STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		4/16/18

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

Electronically Signed | 04/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews the facility failed to maintain dignity by failing to knock on doors or announce their presence before entering resident rooms for 6 of 36 residents observed for dignity. (Resident #3, Resident #49, Resident #32, Resident #13, Resident #283, and Resident #45) Findings included: 1. Resident #3 was admitted to the facility on 3/6/15. Her active diagnoses included end stage renal disease, hypotension, hypothyroidism, and hypertension. Review of Resident #3's most recent quarterly minimum data set assessment dated 12/11/17 revealed the resident was assessed as cognitively intact. During observation on 3/19/18 at 10:08 AM the Geriatric Care Assistant entered Resident #3's room without knocking or announcing her presence. During an interview on 3/19/18 at 10:08 AM Resident #3 stated staff walked into her room all the time without knocking or announcing their presence. She further stated she was sometimesdressing and the staff just came in without knocking and it was embarrassing. She stated she was frustrated by the staff not knocking or announcing themselves. During an interview on 3/19/18 at 10:12 AM the	F 550	F 550 Disclaimer Tower Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Tower Nursing and Rehabilitation□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tower Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding The process which led to this deficiency was determined to be that the Geriatric Care Assistant (GCA) failed to knock on the doors and maintain the dignity of Resident #3, Resident #49, Resident #32, Resident #13, Resident #283, and Resident #45.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 550	Continued From page 2 Geriatric Care Assistant stated staff were supposed to knock or announce their presence before entering resident rooms. She further stated she had not realized she had not knocked when she entered Resident #3's room. She stated it was her mistake and she should have knocked before entering the resident rooms. During an interview on 3/20/18 at 11:44 AM the Director of Nursing stated it was her expectation staff knocked or announced their presence before resident rooms were entered. She further stated it was a dignity concern and staff should never walk in to resident rooms unannounced. 2. Resident #49 was admitted to the facility on 1/19/17. Her active diagnoses included diabetes mellitus, vascular dementia, and acute kidney failure. Review of Resident #49's most recent annual minimum data set assessment dated 1/24/18 revealed the resident was assessed as severely cognitively impaired. During observation on 3/19/18 at 10:08 AM the Geriatric Care Assistant entered Resident #49's room without knocking or announcing her presence. During an interview on 3/19/18 at 10:12 AM the Geriatric Care Assistant stated staff were supposed to knock or announce their presence before entering resident rooms even if the residents were cognitively impaired. She further stated she had not realized she had not knocked when entering Resident #49's room. She stated it was her mistake and she should have knocked before entering the resident rooms.	F 550	On 3/27/18, the GCA was in-serviced by DON on maintaining residents dignity and privacy by knocking on doors and announcing presence prior to entering any resident s room. On 4/4/18, a 100% audit of all staff to include geriatric care assistants will be conducted by DON and Staff Facilitator to ensure staff are knocking on residents doors and announcing presence prior to entering any resident s room, to be completed by 4/16/18. This audit will include the rooms of Resident #3, Resident #49, Resident #32, Resident #13, Resident #283, and Resident #45. Any areas of concern identified will be immediately addressed by (Staff Facilitator) and/or the Director of Nursing (DON) to include retraining of the staff member involved in the concern. On 3/27/18, an in-service for 100% of staff was initiated by DON on Resident Dignity to include knocking on doors and announcing presence prior to entering a resident s room, to be completed by 4/16/18. All newly hired staff to include geriatric nursing assistants and agency will complete the in-service provided by the Staff Facilitator (SF) during orientation on Resident Dignity to include knocking on door and announcing presence prior to entering a resident s room. 10% of all staff to include geriatric nursing assistants (GCA) will be observed weekly for 8 weeks, then monthly for 1 month by DON and SF utilizing a Resident Care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 550	Continued From page 3 During an interview on 3/20/18 at 11:44 AM the Director of Nursing stated that it was her expectation staff knocked or announced their presence before resident rooms were entered. This included rooms of severely cognitively impaired residents. She further stated it was a dignity concern and staff should never walk in to resident rooms without first announcing their presence. 3. Resident #32 was admitted to the facility on 9/24/11. His active diagnoses included epilepsy, dementia, hypertension, and chronic kidney disease. Review of Resident #32's most recent quarterly minimum data set assessment dated 1/11/18 revealed the resident was assessed as severely cognitively impaired. During observation on 3/19/18 10:11 AM the Geriatric Care Assistant entered Resident #32's room without knocking or announcing her presence. During an interview on 3/19/18 at 10:12 AM the Geriatric Care Assistant stated staff were supposed to knock or announce their presence before entering resident rooms even if the residents were cognitively impaired. She further stated she had not realized she had not knocked when she entered Resident #32's room. She stated it was her mistake and she should have knocked before entering the resident rooms. During an interview on 3/20/18 at 11:44 AM the Director of Nursing stated that it was her expectation that staff knocked or announced their	F 550	Audit Tool to ensure staff are providing dignity to residents by knocking on doors and announcing presence to include Resident #3, Resident #49, Resident #32, Resident #13, Resident #283, and Resident #45. Any areas of concern will be immediately addressed by the DON to include retraining of the staff member involved in the concern. The Administrator and/or DON will review and present the findings of the Resident Care Audit Tool to the Executive Quality Improvement (QI) committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 550	Continued From page 4	F 550		

presence before entering resident rooms including rooms with severely cognitively impaired residents. She further stated it was a dignity concern and staff should never walk in to resident rooms without first announcing their presence.

4. Resident #13 was admitted to the facility on 12/17/15. His active diagnoses included hyperlipidemia, anxiety disorder, and traumatic brain injury.

Review of Resident #13's most recent annual minimum data set assessment dated 12/25/17 revealed the resident was assessed as severely cognitively impaired.

During observation on 3/19/18 10:11 AM the Geriatric Care Assistant entered Resident #13's room without knocking or announcing her presence.

During an interview on 3/19/18 at 10:12 AM the Geriatric Care Assistant stated staff were supposed to knock or announce their presence before entering resident rooms even if the residents were cognitively impaired. She further stated she had not realized she had not knocked when entering Resident #13's room. She stated it was her mistake and she should have knocked before entering the resident rooms.

During an interview on 3/20/18 at 11:44 AM the Director of Nursing stated that it was her expectation that staff knocked or announcde their presence before entering resident rooms including rooms with severely cognitively impaired residents. She further stated it was a dignity concern and staff should never walk in to resident rooms without first announcing their presence.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 550	Continued From page 5	F 550		

5. Resident #283 was admitted to the facility on 3/6/18. Her active diagnoses included Alzheimer's disease, diabetes mellitus, and hypertension.

Review of a mini mental assessment dated 3/13/18 revealed Resident #283 was assessed as severely cognitively impaired.

During observation on 3/19/18 at 10:12 AM the Geriatric Care Assistant entered Resident #283's room and had not knocked or announced her presence.

During an interview on 3/19/18 at 10:12 AM the Geriatric Care Assistant stated staff were supposed to knock or announce their presence before entering resident rooms even if the residents were cognitively impaired. She further stated she had not realized she had not knocked when entering Resident #283's room. She stated it was her mistake and she should have knocked before entering the resident rooms.

During an interview on 3/20/18 at 11:44 AM the Director of Nursing stated that it was her expectation that staff knocked or announced their presence before entering resident rooms including rooms with severely cognitively impaired residents. She further stated it was a dignity concern and staff should never walk in to resident rooms without first announcing their presence.

6. Resident #45 was admitted to the facility on 2/9/12. Her active diagnoses included hypotension, hypertension, anemia, and peripheral vascular disease.

Review of Resident #45's most recent quarterly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 550	Continued From page 6 minimum data set assessment dated 1/31/18 revealed Resident #45 was assessed as severely cognitively impaired. During observation on 3/19/18 at 10:12 AM the Geriatric Care Assistant entered Resident #45's room and had not knocked or announced her presence. During an interview on 3/19/18 at 10:12 AM the Geriatric Care Assistant stated staff were supposed to knock or announce their presence before entering resident rooms even if the residents were cognitively impaired. She further stated she had not realized she had not knocked when entering Resident #45's room. She stated it was her mistake and she should have knocked before entering the resident rooms. During an interview on 3/20/18 at 11:44 AM the Director of Nursing stated that it was her expectation that staff knocked or announced their presence before entering resident rooms including rooms with severely cognitively impaired residents. She further stated it was a dignity concern and staff should never walk in to resident rooms without first announcing their presence.	F 550		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms,	F 604		4/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 604	Continued From page 7 consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observations, the facility failed to maintain an environment free from physical restraints for 2 of 2 residents (Resident #15 and Resident #57) by: 1) using a pressure pad, chair alarm, and high winged mattress and side rails for Resident #15 to prevent the resident from getting up without assistance, and 2) placing an alarming bracelet on the left ankle of Resident #57 which prevented him from exiting the facility at will. Findings included: 1) Resident #15 was admitted to the facility 1/19/16 from an acute care hospital. A review of the annual Minimum Data Set- an assessment tool (MDS) dated 12/31/17 revealed Resident #15	F 604	F 604 Disclaimer Tower Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Tower Nursing and Rehabilitation□s response to this Statement of Deficiencies	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 604	Continued From page 8 was severely cognitively impaired and inattention and disorganized thinking were continuously present. Rejection of care, wandering, and verbal behaviors towards others was present during the look back period, and bed mobility required extensive, 2 plus person assistance for completion. All other activities of daily living (ADLs) required extensive to total assistance. Active diagnoses included aphasia (an inability to understand or express speech), non-Alzheimer's dementia, anxiety, repeated falls, cognitive communication deficit, and difficulty walking. Resident #15 had 1 fall without injury since the last MDS assessment dated 9/30/17. A comprehensive review of Resident #15's medical record, electronic and paper, revealed no assessment for restraints, side rails, or chair and bed alarms had been completed since admission. Care plans, revised 1/10/18, included care planning for falls. Stated goals read Resident #15 would not sustain any serious injury through the next review. Interventions included: an environment free of clutter, a scoot chair when out of bed, and a winged mattress to the bed with a non-skid mat at bedside for safety. A review of the care guide located in the resident's closet, dated 11/9/17 and currently used by staff revealed special precautions for Resident #15 included Falls: mat of floor beside bed: Non-skid mattress: specify type (winged - low profile), and alarm: bed and chair. An observation of Resident #15's room was completed on 3/19/18 at 11:31 AM. The bed was a winged mattress with 2 side rails in the "up" position at the head of the bed. There was a pressure pad on the mattress and a speaker box hung on the upper side rail. Additional observations on 3/20/18 at 8:30 AM, and 3/21/18 at 9:25 AM were made and revealed Resident	F 604	does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tower Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding The process which led to the deficiency was the nursing department failed to ensure Resident #15 and Resident #57 were free from physical restraints. On 4/4/18, the pressure pad, chair alarm, and high-winged mattress were removed from the room of Resident #15 by Nursing Supervisor and DON. On 3/22/18, the alarm bracelet was removed from Resident #57 ankle by Administrator. On 3/26/18, a 100% audit of all residents with restraints to include Resident #15 and Resident #57 was conducted by Hall Nurses to ensure all residents with restraints had a care plan reflecting the restraint, a Physical Restraint Evaluation form completed, a physician□s order with a medical symptom documented, and that the resident was evaluated quarterly for reduction attempts with documentation in the electronic health record. Any identified areas of concern were addressed by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 604	Continued From page 9 #15 lying in the winged mattress bed with 2 side rails in the up position at the head of the bed, and a speaker box hanging from the side rail. The resident appeared to be sleeping. An interview was conducted with Nurse #1 on 3/23/18 at 11:30 AM. She stated winged mattresses were used to prevent falls. She also stated Resident #15 had repetitive movements when she was agitated in the past, but now when she was agitated she kicked her legs and tried to get out of bed. An interview was conducted with Nurse #2 on 3/23/18 at 11:35 AM. She stated restraints were not used in the facility. She also stated a side rail assessment was supposed to be done by the admitting nurse at the time of admission. If there were constant safety concerns, the nurse talked to the Director of Nursing (DON) and physician, then an order was received from the doctor for safety interventions. She also stated Resident #15 had tried to get out of bed and the winged mattress kept her comfortable. She also stated, "She hangs her legs off the bed and it doesn't look comfortable, so the winged mattress keeps her from hanging her legs off." The interview continued at Resident #15's bedside. The resident was not present at the time. A pad was present marked "pressure pad" and Nurse #2 stated, "There's a bed alarm. It's for safety, particularly for someone who needs help getting out of bed and has a history of falls." An interview was conducted with the MDS Coordinator on 3/22/18 at 11:45 AM. He stated side rail assessments were completed on every resident and triggered a reminder to care plan the resident for side rails if they were used. If an assessment was not completed by the nurse who completed the admission assessment the MDS nurse stated he completed one during his face to	F 604	Director of Nursing (DON) to include retraining of staff involved in the concern and updating of the involved resident□s medical record. On 4/5/18, an in-service for 100% of licensed nurses was initiated by DON and SF on the Physical Restraint Guidelines, to include examples of restraints, medical symptom requirements, and completing the Physical Restraint Evaluation for any resident with orders for a restraint to include a pressure pad, chair alarm, high-winged mattress, and alarm bracelet. The completion date of the in-service will be 04/16/18. All newly hired and agency licensed nurses will receive the in-service from the Staff Facilitator (SF) during orientation on Physical Restraint Guidelines, to include examples of restraints, medical symptom requirements, and completing the Physical Restraint Evaluation for any resident with orders for a restraint to include a pressure pad, chair alarm, high-winged mattress, and alarm bracelet. On 4/3/18, the administrator and DON were in-serviced by the facility nurse consultant on the Physical Restraint Guidelines and ensuring a Quality Improvement (QI) meeting with Restraints is conducted monthly. 10% of all residents with restraints will be reviewed by DON weekly for 8 weeks, then monthly for 1 month utilizing a QI Restraint Audit form to ensure a physical restraint evaluation has been completed,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 604	Continued From page 10 face assessment. If, during the face to face assessment, the side rails were up he talked with therapy to ask if the side rails were clinically indicated for mobility. If the side rails were not for mobility he indicated side rails were not used. The MDS Coordinator also stated bed and chair alarms, and winged mattresses should be care planned because they were considered restraints. He also stated he fed Resident #15 daily and she had a winged mattress and side rails, but a side rail assessment had not been done. An interview was conducted with the Administrator, the DON, and the Nurse Consultant on 3/22/18 at 1:30 PM. The nurse consultant stated if a resident had side rails up they were for bed mobility and an assessment needed to be completed to insure they were not a restraint. She also stated a restraint or side rail assessment was not done for Resident #15 to show it was an enabler. Side rails assisted residents with bed mobility. A side rail assessment needed to be completed on every resident, and bed and chair alarms, if utilized, should not prevent a resident from trying to get up and should be care planned. The Administrator stated she had never heard an alarm go off and had never put one in place since she arrived in December. The DON stated everyone had a side rail assessment completed within 24 hours of admission. Side rails should be used if the resident was able to actively turn and reposition themselves, or if they were unable to use a grab bar. Side rail assessments were located in the electronic medical record (EMR), unless the system was unavailable. If the EMR was unavailable the DON stated an assessment was completed on paper and scanned into the EMR at a later time. Winged mattresses were used for positioning and were used to prevent a resident	F 604	a QI Restraint/Enabler progress note is completed monthly, a reduction attempt is made with documentation quarterly, a care plan is in place, and a physician□s order has been written to include a medical diagnosis. Any areas of identified concern will be addressed by the DON to include staff retraining. The DON will review and initial the audit tools for completion and accuracy weekly for 8 weeks, then monthly for 1 month. The administrator will present the findings of the QI Restraint Audit form to the Executive Quality Improvement (QI) committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 604	Continued From page 11	F 604		

who moved around a lot, or needed to move a lot, from falling out of bed. She also stated they were used for residents who needed a thicker mattress for wounds. The DON stated the alarms were used to prevent falls, but the facility was trying to get rid of them. If alarms were used there needed to be an evaluation for need, a rationale and the family was notified. All this information was in the chart. She stated she preferred a physician order within 24 hours of alarm placement and alarms were classified as a restraint. Restraints were care planned and Resident #15 had a winged mattress and chair and bed alarms. She also stated a care plan and side rail assessment should have been completed Resident #15.

2) Resident #57 was admitted on 1/31/18. An admission MDS dated 2/7/17 revealed the resident had no cognitive impairment and no behaviors. ADLs required extensive assistance, except eating and locomotion, and both lower extremities were impaired. Active diagnoses included psychotic disorder, intracranial injury, and diabetes mellitus. Resident #57 was positive for tobacco use. The daily and activity preferences section of the MDS indicated Resident #57 preferred going outside to get fresh air when the weather was good.

The Care Area Assessments completed on 2/7/18 revealed Resident #57's mood indicated his maximum level of functioning for the day. Resident #57 was able to transfer himself from the bed to the wheelchair and back and was able to propel himself in a wheelchair without assistance.

A care plan dated 3/2/18 focused on the "Problematic manner in which resident acts characterized by ineffective coping: Wandering and/or at risk for unsupervised exits from facility related to: attempts to leave unit/building if not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 604	Continued From page 12	F 604		

prevented and supervised, related to cognitive impairment." Interventions included Resident #57 was checked daily to ensure the resident had an alarm bracelet on and it was functioning properly.
An observation and interview was conducted on 3/21/18 at 10:30 AM with Resident #57. He stated, "I don't know why they put this thing on my ankle. Why do I have to wear this thing? They put it on me after I tried to go outside to smoke. All I know is they put this thing on me the next day. Can you take it off? I enjoy being outside when it's nice out and now I can't even do that. I used to smoke on my own at (the assisted living facility he was admitted from), but that place closed down so I had to come here. I didn't have no problems until I came here. I don't want to cause no trouble, I just want to smoke. I feel like a prisoner with this thing on." An alarming bracelet was observed on the resident's left ankle.
An interview was conducted with the Social Worker (SW) on 3/21/18 at 10:35 AM. She stated as of 2/7/18 Resident #57 was cognitively intact. She also stated he arrived here from an assisted living facility after the facility closed down. He was a smoker at admission, but she stated, "We're a no smoking facility." She also stated nursing completed the wandering risk assessments on all residents.
An interview was conducted on 3/21/18 at 12:10 PM with Nurse #3. She stated the resident was alert, but "trouble." She stated, "He always give me trouble taking his medicine. I get the supervisor to make him take them, or I call his family because those medicines are very important. He knows the risks and benefits, but he just won't take them." She also stated she did not complete a smoking or wandering assessment on him.
An interview was conducted with Nurse #2 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 604	Continued From page 13	F 604		

3/21/18 at 12:15 PM. She stated, "He (Resident #57) was exit seeking, but we didn't think he was safe to be outside by himself because he said he was going out to smoke. We didn't think he was safe to smoke by himself, and his family didn't like him smoking. I didn't do his smoking assessment. A smoking assessment is supposed to be done for every smoker when they're admitted." She stated no smoking assessment was located for Resident #57.

An interview was conducted on 3/21/18 at 2:20 PM with the Administrator. She stated a smoking assessment was done as soon as possible with the rest of the admission assessments, which included a wandering assessment. If a resident was not a wandering risk and they tried to go outside the facility staff asked why they were going outside. If they answered to smoke the staff checked the smoking assessment to see if the resident was a safe smoker or not. If not, they brought the resident inside the facility. If a smoking assessment had not been completed at the time the resident was trying to go outside a smoking assessment was completed right then. If a family's wishes differed from the resident's wishes the facility was to follow the resident's wishes.

An interview was conducted on 3/21/18 at 4:00 PM with the facility Physician's Assistant (PA). She stated she saw the Resident #57 3/19/18 and believed he had safety awareness and you were able to rationalize with him.

A smoking assessment was completed 3/21/18 and the resident was assessed a safe smoker.

A wandering risk assessment was completed on 3/21/18 and the resident was assessed as not a wandering risk. Stated "(Alarming bracelet) to be d/c'd" (discontinued).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 636	Continued From page 14	F 636		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(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 regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in	F 636		4/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 636	Continued From page 15 assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, and observations, the facility failed to conduct a smoking assessment as part of the comprehensive admission assessment for 1 of 1 residents (Resident #57) reviewed for smoking. Findings included: Resident #57 was admitted to the facility on 1/31/18. A review of an Admission Minimum Data Set-an assessment tool (MDS) dated 2/7/18 revealed Resident #57 was cognitively intact, displayed no behaviors, completed locomotion on and off the unit independently, and was positive for tobacco use. Active diagnoses included diabetes mellitus, and intracranial injury (a closed head injury).	F 636	F 636 Disclaimer Tower Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Tower Nursing and Rehabilitation□s response to this Statement of Deficiencies	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 636	Continued From page 16 A review of the Care Area Assessment dated 2/7/18 revealed Resident #57 transferred himself from the bed to the wheelchair and back to the bed, and propelled himself in a wheelchair. A social services note dated 2/2/18 at 2:50 PM read, in part, "Educated resident today about the smoking policy. He is aware from admission that facility is smoke-free. He verbalized understanding." A progress note dated 2/7/18 at 4:56 PM, and signed by the Social Worker read, in part, "Resident attempting to go outside alone to smoke off property. SW (Social Worker) and CNAs (Nursing Assistant) reminded resident this was a no smoking facility and his (family member) did not think he was safe to independently leave the facility." A comprehensive review of Resident #57's medical record revealed no safe smoking assessment had been completed. An interview was conducted on 3/21/18 at 10:30 AM with Resident #57. He stated, "I used to smoke on my own at (assisted living facility), but that place closed down so I had to come here. I didn't have any problems until I came here. I don't want to cause no trouble-I just want to smoke." An interview was conducted with the Social Worker on 3/21/18 at 10:35 AM. She stated Resident #57 was considered cognitively intact as of 2/7/18. She also stated he was a smoker at admission, but his family had not wanted him to smoke. An interview was conducted on 3/21/18 at 12:15 PM with Nurse #2. She stated a smoking assessment was supposed to be done with the rest of the admission assessments for every smoker when they were admitted. She also stated she was not able to locate a smoking assessment for Resident #57.	F 636	does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tower Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding The process which led to this deficiency was determined to be that the nursing department failed to conduct a smoking evaluation on admission for Resident #57. On 3/21/18, a smoking evaluation was completed by Nursing Supervisor for Resident #57. On 4/5/18, a 100% audit of all residents who desire to smoke to include Resident #57 was completed by Administrator and DON to ensure a smoking evaluation was completed for all residents who desire to smoke upon admission, readmission, and/or with a significant change. Any areas of concern were immediately addressed by (Administrator and DON) to include additional staff training. On 4/5/18, an in-service was started by DON and SF for 100% of licensed nurses on completing a smoking evaluation for all residents who desire to smoke upon admission, readmission, and/or with a significant change. This in-service will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 636	Continued From page 17 An interview was conducted on 3/21/18 at 2:20 PM with the Administrator. She stated a smoking assessment should be done as soon as possible after admission. She stated if a resident was a known smoker at admission a smoking assessment should be completed with the rest of the admission assessments. If a resident tried to go outside staff asked why. If the answer was to smoke the staff checked the smoking assessment. If a family's wishes differed from the resident the facility followed the resident's wishes.	F 636	completed by 4/16/18. All newly hired licensed nurses to include agency will be in-serviced by SF during orientation on completing a smoking evaluation for all residents who desire to smoke upon admission, readmission, and/or with a significant change. On 4/5/18, the Minimum Data Set (MDS) Coordinator was in-serviced by DON regarding all residents who desire to smoke to ensure a smoking evaluation is completed upon admission, readmission, and/or with a significant change. 100% of all residents who desire to smoke to include Resident #57 will be reviewed by Nursing Supervisor utilizing a Resident Smoking Evaluation Audit tool weekly for 8 weeks, then monthly for 1 month to ensure a smoking evaluation has been completed upon admission, readmission, and/or with a significant change. Any areas of concern identified during the audit will be immediately addressed by the (SF) to include additional staff training. The Director of Nursing (DON) will review and initial the Resident Smoking Evaluation Audit tool for accuracy and completion weekly for 8 weeks, then monthly for 1 month. The administrator present the findings of the Resident Smoking Evaluation audit tools to the Executive Quality Improvement (QI) committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 636	Continued From page 18	F 636	include continued frequency of monitoring.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code an admission Minimum Data Set (MDS) correctly to reflect a resident (Resident #26) had been evaluated by Level II Preadmission Screening and Resident Review (PASARR) , and failed to code a resident for dialysis on a quarterly MDS assessment (Resident #22), for 2 of 23 MDS assessments reviewed. Findings included: 1. Resident #26 was admitted to the facility on 1/2/18. His active diagnoses included anxiety disorder, depression, psychotic disorder, schizophrenia, and post-traumatic stress disorder. Review of Resident #26 ' s PASRR screen dated 12/28/17 revealed the resident had been determined to be to be a PASRR Level II with an expiration date of 12/27/18. Review of Resident #26 ' s admission MDS dated 1/9/18 revealed the resident had not been evaluated by Level II PASARR to determine if he had serious mental illness.	F 641	F 641 Disclaimer Tower Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Tower Nursing and Rehabilitation□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tower Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding The process which led to this deficiency	4/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 641	Continued From page 19 During an interview on 3/21/18 at 10:32 AM the MDS Coordinator stated Resident #26 was a PASARR Level II resident. He further stated the admission MDS assessment for Resident #26 dated 1/9/18 was incorrect regarding Resident #26's PASARR status. He indicated a staff member who no longer worked at the facility had completed Resident #26's admission MDS dated 1/9/18. The interview further revealed it was his expectation the MDS be coded correctly and it was not. During an interview on 3/21/18 at 10:43 AM the Director of Nursing stated Resident #26 was a PASARR Level II resident. She further stated it was her expectation the admission MDS dated 1/9/18 accurately reflect this and it had not. 2. Resident #22 was admitted to the facility on 6/29/17. Her active diagnoses included end stage renal disease. Review of Resident #22 ' s orders for 1/1/18 through 1/31/18 revealed the resident was ordered to have dialysis on Tuesdays, Thursdays, and Saturdays. Review of Resident #22 ' s quarterly MDS dated 1/6/18 revealed the resident was coded as not receiving dialysis treatment. During an interview on 3/21/18 at 10:32 AM the MDS Coordinator stated Resident #22 received dialysis during the 7 day look-back period for the quarterly MDS assessment completed on 1/6/18. He indicated a prior staff member, who no longer worked at the facility, had completed Resident #22's quarterly MDS assessment dated 1/6/18. The interview further revealed the quarterly MDS	F 641	was determined to be the Minimum Data Set (MDS) Coordinator failed to accurately code Resident #26 to reflect evaluation by Level II Preadmission Screening and Resident Review (PASRR) on the admission assessment. Additionally, the MDS Coordinator failed to accurately code Resident #22 for receiving dialysis on the quarterly MDS assessment. On 3/21/18, the MDS Nurse modified the MDS assessment to reflect accurate coding that Resident #26 was evaluated by Level II PASARR. On 3/21/18, the MDS Nurse modified the MDS assessment to reflect accurate coding that Resident #22 received dialysis. On 4/6/18, the MDS Coordinator was in-serviced by MDS Consultant on accurately coding MDS assessments as indicated by the Resident Assessment Instrument (RAI) manual with emphasis that all MDS assessments are coded accurately to include all PASRR Level II residents and residents receiving dialysis. All newly hired MDS nurses and MDS Coordinators will be in-serviced by the MDS Consultant during orientation on accurately coding MDS assessments as indicated by the Resident Assessment Instrument (RAI) manual with emphasis that all MDS assessments are coded accurately to include all PASRR Level II residents and residents receiving dialysis. On 4/6/18, a 100% audit was initiated by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 641	Continued From page 20 dated 1/6/18 was incorrect and should have reflected the fact Resident #22 received dialysis at that time. During an interview on 3/21/18 at 10:43 AM the Director of Nursing stated Resident #22 received dialysis care. She further stated it was her expectation the quarterly MDS dated 1/6/18 accurately reflect this and it had not.	F 641	the Director of Nursing (DON) of all residents current MDS assessments to ensure all residents are coded accurately and will be completed by 4/16/18. This audit will also ensure MDS assessments are coded accurately to reflect PASRR level II residents, including Resident #26 and residents receiving dialysis, including Resident #22. Any areas of concern identified during the audit will be immediately addressed by Administrator and MDS Consultant to include additional staff training. 10% of MDS assessments will be reviewed by DON weekly for 8 weeks, then monthly for 1 month, utilizing the MDS Assessment Audit tool to ensure all residents are coded accurately on the MDS assessment. This includes all residents who have been evaluated for Level II PASARR to include Resident #26, and all residents receiving dialysis treatments to include Resident #22. Any areas of identified concern will be immediately addressed by Administrator and MDS Consultant to include additional staff training and corrections to the MDS assessment if applicable. The Director of Nursing will review and initial the MDS Assessment Audit tool weekly for 8 weeks, then monthly for 1 month. The administrator will present the findings of the MDS Assessment Audit tool to the Executive Quality Improvement (QI) committee monthly for 3 months. Any issues, concerns, and/or trends identified	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 641	Continued From page 21	F 641	will be addressed by implementing changes as necessary, to include continued frequency of monitoring.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676		4/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 676	Continued From page 22 §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews and record review the facility failed to provide restorative ambulation as ordered for 1 (Resident #52) of 1 residents reviewed for restorative services. The findings included: Resident #52 was admitted to the facility on 5/01/17 with diagnoses which included cerebral infarct, flaccid hemiplegia, aphasia, intracerebral hemorrhage, heart failure and difficulty walking. A review of the quarterly Minimum Data Set (MDS) dated 2/1/18 revealed the resident was severely cognitively impaired and required extensive assistance with bed mobility, transfers and walking in the room. He was not steady moving from sitting to standing, walking, turning around or surface to surface transfers but was able to stabilize with staff assistance. He had functional limitations on one side of both upper and lower extremities. He had not received therapy or restorative nursing, including walking, during the look back period. A record review revealed Resident #52's care plan was updated 2/26/18 to include that he required assistance to restore or maintain maximum function of self-sufficiency for mobility characterized by position and locomotion/ambulation related to: at risk for decline in ability to ambulate, right sided hemiplegia. The goal was listed as resident will maintain ability to ambulate 75-100 feet using a	F 676	F 676 Disclaimer Tower Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Tower Nursing and Rehabilitation□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tower Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The process which led to this deficiency was determined to be the nursing department failed to provide restorative ambulation to Resident #52 due to not effectively communicating therapy referrals to the restorative program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 676	Continued From page 23 hemi-walker in hallways. A record review of the physician orders revealed an order dated 9/20/17 for "PT (physical therapy) eval. (evaluate) and tx (treatment) for purposes of implementing a restorative program as indicated." A Rehab (rehabilitation) Communication to Nursing form dated 9/26/17 revealed Resident #52 was to begin restorative services on 9/29/17 for his current functional status of CGA (contact guard assistance) for bed to wheelchair, follow using gait belt. Ambulation using a hemi-walker, CGA, close w/c (wheelchair) follow for 150-200 feet X (times) 2 in hallways. The short term goal was to maintain ambulation at level of function. The frequency and duration of the program was listed as 5-6 times per week for 90 days (12/27/17). During an interview on 3/19/18 at 3:44 PM Resident #52's family member stated he was not getting restorative walking as he was supposed to. She stated her concerns were discussed during a care plan meeting. She reported after the concern was discussed the walking improved for a few weeks then would stop again until she discussed the concern again. She stated he had not walked with restorative today and she could not remember when the last time was. She added that she visited daily but was told she could not assist with walking Resident #52. During the survey, the resident was not observed walking with restorative nursing on 3/19/18, 3/20/18 or 3/21/18. The MDS Coordinator was interviewed on 3/20/18 at 4:05 PM. He stated he just started	F 676	Additionally, the nursing department failed to consistently provide adequate staff to complete the restorative program tasks, to include ambulation for Resident #52. On 4/6/18, a 100% audit of all therapy to nursing communication forms for the past 60 days was started by DON and Restorative Nurse to ensure all residents with restorative program referrals including Resident #52 for restorative ambulation, have a care plan in place to receive restorative services. The audit will also ensure all residents with a care plan in place to receive restorative services have been added to the restorative caseload to be communicated with restorative aides (RAs) and licensed nurses. This audit will be completed by 04/16/18 by DON and Restorative Nurse. Any identified areas of concern will be immediately addressed by DON and Restorative Nurse by submitting a therapy evaluation on the involved resident(s) to determine if the restorative program remains appropriate. The Minimum Data Set (MDS) Coordinator will receive all therapy to nursing communication forms and update all care plans to reflect residents who receive restorative services and will also provide an updated list of residents on the restorative caseload for the RAs and licensed nurses. This will be completed by 4/16/18 by the MDS Coordinator. On 4/6/18, a 100% audit of restorative documentation was started by Restorative Nurse including Resident #52 for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 676	Continued From page 24 coordinating restorative services in the last 2 weeks. He stated he received a Rehab. to Nursing Communication form and it was his responsibility to make sure the restorative aids carry out the appropriate therapies. He added that he maintained a computerized spreadsheet to keep a running list of the residents who received restorative therapy. On 3/21/18 at 2:08 PM Restorative Aid (RA) #1 stated she had not worked in restorative since Wednesday of last week (3/14/18). She sated the computer system contained the information about which residents needed to be seen and what exercises they required. She demonstrated in the computer system that Resident #52 was to receive restorative ambulation with a hemi-walker with CGA followed by w/c for 75-100 feet times 2 with escalation to 150-200 feet times 2. She stated sometimes Resident #52 does not walk the whole distance so she let him rest and then let him start again. She added if she was pulled from restorative to do nursing assistant duties the other restorative aid would complete the tasks and if both were pulled then she was not aware of anyone who would complete the restorative tasks. On 3/21/18 at 2:49 PM RA #2 stated if he was the only RA working he had to prioritize his schedule so that he did the weekly and monthly weights, then he worked with residents who required a brace to ensure all the braces were in place. He would then tried to complete the other restorative task listed for residents. He stated the list of residents to be seen was obtained from the MDS Coordinator. He said they found out Resident #52 was not on the list for restorative and now with the new MDS Coordinator he was added.	F 676	ambulation, to ensure residents care planned to receive restorative services have documentation in place for the past 7 days indicating the task was completed. The audit will be completed by Restorative Nurse by 4/16/18. Any identified areas of concern will be immediately addressed by the DON and Restorative Nurse to include staff training. On 4/6/18, a 100% audit of all staffing patterns and assignments for the past 7 days was reviewed by Administrator to ensure adequate staff trained in restorative care were provided daily for residents on restorative caseload to include Resident #52 for ambulation. Any areas of identified concern will be immediately addressed by DON to include staff training. On 4/6/18, a 100% in-service for all licensed nurses was started by DON to ensure residents on restorative caseload receive restorative services as indicated on the care plan, as evidenced by documentation in the electronic medical record. The in-service will be completed by DON and SF by 4/16/18. All newly hired and agency licensed nurses will receive the in-service provided by SF during orientation to ensure residents on restorative caseload receive restorative services as indicated on the care plan, as evidenced by documentation in the electronic medical record. On 4/5/18, the administrator and Director of Nursing were educated by the facility nurse consultant on providing adequate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 676	Continued From page 25 He said he remembered he was trained to provide restorative for Resident #52 but because his name was not on the list he had not received restorative therapy and was just recently added back to the list to receive restorative therapy. During an additional interview with the MDS Coordinator on 3/22/18 at 10:34 AM, he provided the documentation of the days Resident #52 received restorative therapy. A review of the documentation revealed during the week of 3/12/18 - 3/18/18 Resident #52 only received restorative therapy for 4 days not the prescribed 5-6 days. The resident had not received restorative therapy as originally ordered in September 2017 and that was the reason he now maintained the computerized spreadsheet. During an interview on 3/22/18 at 10:53 AM the Rehabilitation Program Director (RPD) stated once a resident reached the goals or plateaued with therapy they were discontinued from the ordered therapy and referred to restorative nursing for therapy. He added that the restorative orders were based on the progress of the resident prior to discharge and the plan for discharge from the facility. The Administrator and Director of Nursing (DON) were interviewed on 3/22/18 at 1:05 PM. The MDS Coordinator was on the telephone answering questions. The DON reported they had identified that Resident #52 had not received restorative therapy as ordered in September when he was evaluated by physical therapy and orders were received to begin a restorative walking program but, at that time, the resident was not on the list to be seen so he had not received restorative therapy as prescribed. She	F 676	staff trained in restorative care to provide daily restorative services for residents on restorative caseload and ensuring the therapy to nursing communication forms are followed correctly. 10% of all therapy to nursing communication forms will be reviewed weekly for 8 weeks, then monthly for 1 month by Restorative Nurse utilizing a Therapy to Nursing Communication Audit tool to ensure all residents with restorative program referrals including Resident #52 for restorative ambulation, have a care plan in place to receive restorative services and are added to the restorative caseload. Any areas of identified concern will be immediately addressed by the Restorative Nurse and DON to include staff retraining. The DON will review and initial the Therapy to Nursing Communication Audit tool for accuracy and completion weekly for 8 weeks, then monthly for 1 month. 10% audit of residents on restorative caseload to include Resident #52 on ambulation, will be reviewed by Restorative Nurse by utilizing a Restorative Caseload audit tool to ensure restorative services have been provided as evidenced by documentation in the electronic health record, weekly for 8 weeks, then monthly for 1 month. The DON will review and initial the Restorative Caseload Audit tool for accuracy and completion weekly for 8 weeks, then monthly for 1 month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER NURSING AND REHABILITATION CENTER	3609 BOND STREET RALEIGH, NC 27604

(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 676	Continued From page 26 said, when the concern was identified, they had a meeting on 2/21/18 to determine which residents needed to be reevaluated and picked up for restorative. The list was sent via email to the RPD. The Administrator stated they were trying to get the problem straightened out but had not been able to accomplish that yet. The DON reported they determined the communication form from therapy to restorative nursing was not being relayed correctly. She added the RAs were educated on how to provide the restorative therapy but the resident was not on the list so he had not received restorative and no one was maintaining the list. She added there were 2 RAs who were pulled to do staffing and the restorative therapy was not completed.	F 676	10% audit of all staffing assignments and staffing patterns by Administrator to ensure adequate staff trained in restorative care were provided daily for residents on restorative caseload to include Resident #52 for ambulation by utilizing a Staffing Audit tool weekly for 8 weeks, then monthly for 1 month. The DON will review and initial the Staffing Audit tool for accuracy and completion weekly for 8 weeks, then monthly for 1 month. The Administrator and/or DON will review and present the findings of the audit tools to the Executive Quality Improvement (QI) committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.	