STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345423	A. BUILDING _____ B. WING _____	C 02/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON REHABILITATION AND NURSING CENTER	1705 SOUTH TARBORO STREET WILSON, NC 27893

(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 000	INITIAL COMMENTS NH requested a management review of the CMS 2567. Management determined the verbiage at F 164 needed to be moved to F 241 and is now example 2.	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to maintain dignity by failing to knock on doors or ask permission to enter resident's rooms for 1 of 35 residents reviewed for dignity which resulted in a resident's feelings of undignified treatment and 7 of 7 failing to knock before entering 7 of 7 resident's rooms. . (Resident #49) Findings included: 1. Record review revealed Resident #49 was admitted to the facility on 11/20/2014 with diagnoses which included Hypertension and Osteoarthritis. The most recent comprehensive Minimum Data Set dated 12/15/2016 indicated Resident #49 was moderately cognitively impaired and required limited to extensive assist with all Activities of Daily Living.	F 241	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Resident # 49, and rooms 201,202,203,205,206,208, and 209 have been ensured dignity by staff knocking and obtaining permission before entering room. Resident rooms have been observed to ensure staff knock and obtain permission before entering room. The administrator and Director of Nursing have provided education to direct care staff in regards to knocking and obtaining permission prior to entering resident rooms.	3/3/17

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

Electronically Signed | 02/27/2017

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F 241	Continued From page 1 On 1/31/2017 at 11:45 AM, Resident #49 was observed in her room, seated by the window in a reclining chair. Resident #49 head was lowered towards her chest and appeared to be sleeping. The door to her room was open. Nursing Assistant (NA) #6 entered Resident #49"s room, walked in the bathroom and exited the room. NA #6 did not knock or ask permission to enter and did not speak to Resident #49. Resident #49 remained in the same position in her reclining chair. On 1/31/2017 at 12:10 PM, NA #6 entered Resident #49"s room and delivered the lunch tray. NA #6 did not knock or ask permission to enter and proceeded to move the over bed table from the bedside to the reclining chair. Resident #49 raised her head and stated she was napping and did not hear the NA enter the room. NA #6 set up the lunch tray and informed Resident #49 she would return later to pick up the tray. At 12:47 PM, NA #6 entered Resident #49's room, retrieved the lunch tray, asked Resident #49 if she needed assistance with anything and exited the room. NA #6 did not knock or ask permission to enter the room. Observations were made on 2/1/2017 at 10:05 AM and 10:40 AM of Resident #49. NA #6 was observed entering Resident #49's room without knocking or asking permission to enter. An interview was conducted with Resident #49 on 2/1/2017 at 11:16 AM. Resident #49 stated the staff were in and out of her room all day. Resident #49 stated they just came in when they wanted to. Resident #49 stated it would sure be nice if everybody knocked but they didn't. Resident #49 stated when she is napping in her chair and they knocked, it gave her a chance to "get my bearings" before they entered. Resident #49 stated sometimes when she woke from her naps	F 241	The Administrator and/or designee will conduct Quality Improvement Monitoring of resident rooms to ensure staff knock and announce before entering resident rooms. Quality Improvement Monitoring will be conducted by checking 5 days per week for 4 weeks, then 6 rooms three days per week for 4 weeks, then 6 rooms weekly for 12 weeks, and/or until substantial compliance is reached. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse.	

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F 241	Continued From page 2	F 241		

in the chair staff would be in her room. Resident #49 indicated it used to startle her but she was used to it now.

An interview was conducted with NA #6 on 2/1/2017 at 1:20 PM. NA #6 reported she was aware staff needed to knock and announce prior to entering residents' rooms. NA #6 stated it was a habit not to knock and she did not think about it when she entered the rooms. NA #6 stated she knew it was important to knock and did not know why she was in the habit of just walking in the rooms.

An interview was conducted with the Director of Nursing (DON) on 2/1/2017 at 2:25 PM. The DON stated the expectation was for every employee to knock and announce themselves when entering resident's rooms. The DON stated the facility was home to all the residents and all employees were expected to respect resident's privacy at all times. A continual observation of the 200 hall was conducted on 1/31/2017 from 12:10 PM to 1:45 PM. During the observation Nursing Assistant (NA) #6 was observed entering rooms 201, 202, 203, 205, 206, 208 and 209. NA #6 was observed to enter each room without knocking or revealing her name, title or purpose for entrance.

2. On 2/1/2017 at 1:00 PM NA #6 was observed to enter rooms 201, 202, 203 and 205 without knocking or revealing her name, title or purpose for entrance.

An interview was conducted with NA #6 on 2/1/2017 at 1:20 PM. NA #6 reported she was aware staff needed to knock and announce prior to entering residents' rooms. NA #6 stated it was a habit not to knock and she did not think about it

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F 241	Continued From page 3 when she entered the rooms. NA #6 stated she knew it was important to knock and did not know why she was in the habit of just walking in the rooms. An interview was conducted with the Director of Nursing (DON) on 2/1/2017 at 2:25 PM. The DON stated the expectation was for every employee to knock and announce themselves when entering resident's rooms. The DON stated the facility was home to all the residents and all employees were expected to respect resident's privacy at all times.	F 241		
F 244 SS=D	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to resolve grievances that were reported in the resident council meetings for four consecutive months. Findings included:	F 244	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by	3/3/17

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F 244	Continued From page 4 The Resident Council Meeting minutes from October 2016 through January 2017 were reviewed. The Resident Council minutes dated 10/20/2016 indicated the residents voiced concerns of water pitchers not being filled consistently and call bells not within reach. The Resident Council minutes dated November 17, 2016 indicated the residents reported the concerns from the previous month's meeting were not improved and voiced continued issues with water pitchers not being filled consistently and call lights not within reach. The Resident Council minutes dated December 22, 2016 indicated the residents reported continued issues with water pitchers not being filled consistently. The Resident Council minutes dated January 19, 2017 indicated the residents reported no improvement in the water pitchers being filled. The minutes reported the residents stated a continued issue with the call lights are not in reach. An interview was conducted on 2/1/2017 at 12:45 PM with the Resident Council president (Resident #64). Resident #64 stated the facility staff did not act on the grievances and concerns the Resident Council reported because the issues of the call lights being out of reach and the water pitchers not filled had been ongoing for several months. Resident #64 indicated the Activities Director told the Resident Council members the concerns/grievances were reported to the managers each month, but the issues were not improved. An interview was conducted with the Activity Director (AD) on 2/1/2017 at 1:15 PM. The AD	F 244	provision of Federal and State regulations. All resident council minutes for past 12 months have been reviewed for concerns and resolution. The Administrator provided education to department managers in regards to resident council meeting process and procedures, and corrective action to be taken in response to any concerns. The Administrator will review resident council minutes monthly and monitor concerns weekly for 12 weeks then monthly thereafter. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment	

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F 244	Continued From page 5 stated that concerns/grievances from the Resident Council members are forwarded to the appropriate Department Head on the day of the meeting or the next day. The AD reported she knew there were issues with the water pitchers and the availability of call lights which were unresolved for the last several months and she continued to notify the appropriate department heads every month. An interview was conducted with the Director of Nursing (DON) on 2/1/2017 at 2:17 PM. The DON stated the AD emailed her the Resident Council meeting concerns/grievances on the day of the meeting or the next morning. The DON stated she was aware of the ongoing concerns with the water pitchers and the call lights. The DON stated she reviewed the concerns monthly and in-serviced staff. The DON reported there was no documentation of in-servicing for the continued issues as there was no implementation of a grievance resolution procedure. The DON further stated there was no actual process the facility used that listed a time when grievances needed to be resolved. The DON stated the expectation was the Resident Council grievances would be resolved and not continue for months.	F 244	Nurse.	
F 246 SS=D	. 483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the	F 246		3/3/17

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F 246	Continued From page 6 resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to place a call light within reach for 1 of 35 residents reviewed for call light placement. (Resident #1) Findings included: Record review revealed Resident #1 was admitted to the facility on 9/11/2012 with diagnoses which included Chronic Pain and Chronic Kidney Disease. Review of the Quarterly Minimum Data Set dated 1/5/2017 indicated Resident #1 was moderately cognitively impaired and required extensive to total assistance of 1 person for all Activities of Daily Living. Review of Resident #1's Care Plan with the most recent revision dated 1/9/2017 included a problem of self-care deficit related to the need for extensive to total assistance with Activities of Daily Living. One of the interventions listed was to keep the call bell within reach and visual field. The Care Plan revised on 1/9/2017 also listed a problem of incontinence of bowel and bladder related to impaired mobility. One of the interventions listed was to keep the call bell within reach and visual field. An interview was conducted with Resident #1 on 1/30/2017 at 3:40 PM. Resident #1 was alert and oriented. Resident #1 was seated in her wheelchair which was positioned approximately 3 feet from the right side of the bed. The bed was positioned with the left side of the bed against the	F 246	Resident # 1□s call light has been placed within reach to ensure reasonable accommodation of needs are met. Current resident rooms have been audited to ensure call bells are within reach in order to ensure reasonable accommodation of needs. The Administrator and/or Director of nursing have provided education to nursing staff in regards to checking resident rooms before and after care to ensure the call light is in place and within reach for residents. The Administrator and/or designee will conduct Quality Improvement Monitoring of resident rooms to ensure call bells are within reach. Quality Improvement Monitoring will be conducted by checking 6 rooms 5 days per week for 4 weeks, then 6 rooms three days per week for 4 weeks, then 6 rooms weekly for 12 weeks, and/or until substantial compliance is reached. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial	

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F 246	Continued From page 7 wall. Resident #1's call bell was observed hanging in the space between the bed and the wall. During the interview Resident #1 reported she was up in her wheelchair every day. Resident #1 further reported there were many times the call light was out of her reach and positioned between the bed and the wall. Resident #1 stated she was unable to reach all the way across the bed when she was in her wheelchair to get the call light. Resident #1 stated she would either yell for someone or wait for staff to come into the room if she needed assistance. An observation of Resident #1 on 1/31/2017 at 1:05 PM revealed Resident #1 sitting in her room in her wheelchair and the call light was located out of her reach between the mattress and the wall. An observation of Resident #1 on 2/1/2017 at 9:20 AM revealed Resident #1 sitting in her room in her wheelchair and the call light was located out of her reach between the mattress and the wall. An observation of Resident #1 on 2/2/2017 at 9:00 AM revealed Resident #1 sitting in her room in her wheelchair and the call light was located out of her reach between the mattress and the wall. An interview was conducted with Nursing Assistant (NA) #5 on 2/2/2017 at 9:15 AM. NA #5 reported she provided AM care for Resident #1 and placed the resident in the wheelchair after the care was completed. NA # 5 also reported she was the NA assigned to Resident #1 daily since 1/30/2016. NA # 5 stated she was in a hurry in the mornings to ensure care was completed and did not place the call light in reach for Resident #1. NA #5 also stated she did not	F 246	compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse.	

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F 246	Continued From page 8 remember to place the call light in reach even though she was aware Resident #1 was capable of calling for assistance. An interview was conducted with the Director of Nursing (DON) on 2/2/2017 at 10:30 AM. The DON stated the expectation was for call lights to be within reach so the residents could call for assistance.	F 246		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F 272		3/3/17

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F 272	Continued From page 9 regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to accurately assess a resident's dental status for 1 of 1 residents reviewed (Resident #22). Findings included: A review of the medical record revealed Resident #22 was admitted 11/2/2016 with diagnoses of dysphagia, Diabetes and altered mental status. The 14 day Minimum Data Set (MDS) dated 11/15/2016 noted Resident #22 was moderately impaired for cognition, needed one person's supervision for eating and was noted by staff to feed herself most foods. On 1/30/2017 at 4:30 PM, Resident #22 was observed propelling herself in a wheel chair in the facility halls. In an interview at that time Resident	F 272	Resident # 22□S Comprehensive assessment has been completed to include oral status. Current resident□s comprehensive assessments have been audited to ensure they are complete and include oral status. Administrator and/or Director of Nursing have provided education to the assessment team on accuracy of the comprehensive assessment to include oral status. Administrator and/or designee will conduct Quality Improvement Monitoring of all newly admitted residents to ensure that comprehensive assessment is completed and includes oral status. Quality Improvement will be completed weekly on any comprehensive	

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F 272	Continued From page 10 #22 stated she did not have dentures but would like to have some. Resident #22 stated she did not have any teeth. The Admission MDS dated 11/9/2017 was reviewed for L0200 dental status. The section B: no natural teeth or tooth fragment(s) (edentulous) was not checked. The last choice of dental status options was: None of the above and this was checked. The admission nursing assessment was reviewed and Oral Status was blank. On 2/1/2017 at 11:25 AM, the MDS nurse was interviewed and stated she did not remember doing this assessment, but she must have made an error. The MDS nurse indicated she goes by the admission nursing assessment and looks at the residents when she does the pain assessment. On 2/2/2017 at 10:50 AM, in an interview, the Director of Nursing (DON) stated the expectation was the MDS would be accurate.	F 272	assessments completed for the week for twelve weeks, then monthly for three months. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.	F 280		3/3/17

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F 280	Continued From page 11 (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 280		

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F 280	Continued From page 12 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to update or revise a care plan after multiple falls for one of 22 residents reviewed for care plans (Resident #22), which provided no precautions or actions to prevent further falls for Resident #22. Findings included: Review of the medical record revealed Resident #22 was admitted to the facility 11/2/2016 with	F 280	Resident # 22□s care plan has been reviewed and updated to reflect any needed interventions for falls. Care Plans for those residents having experienced falls have been reviewed and updated as needed for any new interventions for falls. Administrator and/or Director of Nursing have provided educational training for the care plan team in relation to care plan	

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F 280	Continued From page 13 diagnoses that included abnormal gait and mobility and altered mental status. The 14 day Minimum Data Set (MDS) dated 11/15/2016 indicated Resident #22 was moderately impaired for cognition and needed extensive assistance for transfers and toilet use. The MDS noted Resident #22 was unsteady during transitions and walking. The Care Area Assessment (CAA) indicated a concern for falls and this area went to care plan. Review of the care plan dated 11/16/2016 indicated Resident #22 needed safety measures to minimize the risk of accidents and injury. The plan interventions included checking the resident frequently and assist with toileting routinely, answering the call bell promptly, and giving medications as ordered, monitoring for medication side effects, observing for changes in mental status and transferring carefully with assistance. A review of the falls investigations for Resident #22, revealed there were 9 investigated falls from 11/11/2016 through 1/28/2017. There were no revisions or updated interventions in the care plan after each fall. On 2/2/2017 at 10:43 AM, in an interview, the MDS nurse stated she puts revisions and interventions in the care plan when she received them from the Director of Nursing (DON). In an interview on 2/2/2017 at 10:55 AM, the DON stated the expectation was the care plan would be updated when falls occurred. The DON stated there were no new interventions for the resident's care plan.	F 280	updates as they relate to fall interventions. The Administrator and/or Director of Nursing will conduct Quality Improvement Monitoring for falls to ensure the care plan is updated as necessary for any new interventions for falls. Quality Improvement Monitoring will be conducted 5 days per week for residents with falls in quality improvement meeting and weekly during falls meeting for 12 weeks and then weekly during falls meeting thereafter. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse.	
F 323	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT	F 323		3/3/17

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F 323 SS=E	Continued From page 14 HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to prevent falls and minimize the potential for falls for one of two residents reviewed for accidents (Resident #22), resulting in continued falls for the resident, and the facility failed to maintain safe hot water temperatures in two of two rooms checked for water temperature (rooms 106 and 107) which could pose as a safety hazard for residents.	F 323	Resident # 22□s environment has been checked for any identified potential accident hazards. Resident rooms have been checked to ensure areas are clear of any potential accident hazards. The Administrator and/or Director of nursing have provided education to nursing staff in regards to checking resident rooms before and after care to	

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F 323	Continued From page 15 Findings included: 1. A review of the medical record revealed Resident #22 was admitted to the facility 11/2/2016 with diagnoses that included abnormal gait and mobility, altered mental status and over active bladder. The 30 day Minimum Data Set (MDS) dated 11/29/2016 indicated Resident #22 was moderately impaired for cognition and needed extensive assistance for transfers and toilet use. The MDS noted Resident #22 was unsteady during transitions and walking and was only able to stabilize with human assistance. The Care Area Assessment (CAA) indicated a concern for falls and this area went to care plan. Review of the care plan dated 11/16/2016 indicated Resident #22 needed safety measures to minimize the risk of accidents and injury. The plan interventions included checking the resident frequently and assist with toileting routinely, answering the call bell promptly, and giving medications as ordered, monitoring for medication side effects, observing for changes in mental status and transferring carefully with assistance. A Quality Care Control Report completed by the Director of Nursing (DON) and dated 11/11/2016, indicated at 6:55 PM, Resident #22 tripped over roommate's oxygen tubing, was in the floor with back against the bed and walker was turned over. Resident #22 had an abrasion on her back. Monitors included: Resident asked to call for assistance. Alert and oriented. Poor memory. Poor safety awareness. A Quality Care Control Report dated 12/9/2016 and completed by the DON, indicated at 12:20	F 323	ensure the environment is free and clear of any potential accident hazards. The Administrator and/or Director of Nursing will conduct Quality Improvement Monitoring for room hazards to ensure the resident room environment is free and clear of any potential hazards. Quality Improvement Monitoring will be conducted 5 days per week for 8 resident rooms for 4 weeks, then 5 days per week for six resident rooms for four weeks, then four resident rooms for four weeks, then weekly for three months and/or until substantial compliance is obtained. Rooms 107 and 106 water temperatures were lowered to the acceptable range of 100- 116 fahrenheit. Resident rooms water temperatures have been checked to ensure they are with the acceptable range for safe usage. The Administrator had been educated by engineering director on the acceptable water temp for resident areas. The Administrator and/or maintenance department will conduct Quality Improvement Monitoring for room hazards to ensure the resident room environment is free and clear of any potential hazards. Quality Improvement Monitoring will be conducted 5 days per week for 8 resident rooms for 4 weeks, then 5 days per week for six resident rooms for four weeks, then four resident rooms for four weeks, then weekly for three months and/or until substantial compliance is obtained. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical	

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F 323	Continued From page 16 PM, Resident #22 was found on floor by Physical Therapy. Resident states she didn't fall. Monitors included: Resident with dementia. She has very poor safety awareness and becomes easily agitated if re-directed. Educated resident to call for assistance. Diversional activities and group activities resident does not stay long. Not interested in magazines. No injury noted. No interventions were added at that time. A Quality Care Control Report, completed by the DON and dated 12/11/2016, indicated at 7:30 AM, Resident #22 was seen crawling out of room, down the hallway by nurse who notified unit. No injuries noted and ROM (range of motion) active as resident continued to move around floor while being assisted. Per roommate, Resident slid out of her bed. Ongoing monitors: Resident is confused-gets agitated easily. Unable to re-direct at times. Re-educated in safety, calling for assist, call bell, not getting up by herself. No new interventions were added at that time. A Quality Care Control Report dated 12/29/2016 and completed by the DON, indicated at 11:00 AM, Resident #22 found on floor on 100 hall. She was observed by staff member to pull herself up out of wheelchair with hand rails. She slid to the floor at that time. No injuries noted. The monitors included: Poor safety awareness. Demented, continually self-propels and will try stand and walk when she wants to. No new interventions were initiated at that time. A Quality Care Control Report, completed by the DON and dated 1/2/2017 indicated at 9:10 PM, staff entered room, Resident #22 sitting on buttocks with brief around ankles. Monitors included: Resident very poor safety awareness.	F 323	Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse.	

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Dementia. Gets up when she wants. Propels self in wheel chair (w/c). Wanders around building in her w/c. No new interventions were initiated at that time.

A nurse's note dated 1/2/2017 noted Resident #22 observed sitting on floor in front of bed. Resident unable to state what happened. Denies pain or discomfort stated "I'm alright" Positive ROM to all extremities. No Quality Care Control Report.

A Quality Care Control Report dated 1/4/2017 and completed by the DON, indicated at 7:00 PM, a nurse from 300 hall came and notified 100 nurse that Resident #22 fell in the floor in the hall. Nurse on 100 hall assessed resident for no injuries. Monitors included: Resident has severe dementia and poor safety awareness. Will continue to monitor resident. Frequent safety checks. Offer rest periods/ go back to bed. Staff aware to monitor her while in hallways. No new interventions were initiated or added to the care plan at that time.

A Quality Care Control Report by the DON, dated 1/7/2017, indicated at 1:45 PM, Resident #22 found on floor in hallway-unobserved fall. No injury noted. Resident roommate stated "She tried to take herself to the bathroom and fell. She crawled to the hallway." The ongoing monitors included: Resident demented, poor safety awareness. Wanders, propels self in w/c. Gets up unassisted despite frequent reminders. No new interventions were added at that time.

A Quality Care Control Report dated 1/28/2017, completed by the DON, indicated at 2:55 PM, Resident #22 was noted scooting on floor on

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buttocks with pants lowered to knees, smearing feces on floor. Resident #22 stated in the report that she had gotten out of the chair to get someone to help her. Ongoing monitors included: Resident is demented. Re-educated to safety-calling for assist. Resident was last checked by aide 1 hour prior. Continue to check resident often.

Resident #22 was observed on 1/31/2017 propelling herself in hallways and in her room. Throughout the survey, Resident #22 was observed being assisted into the bathroom and going into and out of the bathroom alone.

On 1/31/2017 at 4:30 PM, Resident #22 stated, in an interview, that she had fallen. Resident #22 indicated if she turned on the call bell and the Nursing Assistants (NAs) did not come, she would get up to the bathroom by herself. Resident #22 stated she had to go to the bathroom and sometimes fell.

On 2/1/2017 at 2:00 PM, NA #1 stated Resident #22 wore a brief because she sometimes had an incontinent episode. NA #1 noted Resident #22 got up on her own and had falls.

In an interview on 2/2/2017 at 10:43 AM, the MDS nurse stated she put revisions and interventions in the care plan when they were received from the Director of Nursing (DON).

On 2/2/2017 at 10:55 AM, in an interview, the DON stated she always re-educated Resident #22, even after multiple falls, and even though the investigations noted Resident #22 was demented and confused. The DON noted she had thought of putting an alarm on Resident #22,

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but felt that might agitate the Resident. The DON stated her expectations were the NAs would make rounds every hour and the nurses would check on Resident #22.

In an interview on 2/2/2017 at 11:15 AM, NA #1 stated she checked most of her residents every hour just to make sure no one was on the floor, or needed something. NA#1 was observed assisting residents on occasion.

On 2/2/2017 at 11:00 AM, NA #2 stated she had a very busy hall and usually made it around her entire hall every 45 minutes. NA #2 was observed to be busy on her hall.

In a telephone interview on 2/2/2017 at 2:15 PM, Resident #22's physician was interviewed and stated the facility notified him when the Resident had falls. The physician stated he would expect nursing and therapy to work together to come up with some precautions, although, a fall mat was not always a good thing and a low bed could be a dignity issue. "It is an ongoing struggle and I feel the staff are doing their best", he stated. The physician maintained there must be a balance between Resident #22's rights and independence, and what she needs to be safe.

On 2/3/2017 at 8:50 AM, in an interview, the Physical Therapy Manager stated Resident #22 started Physical Therapy (PT) and Occupational Therapy (OT) on 11/3/2016 and was discharged on 12/16/2016 from PT and discharged from OT on 12/19/2017, with most goals not being met. The PT Manager stated Resident #22 improved on standing balance and ambulation, but did not meet goals to improve toileting and transfers. The PT Manager stated she was not aware of

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Resident #22 having had falls, but all she needed was a note on the door or a phone call from nursing to screen Resident #22 for further PT and OT. The PT Manager received a telephone call from the MDS nurse, who scheduled a quarterly screening for Resident #22 in March, 2017.

2. On 1/31/2017 at 10:36 during a routine check of water temperatures, the hot water in the bathroom sink of room 107 was found to be very hot to touch. The Maintenance Director was directed to room 107 with a thermometer. The facility Administrator came to the room with a thermometer and the hot water temperature registered 122 Fahrenheit (F). The Administrator was then directed to the bathroom sink of room 106, and the hot water temperature registered 123F. The Administrator stated he was going to have the hot water tank temperature lowered. At 10:50 AM on 1/31/2017, the Administrator stated the Maintenance Director had lowered the water tank temperature by 10 degrees. At 11:00 AM the temperature of the hot water was checked to be 117F in the bathroom sink of room 107. The temperature of the hot water in the bathroom sink of room 106 at 11:35 AM was 113F. No signs were posted in the facility to keep residents from using the hot water.

On 2/2/2017 at 9:30 AM, in an interview, the Maintenance Director stated the hot water tank for the facility had trash in the tank and had to be cleaned out. The Maintenance Director stated he adjusted the tank temperature to get an acceptable level. The Director indicated the hot water temps were checked in two rooms on each hall monthly. The temp logs were reviewed for the previous three months. The highest temperature in room 107 was 113F, and the highest

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F 323	Continued From page 21 temperature in room 106 was 113F. On 2/2/2017 at 4:00 PM, in an interview, the Administrator stated his expectation would be the hot water temperatures would be maintained at a safe level throughout the facility. `	F 323		