STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(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
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to establish a comprehensive Emergency Preparedness (EP) plan. The facility failed to complete a facility-based/community based risk assessment, develop a process for cooperation and collaboration with local, tribal, regional, state and federal EP officials, develop a system of tracking on-duty staff and sheltered residents, develop a communication plan, develop an alternate means of communication, develop a method of sharing information and	E 001	1. The facility failed to establish a comprehensive Emergency Preparedness Plan. The facility failed to complete a facility-based/community-based risk assessment. The Administrator reviewed and updated the emergency plan based on the facility and community-based risk assessment and communication plan utilizing all hazard approach. This was completed by 06/03/19 by the	6/3/19

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

Electronically Signed | 06/01/2019

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E 001	Continued From page 1 medical documentation, develop policy and procedures related to volunteers, develop a means of providing information about the facility's occupancy, needs and its ability to provide assistance, develop a means of sharing the EP plan with residents or responsible party (RP) and provide evidence of staff training on the EP plan. Findings included: 1. A review of the facility EP plan material on 5/15/19 revealed the following: The EP plan was developed 5/14/19 and did not include the following: a. The EP plan did not address the resident population including at-risk residents and the type of services the facility could provide in an emergency. b. The EP plan did not address the procedures for collaboration with local, tribal, regional, state and federal EP officials. c. The EP plan did not address the procedures for tracking staff and residents. d. The EP plan did not address a communication plan. e. The EP plan did not address an alternate means of communication. f. The EP plan did not address a means of sharing medical information for continuity of care. g. The EP plan did not address policy and procedures for volunteers.	E 001	Administrator. a. The EP plan did not address the resident population including at-risk and the type of services the facility could provide in an emergency. The Administrator will have a list of all residents that have difficulty with communications and how they communicate. The staff will be assigned for constant supervision of residents. A staff member and or volunteer will be assigned for at risk residents. Diesel generator Red out let plugs Back up water supply Emergency food supply Emergency pharmacy services O2 cylinders b. The EP plan did not address the procedures for collaboration with local, tribal, regional state and federal EP officials. The Administrator is addressing the issue with the Deputy Director of Public Safety EM Division/EMS Division of Moore County to implement proper procedures. Documentation of on-going efforts to communicate with local, tribal, regional, state and federal EP offices. Scheduled and planned evacuation drill due on 6/26/2019 with local fire, police and EMS services c. The EP plan did not address the procedures for tracking staff and residents. The administrator will use a daily updated resident census sheet as a checklist/headcount as well as a daily staff	

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E 001	Continued From page 2 h. The EP plan did not establish sharing of information on the facility's occupancy, needs and its ability to aid in the event of an emergency. i. The EP plan did not develop a means of sharing the plan with residents or RP. j. The EP plan did not provide evidence of staff training on the EP plan. An interview was conducted with the Administrator, Maintenance Director and the Director of Nursing (DON) on 5/16/19 at 9:45 AM. The Administrator stated the facility had developed an EP plan but was unable to provide evidence until 5/14/19. The DON stated the EP plan provided was completed on 5/14/19 and she was aware of the missing components. The Maintenance Director stated he started his position in June 2018 and he had no previous Long-Term Care experience. The Administrator stated it was possible that the previous Maintenance Director accidently took the EP plan with him when he left. She stated the facility implemented the Disaster Plan during Hurricane Florence in September of 2018 and sheltered in place. The Administrator stated it was her expectation the facility develops and maintains a comprehensive EP plan with annual updates.	E 001	on duty sheet. Sheets will be provided for all administrative members. Midnight census completed Q midnight by charge nurse to ensure accuracy Daily census is printed and brought to morning meeting for interdisciplinary distribution Nurses/ Med Aides head count post emergency or evacuation Activities Director to assist with ensuring all staff and residents accounted for during and after emergency d. The EP plan did not address a communication plan. The Administrator reviewed and updated the emergency plan which coordinates resident care within the facility, across healthcare providers and coordination with state and local public health department. The administrator ensured that the disaster manuals included contact information with state and local health departments. The Administrator will have all administrative staff contact information made available and updated as needed. As well as any repair or city services that is needed. Updated phone list will be at each Nursing station to include administrative staff and floor staff as well as ancillary staff (i.e. activities, medical records, dietary and housekeeping ect.) The phone list will be updated on a weekly basis by the staffing coordinator to remove inactive employees as well as include any new employees All hands on deck phone tree to be created by 06/03/2019 to allow for all staff in house during the event of an	

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E 001	Continued From page 3	E 001	emergency or disaster Red outlet charging in common areas for staff charging when appropriate to ensure continued communication e. The EP did not address an alternate means of communication. The Administrator will initiate the emergency communication plan that offer two options of choice. The Administrator may initiate the use of Facebook or Twitter as necessary. The Administrator will contact Radio station, Red Cross, Military, FEMA. Battery operated radios with access to local weather and emergency stations at each Nurses station Emergency cell phone access to personal cell phones by employees f. Plan did not address a means of sharing medical information for continuity of care. The Administrator will maintain emergency operation in facility by using red outlets. Emergency generator allows facility to operate to meet all residents/ staff needs. Medical records personnel will remove face sheet and H&P out of live chart during evacuation if possible. Nurses will evacuate with current MAR Report will be given to third party by nurse on duty via phone or in writing via nursing communication sheet when the patient is transferred to another facility due to emergency or disaster g. Plan did not address policy and procedure for volunteers. The facility will initiate training upon orientation and	

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E 001	Continued From page 4	E 001	maintain annual emergency preparedness thru policies and procedures to volunteers that is consistent with their expected roles. Administrator and Activity Director will in-service volunteers at next resident/family council meeting. All volunteers that are available to assist with evacuation and emergency will be contacted by the activities director and assistance requested as soon as possible after disaster or emergency h. The EP plan did not establish sharing of information on the facility's occupancy, needs and its ability to aid in the event of an emergency. The Administrator will put in place a plan to notify other facilities of our occupancy and needs in the event of an evacuation. The Administrator will provide a plan for the residents who may need to be evacuated to another facility and what the residents care would be to meet their needs. Medical Records and Social Worker will call and assist in placement if need for transfer. The family members or responsible party will be notified by telephone. All necessary paperwork and medications will transfer with resident. At least one staff member to transfer with residents if necessary to evacuate to another setting. Agreement is in place with St. Josephs of the pines to assist with residents, acuity and facility needs in the event of an emergency or disaster. The Moore County Emergency Response team will receive a copy of the emergency response plan no later than 06/03/2019.	

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E 001	Continued From page 5	E 001	Agreement is in place with Meadow wood Nursing Facility to take bedbound patients in the event of an emergency or disaster i. The EP plan did not develop a means of sharing the plan with residents or RP. The administrator will send a letter out to families and implemented through resident council. The administrator will develop and send out letters to resident's RP and family members by 06/03/2019 informing them of the emergency response plan and facilities in place to assist with disasters or emergencies j. The EP plan did not provide evidence of staff training on the EP plan. The Administrator will in-service all staff and keep a sign –in sheet of attendances as well as new hires to be completed upon orientation of training to include updates accordingly. Staff will be in serviced on Emergency Response plan by 06/03/2019 2. All residents in the facility have the potential to be affected by the alleged deficient practice. 3. The Administrator updated the emergency plan based on the facility and community-based risk assessment and communication plan utilizing an all-hazards approach. The emergency preparedness plan will be evaluated and updated on an as needed basis and reviewed for compliance at least annually. Facility staff will be educated on the updated emergency plan. This will be completed by 06/03/2019.	

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E 001	Continued From page 6	E 001	b. In-services of staff and volunteers on updated emergency plan policy and procedures , as well as communication plan will be completed by 06/03/2019 by Maintenance Director, Administrator, Director of Nursing, Shift Supervisor and or Nurse Manager. 4. The Administrator/Maintenance Director will review, and update emergency plan quarterly and as needed. b. QA tool entitled Disaster Plan Checklist will be reviewed with Department Heads weekly for 4 weeks. Monthly x 2 months. c. Training will be updated at least annually and as needed; Maintenance Director will include staff documentation of Emergency preparedness Plan training on a log. This will be completed by 06/03/2019. d. Any issues or trends identified will be addressed by Quality Assurance Performance Improvement Committee (QAPI) as they arise, and the plan will be revised to ensure continued compliance. 5. The Administrator and Maintenance Director are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 06/03/2019.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable	F 558		6/3/19

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F 558	Continued From page 7 accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide a divided plate during meals for a resident with adaptive equipment needs. This was for 1 (Resident #52) of 1 resident review for accommodation of needs. The findings included: Resident #52 was admitted on 1/15/18 with a diagnosis of Traumatic Brain Injury (TBI). Review of an Occupational Therapy Evaluation and Plan of Treatment dated 3/2/18 indicated was to have a divided plate with meals. Resident #52's care plan last revised 10/25/18 indicated he was dependent on staff to ensure that any adaptive equipment needed for present and provided. His quarterly Minimum Data Set (MDS) dated 4/14/19 indicated severe cognitive impairment with verbal behaviors. Resident #52 was coded for supervision with staff set-up for meals only and he was coded with functional physical limitation for one side of his upper extremity. During an observation on 05/13/19 at 12:35 PM, Resident #52 was observed eating his lunch in his room. He was sitting upright in bed. There	F 558	F558- Reasonable accommodations Needs/ Preference: 1. The facility failed to provide a divided plate during meals for resident #52 with adaptive equipment needs. Resident #52 physician order was processed on 5/15/19 by the Director of Nursing and resident #52 began receiving the divided plate on 5/15/19 during meals. 2. Other residents in the facility receiving adaptive equipment needs for meals have the potential to be affected by the alleged deficient practice. The Registered Dietician (RD) completed an audit on residents requiring adaptive equipment for meals on 5/23/2019. Any concerns identified were addressed.No other concerns identified in the facility. 3. Licensed Nurses and Occupational Therapist were re-educated by the Director of Nursing (DON) and Rehabilitation Therapy Manager (RTM) regarding the process of writing order for adaptive equipment and processing order to ensure resident will receive adaptive equipment this will be completed by June 3, 2019.Any staff with out training will be held at an inactive status and unable to work until in services are completed. This includes all staff on all shifts. Including PRN. 4. Audit Observation via dining adaptive	

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F 558	Continued From page 8 was no divided plate in use. During another observation on 5/14/19 at 9:20 AM, Resident #52 was observed eating his lunch in his room. He was sitting upright in bed. There was no divided plate in use. During an interview on 5/14/19 at 2:15 PM, the Rehabilitation Director stated Resident #52 was evaluated on 3/2/18 for the use of a divided plate which was indicated. She stated she was unable to provide any evidence of a written order for the divided plate. During an observation on 5/15/19 at 8:10 AM, Medication Aide (MA) #1 was administering Resident #52' medications. He was eating his breakfast on a regular plate. His dietary tray ticket read he was to have a divided plate for meals. MA #1 stated she was not aware that Resident #52 was to be provided with a divided plate for meals but confirmed it was documented on his dietary tray ticket. During an interview on 5/15/19 at 8:40 AM, the Dietary Manager (DM) stated he received a Diet Requisition Form yesterday that Resident #52 was to have his meals served on a divided plate, but he could not find one prior to the one he received on 5/14/19. The DM stated he updated Resident #52's dietary tray ticket on 5/14/19 to reflect the need for a divided plate and that he should have been served breakfast 5/15/19 on a divided plate this morning. During an interview on 5/15/19 at 10:33 AM, the Director of Nursing (DON) stated she wrote a	F 558	equipment will be completed by Director of Nursing (DON), Licensed Nurse, Staff Development Coordinator, Minimum Data Assessment Coordinator, Activities Director, Ambassador rounds conducted by Director of Nursing (DON), Licensed Nurse, Staff Development Coordinator, Minimum Data Assessment Coordinator, Activities Director weekly x 4 weeks then monthly x 2 months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee to include the following staff Director of Nursing (DON), Licensed Nurse, Staff Development Coordinator, Minimum Data Assessment Coordinator, Activities Director (QAPI) as they arise, and the plan will be revised to ensure continued compliance. The Director of Nursing will be responsible for maintaining and reporting data to QAPI team. 5. The Director of Nursing, Rehabilitation Therapy Manager and Administrator are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 6/3/2019.	

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F 558	Continued From page 9 physician's order on 5/14/19 for Resident #52 to have a divided plate with meals. She stated it was the expectation that when Rehabilitation prescribed any adaptive equipment, they should write a physician's order and give it to the nursing department. At that time, the nurse taking off the order should complete a Diet Requisition Form and give it to the dietary department. The DON stated that did not occur until 5/14/19. During an interview on 5/16/19 at 10:40 AM, the Administrator and DON stated it was their expectation that Resident #52 receive all meals on a divided plate as ordered.	F 558		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 604		6/3/19

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F 604	Continued From page 10 §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, record review, Physical Therapist (PT) interview, and staff interview, the facility failed to ensure a physical restraint had a medical symptom to justify its use and failed to complete a thorough assessment of the need for the physical restraint prior to its implementation for 1 of 7 residents (Resident #4) reviewed for physical restraints. A pommel cushion (a cushion designed to fill the natural gap between the upper legs when in a seated position preventing the user from sliding forward in their chair) was in place in Resident #4 ' s wheelchair to prevent the resident from sliding out of her wheelchair. The findings included: Resident #4 was admitted to the facility on 1/14/17 and most recently readmitted on 10/9/18 with diagnoses that included a history of falling, difficulty walking, and dementia. Resident #4 ' s care plan included the focus area of the risk for falls (initiated on 11/17/19) related to confusion, deconditioning, incontinence, poor communication/comprehension, and unawareness of safety needs. The quarterly Minimum Data Set (MDS)	F 604	F604- Right to be free from Physical Restraints: 1. The facility failed to ensure a physical restraint had a medical symptom to justify its use and failed to complete a thorough assessment of the need for the physical restraint prior to its implementation for resident #4. Resident #4 was reassessed on 05/29/19 for the least restrictive alternative. Upon reassessment on 05/29/19 by Physical Therapist the resident continues to require the use a Pommel Cushion. (a cushioned designed to fill the natural gap between the upper legs when in a seated position preventing the user from sliding forward in the chair) This was provided to facilitate upright trunk posture and to ease mobility. The Nursing staff initiated a physicians order for the Pommel Cushion on resident #4 on 5/16/2019. The facility completed an updated restraint assessment on 5/16/2019 for resident #4. The facility MDS coordinator updated the care plan to reflect the use of the Pommel Cushion as a restraint on 5/15/2019. The Pommel Cushion will be used for history of falls with serious injury with increase risk of	

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F 604	Continued From page 11 assessment dated 1/29/19 indicated Resident #4 ' s cognition was severely impaired. She had no behaviors and no rejection of care. Resident #4 was assessed as dependent on 2 or more for bed mobility, transfers, dressing, and toileting and dependent on 1 for personal hygiene. She required the extensive of 1 for locomotion on/off the unit. Resident #4 had no functional impairment with range of motion and she utilized a wheelchair. An incident report dated 3/11/19 indicated Resident #4 fell out of her wheelchair. Resident #4 ' s care plan related to falls was revised on 3/18/19 with the intervention of a therapy screen for a new wheelchair cushion. A Rehabilitation Referral Screen dated 3/18/19 indicated Resident #4 was referred for a screen due to increased sliding out of her wheelchair. This screen was conducted by Physical Therapist (PT) #1 on 3/18/19 and indicated a pommel cushion (a cushion designed to fill the natural gap between the upper legs when in a seated position preventing the user from sliding forward in the chair) was provided to facilitate upright trunk posture and to ease mobility. The hard copy medical record and electronic medical record revealed no physical restraint assessment/evaluation was conducted for the use of Resident #4 ' s pommel cushion utilized as a physical restraint. Additionally, there was no information regarding if any lesser restrictive alternatives were attempted prior to the pommel cushion being implemented by staff on 3/18/19.	F 604	falls and repeat injury. 2. Resident□s that reside in the facility and have a device such as pommel cushions, other cushion or any physical or mechanical device, material or equipment attached or adjacent to the resident□s body have the potential to be affected. The Director of Nursing, Nursing Supervisors, Licensed Nurses will complete a reassessment to ensure accuracy and use when indicated no later than 06/3/2019. No other concerns were identified through out the facility. 3. The facility Therapy Manager and Director of Nursing will meet to in service and educate staff in therapy and Nursing as it relates to writing orders for equipment use for restraints and order processing by June 03, 2019. The facility will educate nursing staff regarding proper completion of restraint assessment no later than June 03, 2019. The Director of Nursing will educate staff on proper restraint assessment. Any staff that have not completed mandatory training by 06/03/2019 will be unable to work until requirement is fulfilled. This includes all shifts and PRN staff. Screening by therapy will ensure the least restrictive option is utilized for any and all restraints. 4. The Director of Nursing and Rehabilitation Therapy Manager will review weekly x 4 weeks, then monthly x 2 months any devices that have been added and ensure appropriate order has been received, assessment complete, and care plans are in place. Any issues or trends identified will be addressed by the Quality Assurance Performance	

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F 604	Continued From page 12 The quarterly MDS assessment dated 4/29/19 indicated Resident #4 ' s cognition was severely impaired. Resident #4 was assessed as dependent on 2 or more for bed mobility, transfers, dressing, and toileting and dependent on 1 for personal hygiene. She required the extensive assistance of 1 for locomotion on/off the unit. Resident #4 had no functional impairment with range of motion and she utilized a wheelchair. She was coded with a physical restraint (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) in the category of "other" used daily. An observation was conducted on 5/13/19 at 12:30 PM and revealed Resident #4 seated in her wheelchair with a pommel cushion in place. The resident ' s active care plan was reviewed on 5/13/19, did not have a care plan in place related to Resident #4 ' s pommel cushion was being utilized as a physical restraint. The care plan for Resident #4 was revised on 5/14/19 by MDS Nurse #1 to include the focus area of the utilization of a pommel cushion as a physical restraint. The pommel cushion was to be in place in Resident #4 ' s wheelchair. The intervention was to ensure Resident #4 was positioned correctly with proper body alignment while restrained. The active May 2019 physician ' s orders for Resident #4 were reviewed on 5/14/19 and revealed no order was in place for the pommel	F 604	Improvement Committee (QAPI) as they arise, and the plan will be revised to ensure continued compliance. Restraint Audit tool will be utilized. Record of audit will be maintained by the Director of Nursing as well as presented in QAPI by Director of Nursing. 5. The Director of Nursing, Rehabilitation Therapy Manager and Administrator are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 6/3/2019	

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cushion that was utilized as a physical restraint for Resident #4.

An interview was conducted with MDS Nurse #1 on 5/14/19 at 4:58 PM. She stated that Resident #4 had a pommel cushion in place on her wheelchair. She indicated the pommel cushion was utilized as a physical restraint to prevent Resident #4 from sliding out of her wheelchair and falling onto the ground.

The Nursing Assistant (NA) care guide was reviewed on 5/15/19 and indicated Resident #4 had a pommel cushion in place as a physical restraint.

An interview was conducted with the Director of Nursing (DON) on 5/15/19 at 10:30 AM. She stated that prior to the implementation of a physical restraint, a restraint assessment/evaluation was to be completed, an order was to be obtained, and a care plan was to be developed. The DON revealed Resident #4 had a pommel cushion that was utilized as a physical restraint for the purpose of fall prevention. She indicated the pommel cushion was not able to be removed independently by Resident #4. She explained that Resident #4 fell out of her wheelchair on 3/11/19. She further explained that on 3/18/19 Resident #4 almost fell again as a result of sliding forward in her wheelchair, but staff intervened and prevented a repeat fall. The DON stated that Resident #4 was referred to rehabilitation for an evaluation on 3/18/19 to see if there was something that could be done to prevent her from sliding forward in the wheelchair. She reported that PT #1 recommended and provided the pommel cushion to Resident #4 on 3/18/19. The DON stated that

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PT #1 should have written an order for the pommel cushion and informed the nurse on the floor that the pommel cushion was implemented for Resident #4. She indicated that this would have prompted the nurse to complete a restraint assessment/evaluation and to obtain justification from the physician of the medical symptom that required the use of a physical restraint. The DON reported that all new orders were reviewed in the morning meetings that were held with all department heads every Monday through Friday. She stated that during the morning meeting on 3/19/19, MDS Nurse #1 should have been informed of the new order for the pommel cushion and this would have prompted her to develop a care plan for the use of Resident #4 ' s pommel cushion utilized as a physical restraint. Resident #4 ' s medical record was reviewed with the DON and she verified that there was no physician ' s order for the pommel cushion, no identification of the medical symptom that required the use of a physical restraint, and no restraint assessment/evaluation and no lesser restrictive alternative attempted prior to the pommel cushion being implemented. The DON also verified that there was no care plan in place for the pommel cushion utilized as a physical restraint until 5/14/19.

An interview was conducted with PT #1 on 5/15/19 at 10:35 AM. The 3/18/19 Rehabilitation Screen for Resident #4 was reviewed with PT #1. She indicated the pommel cushion was implemented to prevent Resident #4 from sliding forward out of the wheelchair and falling onto the floor. PT #1 revealed that she was unaware that she was supposed to write an order for the pommel cushion and she was also unaware that she was supposed to inform the resident ' s nurse

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F 604	Continued From page 15 that the pommel cushion was implemented. An interview was conducted with MDS Nurse #1 on 5/15/19 at 10:45 AM. She verified that Resident #4 had a pommel cushion that was utilized as a physical restraint. She indicated that the pommel cushion was implemented as a fall prevention intervention after Resident #4 fell from her wheelchair on 3/11/19. MDS Nurse #1 reported that the pommel cushion restricted Resident #4 ' s ability to slide forward in her wheelchair. She revealed the pommel cushion was initiated on 3/18/19, but she did not develop a care plan for Resident #4 ' s use of the pommel cushion as a physical restraint until 5/14/19. A follow up interview was conducted with the DON on 5/16/19 at 10:40 AM. She reported that there was a miscommunication with PT #1 that was the root cause of no order being in place, no medical symptom identified, no assessment/evaluation, and no care plan in place for the pommel cushion utilized as a physical restraint for Resident #4.	F 604		
F 623 SS=C	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	F 623		6/3/19

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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
(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),

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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.
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

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F 623	Continued From page 18 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 review, responsible party (RP), resident and staff interviews, the facility failed to notify the resident and/or the resident's RP in writing regarding the reason a resident was discharged from the facility to the hospital for 5 (Residents #58, #81, #70, #73 & #185) of 5 sampled residents reviewed for hospitalizations. Findings included: 1. Resident # 58 was originally admitted to the facility on 1/15/18. The quarterly Minimum Data Set (MDS) assessment dated 4/17/19 indicated that Resident #58 had cognitive impairment. Review of the Resident #58's nurse's note dated 11/18/18 at 8:10 AM revealed that Resident #58 was discharged to the hospital due to unresponsiveness and was readmitted back to the facility on 11/23/18. The note dated 12/29/18 at 8:50 AM indicated that Resident #58 was discharged to the hospital due to falls and was readmitted back to the facility on 12/31/18. The notes dated 11/18/18 and 12/29/18 did not indicate that the RP was notified in writing of the reason for the discharge. Resident #58's RP was interviewed on 5/16/19 at 9:24 am. The RP stated that the facility staff had called to notify her that the resident was	F 623	F623- Notice Requirement before Transfer/Discharge: 1. The facility failed to notify the resident and or the resident□s RP in writing regarding the reason a resident was discharged from the facility to the hospital for resident #58, #81, #70, #73 and #185. Resident # 185 no longer resides in the facility. The responsible party for Resident #58 was notified in writing of the discharge that occurred on 11/18/2018. The responsible party for Resident #81 was notified in writing of the discharge that occurred on 05/05/2019. The responsible party for Resident #70 was notified in writing of the discharge that occurred on 01/02/2019. The Responsible Party for resident # 73 was notified in writing of the discharge that occurred 03/05/2019 & 03/21/2019. This was completed 05/30/2019. This was completed by the Social Worker. 2. Residents that reside in the facility have the potential to be affected. An audit was conducted by the Director of Nursing, Staff Development Coordinator, Nursing Supervisor, Licensed Nurses, and Social Worker to identify transfers or discharges in the last 4 weeks to provide written notice to the responsible party to be completed by June 3, 2019. This yielded 20 late discharge notices that were mailed to resident's RP.	

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F 623	Continued From page 19 discharged to the hospital but she had not received any letter or notice from the facility to notify her of the reason for the hospitalization. Unit Manager (UM) #1 was interviewed on 5/15/19 at 2:03 PM. The UM stated that nurses were supposed to call the RP of the resident by phone when a resident was discharged to the hospital. She added that she had never sent a letter or notice to the RP to notify him/her in writing of the reason for the discharge. The Director of Nursing (DON) was interviewed on 5/15/19 at 2:50 PM. The DON stated that she was not aware of the regulation that facility had to notify the resident and or RP in writing of the reason for the discharge. She reported that she expected the regulation to be followed for the notification. 2. Resident #81 was originally admitted to the facility on 4/17/19. The admission Minimum Data Set (MDS) assessment dated 4/28/19 indicated that Resident #81's cognition was intact. Resident #81's nurse's note dated 5/5/19 revealed that Resident #81 was admitted to the hospital due to change in mental status and was readmitted back to the facility on 5/9/19. The note did not indicate that the resident was informed in writing of the reason for the discharge to the hospital. Resident #81 was interviewed on 5/15/19 at 10:50 AM. Resident #81 stated that the nurse informed him that he was going to the hospital but not in writing.	F 623	3. The Director of Nursing on 5/28/19 provided education and training to the Social worker to provide written notification of transfer to another facility or discharge to the hospital to the responsible party. 4. Social Worker or Nursing Supervisor will review all transfers and discharges weekly during clinical morning meeting weekly x 4 weeks to ensure written notification has been provided to the responsible party. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee (QAPI) as they arise, and the plan will be revised to ensure continued compliance. The Social Worker will be responsible for ensuring that all discharges RP received written notice via Discharge Audit tool. The Social Worker will be responsible for maintaining audit tool and bringing it to QAPI monthly. 5. The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 6/3/2019.	

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Unit Manager (UM) #1 was interviewed on 5/15/19 at 2:03 PM. The UM stated that nurses were supposed to notify the resident before the discharge to the hospital. She added that she had never informed the resident or the RP in writing of the reason for the discharge.

The Director of Nursing (DON) was interviewed on 5/15/19 at 2:50 PM. The DON stated that she was not aware of the regulation that facility had to notify the resident and or RP in writing of the reason for the discharge. She reported that she expected the regulation to be followed for the notification.

3. Resident #70 was originally admitted to the facility on 5/22/17. The annual Minimum Data Set (MDS) assessment dated 5/8/19 indicated that Resident #70 had moderate cognitive impairment.

Resident #70's nurse's note dated 1/2/19 at 7:00 AM revealed that Resident #70 was discharged to the hospital due to unresponsiveness and was readmitted back to the facility on 1/5/19.

The nurse's note dated 3/22/19 at 9:00 AM revealed that Resident #70 was sent to the hospital due to shortness of breath and was readmitted back to the facility on 3/26/19.

The 1/2/9 and 3/22/19 notes did not indicate that the resident or the RP was notified in writing of the reason for the discharge to the hospital.

Resident #70 was interviewed on 5/15/19 at 10:55 AM. Resident #70 reported that he could not remember whether or not he was notified in

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writing of the reason for the hospitalization.

Unit Manager (UM) #1 was interviewed on 5/15/19 at 2:03 PM. The UM stated that nurses were supposed to notify the resident before the discharge to the hospital. She added that she had never informed the resident or the RP in writing of the reason for the discharge.

The Director of Nursing (DON) was interviewed on 5/15/19 at 2:50 PM. The DON stated that she was not aware of the regulation that facility had to notify the resident and or RP in writing of the reason for the discharge. She reported that she expected the regulation to be followed for the notification.

4. Resident #73 was admitted to the facility on 2/21/19 with diagnoses that included Down ' s Syndrome.

The admission Minimum Data Set (MDS) assessment dated 2/28/19 indicated Resident #73 ' s cognition was severely impaired.

A medical record review revealed Resident #73 was transferred to the hospital on 3/5/19 (readmitted on 3/8/19) and 3/21/19 (readmitted on 3/28/19). There was no documentation that a written notice of hospital discharge was provided to Resident #73 ' s Responsible Party (RP).

On 5/15/19 at 2:05 PM, Unit Manager (UM) #1 was interviewed. She stated that the RP was notified by phone when a resident was discharged to the hospital. She reported that a written discharge summary was not given and/or sent to the RP. UM #1 stated that she was not

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aware of the regulation that indicated the facility had to notify the RP in writing of the reason for the hospital discharge.

On 5/16/19 at 10:40 AM, the Director of Nursing (DON) was interviewed. The DON also stated that she was not aware of the regulation that indicated the facility had to notify the RP in writing of the reason for the hospital discharge. The DON reported that she expected the regulation for notification to be followed.

5. Resident #185 was admitted to the facility on 12/11/18 with diagnoses that included dementia with behavioral disturbance.

The admission Minimum Data Set (MDS) assessment dated 12/18/18 indicated Resident #185 ' s cognition was severely impaired.

A medical record review revealed Resident #185 was transferred to the hospital on 3/12/19 and readmitted to the facility on 3/25/19. There was no documentation that a written notice of hospital discharge was provided to Resident #185 ' s Responsible Party (RP).

On 5/15/19 at 2:05 PM, Unit Manager (UM) #1 was interviewed. She stated that the RP was notified by phone when a resident was discharged to the hospital. She reported that a written discharge summary was not given and/or sent to the RP. UM #1 stated that she was not aware of the regulation that indicated the facility had to notify the RP in writing of the reason for the hospital discharge.

On 5/16/19 at 10:40 AM, the Director of Nursing

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F 623	Continued From page 23 (DON) was interviewed. The DON also stated that she was not aware of the regulation that indicated the facility had to notify the RP in writing of the reason for the hospital discharge. The DON reported that she expected the regulation for notification to be followed.	F 623		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medications (Residents #36, #41, #56, and #81), active diagnoses (Residents #36 and #41), physical restraints (Residents #4 and #23), falls (Residents #4 and #81), and gender (Resident #75) for 7 of 20 residents reviewed. The findings included: 1a. Resident #4 was admitted to the facility on 1/14/17 and most recently readmitted on 10/9/18 with diagnoses that included a history of falling, difficulty walking, and dementia. A Rehabilitation Referral Screen dated 3/18/19 indicated Resident #4 was referred for a screen due to increased sliding out of her wheelchair. This screen was conducted on 3/18/19 and indicated a pommel cushion (a cushion designed to fill the natural gap between the upper legs when in a seated position preventing the user from sliding forward in the chair) was provided to	F 641	F641- Accuracy of Assessments: 1. The facility failed to code the MDS assessment accurately in the following areas: medication for resident #36, #41, #56 and #81 Active diagnosis for resident #36 and #41 Physical restraint for resident #4 and #23 Falls for resident #4 and #81 Gender for resident #75 MDS coordinator corrected accuracy of assessments in the area of medications as it relates to resident #36, #41, #56 and #81 as of 05/16/2019. MDS coordinator corrected accuracy of assessment in the area of active diagnosis as it relates to resident #36 and #41 as of 05/16/2019. MDS coordinator corrected accuracy of assessments in the area of physical restraints as it relates to resident #4 and #23 as of 05/16/2019. MDS coordinator corrected accuracy of assessment as it relates to falls for resident #4 and #81 as of 05/16/2019. MDS coordinator corrected accuracy of assessments in the area of	6/3/19

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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 641	Continued From page 24 facilitate upright trunk posture and to ease mobility. The quarterly Minimum Data Set (MDS) assessment dated 4/29/19 indicated Resident #4 ' s cognition was severely impaired. She was coded with a physical restraint (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) in the category of "other" used daily when in bed. MDS Nurse #2 coded Resident #4 ' s 4/29/19 MDS in the area of physical restraints. An observation was conducted on 5/13/19 at 12:30 PM and revealed Resident #4 seated in her wheelchair with a pommel cushion in place. An interview was conducted with MDS Nurse #1 on 5/14/19 at 4:58 PM. She stated that Resident #4 had a pommel cushion in place on her wheelchair. She indicated the pommel cushion was utilized as a physical restraint to prevent Resident #4 from sliding out of her wheelchair and falling onto the ground. The Nursing Assistant (NA) care guide was reviewed on 5/15/19 and indicated Resident #4 had a pommel cushion in place as a physical restraint. A phone interview was conducted with MDS Nurse #2 on 5/15/19 at 11:40 AM. The 4/29/19 MDS for Resident #4 that indicated she had a physical restraint in the category of "other" utilized daily when in bed was reviewed with MDS Nurse #2. The interview with MDS Nurse #1 and the NA	F 641	gender as it relates to resident #75 as of 05/16/2019. The corrections were transmitted and submitted 05/17/2019. 2. Other residents in the facility have the potential to be affected by the deficit. An audit was conducted on MDS for accuracy in the areas of medication, active diagnosis, physical restraint, falls and gender on 05/15-16/2019 by the MDS coordinator. No other concerns found for the facility. MDS coordinators will audit opposite one another. MDS coordinators will not audit their own assessments. 3. MDS education related to accuracy of coding as stated in Resident Assessment Instrument manual and capturing data from resident chart to be completed by the Director of Nursing with MDS coordinators no later than 06/03/2019. 4. MDS Coordinator and/or Director of Nursing will randomly audit 5 completed MDS weekly x4 week; then randomly audit 5 completed MDS monthly x2 months to verify accuracy of coding for MDS sections as it relates to medications, active diagnosis, physical restraints, falls and gender. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee (QAPI) as they arise, and the plan will be revised to ensure continued compliance. The Unit Managers and Director of Nursing will be responsible for utilization of Assessment Accuracy tool and bringing it to QAPI monthly. 5. The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed	

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care guide that indicated Resident #4 had a pommel cushion in her wheelchair utilized as a physical restraint was reviewed with MDS Nurse #2. MDS Nurse #2 revealed the 4/29/19 MDS for Resident #4 was coded inaccurately in the area of physical restraints. She reported that Resident #4 ' s pommel cushion should have been coded as a physical restraint in the category of "other" was utilized daily when Resident #4 was out of bed or in chair.

An interview was conducted with the Director of Nursing on 5/16/19 at 10:40 AM. She indicated that she expected the MDS to be coded accurately.

1b. Resident #4 was admitted to the facility on 1/14/17 and most recently readmitted on 10/9/18 with diagnoses that included a history of falling, difficulty walking, and dementia.

An incident report dated 3/11/19 indicated Resident #4 had a fall that resulted in a nasal fracture.

The quarterly MDS assessment dated 4/29/19 indicated Resident #4 ' s cognition was severely impaired. She was coded with no falls since her previous MDS assessment (1/29/19). MDS Nurse #2 coded Resident #4 ' s 4/29/19 MDS in the area of falls.

A phone interview was conducted with MDS Nurse #2 on 5/15/19 at 11:40 AM. MDS Nurse #2 stated that she reviewed nursing notes when she coded the MDS for falls. She reported that she had not reviewed incident reports. The 4/29/19 MDS for Resident #4 that indicated Resident #4 had no falls since her previous MDS (1/29/19)

by 6/3/2019.

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was reviewed with MDS Nurse #2. The incident report and nursing note dated 3/11/19 that indicated Resident #4 had a fall that resulted in a nasal fracture was reviewed with MDS Nurse #2. MDS Nurse #2 revealed the 4/29/19 MDS for Resident #4 was coded inaccurately in the area of falls. She reported that she must have missed the 3/11/19 nursing note that indicated Resident #4 had a fall with major injury.

An interview was conducted with the Director of Nursing on 5/16/19 at 10:40 AM. She indicated that she expected the MDS to be coded accurately.

2a. Resident #36 was admitted to the facility on 11/30/18 with diagnoses that included anxiety.

A physician ' s order for Resident #36 dated 11/30/18 indicated Xanax (antianxiety medication) 0.5 milligrams (mg) three times daily as needed (PRN) for anxiety/agitation.

The March 2019 Medication Administration Record (MAR) indicated Resident #36 was administered PRN Xanax on 2 of 7 days (3/4/19 and 3/5/19) from 3/1/19 through 3/7/19.

The quarterly Minimum Data Set (MDS) assessment dated 3/7/19 indicated Resident #36 ' s cognition was severely impaired. She was coded with no antianxiety medication during the 7-day MDS look back period (3/1/19 through 3/7/19). MDS Nurse #1 coded the 3/7/19 MDS for Resident #36 in the area of medications.

An interview was conducted on 5/15/19 at 2:50 PM with MDS Nurse #1. The 3/7/19 MDS for Resident #36 that indicated she received no

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antianxiety medication was reviewed with MDS Nurse #1. The March 2019 MAR that indicated PRN Xanax was administered to Resident #36 on 3/4/19 and 3/5/19 was reviewed with MDS Nurse #1. MDS Nurse #1 revealed the 3/7/19 MDS for Resident #36 was coded in accurately in the area of medications. She stated that she should have coded this MDS to indicate that antianxiety medication was received on 2 of 7 days.

An interview was conducted with the Director of Nursing on 5/16/19 at 10:40 AM. She indicated that she expected the MDS to be coded accurately.

2b. Resident #36 was admitted to the facility on 11/30/18 with diagnoses that included anxiety and depression.

A physician ' s order for Resident #36 dated 11/30/18 indicated Cymbalta (antidepressant medication) 60 milligrams (mg) once daily at bed for depression.

A physician ' s order for Resident #36 dated 11/30/18 indicated Xanax (antianxiety medication) 0.5 mg three times daily as needed (PRN) for anxiety/agitation.

The March 2019 Medication Administration Record (MAR) indicated Resident #36 was administered routine Cymbalta for depression on 7 of 7 days from 3/1/19 through 3/7/19 and PRN Xanax for anxiety/agitation on 2 of 7 days (3/4/19 and 3/5/19) from 3/1/19 through 3/7/19.

The quarterly Minimum Data Set (MDS) assessment dated 3/7/19 indicated Resident #36 ' s cognition was severely impaired. She was

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coded with no active diagnoses of depression or anxiety. MDS Nurse #1 coded the 3/7/19 for Resident #36 in the area of active diagnoses.

An interview was conducted on 5/15/19 at 2:50 PM with MDS Nurse #1. The 3/7/19 MDS for Resident #36 that indicated no active diagnoses of anxiety or depression was reviewed with MDS Nurse #1. The March 2019 MAR that indicated routine Cymbalta was administered to Resident #36 on 7 of 7 days from 3/1/19 through 3/7/19 was reviewed with MDS Nurse #1. The March 2019 MAR that indicated PRN Xanax for anxiety/agitation was administered to Resident #36 on 2 of 7 days (3/4/19 and 3/5/19) from 3/1/19 through 3/7/19 was reviewed with MDS Nurse #1. MDS Nurse #1 revealed the 3/7/19 MDS for Resident #36 was coded in accurately in the area of active diagnoses. She stated that she should have coded this MDS to indicate that Resident #36 ' s active diagnoses included anxiety and depression.

An interview was conducted with the Director of Nursing on 5/16/19 at 10:40 AM. She indicated that she expected the MDS to be coded accurately.

3a. Resident #41 was admitted to the facility on 12/17/18 with diagnoses that included Alzheimer ' s disease, depression, and anxiety.

The March 2019 Medication Administration Record (MAR) from 3/22/19 through 3/28/19 indicated Resident #41 was administered Klonopin (antianxiety medication) 1 milligram (mg) once daily on 7 of 7 days and no injections.

The quarterly Minimum Data Set (MDS)

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assessment dated 3/28/19 indicated Resident #41 ' s cognition was severely impaired. Resident #41 was coded with an injection on 1 of 7 days and antianxiety medication on 1 on 7 days. MDS Nurse #1 coded the 3/28/19 MDS for Resident #41 in the area of medications.

An interview was conducted with MDS Nurse #1 on 5/15/19 at 4:35 PM. The 3/28/19 MDS for Resident #41 that indicated she received an injection on 1 of 7 days and antianxiety medication on 1 of 7 days was reviewed with MDS Nurse #1. The March 2019 MAR from 3/22/19 through 3/28/19 that indicated Resident #41 received Klonopin on 7 of 7 days and no injections was reviewed with MDS Nurse #1. MDS Nurse #1 revealed that the 3/28/19 MDS for resident #41 was coded inaccurately in the area of medications. She stated that she should have coded this MDS to indicate that Resident #41 received antianxiety medications were received on 7 of 7 days and had received no injections.

An interview was conducted with the Director of Nursing on 5/16/19 at 10:40 AM. She indicated that she expected the MDS to be coded accurately.

3b. Resident #41 was admitted to the facility on 12/17/18 with diagnoses that included anxiety.

A physician ' s order for Resident #41 dated 2/21/19 indicated Klonopin (antianxiety medication) 1 milligram (mg) once daily for a diagnosis of anxiety.

The March 2019 Medication Administration Record (MAR) indicated Resident #41 was administered routine Klonopin 1 mg once daily as

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ordered.

The quarterly Minimum Data Set (MDS) assessment dated 3/28/19 indicated Resident #41 ' s cognition was severely impaired. She received antianxiety medication during the MDS review period. Resident #41 was coded with no active diagnosis of anxiety. MDS Nurse #1 coded the 3/28/19 MDS for Resident #41 in the area of active diagnoses.

An interview was conducted with MDS Nurse #1 on 5/15/19 at 4:35 PM. The 3/28/19 MDS for Resident #41 that indicated her active diagnoses had not included anxiety was reviewed with MDS Nurse #1. The 2/21/19 physician ' s order for Resident #41 ' s Klonopin 1 mg once daily for anxiety was reviewed with MDS Nurse #1. The March 2019 MAR that indicated Resident #41 was administered Klonopin 1 mg once daily as ordered was reviewed with MDS Nurse #1. MDS Nurse #1 revealed the 3/28/18 MDS for Resident #41 was coded inaccurately for active diagnoses. She stated this MDS should have included the active diagnosis of anxiety for Resident #41.

An interview was conducted with the Director of Nursing on 5/16/19 at 10:40 AM. She indicated that she expected the MDS to be coded accurately.

4. Resident #23 was admitted to the facility on 12/24/12 with diagnoses that included dementia with behavioral disturbance and Parkinson ' s.

The quarterly Minimum Data Set (MDS) assessment dated 2/28/19 indicated Resident #23 ' s cognition was moderately impaired. Resident #23 was coded with a physical restraint

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in the category of "other" used daily when in bed. MDS Nurse #1 coded Resident #23 ' s 2/28/19 MDS in the area of physical restraints.

An observation was conducted of Resident #23 in her room on 5/15/19 at 1:15 PM. Resident #23 was asleep on a winged mattress.

An observation was conducted of Resident #23 in a common area of the secured memory care unit on 5/15/19 at 3:30 PM. Resident #23 was walking independently with the assistance of a walker.

An interview was conducted with MDS Nurse #1 on 5/15/19 at 1:18 PM. MDS Nurse #1 reported that the winged mattress was not a physical restraint for Resident #23 and that the 2/28/19 MDS was coded inaccurately in the area of physical restraints. MDS Nurse #1 explained that the winged mattress was in place for Resident #23, but that it had not restricted Resident #23 ' s movement and it had not prevented her from getting out of bed. She further explained that Resident #23 was able to get in and out of bed independently with the winged mattress in place. She stated that the 2/28/19 MDS should have indicated that no physical restraints were used for Resident #23.

An interview was conducted with the Director of Nursing on 5/16/19 at 10:40 AM. She indicated that she expected the MDS to be coded accurately.

5a. Resident #81 was admitted to the facility on 4/17/19 with multiple diagnoses including congestive heart failure (CHF), anxiety disorder, chronic pain, depressive disorder and psychosis.

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The admission Minimum Data Set (MDS) assessment dated 4/28/19 indicated that Resident #81 did not receive an antipsychotic medication, antidepressant medication, antianxiety medication, diuretic medication and opioid medication during the assessment period.

Resident #81 had physician orders on admission (4/17/19) for Risperdal for psychosis, Valium for anxiety, Trazodone for depressive disorder, Torsemide for CHF and oxycodone for chronic pain.

The April 2019 Medication Administration Records (MARs) revealed that Resident #81 had received Risperdal, Valium, Trazodone, Torsemide and Oxycodone during the assessment period (April 22-April 28, 2019).

On 5/15/19 at 2:45 PM, MDS Nurse #1 was interviewed. She reviewed the physician's orders and the April 2019 MARs and acknowledged that Resident #81 had orders and had received antipsychotic, antidepressant, antianxiety, diuretic and opioid medications during the assessment period. MDS Nurse #1 reviewed the admission MDS assessment dated 4/28/19 and indicated that these medications were not coded accurately. She reported that MDS Nurse #2 completed the admission MDS assessment and she only worked part time at the facility.

On 5/15/19 at 3:56 PM, MDS Nurse #2 was interviewed by phone. MDS Nurse #2 stated that she didn't understand why she coded the admission MDS assessment wrong for antipsychotic, antianxiety, antidepressant, diuretic and opioid medications. She added that it might be an oversight.

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On 5/15/19 at 3:05 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the MDS assessments to be coded accurately.

5b. Resident #81 was admitted to the facility on 4/17/19 with multiple diagnoses including congestive heart failure (CHF), anxiety disorder, chronic pain, depressive disorder and psychosis. The admission Minimum Data Set (MDS) assessment dated 4/28/19 indicated that Resident #81's cognition was intact and he had no falls since admission to the facility.

Review of the nurse's note and incident report dated 4/26/19 at 6:25 PM revealed that Resident #81 was found sitting on the floor in front of the wheelchair.

On 5/15/19 at 2:45 PM, MDS Nurse #1 was interviewed. She reviewed the incident reports and acknowledged that Resident #81 had a fall on 4/26/19. She indicated that the admission MDS assessment dated 4/28/19 was coded incorrectly under falls.

On 5/15/19 at 3:05 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the MDS assessments to be coded accurately.

6a. Resident #56 was admitted to the facility on 4/2/19 with multiple diagnoses including Transient Ischemic Attack (TIA) and cerebral infarction. The admission Minimum Data Set (MDS) assessment dated 4/13/19 indicated that

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Resident #56 had received an anticoagulant medication for 7 days during the assessment period.

Review of Resident #56's physician's orders revealed that he had no order for an anticoagulant medication.

Review of the Medication Administration Record (MAR) for April 2019 revealed that Resident #56 had not received an anticoagulant medication during the assessment period (April 7-13, 2019).

On 5/16/19 at 10:17 AM, MDS Nurse #1 was interviewed. She reviewed the physician's orders and the MAR for April 2019 and acknowledged that Resident #56 had no order and had not received an anticoagulant medication during the assessment period.

On 5/16/19 at 10:43 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the MDS assessments to be coded accurately.

6b. Resident #56 was admitted to the facility on 4/2/19 from another facility with diagnoses of displaced fracture femur neck, initial encounter for closed fracture, and repeated falls.

A review of Resident #56 ' s Admission Minimum Data Set (MDS) dated 4/13/19 revealed the resident was rarely or never understood and usually understands others. Cognition was moderately impaired for decision making skills. The resident required total dependence of 2 staff for all transfers and toileting, of one for bathing and dressing, and set up with supervision for

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meals. The active diagnoses were displaced fracture of femur neck encounter for closed fracture, and repeated falls.

A review of Resident #56 ' s care plan dated on 4/2/19 revealed a focus for falls and injury based on prior fall with injury. There was no documented depression or psychotropic medication identified.

A review of Resident #56 ' s current physician orders dated 5/1/19 did not reveal an order for antidepressant medication.

On 5/15/19 at 3:00 pm an interview was conducted of the MDS Nurse #1 who stated that Resident #56 ' s admission MDS dated 4/13/19 was incorrectly coded for antidepressant medication for 7 days and would be corrected.

On 5/15/19 at 3:10 pm an interview was conducted with the Director of Nursing who stated she expected the MDS to be coded accurately.

7. Resident #75 was admitted on 4/8/19 with a diagnosis of Dementia.

Review of Resident #75 admission section A Minimum Data Set (MDS) dated 4/21/19 indicated his gender as female.

During an interview on 5/15/19 at 2:50 PM, MDS Nurse #1 stated it was a mistake and the likely reason she incorrectly coded Resident #75 gender as female was because his hospital paperwork referred to him as "she". She stated Resident #75 should have been coded as male on his admission MDS.

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F 641	Continued From page 36 During an interview on 5/16/19 at 10:40 AM, the Administrator and Director of Nursing stated it was their expectation that Resident #75's MDS be accurate and reflect his gender as male.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §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.	F 656		6/3/19

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F 656	Continued From page 37 (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 section. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to develop a care pan in the areas of restraints (Resident #4), psychotropic medications (Residents #36 & 81), side rails (Resident #56), urinary catheter (Resident #81), pain management (Resident #81), and contracture (Resident #57) for 5 of 20 sampled residents reviewed. Findings included: 1a. Resident #81 was admitted to the facility on 4/17/19 with multiple diagnoses including low back pain, lumbar radiculopathy status post-surgery, malignant neoplasm of the prostate, anxiety disorder, depressive disorder and psychosis. Review of the physician's orders and Medication Administration Records (MARs) revealed that Resident #81 had orders and had received an antipsychotic, antianxiety and antidepressant medications since admission to the facility on 4/17/19. The care area assessment (CAAs) dated 4/28/19 revealed that Resident #81 had received	F 656	F656- Development/ Implementation Comprehensive Care Plan: 1. The facility failed to develop a care plans in the following areas: Restraints resident #4 Psychotropic medications Resident #36 and #81 Side rails resident #56 Urinary catheters resident #81 Pain management resident #81 Contractures resident #57 The MDS coordinator updated the care plans for resident #4 as it relates to restraints 05/16/2019, resident #36 and #81 as it relates to psychotropic medications 05/16/2019, resident #56 as it relates to side rails 05/16/2019, resident #81 as it relates to urinary catheters 05/16/2019, resident #81 as it relates to pain management 05/16/2019 and Resident #57 as it relates to contractures on 05/16/2019. 2. Other residents in the facility have the potential to be affected by this alleged deficient practice. An audit of care plans in the areas of restrains, psychotropic meds, side rails, urinary catheters, pain	

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F 656	Continued From page 38 Diazepam (an antianxiety medication), Duloxetine (an antidepressant medication), Risperdal (an antipsychotic medication) and Trazodone (an antidepressant medication). The assessment indicated that the resident needed a care plan for psychotropic medications to ensure the resident suffers little to no side effects related to medication use and to provide the highest quality of life for this resident. The CAAs indicated to proceed to care plan for the use of the psychotropic medication. Resident #81's care plan developed on 4/29/19 was reviewed. There were only 2 care plans developed, a care plan for falls and for nutrition. There was no care plan developed for the use of the psychotropic medications. On 5/15/19 at 2:45 PM, MDS Nurse #1 was interviewed. She stated that residents on psychotropic medication should have a care plan developed for the use of psychotropic medication. She reviewed the care plan for Resident #81 and acknowledged that there was no care plan developed for the use of the psychotropic medications. On 5/15/19 at 3:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected a care plan developed for residents receiving psychotropic medications. 1b. Resident #81 was admitted to the facility on 4/17/19 with multiple diagnoses including low back pain, lumbar radiculopathy status post-surgery, malignant neoplasm of the prostate, anxiety disorder, depressive disorder and psychosis.	F 656	management and contractures was completed by the MDS coordinator 05/16/2019. Any concerns identified were addressed. No other issues identified in the facility. 3. Education with MDS coordinators by the Director of Nursing as it relates to developing and implementation of a patient specific care plan will be completed no later than June 3, 2019. 4. The Unit Managers and or Director of Nursing will randomly audit 5 care plans per week x 4 weeks then randomly audit 5 care plans monthly x 2 months on residents who have restraints, psychotropic medications, side rails, urinary catheters, pain management and contractures to ensure accuracy and execution/ utilization of care plans. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee (QAPI) as they arise, and the plan will be revised to ensure continued compliance. MDS coordinator will be responsible for maintaining and performing Care Plan audit opposite of one another as MDS cannot audit self. MDS coordinators will be responsible for bringing information to QAPI monthly. 5. The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 6/3/2019.	

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Resident #81 was admitted to the facility with a physician's order for urinary catheter.

The care area assessment (CAAs) dated 4/28/19 revealed that Resident #81 was at risk for infection due to indwelling urinary catheter, a history of urinary tract infection and history of infection and other parasitic disease. The assessment indicated that the resident needed a care plan for the use of the indwelling urinary catheter to ensure the resident was clean, dry and odor free, free from skin breakdown due to incontinence and free from signs of infection related to catheter and to provide the highest quality of life for this resident. The assessment indicated to proceed to care plan to address the urinary incontinence and indwelling catheter.

Resident #81's care plan developed on 4/29/19 was reviewed. There were only 2 care plans developed, a care plan for falls and for nutrition. There was no care plan developed for the use of the indwelling urinary catheter.

On 5/15/19 at 2:45 PM, MDS Nurse #1 was interviewed. She stated that residents with indwelling urinary catheter should have a care plan developed. She reviewed the care plan for Resident #81 and acknowledged that there was no care plan developed for the indwelling urinary catheter.

On 5/15/19 at 3:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected a care plan developed for residents with urinary catheter.

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1c. Resident #81 was admitted to the facility on 4/17/19 with multiple diagnoses including low back pain, lumbar radiculopathy status post-surgery, malignant neoplasm of the prostate, anxiety disorder, depressive disorder and psychosis.

Resident #81 was admitted with a physician's order for oxycodone for chronic pain.

The care area assessment (CAAs) dated 4/28/19 revealed that Resident #81 was receiving oxycodone for pain. The assessment further indicated that Resident #81 needed a care plan for pain to ensure the resident was comfortable as possible and to provide the highest quality of life for this resident.

Resident #81's care plan developed on 4/29/19 was reviewed. There were only 2 care plans developed, a care plan for falls and for nutrition. There was no care plan developed for pain management.

On 5/15/19 at 2:45 PM, MDS Nurse #1 was interviewed. She stated that residents on pain medication should have a care plan developed for pain management. She reviewed the care plan for Resident #81 and acknowledged that there was no care plan developed for pain management.

On 5/15/19 at 3:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected a care plan developed for residents receiving pain medications.

2a. Resident #57 was admitted to the facility on

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F 656	Continued From page 41 11/16/12 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 4/17/19 indicated that Resident #57 had impaired cognition and had impairment in ROM on one side of upper and lower extremities. Resident #57's care plan dated 4/17/19 was reviewed and there was no care plan developed to prevent further decline of the hand contracture. On 5/15/19 at 2:45 PM, MDS Nurse #1 was interviewed. She stated that residents with contracture should have a care plan developed. She reviewed the care plan for Resident #57 and acknowledged that there was no care plan developed for the hand contractures. On 5/15/19 at 3:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected a care plan developed for residents with contracture 2b. Resident #57 was admitted to the facility on 11/16/12 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 4/17/19 indicated that Resident #57 had impaired cognition and had not used side rails as a restraint. Resident #57's care plan dated 4/17/19 was reviewed. The care plan approaches for falls included low bed with no side rails (added on 2/26/18). Resident #57 had a physician's order dated 2/26/18 for low bed with no side rails.	F 656		

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On 5/13/19 at 3:20 PM and on 5/14/19 at 3:50 PM, Resident #57 was observed in bed. The bed had ¼ side rails on both sides of the bed.

On 5/15/19 at 9:52 AM, the Unit Manager (UM) #1 was interviewed. She verified that Resident #57 had a physician order for no side rails in bed. She stated that Resident #57 was a hospice resident and all hospice beds have side rails in them. The UM indicated that she would get the maintenance to remove the side rails in resident's bed.

On 5/16/19 at 10:43 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected residents with an order for no side rails to have no side rails in their beds.
3. Resident #4 was admitted to the facility on 1/14/17 and most recently readmitted on 10/9/18 with diagnoses that included a history of falling, difficulty walking, and dementia.

A Rehabilitation Referral Screen dated 3/18/19 indicated Resident #4 was referred for a screen due to increased sliding out of her wheelchair. This screen was conducted by Physical Therapist (PT) #1 on 3/18/19 and indicated a pommel cushion (a cushion designed to fill the natural gap between the upper legs when in a seated position preventing the user from sliding forward in the chair) was provided to facilitate upright trunk posture and to ease mobility.

The quarterly MDS assessment dated 4/29/19 indicated Resident #4' s cognition was severely impaired. Resident #4 was assessed as dependent on 2 or more for bed mobility, transfers, dressing, and toileting and dependent

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on 1 for personal hygiene. She required the extensive assistance of 1 for locomotion on/off the unit. Resident #4 had no functional impairment with range of motion and she utilized a wheelchair. She was coded with a physical restraint (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) in the category of "other" used daily.

An observation was conducted on 5/13/19 at 12:30 PM and revealed Resident #4 seated in her wheelchair with a pommel cushion in place.

The resident ' s active care plan was reviewed on 5/13/19, did not have a care plan in place related to Resident #4 ' s pommel cushion was being utilized as a physical restraint.

The care plan for Resident #4 was revised on 5/14/19 by MDS Nurse #1 to include the focus area of the utilization of a pommel cushion as a physical restraint. The pommel cushion was to be in place in Resident #4 ' s wheelchair. The intervention was to ensure Resident #4 was positioned correctly with proper body alignment while restrained.

An interview was conducted with MDS Nurse #1 on 5/14/19 at 4:58 PM. She stated that Resident #4 had a pommel cushion in place on her wheelchair. She indicated the pommel cushion was utilized as a physical restraint to prevent Resident #4 from sliding out of her wheelchair and falling onto the ground.

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The Nursing Assistant (NA) care guide was reviewed on 5/15/19 and indicated Resident #4 had a pommel cushion in place as a physical restraint.

An interview was conducted with PT #1 on 5/15/19 at 10:35 AM. The 3/18/19 Rehabilitation Screen for Resident #4 was reviewed with PT #1. She indicated the pommel cushion was implemented to prevent Resident #4 from sliding forward out of the wheelchair and falling onto the floor.

An interview was conducted with MDS Nurse #1 on 5/15/19 at 10:45 AM. She stated that Resident #4 had a pommel cushion that was utilized as a physical restraint. She indicated that the pommel cushion was implemented as a fall prevention intervention after Resident #4 fell from her wheelchair on 3/11/19. MDS Nurse #1 reported that the pommel cushion restricted Resident #4 ' s ability to slide forward in her wheelchair and that the resident was unable to remove the pommel cushion independently. She revealed the pommel cushion was initiated on 3/18/19, but she had not developed a care plan for Resident #4 ' s use of the pommel cushion as a physical restraint until 5/14/19.

An interview was conducted with the Director of Nursing on 5/16/19 at 10:40 AM. She verified that Resident #4 had a pommel cushion that was utilized as a physical restraint. She indicated that she expected a care plan to be in place for the use of Resident #4 ' s physical restraint.

4. Resident #36 was admitted to the facility on 11/30/18 with diagnoses that included dementia,

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anxiety, and depression.

The quarterly Minimum Data Set (MDS) assessment dated 3/7/19 indicated Resident #36 ' s cognition was severely impaired. She received antipsychotic medication and antidepressant medication on 7 of 7 days.

A review of the active physician ' s orders was conducted on 5/15/19 and indicated Resident #36 was on routine Seroquel (antipsychotic medication) 12.5 milligrams (mg) twice daily, routine Cymbalta (antidepressant medication) 60 mg at bed, and as needed (PRN) Xanax (antianxiety medication) 0.25 mg every 12 hours as needed (PRN).

Resident #36 ' s active care plan was reviewed on 5/15/19 and revealed no care plan was in place related to psychotropic medications.

An interview was conducted on 5/15/19 at 2:50 PM with MDS Nurse #1. Resident #36 ' s active physician ' s orders that included antipsychotic medication, antidepressant medication, and antianxiety medication were reviewed with MDS Nurse #1. The active care plan that revealed no care plan was place related to Resident #36 ' s psychotropic medication use was reviewed with MDS Nurse #1. MDS Nurse #1 stated that this was an error and that a care plan should have been developed related to Resident #36 ' s utilization of psychotropic medications.

An interview was conducted with the Director of Nursing on 5/16/19 at 10:40 AM. She indicated that she expected a care plan to be in place to address the use of psychotropic medication.
5. Resident #56 was admitted to the facility on

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4/2/19 from another facility with diagnoses of displaced fracture femur neck, initial encounter for closed fracture, and repeated falls.

A review of Resident #56 ' s Admission Minimum Data Set (MDS) dated 4/13/19 revealed the resident was rarely or never understood and usually understands others. Cognition was moderately impaired for decision making skills. The resident required total dependence of 2 staff for all transfers and toileting, of one for bathing and dressing, and set up with supervision for meals. The active diagnoses were displaced fracture of femur neck encounter for closed fracture, and repeated falls. The resident had no fall since admission to the facility.

A review of Resident #56 ' s care plan dated 4/2/19 revealed a focus for falls and injury based on prior fall with injury. There was no goal or intervention for use of bilateral, padded, half side rails documented.

A review of Resident #56 ' s Bed Rail Evaluation Form dated 4/2/19 completed by the Unit Manager revealed "no rails indicated."

A review of Resident #56 ' s Physical Restrain Review Form dated 4/2/19 completed by the Unit Manager revealed "no restraints warranted."

On 5/15/19 at 1:10 pm Resident #56 was observed to be residing in his bed with bilateral half, padded side rails.

On 5/15/19 at 2:30 pm an interview was conducted with Resident #56 who was oriented to self and surroundings. The resident indicated he was aware of his side rails and was able to state

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F 656	Continued From page 47 that he wanted them because he held them when he turned. The resident commented that he used to sleep in a queen size bed and had rolled out of this bed and wanted the side rails. The resident verbalized no concerns. On 5/15/19 at 3:00 pm an interview was conducted with MDS Nurse #1 who stated Resident #56 did not have a care plan for side rails and she was not aware when the side rails were added. The MDS Coordinator stated that the resident should have had an evaluation and care plan for side rails. On 5/15/19 at 3:10 pm an interview was conducted with the Director of Nursing (DON) who stated that when Resident #56 was admitted he did not have the side rails. The care plan needed to be updated and an order would be obtained for side rails. The resident was using the side rail as an enabler. The DON expected staff to evaluate for side rail use and develop a care plan for use.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		6/3/19

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F 657	Continued From page 48 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to revise care plans in the areas of code status (#73) and physical restraints (Resident #23) for 2 of 20 residents reviewed. The findings included: 1. Resident #73 was admitted 2/21/19 and most recently readmitted on 3/28/19 with diagnoses that included Down ' s Syndrome. A physician ' s order dated 2/21/19 indicated Resident #73 had a full code status. The admission Minimum Data Set (MDS) assessment dated 2/28/19 indicated Resident #73 ' s cognition was severely impaired. The care plan for Resident #73 included the focus area of full code status (initiated on 2/21/19). This focus area was most recently	F 657	F657- Care Plan Timing and Revision: 1. The facility failed to revise care plans in the area of code status on resident #73 as well as physical restraint for resident #23 The facility MDS coordinator corrected the care plan for resident #73 as it relates to code status as of 05/16/2019. The facility MDS coordinator updated the care plan for resident #23 as it relates to physical restraints on 05/16/2019. 2. Other residents in the facility have the potential to be affected by this deficient practice as it relates to care plan revision with code status and restraints. The facility implemented code status and restraint audit 5/16/2019. This was completed to ensure all code status and restraints are correct as well as reflected correctly on the order. No other concerns identified. This will be completed by the Unit Managers.	

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F 657	Continued From page 49 revised on 3/5/19 by MDS Nurse #1. A physician ' s order dated 3/28/19 indicated Resident #73 had a change in code status to Do Not Resuscitate (DNR). An interview was conducted with MDS Nurse #1 on 5/15/19 at 1:50 PM. She stated that she reviewed new physician ' s orders during the morning meeting that was held every Monday through Friday. The physician ' s order dated 3/28/19 that indicated Resident #73 ' s code status was changed from a full code to a DNR was reviewed with MDS Nurse #1. The care plan that indicated Resident #73 was a full code was reviewed with MDS Nurse #1. MDS Nurse #1 revealed that this care plan should have been revised when Resident #73 ' s code status changed from full code to DNR on 3/28/19. She stated that she missed this and she was going to revise Resident #73 ' s care plan. An interview was conducted with the Director of Nursing (DON) on 5/16/19 at 10:40 AM. She indicated that she expected care plans to be reviewed and revised to reflect the current status of the resident. 2. Resident #23 was admitted to the facility on 12/24/12 with diagnoses that included dementia with behavioral disturbance and Parkinson ' s. The quarterly Minimum Data Set (MDS) assessment dated 2/28/19 indicated Resident #23 ' s cognition was moderately impaired. She required supervision and set up help only for bed mobility, transfers, walking room/corridor, and	F 657	3. Education with the MDS coordinators and review of care plan revision will be completed by the Director of Nursing to ensure care plan timing and revision is done with in a timely manner. This will be completed no later than June 3, 2019 4. The facility MDS coordinator will update care plans on all admission and readmissions and use code status/restraint audit tool 1x per week x 2 months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee (QAPI) as they arise, and the plan will be revised to ensure continued compliance. MDS coordinators will be responsible for bringing information to QAPI monthly. 5. The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 6/3/2019.	

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F 657	Continued From page 50	F 657		

locomotion on/off unit. Resident #23 had no functional impairment with range of motion and she utilized a walker.

Resident #23 ' s active care plan was reviewed on 5/15/19. This care plan included the focus area for the utilization of a winged mattress as a physical restraint. This focus area was initiated on 8/6/18.

An observation was conducted of Resident #23 in her room on 5/15/19 at 1:15 PM. Resident #23 was asleep on a winged mattress.

An observation was conducted of Resident #23 in a common area of the secured memory care unit on 5/15/19 at 3:30 PM. Resident #23 was walking independently with the assistance of a walker.

An interview was conducted with MDS Nurse #1 and the Director of Nursing (DON) on 5/15/19 at 1:18 PM. Resident #23 ' s care plan that indicated the winged mattress was utilized as a physical restraint was reviewed with MDS Nurse #1 and the DON. They both reported that the winged mattress was not a physical restraint for Resident #23 and that the care plan needed to be revised. The DON explained that the winged mattress was in place for Resident #23, but that it had not restricted Resident #23 ' s movement and it had not prevented her from getting out of bed. She further explained that Resident #23 was able to get in and out of bed independently with the winged mattress in place. MDS Nurse #1 confirmed the DON ' s statement that the winged mattress had not prevented Resident #23 from getting in or out of bed. MDS Nurse #1 stated that she was going to revise the care plan for

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F 657	Continued From page 51 Resident #23. A follow up interview was conducted with the DON on 5/16/19 at 10:40 AM. She indicated she expected care plans to be reviewed and revised to accurately reflect the current status of the resident.	F 657		
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 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 record review, observation and staff interview, the facility failed to provide care to prevent further decrease in range of motion for 1 (Resident #57) of 2 sampled residents reviewed with limitation in range of motion (ROM). Findings included:	F 688	F688- Increase/Prevent Decrease in ROM/Mobility: 1. The facility failed to provide care to prevent further decrease in range of motion for resident #57. The facility requested therapy screen 05/16/2019 for resident #57 for bilateral hand contractures.	6/3/19

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F 688	Continued From page 52 Resident #57 was admitted to the facility on 11/16/12 with multiple diagnoses including dementia and hypertension. The quarterly Minimum Data Set (MDS) assessment dated 4/17/19 indicated that Resident #57 had impaired cognition and had impairment in ROM on one side of upper and lower extremities. The assessment further indicated that the resident was receiving hospice care. Resident #57's care plan dated 4/17/19 was reviewed and there was no care plan developed to prevent further decline in ROM of both hands. On 4/4/19, a rehab (rehabilitation) referral screen was requested by nursing due to bilateral hand contractures. On 4/11/19, Resident #57 was seen by the physician and the physician note revealed that Resident #57's hands were contracted. On 5/13/19 at 9:15 AM, on 5/14/19 at 2:20 PM and on 5/15/19 at 8:50 AM, Resident #57 was observed in bed with both hands in fist position. There was no device to prevent further decrease in ROM noted on both hands. On 5/15/19 at 8:53 AM, Nursing Aide (NA) # 3, assigned to Resident #57, was interviewed. She stated that she didn't know if the resident was wearing a splint/brace or not. The NA reported that if a resident was on splint or ROM exercise, the restorative aide was responsible for the application of the splint and the provision of the exercise. On 5/15/19 at 8:54 AM, Nurse #2, assigned to Resident #57, was interviewed. She stated that	F 688	2. Other residents in the facility have the potential to be affected by this deficient practice related to ROM/Mobility. A facility wide audit was completed on 05/16/2019 to ensure residents with contractures are currently using splints and have been screened by therapy. This was completed by the Director of Nursing and the Activities Director. No other issues identified. 3. The facility Director of Nursing and Therapy Manager will provide education with nursing and therapy staff related to process of screening and providing care to residents as well as hospice communication to ensure residents receive contracture care in a timely manner by June 3, 2019. Any staff that have not completed mandatory training by 06/03/2019 will be unable to work until requirement is fulfilled. This includes all shifts and PRN staff. 4. This will be audited by the Director of Nursing and or Nurse Supervisor for random audit of 5 residents with contractures per week x 4 weeks then randomly audit of 5 residents with contractures monthly x 2 months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee (QAPI) as they arise, and the plan will be revised to ensure continued compliance.The director will be responsible for maintaining the audit tool and bringing it to QAPI. 5. The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of	

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F 688	Continued From page 53 she didn't know if the resident was on splint/brace or not. She added that if the resident was on splint/brace, the restorative aide was responsible for the application. On 5/15/19 at 8:55 AM, Restorative Aide #1 was interviewed. She stated that Resident #57 was not on their work load for ROM exercise nor for splint application. On 5/15/19 at 10:21 AM, the Director of Nursing (DON) was interviewed. She stated that on 4/4/19, Resident #57 was referred to therapy for screening due to bilateral hand contractures. The therapy department referred the resident to hospice. The Restorative Nurse who was responsible for restorative nursing was new to her role and failed to refer Resident #57 to hospice. On 5/15/19 at 10:30 AM, the Rehab Director was interviewed. She stated that she had received a referral from nursing to screen Resident #57 for bilateral hand contracture. Resident #57 was a hospice resident so she sent a referral to hospice to get an approval from hospice to treat the resident however she never heard back from nursing nor hospice after the referral. On 5/15/19 at 11:33 AM, the Restorative Nurse was interviewed. She stated that she started working at the facility in March 2019 as staff development coordinator (SDC) and as a Restorative Nurse. She stated that she received the referral from therapy to refer Resident #57 to hospice however she might have missed to call hospice. On 5/16/19 at 10:43 AM, the DON was again interviewed. The DON stated that she expected	F 688	correction. Corrective action completed by 6/3/2019.	

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F 688	Continued From page 54 the staff to provide care to a resident with contracture to prevent further decline in ROM.	F 688		
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: Based on observations, resident and staff interviews and record review, the facility failed to secure a resident's cigarettes and lighter as ordered for 1 (Resident #14) of 2 residents reviewed for safe smoking. The findings included: Review of the facility's undated policy titled "Smoking" read that in some instances smoking restrictions may be necessary because of safety or medical reasons. The restrictions should be noted in the resident care plan. Resident #14 was admitted on 1/12/18 with cumulative diagnoses of Cerebral Vascular Accident and hemiplegia. Review of a physician order dated 5/23/18 read Resident #14's smoking material (cigarettes and lighter) were to be stored on the medication cart at all times. Resident #14's quarterly Minimum Data Set (MDS) stated 2/10/19 indicated she was	F 689	F689- Free of Accident Hazards/Supervision/Devices: 1. The facility failed to secure a resident□s cigarettes and lighter as ordered for resident #14.The facility implemented a dual person check for smoking materials when resident is in bed and smoking material not in use as of 05/27/2019. Resident was Re- Evaluated 05/29/2019 and has been deemed safe and appropriate to carry tobacco products and smoking material during any hours out of bed. The facility implemented supervised smoking audit for supervised smokers in the facility to ensure that there is no smoking material at the bedside or on resident's person when not in use. This was started 05/20/2019. 2. Other residents that smoke have a potential to be affected by this deficient practice as it relates to unsecured smoking material. Supervised smokers were checked for contraband 5/17/2019	6/3/19

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F 689	Continued From page 55 cognitively intact and exhibited no behaviors. She was coded as having physical limitations to one side of her upper extremities. Review of Resident #14's Tobacco Assessment dated 2/10/19 indicated her cigarettes and lighter were to be stored by the nursing department when not in use. This form was not signed by the nurse who completed the form. Review of Resident #14's care plan last revised 3/20/19 read she was not allowed to keep her smoking materials in her purse during the day. Smoking material was to secure on the medication cart. Review of April 2019 Medication Administration Record (MAR) indicated first, second and third shift were documenting validation that Resident #14's smoking materials (cigarettes and lighter) were to be stored on the medication cart at all times. Review of the facility's Tobacco/Smokeless Tobacco Use form dated revised 4/2/19 indicated the facility was to store Resident #14's cigarettes and lighter. Review of Resident #14's Tobacco Assessment dated 5/11/19 did not indicate any smoking restrictions related to the storage of her cigarettes or lighter. This form was signed by Nurse #1. Review of May 2019 MAR from 5/1/19 through 5/14/19 indicated first, second and third shift were documenting validation that Resident #14's smoking material (cigarettes and lighter) were to be stored on the medication cart at all times.	F 689	and no other concerns were identified. This was completed by the Director of Nursing and was implemented on only supervised smoking residents. 3. The Licensed Nursing staff and Medication Aides will be educated by Director of Nursing, Staff Development Coordinator, Unit Manager or shift Supervisor on importance of following supervised smoking guidelines to ensure fire and patient safety. This will occur no later than June 3, 2019. Any staff that have not completed mandatory training by 06/03/2019 will be unable to work until requirement is fulfilled. This includes all shifts and PRN staff. 4. The Department Heads and or licensed Nurses will complete random audits on supervised smokers once a week during environmental rounds x 4 weeks then monthly x 2 months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee (QAPI) as they arise, and the plan will be revised to ensure continued compliance. A supervised smoking audit will be completed by the Director of Nursing and brought to QAPI monthly by the DON. 5. The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 6/3/2019.	

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During an observation and interview on 5/13/19 at 3:43 PM Resident #14 was sitting in her wheelchair in her room. Observed in the right side of her wheelchair was a gray zipper top bag. The bag was unzipped and visible was a red pack of cigarettes. Resident #14 zipped the bag stating she did not have a lighter. She said the nurse kept her lighter until she went outside. There was no visible evidence of ashes or cigarette burns observed on her clothing.

During an observation on 5/14/19 at 9:30 AM and again at 11:30 AM, Resident #14 was outside smoking in the designated smoking area.

During an observation on 5/14/19 at 2:35 PM, Resident #14 was in the main dining room during a Resident Council Meeting with her gray bag unzipped on the right side of her wheelchair. Again, a red pack of cigarettes was visible.

On 5/14/19 at 3:00 PM, Resident #14 went back outside to smoke.

During an observation on 5/14/19 at 3:50 PM, Resident #14 was observed in the Rehabilitation room eating a sandwich. She had her gray bag in her wheelchair and it was unzipped. Visible were her cigarettes and her red lighter.

During an observation on 5/15/19 at 8:15 AM, Medication Aide (MA) #1 checked the medication cart for Somerset hall. There was no gray bag observed on the cart and MA #1 confirmed

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Resident #14's smoking items were not secured in the medication cart. On entry to Resident #14's room with MA #1, observed on the bedside table was the gray bag unzipped with a red pack of cigarettes visible inside the bag. Resident #14 was asleep and did not arouse of request. The sheet was covering her head.
MA #1 stated the normal process was the second shift nurse or MA locked up Resident #14's smoking items around 8:00 PM when she went to bed. She stated MA #2 worked second shift on 5/14/19 and she relieved Nurse #1 this morning on third shift. MA #1 stated during the day, Resident #14 had possession of her smoking items because she stays outside in smoking area most of day. MA #1 confirmed Resident #14 was not supposed to have her smoking items due to concerns with noncompliance with the smoking rules.

In an observation on 5/15/19 at 9:25 AM, Resident #14's door was open, and she was still asleep in bed. Visible was the gray bag still on the bedside table with the red pack of cigarette visible sticking out of the bag.

In an observation on 5/15/19 at 1:20 PM, Resident #14 was in the main dining room eating. She was in possession of the gray bag that was unzipped. There was no visible evidence of the red pack of cigarettes inside the bag.

During an interview on 5/15/19 at 1:30 PM, MA #1 stated she removed Resident #14's cigarettes and lighter and stored them on her medication cart. She stated management was to have a conversation with her sometime today about

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securing her smoking items on the medication cart when not in use.

During an interview on 5/15/19 at 3:20 PM, MA #2 stated Resident #14's brother came to see her last evening and they sat outside in the smoking area till about 11:00 PM. As he was leaving, Resident #14 came inside and went to sit in the television room. MA #2 stated normally Resident #14 was not up that late and he normally secured her cigarettes and lighter on the medication cart after she went to bed. MA #2 stated the facility allowed Resident #14 to keep her cigarettes and lighter during the day since she spent so much time outside smoking. MA #2 stated her cigarettes and lighter should have been locked on the medication cart after she went to bed sometime after he left at 11:00 PM and confirmed he was relieved by Nurse #1.

During a telephone interview on 5/15/19 at 3:25 PM, Nurse #1 confirmed she worked third shift last night. She stated normally Resident #14 was already in the bed when she arrived at work, and she only verified Resident #14's cigarettes and lighter were secured on the medication cart before she signed off on the MAR. She confirmed she signed off on the MAR for third shift last night. Nurse #1 confirmed she administered Resident #14 medications this morning at 6:00 AM and she did not notice the gray bag unzipped sitting on her bedside table with her cigarettes inside. Regarding the incomplete Tobacco Assessment dated 5/11/19 that did not indicate any smoking restrictions related to the storage of her cigarettes or lighter, she stated it was an oversight and should have indicated her ordered

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F 689	Continued From page 59 restrictions. Nurse #1 stated she would have to be more observant in the future. During an interview on 5/16 at 10:40 AM, the Administrator and DON stated it was their expectation that Resident #14's cigarettes and lighter were to be secured on the medication cart when they were not in use during the day and secured on the medication cart once she went to bed at night and not returned to her until she was up and going outside to smoke.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		6/3/19

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F 690	Continued From page 60 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow up on a positive urinary culture report that required antibiotic treatment for a urinary tract infection for 1 (Resident #56) of 1 residents reviewed for urinary tract infection. Findings included: Resident #56 was admitted to the facility on 4/2/19 from another facility with diagnoses of cystitis and history of urinary tract infections (UTI). A review of Resident #56 ' s Admission Minimum Data Set (MDS) dated 4/13/19 revealed the resident was rarely or never understood and usually understands others. Cognition was moderately impaired for decision making skills. Resident #56 required total dependence of 2 staff for all transfers and toileting, of one for bathing and dressing, and set up with supervision for meals. The active diagnoses were cystitis and urinary retention. A review of Resident #56 ' s care plan dated 4/2/19 revealed a focus at risk for urinary tract infection.	F 690	F690- Bowel/Bladder Incontinence Catheter, UTI: 1. The facility failed to follow up on a positive urinary culture report that required antibiotic treatment for a urinary tract infection for resident #56. The facility spoke with the doctor for resident #56 and implemented secondary contact regarding lab results should the doctor not be accessible via primary phone number. This was established 05/16/2019. The secondary point of contact will be the Medical Director as well as another physician working in Kingswood. 2. Other residents have the potential to be affected by the deficient practice as it relates to potential delay in treatment for active Urinary Tract Infections. The Director of Nursing, Unit Manager and or Shift Supervisor will audit the past 2 weeks Urinary Culture Reports this will be completed by 06/03/19. No issues identified. 3. The staff education will be completed by the Director of Nursing to include education to reflect procedure changes	

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F 690	Continued From page 61 Resident #56 had a physician order dated 4/29/19 which revealed obtain urine for urinalysis and culture. A review of Resident #56 ' s lab report results dated 5/2/19 revealed urine culture positive for organism Enterococcus faecalis (A). Susceptible antibiotics for treatment were provided. On 5/6/19 Resident #56 ' s physician ordered Tetracycline each day for 10 days for UTI (physician order). On 5/15/19 at 4:00 pm an interview was conducted with Unit Manager (UM) #1 who stated she was aware of Resident #56 ' s positive urinalysis on 4/29/18 and informed the physician. UM #1 stated that she received via fax positive culture from the lab on 5/2/19 that the resident had a UTI. UM #1 stated that she called the resident's physician and her voice mail was full and was unable to leave a message regarding the culture. UM #1 stated that she did not call the Medical Director and waited until the resident's physician returned to the facility on 5/6/19 to order the antibiotic for the UTI. UM #1 agreed that since the Resident #56 had altered mental status on 4/28/19 for which the physician ordered the urinalysis and culture, had cystitis and bladder cancer history, she should have attempted to call the Medical Director when the resident's physician was not available. On 5/15/15 at 4:10 pm an interview was conducted with the Director of Nursing who stated she expected the staff to contact the physician for positive urine culture when reported from the lab and not to wait until the physician returned to the	F 690	which include a lab audit tool no later than June 3, 2019. Any staff that have not completed mandatory training by 06/03/2019 will be unable to work until requirement is fulfilled. This includes all shifts and PRN staff. 4. A lab tool will be implemented by the Unit Managers on labs and communication tracking no later than June 3, 2019. Nursing Management will implement procedure for a positive urinary culture requiring further treatment to include Primary Physician is contacted 2 times minimum on the day of resulting. If the primary physician is not available, the Medical Director will be contacted to give further orders based on culture and sensitivity. Also, if the Medical Director is the Primary Doctor a different doctor in the facility will be contacted in the event that he/she is not available with in a timely manner. This will be implemented with staff education to reflect procedure change no later than June 3, 2019. A lab tool will be implemented by the Unit Manager on labs and communication tracking no later than June 3, 2019. This will be completed weekly x 4 weeks then monthly x 2 months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee (QAPI) as they arise, and the plan will be revised to ensure continued compliance. The Unit Managers will perform audits and bring results to QAPI monthly. 5. The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of	

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F 690	Continued From page 62 facility. If the attending physician was not available, the Medical Director should be contacted.	F 690	correction. Corrective action completed by 6/3/2019.	
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to evaluate side rails before use (Residents #56 and #57) and used side rails for a resident who was assessed as not requiring side rails (Resident #4) for 3 of 7 residents reviewed for restraints. Findings included:	F 700	F700- Bedrails: 1. The facility failed to evaluate side rails before use on resident #56 and #57 and used side rails for a resident who was assessed as not requiring side rails for resident #4. The facility reviewed and updated side rail assessment on resident #56 and #57 as	6/3/19

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F 700	Continued From page 63 1. Resident #56 was admitted to the facility on 4/2/19 from another facility with diagnoses of displaced fracture femur neck, initial encounter for closed fracture, and repeated falls. A review of Resident #56 ' s Admission Minimum Data Set (MDS) dated 4/13/19 revealed the resident was rarely or never understood and usually understands others. Cognition was moderately impaired for decision making skills. The resident required total dependence of 2 staff for all transfers and toileting, of one for bathing and dressing, and set up with supervision for meals. The active diagnoses were displaced fracture of femur neck encounter for closed fracture, and repeated falls. A review of Resident #56 ' s care plan dated on 4/2/19 revealed a focus for falls and injury based on prior fall with injury. There was no goal or intervention for use of bilateral, padded, half side rails documented. A review of Resident #56 ' s current physician orders revealed there was no order for side rail use. A review of Resident #56 ' s Bed Rail Evaluation Form dated 4/2/19 completed by the Unit Manager revealed "no rails indicated." A review of Resident #56 ' s Physical Restrain Review Form dated 4/2/19 completed by the Unit Manager revealed "no restraints warranted." On 5/15/19 at 1:10 pm Resident #56 was observed to be residing in his bed with bilateral half, padded side rails.	F 700	of 05/16/2019 to reflect accuracy. This was completed by Unit Manager. The facility removed the rails from resident #4 as of 05/15/2019. This was completed by the Unit Manager. 2. Other residents have the potential to be affected by this deficient practice as it relates to improper side rail use. A side rail assessment will be completed on residents that have side rails by the Unit Manager. This will be completed by 6/3/19. Any concerns identified will be addressed. No other concerns identified. 3. Education with Licensed Nursing staff will be completed regarding properly completing and assessing side rails no later than June 3, 2019 by DON, Unit Managers, Staff Development Coordinator or MDS. Any staff that have not completed mandatory training by 06/03/2019 will be unable to work until requirement is fulfilled. This includes all shifts and PRN staff. 4. An audit of 10 bed rails will be completed weekly x 4 weeks then 5 monthly x 2 months to ensure proper use of side rails. This will be completed by the Unit manager. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee (QAPI) as they arise, and the plan will be revised to ensure continued compliance. A bedrail audit will be completed by the Unit Manager and brought to QAPI monthly by the Unit Manager. 5. The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of	

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F 700	Continued From page 64 On 5/15/19 at 2:30 pm an interview was conducted with Resident #56 who was oriented to self and surroundings. The resident indicated he was aware of his side rails and was able to indicate that he wanted them because he held them when he turned. The resident commented that he used to sleep in a queen size bed and had rolled out of this bed. He wanted the side rails. The resident verbalized no concerns. On 5/15/19 at 3:00 pm an interview was conducted with the MDS Nurse #1 who stated Resident #56 did not have a care plan for side rails and she was not aware when the side rails were added. The MDS Coordinator stated that the resident should have had an evaluation and care plan for side rails. On 5/15/19 at 3:10 pm an interview was conducted with the Director of Nursing (DON) who stated that when Resident #56 was admitted he did not have the side rails. The care plan needed to be updated and an order would be obtained for the side rails. The resident used side rails as an enabler. The DON expected staff to evaluate for side rail use and develop a care plan for their use as indicated. 2. Resident #57 was admitted to the facility on 11/16/12 with multiple diagnoses including dementia and hypertension. The quarterly Minimum Data Set (MDS) assessment dated 4/17/19 indicated that Resident #57 had impaired cognition, was dependent with bed mobility, transfer and was non ambulatory. The assessment further indicated that Resident #57 was not using bed rail as a restraint. Resident #57's care plan for falls dated 4/17/19	F 700	correction. Corrective action completed by 6/3/2019.	

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F 700	Continued From page 65	F 700		

was reviewed. One of the care plan interventions was low bed with no side rails (added on 2/26/18).

A bed rail/assist bar evaluation form was partially completed on 5/4/19. The form did not indicate the reason for the use of the side rail.

On 5/13/19 at 3:20 PM, and on 5/14/19 at 3:50 PM, Resident #57 was observed in bed. The bed had ¼ side rails on both sides of the bed.

On 5/14/19 at 3:51 PM, NA #4, assigned to Resident #57, was interviewed. She stated that the side rails were used to prevent Resident #57 from falling.

On 5/14/19 at 3:52 PM, Nurse # 3, assigned to Resident #57, was interviewed. The Nurse stated that the side rails were used to prevent Resident #57 from falling out of bed.

On 5/15/19 at 8:38 AM, NA #3, assigned to Resident #57, was interviewed. She stated that Resident #57 was totally dependent for bed mobility, transfer and she was non - ambulatory. She added that the side rails were used to prevent her from falling out of bed.

On 5/15/19 at 9:31 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the bed rail/assist bar evaluation form completed to include the reason for the use of the side rails. The DON reported that Resident #57 was not supposed to have side rails in her bed as ordered.

On 5/16/19 at 10:43 AM, the DON was again interviewed. She stated that she expected

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F 700	Continued From page 66	F 700		

residents with an order for no side rails to have no side rails in their bed. She also indicated that residents should be evaluated for use of the side rails including the reason for the use of the side rails prior to installing the side rails in their bed.
3. Resident #4 was admitted to the facility on 1/14/17 and most recently readmitted on 10/9/18 with diagnoses that included a history of falling, difficulty walking, and dementia.

The quarterly Minimum Data Set (MDS) assessment dated 4/29/19 indicated Resident #4 ' s cognition was severely impaired. Resident #4 was assessed as dependent on 2 or more for bed mobility and transfers.

A Bed Rail/Assist Bar Evaluation dated 4/29/19 indicated Resident #4 was assessed as not needing side rails.

An observation was conducted of Resident #4 on 5/15/19 at 10:10 AM. Resident #4 was asleep in her bed with bilateral quarter side rails in place.

An interview was conducted with the Director of Nursing (DON) on 5/15/19 at 11:30 AM. The Bed Rail/Assist Bar Evaluation dated 4/29/19 that indicated Resident #4 was assessed as not needing side rails was reviewed with the DON. The 5/15/19 observation of Resident #4 in bed with bilateral quarter side rails in place was reviewed with the DON. She revealed that Resident #4 was not supposed to have any side rails. She explained that Resident #4 previously was on a different unit in a different bed. She further explained that when Resident #4 was moved to the secured memory care unit (3/15/19) the bed she was moved to already had the bilateral quarter rails in place. The DON revealed

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F 700	Continued From page 67 it had not been identified that these side rails were mistakenly in place for Resident #4. She reported that this error was going to be corrected today (5/15/19). A follow up interview was conducted with the DON on 5/16/19 at 10:40 AM. She stated that it was her expectation that side rails not be utilized for a resident who was assessed with no need for side rails. She additionally indicated that when residents were moved to different rooms with different beds, that the new bed needed to be checked to ensure side rails were only in place for residents that had been thoroughly evaluated and determined to have a need for side rail usage.	F 700		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 2 of 5 Nursing Assistants (NA) reviewed for staffing, received annual Dementia training. The findings included: NA #1's date of hire was 6/30/15. Review of NA #1's education/In-services records indicated her last Dementia training was in September 2017. NA #2's date of hire was 7/9/14. Review of NA	F 730	F730- Nurse Aide Perform Review-12hr/yr in service: 1. The facility failed to ensure 2 nursing assistants reviewed for staffing received annual dementia training. The facility implemented session 1 of 12 for annual Alzheimer and dementia training as of 05/27/2019. This was implemented by the Activities Director and the Staff Development Coordinator.	6/3/19

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F 730	Continued From page 68 #2's education/In-services records indicated her last Dementia training was in September 2017. During an interview on 5/16/19 at 9:47 AM, the Staff Development Coordinator (SDC) stated she recently to the position of SDC March 2019. She confirmed she was aware that annual Dementia training was required. The SDC stated NA #1 only works weekends and NA #2 worked as needed (prn) and that was likely the reason they were missed. During an interview on 5/16/19 at 10:40 AM, the Administrator and Director of Nursing stated it was their expectation that all employed aides receive annual Dementia training.	F 730	2. Other residents in the facility have the potential to be affected by this deficient practice as it relates to knowledge deficit regarding dementia and Alzheimer's. Annual training was implemented 05/27/2019. An audit of staff that have received 12 hours/yr was completed on 05/16/2019. Any concerns identified will be addressed. This was implemented by The Activities Director and the Staff Development Coordinator. No other issues identified. 3. The Activities Director and Staff Development coordinator will provide 1 educational hour 2 times a month until 12 hours of dementia training is complete by active employees. The education will continue through December 2019. The facility will provide 8 hours of dementia training for new hires on start date and provide the opportunity for 4 additional hours until 1st annual evaluation. The facility has posted a list of dates and times for mandatory dementia/ Alzheimer through December 2019 at various locations through out the building as of 05/27/2019. 4. This will be monitored q month x 3 months and as necessary. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee (QAPI) as they arise, and the plan will be revised to ensure continued compliance. This will be audited with Educational Audit and monitored by Staff Development and Activities Director. This will be brought to QAPI by the Staff Development Coordinator.	

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F 730	Continued From page 69	F 730	5. The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 6/3/2019.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility's Quality Assurance Committee (QA) failed to maintain procedures and monitor interventions that the committee put into to place following the annual recertification survey dated 3/1/18. This was for two recited deficiencies in the areas of Accuracy of Assessments at F641-not accurately coding the Minimum Data Set (MDS) in the areas of medications, diagnosis and falls previously cited on 3/1/18 and Develop/Implement Comprehensive Care Plan at F656-not developing a care plan for a urinary catheter previously cited 3/1/18. The findings included: This citation is cross referenced to: F641-Based on record review, observation, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medications (Residents #36, #41,	F 867	F867- QAPI/QAA: 1. The facility failed to maintain procedures and monitor interventions that the committee put into place following the annual recertification survey date 03/01/2018. This was for 2 recited deficiencies in the area of Accuracy of assessments and Develop/Implement Comprehensive Care Plans. The facility implemented immediate correction in the areas recited to reflect correction on 05/15-16/2019 for the accuracy of assessments and the development and implementation of comprehensive care plans. This was completed by the MDS coordinator 2. Other residents have the potential to be affected by this deficient practice as it relates to Accuracy of assessment and Comprehensive Care Plans. 3. MDS coordinators will be in serviced re-educated regarding Accuracy of	6/3/19

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F 867	Continued From page 70 #56, and #81), active diagnoses (Residents #36 and #41), physical restraints (Residents #4 and #23), falls (Residents #4 and #81), and gender (Resident #75) for 7 of 20 residents reviewed. F656-Based on record review, observation and staff interview, the facility failed to develop a care pan in the areas of restraints (Resident #4), psychotropic medications (Residents #36 & 81), side rails (Resident #56), urinary catheter (Resident #81), pain management (Resident #81), and contracture (Resident #57) for 5 of 20 sampled residents reviewed. In an interview on 5/16/19 at 10:10 AM, the Administrator and Director of Nursing (DON) stated they hired a part-time MDS Nurse who apparently was not properly coding the MDS assessments. The DON stated the facility's systems were implemented to identify "hot spots" areas that needed to be care planned but the system failed. The DON stated she started in December 2018 and focused their efforts on the nursing department.	F 867	assessments and Care Plans by the Director of Nursing by June 3, 2019. 4. The MDS coordinators that complete sections on the MDS. They will meet and review recited areas at each monthly QAPI review x 3 months. The facility will utilize all team members that complete sections on the MDS to review, monitor and make suggestions to prevent further recitations. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee (QAPI) as they arise, and the plan will be revised to ensure continued compliance. Audit tool for accuracy and care plans will be completed by the Unit Manager. The Unit Manager will maintain all audits and present the to QAPI. 5. The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 6/3/2019	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		6/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 880	Continued From page 71	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 72 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to use universal precautions during blood retrieval by disposal of a contaminated sharp in a non-approved sharps container during blood glucose monitoring for 1 of 1 resident ' s observed for finger stick (Resident #71). Findings included: Resident #71 ' s quarterly Minimum Data Set dated 2/14/19 revealed an intact cognition. The resident was dependent for all activities of daily living except meals. The active diagnosis was long-term use of insulin. Resident #71 was re-admitted to the facility on 3/20/19 with the diagnosis long term use of insulin. Resident #71 had a monthly physician order dated 5/1/19 for blood glucose monitor before meals and at bedtime.	F 880	F880- Infection control and prevention: 1. The facility failed to use universal precautions during blood retrieval by disposal of a contaminated sharp in a non approved sharps container during blood glucose monitoring. There were no adverse effects for resident # 71. Nurse #2 received re-education on 5/15/19 by the Staff Development Coordinator regarding proper disposal of sharps into the appropriate sharps□ container and not regular garbage, re-education of universal precaution, contamination, removing the glucometer from the plastic bag that house the glucometer prior to entry into a resident□s room. 2. Other residents that have blood retrieval have the potential to be affected by this deficient practice as it relates to contamination and infection control. There were no concerns identified from other	

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F 880	Continued From page 73 On 5/15/19 at 11:30 am an observation was done of Nurse #2 who used a disposable finger stick sharp for blood retrieval and glucose evaluation. After Nurse #2 used the sharp for blood retrieval, the nurse placed the contaminated sharp on the multiuse (more than one resident) plastic bag that housed the glucometer and discarded the contaminated sharp in the regular garbage on the medication cart. There was an available sharps container (regulated sharps disposal) on the medication cart. On 5/15/19 at 11:33 am an interview was conducted with Nurse #2 who stated she was ready to start her next finger stick for blood glucose evaluation. Nurse #2 was asked to stop for interview. Nurse #2 agreed that she placed a dirty finger stick sharp on the multiuse plastic bag and discarded the used sharp in the regular garbage. Nurse #2 added that she should have placed the contaminated sharp in the sharps container as required by the facility and should not have placed the sharp on the multiuse bag. On 5/16/19 at 11:00 am an interview was conducted with the Director of Nursing (DON) who stated she expected staff to follow universal precautions at all times and to place sharps items in the sharps containers as required.	F 880	residents that received a fingerstick. The Staff Development Coordinator implemented random monitoring of CBG during environmental rounds as well as while on the halls. This was started 05/26/2019. 3. The Staff Development Coordinator initiated re-education with Licensed Nurses and Medication Aides for policy and procedure to check blood sugars. This included disposing of sharps into proper receptacle after obtaining blood sample, universal precaution, removing glucometer from plastic bag prior to entering the residents room. This will be completed on 06/3/19. Any staff that have not completed mandatory training by 06/03/2019 will be unable to work until requirement is fulfilled. This includes all shifts and PRN staff. 4. Staff Development Coordinator will randomly audit 3 blood glucose checks weekly x4 weeks then monthly x2 months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee (QAPI) as they arise, and the plan will be revised to ensure continued compliance. The Staff Development Coordinator will implement Glucose/Sharps audit tool and be responsible to bring it QAPI weekly. 5. The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 6/3/2019	