STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

(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 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		6/14/18

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

Electronically Signed | 06/08/2018

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F 623	Continued From page 1 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 2 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide written notification to the resident/resident representative of the reason for discharge to the hospital and failed to provide a copy of the notice to the Ombudsman for 3 of 3 sampled residents reviewed (Resident #32, Resident #54 and Resident #116) for hospitalization. The findings included: 1. Resident #32 was originally admitted to the facility on 1/25/18 with diagnoses including Unspecified Fracture of Shaft of Unspecified Tibia, Initial Encounter for Closed Fracture, Unspecified Fracture of Shaft of Fibula, Initial Encounter for Closed Fracture, Unspecified Consequence of a Previous Condition of Unspecified Cerebrovascular disease, Hemiplegia, Atrial Fibrillation, Type 2 Diabetes without Complications, Dementia without	F 623	The plan of correcting the specified deficiency: The Administrator and Director of Nursing reviewed medical records for residents #32, #54, and #116 for verification that verbal notice of transfer/discharge was appropriately performed and documented for the identified dates. We are unable to correct for identified residents as written notice of transfer/discharge was not provided at the time of transfer/discharge and the residents have all since returned to the facility. To correct this deficiency, transfer/discharge packets have been placed at the nurse□s stations to be completed by the staff nurses and included in the transfer paperwork given to the resident when they are transferred or discharged. Copies of the transfer/discharge notice will be placed in	

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F 623	Continued From page 3	F 623		

Behavioral Disturbance, and Hypertension.

According to the most recent Quarterly Minimum Data Set (MDS) dated 4/6/18, Resident #32 was severely cognitively impaired. The resident required extensive assistance in bed mobility and transfers with one person physical assistance. Resident #32 required supervision during meals and extensive supervision in toileting.

Review of Resident #32's medical record revealed hospital stays from 3/4/18 through 3/12/18, 3/26/18 through 3/28/18, and 4/28/18 through 5/3/18.

During an interview on 5/16/18 at 10:54 AM, the facility Social Worker revealed the resident/resident representative was usually notified by telephone call and documentation in the resident's record. She revealed she was not aware that a letter was supposed to be sent to the resident/resident representative regarding the reason a resident was being discharged to the hospital. The Social Worker also revealed she did not know anything about sending a letter to the Ombudsman when a resident was discharged to the hospital.

During an interview on 5/16/18 at 10:54 AM, the Administrator revealed a log of admissions and discharges was sent to the Ombudsman monthly. She revealed she was not aware a letter had to be sent to the resident/resident representative when a resident was discharged to the hospital. She stated the resident's family member was called and information was documented in the record.

During another interview on 5/17/18 at 4:50 PM,

the resident□s medical record, mailed to the resident□s responsible party, and to the ombudsman pre-transfer/discharge if possible and as soon as practicable after acute/emergent transfer/discharge.

The procedure for implementing the acceptable plan of correction:

1. Transfer/discharge packets containing Notice of Transfer/Discharge form will be placed at each nurse□s station by the Director of Nursing (DON).
2. Licensed staff will be in-serviced by the Administrator and/or Staff Development Coordinator on completion of the Notice of Transfer/Discharge form prior to resident transfer/discharge, placing the completed form in the transfer paperwork given to the resident, and placing a copy of the completed form in the resident□s medical record. This process will be used for acute transfers/discharges.
3. The Social Worker, Director of Nursing, and Assistant Director of Nursing will be in-serviced by the Administrator and/or Staff Development Coordinator on providing the resident□s responsible party a copy of the completed Notice of Transfer/Discharge form. The Social Worker and/or designee will mail a copy of the transfer/discharge notice to the resident□s responsible party as soon as practicable after acute transfers/discharges.
4. The Social Worker and/or designee will also mail a copy of the completed Notice of Transfer/Discharge to the local

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F 623	Continued From page 4 the Administrator stated she thought they were doing fine. She revealed she thought the things they were doing was what they should have been doing. She stated that they called family members. 2. Resident # 54 was admitted to the facility on 2/8/18 with diagnoses Congestive Heart Failure, Chronic Kidney Disease, Chronic Respiratory Failure and Diabetes Mellitus. A review of the admission Minimum Data Set (MDS) completed on 2/8/18 revealed Resident # 54 was severely cognitively impaired. Review of Resident # 54's medical record revealed hospital stays from 3/13/18 through 4/3/18, 4/4/18 through 4/9/18 and 4/11/18 through 4/16/18. During an interview on 5/16/18 at 10:54 AM, the facility Social Worker stated the family/responsible party was usually notified by telephone call and documentation in the resident's record. She revealed she was not aware that a letter was supposed to be sent to family members/responsible party regarding the reason a resident was being discharged to the hospital. During an interview on 5/17/18 at 4:13 PM the Administrator stated that she sends a letter to the Ombudsman, but did not send a letter to the resident's responsible party. 3. Resident #116 was admitted on 08/29/17. The resident's documented diagnoses included muliptle fractures, end stage renal disease with	F 623	ombudsman as soon as practicable after acute transfers/discharges. 5. For transfers/discharges when time permits, advance written notice will be provided to both the resident, the resident□s responsible party, and the local ombudsman by the Social Worker or designee. For transfers/discharges that are emergent in nature, the completed Notice of Transfer/Discharge will be mailed to the resident, the resident□s responsible party and the local ombudsman as soon as practicable after the emergency transfer. 6. The Social Worker or designee will document in the resident□s medical record that the Notice of Transfer/Discharge was mailed to both the resident□s responsible party and the local ombudsman. The monitoring procedure to ensure that the plan of correction is effective and remains corrected and/or in compliance with the regulatory requirements: 1. The Director of Nursing or designee will review the daily census report in Point Click Care daily Monday-Friday to identify residents that have been transferred or discharged. 2. The Director of Nursing or designee will maintain an audit log of those resident identified. 3. The medical record of the identified residents will be reviewed by the Director of Nursing or designee to validate the Notice of Transfer/Discharge was completed, placed in the resident□s	

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F 623	Continued From page 5 hemodialysis, diabetes, hypertension, and chronic obstructive pulmonary disease. The resident's 02/19/18 quarterly minimum data set (MDS) documented her cognition was intact. Record review revealed Resident #116 was hospitalized from 12/24/17 through 12/28/17, from 02/06/18 through 02/08/18, and 05/01/18 through 05/07/18. During an interview on 5/16/18 at 10:54 AM, the facility Social Worker stated the family/responsible party was usually notified by telephone call and documentation in the resident's record. She revealed she was not aware that a letter was supposed to be sent to family members/responsible party regarding the reason a resident was being discharged to the hospital. During an interview on 5/17/18 at 4:13 PM the Administrator stated that she sent a letter to the Ombudsman, but did not send a letter to the resident's responsible party.	F 623	medical record, and a copy sent with the resident. 4. The Director of Nursing or designee will notify the Social Worker or designee of the residents identified as transferred or discharged. 5. The Social Worker or designee will mail copies of the Notice of Transfer/Discharge to the responsible parties of the identified residents as well as the local ombudsman and document in the resident□s medical record that these copies have been mailed. 6. For any resident identified as not having the Notice of Transfer/Discharge completed and given to them at the time of transfer/discharge, the Director of Nursing or designee will complete the form and mail to the resident, the resident□s responsible party, and the local ombudsman. The Director of Nursing or designee will also do this for emergency transfers when time did not allow for the completion of the form prior to transfer/discharge. 7. Further staff education will be provided by the Staff Development Coordinator or designee as need is identified. 8. The Director of Nursing or designee will provide a copy of the audit log to the facility'□s Performance Improvement Committee monthly x 3 months for review and to ensure continued compliance. The title of the person responsible for implementing the acceptable plan of correction:	

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F 623	Continued From page 6	F 623	The Administrator is responsible for implementing this plan of correction. Completion Date: 6/14/18	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the	F 625	The plan of correcting the specified	6/14/18

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F 625	Continued From page 7 facility failed to provide a bed hold policy upon a resident's discharge to the hospital for 3 of 3 residents (Resident #32, Resident #54 and Resident #116) reviewed for hospitalization. The findings include: Review of the facility's bed hold policy, revised date: 8/2006, titled, Policy Name: Room Hold, Department: Nursing, under Procedure: read in part, "2. At the time of transfer the nurse will attach the policy and procedure dealing with room hold to the information that is sent to the hospital. 3. The family should notify the social worker within 24 hours after transfer concerning plans for room hold. On the weekends, they must notify the supervisor in charge." 1. Resident #32 was originally admitted to the facility on 1/25/18 with diagnoses including Unspecified Fracture of Shaft of Unspecified Tibia, Initial Encounter for Closed Fracture, Unspecified Fracture of Shaft of Fibula, Initial Encounter for Closed Fracture, Unspecified Consequence of a Previous Condition of Unspecified Cerebrovascular disease, Hemiplegia, Atrial Fribillation, Type 2 Diabetes Without Complications, Dementia Without Behavioral Disturbance, and Hypertension. According to the most recent Quarterly Minimum Data Set (MDS) dated 4/6/18, Resident #32 was severely cognitively impaired. The resident required extensive assistance in bed mobility and transfers with one person physical assistance. Resident #32 required supervision during meals and extensive supervision in toileting. Review of Resident #32's medical record	F 625	deficiency: The facility is unable to correct cited deficiency for residents #32, #54, and #116 as the facility Bed Hold Policy was not provided at the time of transfer/discharge and the residents have all since returned to the facility. To correct this deficiency, the facility Bed Hold Policy has been placed in the transfer/discharge packets at the nurse□s stations to be included in the transfer paperwork given to the resident when they are transferred or discharged. The staff nurse assigned to the resident at the time of transfer/discharge will document in the resident□s medical record that the facility Bed Hold Policy was provided to the resident at the time of transfer/discharge. The procedure for implementing the acceptable plan of correction: 1. Transfer/discharge packets containing the facility□s Bed Hold Policy will be placed at each nurse□s station by the Director of Nursing (DON). 2. Licensed staff will be in-serviced by the Administrator and/or Staff Development Coordinator on including the facility'□s Bed Hold Policy in the transfer paperwork given to the resident at the time of transfer/discharge and documenting in the resident□s medical record that the policy was provided to the resident at the time of transfer/discharge. The monitoring procedure to ensure that the plan of correction is effective and	

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F 625	Continued From page 8 revealed hospital stays from 3/4/18 through 3/12/18, 3/26/18 through 3/28/18, and 4/28/18 through 5/3/18. During an interview on 5/16/18 at 10:36 AM, Staff Nurse#3 reported Resident #32 had been in and out of the hospital. She revealed the last time Resident #32 was admitted to the hospital was because she sustained a fractured ankle after a fall. Staff Nurse#3 revealed Resident #32 liked to transfer by herself and the next day it was discovered that she had a fracture. Staff Nurse #3 added Resident #32 had brittle bones. She said the last two times Resident #32 was admitted to the hospital was because the resident experienced Cardiovascular Exacerbation and Respiratory Distress. Staff Nurse #3 revealed when a resident was discharged to the hospital, nurses sent the resident's face sheet, medication administration record, history and physical, progress notes from the doctor and a do not resuscitate (DNR) directive if the resident had one. When asked about the bed hold policy, Staff Nurse #3 revealed she did not generally deal with the bed hold. During an interview on 5/16/18 at 10:54 AM, the facility Social Worker stated they did not have any issues with resident's beds not being available when they returned from the hospital. She revealed residents usually returned to their same bed. She said she was not aware of the bed hold policy. During an interview on 5/16/18 at 4:23 PM, Staff Nurse #1 stated when a resident was discharged to the hospital she sent a copy of the resident's medication list, current labs., and x-rays, in addition to vital signs. She stated she did not	F 625	remains corrected and/or in compliance with the regulatory requirements: 1. The Director of Nursing or designee will review the daily census report in Point Click Care daily Monday-Friday to identify residents that have been transferred or discharged. 2. The Director of Nursing or designee will maintain an audit log of those resident identified. 3. The medical record of the identified residents will be reviewed by the Director of Nursing or designee to validate the facility'□s Bed Hold Policy was provided to the resident at the time of the transfer/discharge. 4. For any resident identified as not receiving the facility Bed Hold Policy at the time of transfer/discharge, the Director of Nursing or designee will identify the licensed nurse responsible and provide further education on the process of providing the Bed Hold Policy. 5. The Director of Nursing or designee will provide a copy of the audit log to the facility□s Performance Improvement Committee monthly x 3 months for review and to ensure continued compliance. The title of the person responsible for implementing the acceptable plan of correction: The Administrator is responsible for implementing this plan of correction. Completion Date: 6/14/18	

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F 625	Continued From page 9	F 625		

have anything to do with a bed hold policy.

During an interview on 5/17/18 at 1:48 PM, Staff Nurse #6 revealed when a resident was discharged to the hospital , she sent profile and insurance information, current medication list, labs., medical doctor's consults and transfer sheet with vital signs. When asked about the bed hold policy, Staff Nurse #6 said she did not have anything to do with the bed hold policy.

During an interview on 5/17/18 at 2:43 PM, the Admissions Director revealed Residents/Responsible Party received a copy of the bed hold policy when the resident was initially admitted to the facility and another one was sent with the resident when the resident was admitted to the hospital. She stated the Social Worker from the hospital would call back and ask if the resident could return to the facility. The Admissions Director revealed nursing staff sent a copy of the bed hold policy with the resident to the hospital. She said she was not aware nurses did not know about sending the bed hold policy with the resident to hospital. She said she would talk to the Director of Nursing about it.

During an interview on 5/17/18 at 2:54 PM, the Director of Nursing revealed it was part of policy to send the the bed hold policy to the hospital with the resident. She stated nurses were supposed to attach the bed hold policy with the packet of information that was sent to the hospital. She stated nurses needed more inservicing.

During an interview on 5/17/18 at 4:50 PM, the Administrator stated she thought they were doing fine. She revealed she thought the things they were doing was what they should have been

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F 625	Continued From page 10 doing. She stated that they called family members. 2. Resident # 54 was admitted to the facility on 2/8/18 with diagnoses Congestive Heart Failure, Chronic Kidney Disease, Chronic Respiratory Failure and Diabetes Mellitus. Review of Resident #54's admission Minimum Data Set (MDS) dated 2/15/18 identified Resident #54 as severely cognitively impaired. Review of Resident # 54's medical record revealed hospital stays from 3/13/18 through 4/3/18, 4/4/18 through 4/9/18 and 4/11/18 through 4/16/18. A review of Resident # 54's medical record indicated Resident #54's responsible party was her sister. A phone interview was attempted with Resident # 54's responsible party on 5/15/18 at 11:22 AM with a message left to return the call. The resident's representative did not return the call. During an interview on 5/16/18 at 10:54 AM, the facility Social Worker stated they did not have any issues with resident's beds not being available when they returned from the hospital. She revealed residents usually returned to their same bed. She said she was not aware of the bed hold policy. During an interview on 5/17/18 at 11:47 AM Nurse	F 625		

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BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

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F 625	Continued From page 11	F 625		

#6 revealed when a resident was sent out to the hospital, she sent profile paper with insurance information, current medication list, labs, medical doctor consults and transfer sheet with vital signs.

During an interview on 5/17/18 at 2:43 PM, the Admissions Director revealed Residents/Responsible Party received a copy of the bed hold policy when the resident was initially admitted to the facility and another one was sent with the resident when the resident was admitted to the hospital. She stated the Social Worker from the hospital would call back and ask if the resident could return to the facility. The Admissions Director revealed nursing staff sent a copy of the bed hold policy with the resident to the hospital. The Admissions Director said she was not aware nurses did not know about sending the bed hold policy with the resident to hospital. She said she would talk to the Director of Nursing about it.

3. Resident #116 was admitted on 08/29/17. The resident's documented diagnoses included muliptle fractures, end stage renal disease with hemodialysis, diabetes, hypertension, and chronic obstructive pulmonary disease.

The resident's 02/19/18 quarterly minimum data set (MDS) documented her cognition was intact.

Record review revealed Resident #116 was hospitalized from 12/24/17 through 12/28/17, from 02/06/18 through 02/08/18, and 05/01/18 through 05/07/18.

During an interview on 05/16/18 at 10:54 AM the Social Worker stated the facility did not have any issues with residents' beds not being available

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F 625	Continued From page 12	F 625		

when they returned from the hospital. She revealed residents usually returned to their same bed. She said she was not aware of the bed hold policy.

During an interview on 05/16/18 at 4:23 PM Nurse #1 stated when a resident was discharged to the hospital she sent a copy of the resident's medication list, current labs., and x-rays, in addition to vital signs. She stated she did not have anything to do with a bed hold policy.

During an interview on 5/17/18 at 1:48 PM Nurse #6 revealed when a resident was discharged to the hospital , she sent profile and insurance information, current medication list, labs., medical doctor's consults and transfer sheet with vital signs. When asked about the bed hold policy, Nurse #6 said she did not have anything to do with the bed hold policy.

During an interview on 5/17/18 at 2:43 PM, the Admissions Director revealed Residents/Responsible Party received a copy of the bed hold policy when the residents were initially admitted to the facility, and another copy was sent with the resident when the resident was admitted to the hospital. She stated the Social Worker from the hospital would call back and ask if the resident could return to the facility. The Admissions Director revealed nursing staff sent a copy of the bed hold policy with the residents to the hospital. She said she was not aware nurses did not know about sending the bed hold policy with the residents to the hospital. She said she would talk to the Director of Nursing about it.

During an interview on 5/17/18 at 2:54 PM the Director of Nursing revealed it was part of policy

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F 625	Continued From page 13 to send the the bed hold policy to the hospital with the resident. She stated nurses were supposed to attach the bed hold policy with the packet of information that was sent to the hospital. She stated nurses needed more in-servicing.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 636		6/14/18

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F 636	Continued From page 14 (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 resident and staff interviews, the facility failed to assess a resident ' s bowel and bladder status in order to conduct an accurate resident assessment for 1 of 20 residents whose Minimum Data Set Assessments were reviewed (Resident #56). The findings included: Resident #56 was admitted to the facility on	F 636	The plan of correcting the specified deficiency: Facility Administrator, Director of Nursing, and MDS nurse reviewed MDS documentation for resident #56 bowel and bladder. MDS dated 4/17/18 indicated the resident was always incontinent of bowel and bladder. After staff and resident interviews and observations it was	

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F 636	Continued From page 15 8/29/12 and had a diagnosis of neuromuscular dysfunction of the bladder and dementia. A Minimum Data Set Assessment is an assessment completed quarterly by the facility to determine a resident ' s strengths and weakness and includes a care area assessment summary used to develop a plan of care to meet the resident ' s needs. The Annual Minimum Data Set (MDS) Assessment dated 4/18/18 revealed Resident #56 was cognitively intact and was totally incontinent of bowel and bladder. The Care Area Assessment dated 4/18/18 for Urinary Incontinence noted the resident had bowel and bladder incontinence. The resident ' s Care Plan dated 4/18/18 noted the resident was incontinent of bowel and bladder. On 5/15/18 at 12:30 PM an interview was conducted with Resident #56. The resident stated she knew when she had to go to the bathroom and would roll her wheelchair into the bathroom and the staff helped her to sit on the toilet. The Resident further stated she occasionally had an accident and wet herself but never soiled herself. On 5/16/18 at 11:27 AM Nursing Assistant (NA) #3 stated in an interview that Resident #56 was always wet first thing in the morning but after getting her up, the resident would usually tell her when she had to go to the bathroom. On 5/16/18, at 12:04 PM, Nurse #4 stated she worked with Resident #56 on a regular basis. The	F 636	determined that resident #56 was always continent of bowel, continent of urine during day time hours, and incontinent of urine during night time hours. The resident and staff also report at least daily leakage of urine even with continent episodes. Resident should be coded as always continent of bowel and frequently incontinent of urine. ADL documentation shows resident #56 as always incontinent of bowel and bladder. To correct this deficiency, resident #56 MDS dated 4/17/18 and 5/1/18 was corrected to reflect accurate bowel and bladder function. The care plan for resident #56 was also updated to reflect the resident□s preference of wearing briefs during night time hours and continuing to toilet during the day time hours. Other residents identified with bowel or bladder incontinence will be reviewed with input from staff nurses, nursing assistants, and residents to determine if residents□ bowel and bladder status is coded accurately. The ADL records of identified resident will also be reviewed to determine accuracy of documentation. MDS corrections will be made as needed to ensure residents are coded accurately and have an individualized care plan to meet each resident□'s specific needs and/or preferences. Training for ADL coding will be provided for nursing assistants to ensure accurate coding by the Staff Development Coordinator. In-service education will also be provided by the Administrator for the MDS nurse on MDS coding accurately reflecting the status of the resident.	

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F 636	Continued From page 16 Nurse further stated the resident was continent of bowel and sometimes incontinent of urine. On 5/16/18 at 5:39 PM, NA #4 that worked on the day and evening shifts stated in an interview that the resident was continent of urine about 60 percent of the time and was continent of bowel. The NA stated around the middle of April she noted an improvement in the resident asking to go to the bathroom. The NA stated in early April, the resident was continent of bowel but more incontinent of urine. On 5/16/18 at 5:47 PM, NA #5 stated in an interview she would take the resident to the bathroom about 60 percent of the time and sometimes she was already wet. The NA stated the resident was continent of bowel. On 5/17/18 at 7:54 AM, NA #6 stated in an interview when she first checked the resident in the morning she was wet but after she got up, she would let her know when she needed to go to the bathroom. The NA stated sometimes when she took the resident to the bathroom she was a little wet but was mostly continent and was continent of bowel. The NA stated the resident ' s continence status had not really changed since early April. An interview was conducted with the MDS Nurse on 5/17/18 at 10:32 AM. The Nurse stated when she coded the bowel and bladder status on the MDS for the resident she referred to the ADL (activities of daily living) sheet filled out by the nursing assistants. The MDS Nurse provided the ADL sheet used to code the MDS and noted Resident #56 was incontinent of bowel and bladder during the 7 day assessment period. The	F 636	The procedure for implementing the acceptable plan of correction: 1. Director of Nursing will identify residents coded as always incontinent on the most recent MDS for bowel and bladder status. 2. The Director of Nursing, Assistant Director of Nursing, MDS Nurse, and Staff Development Nurse will review these identified residents with input from staff nurses, nursing assistants, and residents to determine if bowel and bladder status is accurately coded. ADL documentation for these residents will also be reviewed to determine accuracy of documentation. 3. Corrections will be completed by the MDS nurse for residents assessed to have inaccurate coding and care plans developed by the Director of Nursing and/or Assistant Director of Nursing which meet their individual needs and preferences. 4. In-service training will be provided for the nursing assistants by the Staff Development Nurse on Accurate ADL Coding of Bowel and Bladder function. 5. In-service education for the MDS Nurse will be provided by the Administrator on accurate coding of bowel and bladder status on the MDS and development of a care plan which reflects the status and preference of the resident. The monitoring procedure to ensure that the plan of correction is effective and remains corrected and/or in compliance with the regulatory requirements:	

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F 636	Continued From page 17 MDS Nurse stated she did not interview the staff or make any observations of the resident during the assessment period. On 5/17/18 at 3:10 PM the Administrator stated in an interview the MDS should be an accurate reflection of the resident and would expect the MDS nurse to assess the resident. On 5/17/18 at 4:08 PM an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated the resident had a physician who had her on a lot of medications and on 3/7/18 another physician took over and took the resident off some of her medications and over the next 2-3 weeks the resident became more alert and verbal, got out of bed more and was like a different person.	F 636	1. The Director of Nursing or designee will maintain a log of residents identified as incontinent with verified status of occasionally, frequently, or always noted. 2. The Director of Nursing or designee will audit ADL documentation for 20 residents weekly x 4 weeks, then monthly x 2 months to ensure coding accurately reflects resident bowel and bladder status. 3. The Director of Nursing or designee will validate accurate coding of Section H (Bowel and Bladder) on the MDS prior to assessment transmission weekly x 4, then monthly x 2 months. 4. The Director of Nursing or designee will audit care plans for appropriate bowel and bladder function and intervention based on the current care plan schedule for quarterly reviews x 3 months. 5. The Director of Nursing or designee will provide a copy of the audit logs to the facility□s Performance Improvement Committee monthly x 3 months for review and to ensure continued compliance. The title of the person responsible for implementing the acceptable plan of correction: The Administrator is responsible for implementing this plan of correction. Completion Date: 6/14/18	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		6/14/18

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F 656	Continued From page 18 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 19 section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to include in a resident's plan of care a psychotropic medication for 1 of 5 whose medications were reviewed (Resident #56). The findings included: Resident #56 was admitted to the facility on 8/29/12 and had a diagnosis of bi-polar disorder and anxiety. The Annual Minimum Data Set (MDS) dated 4/10/18 revealed the resident was cognitively intact and received an antidepressant x 7 days during the assessment period. The Care Area Assessment (CAA) dated 4/18/18 revealed the resident was at risk due to psychotropic medications related to the use of Cymbalta for anxiety and depression. Staff to monitor any changes in behavior. Will continue with care plan. Review of the May 2018 monthly physician's orders revealed an order dated 1/20/18 for Cymbalta delayed released 20mg, 2 tablets one time a day. (Cymbalta is a psychotropic medication used to treat depression and anxiety. A psychotropic medication is a medication capable of affecting the mind, emotions and behavior). Review of the Care Plan for Resident #56 revealed that the psychotropic medication was not included in the resident's Care Plan.	F 656	The plan of correcting the specified deficiency: Facility Administrator, Director of Nursing, and MDS nurse reviewed care plan for resident #56 and updated the care plan on 6/7/18 to include the use of the psychotropic medication Cymbalta. The Administrator and the Director of Nursing will identify current residents receiving psychotropic medications through medical record review. Care plans for these identified residents will be reviewed to ensure psychotropic medications are included with appropriate interventions. In-service education will be provided for licensed staff on resident plans of care including psychotropic medication use. The procedure for implementing the acceptable plan of correction: 1. The Administrator and Director of Nursing will identify residents currently receiving psychotropic medications. 2. The Director of Nursing, Assistant Director of Nursing, MDS Nurse, and Staff Development Nurse will review these identified residents□ care plans to validate psychotropic medication use is included. If psychotropic medication is not included in the plan of care, it will be added during these reviews. 3. In-service training will be provided by the Staff Development Nurse for the licensed staff on including psychotropic	

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F 656	Continued From page 20 An interview was conducted with the MDS Nurse on 5/16/18 at 2:30 PM. The Nurse was observed to review the resident's care plan and stated it must have been an oversight that she did not care plan the psychotropic medication. On 5/17/18 at 3:10 PM an interview was conducted with the Administrator who stated it was her expectation that the antipsychotic medication would be included in the resident's Care Plan.	F 656	medications in the residents plan of care. The monitoring procedure to ensure that the plan of correction is effective and remains corrected and/or in compliance with the regulatory requirements: 1. The Director of Nursing or designee will maintain a list of residents identified with psychotropic use. 2. The Director of Nursing or designee will audit care plans based on the current care plan schedule for quarterly reviews x 3 months to ensure psychotropic medications are included when appropriate. 3. The Director of Nursing or designee will provide a copy of the audit logs to the facility s Performance Improvement Committee monthly x 3 months for review and to ensure continued compliance. The title of the person responsible for implementing the acceptable plan of correction: The Administrator is responsible for implementing this plan of correction. Completion Date: 6/14/18	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		6/14/18

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F 686	Continued From page 21 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, staff interview, and record review the facility failed to complete a nutrition assessment and utilize nutrition supplementation for low albumin and total protein levels to help promote wound healing for 1 of 3 sampled residents (Resident #49) reviewed for pressure ulcers. Findings included: Record review revealed Resident #49 was admitted to the facility on 09/18/17. The resident's documented diagnoses included pressure ulcers, diabetes, gout, chronic kidney disease, and atrial fibrillation. The resident's most recent nutrition assessment was completed by the facility's registered dietitian (RD) on 10/23/17. This assessment documented, "...staff reports meal intakes of 50 - 100%. above (ideal body weight), (weight) loss of 7.96 (pounds) in one month, albumin moderately depleted at 2.9 (grams per deciliter on 09/21/17), but skin intact. Recommend Resource 2.0, two ounces (twice daily). Currently 65 (inches) and 189.4 (pounds)." (Resident's weight was 197 pounds on 09/19/17). A 11/01/17 physician order placed Resident #49	F 686	The plan of correcting the specified deficiency: Resident #49 was evaluated by the dietitian on 5/22/18 with recommendation made and implemented for Multivitamin by mouth every day and Prostat 30ml by mouth two times daily to aid in wound healing. Current residents with wounds will be identified and reviewed to determine if nutritional assessment has been completed and nutrition supplementation ordered as appropriate. Facility will implement wound protocol for nutritional supplementation to be initiated upon wound identification. The dietitian will receive a list of current residents with wounds on each visit to the facility. The dietitian will complete a nutritional assessment of the residents with wounds on her next scheduled facility visit following the identification of the wound. Nutritional supplementation will be reviewed at that time and adjusted as indicated. The procedure for implementing the	

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F 686	Continued From page 22 on Resource 2.0 two ounces twice daily (BID). A 11/21/17 physician order placed Resident #49 on weekly weights indefinitely (every Tuesday). A 11/30/17 physician order placed Resident #49 on a regular mechanical soft diet. 03/06/18 lab results documented Resident #49's albumin level was low at 2.8 grams per deciliter (g/dL), with the normal range being 3.1 - 4.7 g/dL and the resident's total protein was low at 5.7 g/dL, with the normal range being 6 - 8 g/dL. A 03/16/18 10:05 AM progress note documented Resident #49 returned to the facility from her last appointment with the wound care center where the ulcers to her right foot had been treated and healed. A 03/19/18 Weekly Skin Check documented a nurse applying Eucerin cream to the resident's feet found an intact blister to the resident's left heel. According to a 03/19/18 Skin Integrity Report the blister to Resident #49's left heel measured 3 x 4 centimeters (cm), and presented as a stage II wound. Skin Integrity Reports completed on 03/30/18, 04/06/18, 04/12/18, and 04/16/18 documented Resident #49 had a 4.8 x 5.8 cm unstageable ulcer/blister to her left heel with the wound bed being 100% eschar. A 04/08/18 2:00 PM progress note documented, "Reported to nurse that resident had an open area to buttocks. Nurse had CNA's (certified	F 686	acceptable plan of correction: 1. The Assistant Director of Nursing will identify and maintain a current list of residents with wounds. She will provide a copy of this list to the dietitian on each facility visit. 2. The Assistant Director of Nursing will assess each new wound and implement nutritional supplementation per wound protocol. 3. In-service training will be provided by the Administrator for the dietitian regarding facility expectations for nutritional assessments and supplementation for residents with wounds. 4. In-service training will be provided by the Administrator for the Assistant Director of Nursing regarding assessment of new wounds and implementation of nutritional supplementation per wound protocol. 5. The date of the nutritional assessment and nutritional supplementation implemented will be noted by the Assistant Director of Nursing on the current list of residents with wounds. The monitoring procedure to ensure that the plan of correction is effective and remains corrected and/or in compliance with the regulatory requirements: 1. The Director of Nursing will review the list of current residents with wounds weekly to ensure nutritional assessments are completed timely and nutritional supplementation is implemented as	

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F 686	Continued From page 23 nursing assistants) put resident back to bed and noted open area to mid upper gluteal area with yellow slough noted in middle of wound bed. No drainage noted. Area cleaned and protective cream applied." A 04/08/18 Skin Integrity Report documented Resident #49's unstageable sacral pressure ulcer measured 4.5 x 2.0 cm, and the wound bed was 100% slough. The wound also presented with purulent drainage and mild odor. The resident's care plan, last updated on 04/09/18, identified, "The resident has actual skin impairment, intact blister to left inner heel, unstageable pressure to sacrum r/t (due to) decreased mobility when in bed and when up in chair, diabetes" as a problem. Interventions to this problem included, "Good nutrition and hydration in order to promote healthier skin." The resident's 04/19/18 quarterly minimum data set (MDS) documented her decision making skills were severely impaired, she was experiencing appetite problems, she exhibited no behaviors including resistance to care, she was dependent on 1 - 2 staff members for all of her activities of daily living (ADLs) including eating, she was 65 inches tall and weighed 181 pounds, her weight was stable, she was on a mechanically altered diet, she was always incontinent of bowel and bladder, and she had one stage II and one unstageable pressure ulcer with slough comprising the most compromised wound bed. A 04/10/18 12:14 PM progress note documented, "...FNP (family nurse practitioner) in to see resident and assess open area to top of gluteal crease. New order received for Doxycycline	F 686	appropriate when new wounds are identified. The Director of Nursing will maintain an audit log for these weekly reviews. 2. The Director of Nursing will provide a copy of the audit logs to the facility□s Performance Improvement Committee monthly x 3 months for review and to ensure continued compliance. The title of the person responsible for implementing the acceptable plan of correction: The Administrator is responsible for implementing this plan of correction. Completion Date: 6/14/18	

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F 686	Continued From page 24	F 686		

(antibiotic) 100 mg po BID x 10 days for infection to ulcer. Order faxed to pharmacy. Review of the resident's medication administration record (MAR) revealed the resident received this antibiotic as ordered from 04/10/18 until 04/20/18.

A 04/20/18 Skin Integrity Report documented Resident #49's left inner heel "unroofed blister" measured 5.5 x 6 x 0.1 cm, and her unstageable sacral ulcer measured 6.5 x 4 with the wound bed remaining 100% slough. The sacral wound also presented with purulent drainage and mild odor.

The resident's treatment administration record (TAR) documented she received Flagyl ointment BID to her sacrum from 04/20/18 until 04/30/18.

A 04/27/18 Skin Integrity Report documented Resident #49's left heel ulcer measured 3.2 x 4.2 cm with the wound bed being 100%epitheleal tissue, and her unstageable sacral ulcer measured 6.4 x 4 with the wound bed remaining 100% slough. The sacral wound also presented with purulent drainage and mild odor.

The resident's most recent weight was 184.2 pounds on 05/01/18.

A 05/04/18 Skin Integrity Report documented Resident #49's left heel ulcer measured 3 x 2.4 x 0.1 cm with the wound bed being 100% epitheleal tissue and with minimal serous drainage, and her unstageable sacral ulcer measured 6.3 x 6.5 x 3 with the wound bed being 70% slough and 30% granulation tissue. The sacral wound also presented with purulent drainage and mild odor.

A 05/10/18 Skin Integrity Report documented Resident #49's left heel ulcer measured 2.7 x 1.8

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F 686	Continued From page 25	F 686		

x 0.1 cm with the wound bed being 100% epitheleal tissue and with minimal serous drainage, and her unstageable sacral ulcer measured 6.4 x 6 x 3.2 with the wound bed being 100% granulation tissue and with minimal serous drainage.

On 05/16/18 at 11:38 AM the Medical Director and Resident #49's primary physician stated nutrition was important in the wound healing process. However, he reported he was not a fan of providing nutritional supplements on an on-going basis. He commented his philosophy was when vitamin and nutrient deficiencies were identified to use nutritional supplementation for 14 - 30 days in order to correct the deficiency and then discontinue the supplements. The Medical Director stated if residents had low albumin and total protein levels with wounds then he encouraged protein replenishment from supplements or food, with his preference source being natural foods.
On 05/16/18 at 2:12 PM, during a follow-up interview with the Medical Director, he stated he had observed rapid deterioration of skin and wounds in residents, especially if they were frail, bedbound, totally incontinent, and/or had poor nutritional status.
On 05/17/18 at 10:08 AM the facility's RD stated she was in the building one time a month for a full day. She reported she was present in the facility on 03/19/18 and 04/23/18. She commented the facility had a new dietary manager (DM) who was orienting and spending most of her time addressing kitchen sanitation and training issues. She explained she was used to getting a list of residents to be seen from the DM, but since the new DM was devoting most of her time to food preparation and kitchen sanitation, she (the RD)

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F 686	Continued From page 26 had to develop her own lists of residents to assess. The RD stated she tried to review and assess new admissions (obtained from review of the MDS's), residents with significant weight loss (obtained from review of weight reports), and residents who were fed via tube (obtained from rounds in the facility). She commented staff also informed her of residents who expressed nutrition needs to them. The RD reported that she did not always get a list of pressure ulcers in the building so she tried to piece together that information herself. According to the RD, when residents developed ulcers she wanted an albumin level to be drawn to see if the residents needed protein supplementation. She explained when residents had depleted albumin levels she started them on liquid or powdered protein, and also liked to see the residents placed on vitamin C and a multi-vitamin. On 05/17/18 at 10:27 AM the DON reported it was her expectation for the RD to assess residents with pressure ulcers, especially when the wounds were greater than stage II ulcers. She reported she would expect the RD to begin protein supplementation for residents with compromised albumin and total protein levels, especially for residents with stage IV or unstageable ulcers. She commented the facility depended on the RD to complete assessments and give recommendations to help promote wound healing.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		6/14/18

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F 688	Continued From page 27 range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow therapy recommendations to apply splints for a resident's knee contractures for 1 of 6 residents reviewed for range of motion (Resident #21). The findings included: Resident #21 was admitted to the facility on 4/25/14, re-admitted to the facility on 9/5/17 and had a diagnosis of cerebrovascular accident (stroke), aphasia (unable to speak) and contractures of the right and left knees. An Admission Nursing Assessment dated 9/5/17 revealed the resident's right and left legs were contracted. The Quarterly Minimum Data Set (MDS) Assessment dated 4/9/18 revealed the resident was rarely/never understood, required extensive assistance with bed mobility, was not ambulatory and required extensive to total assistance with	F 688	The plan of correcting the specified deficiency: Resident #21 was placed on physical therapy caseload on 5/17/18 for staff education for knee splint application, splint schedule, and positioning. Recommendation was provided for nursing on 5/21/18 for resident to wear bilateral knee splints for 6 hours daily. Resident was also discharged from Physical Therapy on 5/21/18. The recommendation was approved by the physician and implemented on 5/21/18. Splint schedule is now on the Treatment Administration Record for the nurses to document when the splints are applied and removed. The therapy department will provide a current list of residents with active splint recommendations to the Director of Nursing. The list will be compared to the physician orders in Point Click Care to ensure all recommendations	

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F 688	Continued From page 28 ADLs (activities of daily living). Functional limitation in range of motion of the lower extremities noted impairment on both sides. The MDS revealed the resident received physical and occupational therapy during the assessment period. Review of the resident's most recent Care Plan dated 4/11/18 revealed no information regarding the resident ' s knee contractures. Review of the May 2018 monthly physician's orders revealed no orders for range of motion or splints to the resident ' s legs. On 5/15/18 at 12:22 PM the Assistant Director of Nursing (ADON) was observed to reposition Resident #21 and stated the resident had contractures of both knees. The ADON stated currently the resident received no splinting of the contracted knees. Review of the Physical Therapy (PT) discharge summary revealed the resident received PT from 4/3/18 to 4/30/18. The summary noted the resident had tolerated bilateral knee splints for prevention of increased knee flexion contractures and the patient was to be discharged for nursing to continue with bilateral knee splints. On 5/16/18 at 2:33 PM an interview was conducted with nursing assistant (NA) #1 who was assigned to the resident on day shift. The NA stated the resident received range of motion to the extremities during her bath and she put a pillow between her legs. The NA stated the resident did not have splints for her legs. On 5/16/18 at 3:15 PM an interview was	F 688	have been approved by the physician and implemented. Going forward, the therapy manager will give therapy recommendations to the Administrator or Director of Nursing daily for physician approval and implementation. Therapy and nursing will meet weekly to review the current list of residents with splints to ensure no recommendations have been missed. The procedure for implementing the acceptable plan of correction: 1. The Therapy Manager will identify residents with active splint recommendations and will provide a copy of this list to the Director of Nursing for validation the recommendations were approved by the physician and implemented in Point Click Care. 2. The Therapy Manager will deliver therapy recommendations to the Administrator or the Director of Nursing daily for physician approval and implementation in Point Click Care. 3. In-service training will be provided by the Administrator for the Therapy Manager and the Director of Nursing on the management, approval, and implementation of therapy recommendations. 4. The Therapy Manager and the Director of Nursing will meet weekly to review the current list of residents with active splint recommendations to ensure therapy recommendations have been approved and implemented and none have been missed.	

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F 688	Continued From page 29 conducted with the rehab (rehabilitation) director. The Rehab Director stated Resident #21 was supposed to have knee splints for 6 hours a day and she had trained the staff to apply the knee splints. The Rehab Director provided an order dated 4/30/18 that noted the resident was discharged from skilled services at that time. Nursing to don/doff braces 6 hours daily with skin checks pre and post treatment. The Rehab Director further stated therapy would write the recommendations and give to nursing as therapy was not allowed to enter orders in the computer. The Rehab Director stated the splints should be in the resident ' s closet. At the completion of the interview an observation of the resident ' s closet was made with the rehab director. She was observed to remove 2 splints from the top of the resident's closet. On 5/16/18 at 3:21 PM an interview was conducted with Nurse #5 that worked on the 3 PM to 11 PM shift. The Nurse stated she did not think the resident had knee splints and was observed to check the Medication Administration Record (MAR). The Nurse stated treatment orders were entered onto the MAR and there were no orders for knee splints. On 5/16/18 at 3:25 PM an interview was conducted with Nurse #2 who worked with the resident on the 11 PM to 7 AM shift. The Nurse stated there were no splints for the resident's legs but they had to use a lot of pillows for positioning. On 5/17/18 at 9:30 AM an interview was conducted with the Director of Nursing (DON). The DON stated she received all orders from therapy and entered them into the computer. The DON further stated she never received the order	F 688	The monitoring procedure to ensure that the plan of correction is effective and remains corrected and/or in compliance with the regulatory requirements: 1. The Administrator will review the splint meeting documentation weekly to ensure continued compliance. 2. The Therapy Manager will provide a monthly report identifying any missed splint recommendations to the facility□'s Performance Improvement Committee monthly x 3 months for review and to ensure continued compliance. The title of the person responsible for implementing the acceptable plan of correction: The Administrator is responsible for implementing this plan of correction. Completion Date: 6/14/18	

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F 688	Continued From page 30	F 688		

from therapy for the braces for the resident ' s contractures.

On 5/17/18 at 9:51 AM, the Rehab Director stated in an interview they had a rehab tech (technician) that was responsible for giving the rehab orders to the DON and a couple of weeks ago the tech was let go because of issues with the tech. The Rehab Director further stated apparently the rehab tech did not give the copy of the orders to the DON.

On 5/17/18 at 3:17, the Administrator stated in an interview that she and the DON were the only ones who put therapy orders in the computer and they never received the order. The Administrator further stated they enter the recommendations from therapy and the physician would sign the order. The Administrator stated the order must have gotten lost in the shuffle and she had no knowledge of knee splints for this resident. The Administrator stated it was her expectation for therapy to provide them with the therapy recommendations.