulcers related to impaired mobility and incontinence. A decision was made to address her risk of developing pressure ulcers in the care plan. A care plan had been initiated identifying Resident #52 had the potential for impaired skin integrity related to incontinence and limited mobility. The care plan had been most recently updated on 9/07/2016. Interventions included to inform the physician, resident, family or caregivers of any new area of skin breakdown and, identify potential causative factors and eliminate or resolve where possible. Resident #52 had been seen by an orthopedic	F 280	MDS Coordinator for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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F 280	Continued From page 8	F 280		

physician on 9/27/2016 for a fractured left ankle. Orders had been written on the consultation report and included " treatment of left fibula fracture in boot (removable splinting boot) and, may remove boot for bathing and skin checks only, skin checks done daily. "

An orthopedic physician ' s note dated 10/18/2016 indicated " skin over lateral malleolus (outside ankle) is broken down secondary to pressure. "

Physician orders dated 10/18/2016 at 11:00 PM indicated a wound physician was to evaluate Resident #52 for left outside ankle breakdown. Allevyn (a brand of dressing which is non-adherent to the wound bed and provides a moist environment for wound healing) foam dressing to the left outside ankle twice weekly was ordered for wound treatment.

The Pressure Ulcer Record dated 10/19/2016 indicated Resident #52 ' s left outside ankle had a Stage 2 pressure ulcer (a partial thickness loss of the dermis presenting as a shallow open ulcer) with a red wound bed, red edges and no drainage. The left medial (inside) ankle had an unstageable wound (deep tissue injury) described with redness on the wound edges and no drainage.

The October 2016 Treatment Administration Record (TAR) was reviewed. Care for the left outside ankle pressure ulcer had been initiated on 10/18/2016.

A physician order dated 11/04/2016 indicated Resident #52 should receive Zinc 220 milligrams (mg) by mouth daily for 10 days for wound

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F 280	Continued From page 9	F 280		

healing and Vitamin C 500 mg by mouth daily until the wounds resolved.

Review of the Pressure Ulcer Record dated 11/14/2016 indicated there were 2 left ankle wounds , one on the outside ankle and one on the inside ankle, both were unstageable (the wound bed is partly or completely obscured by slough or eschar, the base of the wound needs to be visible to properly stage the wound).
An observation was made of Resident #52 ' s wound care provided by Nurse #5 on 11/15/2016 at 2:32 PM. The old dressing was removed and a moderate amount of light pink drainage was observed on the removed dressing. The medial (inside) ankle wound was approximately nickel sized, pink with yellow slough. The lateral (outside) ankle wound was approximately quarter sized, pink with yellow slough and white edges. Nurse #5 treated the wounds as ordered and redressed the wounds.
An interview with Nurse #5 was conducted after the wound care was completed on 11/15/2016 at 2:42 PM. The nurse stated Resident #52 had fractured her left ankle and had a brace in place. The nurse stated the brace had been removed and the outside ankle wound had been discovered by the orthopedic physician on 10/18/2016.
An interview with the Director of Nursing (DON) was conducted on 11/17/2016 at 5:19 PM. The DON stated she would expect the care plans to reflect the condition and care needs of the resident.
An interview with the MDS nurse was conducted on 11/18/2016 at 4:55 PM. The nurse stated she had updated Resident #52 ' s wound care plan on 11/16/2016 to include the inside and outside ankle wounds. The nurse indicated the care plan

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F 280	Continued From page 10 should have been updated when the wounds had been first identified.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to change the bath water and wash cloth after washing a dried brown substance off of the resident's buttocks and before washing her back and legs for 1 of 1 resident (Resident #12) reviewed for activities of daily living Resident #12 was admitted on 7/15/14 with diagnoses that included coronary artery disease, hypertension and dementia. Review of the 8/10/16 Annual Minimum Data Set (MDS) indicated the resident was cognitively impaired. During the assessment period, Resident #12 exhibited verbal behaviors directed toward others and other behaviors 4-6 days during the assessment period. The MDS was coded to indicate Resident #12 required extensive assistance with all activities of daily living. The resident ' s care plan, reviewed on 11/16/16 revealed she required assistance with bathing	F 312	F312 483.25(a)(3) – ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Corrective Action or the Resident Affected On 11/23/16 the DCS met with Nursing Assistant #8 and re-educated on procedures for bed bad and changing the bath water and wash cloth. Resident # 12 receives bed baths per facility policy. Corrective Action for the Resident Potentially Affected Unit Managers and or DCS conducted return demonstrations with certified nursing assistants (CNAs) for performing bed baths per facility policy. Follow up conducted on findings of return demonstrations. Systemic Changes On 11/30/16, the DCS re-educated and provided demonstration to Nursing Assistant #8 on the proper procedures for providing a bed bath, to include changing the bath water and wash cloth.. On 12/13/16 an in-service was initiated by	1/3/17

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F 312	Continued From page 11 An observation was made on 11/16/16 at 10:42 AM of Resident #12 receiving a bed bath from Nursing Assistant (NA) #8. The NA was observed washing the resident's face, upper body and perineum. NA #8 turned the resident on her right side and washed her buttocks, removing a dried brown substance that was observed on the resident ' s buttocks. The NA completed Resident #12 ' s bed bath by washing her upper back using the same water and washcloth as had been used to remove the dried brown substance from her buttocks. NA #8 was interviewed via telephone on 11/17/16 at 3:40 PM. She acknowledged she had not changed the bath water after removing the dried brown substance from the resident's buttocks and prior to washing her back and legs. The NA stated she had forgotten to change the water and the wash cloth used during the entire bath because she was nervous. The Director of Nursing (DON) was interviewed on 11/17/16 at 4:58 PM. She stated she thought it was terrible Resident #12 had been washed with one cloth and without changing the water after the removal of the dried brown substance from her buttocks.	F 312	the DCS and ADCS on the procedure for providing a bed bath to certified nursing assistants to include changing the bath water and wash cloth. The DCS, ADCS, RN Supervisor and or Unit Managers to randomly observe 3 nursing assistants providing a bed bath weekly for 12 weeks, then quarterly to validate that the nursing assistants are utilizing proper procedures for giving a bed bath. The results of this monitoring will be documented on the QI Monitoring Tool observation of bed baths. Opportunities will be corrected by the DCS, ADCS, RN Supervisor and or Unit Nurse as identified during these audits. Quality Assurance The results of these reviews will be submitted to the QAPI Committee by the MDS Coordinator for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314		1/3/17

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F 314	Continued From page 12 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observations, the facility failed to report and initiate a treatment for a pressure ulcer for 1 of 1 residents reviewed for pressure ulcers (Resident #52). Findings included: Resident #52 had been admitted to the facility on 12/21/2015 with diagnoses including pneumonia, anemia, heart failure, cardiovascular accident, chronic obstructive pulmonary disease, hypertension, and dementia. Resident #52's Admission Minimum Data Set (MDS) dated 12/28/2015 indicated she had severe cognitive impairment, required supervision with eating and extensive assistance with all other activities of daily living, and was frequently incontinent of urine. The MDS indicated no pressure ulcers were present upon admission and Resident #52 was at risk for developing pressure ulcers. A Care Area Assessment (CAA) was completed and identified Resident #52 was at risk for developing pressure ulcers related to impaired mobility and incontinence. A decision was made to address her risk of developing pressure ulcers in the care plan. A care plan had been initiated identifying Resident #52 had the potential for impaired skin integrity related to incontinence and limited mobility. The care plan had been most recently updated on 9/07/2016. Interventions included to inform the physician, resident, family or	F 314	F314 483.25(c) – TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Corrective Action or the Resident Affected On 10/18/16 the DCS met with Nurse #2 and performed re-education for failure to report and initiate a treatment for a pressure ulcer for resident #52. Corrective Action for the Resident Potentially Affected On 12-11-16 and 12-15-16 the RN Supervisor performed a 100% Skin Sweep on all residents and assessed for any pressure ulcers that had not been identified. Any new areas identified a treatment plan was initiated and MD and RP notified. Systemic Changes An In-serviced was initiated on 12/12/16 by the DCS to the Licensed Nurses and Nursing Assistants on identifying residents with any skin integrity issues, such as Redness, bruises, rashes, skin tears, blisters and any other issues appearing abnormal and utilization of the Med-pass skin care alert form. If any skin integrity issues are identified, the Licensed Nurse notify physician for treatment orders, will initiate a treatment plan and I notify the RP. The DCS, ADCS, Nurse Supervisor and or Treatment Nurse will randomly observe	

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F 314	Continued From page 13 caregivers of any new area of skin breakdown and, identify potential causative factors and eliminate or resolve where possible. Resident #52 had been seen by an orthopedic physician on 9/27/2016. Orders had been written on the consultation report and included "treatment of left fibula fracture in boot (removable splinting boot) and, may remove boot for bathing and skin checks only, skin checks done daily." The Weekly Skin Integrity Review dated 10/15/2016 indicated old wounds to the toes of both feet. Nurse #2's note dated 10/17/2016 at 11 AM indicated "left ankle with old scab, reddened area noted, no swelling noted." An orthopedic physician's note dated 10/18/2016 indicated "skin over lateral malleolus (outside ankle) is broken down secondary to pressure." Physician orders dated 10/18/2016 at 11:00 PM indicated a wound physician was to evaluate Resident #52 for left outside ankle breakdown. Allevyn (a brand of dressing which is non-adherent to the wound bed and provides a moist environment for wound healing) foam dressing to the left outside ankle twice weekly was ordered for wound treatment. The Pressure Ulcer Record dated 10/19/2016 indicated Resident #52's left outside ankle had a Stage 2 pressure ulcer (a partial thickness loss of the dermis presenting as a shallow open ulcer) with a red wound bed, red edges and no drainage. The left medial (inside) ankle had an unstageable wound (deep tissue injury) described	F 314	5 residents to ensure that if areas of redness, bruising, rashes, skin tears, blisters and any other issues appearing abnormal were identified and physician notified and treatment orders obtained and initiated, and the RP were notified weekly for 12 weeks, then quarterly utilizing the QI Monitoring Tool for Initiating treatments for pressure ulcers. Opportunities will be corrected by the Treatment Nurse, DCS and or ADCS as identified during these audits. Quality Assurance The results of these observations will be submitted to the QAPI Committee by the Treatment for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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with redness on the wound edges and no drainage.

A statement written by Nurse Aide (NA) #1 on 10/21/2016 indicated on 10/17/2016 she had given Resident #52 a bed bath. The NA indicated Resident #52 had a stocking on her left leg which the NA did not remove. The NA stated Nurse#2 had been in the room and had looked under the stocking. The NA indicated she and the nurse observed a bruise.

The October 2016 Treatment Administration Record (TAR) was reviewed. Care for the left outside ankle pressure ulcer had been initiated on 10/18/2016.
Review of the Pressure Ulcer Record dated 11/14/2016 indicated there were 2 left ankle wounds , one on the outside ankle and one on the inside ankle, both were unstageable (the wound bed is partly or completely obscured by slough or eschar, the base of the wound needs to be visible to properly stage the wound).
An observation was made of Resident #52's wound care provided by Nurse #5 on 11/15/2016 at 2:32 PM. The old dressing was removed and a moderate amount of light pink drainage was observed on the removed dressing. The medial (inside) ankle wound was approximately nickel sized, pink with yellow slough. The lateral (outside) ankle wound was approximately quarter sized, pink with yellow slough and white edges. Nurse #5 treated the wounds as ordered and redressed the wounds.
An interview with Nurse #5 was conducted after the wound care was completed on 11/15/2016 at 2:42 PM. The nurse stated the left outside ankle wound had been discovered by the physician on 10/18/2016. The nurse stated she was unsure

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when the left inside ankle wound had developed.
An interview with the Director of Nursing (DON) was conducted on 11/17/2016 at 11:00 AM. The DON stated she had been unaware of Resident #52 ' s wound until after she had been seen by the orthopedic physician on 10/18/2016.
An interview with Nurse #4 was conducted on 11/17/2016 at 6:23 PM. The nurse stated she had completed the weekly skin assessment on 10/15/2016. The nurse stated if any problems had been discovered a nurse's note would be written, the supervisor, the physician and the family would be contacted and an incident report would be written.

An interview with the Administrator (AD) was conducted on 11/17/2016 at 3:35 PM. The AD stated a skin check had been completed on 10/15/2016 with no concerns identified. Resident #52 had an orthopedic physician appointment on 10/18/2016 and the physician had discovered the skin break down. The AD stated she had not been aware of skin breakdown until after the appointment.

11/17/2016 The Physician Assistant (PA) who had cared for Resident #52 was unavailable for an interview.

An interview with NA #1 was conducted on 11/18/2016 at 8:16 AM. The NA stated she had worked with Resident #52 on Monday 10/17/2016 during the day shift. The NA stated on 10/17/2016 she was giving Resident #52 a bed bath. The resident had on a brown stocking which only covered the leg and not the toes. The NA stated she did not want to remove the stocking and had only washed her toes which were accessible. The NA stated Nurse #2 had been in the room and

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had pulled the stocking back and they both had seen a wound on Resident #52's left outside ankle. The NA stated it had been about quarter sized and medium dark red in color. The NA stated she had only observed the outer ankle. The NA stated this day had only been the first or second time she had cared for Resident #52.

An interview was conducted with Nurse #2 on 11/18/2016 at 9:31 AM. The nurse stated on 10/17/2016 she and NA#1 had observed an open area on Resident #52 ' s left outer ankle, about the size of a quarter. The nurse stated she could not recall if she had told anyone about the wound and stated she had not started a treatment.

An interview with the AD and the DON was conducted on 11/18/2016 at 10:18 AM. The DON stated it was her expectation for the NA to report any skin issues to the nurse and for the nurse to contact the treatment nurse and the physician for wound care orders. The nurse was expected to transcribe those orders onto the Treatment Administration Record (TAR) and to start treatments. The AD stated after the wound had been discovered by the physician, she completed an investigation as to the cause of the wound. The AD indicated the wound had been caused by pressure from the fracture boot. She stated NA #1 had written a statement indicating the wound had been observed by the NA and Nurse #2 on 10/17/2016. No treatment had been initiated by the nurse. The AD stated it was her expectation for the nurse to start a treatment when a wound was discovered, for the NA to check the skin daily when bathing a resident and for the nurse to communicate with the NA about resident concerns and needs.

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record reviews, the facility failed to assess the resident for participation in a toileting retraining program or a scheduled toileting program and failed to implement a toileting program for 1 of 3 residents (Resident #57) reviewed for urinary incontinence. Findings included: Resident # 57 was admitted to the facility on 7/14/16 with rheumatoid arthritis, cancer, hypertension, chronic anemia and peripheral arterial disease. The 7/14/16 hospital discharge summary indicated Resident #57 had a normal cognition and occasionally walked. Current mobility was identified as slightly limited. The 7/14/16 facility Admission Data Collection revealed Resident #57 was oriented to person,	F 315	F315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADER Corrective Action or the Resident Affected Resident #57 was discharged to the hospital on 12-05-16. Corrective Action for the Resident Potentially Affected On 12/13/16 the ADCS initiated a 100% QI Monitor on residents to assess their participation in a toileting retraining program or a scheduled toileting program. Any residents that met the criteria for participation in a toileting retraining program were placed on a scheduled toileting program. Systemic Changes On 12/08/16 the Regional Nurse Consulate in-serviced the DCS and ADCS on how to assess residents for a toileting retraining program reviewing the policies and procedures for bowel and Bladder	1/3/17

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F 315	Continued From page 18 place and time. She was assessed as independent with bed mobility, had full weight bearing and required the assistance of 1 person for transfers and ambulation. She was coded as occasionally incontinent of urine. Beneath the area where continence was coded was a section that directed staff to determine if the resident was appropriate for a toileting program. This area had been left blank. The 7/14/16 Admission Care Plan, identified Resident #57 was to be toileted with the assistance of 1 person. Review of the 7/15/16 Occupational Therapy (OT) evaluation indicated Resident #57's prior level of functioning was independent with all activities of daily living. At the time of evaluation, the resident was identified as requiring moderate assistance with toilet use. Resident #57's 7/21/16 Admission Minimum Data Set (MDS) indicated the resident was cognitively intact and required extensive assistance with toilet use, dressing and transfer. The resident was assessed as frequently incontinent of urine and always continent of bowel with no toileting program attempted. Review of the care plan with an onset date of 8/17/16, indicated the resident had a self- care deficit due to fatigue and non-ambulatory status. A goal was set that the resident would receive appropriate staff support with activities of daily living, including toilet use. Interventions included transferring on and off the toilet. A Significant Change in Status MDS, dated 8/20/16, revealed Resident #57 was cognitively	F 315	Evaluation along with the med pass for potential for bowel/bladder retraining. On 12/13/16, the DCS and ADCS initiated an in-service for the Licensed Nurses on identifying and assessing residents that is appropriate for the bowel and bladder program upon admission and change of condition. Residents are evaluated for continence on admission/readmission, quarterly, and with significant change in status. Residents who have been determined to be incontinent without a documented irreversible cause, presenting with significant change in continence, will be further evaluated for potential for bowel and bladder management. The DCS, ADCS, MDS Coordinator, Nurse Supervisor and or Treatment Nurse will randomly assess 5 residents to ensure that a bowel and bladder assessment was completed and if the resident was placed on the bowel and bladder program weekly for 12 weeks, then quarterly utilizing the QI Monitoring Tool for assessing for the bowel and bladder program. Opportunities will be corrected by the Treatment Nurse, DCS and or ADCS as identified during these audits. Quality Assurance The results of these reviews will be submitted to the QAPI Committee by the DCS, ADCS and or Nurse Supervisor for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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intact and required extensive assistance for transfer, and toilet use with limited assistance required for personal hygiene. The resident was identified as frequently incontinent of urine and occasionally incontinent of bowel. A toileting program had not been attempted.

Review of the 8/20/16 Care Area Assessment (CAA) for urinary incontinence indicated Resident #57 had an actual problem with frequent urinary incontinence and was at risk for skin breakdown and infection. The CAA indicated staff would assist the resident with toileting and incontinence care per the facility policy and procedure. A decision was made to care plan in order to maintain the resident's abilities. Modifiable factors that contributed to the incontinence included pain and restricted mobility. Other factors included urinary urgency and the need for toilet assistance. The CAA noted therapy services worked with the resident to improve toilet transfers.

The Nurse Tech Information Kardex (a card system used by the NAs to assist with care), revised on 10/1/16, was reviewed. The Kardex revealed Resident #57 was alert with clear communication. Assistance of 1 person was needed for transfers, ambulation and elimination. The resident was not identified as incontinent of bowel or bladder.

The 10/10/16 Quarterly MDS indicated the resident was cognitively intact. She required extensive assistance for transfer, dressing, toilet use and personal hygiene. The resident was coded always incontinent of bladder and always continent of bowel with no toileting program or

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trial had not been attempted.

An interview was held with Resident #57 on 11/16/16 at 11:05 AM. She confirmed she was incontinent of urine. The resident stated at times she knew when she had to void and at times, the urine just flowed. Resident #57 added that while no one had offered to take her to the toilet and had not proposed a scheduled toileting plan, it was something she was interested in trying. The resident stated she was able to bear a little bit of weight.

Nursing Assistant (NA) #9 was interviewed on 11/16/16 at 1:59 PM. The NA stated she offered the resident a bed pan before and after lunch and as needed. She added at times, Resident #57 was found continent of urine and sometimes she had already voided. NA #9 stated while Resident #57 had difficulty standing, a mechanical lift could be used that would help stand her from a sitting position. The NA stated she had not asked the resident her voiding preference.

The OT was interviewed on 11/16/16 at 2:12 PM. On initial evaluation, the OT stated Resident #57 had been unable to come to a complete stand with the maximum assistance of one person. She described Resident #57 as poor tolerance while sitting on the edge of the bed; adding she was cooperative, but not super motivated. The OT stated the most recent evaluation completed on Resident #57 was on 11/4/16. The OT stated she had not discussed a toileting plan with the resident due to her low motivation and endurance. She added if Resident #57 needed to toilet, the safest method would be to use a bed pan.

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On11/16/16 3:19 PM Nurse #6 was interviewed. The nurse stated the nurse that received the resident on admission was responsible for all assessments, including a bowel and bladder assessment. Residents that were a good candidate for bowel and bladder retraining was based on admission diagnoses. Nurse #6 added she was unaware of a specific assessment to help determine if a resident was a candidate for bowel and bladder retraining.

During an interview with the Nurse Supervisor (NS) on 11/16/16 at 3:28 PM, she stated residents that were alert were appropriate for bowel and bladder retraining programs. She added she was unaware of an assessment to determine if a resident was appropriate for a bowel and bladder retraining program. While the nurse stated that alert and oriented resident experiencing incontinence was appropriate for the retraining program, she was unaware of any resident that was alert, oriented and incontinent. The NS stated she could only think of one resident that had been placed on a bladder retraining program; the named resident was not Resident #57. Additionally, the NS stated she had instructed NAs to ask Resident #57 hourly if she needed to void and to assist her with toileting every 2 hours.

The Director of Nursing (DON) and Administrator were interviewed on 11/16/16 on 3:37 PM. The DON stated since she was new to the company she was unsure of the bowel and bladder retraining program policy. The Administrator stated the NS, who also oversaw the restorative program, was responsible for assessing residents to determine if the resident was appropriate for a retraining program. The Administrator added if a

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resident was having new onset incontinence, the expectation would be for the NA to share that with the nursing staff. During the quarterly reviews, the Administrator added she expected the MDS nurse to alert the NS if any resident had experienced a decline in continence. The NS had guidelines to determine the appropriateness of a bowel and bladder retraining program. The Administrator added when the NS took her current position, she was informed of her responsibility for all restorative programs including bladder retraining.

On 11/16/16 at 4:17 PM, the NS was interviewed. She stated she had found out earlier that day she had been responsible for determining which residents were appropriate for bowel and bladder retraining. Prior to today, she had been unaware she was responsible. The NS stated if the MDS nurse had reported anyone that had declined in bladder continence she had forgotten. She added she got a list of the number of incontinent residents from the MDS nurse, but there were no names attached since the numbers were input into the system for tracking. The NS stated Resident #57 was alert and oriented. She added the resident would ask to go to the bathroom and when staff tried to assist, the resident dropped to the floor. She acknowledged the resident was incontinent at least 3 times per day. The NS stated a bedside commode had not been used for Resident #57. Each MDS for Resident #57 was reviewed with the NS. She stated she had been unaware of the resident ' s decline in bladder status and acknowledged a bladder retraining program had not been attempted. She stated on the admission data collection form contained an area that was to be checked if the resident was appropriate for bladder retraining, but added

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON REHABILITATION AND HEALTHCARE	1000 TANDALL PLACE KNIGHTDALE, NC 27545

(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 315	Continued From page 23	F 315		

she was unaware of the procedure used to determine if the resident was appropriate for the bladder retraining program.

The MDS nurse was interviewed on 11/16/16 at 4:55 PM. The MDS nurse stated if she noted a decline in a resident ' s status, she may refer to therapy, but would not typically report the decline to the floor staff. The MDS nurse added she gave the NS a weekly list of residents with a decline in continence, but it was just numbers with no names attached. Additionally, a weekly quality of life meeting was held, attended by nursing and therapy staff to discuss new concerns for residents. She stated while declines and improvements in residents ' conditions are discussed, minutes are not kept of the meeting. She stated she was unable to remember if Resident #57's decline in bladder continence had been discussed and was unable to recall if she had been instructed to report a decline in continence to anyone.

NA #3 was interviewed on 11/17/16 at 10:53 AM. The NA stated previously Resident #57 had been able to transfer to the toilet with a 2 person assist, but now, because of the condition of her legs, she used a bedpan. The NA was able to remember one resident that had been on a bladder retraining program, but it was not Resident #57. The NA remembered for that resident she had documented each time the resident had been toileted and had recorded if the resident was continent or incontinent.

An interview was held with the Administrator on 11/17/16 at 11:30 AM. She stated she had spoken to the NS, who was aware she was responsible for the restorative program, but was

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F 315	Continued From page 24 unaware the bladder retraining program was part of the restorative program. The Administrator added upon admission, the proper assessment had not been completed to determine if Resident #57 had been appropriate for a bladder retraining program. She added due to Resident #57 being alert and oriented, on admission Resident #57 should have been placed on a trial bladder retraining program, but due to her declining health would not have altered the outcome. An interview and observation was held with Resident #57 and a family member on 11/17/16 at 3:10 PM. Resident #57 was observed sitting up in a chair. The resident stated it felt good to sit up. Balance was good as evidenced by the resident not swaying back and forth or leaning forward. The family member stated Resident #57 had been sitting up for about 30 minutes. The resident stated staff had offered her the bed pan a few times, but was unsure of the exact number. The family member stated he had been in the resident's room since 1:30 PM and a staff person had been in the room and asked the resident if she had to void.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced	F 318		1/3/17

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F 318	Continued From page 25 by: The facility failed to place and utilize interventions to minimize the risk of contractures worsening for 1 of 1 sampled residents (Resident #12) reviewed for range of motion. The findings included: Resident #12 was admitted on 7/15/14 with diagnoses that included coronary artery disease, hypertension and dementia. Review of the 8/10/16 Annual Minimum Data Set (MDS) indicated Resident #12 was cognitively impaired and required extensive to total assistance for all activities of daily living. Arthritis and contractures were not identified as active diagnoses. The MDS indicated the resident had no impairment in functional range of motion of lower extremities or upper extremities including shoulder, elbow, wrist or hand that interfered with daily functions. Review of the Restorative Nursing-Range of Motion (ROM) Evaluation, dated 9/2/16, indicated Resident #12 had contractures of her right and left hand. There were no interventions included on the evaluation. The 10/1216 Quarterly Data Collection tool indicated Resident #12 had contractures of the fingers, hand, wrist, elbow, shoulder of the dominant or non-dominant side. Review of Resident #12's chart revealed no restorative notes or therapy notes that indicated how the resident's foot drop and bilateral hand contractures were being managed. During Stage I staff interviews, on 11/14/16 at	F 318	F318 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Corrective Action or the Resident Affected On 12/12/16 Occupational Therapy evaluated resident #12 for range of motion, contractures and splinting devices. Corrective Action for the Resident Potentially Affected On 12-11-16, Genesis Rehabilitation Services initiated a 100% screening of residents to evaluate their needs for range of motion, contractures and splinting devices. Any resident found needing range of motion active or passive contractures or splinting devices, a plan of care was put in place Systemic Changes An In-serviced was initiated on 12/12/16 by the Director of Rehabilitation to the DCS, ADCS, licensed Nursing staff and Nursing Assistants on identifying residents with decrease in range of motion, new on-set contractures and splinting devices The DCS, ADCS, Nurse Supervisor, MDS Coordinator and or Treatment Nurse will randomly observe 5 residents with contractures and or splinting devices to ensure that their treatment plan is being followed and that their splinting devices are in place weekly for 12 weeks, then quarterly utilizing the QI Monitoring Tool for range of motion, contractures and splinting devices. Opportunities will be corrected by the DCS, ADCS, MDS Coordinator and or Treatment Nurse as identified during these audits.	

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F 318	Continued From page 26 10:31 AM, the nurse stated Resident #12 had contractures with no splinting device or ROM received. Observations made on 11/14/16 at 11:20 AM revealed Resident #12 lying in bed. The resident held up her hands which were contracted. When asked to open her hands, she was unable to fully extend the fingers of either hand. There was no splint seen and no device had been placed in her palms for protection. The resident ' s care plan with a revision date of 11/16/16 indicated a carrot (a carrot shaped, soft device) should be used in the resident ' s contracted hands. At 9:44 AM on 11/16/16 the Nurse Supervisor (NS) entered the resident ' s room. She stated the resident could open her hands only minimally, adding her hands had been contracted for a long time. The resident had nothing in her hands for splinting or protection and the NS made no attempt to place anything in the resident ' s hands to protect her palms. The Director of Nursing (DON) entered Resident #12 ' s room on 11/16/16 at 10:10 AM. The DON was not observed to perform ROM on the resident's hands or place any device into her contracted hands. During an observation on 11/16/16 at 10:42 AM, Resident #12 received her bed bath, the NA did not attempt ROM of the resident's upper or lower extremities. The NA was unaware anything should be placed in the resident ' s hands, although she acknowledged the resident could not fully extend her hands.	F 318	Quality Assurance The results of these reviews will be submitted to the QAPI Committee by the MDS Coordinator for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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F 318	Continued From page 27 An observation was made on 11/17/16 at 8:15 AM. Nothing had been placed in Resident #12's contracted hands. The Nurse Tech Information Kardex (a card system used by NAs to direct residents' care) with an initiation date of 11/17/16, failed to include the resident's contractures or any contracture management instructions. The DON and Administrator were interviewed on 11/17/16 at 5:19 PM. The DON and Administrator confirmed Resident #12 had contractures. NA #3 was interviewed on 11/17/16 at 10:34 AM. The NA stated Resident #12 could not open her hands fully, but can open them more than she did. She added at times, the resident chose to keep her hands closed. NA #3 added in the past, the resident wore splints and had not refused splints; adding she was unsure when or if the splints were discontinued. The NA added in order to make sure the resident had no skin breakdown in the palms of hands, she washed her hands and dried them thoroughly. The NA stated she had not been instructed and had not used rolled washcloths or other objects in the resident's hands to protect her palms. The NS was interviewed on 11/17/16 at 2:58 PM. The nurse confirmed Resident #12's hands were contracted She added in order to prevent the contractures from worsening, ROM was provided during the resident's morning bath.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		1/3/17

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F 325	Continued From page 28 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to set up the resident's meal tray, failed to record the amount of supplement consumed and failed to review and revise interventions to prevent further weight loss for 1 of 4 residents (Resident #12) reviewed for nutrition. Findings included: Resident #12 was admitted on 7/15/14 with diagnoses that included coronary artery disease, hypertension and dementia The 5/18/16 Nutritional review indicated Resident #12 consumed 50-75% of her diet. The amount of the Healthy Shake (a nutritional supplement) consumed was not documented. The review indicated the resident required assistance in her ability to feed herself. A Nutritional Review, dated 8/10/16, indicated the resident ' s intake was 50% to 75% of each meal. The note indicated the resident was able to feel herself after tray set up. The resident ' s diet plan	F 325	F325 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Corrective Action or the Resident Affected On 11/16/16, the DCS met with nursing assistant #3 and re-educated her about setting up resident #12 meal tray. On 12/12/16 the DCS reviewed resident #12 Medication Administration Record (MAR) and added supplements consumed daily. On 12/08/16 facility received orders from MD for resident #12 for extra snacks with and between meals. Corrective Action for the Resident Potentially Affected On 12/05/16 residents were weighed by nursing assistants. Any resident that had a significant weight loss of 5% in 30 days, 7.5% in 90 days and 10% in 180 days were identified by the Certified Dietary Manager and orders received to initiate dietary interventions. The supplements were added to the MAR for monitoring %	

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F 325	Continued From page 29 included a mechanical soft diet and Healthy Shakes three times daily with meal trays. Resident #12's weight was documented at 99 pounds. The determination was made for Resident #12 ' s plan of care to continue without revision. Review of Resident #12's 8/10/16, Annual Minimum Data Set (MDS) revealed the resident was significantly cognitively impaired. Refusal of care was not identified. The MDS coded Resident #12 as requiring extensive to total assistance for all activities of daily living, including eating. No functional limitation of the upper extremities, including the hands, was identified. Resident #12's weight was recorded as 99 pounds with no weight loss or gain coded. Review of physician's orders for September and October 2016 revealed Healthy Shakes had been ordered for Resident #12 three times daily. Review of the September and October 2016 Medication Administration Record (MAR) revealed Healthy Shakes were received three times daily had been added as an entry. Nurses had initialed each square indicating the resident received the supplement. There was no documentation that indicated how much of the supplement Resident #12 had consumed. The November 2016 physician orders indicated Resident #12 received a mechanical soft diet with chocolate milk with meals and staff to assist with all meals. Orders also included a health shake to be given three times a day with meals at 8:00 AM, 12:00 PM and 5:00 PM. Review of the November 2016 MAR indicated Healthy Shakes had been added as an entry.	F 325	consumed. Systemic Changes On 12/13/16 an in-service was initiated by the DCS to Licensed Nurses and Nursing Assistants on setting up meal trays for residents that are unable or need assistance with their meals. On 12/12/16 an in-service was initiated by the DCS to the Licensed Nurses and Nursing Assistants on monitoring, reporting and documenting residents on dietary supplements. Orders will be written on any resident receiving any dietary supplement, added to the MAR and recorded daily by the Licensed Nurse. The DCS, ADCS, RN Supervisor and Unit Nurse will randomly observe 5 residents that need assistance with their meal tray set up for 12 weeks, then quarterly utilizing the QI Monitoring Tool for meal tray set up. Opportunities will be corrected by the DCS, ADCS, RN Supervisor and or licensed nurse as identified during these audits. The DCS, ADCS, RN Supervisor and Certified Dietary Manager will randomly observe 5 residents triggering for significant weight loss of 5% in 30 days, 7.5% in 90 days and 10% in 180 days will be monitored weekly for 12 weeks, then quarterly utilizing the QI Monitoring Tool for weight loss. Opportunities will be corrected by the DCS, ADCS, RN Supervisor and or Certified Dietary Manager as identified during these reviews. Quality Assurance The results of these reviews will be submitted to the QAPI Committee by the	

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F 325	Continued From page 30 Handwritten beside the entry directed nursing staff to check Resident #12's meal tray for the supplement. There was no documentation that indicated if Resident #12 had received her Healthy Shakes as ordered. On 11/4/16, a nutritional progress note indicated the resident's current weight was 93 pounds which represented a 5.1% weight loss in one month. The note indicated Resident #12's intake varied. Her diet was listed as mechanical soft and she received chocolate milk with meals as well as Health Shakes three times a day. The note also indicated Resident #12 received assistance at meal time as needed. A recommendation was made and approved for fortified foods to be added to the resident ' s diet. Nurses notes dated 11/7/16 indicated Resident #12 had experienced a 10% weight loss in one month. The note indicated fortified foods were added for all meals, health shakes received three times a day, chocolate milk with meal trays and staff to assist with all meals. Resident #12's care plan, revised on 11/16/16, indicated she had a nutritional problem due to poor intake. Interventions included offering assistance with fluid intake as needed, providing and serving the Healthy Shake as ordered, monitoring and reporting malnutrition and significant weight loss, fortified foods, providing and serving a mechanical soft diet and assisting with feeding as needed. Resident #12 also was identified with memory impairment that required prompting and cueing to carry out activities of daily living. The care plan also identified Resident #12 sometimes was resistant to eating. Interventions included updating the physician with resident refusals, eliciting family input for	F 325	Certified Dietary Manager for review by IDT members each month 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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approaches and discussing with the resident the implications of not complying with the prescribed diet.

During a continuous observation beginning on 11/16/16 at 8:25 AM, Resident #12's breakfast tray was seen setting on her chest of drawers approximately 10 feet from her bed. The tray contained grits, ground sausage, scrambled eggs and toast. The fluids included coffee, chocolate milk and a Health shake. The tray card for Resident #12 indicated she was to have received 1/4 cup scrambled eggs, 2 ounces of ground sausage, 4 ounces of cream gravy, 4 ounces of juice, 1 slice of toast, jelly, margarine, chocolate milk and a mighty shake. The fluids and utensils were unopened and the food remained unstirred. At 8:46 AM, while Resident #12 ' s tray remained out of reach and untouched, two unidentified nursing assistants (NA) were in the hall and one asked if anyone else needed assistance. The other NA replied "no, everyone has been fed." Neither of the two NAs walked to the end of the hall where Resident #12 lived. At 9:35 AM, the Nurse Supervisor (NS) came into the room and offered Resident #12 her breakfast tray, which she declined. At this point, the ice cream had melted and the cartons containing the fluids were warm to touch. The NS started to remove the breakfast tray, telling Resident #12 she would return with more ice cream. Not until prompted did the NS offer the resident her Health Shake, but replied, "She doesn ' t like it." Upon further prompting, the NS asked Resident #12 if she wanted the Health Shake and the resident told her yes. On the NS return to Resident #12's room at 9:44, she opened the health shake and ice cream for the resident.

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An interview with the dietary manager (DM) was held on 11/16/16 at 8:50 AM. The DM stated the process for confirming accuracy of the meals trays included one staff member calling out the tray ticket items and then the cook placed those items on the tray. He stated he could not explain the breakdown in the system and why items were missing from Resident #12's tray. The DM added grits was the fortified food served during the breakfast meal and included extra butter and powdered milk. He added the fortified product for breakfast was usually the grits or the oatmeal. He was unsure the gravy had been served that morning.

Resident #12's lunch was served by on 11/16/16 at 12:28. Ice cream, chocolate milk and a healthy shake were included on the tray. The NA had placed the tray on the resident's over bed table and had opened all liquids and foods.

The Nurse Tech Information Kardex (a card system used by the nursing assistants (NA), kept at the nurse's station and used to direct care), initiated on 11/17/16 indicated the resident received a mechanical soft diet and required set up of her meals. There was no information included for meal assistance or information about the supplements.
On 11/17/16 at 8:18 AM, the items on Resident #12's breakfast tray were compared to the tray card. All items had been received. The tray had been set up by the NA for the resident to eat.

NA #3 reported on 11/17/16 12:10 PM that although breakfast had been offered to Resident #12, she had declined. The NA stated the resident ate the ice cream and drank the chocolate milk, but refused the supplement and

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her oatmeal, adding the resident did not like oatmeal. This dislike had not been reported

Nurse #6 was interviewed on 11/17/16 at 2:35 PM. The nurse stated Resident #12 was able to feed herself after set up. She added while the resident refused food at times, the expectation was for the NA to report the refusal to the nurse. Nurse #6 stated she was unable to remember if a meal refusal for Resident #12 had been reported. Nurse #6 added if the supplement was served on the meal tray, the NA and not the nurse was responsible for recording the amount consumed. She was unsure if the amount of fluids consumed was separated from the meal intake or the total of food and fluid were added together. The nurse was unaware the resident had not consumed any of the supplement served with her breakfast meal. Nurse #6 added if Resident #6 consumed only a partial supplement or no supplement then she considered the healthy shake an ineffective intervention to halt weight loss.

NA #8 was interviewed by telephone on 11/17/16 at 3:40 PM. She acknowledged she had been assigned to care for Resident #12 on 11/16/16 during the 7:00 AM to 3:00 PM shift. The NA denied she had served Resident #12 her breakfast and left the tray on the chest of drawers, adding she was unsure who had served the resident. The NA stated she had been unaware how long the resident ' s tray had been in the room unopened the prior day. NA #8 stated she had not observed the resident feeding herself, but knew she ate a lot of snack food. She stated if the resident required assistance with meals, she would find that information on the Kardex, but stated she had no idea if the resident required assistance with meals.

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The DM and the District Nutritional Manager (DNM) were interviewed on 11/17/16 at 3:53 PM. The DM stated it was very important to know the amount of supplement residents consumed in order to determine if the supplement was an effective and appropriate intervention. The DM stated when he reviewed the report of meal intake, he did not think the supplement was included. The DM added that encouragement and assistance was important. He added he had seen staff offer Resident #12 and other residents food once, heard the resident refuse, and staff would walk away without encouraging the residents The DM and the DNM reviewed the intake of food and snacks the resident consumed and stated while the snacks were not sound nutritionally, they would maintain her caloric intake. The DNM stated if the resident was independent she did not understand why the tray was not placed in front of her on 11/16/16 and intermittent encouragement given. The DNM stated Resident #12 ' s weight had stable, hovering around 98-100 pounds until the weight taken on 11/4/16 which showed the resident weighed 93 pounds. With that weight loss, fortified foods were added. The RNM stated she went to see Resident #12 around 10:00 AM and offered the health shake. With encouragement she took sips of the health shake. The RNM stated she went back to Resident #12 two more times and with encouragement, the resident drank a few more sips, but added even with encouragement the resident probably consumed 2 ounces or less. She stated given her observation, she did not consider the supplement a successful intervention and would have expected someone to notice the resident did not drink the supplement and revised the care plan

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	345436	A. BUILDING _____ B. WING _____	11/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON REHABILITATION AND HEALTHCARE	1000 TANDALL PLACE KNIGHTDALE, NC 27545

(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 325	Continued From page 35	F 325		

for weight loss. The DNM stated without the amount of supplement consumed, it was impossible to know if the resident consistently consumed the health shake. The resident ' s weight was reported today as 88 pounds which reflected a loss of 5 pounds since 11/4/16.

The Director of Nursing (DON) and the Administrator were interviewed on 11/17/16 at 5:08 PM. The Administrator stated the health shake and all fluids were counted as part of the total meal. She added that meant if the resident ate 50% of the meal that was 50% of food and fluid added together. The DON stated weekly weight loss meetings were held, but could not specifically remember if Resident #12 had been discussed. She added there should have been some type of documentation for how much of the nourishment Resident #12 consumed. The DON added she was upset about Resident #12 ' s breakfast tray being left untouched and not served for an hour.