STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 04/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(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=G	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		5/9/18

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

Electronically Signed | 05/07/2018

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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 medical record review, staff and resident interviews it was determined that facility staff failed to treat 1 of 1 sampled resident's with dignity while providing care; talking down to the resident and snatching pillow from under the residents head (Resident #16). Findings included: Resident # 16 was admitted to the facility on 3/29/18 with diagnosis including acute cerebral vascular accident, urinary retention, anxiety and hypertension. Review of the Minimum Data Set Assessment (MDS) revealed that the resident scored 13 on the brief interview of mental indicating that the resident had good memory. The resident did not have disorganized thinking or altered level of consciousness. The resident was not exhibiting behavioral symptoms per the MDS. The resident was coded as requiring extensive two person assistance for bed mobility, transfer and toilet use. He was coded as requiring extensive one person assistance for eating, dressing and personal hygiene. Interview with the resident's family member on 4/14/18 at 1:10 PM revealed that she had video evidence of Resident #16 being abused. She stated the resident told her that staff threw him in the bed, they talked down to him and that they treated him horrible at the facility. She reported installing a recording device because she thought the resident was exaggerating his treatment. She said that one night she came in and the resident's television was on full blast, his phone was across the room and his call bell was	F 550	F 550 Root cause analysis: Based on root cause analysis by the facility administrative staff and facility executive director the facility determined that an individual staff member acted independently outside of the facility directive and expectation for treating residents with Dignity and Respect. Despite training and ongoing education by the facility, the individual staff member did not speak to or provide care for Resident #16 in a respectful manner. Immediate Action On 4/14/18, when learning of the allegation of inappropriate conduct by a C.N.A (Certified Nursing Assistant) and Nurse #4, the facility initiated an investigation. The staff members were suspended pending the completion of the investigation. The facility conducted the investigation according to the abuse policy. At the conclusion of the investigation the facility implemented disciplinary action as appropriate, C.N.A and Nurse #4 are no longer working in the facility. The Social Services Director visited Resident #16 to allow opportunity to express thoughts regarding the incident and over other appropriate services if needed. Identification of Others:	

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F 550	Continued From page 2 dropped over the night staff. Both items were out of the resident's reach. She stated that the resident is able to use the telephone and the call bell. She reported that there was no need for the television to be on full blast and she had spoken to staff about it. During interview with the resident at 1:54 PM on 4/14/17 he stated that the staff are mean all the time; mostly at night. He said, "One girl picks me up and flips me around like I'm a rag doll." He reported staff used the lift to get him up sometimes. He said one girl told him he needed a longer leash. Review of a video recorded on 4/9/18 during 3rd shift (am of the 10th) at 3:00 on 4/14/18 revealed a staff member enter the resident's room during 3rd shift and state "aww you stink." Another staff member entered the room and appeared to be cleaning the resident up while he lay on the floor. Neither resident #16 nor the floor could be seen from the camera angle. Another staff member entered the room and the resident was placed on the bed by the 3 staff. One staff exited the room while two remained in the room. The NA (later identified); then dropped the resident's legs onto the bed. The same nursing assistant was then observed snatching the pillow from underneath the resident's head without informing the resident of what she was doing. Review of the recording revealed the NA stating, "How old are you? U should be enjoying your retirement; pooping on yourself-shame on u." The nurse #4 was observed in the room at this time giving the resident a tube feeding. Per the video it appeared she Nurse #4 responded, "1" when the NA asked Resident #16 how old he was. Interview with NA at 1:31 PM on 4/15/18 revealed	F 550	On 4/14/18 the Social Services Director interviewed all alert oriented residents who were assigned to the care of the identified staff members to ensure there were no other concerns related to care and treatment. A skin check was completed for those residents who were unable to answer to ensure there were no signs of injury indicating mistreatment. This was completed on 4/23/18 by the DON, ADON, and/or Unit Manager. No other residents were identified to have concerns related to their care provided by the identified individuals. Systemic Changes 100% Staff education was provided by the DON (Director of Nursing), ADON (Assistant Director of Nursing) and Department Managers regarding Resident Rights. Included in the discussion was resident treatment and handling and speaking to residents with respect and dignity and was completed on 5/7/18. Any staff not receiving this education on or before 5/7/18 will be required to have training prior to working their next shift. Beginning 5/7/18 DON, ADON and RN Supervisor will conduct 1-2 unannounced visits/rounds in the facility after hours to monitor staff interaction with residents and ensure that residents are being treated with dignity and respect. Beginning 5/7/18 the facility Department Managers will conduct Ambassador Rounds daily Monday-Friday. During the rounds the Department Managers will ask residents if they have any concerns with treatment and will document on the	

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F 550	Continued From page 3 that she found Resident #16 on the floor and reported it to the nurse. She stated that she asked the resident if he was ok and told him to wait a minute. She stated the resident was lying on the mat. He had taken off his brief and had bowel movement all over. She said she asked him if he could stay in bed so he wouldn't fall again when she was in the room. The nursing assistant denied telling the resident that he should be ashamed of himself. She stated that maybe she asked him how old he was because he tried to touch her. The NA said that the resident did not ring his bell to go to the bathroom. She said she gave him the call bell but he tried to rip it from the wall. She did not want him to get hurt so she put it to the other side and moved the table because he kept reaching for the phone. She stated that she did not want him to get hurt reaching because them he goes to the floor. During interview on 04/15/18 at approximately 5:20 PM with Resident #16 he stated he felt like "hell" on the day when the Nursing assistant and nurses got him up off the floor and back into bed. Stated he did not like the way he was treated and talked to, that he felt very depressed about it. Stated he does not care what happens to him anymore. Interview via telephone on 4/15/18 at 2:45 PM with nurse #4 who was present on 3rd shift revealed that the NA (nursing assistant) reported that when she went to change Resident #16 he put his feet off the bed. The NA said she saw him roll off the bed. Nurse #4 stated she went to the room but did not go inside immediately because she needed help to get him up. The nurse stated that she, another nurse and the NA went into the	F 550	ambassador rounds sheet. Any identified concerns will be discussed during Morning Managers Meeting and followed up as appropriate. The Weekend Supervisor and/or Manager on Duty will make rounds throughout the facility on Saturday-Sunday and will respond to any resident concerns identified related to treatment. Monitoring The DON, ADON and RN Supervisor will continue to make unannounced off hour visits to the facility 1-2 times weekly. Weekly off hour visits will continue for 3 months or until a pattern of compliance is achieved. The DON will review the results from all visits and will summarize monthly. The summary will include any identified concerns and trends. This summary will be presented to the QAPI committee monthly for recommendation or modification as needed. This monitoring will continue monthly for three months or until a pattern of compliance is achieved.	

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F 550	Continued From page 4 room where the resident was lying on the mat. She reported that she did not see any injuries. She said that the Resident was very heavy, so they lifted him up. She stated she thought they were gentle enough with him. NA stated, "You keep falling and it is hurting our backs." She said she could not remember the details about the conversation. NA said "you are breaking our backs." The nurse said she did remember NA saying "shame on you for pooping on yourself." She said the resident would say some things. The nurse stated she talked to the nursing assistant and told her not to go overboard with what she was saying to him. Nurse #4 said she also remembered someone saying " ...aww you stink!" During interview with the social worker at 4:25 PM on 4/14/18 she reported that she, the rehabilitation manager and the resident's family member had a care plan meeting in 4/12/18. She said that she asked about concerns at the end of the meeting. Resident #16's family member said that the resident complained about staff being rude on 3rd shift. The social worker wrote the concerns up on a grievance form. Per review of the grievance form dated 4/12/18; the concern was addressed in the interdisciplinary team meeting on 4/12/18. Social worker planned to follow up with the resident's family member on Monday 4/17/18.	F 550		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		5/9/18

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F 580	Continued From page 5 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580		

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F 580	Continued From page 6 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on medical record review, staff, family and resident interviews it was determined that facility staff failed to notify the physician and family of a fall for 1 of 2 sampled residents (#16) with falls. Findings included: Resident # 16 was admitted to the facility on 3/29/18 with diagnosis including acute cerebral vascular accident, urinary retention, anxiety and hypertension. Review of the Minimum Data Set Assessment (MDS) revealed that the resident scored 13 on the brief interview of mental indicating that the resident had good memory. The resident did not have disorganized thinking or altered level of consciousness. The resident was not exhibiting behavioral symptoms per the MDS. The resident was coded as requiring extensive two person assistance for bed mobility, transfer and toilet use. He was coded as requiring extensive one person assistance for eating, dressing and personal hygiene. Review of the medical record 4/14/18 revealed a nursing note (Nurse #4)4/11/18 4:51 am which stated, "4/10/18 at 7:45 PM patient noted to be hanging almost off the bed. Patient assisted back to bed 8:10 PM. One of the (family) members alerted this nurse that he had observed patient using his bed control to high position and was almost sliding off the bed. Patient observed way up hanging the bed. Patient continue to hang off the bed, restless throughout the night. Unable to redirect. Will continue to monitor." Therapy note 4/11/18 1:22 PM stated, "Patient	F 580	F 580 Root Cause Analysis Based on root cause analysis by the facility administrative staff and facility executive director Nurse #4 did not follow policy and procedure for reporting of an incident. By completing the appropriate documentation Nurse #4 would have been prompted to notify the physician and the family of a fall. Immediate Action On 4/14/18, once notified of the fall on 4/10/18 for Resident #16, the DON completed the appropriated documentation which included notification of the Physician and Family. Resident #16 was assessed on 4/15/18 by the RN supervisor to ensure no significant injury was noted. Identification of others On 5/4/18 an audit was completed for the period of 4/1/18 to 4/30/18 of 100% current residents□ nurses□ notes and incident reports to determine if there were other residents who experienced a fall that was not reported to the physician or family. No other concerns were identified with the appropriate notification of the physician or family.	

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F 580	Continued From page 7 reports recent fall, but unclear about details and number of falls." Interview with the resident's family member on 4/14/18 at 1:10 PM revealed that the resident was telling her every time he had a fall. She stated that he had goose egg on his head. She said that she had not been notified by the facility that Resident #16 had any falls. She stated that the rehabilitation manager and the social worker admitted that the resident had 6 falls during a care plan meeting. Review of a video recorded on 4/9/18 during 3rd shift (am of the 10th) at 3:00 on 4/14/18 revealed a shot of the resident's unoccupied bed. Staff was seen entering the room and talking to someone below the bed on the other side. A staff member entered the room and appeared to be cleaning the resident up while he lay on the floor. Neither resident #16 nor the floor could be seen from the camera angle. Interview with the administrator at 3:53 PM on 4/14/18 revealed that if a resident has a fall the nurse will assess for injury, the MD and family are notified and the incident is available for review in clinical rounds. Falls are investigated as needed. During interview with the social worker at 4:25 PM on 4/14/18 she reported that she, the rehabilitation manager and the resident's family member had a care plan meeting in 4/12/18. She said that she asked about concerns at the end of the meeting. Resident #16's family member said that the resident complained about staff being rude on 3rd shift. The social worker wrote the concerns up on a grievance form. Per review of the grievance form dated 4/12/18; the concern was addressed in the interdisciplinary team meeting on 4/12/18. The attachment to the grievance form stated 4/1/18 (fall). Social worker planned to follow up with the resident's family	F 580	Systemic changes Education was provided by the DON/ADON regarding the requirement for notification of the physician and resident representative of any significant change in status, including incidents/falls. This education was completed on 5/4/18 for all licensed nurses. Any nurse not receiving this information on or before 5/4/18 will be educated prior to working their next shift. Beginning 5/7/18, falls will be reviewed daily Monday-Friday during IDT clinical rounds for notification of the physician and the resident representative. This review will be completed by the DON, ADON and/or supervisor. Weekend Supervisor will review falls on Saturday and Sunday to ensure that the physician and the resident representative have been notified. Monitoring Beginning 5/7/18 the DON will monitor fall incidents Monday-Friday for physician and family notification. This monitoring will be documented on the Notification of Falls monitoring tool and maintained by the DON. Monitoring will continue daily Monday-Friday 3 months or until a pattern of compliance is achieved. The DON will summarize the results of this monitoring and present to the QAPI committee monthly for three months or until a pattern of compliance is achieved. The QAPI committee will make recommendations and modifications to this plan as necessary.	

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F 580	Continued From page 8 member on Monday 4/17/18. During interview with the rehabilitation manager on 4/15/18 at 2:20 PM, he stated that he did not remember the family member saying anything about falls during the care plan meeting. He reported that the falls log indicated that the resident had 2 falls per the incident log, one fall occurred on April 1st. Interview with a nursing assistant on 4/15/18 at 1:31 PM revealed that she found the Resident #16 on the floor and reported it to the nurse. She stated they tried to transfer him to bed because the lift could not go down to the floor. They got a 3rd person to help because it was so hard and it was killing their back. The NA said she did not report the fall to the nurse because the nurse was there. Interview via telephone on 4/15/18 at 2:45 PM with Nurse #4 who was present on 3rd shift revealed that the NA (nursing assistant) reported to her that when she went to change Resident #16 he put his feet off the bed. The NA said she saw him roll off the bed. Nurse#4 stated she went to the room but did not go inside immediately because she needed help to get him up. Nurse #4 stated that she, another nurse and the NA #1 went into the room the resident was laying on the mat. She reported that she did not see any injuries. She said that the Resident was very heavy, so they lifted him up. She further stated that the night he fell it was documented. Put in electronic chart under notes. Review of facility records revealed no documentation of the incident. There was no indication that the family or the resident's physician had been notified of the fall.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4)	F 585		5/17/18

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§483.10(j) Grievances.
§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for

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completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

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F 585	Continued From page 11 taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews the facility failed to record a grievance and failed to provide a written grievance summary for 1 of 3 residents (Resident #8) reviewed for grievances. Findings included: Resident #8 was admitted on 3/14/18 with diagnoses which included obesity, recent lower limb amputation and cellulitis. The admission Minimum Data Set (MDS), dated 3/27/18, indicated the resident was cognitively intact and had no behaviors. It also revealed a functional limitation of one lower limb. Resident #8's clinical record was reviewed and revealed the following entries in the Departmental Notes: A Therapy note dated 3/26/18 included, "Pt (Patient) reported that his W/C (wheelchair) is too small" The note was signed by Physical Therapy	F 585	F 585 Root Cause Analysis Based on root cause analysis by the facility administrative staff and facility executive director that staff did not clearly understand the grievance process and therefore did not carry out the facility grievance policy as intended. Immediate Resident #8 was discharged home on 4/18/18. Prior to discharge efforts were made to ensure resolution to Resident #8 concerns regarding the wheelchair. At the time of discharge the resident had been measured for a wheelchair and the medical equipment for home use was ordered. Identification of others On 5/7/18 the Executive Director (ED) completed a review of all grievances for the last 3 months to validate that there	

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F 585	Continued From page 12 Assistant (PTA) #1. A Therapy note dated 3/28/18 included, "Pt continues to report that he is not happy at this facility, and that we did not have the equipment required for proper rehab - Pt declined participation - [Rehab Director] and supervising OTR (Occupational Therapist) notified." The note was signed by Certified Occupational Therapy Assistant (COTA) #1. A Therapy note dated 3/31/18 included, "Pt was seated to the R-side (right side) of WC leaving 3-4 inch gap on L-side (left side) making complaint that his WC was inappropriately sized, and declining position change." The note was signed by Occupational Therapist (OT) #1. A Therapy note dated 4/5/18 included, "Pt stated wc (wheelchair) is too small for him and that he has spoken with the [Rehab Director] and other therapist [regarding] this issue. [Rehab Director] is aware of complaints." The note was signed by COTA #1. A Therapy note dated 4/5/18 included, "Patient refused therapy stating his w/c wasn't big enough. Stated he requested a mobile w/c for home." The note was signed by PTA #2. A Therapy note dated 4/6/18 included, "Patient refused therapy claiming that wheelchair is too small and that is rubbing against his thighs." The note also indicated the writer had asked the wound nurse, who said the resident had never complained to her about any irritation to the thigh area. The note was signed by Occupational Therapist #2.	F 585	was resolution. Any grievances noted without satisfactory resolutions were revisited to ensure that residents' concerns were addressed. Systemic Changes Education was provided to Department Managers by the Regional Clinical Consultant on 5/17/18 regarding the grievance policy. This education included expectations for documenting grievances and timely response and resolution. In addition, once resolved, a written summary of the grievance and resolution will be provided to the resident and/or resident representative. Education was provided to 100% of facility staff regarding the Grievance Policy. This education emphasized that anyone can complete a grievance, staff can complete a grievance on behave of a resident. Also communicated during this education is the expectation that residents' concerns are reported promptly and that the resident/representative will be provided a written summary of the actions taken. Education was completed by the ED and Department Managers on 5/17/18. As of 5/1/18 Grievance forms have been placed in various stations in the facility, accessible to families, residents and staff. The forms are on brightly colored paper to improve visibility and there is a locked box in the front lobby for depositing the grievance if desired. On 5/11/18, the facility ED mailed a letter to all current family members reviewing the grievance policy and expressing the goal of the facility to work in conjunction	

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F 585	Continued From page 13 On 4/14/18 at 10:38 AM, the Administrator provided one grievance filed on behalf of Resident #8. The single grievance was dated 3/18/18 and indicated the resident had expressed concern regarding the portion sizes on his meal trays. The grievance was addressed by the dietary manager on 3/20/18 and the response was that the resident would receive double portions. There were no grievances regarding the size of Resident #8's wheelchair. The Administrator confirmed there were no other grievances from Resident #8. On 4/14/18 at 11:11 AM, Occupational Therapist #1 was interviewed about why she had not filed a grievance on behalf of Resident #8 when he complained about the size of his wheelchair. OT #1 said the resident only complained to her about the chair on that one occasion. On 4/14/18 at 3:03 PM, the Rehab Manager indicated he was aware that Resident #8 believed the wheelchair was too small and said, "He (Resident #8) told at least 3 therapists about the chair." The Rehab Manager said he had also spoken to the resident about the size of the wheelchair, but at the time the Rehab Manager thought it was the correct size wheelchair for Resident #8. When asked if he or his staff had completed a grievance form on Resident #8's behalf, the Rehab Manager said, "I did not think of doing one or suggesting my staff complete a grievance. Looking back, I should have." The Rehab Manager added that the resident had the largest chair available from the supplier but a custom wheelchair was in process and Resident #8 should have been made aware. During an interview on 4/14/18 at 4:00 PM,	F 585	with the resident and family to ensure a positive experience. Beginning 5/7/18 the facility Department Managers will conduct Ambassador Rounds daily Monday-Friday. During the rounds the Department Managers will ask residents if they have any concerns will document on the ambassador rounds sheet. Any identified concerns will be discussed during Morning Managers Meeting and followed up as appropriate, a grievance form will be offered to the resident or the Manager will assist in completing when appropriate. The Weekend Supervisor and/or Manager on Duty will make rounds throughout the facility on Saturday-Sunday and will respond to any resident concerns identified and will assist as needed in completing a grievance form. Monitoring Beginning 5/7/18 the ED will maintain a copy of each grievance in a binder in the ED office, the designated Department Manager will respond to a grievance on the original form promptly and return the original form to the ED for filing. The ED will review the grievance to ensure that there has been appropriate resolution and notification to resident/representative. Once the ED validates the grievance has been resolved the copy will be removed from the binder and the completed original form will be placed in the binder.	

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F 585	Continued From page 14 Physical Therapy Assistant #1 stated she had never seen Resident #8 in the wheelchair but to her knowledge the resident had been measured and he fit the wheelchair. PTA #1 said she did not fill out a grievance form because the Physical Therapy Department was already aware Resident #8 was not happy with the wheelchair the facility was able to provide. COTA #1 was interviewed on 4/14/18 at 5:30 PM. COTA #1 was aware of the Grievance Policy and indicated she knew the policy said staff could complete a Grievance form on a resident's behalf. COTA #1 said she had not completed a form for Resident #8 but, "I certainly brought it to my supervisor's and Rehab Manager's attention and thought that was enough." Occupational Therapist #2 and PTA #2 were not able to be interviewed. An interview was conducted with the Administrator on 4/15/18 /18 at 4:19 PM. The Administrator stated she had not been aware the resident was unhappy about his wheelchair. She also stated it was her expectation that resident complaints would be documented by staff on the Grievance/Complaint form. Part of the facility's grievance process, would be to provide the complainant with information regarding resolution.	F 585		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600		5/16/18

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F 600	Continued From page 15 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interviews it was determined that facility staff spoke to 1 of 1 sampled resident's in a verbally abusive manner (Resident #16). Findings included: Resident # 16 was admitted to the facility on 3/29/18 with diagnosis including acute cerebral vascular accident, urinary retention, anxiety and hypertension. Review of the Minimum Data Set Assessment (MDS) revealed that the resident scored 13 on the brief interview of mental indicating that the resident had good memory. The resident did not have disorganized thinking or altered level of consciousness. The resident was not exhibiting behavioral symptoms per the MDS. The resident was coded as requiring extensive two person assistance for bed mobility, transfer and toilet use. He was coded as requiring extensive one person assistance for eating, dressing and personal hygiene. Interview with the resident's family member on 4/14/18 at 1:10 PM revealed that she had video evidence of Resident #16 being abused. She stated the resident told her that staff threw him in the bed, they talked down to him and that they	F 600	F 600 Root cause analysis: Based on root cause analysis by the facility administrative staff and facility executive director the facility determined that an individual staff member acted independently outside of the facility directive and expectation regarding treatment of residents. Despite training and ongoing education by the facility, the individual staff member did not speak to or provide care for Resident #16 in an appropriate manner. The tone and comments made by the staff member were verbal abuse. Immediate Action On 4/14/18, when learning of the allegation of inappropriate conduct/verbal abuse by a C.N.A (Certified Nursing Assistant) and Nurse #4, the facility initiated an investigation. The staff members were suspended pending the completion of the investigation. The facility conducted the investigation according to the abuse policy. At the conclusion of the investigation the facility	

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F 600	Continued From page 16 treated him horrible at the facility. She reported installing a recording device because she thought the resident was exaggerating his treatment. The resident's family member stated that on her recording she saw a staff member enter the resident's room on 3rd shift; look at the resident then leave. She reported that no one returned to the room for 12-15 minutes. During interview with the resident at 1:54 PM on 4/14/17 he stated that the staff are mean all the time; mostly at night. He said, "One girl picks me up and flips me around like I'm a rag doll." He reported staff used the lift to get him up sometimes. He said one girl told him he needed a longer leash. Review of a video recorded on 4/9/18 during 3rd shift (am of the 10th) at 3:00 on 4/14/18 revealed a staff member enter the resident's room during 3rd shift and state "aww you stink." Another staff member entered the room and appeared to be cleaning the resident up while he lay on the floor. Neither resident #16 nor the floor could be seen from the camera angle. Another staff member entered the room and the resident was placed on the bed by the 3 staff members. One staff exited the room while two remained in the room. The NA (later identified); then dropped the resident's legs onto the bed. The same nursing assistant was then observed snatching the pillow from underneath the resident's head without informing the resident of what she was doing. Review of the recording revealed the NA #1 stating, "How old are you? You should be enjoying your retirement; pooping on yourself-shame on you." Nurse #4 was observed in the room at this time giving the resident a tube feeding. It appeared	F 600	implemented disciplinary action as appropriate, C.N.A and Nurse #4 are no longer working in the facility. Identification of Others: On 4/14/18 the Social Services Director interviewed all alert oriented residents who were assigned to the care of the identified staff members to ensure there were no other concerns related to care and treatment. A skin check was completed for those residents who were unable to answer to ensure there were no signs of injury indicating mistreatment. This was completed by 4/23/18 by the DON, ADON, and/or Unit Manager. No other residents were identified to have concerns related to their care provided by the identified individuals. Systemic Changes 100% Staff education was provided by the DON (Director of Nursing), ADON (Assistant Director of Nursing) and Department Managers regarding Resident Rights and the facility Abuse and Neglect policy. This education included discussion of the Right to be Free from Abuse, the types of abuse (verbal, physical, emotional, isolation, sexual), immediate separation of the involved staff from the resident and the responsibility for reporting any suspected abuse. This education was completed on 5/16/18. Any staff not receiving this education on or before 5/16/18 will be required to have training prior to working their next shift. Beginning 5/7/18 DON, ADON and RN Supervisor will conduct 1-2 unannounced	

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F 600	Continued From page 17 that she responded, "1" when the NA asked Resident #16 how old he was. During interview on 04/15/18 at approximately 5:20 PM with Resident #16 he stated he felt like "hell" on the day when the Nursing assistant and nurses got him up off the floor and back into bed. Stated he did not like the way he was treated and talked to, that he felt very depressed about it. Stated he does not care what happens to him anymore. Interview with a nursing assistant at 1:31 PM on 4/15/18 revealed that she found Resident #16 on the floor and reported it to the nurse #4. She stated that she asked the resident if he was ok and told him to wait a minute. She stated the resident was lying on the mat. He had taken off his brief and had bowel movement all over. She said she asked him if he could stay in bed so he wouldn't fall again. The nursing assistant denied telling the resident that he should be ashamed of himself. She stated that maybe she asked him how old he was because he tried to touch her. Interview with the Administrator at 2:26 PM on 4/15/18 revealed that she learned about the incident from the Resident's family member on 4/14/17. She reported that staff members involved in the incident were identified from the video. The staff was placed on leave pending investigation. She filed a 24hour with the Division of Health Service regulation and made a police report. Resident's on the hall were interviewed by the social worker regarding staff treatment. Interview via telephone on 4/15/18 at 2:45 PM with nurse #4 who was present on 3rd shift revealed that the NA (nursing assistant) reported	F 600	visits/rounds in the facility after hours to monitor staff interaction with residents and ensure that residents are free of abuse. Beginning 5/7/18 the facility Department Managers will conduct Ambassador Rounds daily Monday-Friday. During the rounds the Department Managers will ask residents if they have any concerns with treatment and will document on the ambassador rounds sheet. Any identified concerns will be discussed during Morning Managers Meeting and followed up as appropriate. The Weekend Supervisor and/or Manager on Duty will make rounds throughout the facility on Saturday-Sunday and will respond to any resident concerns identified related to treatment. Beginning 5/7/18 the ED will review grievances daily during the AM manager meeting, any grievance indicating concerns with potential abuse will be investigated according to the facility Abuse policy. Beginning 5/7/18 the ED/DON all abuse allegations will be included in the 24 hour and 5 day report to the Health Care Personnel Registry, the Nurse Registry will be notified of allegation for staff. Monitoring Beginning 5/7/18 DON, ADON and RN Supervisor will conduct 1-2 unannounced visits/rounds in the facility after hours to monitor staff interaction with residents and ensure that residents are being treated with dignity and respect/free of abuse. Weekly off hour visits will continue for 3 months or until a pattern of compliance is	

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F 600	Continued From page 18 that when she went to change Resident #16 he put his feet off the bed. The NA said she saw him roll off the bed. Nurse #4 stated she went to the room but did not go inside immediately because she needed help to get him up. Nurse #4 stated that she, another nurse and the NA went into the room where the resident was lying on the mat. She reported that she did not see any injuries. She said that the Resident was very heavy, so they lifted him up. She stated she thought they were gentle enough with him. The resident kept talking about doctors made him stay at the facility. "He always gives this story when you talk to him." NA stated, "You keep falling and it is hurting our backs." She said she could not remember the details about the conversation. NA said "you are breaking our backs." Nurse #4 said she did remember NA saying "shame on you for pooping on yourself." She said the resident would say some things. The nurse stated she talked to the nursing assistant and told her not to go overboard with what she was saying to him. The nurse said she also remembered someone saying " ...aww you stink!" Nurse #4 further stated, now that she thought about it, it was probably verbal abuse, but at the time, she did not think of it that way. She talked to NA later and told her she should avoid saying things like this to the resident. She did not have NA leave the room when she said them. She stated the NA continued to talk to resident while she him gave the tube feeding. During interview at 3:01 PM on 4/15/18 with 3rd staff member (nurse #2), she stated that she just went in to help get him off the floor. She stated that she had worked with the NA when she worked the 400 hall sometimes. She stated that	F 600	achieved. The DON will review the results from all visits and will summarize monthly. The summary will include any identified concerns and trends. This summary will be presented to the QAPI committee monthly for recommendation or modification as needed. This monitoring will continue monthly for three months or until a pattern of compliance is achieved.	

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F 600	Continued From page 19 she had seen the NA talk to residents in the am and she talked to them so well. She reported no complaints from residents regarding the nursing assistant. Interview with the Administrator on 4/15/18 at 3:30 PM - The administrator stated that the video spoke for itself and that verbal abuse was clear. The administrator stated that resident was not handled in a dignified manner when found on floor and transferred back to bed. She stated she was following steps to report the abuse and that she was following the facility abuse protocol.	F 600		
F 636 SS=E	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.	F 636		5/9/18

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F 636	Continued From page 20 (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 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 and staff interviews, the facility failed to complete care area assessment (CAA) summaries for 5 of 6 residents reviewed	F 636	F 636 Root Cause Analysis Based on root cause analysis by the	

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F 636	Continued From page 21 for comprehensive minimum data set assessments (Resident # 2, Resident # 4, Resident # 16, Resident # 3, and Resident # 8.) Findings included: 1. Resident #2 was a long term care resident who was admitted to the facility with diagnoses which included hypertension, diabetes mellitus, dementia, depression, thyroid disorder, and chronic obstructive pulmonary disease. Review of the admission minimum data set (MDS) assessment dated 10/30/17 revealed Resident #2 was severely cognitively impaired, was receiving a therapeutic diet, and had a weight loss of 5% over the past month or 10% over the past 6 months. On the same admission MDS of 10/30/17, cognitive loss/dementia and nutritional status were among the care areas that triggered for further review. There was no indication that any of these CAA summaries were completed for this MDS assessment. In an interview with the MDS Coordinator on 4/13/18 at 11:15 AM, she stated that the care areas for cognitive loss/dementia and for nutritional status were evidently missed but should have been completed in order to determine whether care planning should proceed. She also stated that she was the staff member who was ultimately responsible for seeing that CAA summaries were completed. The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing	F 636	facility administrative staff and facility executive director it was determined that Care Area Summaries were not accurately marked with a check on Section V CAA Summary page. There is a button at the bottom of the page for each CAA summary that states Worksheet Complete. This button must be checked once the summary is completed in order to denote completion on Section V with a check mark. Immediate Action CAA areas triggered were completed for Residents #2 assessment dated 10/30/17, #4 assessment dated 3/2/18, #16 assessment dated 4/5/18, #3 assessment dated 3/6/18 and #8 assessment date 3/27/18 by the Dietary Manager (DM), Social Services Director (SSD), and/or MDS Coordinator on 5/1/18. Identification of others A 100% audit was completed by the DM of current residents most recent comprehensive assessments. The DM reviewed each nutritional CAA area triggered to ensure that the CAA summary was completed and noted as completed by a check mark on Section V. This audit was completed on 5/7/18. A 100% audit was completed by the SSD of current residents most recent comprehensive assessments. The SSD reviewed each cognitive loss/dementia and behavioral symptoms CAA area triggered to ensure that ensure that the CAA summary was completed and noted as completed by a check mark on Section V. This audit was completed on 5/7/18.	

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F 636	Continued From page 22 them as complete. On 04/14/18 at 11:34 AM, the Dietary Manager stated that she was responsible for writing the CAA summaries for specifically for nutrition, and she thought she had completed them for each resident who triggered for nutritional status. 2. Resident #4 was admitted to the facility with diagnoses which included, in part, heart failure, hypertension, and cerebral vascular accident. A review of the admission minimum data set (MDS) assessment dated 3/2/18 revealed Resident #2 was moderately cognitively impaired and had complaints of difficulty or pain with swallowing. The same assessment indicated Resident #4 had a feeding tube through which he received 51% or more of his calories. The care areas which triggered for further review on the admission MDS of 3/2/18 included cognitive loss/dementia, feeding tube, and dehydration/fluid maintenance. There was no check to indicate CAA summaries had been completed for these care areas. In an interview with the MDS Coordinator on 4/14/18 at 9:30 AM, she stated that CAA summaries had not been completed for the triggered care areas of cognitive loss/dementia, feeding tube, or dehydration/fluid maintenance. She also indicated she was the staff member who was ultimately responsible for seeing that CAA summaries were completed before signing the MDS assessment. The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS	F 636	Any CAA area noted as not being marked as completed were reviewed and completed as required. Systemic changes Education was provided to the IDT by the Regional Clinical Consultant on 5/3/18. This education included regulatory requirements for completion of the CAA Summary, use of a tool that is evidence based and expert endorsed when completing, as well as ensuring that the Worksheet Complete button is checked denoting completion in Section V. Beginning 5/7/18 the MDS Coordinators will review the CAA Summary of all comprehensive assessments completed weekly to validate that the Summary has been completed and noted as completed with a check mark. This review will be completed prior to the MDS Coordinator signing to certify the assessment as complete and prior to transmitting. This review will be documented on a CAA Summary review tool and maintained by the MDS Coordinator. Monitoring The MDS Coordinators will continue reviews of the CAA Summary for comprehensive assessments weekly for 4 weeks, 3 comprehensive assessments CAA Summaries weekly for 1 month, then 4 comprehensive assessments CAA Summaries for 1 month or until a pattern of compliance is noted. The MDS Coordinator will summarize the results of weekly monitoring a present to the QAPI committee monthly for revisions and/or	

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Coordinator and the MDS staff to complete all comprehensive MDS assessments and write care area summaries before signing them as complete.

On 04/14/18 at 11:34 AM, the Dietary Manager stated that she was responsible for writing the CAA summaries for nutrition, and she thought she had completed them for each resident who triggered for nutritional status.

3. Resident #16 was admitted to the facility with multiple diagnoses, some of which included atrial fibrillation, hypertension, cerebral vascular accident, and depression.

The admission minimum data set (MDS) assessment dated 04/05/2018 indicated that Resident #16 had a feeding tube and that he received 51% or more of calories via a feeding tube.

On the admission MDS of 04/05/2018, one of the care areas which triggered for assessment was a feeding tube. There was no indication on the MDS that a CAA summary was completed.

In an interview with the MDS Coordinator on 04/14/18 at 9:30 AM, she stated that the feeding tube CAA summary was not completed but should have been to determine whether care planning should proceed. She indicated she was the staff member who was ultimately responsible for seeing that CAA summaries were completed before signing the MDS assessment.

The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all

modifications of the plan.

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comprehensive MDS assessments before signing them as complete.

On 04/14/18 at 11:34 AM, the Dietary Manager stated that she was responsible for writing the CAA summaries for nutrition, and she thought she had completed them for each resident who triggered for nutritional status.

4. Resident #3 was admitted to the facility with diagnoses which included anemia, coronary artery disease, hypertension, and diabetes mellitus.

A review of the admission minimum data set assessment (MDS) dated 03/06/18 revealed Resident #3 was severely cognitively impaired, exhibited behaviors of wandering 1-3 days during the look back period, and was receiving a therapeutic diet.

On the same admission MDS of 03/06/18, the care areas that triggered for further review included, in part, cognitive loss/dementia, behavioral symptoms, and nutritional status. There was no indication that any of these CAA summaries were completed for the assessment.

In an interview with the MDS Coordinator on 4/13/18 at 11:15 AM, she indicated that CAAs were not completed for cognitive loss/dementia, behavioral symptoms, and nutritional status and that they should have been completed to determine whether care planning should proceed for those areas. She indicated she was the staff member who was ultimately responsible for seeing that CAA summaries were completed before signing the assessment.

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The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments and CAA summaries before signing them as complete.

On 04/14/18 at 11:34 AM, the Dietary Manager stated she was responsible for writing the CAA summaries for nutrition, and she thought she had completed them for each resident who triggered for nutrition.

5. Resident #8 was admitted to the facility on 3/14/18 with diagnoses which included Type 2 diabetes mellitus, obesity, and hypertension.

The admission Minimum Data Set (MDS), dated 3/27/18, indicated the resident was cognitively intact and had no behaviors. It also revealed the resident required a therapeutic diet and received insulin.

Cognitive Loss/Dementia, Behavior Symptoms, and Nutritional status were among the care areas that triggered for further review. There was no indication that these Care Area Assessment (CAA) Summaries were completed for assessment.

During an interview on 4/13/18 at 11:15 AM, the MDS Coordinator stated that the care areas for cognitive loss/dementia and for nutritional status were evidently missed but should have been completed in order to determine whether care planning should proceed.

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F 636	Continued From page 26 The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete. On 4/14/18 at 11:34, the Dietary Manager (DM) stated that she was responsible for writing the Nutrition CAA Summary.	F 636		
F 642 SS=E	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not	F 642		5/9/18

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F 642	Continued From page 27 constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to certify that the comprehensive minimum data set (MDS) assessments were complete before submitting the comprehensive MDS assessments to the national database for 6 of 6 residents (Resident # 2, Resident # 4, Resident # 11, Resident # 16, Resident # 3, and Resident # 8.) The findings included: 1. Resident #2 was a long term care resident who was admitted to the facility with diagnoses which included hypertension, diabetes mellitus, dementia, depression, thyroid disorder, and chronic obstructive pulmonary disease. Review of the admission minimum data set (MDS) assessment dated 10/30/17 revealed Resident #2 was severely cognitively impaired, was receiving a therapeutic diet, and had a weight loss of 5% over the past month or 10% over the past 6 months. The care areas that triggered for completion of care area assessment (CAA) summaries were cognitive loss/dementia and nutritional status. There was no indication that any of these CAA summaries were completed on the MDS. The admission MDS of 10/30/17 was signed and certified as complete on 11/03/17 by the MDS Coordinator and was submitted on 11/09/17. In an interview with the MDS Coordinator on 04/13/18 at 3:45 PM, she stated she took full responsibility for signing to certify the admission MDS was complete even though the CAA Summaries had not been completed.	F 642	F642 Root Cause Analysis Based on root cause analysis the facility administrative staff and the Executive Director of the facility it was determined that Care Area Summaries were not accurately marked with a check on Section V CAA Summary page. There is a button at the bottom of the page for each CAA summary that states Worksheet Complete. This button must be checked once the summary is completed in order to denote completion on Section V with a check mark. The RN MDS Coordinator further signed and certified assessments as complete prior to ensuring that all trigger CAA summaries were complete. Immediate Action CAA areas triggered were completed for Residents #2 assessment dated 10/30/17, #4 assessment dated 3/2/18, #16 assessment dated 4/5/18, #3 assessment dated 3/6/18, #8 assessment date 3/27/18 and Resident #11 assessment date 3/31/18 by the Dietary Manager (DM), Social Services Director (SSD), and/or MDS Coordinator on 5/1/18. Identification of others A 100% audit was completed by the DM of current residents most recent comprehensive assessments. The DM reviewed each nutritional CAA area triggered to ensure that the CAA summary was completed and noted as completed	

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F 642	Continued From page 28 The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete. 2. Resident #4 was admitted to the facility with diagnoses which included in part, heart failure, hypertension, and cerebral vascular accident. A review of the admission minimum data set (MDS) assessment dated 03/02/18 revealed Resident #2 was moderately cognitively impaired, had complaints of difficulty or pain with swallowing, and that he had a feeding tube through which he received 51% or more of his calories. Three of the care areas which triggered for further review on the MDS of 03/02/18 were cognitive loss/dementia, a feeding tube, and dehydration/fluid maintenance. There was no indication that care area assessment (CAA) summaries were completed on these care areas. The admission MDS of 03/06/18 was signed by the MDS Coordinator as complete on 03/07/18 and was submitted on 03/07/18. In an interview with the MDS Coordinator on 04/13/18 at 3:45 PM, she stated she took full responsibility for signing to certify the admission MDS was complete even though the CAA Summaries had not been completed. The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete.	F 642	by a check mark on Section V. This audit was completed on 5/7/18. A 100% audit was completed by the SSD of current residents most recent comprehensive assessments. The SSD reviewed each cognitive loss/dementia and behavioral symptoms CAA area triggered to ensure that ensure that the CAA summary was completed and noted as completed by a check mark on Section V. This audit was completed on 5/7/18. A 100% audit was completed by the MDS Coordinators of current residents most recent comprehensive assessments to validate that all CAAs triggered have a CAA Summary completed prior to signing and certifying as complete. Any CAA area noted as not being completed were reviewed and completed as required. Systemic Changes Education was provided to the IDT by the Regional Clinical Consultant on 5/3/18. This education included regulatory requirements for completion of the CAA Summary as well as ensuring that the Worksheet Complete button is checked denoting completion in Section V. Education was provided to the MDS Coordinators by the Regional Clinical Consultant on 5/3/18. This education included ensuring that all triggered CAAs have been completed prior to signing the assessment and certifying completion. Beginning 5/7/18 the MDS Coordinators will review the CAA Summary of all comprehensive assessments completed weekly to validate that the Summary has	

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F 642	Continued From page 29 3. Resident #11 was a long term resident admitted to the facility with a partial list of diagnoses of atrial fibrillation, coronary artery disease, hypertension, and renal insufficiency. A review of the annual comprehensive minimum data set (MDS) assessment dated 3/31/18 indicated Resident #11 was always incontinent of urine. One of the care areas that triggered for further review on the annual MDS of 3/31/18 included urinary incontinence/indwelling catheter. There was no indication that a care area assessment (CAA) summary had been completed for incontinence/indwelling catheter. The CAA indicated "Current Care Plan continued." The annual comprehensive MDS of 03/31/18 was signed by the MDS Coordinator as complete on 04/03/2018 and was transmitted on 04/03/18. In an interview with the MDS Coordinator on 4/13/18 at 11:15 AM, she stated she took full responsibility for signing to certify the admission MDS dated 03/31/18 was complete even though the CAA summary for urinary incontinence/indwelling catheter had not been completed. The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete. 4. Resident #16 was admitted to the facility with multiple diagnoses, some of which included atrial fibrillation, hypertension, cerebral vascular accident, and depression.	F 642	been completed and noted as completed with a check mark. This review will be completed prior to the MDS Coordinator signing to certify the assessment as complete and prior to transmitting. This review will be documented on a CAA Summary review tool and maintained by the MDS Coordinator Monitoring The MDS Coordinators will continue reviews of the CAA Summary for comprehensive assessments weekly for 4 weeks, 3 comprehensive assessments CAA Summaries weekly for 1 month, then 4 comprehensive assessments CAA Summaries for 1 month or until a pattern of compliance is noted. The MDS Coordinator will summarize the results of weekly monitoring a present to the QAPI committee monthly for revisions and/or modifications of the plan.	

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A review of the admission minimum data set (MDS) assessment dated 04/05/2018 indicated that Resident #16 had a feeding tube and that he received 51% or more of calories via a feeding tube. One of the care areas which triggered for further review was a feeding tube. There was no indication on the MDS that a care area assessment (CAA) summary was completed for the feeding tube.
The admission MDS of 04/05/18 was signed as complete on 04/05/18 and was submitted.

In an interview with the MDS Coordinator on 04/14/18 at 9:30 AM, she stated that she took full responsibility for signing to certify the admission MDS assessment dated 04/05/18 was complete even though the CAA Summary had not been completed.
The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete.

On 04/14/18 at 11:34 AM, the Dietary Manager stated that she was responsible for writing the CAA summaries for nutrition, and she thought she had completed them for each resident who triggered for nutritional status.

5. Resident #3 was admitted to the facility with a partial list of diagnoses which included anemia, coronary artery disease, hypertension, and diabetes mellitus.

A review of the admission minimum data set assessment (MDS) dated 3/6/18 revealed Resident #3 was severely cognitively impaired,

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exhibited behaviors of wandering 1-3 days during the look back period, and was receiving a therapeutic diet. The care areas which triggered for further review included, in part, cognitive loss/dementia, behavioral symptoms, and nutritional status. There was no indication that these care area assessment (CAA) summaries had been completed for Resident #3.
The admission MDS of 03/06/18 was signed by the MDS Coordinator as complete on 03/07/18 and was submitted on 03/07/18.
In an interview with the MDS Coordinator on 04/13/18 at 3:45 PM, she stated she took full responsibility for signing to certify the admission MDS was complete even though the CAA Summaries for cognitive loss/dementia, behavioral symptoms, and nutritional status had not been completed.

The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete.

6. Resident #8 was admitted to the facility on 3/14/18 with diagnoses which included Type 2 diabetes mellitus, and hypertension.

The admission Minimum Data Set (MDS), dated 3/27/18, indicated the resident was cognitively intact and had no behaviors. It also revealed the resident required a therapeutic diet and received insulin.

Cognitive Loss/Dementia, Behavior Symptoms, and Nutritional status were among the care areas

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F 642	Continued From page 32 that triggered for further review. There was no indication that these Care Area Assessment Summaries were completed for assessment. The admission MDS of 03/27/18 was signed by the MDS Coordinator as complete on 04/05/18 and was submitted on 04/05/18. In an interview with the MDS Coordinator on 04/13/18 at 3:45 PM, she stated she took full responsibility for signing to certify the admission MDS was complete even though the CAA Summaries for cognitive loss/dementia, behavioral symptoms, and nutritional status had not been completed. The Director of Nursing stated in an interview on 4/13/18 at 4:30 PM that he would expect the MDS Coordinator and the MDS staff to complete all comprehensive MDS assessments before signing them as complete.	F 642		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to administer nitroglycerin for chest pain, document times for assessment, and to	F 684	F684 Root Cause Analysis Based on root cause analysis by the	5/9/18

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F 684	Continued From page 33 monitor the resident for acute changes in weight as ordered for 1 of 3 residents reviewed who had a decline in condition (Resident #3.) The facility also failed to clarify insulin orders and medication orders for 3 of 5 residents who were reviewed for medication orders (Residents #3, # 2, and #8.) The findings included: 1. a. Resident #3 was admitted to the facility with multiple diagnoses including anemia, coronary artery disease, hypertension, and subacute infective endocarditis. (Subacute infective endocarditis is an infection of the inner lining of the heart and the heart valves.) The signed physician orders dated 02/27/18 included the following order: Nitroglycerin 0.4 milligram (mg) tablet, put one under tongue every five minutes as needed for maximum of 3 tablets for chest pain. A review of the admission minimum data set (MDS) assessment dated 03/06/18 revealed Resident #3 was admitted from an acute hospital stay, was severely cognitively impaired, and there was no indication that he had a prognosis of a life expectancy of less than 6 months. The March 2018 medication administration record (MAR) revealed there were no checkmarks or initials in place to indicate any nitroglycerin had been administered to Resident #3 on 03/18/18 or 03/19/18 as ordered for chest pain. Review of a progress note dated 03/18/18 which was written by the Occupational Therapist (OT #2) revealed the Resident #3 did not feel good and described a dull aching pain to his chest. The same note revealed that his vital signs were	F 684	facility administrative staff and facility executive director it was determined that licensed nurses are not always acting on physician orders as specified. Also determined that licensed nurses are not always entering new physicians orders with all required components of an order and not identifying specific information in their documentation such as time of care. Immediate Action Resident #3 no longer resides in the facility. Nurse #1 is currently unavailable; however, upon return to work this staff member will receive 1:1 education regarding following physician orders and complete accurate documentation including dates and times of specific events. Resident #2 no longer resides in the facility. Resident #2 was discharged on 4/13/18 Resident #8 no longer resides in the facility. Resident #8 was discharged on 4/18/18 Identification of others A 100% audit was completed by the DON on 5/11/18 to review physician orders from 4/1/18 to 4/30/18 to ensure that all orders are complete with all required components to include frequency, site, and method of delivery. A clarification order was obtained for any order that was noted without all required components. By clarifying the orders as needed the entire MD order will appear in the text. Systemic Changes Education was provided to 100%	

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F 684	Continued From page 34 checked and that his blood pressure started at 95/43, and that it went down to 95/39 after a few minutes. The note continued, indicating that Resident #3 was transferred back to bed and instructed not to get out of bed until the nurse had seen him. In an interview with Resident #3's family member on 04/10/18 at 2:45 PM, she stated OT #2 returned Resident #3 to his room because his blood pressure was low and he was complaining of chest pain. The family member was concerned so she went to get a nurse to check on him, but she was told the nurse would come after she finished her medication administration pass. Resident #3's family member stated she could not remember what time OT #2 brought him back to the room, although it was during the morning hours on 03/19/18. In an interview with OT #2 on 04/12/18 at 10:42 AM, she stated on 03/19/18 she went to work with Resident #3 and she found him at the nurse's station and that he was complaining of a dull ache in his chest. OT #2 explained that she checked his blood pressure and immediately took him to his room and assisted him into the bed. She further stated she instructed Resident #3 not to get out of bed until he had been seen by his nurse, and then she left his room and reported to his nurse, Nurse #1, that he had chest pain, shortness of breath, and a low blood pressure. She added that she did not know whether Nurse #1 immediately went to Resident #3's room after she reported his condition to her. OT #2 stated this chest pain event occurred between 8:00 AM and 10:00 AM. A review of the progress notes revealed a note	F 684	Licensed Nurses by the DON/ADON and completed by 5/7/18. This education included how to properly write a physician□s order and the required components such as site, frequency of administration and method of delivery, ensuring that the MD order is completely documented in the text. Education provided also reviewed the expectation to follow the physician□s orders as written and to contact the physician if clarification is needed and notification of the physician in the event a resident refuses prescribed medication/treatment orders as more than 2 times consecutively. Beginning 5/7/18 the DON, ADON, and /or Nurse Supervisor will print all newly obtained physician□s orders and review how the order was transcribed in the electronic medical record. The copy of the printed orders will be initialed and placed in the Daily Clinical Rounds Binder daily Monday-Friday. Any order that does not have all required components will be clarified and correctly transcribed in the electronic medical record at that time. Beginning 5/7/18 the DON, ADON, and/or Nurse Supervisor will review Electronic Medication Administration Records 2 times weekly to determine any resident who may have refused medication/treatment more than 2 consecutive times and validate that the physician has been notified. This review will be documented on the EMAR Review Tool. Monitoring	

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F 684	Continued From page 35 dated 03/19/18 written by Nurse #1 which indicated Resident #3 complained of chest tightness and shortness of breath, looked weak, was afebrile, and his skin was warm and moist. The same note indicated Resident #3's temperature was 97.4, his pulse was 97, and his blood pressure was 98/56. In a phone interview on 04/11/18 at 4:40 PM, Nurse #1 stated she could not remember many details about Resident #3's chest pain during her day shift on 03/19/18. Nurse #1 stated that she did not administer nitroglycerin 0.4 mg sublingually as ordered for chest pain, however she did remember reporting the resident's condition to the Assistant Director of Nursing (ADON) who came to Resident #3's room to look at him. Nurse #1 also stated she could not remember who told her the resident was having the chest pain and shortness of breath, and she did not know if she went immediately to assess Resident #3. In an interview with the ADON on 04/12/2018 at 3:40 PM, she stated she was called to Resident #3's room by Nurse #1 on 03/19/18. The ADON stated she and Nurse #1 both assessed Resident #3's vital signs, and that his family member was present in the room. The ADON explained Resident #3 was lying down and she did not think he appeared to be short of breath or in distress, but his family member told her he did not "look right." The ADON stated she would have expected for the nitroglycerin to be administered as ordered for chest pain, and she thought Nurse #1 had administered it. The Director of Nursing (DON) stated in an interview on 04/12/18 at 4:30 PM that he would	F 684	The DON, ADON, and/or Nurse Supervisor will continue to print and review newly obtained physician□s orders daily Monday-Friday to validate accurate input into the electronic medical record. The DON will summarize the results of this monitoring on a monthly basis. The DON, ADON, Nurse Supervisor will continue to monitor the EMAR for refusals and physician notification 2 times weekly for 2 months, then 1 time weekly for 1 month or until compliance is achieved. The results of ongoing monitoring will be presented by the DON to the QAPI committee monthly for revisions and modifications to the plan as needed.	

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expect the nurse to follow the physician's order and administer nitroglycerin as ordered for chest pain. The DON added that Nurse #1 might have felt that Resident #3's issue was chest tightness instead of chest pain.

The physician stated in a phone interview on 04/13/18 at 9:55 AM that he would expect the nurse to follow the physician's order to administer the nitroglycerin 0.4 mg as needed for chest pain and it could have relieved Resident #3's chest tightness or chest pain, but it would not have improved his poor cardiac condition.

b. Review of Nurse #1's progress note dated 03/19/18 indicated that Resident #3 complained of chest tightness and shortness of breath, and that though he was weak, he was alert and verbal. The same note indicated Resident #3 was lethargic and that the physician was called and an order was received to send Resident #3 to the emergency room for further evaluation. The note indicated Resident #3 left the facility at 7:00 PM. There was no time of day included in the note to indicate the time of day when Resident #3 experienced the shortness of breath or chest tightness, when he was assessed, or when the physician was notified.
A review of the transfer form completed before Resident #3 was sent to the emergency department included the date of 03/19/18; the time of day for the transfer was left blank beside the date.

A review of the hospital emergency department discharge triage note revealed Resident #3 was first assessed in the emergency department by a nurse at 1:29 PM on 03/19/18 and expired at 5:35 pm the same day.

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F 684	Continued From page 37 In an interview with OT #2 on 04/12/18 at 10:42 AM, she stated on 03/19/18 she went to work with Resident #3 and found him at the nurse's station and that he was complaining of a dull ache in his chest. OT #2 explained that she checked his blood pressure (98/39), then immediately took him to his room and assisted him into the bed. She further stated she reported his condition to his nurse (Nurse #1) that Resident #3 had chest pain, shortness of breath, and a low blood pressure. OT #2 added she did not know whether Nurse #1 immediately went to Resident #3's room after she reported his condition to her. OT#2 stated this event occurred between 8:00 AM and 10:00 AM on 03/19/18. In a phone interview with Nurse #1 on 04/11/18 at 3:40 PM, she stated she was unable to remember what time of day on 03/19/18 when Resident #3 started experiencing chest tightness and shortness of breath. Nurse #1 stated she was not certain who reported to her the resident was experiencing chest pain and a low blood pressure. She stated she was not sure what time of day when she assessed Resident #3 or when the physician was called about his condition. Nurse #1 added she thought the resident left the facility earlier than 7:00 PM to go to the emergency room. In an interview with the DON on 04/12/18 at 4:30 PM, he stated that the documentation regarding Resident #3's condition did not include the time when the physician was called and did not include the correct time when Resident #3 was transferred by the emergency medical technicians to the emergency department at the hospital. He stated the time of day when Resident #3	F 684		

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experienced his decline in condition should have been documented in the Nurse #1's progress note. The DON added he would expect the time of Resident #3's transfer to the hospital to be included on the transfer form and for the time of physician notification of the resident's condition to be included.

c. A review of the physician's orders for Resident #3 revealed the following order dated 02/27/18: "Weigh resident every Mon [Monday], Wed [Wednesday], and Fri [Friday]. Notify MD if weight gain more than five pounds in one week." (According to the Mayo Clinic, rapid weight gain from fluid retention may indicate a change in treatment for heart failure might be needed.)

A review of the March 2018 medication administration record (MAR) for Resident #3 revealed there were initials and checks in place with weights recorded to indicate he had been weighed on Friday, March 2 (174.3 pounds) and on Wednesday, March 7, 2018 (175.4 pounds). There were no other checks present to indicate any weights were taken on any Monday, Wednesday, or Friday during the month of March until the resident was discharged on 03/19/18. There was "N" present on the MAR for the weights on the following dates: Monday 03/05/18, Friday 03/09/18, Monday 03/12/18, Wednesday 3/14/18, Friday 3/16/18, and Monday, 03/19/18.
In a phone interview with Nurse #2 who marked the "N" on the March 2018 MAR for the weights on 03/11/18 at 3:58 PM, she stated the "N" marked in place of the weight on Resident #3's MAR indicated that the resident refused to have his weight taken. Nurse #2 stated she did not know if there was a way to check Resident #3's

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weight on another day if a weight had been missed on a Monday, Wednesday, or Friday. She added that she did not call the physician to report missed weights or to find out if the weights could be delayed to another weekday if one had been refused the day before. Nurse #2 further stated she would not know whether there was a weight gain or loss or five pounds if weights were not taken.

The DON stated in an interview on 04/12/2018 at 4:30 PM that he would expect the nurse to at least notify the physician if an order could not be carried out due to resident refusal.

The physician stated in a phone interview on 04/13/2018 at 9:55 AM that if Resident #3 was refusing to have his weights taken, he would expect the nurse to contact him to receive further direction. The physician also stated that if weights were not being taken as ordered three days per week, there would be no weight data to determine if Resident #3 had a five pound weight loss or gain in one week which could be a sign of heart failure.

d. A review of the physician's orders for Resident #3 revealed the following order dated 02/27/2018: "Triamcinolone 0.1% ointment, apply topically twice daily for two weeks." The order did not indicate where to apply the Triamcinolone on Resident #3's body surface.

The March 2018 MAR revealed initials and checks were in place to indicate the Triamcinolone 0.1% ointment had been applied twice per day at 9:00 AM and 9:00 PM from 03/01/18 at 9:00 AM through 03/14/18.

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In an interview with Nurse #3 on 04/11/18 at 3:08 PM, she stated the order for Triamcinolone 0.1% ointment needed to be clarified in order to know where to apply it to the resident's skin. She stated she did not process the order for Resident #3 and did not process this order upon admission. Nurse #3 stated she did not take care of Resident #3, but if she did, she would not know where to apply it.

On 04/11/18 at 4:40 PM, in a phone interview with Nurse #1, she stated she would need to clarify the order to know where to apply the Triamcinolone ointment on Resident #3's skin. Nurse #1 stated she could not remember who would have processed this order and said she did not contact the physician for clarification. Nurse #1 stated she was not certain where it was applied.

The DON stated in an interview on 04/12/18 at 4:30 PM that the order for the Triamcinolone 0.1% ointment should have been clarified so that staff would know where to apply it on Resident #3's body.

The physician stated in an interview on 04/13/18 at 9:55 AM that he would expect the nurse to contact the physician who ordered the Triamcinolone ointment to clarify where it was to be applied.

2. Resident # 2 was admitted to the facility with diagnoses which included, in part, diabetes mellitus, hypertension, and atrial fibrillation.

A review of the admission minimum Data Set (MDS) assessment dated 10/30/17 revealed Resident #2 received insulin seven of seven days

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per week.

The physician's orders for Resident #2 included the following order dated 01/17/18: Lantus 100 units per milliliter (ml), give 18 units subcutaneously every day.

An additional insulin order dated 02/14/18 for Resident # 2 was present as follows: Novolog 100 units per ml Flexpen, give 8 units with or after meals. The order did not indicate which meals were to be included with the insulin administration, and there was no route of administration included in the order.

Another physician's order for insulin dated 02/14/18 was as follows: Novolog Flexpen 100 units per ml, give 6 units before or with lunch.

Further review of the physician's orders revealed an order dated 03/24/18 for Accucheck with the use of sliding scale insulin, use with Novolog insulin subcutaneously for blood sugar greater than 200. The sliding scale included with the order was as follows: 201 - 250 = 4 units, 251 - 300 = 6 units, 301 - 350 = 8 units, 351 - 400 = 10 units.

A review of the March and April 2018 medication administration record (MAR) revealed there were checks and initials in place to show Resident #3 received Novolog Flexpen, 8 units daily at 8:00 AM and at 4:30 PM. The March 2018 MAR also included checks and initials to reflect the administration of 6 units of Novolog with or before lunch, and there were checks, initials, and blood sugars in place to reflect the administration of Novolog before and after meals and at bedtime (four times daily) for the separate sliding scale

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Novolog insulin order.

In an interview with Nurse # 3 on 04/11/18 at 3:08 PM, she reviewed the Novolog insulin order dated 02/14/18 and stated the order needed to be clarified to determine the number of meals (all 3 meals or just 2 meals) when the Novolog Flexpen insulin 8 units should be administered. Nurse #3 further stated that a route of administration (subcutaneously) should be included with the order. She also added that Resident #3 had several different orders for insulin, including another Novolog insulin order to be administered at lunch time, as well as Novolog per sliding scale four times per day, and that each order needed to include frequency of administration to avoid confusion. Nurse #3 continued, saying that it was not clear whether the Novolog should be administered per sliding scale in addition to the other meal time Novolog insulin orders. She explained she did not process the order for the Novolog and she did not know who did.

The Director of Nursing (DON) stated in an interview on 04/12/18 at 4:30 PM that he would clarify the Novolog orders so that it would be clear when the 8 units should be administered (with breakfast and supper) and to determine if the sliding scale insulin should be included with each meal in addition to the separate insulin administration with breakfast, lunch, and supper. He stated the physician orders should be clarified and transcribed accurately onto the MAR.

3. Resident #8 was admitted to the facility on

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F 684	Continued From page 43 3/14/18 with diagnoses which included Type 2 diabetes mellitus, and constipation. The resident's Physician Orders for the following medications were reviewed. a. An order dated 3/14/18 read, "Miralax Powder Packet mix 4-6 ounces of fluid and give for constipation" There was no frequency included in the order. b. An order dated 3/14/18 read, "Humulin 70/30 Kwikpen, inject 20 units under the skin every evening." c. An order dated 4/9/18 read, "Humulin 70/30 Kwikpen, give 33 units under the skin every morning." The medication orders were shared with the Administrator on 4/12/18 at 1:20 PM. The Administrator indicated the Miralax order should include the frequency of administration. At 2:42 PM on 4/13/18, the Director of Nursing specified the insulin orders should have been recorded with the medical term 'subcutaneous' instead of 'under the skin' as it had been written.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		5/17/18

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(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 689	Continued From page 44 Based on medical record review, staff, family and resident interviews it was determined that facility staff failed to report a fall for 1 of 2 sampled residents (#16) to administration for analysis and implementation of appropriate fall interventions. Findings included: Resident # 16 was admitted to the facility on 3/29/18 with diagnosis including acute cerebral vascular accident, urinary retention, anxiety and hypertension. Review of the Minimum Data Set Assessment (MDS) revealed that the resident scored 13 on the brief interview of mental indicating that the resident had good memory. The resident did not have disorganized thinking or altered level of consciousness. The resident was not exhibiting behavioral symptoms per the MDS. The resident was coded as requiring extensive two person assistance for bed mobility, transfer and toilet use. He was coded as requiring extensive one person assistance for eating, dressing and personal hygiene. Review of the medical record 4/14/18 revealed a nursing note 4/11/18 4:51 am which stated, "4/10/18 at 7:45 PM patient noted to be hanging almost off the bed. Patient assisted back to bed 8:10 PM. One of the (family) members alerted this nurse that he had observed patient using his bed control to high position and was almost sliding off the bed. Patient observed way up hanging the bed. Patient continue to hang off the bed, restless throughout the night. Unable to redirect. Will continue to monitor." Therapy note 4/11/18 1:22 PM stated, "Patient reports recent fall, but unclear about details and number of falls." Interview with the resident's family member on	F 689	F689 Root Cause Analysis Based on root cause analysis by the facility administrative staff and facility executive director Nurse #4 did not follow policy and procedure for reporting of an incident. Nurse #4 did not complete the required documentation or report a fall. Immediate Action On 4/14/18, once notified of the fall on 4/10/18 for Resident #16, the DON completed the appropriated documentation which included notification of the Physician and Family. Resident #16 was assessed on 4/15/18 by the RN supervisor to ensure no significant injury was noted. On 4/14/18 the facility initiated an investigation regarding the identified incident. Upon conclusion of the investigation, appropriate disciplinary action was taken, nurse #4 is no longer working at the facility. Identification of others On 5/7/18 an audit was completed by the DON, ADON and RN Supervisor for the period of 4/1/18 to 4/30/18 of 100% current residents' nurses' notes and incident reports to determine if there were other residents who experienced a fall that was not reported or appropriate documentation not completed. No other instances were identified. Systemic Changes Education was provided by the DON/ADON regarding the requirement of completed documentation for all	

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	345529	A. BUILDING _____ B. WING _____	C 04/15/2018

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F 689	Continued From page 45 4/14/18 at 1:10 PM revealed that the resident was telling her every time he had a fall. She stated that he had goose egg on his head. She said that she had not been notified by the facility that Resident #16 had any falls. She stated that the rehabilitation manager and the social worker admitted that the resident had 6 falls during a care plan meeting. Review of a video recorded on 4/9/18 during 3rd shift (am of the 10th) at 3:00 on 4/14/18 revealed a shot of the resident's unoccupied bed. Staff was seen entering the room and talking to someone below the bed on the other side. A staff member entered the room and appeared to be cleaning the resident up while he lay on the floor. Neither resident #16 nor the floor could be seen from the camera angle. Interview with the administrator at 3:53 PM on 4/14/18 revealed that if a resident has a fall the nurse will assess for injury, the MD and family are notified and the incident is available for review in clinical rounds. Falls are investigated as needed. During interview with the social worker at 4:25 PM on 4/14/18 she reported that she, the rehabilitation manager and the resident's family member had a care plan meeting in 4/12/18. She said that she asked about concerns at the end of the meeting. Resident #16's family member said that the resident complained about staff being rude on 3rd shift. The social worker wrote the concerns up on a grievance form. Per review of the grievance form dated 4/12/18; the concern was addressed in the interdisciplinary team meeting on 4/12/18. The attachment to the grievance form stated 4/1/18 (fall). Social worker planned to follow up with the resident's family member on Monday 4/17/18.	F 689	incidents/falls. This education was completed on 5/7/18 for all licensed nurses. Any nurse not receiving this information on or before 5/7/18 will be educated prior to working their next shift. 100% Nursing Assistants were provided education regarding ensuring that all falls are reported to the nurse. The Nursing Assistant should not move the resident until the nurse assesses and determines that the resident is safe to be moved. Education was completed on 5/17/18. Beginning 5/7/18, falls will be reviewed daily Monday-Friday during IDT clinical rounds for completion of required documentation by the licensed nurse. If documentation is not completed the Licensed Nurse will be notified and required to ensure completion. This review will be completed by the DON, ADON and/or supervisor. By completing the appropriate documentation the DON, ADON and RN Supervisor will have the ability to review the incidents in the electronic medical record in order to determine need for further investigation and/or intervention. Monitoring Beginning 5/7/18 the DON will monitor fall incidents Monday-Friday for completion of appropriate documentation which will be utilized for tracking and developing a plan to ensure compliance with reporting of incidents. This monitoring will be documented on the Notification of Falls monitoring tool and maintained by the DON. Monitoring will continue daily Monday-Friday for 3 months or until a	

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F 689	Continued From page 46 During interview with the rehabilitation manager on 4/15/18 at 2:20 PM, he stated that he did not remember the family member saying anything about falls during the care plan meeting. He reported that the falls log indicated that the resident had 2 falls per the incident log, one fall occurred on April 1st. Interview with a nursing assistant on 4/15/18 at 1:31 PM revealed that she found the Resident #16 on the floor and reported it to the nurse. She stated they tried to transfer him to bed because the lift could not go down to the floor. They got a 3rd person to help because it was so hard and it was killing their back. The NA said she did not report the fall to the nurse because the nurse was there. Interview via telephone on 4/15/18 at 2:45 PM with nurse #4 who was present on 3rd shift revealed that the NA (nursing assistant) reported to her that when she went to change Resident #16 he put his feet off the bed. The NA said she saw him roll off the bed. Nurse #4 stated she went to the room but did not go inside immediately because she needed help to get him up. The nurse stated that she, another nurse and the NA went into the room the resident was laying on the mat. She reported that she did not see any injuries. She said that the Resident was very heavy, so they lifted him up. She further stated that the night he fell it was documented, put in electronic chart under notes.	F 689	pattern of compliance is achieved. The DON will summarize the results of this monitoring and present to the QAPI committee monthly for three months or until a pattern of compliance is achieved. The QAPI committee will make recommendations and modifications to this plan as necessary	