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	345534	A. BUILDING _____ B. WING _____	C 08/08/2019

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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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E 000	Initial Comments An unannounced Recertification and Complaint survey was conducted on 8/4/19 through 8/8/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #56T711.	E 000		
F 000	INITIAL COMMENTS A recertification with complaint investigation was conducted from 8/4/19 through 8/8/19. Four of the four complaint allegations were not substantiated. Past non-compliance was identified at CFR 483.12 at tag F600 at a scope and severity G.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interview, the facility neglected to report and to assess a resident after a fall and after the	F 600	Past noncompliance: no plan of correction required.	8/21/19

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

Electronically Signed | 08/21/2019

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resident complained of ankle pain for 1 of 5 sampled residents reviewed for accidents (Resident #102). Resident #102 had a fall and had complained of ankle pain on 5/15/19 was not assessed until the next day and the x-ray showed an acute avulsion fracture of the inferior tip of the medial malleolus (a bone chip caused by a ligament or tendon that tears away a part of the bone).

Findings included:

Resident #102 was admitted to the facility on 7/22/18 with multiple diagnoses including glaucoma and congestive heart failure (CHF). The quarterly Minimum Data Set (MDS) assessment dated 4/14/19 indicated that Resident #102's cognition was intact, and she needed extensive assistance with transfers.

Resident #102 had a doctor's order dated 3/20/19 for Tylenol (pain reliever) 325 milligrams (mgs) 2 tablets by mouth every 6 hours as needed (PRN) for mild pain.

Resident #102's care plan with the revised date of 4/14/19 and the Kardex revealed that the resident needed 1 person assist with transfer.

Resident #102's nurse's notes were reviewed. There were no notes on 5/15/19 and 5/16/19 regarding a fall. A note dated 5/17/19 at 6:08 AM (written by Nurse #2) revealed that the nurse was called to the resident's room around 9 PM of 5/16/19 to look at the resident's right ankle. The right ankle appeared to be swollen with bruising and the resident stated that it was hurting. The resident also stated that she stumbled with a walker the previous day. The nurse reported that

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she notified the doctor and an order for x-ray was obtained.

The right ankle x-ray report dated 5/17/18 revealed "acute avulsion fracture of the inferior tip of the medial malleolus".

The May 2019 Medication Administration Record (MAR) revealed that Medication Aide (Med Aide), assigned to Resident #102, administered Tylenol 650 mgs to the resident for ankle pain on 5/15/19 at 8:35 PM.

The Physician Assistant (PA) progress notes were reviewed. The note dated 5/15/19 indicated that Resident #102 was seen for a routine visit and the resident had no concerns per nursing. The note dated 5/17/19 revealed that Resident #102 was seen for a follow up visit. X-ray of the right ankle was done, and the resident has acute avulsion fracture of the inferior tip of the medial malleolus. The resident reported she stumbled a couple of days ago, felt a "pop" when she fell. She had increasing pain last night, swelling and bruising noted. Pain improved with Tylenol. The note further indicated that the right ankle was edematous with several ecchymosis and tenderness noted to medial malleolus. The range of motion was restricted due to pain. The plans were to apply immobilizer per therapy, to refer to orthopedic for definitive management, weight bearing as tolerated, Tylenol and Tramadol for pain and ice packs for 15 minutes (min) on and 45 min off every hour as needed (PRN).

Resident #102's nurse's note dated 5/17/19 at 8:57 PM indicated that the doctor was informed of the right ankle x-ray result. Orthopedic consult was ordered, and the resident was placed on

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right foot air boot to float and to stabilize the foot at all times and non- weight bearing to the right foot. The doctor also ordered Tramadol (narcotic pain reliever) 50 milligrams (mgs) every 6 hours as needed (PRN) for pain. Tylenol was administered for complaint of right ankle pain with positive results.

The orthopedic consult dated 5/23/19 revealed that Resident #102's ankle would be immobilized with a short leg cast and she would need to be on non-weight bearing on the right leg. The follow up appointment would be in 3 weeks or sooner if needed and to continue with the Tramadol for pain.

On 8/4/19 at 1:30 PM, Resident #102 was observed up in wheelchair in her room with a boot on the right leg. When interviewed, the resident stated that she had a fall few months ago when a Nurse Aide (NA) assisted her with transfer from bed to wheelchair using a walker. The resident added that she had complained of pain on her ankle after the fall and the nurse assigned to her did not assess her after the fall and did not report the fall.

On 8/5/19 at 4:10 PM, a follow up interview was conducted with Resident #102. She reported that it was in May 2019 when she requested to use the bathroom. A NA assisted her with the transfer from bed to the wheelchair using a walker, when she fell onto the floor. She heard a "pop" and told the NA that her ankle was hurting. The NA took her anyway to the bathroom. The resident stated that she could not stand up from the wheelchair to the commode due to pain on her ankle. The NA went to get another NA to help her. Resident #102 stated that the next day after the fall, the

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same NA was assigned to her. When she requested to use the bathroom, two (2) NAs assisted her with the transfer and she was telling the NA that her ankle was hurting.

On 8/6/19 at 9:45 AM, NA #1, assigned to Resident #102 on 5/15/19, was interviewed. The NA stated that she had worked on 5/15/19 and 5/16/19 (7-3 shift) and was assigned to Resident #102. She stated that it was before lunch on 5/15/19 when she assisted the resident from the bed to the wheelchair using a walker, when the resident fell. The resident was on the floor sitting on her leg. She went to get help and Nurse #1 assisted her to get the resident up from the floor to the wheelchair. The resident stated that she was fine. The NA denied that resident had told her she heard a "pop". NA #1 further reported that around 1:30 PM, the resident requested to use the bathroom. The NA noticed that the resident was unable to stand on her feet and was complaining of pain on her ankle, so she went to get another NA (didn't remember the name of the NA) to help her. She then informed Nurse #1 that the resident was complaining of pain on her ankle. The NA indicated that she didn't know if Nurse #1 had assessed the resident and she didn't remember if she had informed the 3-11 shift NA about the resident's fall and complained of ankle pain.

On 8/6/19 at 12:30 PM, NA #4 was interviewed. The NA indicated that she was with NA #1 in the room of Resident #102 when the resident complained of pain on her ankle on 5/15/19. She informed NA #1 to let the nurse know about the resident's complaint. NA #4 reported that she heard NA #1 informing Nurse #1 about Resident #102's complaint of pain. The NA further

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indicated that she didn't know if the nurse had assessed the resident afterwards.

On 8/6/19 at 1:08 PM, the Treatment Nurse was interviewed. The Treatment Nurse stated that she went to Resident #102's room on 5/15/19 with the wound doctor. When she asked the resident how her day was, the resident responded "not good" since she had a fall that morning. The nurse reported that when she asked the resident if the nurse was aware about the fall and the resident responded "yes".

On 8/6/19 at 4:44 PM, a phone interview was conducted with Nurse #1. She stated that she was assigned to Resident #102 on 5/15/19 and she worked from 7 AM to 5 PM that day. The Nurse indicated that she was questioned by the administration and the corporate on several occasions and her story did not change. She reported that she did not assist NA #1 in getting Resident #102 up from the floor to the wheelchair and she was not informed about the fall. She went to the resident's room to administer the resident's medications and the resident was already up in her wheelchair and she did not complain of any pain.

Attempted to interview the PA and the doctor but were not available.

On 8/7/19 at 9:50 AM, the Med Aide was interviewed. She stated that she was assigned to Resident #102 on 5/15/19 from 5 PM to 1 AM. She verified that she administered Tylenol to Resident #102 on 5/15/19 at 8:35 PM due to complain of ankle pain. The Med Aide indicated that she didn't look/assess the ankle since she was not a nurse. She also stated that she was

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not aware that Resident #102 had a fall that morning.

On 8/7/19 at 10:10 AM, Unit Manager (UM) #2 was interviewed. She stated that she worked 5/15/19 and 5/16/19 and she was not made aware that Resident #102 had a fall. She stated that she heard about the fall on 5/17/19 and she was asked to interview the resident. The resident stated that she fell on a Wednesday (5/15/19) when the NA was assisting her transfer from bed to the wheelchair using a walker and she fell to the floor landing on her knees and she heard something "pop".

On 8/7/19 at 1:30 PM, the Director of Nursing (DON) was interviewed. The DON stated that when she heard that Resident #102 had acute fracture on her ankle, she reported it as "injury of unknown origin". She started the investigation by interviewing the staff and the resident and after the interview, it was not an injury of unknown origin, she found out that the resident had a fall. The corporate took over the investigation.

On 8/7/19 at 1:47 PM, the Regional Consultant was interviewed. She stated that she was made aware of the incident with Resident #102 on 5/17/19. She was informed that the DON had started the investigation and had suspended NA #1 for not reporting the fall. She came to the facility on 5/20/19 and again interviewed the staff and Resident #102. She suspended Nurse #1 and after the investigation, she substantiated neglect for not reporting, not assessing the resident and not documenting the fall in the resident's medical records. Nurse #1 was terminated, and NA #1 was educated on reporting incident to the nurse and to the next shift NA and

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if the nurse would not intervene, to report the incident to the managers. The Regional Consultant also indicated that the DON had completed a Quality Assurance and Performance Improvement (QAPI) of the incident.

On 8/7/19 at 4:30 PM, the DON had provided a copy of the time line and the QAPI and were reviewed. The time line revealed that on 5/16/19, Resident #102 had complained of right ankle pain and x-ray was ordered, and the report showed acute fracture of the right ankle. There was no incident report or nurse's notes suggested evidence of a fall. Fall was reported on 5/17/19 by Resident #102 and the incident of fall occurred on 5/15/19. Interview with Resident #102 revealed that upon getting out of chair, resident grabbed her walker, the walker went forward, she lost her balance and fell onto the floor on her knees and then to her side. The resident stated that she felt something "pop". NA #1 asked Nurse #1 for assistance in helping resident off the floor. Nurse #1 assisted resident from the floor to the chair. The conclusion of the investigation was: Resident #102 had a brief interview for mental status score (BIMs) of 15. Nurse #1 failed to report the fall and assess Resident #102 following the incident. Assessment of skin and pain was conducted on all residents. Physical Therapy conducted an in-service on transfer to all staff. All staff were in-serviced on fall assessment, reporting and neglect. Law enforcement was notified. The investigation was completed on 5/21/19. Nurse #1 was terminated due to failure to report and to assess Resident #102. Allegation of neglect was substantiated based on interviews with the staff and resident. Nurse #1 failed to report the fall and failed to assess the resident after the fall.

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The QAPI has the completion date of 5/17/19.

A. Resident #102 reported to NA #1 that she hurt her foot when she fell on 5/15/19. No record of fall was made in the resident's medical record. Resident's pain and skin was immediately assessed, and findings were reported to the responsible party (RP) and the doctor. X-ray was ordered and the resident was found to have a right ankle fracture. Orders for a boot, pain medication, orthopedic consult and ice to ankle.

B. A 100% audit was completed by assessing all residents' skin and pain. The results of the assessment were communicated to the RP and to the doctor. All care plans were updated by the MDS Nurse. The audit was completed by the Unit Managers, Treatment Nurse and the Assistant Director of Nursing (ADON) on 5/17/19.

C. All staff were educated on fall reporting (if nurse would not intervene to report to the managers), neglect and gait belt usage. All licensed nurses were educated on facility's fall protocol which included reporting, assessment and documentation. Education was conducted by the DON and the ADON and was completed on 5/17/19.

D. A Quality Assurance meeting was held on 5/24/19 to review pertinent incident information, investigation, all audits and education associated with the event. The DON or her designee with continue to monitor skin assessment and review pain assessment to ensure appropriate follow up. The DON or her designee will do random audit on 5 skin and pain assessment 5 days a week weekly x 4 weeks, 2 days a week x 4 weeks and then monthly.

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F 600	Continued From page 9 A copy of the 24 hour (5/17/19) and the 5-day (5/21/19) reports were provided by the DON. The allegation on the 5-day report was resident neglect. The allegation was substantiated, and Nurse #1 was terminated. Education was validated on 8/8/19 by staff interview. The staff stated that they had received in-service on facility's Falls Protocol (reporting, assessment and documentation), Neglect, and Safe transfer.	F 600		
F 604 SS=E	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- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for	F 604		8/28/19

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F 604	Continued From page 10 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, and staff interview, the facility utilized bilateral roll guards (cylinder shaped cushions 25 inches in length and 9 inches in diameter) on Resident #73 ' s and Resident #105 ' s beds without considering them as a restraint and without a medical diagnosis for 2 of 3 residents reviewed for physical restraints. The findings included: 1. Resident #105 was most recently readmitted to the facility on 1/2/19 with diagnoses that included vascular dementia with behavioral disturbance, Alzheimer ' s disease, and repeated falls. The plan of care for Resident #105 included the problem area of the risk for falls and fall related injury initiated on 1/21/19. The interventions included, in part: - Assist resident with transfers (initiated 1/21/19) - Anti-rollbacks to wheelchair (initiated 1/21/19) - Resident to have non-skid socks on while in bed (initiated 1/21/19) The quarterly Minimum Data Set (MDS) assessment dated 4/15/19 indicated Resident #105 ' s cognition was severely impaired. She had no behaviors and no rejection of care. Resident #105 was assessed as requiring the extensive assistance of 1 with bed mobility,	F 604	Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal Law. F604 Resident # 105 and Resident # 73 were assessed on 8-19-19 with use of bolsters using the restraint assessment by the Director of Nursing and the Unit Manager. Bolsters were removed from both residents on 8-19-19. All residents with bolsters related to defining the perimeter of the mattress were assessed on 8-19-19 by the Director of Nursing and Nurse Supervisors. No other bolsters were found to be in use at the time of the audit. A restraint assessment will be completed prior to the use of bolsters for any resident who may require the use. An In service was provided to the Director of Nursing by the Regional Operations Manager on 8/9/19 regarding use of bolsters and restraint assessments. An In	

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F 604	Continued From page 11 transfers, dressing, and toileting. She was dependent on 1 for personal hygiene. She required the supervision of 1 for locomotion with a wheelchair on/off the unit and walking had not occurred during the 7-day MDS review period. Resident #105 was not steady on her feet and she was only able to stabilize with staff assistance. She had two or more falls with minor injury since her previous MDS assessment (1/16/19). She was always incontinent of bladder and bowel. The assessment indicated Resident #105 had no physical restraints. A Fall Risk Assessment completed on 4/15/19 indicated Resident #105 was a high fall risk with a score of 18 total points on an assessment that required a score greater than 13 to be considered at high risk. The risk factors included having a fall within the previous 6 months, urgency/frequency of elimination (bowel/bladder), being on 2 or more high risk medications, requiring assistance or supervision for mobility/transfer/ambulation, and altered awareness of immediate physical environment. A nursing note completed by Nurse #3 dated 6/17/19 indicated Resident #105 had a fall on 6/16/19 at 9:30 PM. Resident #105 was witnessed to slide off of bed and onto buttocks causing a reopening of a skin tear located on her right shin and right forearm. Steri-strips were applied to the areas and no pain was noted. An incident report was created by Nurse #3 on 6/19/19 for Resident #105 ' s 6/17/19 fall that occurred at 9:30 PM. The report indicated that prior to the fall Resident #105 was resting in her bed. She was noted to be alert with confusion and was witness by Nurse #3 to slide off the side	F 604	Service was conducted by the Director of Nursing to all licensed staff regarding the appropriate use of bolsters, assessing resident for use and understanding of restraint. This in service was completed on 8-23-19, any licensed nurse who did not have the in service by 8-23-19 will not be allowed to work until the in service is completed. Room rounds will be conducted 5x a week x 4 weeks by the Director of Nursing, Nurse Supervisors, Administrator, Wound Nurse, Scheduler, Business Office Manager, Payroll Manager, Minimum Data Set Nurse, Social Worker, Housekeeping Supervisor, Activities Director and Assistant, Admissions, and/or Dietary Manager to observe for use of bolsters in beds of residents, then weekly x 4 weeks then monthly x 1. The Administrator will review the audits weekly and bring the audit findings to the Quality Assurance Committee monthly x 3 months.	

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of her bed. The incident evaluation note indicated that Resident #105 had poor safety awareness and that bilateral bolsters (cylinder-shaped cushions) were added to her bed. The incident report was signed as completed by Unit Manager (UM) #1.

The plan of care for Resident #105 related to the risk of falls was updated on 6/17/19 with the intervention of bolsters to her bed.

A Fall Risk Assessment completed on 6/24/19 indicated Resident #105 was a high fall risk with a score of 26 total points. The risk factors included having one fall within the previous 6 months, urgency/frequency of elimination (bowel/bladder), incontinence, being on 2 or more high risk medications, requiring assistance or supervision for mobility/transfer/ambulation, altered awareness of immediate physical environment, impulsive, and lack of understanding of one ' s physical and cognitive limitations.

The quarterly Minimum Data Set (MDS) assessment dated 7/17/19 indicated Resident #105 ' s cognition was severely impaired. She had no behaviors and no rejection of care. Resident #105 was assessed as requiring the extensive assistance of 2 or more with bed mobility, transfers, and dressing. She was dependent on 1 for toileting and dependent on 2 or more for personal hygiene. Resident #105 required the extensive assistance 1 for locomotion by wheelchair on the unit and the limited assistance of 1 for locomotion by wheelchair off the unit. Walking had not occurred during the 7-day MDS review period. Resident #105 was not steady on her feet and she was

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only able to stabilize with staff assistance. She had one fall with minor injury since her previous MDS assessment (4/15/19). She was always incontinent of bladder and frequently incontinent of bowel. The assessment indicated Resident #105 had no physical restraints.

The Nursing Assistant (NA) care guide dated 7/24/19 indicated that Resident #105 was a fall risk. She was noted with bolsters to her bed.

An observation was conducted of Resident #105 ' s room in the secured unit on 8/4/19 at 1:22 PM. Resident #105 had bilateral bolsters positioned in the middle third section of her bed.

On 8/6/19 at 10:57 AM UM #1 provided the manufacturer ' s information for the bolsters utilized for Resident #105. These bolsters were termed by the manufacturer as roll guards. The manufacturer ' s instructions, dated 8/7/12, indicated the roll guards were an alternative to side rails and were to help high-risk persons from rolling out of bed. The roll guards were cylinder shaped and measured 25" in length with a diameter of 9". The roll guards were connected by a piece of material that was to be positioned underneath the person when in bed leaving a 23" wide section in between the right roll guard and the left roll guard. The instructions indicated the roll guards were to be placed approximately 20" from head board. The straps were to be placed under the roll guards and wrapped once around the bed frame with the release buckles positioned away from the person.

A second observation was conducted of Resident #105 ' s bed on 8/6/19 at 11:30 AM. Resident #105 ' s bed was approximately 79" length. The

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bilateral roll guards (bolsters) were positioned approximately 20" from the top of the mattress as indicated in the manufacturer ' s instructions. The roll guard covered 25" of the center portion of the mattress leaving approximately 34" of open space from the bottom of the roll guard to the bottom the mattress.

An interview was conducted with UM #1 on 8/6/19 at 10:25 AM. The incident report related to Resident #105 ' s 6/17/19 fall out of bed was reviewed with UM #1. She stated that Nurse #3 initiated the incident report and that she had completed the evaluation section that indicated bolsters (roll guards) were added as a fall risk intervention after this fall. She reported that the bolsters were implemented to prevent Resident #105 from falling out of bed. She stated that the intent of the bolsters were to define the perimeter of the mattress for the resident. She indicated she had not considered the bolsters to be a physical restraint and therefore she had not completed any assessment to determine if the bilateral bolsters were restraining Resident #105.

Phone interviews were attempted with Nurse #3 on 8/5/19 at 3:30 PM and 8/6/19 at 8:59 AM. She was unable to be reached.

An interview was conducted with NA #2 on 8/5/19 at 2:00 PM. She stated she regularly worked on the secured unit and she was familiar with Resident #105. She indicated that Resident #105 was at risk for falls and that she was unable to get out of bed safely without assistance. NA #2 reported that she believed the bilateral bolsters (roll guards) were in place to prevent a fall for Resident #105. She explained that Resident #105 moved around in bed and she thought the

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resident had previously fallen out of bed. She further explained that the bolsters would have stopped her from falling onto the ground if she rolled into it. She reported if the bolsters were not on the bed and Resident #105 rolled over too far she would have fallen to the ground. NA #2 indicated that Resident #105 was not able to remove the bolsters from the bed on her own.

An interview was conducted with NA #3 on 8/5/19 at 3:25 PM. She stated she regularly worked on the secured unit and she was familiar with Resident #105. She indicated that Resident #105 was at risk for falls and that she was unable to get out of bed safely without assistance. NA #3 reported that the bilateral bolsters (roll guards) were in place to keep Resident #105 from falling out of bed. She explained that Resident #105 moved around a lot in bed and that the bolsters stopped her from falling off the side of the bed. She reported if the bolsters were not on the bed and Resident #105 rolled over too far she would have fallen to the ground. NA #3 indicated that Resident #105 was not able to remove the bolsters from the bed on her own.

An interview was conducted with the Director of Nursing (DON) on 8/6/19 at 1:45 PM. The bilateral bolsters (roll guards) in place for Resident #105 were reviewed with the DON. She stated that the bolsters were in place to keep Resident #105 from falling out of bed and sustaining an injury. She indicated it was a safety intervention to prevent falls. She stated she had not considered the bolsters to be a physical restraint and therefore she had not completed any assessment to determine if the bilateral bolsters were restraining Resident #105.

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An interview was conducted with the MDS Nurse on 8/7/19 at 9:10 AM. The bilateral bolsters (roll guards) in place for Resident #105 were reviewed with the MDS Nurse. The MDS Nurse reported that she was aware Resident #105 had bilateral bolsters in place to her bed. She indicated that Resident #105 was unable to get out of bed on her own. She stated that if Resident #105 tried to get up out of bed independently she most likely would fall. She stated that the bolsters prevented Resident #105 from falling onto the floor. The MDS Nurse indicated that Resident #105 had voluntary movement in bed and that the intent of the bolsters were to define the perimeter of the bed, so she would not roll off the bed and onto the ground. She acknowledged that the effect the bolsters had on Resident #105 was to keep her bed in bed.

A follow up interview was conducted with the DON on 8/8/19 at 10:10 AM. She stated that in her opinion bilateral bolsters were not a restraint for any resident. She indicated that the intent of the bolsters were to define the perimeter of the mattress. The DON reported that she expected regulations related to physical restraints to be followed, but that she had reviewed the regulations and she was unable to find any specific mention of bolsters being considered a physical restraint.

2. Resident #73 was admitted to the facility on 5/22/17 with diagnoses that included dementia with behavioral disturbance, muscle weakness, and contractures of left and right knees.

The plan of care for Resident #73 included the

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problem area of the risk for falls and fall related injury initiated on 5/9/19. The interventions included, in part:
- Bolsters (cylinder-shaped cushions) to bed per family request to assist with proper positioning when in bed (initiated 5/9/19)
- Fall mat (initiated 5/9/19)
- Properly fitting and non-skid footwear (initiated 5/9/19)
- Assistance with transfers (initiated 5/9/19)

A Fall Risk Assessment completed on 6/2/19 indicated Resident #73 was a high fall risk with a score of 25 total points on an assessment that required a score greater than 13 to be considered at high risk. The risk factors included having one fall within the previous 6 months, urgency/frequency of elimination (bowel/bladder), incontinence, being on 2 or more high risk medications, requiring assistance or supervision for mobility/transfer/ambulation, altered awareness of immediate physical environment, impulsive, and lack of understanding of one ' s physical and cognitive limitations.

The quarterly Minimum Data Set (MDS) assessment dated 7/1/19 indicated Resident #73 ' s cognition was severely impaired. She had no behaviors and no rejection of care. Resident #73 was assessed as requiring the extensive assistance of 2 or more with bed mobility. She was dependent on 2 or more for transfers and was dependent on 1 for locomotion by wheelchair on/off the unit, toileting, dressing, and personal hygiene. Walking had not occurred during the 7-day MDS review period. Resident #73 was not steady on her feet and she was only able to stabilize with staff assistance. She had no falls since her previous MDS assessment. She was

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always incontinent of bladder and bowel. The assessment indicated Resident #73 had no physical restraints.

The Nursing Assistant (NA) care guide dated 7/10/19 indicated that Resident #73 was a fall risk. She was noted with bolsters to her bed.

An observation was conducted of Resident #73 in the secured unit on 8/5/19 at 3:40 PM. Resident #73 was asleep in bed and bilateral bolsters were positioned in the middle third section of her bed.

On 8/6/19 at 10:57 AM Unit Manager (UM) #1 provided the manufacturer ' s information for the bolsters utilized for Resident #73. These bolsters were termed by the manufacturer as roll guards. The manufacturer ' s instructions, dated 8/7/12, indicated the roll guards were an alternative to side rails and were to help high-risk persons from rolling out of bed. The roll guards were cylinder shaped and measured 25" in length with a diameter of 9". The roll guards were connected by a piece of material that was to be positioned underneath the person when in bed leaving a 23" wide section in between the right roll guard and the left roll guard. The instructions indicated the roll guards were to be placed approximately 20" from head board. The straps were to be placed under the roll guards and wrapped once around the bed frame with the release buckles positioned away from the person.

A second observation was conducted of Resident #73 ' s bed on 8/6/19 at 11:33 AM. Resident #73 ' s bed was approximately 79" length. The bilateral roll guards (bolsters) were positioned approximately 20" from the top of the mattress as indicated in the manufacturer ' s instructions. The

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roll guard covered 25" of the center portion of the mattress leaving approximately 34" of open space from the bottom of the roll guard to the bottom the mattress.

An interview was conducted with UM #1 on 8/6/19 at 10:25 AM. She stated that she was aware Resident #73 had bilateral bolsters (roll guards) on her bed. She reported that Resident #73 was a fall risk and she was unable to get out of bed safely on her own. She indicated that Resident #73 ' s family had requested the addition of the bolsters to her bed as a fall prevention intervention. She stated that the intent of the bolsters were to define the perimeter of the mattress for the resident. She indicated she had not considered the bolsters to be a physical restraint and therefore she had not completed any assessment to determine if the bilateral bolsters were restraining Resident #73.

An interview was conducted with NA #2 on 8/5/19 at 2:00 PM. She stated she regularly worked on the secured unit and she was familiar with Resident #73. She indicated that Resident #73 was at risk for falls and that she was unable to get out of bed safely without assistance. NA #2 reported that she believed the bilateral bolsters (roll guards) were in place to prevent a fall for Resident #73. She explained that Resident #73 moved around in bed and that the bolsters would have stopped her from falling onto the ground if she rolled into it. She reported if the bolsters were not on the bed and Resident #73 rolled over too far she would have fallen to the ground. NA #2 indicated that Resident #73 was not able to remove the bolsters from the bed on her own.

An interview was conducted with NA #3 on 8/5/19

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at 3:25 PM. She stated she regularly worked on the secured unit and she was familiar with Resident #73. She indicated that Resident #73 was at risk for falls and that she was unable to get out of bed safely without assistance. NA #3 reported that the bilateral bolsters (roll guards) were in place to keep Resident #73 from falling out of bed. She explained that Resident #73 moved around a lot in bed and that the bolsters stopped her from falling off the side of the bed. She reported if the bolsters were not on the bed and Resident #73 rolled over too far she would have fallen to the ground. NA #3 indicated that Resident #73 was not able to remove the bolsters from the bed on her own.

An interview was conducted with the Director of Nursing (DON) on 8/6/19 at 1:45 PM. The bilateral bolsters (roll guards) in place for Resident #73 were reviewed with the DON. She stated that the bolsters were in place to keep Resident #73 from falling out of bed and sustaining an injury. She indicated it was a safety intervention to prevent falls. She stated she had not considered the bolsters to be a physical restraint and therefore she had not completed any assessment to determine if the bilateral bolsters were restraining Resident #73.

An interview was conducted with the MDS Nurse on 8/7/19 at 9:10 AM. The bilateral bolsters (roll guards) in place for Resident #73 were reviewed with the MDS Nurse. The MDS Nurse reported that she was aware Resident #73 had bilateral bolsters in place to her bed. She indicated that Resident #73 was unable to get out of bed on her own. She stated that if Resident #73 tried to get up out of bed independently she most likely would fall. She reported that the bolsters prevented

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F 604	Continued From page 21 Resident #73 from falling onto the floor. The MDS Nurse indicated that Resident #73 had voluntary movement in bed and that the intent of the bolsters were to define the perimeter of the bed, so she would not roll off the bed and onto the ground. She acknowledged that the effect the bolsters had on Resident #73 was to keep her in bed. A follow up interview was conducted with the DON on 8/8/19 at 10:10 AM. She stated that in her opinion bilateral bolsters were not a restraint for any resident. She indicated that the intent of the bolsters were to define the perimeter of the mattress. The DON reported that she expected regulations related to physical restraints to be followed, but that she had reviewed the regulations and she was unable to find any specific mention of bolsters being considered a physical restraint.	F 604		
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 observation, record review, resident interview, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of physical restraints (Residents #73 and #105), special treatments/procedures/programs (Residents #72 and #113), and cognition (Resident #17) for 5 of 27 residents reviewed. The findings included:	F 641	F641 Minimum Data Set Assessment (MDS) modifications for residents #73 and #103 were modified on 8/21/19 by the Regional Reimbursement Manager to show /use of restraint section P. Resident # 113, MDS modification to section O was completed on 8/7/19 by the Regional Reimbursement Manager to show hospice services prior to	8/28/19

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F 641	Continued From page 22 1. Resident #105 was most recently readmitted to the facility on 1/2/19 with diagnoses that included vascular dementia with behavioral disturbance, Alzheimer ' s disease, and repeated falls. The plan of care for Resident #105 included the risk of falls and indicated the intervention of bolsters (cylinder-shaped cushions) to her bed was initiated on 6/17/19. The quarterly Minimum Data Set (MDS) assessment dated 7/17/19 indicated Resident #105 ' s cognition was severely impaired. She had no behaviors and no rejection of care. Resident #105 was assessed as requiring the extensive assistance of 2 or more with bed mobility and transfers. Resident #105 was not steady on her feet and she was only able to stabilize with staff assistance. The assessment indicated Resident #105 had no physical restraints (defined as 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). An observation was conducted of Resident #105 ' s room in the secured unit on 8/4/19 at 1:22 PM. Resident #105 had bilateral bolsters positioned in the middle third section of her bed. On 8/6/19 at 10:57 AM Unit Manager (UM) #1 provided the manufacturer ' s information for the bolsters utilized for Resident #105. These bolsters were termed by the manufacturer as roll guards. The manufacturer ' s instructions, dated 8/7/12, indicated the roll guards were an	F 641	admission. Resident # 72, MDS modification, section 0 for use of Bipap was completed on 8/7/19 by the MDS Nurse. Resident #17 MDS modification was not needed after review on 8/8/19 by the Regional Reimbursement Manager, resident #17 MDS was accurately coded by the Social Worker. The last comprehensive or quarterly Minimum Data Set (MDS) Assessment for all current residents was completed no later than 8/23/19. Section C was audited by the Social Worker on 8/12/19, which resulted in 7 modifications. Modifications completed on 8/14/19 by the Social Worker. All Current residents last comprehensive or quarterly assessment was audited for Section O. This audit was completed by the MDS nurse and Regional Reimbursement Manager on 8/19/19. Modifications required to 1 resident for services prior to admission, completed on 8/19/19 by the MDS nurse. All Current Residents last comprehensive or quarterly assessment was audited for Section P related to hospice services was completed on 8/19/19 by the MDS Nurse and Regional Reimbursement Nurse. No additional residents were identified as requiring modifications. An in service was provided to the Social Worker and MDS nurse regarding accuracy of assessments on 8/14/19 by the Regional Reimbursement Manager. The Regional Reimbursement Manager will audit 5 charts weekly x 4 weeks, then 2 charts weekly x 4 weeks then 1 chart monthly x 1 month for accuracy of section C, O and P.	

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F 641	Continued From page 23	F 641	The Administrator will review the audits weekly and bring the audit findings to the Quality Assurance Committee monthly x 3 months.	

alternative to side rails and were to help high-risk persons from rolling out of bed. The roll guards were cylinder shaped and measured 25" in length with a diameter of 9". The roll guards were connected by a piece of material that was to be positioned underneath the person when in bed leaving a 23" wide section in between the right roll guard and the left roll guard. The instructions indicated the roll guards were to be placed approximately 20" from head board. The straps were to be placed under the roll guards and wrapped once around the bed frame with the release buckles positioned away from the person.

A second observation was conducted of Resident #105 ' s bed on 8/6/19 at 11:30 AM. Resident #105 ' s bed was approximately 79" length. The bilateral roll guards (bolsters) were positioned approximately 20" from the top of the mattress as indicated in the manufacturer ' s instructions. The roll guard covered 25" of the center portion of the mattress leaving approximately 34" of open space from the bottom of the roll guard to the bottom the mattress.

An interview was conducted with Nursing Assistant (NA) #2 on 8/5/19 at 2:00 PM. She stated she regularly worked on the secured unit and she was familiar with Resident #105. She indicated that Resident #105 was at risk for falls and that she was unable to get out of bed safely without assistance. NA #2 reported that she believed the bilateral bolsters (roll guards) were in place to prevent a fall for Resident #105. She explained that Resident #105 moved around in bed and she thought the resident had previously fallen out of bed. She further explained that the bolsters would have stopped her from falling onto the ground if she rolled into it. She reported if the

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bolsters were not on the bed and Resident #105 rolled over too far she would have fallen to the ground. NA #2 indicated that Resident #105 was not able to remove the bolsters from the bed on her own.

An interview was conducted with NA #3 on 8/5/19 at 3:25 PM. She stated she regularly worked on the secured unit and she was familiar with Resident #105. She indicated that Resident #105 was at risk for falls and that she was unable to get out of bed safely without assistance. NA #3 reported that the bilateral bolsters (roll guards) were in place to keep Resident #105 from falling out of bed. She explained that Resident #105 moved around a lot in bed and that the bolsters stopped her from falling off the side of the bed. She reported if the bolsters were not on the bed and Resident #105 rolled over too far she would have fallen to the ground. NA #3 indicated that Resident #105 was not able to remove the bolsters from the bed on her own.

An interview was conducted with the Director of Nursing (DON) on 8/6/19 at 1:45 PM. The bilateral bolsters (roll guards) in place for Resident #105 were reviewed with the DON. She stated that the bolsters were in place to keep Resident #105 from falling out of bed and sustaining an injury. She indicated it was a safety intervention to prevent falls.

An interview was conducted with the MDS Nurse on 8/7/19 at 9:10 AM. The MDS Nurse confirmed Resident #105 had bilateral bolsters (roll guards) in place to her bed at the time of her 7/17/19 MDS assessment. She indicated that Resident #105 was unable to get out of bed on her own. She stated that if Resident #105 tried to get up

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out of bed independently she most likely would fall. She stated that the bolsters prevented Resident #105 from falling onto the floor. The MDS Nurse indicated that Resident #105 had voluntary movement in bed and that the intent of the bolsters were to define the perimeter of the bed, so she would not roll off the bed and onto the ground. She acknowledged that the effect the bolsters had on Resident #105 was to keep her bed in bed. The MDS Nurse revealed she had not considered the effect the bolsters had on Resident #105 when she completed the MDS assessment in the area of physical restraints.

A follow up interview was conducted with the DON on 8/8/19 at 10:10 AM. She stated that in her opinion bilateral bolsters (roll guards) were not a physical restraint for any resident. She indicated that the intent of the bolsters were to define the perimeter of the mattress. The DON reported that she expected the MDS to be coded accurately, however, she had reviewed the regulations and she was unable to find any specific mention of bolsters being considered a physical restraint.

2. Resident #73 was admitted to the facility on 5/22/17 with diagnoses that included dementia with behavioral disturbance, muscle weakness, and contractures of left and right knees.

The plan of care for Resident #73 included the risk of falls and indicated the intervention of bolsters (cylinder-shaped cushions) to bed per family request to assist with proper positioning when in bed was initiated on 6/17/19.

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The quarterly Minimum Data Set (MDS) assessment dated 7/1/19 indicated Resident #73 ' s cognition was severely impaired. She had no behaviors and no rejection of care. Resident #73 was assessed as requiring the extensive assistance of 2 or more with bed mobility. She was dependent on 2 or more for transfers. Resident #73 was not steady on her feet and she was only able to stabilize with staff assistance. The assessment indicated Resident #73 had no physical restraints (defined as 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).

An observation was conducted of Resident #73 in the secured unit on 8/5/19 at 3:40 PM. Resident #73 was asleep in bed and bilateral bolsters were positioned in the middle third section of her bed.

On 8/6/19 at 10:57 AM Unit Manager (UM) #1 provided the manufacturer ' s information for the bolsters utilized for Resident #73. These bolsters were termed by the manufacturer as roll guards. The manufacturer ' s instructions, dated 8/7/12, indicated the roll guards were an alternative to side rails and were to help high-risk persons from rolling out of bed. The roll guards were cylinder shaped and measured 25" in length with a diameter of 9". The roll guards were connected by a piece of material that was to be positioned underneath the person when in bed leaving a 23" wide section in between the right roll guard and the left roll guard. The instructions indicated the roll guards were to be placed approximately 20" from head board. The straps were to be placed under the roll guards and wrapped once around

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the bed frame with the release buckles positioned away from the person.

A second observation was conducted of Resident #73 ' s bed on 8/6/19 at 11:33 AM. Resident #73 ' s bed was approximately 79" length. The bilateral roll guards (bolsters) were positioned approximately 20" from the top of the mattress as indicated in the manufacturer ' s instructions. The roll guard covered 25" of the center portion of the mattress leaving approximately 34" of open space from the bottom of the roll guard to the bottom the mattress.

An interview was conducted with Nursing Assistant (NA) #2 on 8/5/19 at 2:00 PM. She stated she regularly worked on the secured unit and she was familiar with Resident #73. She indicated that Resident #73 was at risk for falls and that she was unable to get out of bed safely without assistance. NA #2 reported that she believed the bilateral bolsters (roll guards) were in place to prevent a fall for Resident #73. She explained that Resident #73 moved around in bed and that the bolsters would have stopped her from falling onto the ground if she rolled into it. She reported if the bolsters were not on the bed and Resident #73 rolled over too far she would have fallen to the ground. NA #2 indicated that Resident #73 was not able to remove the bolsters from the bed on her own.

An interview was conducted with NA #3 on 8/5/19 at 3:25 PM. She stated she regularly worked on the secured unit and she was familiar with Resident #73. She indicated that Resident #73 was at risk for falls and that she was unable to get out of bed safely without assistance. NA #3 reported that the bilateral bolsters (roll guards)

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were in place to keep Resident #73 from falling out of bed. She explained that Resident #73 moved around a lot in bed and that the bolsters stopped her from falling off the side of the bed. She reported if the bolsters were not on the bed and Resident #73 rolled over too far she would have fallen to the ground. NA #3 indicated that Resident #73 was not able to remove the bolsters from the bed on her own.

An interview was conducted with the Director of Nursing (DON) on 8/6/19 at 1:45 PM. The bilateral bolsters (roll guards) in place for Resident #73 were reviewed with the DON. She stated that the bolsters were in place to keep Resident #73 from falling out of bed and sustaining an injury. She indicated it was a safety intervention to prevent falls.

An interview was conducted with the MDS Nurse on 8/7/19 at 9:10 AM. The MDS Nurse confirmed Resident #73 had bilateral bolsters in place to her bed at the time of her 7/1/19 MDS. She indicated that Resident #73 was unable to get out of bed on her own. She stated that if Resident #73 tried to get up out of bed independently she most likely would fall. She reported that the bolsters prevented Resident #73 from falling onto the floor. The MDS Nurse indicated that Resident #73 had voluntary movement in bed and that the intent of the bolsters were to define the perimeter of the bed, so she would not roll off the bed and onto the ground. She acknowledged that the effect the bolsters had on Resident #73 was to keep her in bed. The MDS Nurse revealed she had not considered the effect the bolsters had on Resident #73 when she completed the MDS assessment in the area of physical restraints.

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A follow up interview was conducted with the DON on 8/8/19 at 10:10 AM. She stated that in her opinion bilateral bolsters (roll guards) were not a physical restraint for any resident. She indicated that the intent of the bolsters were to define the perimeter of the mattress. The DON reported that she expected the MDS to be coded accurately, however, she had reviewed the regulations and she was unable to find any specific mention of bolsters being considered a physical restraint.

3. Resident #113 was admitted to the facility on 5/16/19 with diagnoses that included heart failure.

A nursing note dated 5/16/19 indicated Resident #113 was admitted to the facility from home for a 5-day respite stay through hospice services.

The interim plan of care dated 5/16/19 indicated Resident #113 was admitted to the facility for a respite stay under the care of hospice.

A Physician ' s Assistant (PA) note dated 5/21/19 indicated Resident #113 was admitted for a 5-day respite stay under the care of hospice and had transitioned to long term care at the completion of the 5-day respite stay (5/21/19). Resident #113 continued with hospice services.

The admission Minimum Data Set (MDS) assessment dated 5/23/19 indicated Resident #113 ' s cognition was intact, and he had a life expectancy of less than 6 months. Resident #113 ' s 5/23/19 MDS indicated he was receiving hospice services while a resident at the facility during the last 14 days. Resident #113 was not identified as receiving hospice services while not

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a resident at the facility during the last 14 days. He also was not identified as receiving respite care while a resident at the facility during the last 14 days. The hospice care and respite care sections of the 5/23/19 MDS for Resident #113 were completed by the MDS Nurse.

An interview was conducted with the MDS Nurse on 8/6/19 at 1:24 PM. The 5/23/19 MDS for Resident #113 that had not indicated he received respite care while a resident at the facility during the last 14 days and had not indicated he received hospice care while not a resident at the facility during the last 14 days were reviewed with the MDS Nurse. She revealed the MDS was coded inaccurately. She confirmed that Resident #113 was on hospice services prior to his admission to the facility and within the last 14 days (from the dated of the 5/23/19 MDS assessment). She additionally confirmed that Resident #113 was admitted for respite care on 5/16/19 and that this should have been marked on the 5/23/19 MDS. The MDS Nurse stated that this was an oversight.

An interview was conducted with the Director of Nursing on 8/8/19 at 10:10 AM. She stated she expected the MDS to be coded accurately.

4. Resident # 72 was admitted to the facility on 8/25/16 with multiple diagnoses including Obstructive Sleep Apnea (OSA) and Chronic Obstructive Pulmonary Disease (COPD). The annual Minimum Data Set (MDS) assessment dated 4/1/19 indicated Resident #72 had moderate cognitive impairment and he was not on BIPAP (Bilevel Positive Airway Pressure) /CPAP (Continuous Positive Airway Pressure)

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while at the facility.

Resident #72 had a doctor's order dated 11/12/18 for BIPAP on at bedtime - settings for OSA, 400 milliliter (mls). EPAP (expiratory positive airway pressure):8 centimeter (cm), minimum pressure of 20 and maximum pressure of 25, rate at 18.

The March 2019 Medication Administration Records (MARs) revealed that Resident #72 was provided BIPAP daily at bedtime.

On 8/7/19 at 9:30 AM, the MDS Nurse was interviewed. She verified that Resident #72 was on BIPAP. The MDS Nurse reviewed the March 2019 MAR and stated that the annual MDS assessment dated 4/1/19 was coded incorrectly since the resident was on BIPAP during the assessment period.

On 8/7/19 at 10:14 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.

5) Resident #17 was admitted to the facility on 1/18/18 with diagnoses that included Alzheimer's disease, Hypertension and Diabetes.

The quarterly Minimum Data Set (MDS) dated 5/9/19 assessed the resident as being severely impaired for decision making with long and short-term memory impairment. She was marked as no for the attempt to conduct the Brief Interview for Mental Status (BIMS).

The resident's active care plan dated 5/16/19

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F 641	Continued From page 32 revealed a problem area of communication deficit due to Alzheimer's disease. The interventions included to ask yes or no questions when able and allow adequate time for a response. A review of the Social Services notes revealed on 5/9/19 the BIMS was attempted with no success, due to mumbling words and confusion. On 8/6/19 at 8:45am Resident #17 was observed eating breakfast. She responded the food was good and asked if this writer would like some. At 3:10pm on 8/6/19 Resident #17 was interviewed. The resident was able to answer simple yes and no questions, such as whether she was in pain or cold. On 8/7/19 at 9:18am during an interview with the Social Worker she stated it was an oversight that she marked Resident #17's 5/09/19 MDS that no attempt was made to conduct the BIMS, when she had attempted to complete this interview with the resident. The Director of Nursing was interviewed on 8/8/19 at 10:19am. She stated it was her expectation for the MDS to be coded correctly after a BIMS test had been attempted.	F 641		
F 727 SS=B	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 727		8/28/19

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F 727	Continued From page 33 §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to have a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week for 2 of 45 days reviewed (6/29/19 and 6/30/19). Findings included: The nursing staff schedule and the staff posting were reviewed for the last 6 weeks. The nursing staff schedule had listed an RN (Nurse # 5) for 6/29/19 and 6/30/19. Review of the time sheets revealed that Nurse #5 did not work on 6/29/19 and 6/30/19. On 8/7/19 at 1:45 PM, the Payroll/Human Resources (HR) staff member was interviewed. She stated that she reviewed the nurses' time sheets for 6/29/19 and there was no RN who worked that day. She also reported that Nurse #4 (an RN) had worked on 6/30/19 for 3.5 hours. The Payroll/HR staff member stated that she didn't know that the facility should have an RN for at least 8 consecutive hours a day, 7 days a week. On 8/7/19 at 3:20 PM, the Regional Consultant reported that she had verified that there was no RN coverage for 6/29/19 and there was only 3.5	F 727	F727 The Regional Operations Manager in serviced the Director of Nursing on 8/7/19 regarding the Registered Nurse consecutive 8 hours a day seven day a week regulation. The Registered Nurse coverage was adjusted on 8/8/19 to validate 7 day a week coverage with 8 consecutive hours a day. The Director of Nursing will review daily the next day schedule to ensure 8 hours of Registered Nurse coverage is addressed. The Weekend coverage of the Registered Nurse will be reviewed prior to the weekend. In the event of a call out, another Registered Nurse will cover the 8 hours of coverage, to include the use of the Regional Registered Nurses. The Administrator or Director of Nursing will review daily, time cards of the Registered Nurses from the day before or on Mondays following a weekend to ensure 8 hours of coverage was sustained. This will be done 5x/week x 4 weeks then 3x/week x 2 weeks, then weekly x 2 weeks then monthly x 1 month. The Director of Nursing will audit the scheduled Registered Nurse coverage	

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F 727	Continued From page 34 hours of RN coverage for 6/30/19. She further indicated that the RN scheduled for that weekend had called out. On 8/7/19 at 4:10 PM, Unit Manager #1 (a licensed practical nurse (LPN)) reported that she was on call the weekend of 6/29/19 and 6/30/19. She had tried to call several RNs and even the staffing agency and she could not find an RN to come on 6/29/19. She added that Nurse #4 came to help for 3.5 hours on 6/30/19. The Unit Manager reported that the Director of Nursing (DON) was not available that weekend, she was on vacation. On 8/7/19 at 4:15 PM, the Administrator reported that the facility had difficulty in hiring RNs to work at the facility due to its location. He added that he would be checking out on how to apply for a waiver. On 8/8/19 at 10:14 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the regulation be followed for the RN coverage.	F 727	5x/week x 4 weeks, then 3x/week x 2 weeks, then weekly x 2 weeks, then monthly x 1 month. The Administrator will review the audit results and present the findings to the Quality Assurance Committee monthly x 3 months.	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 732		8/28/19

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F 732	Continued From page 35 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to post the nurse staffing information accurately in the area of Registered Nurse (RN) for 2 of 45 days reviewed (6/29/19 and 6/30/19). Findings included: The nursing staff schedule and the staff posting were reviewed for the last 6 weeks. The nursing staff schedule had listed an RN (Nurse # 5) for	F 732	F732 F732 The Daily Facility Posting for 6/29/19 and 6/30/19 were corrected on 8/8/19 by the front office receptionist. The Regional Operations Manager in serviced the Director of Nursing, staffing scheduler and front office receptionist on maintaining accuracy of the Daily Facility Posting. The Director of Nursing in serviced the Nursing Supervisors on	

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F 732	Continued From page 36 6/29/19 and 6/30/19. The staff posting had listed an RN for 8 hours on 6/29/19 and 6/30/19. Review of the time sheets revealed that Nurse #5 did not work on 6/29/19 and 6/30/19. On 8/7/19 at 1:45 PM, the Payroll/Human Resources (HR) staff member was interviewed. She stated that she reviewed the nurses' time sheets for 6/29/19 and there was no RN who worked that day. She also reported that Nurse #4 (an RN) had worked on 6/30/19 for 3.5 hours. On 8/7/19 at 3:20 PM, the Regional Consultant reported that she had verified that there was no RN coverage for 6/29/19 and there was only 3.5 hours of RN coverage for 6/30/19. She further indicated that the RN scheduled for that weekend had called out. On 8/7/19 at 4:10 PM, Unit Manager #1 (a licensed practical nurse (LPN)) reported that the RN supervisor was responsible in updating the staff posting on the weekends. On 8/8/19 at 10:14 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff posting to be accurate.	F 732	8/19/19, on reflection of accurate posting of Registered Nurse hours. The daily staff posting will be reviewed by the Nurse Supervisor, Director of Nursing or the Administrator for weekends. The Director of Nursing will compare time cards to the Daily Posting, each morning, 5x/week x 4 weeks, then 3x/week x 2 weeks, then weekly x 2 weeks, then monthly x 1 month. The Director of Nursing will review the results and present the findings to the Quality Assurance Committee monthly x 3 months.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		8/28/19

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	345534	A. BUILDING _____ B. WING _____	C 08/08/2019

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F 758	Continued From page 37 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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F 758	Continued From page 38 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to have a documented indication or a clinical rationale for the use of the antipsychotic medication for 1 of 5 sampled residents reviewed for unnecessary medications (Resident # 213). Findings included: Resident #213 was admitted to the facility from the hospital on 7/17/19 with multiple diagnoses including dementia, Alzheimer's Disease and left hip intertrochanteric fracture. The admission Minimum Data Set (MDS) assessment dated 7/24/19 indicated that Resident #213 had moderate cognitive impairment and she had received an antipsychotic medication for 7 days during the assessment period. The care area assessment (CAA) dated 7/25/19 revealed that Resident #213 had diagnoses of depression as well as Alzheimer's disease with a history of delirium and the resident was receiving Lexapro (an antidepressant medication) and Seroquel (an antipsychotic medication). Review of Resident #213's medical records including history and physical dated 7/15/19, and hospital discharge summary dated 7/17/19 revealed no documented indication/rationale for the use of the Seroquel. Resident #213 had a doctor's order dated 7/17/19 for Seroquel 25 milligrams (mgs) in AM and 50 mgs in the evening for dementia. The Physician Assistant (PA) progress note dated	F 758	F758 For resident #213, an order was obtained on 8/7/19 to clarify the diagnosis for Seroquel, diagnosis being dementia with behaviors. All in house residents on antipsychotic medications were audited on 8/8/19 for diagnosis or rationale for use by the Director of Nursing and Nurse Supervisors. Any resident who did not have a diagnosis, was reviewed by the Physician Assistant, Psychiatric Nurse Practitioner, or Primary Medical Doctor for use indication/rationale. 3 of 25 residents required a clarification of use based on diagnosis. An In service was provided by the Regional Clinical Manager to the Director of Nursing and Nursing Supervisors on 8/8/19 to ensure that all antipsychotic medications had a diagnosis or rationale for the indications of use. The Director of Nursing in serviced all licensed nurses on the diagnosis and rationale in the use of antipsychotic medications, with a completion date of 8/23/19. No licensed staff will be allowed to work until in service is completed. All antipsychotics will be reviewed by the licensed nurse, with second check completed by the Nurse Supervisor or Director of Nursing to ensure appropriate use, to include diagnosis, with each order written. The Director of Nursing and Nurse Supervisors will review orders for antipsychotic medications and	

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F 758	Continued From page 39 7/18/19 revealed Resident #213 was admitted to the hospital after a fall with left intertrochanteric fracture. The resident underwent left hip open reduction and internal fixation (ORIF). The assessment and plan included to continue Aricept, Namenda and Seroquel for Alzheimer's dementia. On 8/7/19 at 10:33 AM, Nurse Aide (NA) # 5, assigned to Resident #213, was interviewed. She stated that Resident #213 did not have any behaviors. On 8/7/19 at 10:35 AM, Nurse #4, assigned to Resident #213, was interviewed. The Nurse stated that Resident #213 had no behavioral problems. The Nurse also indicated that the resident was on Seroquel for dementia. On 8/7/19 at 11:05 AM, the Director of Nursing (DON) was interviewed. She stated that she would review Resident #213's medical records to search for the indication of the Seroquel. At 12:05 PM, the DON reported that she could not find any documented indication/rationale for the use of the Seroquel in the resident's medical records. She reported that she had called the facility (name of the assisted living facility) where the resident resided before the hospitalization and the facility indicated that the resident had behaviors and hallucinations. The DON further stated that she had called the doctor and she had written a clarification order for the Seroquel. The DON also reported that she would request a psychiatric evaluation for the resident. On 8/7/19, Resident #213 had a doctor's order for Seroquel 25 mgs in AM and 50 mgs at bedtime for dementia with behavioral disturbances.	F 758	indication/rationale 5x/week x 4 weeks, then 3x week x 2 weeks, then weekly x 2 weeks then monthly x 1 month. The Director of Nursing will review the findings of these audits and present the findings to the Quality Assurance Committee monthly x 3 months.	

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F 758	Continued From page 40 Attempted to interview the doctor and the Physician Assistant (PA) but were not available. On 8/8/19 at 10:14 AM, the DON was again interviewed. She stated that she expected all psychotropic medications to have a documented indication/rationale for use.	F 758		