STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495302	A. BUILDING _____ B. WING _____	C 03/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARRINGTON	2406 ATHERHOLT ROAD LYNCHBURG, VA 24501

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/28/17 through 3/1/17. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 97 certified bed facility was 78 at the time of the survey. The survey sample consisted of fifteen current resident reviews (Residents 1 through 14 and #18) and three closed record reviews (Residents 15 through 17).	F 000		
F 223 SS=D	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 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 symptoms. 483.12(a) The facility must- (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 staff interview and clinical record review, facility staff failed to ensure one of 18 residents was free from abuse, Resident #10. Facility staff failed to keep Resident #2 from sexually abusing of Resident 10.	F 223	The Carrington (Facility) is filing this plan of correction for the purpose of regulatory compliance. The Facility is submitting this plan of correction to comply with the applicable law. The submission of this plan of correction does not represent an	4/10/17

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

Electronically Signed | 03/20/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 Findings included: Resident # 10 was admitted to the facility on 5/17/13 with, but not limited to, the following diagnoses: dementia without behaviors and diabetes mellitus type 2. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/6/17 was a quarterly assessment. The resident was assessed as being a three (3) for cognitive impairments, severely impaired. Resident #2 was originally admitted to the facility on 06/23/2015 and readmitted on 01/17/2017 with diagnoses including, but not limited to: Stroke, Atrial Fibrillation, Coronary Artery Disease with Bypass Surgery, Diabetes, Hypertension, Depression, and Vitamin D Deficiency. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/09/2016. Resident #2 was assessed as cognitively intact with a total cognitive score of 13 out of 15. Resident #2's clinical record was reviewed on 02/28/2017 at 3:10 p.m. A Nurse's Note dated 2/15/17 at 1720 (5:20 p.m.) included, "Staff member stated she witnessed resident pulling another resident in W/C (wheelchair) into room. Witnessed this resident (room #) inappropriately touching resident in W/C private area. Resident moved away to safe area by staff member. DON (director of nursing), administrator & (and) social worker notified via telephone. Call placed to Dr. (doctor) (Name). Order received to transport resident to ER (emergency room) for psych (psychiatric) eval (evaluation)." A note dated	F 223	admission or statement of agreement with respect to the alleged deficiencies. A. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident #2 was immediately removed from resident #10□s presence. Staff immediately implemented every 15 minute checks and issued a 30 Day Discharge Notice to Resident #2. Resident # 10 was removed from the doorway and away from resident #2. No adverse effect. B. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: 1. Female residents with cognitive impairments have the potential to be affected by this deficient practice. 2. Resident #2 will remain on every 15 monitoring until s/he is discharged from the facility 3. A psychiatric consultation has been obtained to evaluate and treat Resident #2□s behaviors. C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: 1. The facility administrator and department heads will be in serviced by the Regional Director of Clinical Services	

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2/15/17 at 1830 (6:30 p.m.), "Transported to (Hospital Initials) ER via (Transport Initials) 911. Report called to ER." A note dated 2/16/17 at 0227 (2:27 a.m.), "Resident returned to facility via stretcher..."

The Administrator and DON were asked for a copy of an Incident Report or investigation during a meeting with the survey team on 02/28/17 at approximately 5:30 p.m. A copy of this report was received on 03/01/2017 at approximately 7:45 a.m. The "Incident/Accident Report" dated "2/15/17 1720" (5:20 p.m.) included the following, "...CNA (certified nursing assistant) reported she witnessed this resident pulling a female resident in W/C into his room. States she witnessed male resident inappropriately touching female resident in W/C in private body part..." A witness statement from the CNA included the following, "...I, CNA (Name), saw (Name) Resident #2 pull (Name-female resident) into his room, by her wheelchair. They were facing each other. As I walked closer to see what was going on I saw (Name) Resident #2 reach his right hand out and touch (Name-female resident) private area [through her clothes]. I then went to remove (Name-female resident) from the room and immediately told the nurse."

The hospital ER discharge plan dated 2/15/17 at 2302 (11:02 p.m.) by the ER physician included the following, "...Discharge plan: The patient is discharged to their long term care facility. Patient's condition is stable and improved. Please follow up with the resources provided in the ED (emergency department) by the mental health consultant..."

Further review of Resident #2's clinical record

on:
a. Facility P&P for Reporting Suspected Crimes Under the federal Elder Justice Act
i. Required employee training
ii. Reporting requirements poster displayed in employee break room and by time clock
iii. Each Employee□s responsibility for reporting suspicion of a crime against an elder without fear of retaliation
iv. Definition of crime, exploitation, neglect, self-neglect, serious bodily injury
v. Reporting requirements and timeframes
vi. How to report suspicion of a crime (to facility administration, state survey agency and local law enforcement) / Form to be used for reporting a suspected crime under the Elder Justice Act
b. Review of Facility□s policy and procedure for Abuse, Neglect, Exploitation prevention, investigation and reporting
i. Review of training requirements
ii. Identifying abuse(physical, verbal, sexual) neglect, exploitation
iii. Investigation procedures and documentation including immediate suspension of alleged perpetrator until investigation completed and conclusions drawn (if perpetrator is a Resident immediately place on every 15 minute monitoring and obtain a psychiatric consult to evaluate and treat behaviors)
iv. Investigation Injuries of Unknown Origin as potential ANE
v. Process for monitoring an employee who is returned to work following an ANE allegation whereby the ANE was not

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F 223	Continued From page 3 included a nurse's note where Resident #2 had been sent out to the hospital on 01/14/17 for shortness of breath and edema. He was hospitalized from 01/14/17 until his readmission to the facility on 01/17/17. Prior to his hospitalization Resident #2 had been on every 15 minute checks from a previous incident noted in the clinical record. Upon Resident #2's readmission to the facility the every 15 minute checks were not restarted in his physician orders. The Administrator and DON were interviewed on 03/01/2017 at 2:25 p.m. regarding the above noted incident, resources provided in the ED, and why every 15 minute checks were not reordered by the physician. The Administrator stated regarding resources provided in the ER, "He said he was going to take care of it. Dr. (Name) in the ER. I spoke to him personally and he assured me he would follow up, but he didn't." Regarding if the Administrator or anyone in the facility had followed up the Administrator stated, "I did not. I believe it was mentioned to (Name) social worker and I don't believe she has at this time." The DON stated regarding every 15 minute checks, "We discussed it ourselves" (the DON gestured to the Administrator and mentioned a couple of other facility employees by name), "and felt he did not need every 15 minute checks any longer. I guess we were wrong..." Other #9 (social worker/admissions coordinator) was interviewed on 03/01/17 at 2:50 p.m. regarding any follow up of resources provided in the ED. Other #9 stated, "Yes it was mentioned in passing by (Name) Administrator. No, I have not followed up with the doctor. I didn't even know who the doctor was until now. What I have done is try to find alternate placement for him."	F 223	substantiated but management still has concerns with the employee vi. Reporting requirements and documentation of same vii. Review of investigation forms packet and required summary / compiling and maintaining the investigative file viii. Staff discipline ix. Identifying and addressing risk factors in which abuse is more likely to occur 2. The facility staff will be in serviced by the administrator and/or his designee on the following: a. Residents rights b. Definition of resident abuse/neglect c. Facility□s Abuse prevention P&P and the Elder Justice Act d. Signs of staff burn out e. Reporting potential abuse/neglect f. How to intervene with aggressive residents g. Staff Reporting Requirements i. When staff suspect a crime has occurred against a resident at this facility, they must report the incident immediately to the facility Administrator. ii. Staff must report a suspicion of a crime to the state survey agency and at least one local law enforcement entity within a designated time frame by e-mail, fax or telephone iii. If the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately, but not later than 2 hours after forming the suspicion. iv. If the reportable event does not result in serious bodily injury, the staff member	

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F 223	Continued From page 4 A physician order dated "2/16/17" stated, "Have pt. (patient) on 15 min (minute) checks." This order was signed by an RN (registered nurse) and timed at 12N (12 noon). The physician signed the order on "2/21/17." Resident #2 remained on every 15 minute checks throughout the survey. No further information was received prior to the exit conference on 03/01/2017.	F 223	shall report the suspicion not later than 24 hours after forming the suspicion. v. Failure to report in the required time frames may result in disciplinary action, including up to termination. vi. Staff must report the suspicion of an incident to the shift supervisor, facility Administrator and/or Director of Nursing immediately upon forming the suspicion. vii. This training will be done on hire for all new employees and annually for all employees D. Monitoring of corrective action to ensure the deficient practice will not reoccur: 1. Director of Nursing or designee will audit resident #2 physician ordered 15 minute checks form to ensure safety monitoring X 1 week for 3 months. 2. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. 3. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy 4. The Administrator will be responsible for overseeing all abuse/neglect allegation investigations and ascertaining that the facility policy for Abuse Prevention, Investigation and Reporting is followed including reporting requirements. The	

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F 223	Continued From page 5	F 223	Administrator will contact the Corporate Director of Clinical Services within eight hours of being informed of an abuse allegation to review the allegations of abuse, review the investigation process, the reporting requirements and the overall compliance with the facility policy for abuse reporting and investigation as well as the Elder Justice Act. 5. The facility administrator will report all allegations of abuse to the facility QAPI Committee for review and further recommendations.	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or	F 225		4/10/17

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licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate

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F 225	Continued From page 7 corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to thoroughly investigate and report to the state agency allegations of abuse involving two of 18 residents in the survey sample (Residents #2 and #14) and failed to investigate an accident of unknown circumstances for one of 18 residents in the survey sample (Resident #6). A witnessed incident of sexual abuse of Resident #14 by Resident #2 was not investigated or reported to the state agency. A second incident of inappropriate sexual contact by Resident #2 toward Resident #10 was not thoroughly investigated or promptly reported to the state agency. The facility did not investigate Resident #6's fall from her wheelchair in a van during transportation to dialysis by a paid transport service. The findings include: 1. A witnessed incident of sexual abuse of Resident #14 was not investigated or reported to the state agency. Resident #14 was admitted to the facility on 5/1/15 with diagnoses that included advanced dementia, arthritis and gastroesophageal reflux disease. The minimum data set (MDS) dated 1/27/17 assessed Resident #14 with short and long-term memory problems and severely impaired cognitive skills. The MDS completed prior to the abusive incident dated 3/4/16 also assessed Resident #14 with short and long-term memory problems and severely impaired cognitive skills.	F 225	A. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: 1. In-service Administrator/Director of Nursing on Reporting abuse to State Agencies and Other Entities/ Individuals policy and Abuse Investigation policy. 2. Reporting abuse to State Agencies and Other Entities/ Individuals policy amended to correct time for timeliness of reporting. 3. Outside facility accident investigation form created. B. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: 1. All residents with incidents, accidents, and allegations of abuse have the potential to be affected by deficient practice. C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: 1. Corporate Clinical Consultant in-serviced Administrator/ Director of Nursing on Virginia Department of Health Reporting of Incidences and facility policy on Abuse Prohibition. 2. The facility nursing staff have been inserviced on how to follow up on	

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F 225	Continued From page 8 Resident #14's clinical record documented a nursing note dated 4/23/16 stating, "...CNA [certified nurses' aide] reported another resident [Resident #2] had their hands down the pants of this resident, this happened at the nurse's station. The resident [Resident #2] was told to go back to his room by his nurse...[social worker] notified us to contact APS [adult protective services], this was done...this resident was laid in bed + changed, 0 [no] scratches, 0 [no] red areas, 0 [no] injuries noted on legs or in peri-area...Contacted [family member], notified him that his mother had been inappropriately touched by another male resident at the nurse's station while no one was around. It was seen by a CNA walking down the hall. Notified him [family member] APS has been contacted + offending male resident has been moved to the other side of the building..." The facility's incident/accident report dated 4/23/16 documented the incident occurred at 10:45 a.m. on 4/23/16 in the hall at the nurses' station. This incident form documented, "CNA reported res [Resident #2] had his hands down res [Resident#14's] pants, res layed down and checked over..." (sic) The form documented APS was notified and Resident #2 was moved to the other side of the building. This form was signed by the licensed practical nurse reporting the incident, the director of nursing, the administrator and a physician's assistant. There was no documentation of any notification to the state agency of the incident. Attached to the incident form was a letter from APS dated 6/3/16 stating, "The investigation has been completed. Although there is a preponderance of evidence that [Resident #14] was a victim of abuse, neglect, or exploitation, the need for protective services no	F 225	accidents that occur outside the facility to include physician and responsible party notification; resident assessment; documentation of event in nurses notes; completion of incident & accident report; document on 24 hour report for Administrator and DON to conduct an investigation into the accident and implement measures to prevent a recurrence. D. Monitoring of corrective action to ensure the deficient practice will not reoccur: 1. All incidents, accidents, and allegations of abuse will be immediately reported to the Corporate Clinical Consultant to ensure that all are reported and thoroughly investigated to report to the appropriate agencies per guidelines. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. 2. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy 3. The Administrator will be responsible for overseeing all abuse/neglect allegation investigations and ascertaining that the facility policy for Abuse Prevention, Investigation and Reporting is followed including reporting requirements. The Administrator will contact the Corporate	

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F 225	Continued From page 9 longer exists..." As of 2/28/17 there was no report of this incident to the state agency and no evidence of any investigation of the incident by the facility. On 3/1/17 at 11:30 a.m. the administrator was interviewed about reporting and investigating the 4/23/16 incident of Resident #2 with his hands in Resident#14's pants. The administrator stated the facility did not investigate or report the incident to the state agency because APS was notified and conducted an investigation. When asked if there were any witness statements from staff or review of the events occurring around the time of the incident, the administrator stated, "No." When asked why this incident was not reported to the state agency, the administrator stated he did not know he was supposed to investigate or report the incident. The administrator stated, "I was thinking it [investigation] was needed just for staff abusing residents." The administrator stated he was not thinking about abuse occurring from resident to resident. The administrator stated APS came to the facility and interviewed staff but the facility did not interview or get statements from staff or other residents about the incident. The administrator stated, "We let APS do the investigation." The administrator stated they moved Resident #2 to the other side of the building. The facility's policy titled Resident Abuse/Neglect/Mistreatment (issued August 1999) documented, "It is the policy of this facility to maintain an environment free of abuse and neglect. Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion.	F 225	Director of Clinical Services within eight hours of being informed of an abuse allegation to review the allegations of abuse, review the investigation process, the reporting requirements and the overall compliance with the facility policy for abuse reporting and investigation as well as the Elder Justice Act.	

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Residents will not be subjected to abuse from anyone including, but not limited to, facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals...All alleged violations involving mistreatment, abuse or neglect will be thoroughly investigated by the facility under the direction of the Administrator and in accordance with state law...Individual state reporting requirements will be adhered to. The results of the facility investigation will be reported to appropriate regulatory officials within the time frames established at the state level..." The facility's policy titled Reporting Abuse to State Agencies and Other Entities/Individuals (revised December 2009) stated, "All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law...Should a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse (including resident to resident abuse) be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident...The State licensing/certification agency responsible for surveying/licensing the facility...The local State Ombudsman...Adult Protective Services...Law enforcement officials...resident's Attending Physician...The facility Medical Director...The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation with five (5) working days of the occurrence of the incident..."

These findings were reviewed with the

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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
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administrator and director of nursing during a meeting on 3/1/17 at 2:10 p.m.

2. Facility staff failed to report an incident of sexual abuse that occurred on 02/15/2017 that involved Resident #2 and another resident in the facility to the Office of Licensure and Certification (OLC) within two hours of the occurrence.

Resident #2 was originally admitted to the facility on 06/23/2015 and readmitted on 01/17/2017 with diagnoses including, but not limited to: Stroke, Atrial Fibrillation, Coronary Artery Disease with Bypass Surgery, Diabetes, Hypertension, Depression, and Vitamin D Deficiency.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/09/2016. Resident #2 was assessed as cognitively intact with a total cognitive score of 13 out of 15.

Resident #2's clinical record was reviewed on 02/28/2017 at 3:10 p.m. A Nurse's Note dated 2/15/17 at 1720 (5:20 p.m.) included, "Staff member stated she witnessed resident pulling another resident in W/C (wheelchair) into room. Witnessed this resident (room #) inappropriately touching resident in W/C private area. Resident moved away to safe area by staff member. DON (director of nursing), administrator & (and) social worker notified via telephone. Call placed to Dr. (doctor) (Name). Order received to transport resident to ER (emergency room) for psych (psychiatric) eval (evaluation)." A note dated 2/15/17 at 1830 (6:30 p.m.), "Transported to (Hospital Initials) ER via (Transport Initials) 911.

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Report called to ER." A note dated 2/16/17 at 0227 (2:27 a.m.), "Resident returned to facility via stretcher..."

The Administrator and DON were asked for a copy of an Incident Report or investigation during a meeting with the survey team on 02/28/17 at approximately 5:30 p.m. A copy of this report was received on 03/01/2017 at approximately 7:45 a.m. The "Incident/Accident Report" dated "2/15/17 1720" (5:20 p.m.) included the following, "...CNA (certified nursing assistant) reported she witnessed this resident pulling a female resident in W/C into his room. States she witnessed male resident inappropriately touching female resident in W/C in private body part..." A witness statement from the CNA included the following, "...I, CNA (Name), saw (Name) Resident #2 pull (Name-female resident) into his room, by her wheelchair. They were facing each other. As I walked closer to see what was going on I saw (Name) Resident #2 reach his right hand out and touch (Name-female resident) private area [through her clothes]. I then went to remove (Name-female resident) from the room and immediately told the nurse."

The Administrator was interviewed on 03/01/2017 at 2:00 p.m. regarding if the above noted incident had been reported to the Office of Licensure and Certification and if he had proof of a time stamp when the incident had been reported. The Administrator provided a copy of the Facility Reported Incident (FRI) that stated, "...Report date: February 16, 2017 Incident date: February 15, 2017..." A copy of the fax confirmation sheet included the following: "...ST. TIME 02/16 13:06 (1:06 p.m.)...RESULT OK."

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Per documentation in the clinical record, the above mentioned incident occurred on 02/15/17 at 5:20 p.m. The incident was not reported to the Office of Licensure and Certification until 02/16/17 at 1:06 p.m. A time difference of almost twenty hours. The Administrator stated regarding the delay in reporting to the OLC, "I reported the incident the next day during the work day."

No further information was received prior to the exit conference on 03/01/2017.

3. For Resident # 6, the facility staff failed to report and thoroughly investigate an accident of unusual circumstances.

Resident # 6 in the survey sample, a 61 year-old female, was admitted to the facility on 4/27/15, and most recently readmitted on 9/21/15 with diagnoses that included hypertension, end stage renal disease, diabetes mellitus, seizure disorder, cerebrovascular accident, depression, gout, and hyperparathyroidism. According to the most recent Minimum Data Set, a Quarterly with an Assessment Reference Date of 1/20/17, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15.

Review of the Nurses Notes in the Resident # 6's clinical record revealed the following entries:

1/17/17 - 5:30 a.m. "Resident LOA (Leave of

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Absence) to dialysis."

1/17/17 - 5:45 a.m. "Transport driver returned to say resident had fallen out of wheelchair in van."

1/17/17 - 5:50 a.m. "Resident observed on floor of van. Resident assisted in to sitting position. Resident assessed for injury. NAI (No Additional Injuries) noted. (No) c/o (complaint of) pain/discomfort. Assisted x (times) 3 back into wheelchair. Resident stated she was OK. LOA to dialysis."

At approximately 10:00 a.m. on 2/28/17, the surveyor requested to see the Incident/Accident Report concerning the incident on 1/17/17. The report was provided by the Director of Nursing (DON). Review of the report noted the following entry under the question, "Describe exactly what happened and what were the causes...." The response to the question was as follows, "Resident LOA to dialysis. Transport driver returned in to facility and stated resident was leaning forward and fell out of chair. Resident assisted to sitting position. NAI noted." The Incident/Accident Report also included the following notation: "Resident fell in transport van, was not in facility."

During an end of day meeting at 5:00 p.m. on 2/28/17 that included the Administrator, DON, other administrative staff, and the survey team, the DON was asked to identify the staff member who had completed the Incident/Accident Report. The DON identified the staff member as LPN # 7 (Licensed Practical Nurse), and said she worked the third (11:00 p.m. - 7:00 a.m.) shift. The DON also offered to give the surveyor a copy of the Incident/Accident Report.

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At 7:10 a.m. on 3/1/17, LPN # 7 was interviewed regarding the incident on 1/17/17. Asked if she knew exactly how resident # 6 fell, LPN # 7 indicated that she did not. When asked if Resident # 7 had a seat belt on her wheelchair and was it in use the day of the incident, LPN # 7 said, "Yes. When she left here she had her seat belt on." LPN # 7 went on to say that, "There is a chance she (Resident # 6) took it off herself."

At 1:45 p.m. on 3/1/17, the surveyor obtained the copy of the Incident/Accident Report that the DON had offered to provide. The report consisted of three pages. Asked if the incident had been reported to the State Agency, the DON indicated it had not. When asked if the three pages given the surveyor were the entire report, the DON said, "That is the sum total of the investigation."

Further review of the Incident/Accident Report revealed that the INVESTIGATE portion included the following directions, "Gather first impressions. List each staff member that was involved in this incident. List their location, and if they have knowledge of the incident. Knowledge would include witnessing the fall, being the first responder, being the last person to see the resident. What was the resident doing before the fall?"

The INVESTIGATE portion of the Incident/Accident Report was blank. There were no names of staff members listed, including LPN # 7, who said the resident had her seat belt on, or any of the staff members who assessed the resident and assisted her back into her wheelchair. The name of the van driver was not

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F 225	Continued From page 16 listed. There was no documentation to indicate the van company was notified of the incident. There were no written statements from any staff member that had knowledge of, or may have had knowledge of the incident, or who assessed and assisted the resident after the fall. During a meeting at 2:00 p.m. on 3/1/17 that included the Administrator, DON, other administrative staff and the survey team, the failure of the facility to report and investigate the incident of 1/17/17 involving Resident # 6 was discussed.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-	F 226		4/10/17

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F 226	Continued From page 17 (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to implement their abuse prevention policies for investigating and reporting allegations of abuse involving two of 18 residents in the survey sample (Residents #2 and #14) and failed to follow their abuse prevention policies for investigating an accident of unknown circumstances for one of 18 residents in the survey sample (Resident #6). A witnessed incident of sexual abuse of Resident #14 by another resident was not investigated or reported to the state agency. A second incident of inappropriate sexual contact by Resident #2 toward Resident #10 was not thoroughly investigated or promptly reported to the state agency. The facility did not investigate Resident #6's fall from her wheelchair in a van during transportation to dialysis by a paid transport service. The findings include: 1. A witnessed incident of sexual abuse of Resident #14 by Resident #2 was not investigated or reported to the state agency. Resident #14 was admitted to the facility on	F 226	A. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: 1. In-service Administrator/Director of Nursing on Reporting abuse to State Agencies and Other Entities/ Individuals policy and Abuse Investigation policy. 2. Reporting abuse to State Agencies and Other Entities/ Individuals policy amended to correct time for timeliness of reporting. 3. Outside facility accident investigation form created. B. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: 1. All residents with incidents, accidents, and allegations of abuse have the potential to be affected by deficient practice. C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur:	

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F 226	Continued From page 18 5/1/15 with diagnoses that included advanced dementia, arthritis and gastroesophageal reflux disease. The minimum data set (MDS) dated 1/27/17 assessed Resident #14 with short and long-term memory problems and severely impaired cognitive skills. The MDS dated 3/4/16 also assessed Resident#14 with short and long-term memory problems and severely impaired cognitive skills. Resident #14's clinical record documented a nursing note dated 4/23/16 stating, "...CNA [certified nurses' aide] reported another resident [Resident #2] had their hands down the pants of this resident, this happened at the nurse's station. The resident [Resident #2] was told to go back to his room by his nurse...[social worker] notified us to contact APS [adult protective services], this was done...this resident was laid in bed + changed, 0 [no] scratches, 0 [no] red areas, 0 [no] injuries noted on legs or in peri-area...Contacted [family member], notified him that his mother had been inappropriately touched by another male resident at the nurse's station while no one was around. It was seen by a CNA walking down the hall. Notified him [family member] APS has been contacted + offending male resident has been moved to the other side of the building..." The facility's incident/accident report dated 4/23/16 documented the incident occurred at 10:45 a.m. on 4/23/16 in the hall at the nurses' station. This incident form documented, "CNA reported res [Resident #2] had his hands down res [Resident#14's] pants, res layed down and checked over..." (sic) The form documented APS was notified and Resident #2 was moved to the other side of the building. This form was signed by the licensed practical nurse reporting the	F 226	1. Corporate Clinical Consultant in-serviced Administrator/ Director of Nursing on Virginia Department of Health Reporting of Incidences and facility policy on Abuse Prohibition. 2. The facility nursing staff have been inserviced on how to follow up on accidents that occur outside the facility to include physician and responsible party notification; resident assessment; documentation of event in nurses notes; completion of incident & accident report; document on 24 hour report for Administrator and DON to conduct an investigation into the accident and implement measures to prevent a recurrence. The Licensed nurses have also been retrained on the facility policy and procedure for completing a thorough investigation of all incident and accidents and how to correctly and thoroughly complete the Incident/Accident form. D. Monitoring of corrective action to ensure the deficient practice will not reoccur: 1. All incidents, accidents, and allegations of abuse will be immediately reported to the Corporate Clinical Consultant to ensure that all are reported and thoroughly investigated to report to the appropriate agencies per guidelines. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. 2. Failure to adhere to facility policy will	

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F 226	Continued From page 19 incident, the director of nursing, the administrator and a physician's assistant. There was no documentation of any notification to the state agency of the incident. Attached to the incident form was a letter from APS dated 6/3/16 stating, "The investigation has been completed. Although there is a preponderance of evidence that [Resident #14] was a victim of abuse, neglect, or exploitation, the need for protective services no longer exists..." As of 2/28/17 there was no report of this incident to the state agency and no evidence of any investigation of the incident by the facility. On 3/1/17 at 11:30 a.m. the administrator was interviewed about reporting and investigating the 4/23/16 incident of Resident #2 with his hands in Resident#14's pants. The administrator stated the facility did not investigate or report the incident to the state agency because APS was notified and conducted an investigation. When asked if there were any witness statements from staff or review of the events occurring around the time of the incident, the administrator stated, "No." When asked why this incident was not reported to the state agency, the administrator stated he did not know he was supposed to investigate or report the incident. The administrator stated, "I was thinking it [investigation] was needed just for staff abusing residents." The administrator stated he was not thinking about abuse occurring from resident to resident. The administrator stated APS came to the facility and interviewed staff but the facility did not interview or get statements from staff or other residents about the incident. The administrator stated, "We let APS do the investigation." The administrator stated they moved Resident #2 to	F 226	be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy 3. The Administrator will be responsible for overseeing all abuse/neglect allegation investigations and ascertaining that the facility policy for Abuse Prevention, Investigation and Reporting is followed including reporting requirements. The Administrator will contact the Corporate Director of Clinical Services within eight hours of being informed of an abuse allegation to review the allegations of abuse, review the investigation process, the reporting requirements and the overall compliance with the facility policy for abuse reporting and investigation as well as the Elder Justice Act.	

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the other side of the building.

The facility's policy titled Resident Abuse/Neglect/Mistreatment (issued August 1999) documented, "It is the policy of this facility to maintain an environment free of abuse and neglect. Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. Residents will not be subjected to abuse from anyone including, but not limited to, facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals...All alleged violations involving mistreatment, abuse or neglect will be thoroughly investigated by the facility under the direction of the Administrator and in accordance with state law...Individual state reporting requirements will be adhered to. The results of the facility investigation will be reported to appropriate regulatory officials within the time frames established at the state level..." The facility's policy titled Reporting Abuse to State Agencies and Other Entities/Individuals (revised December 2009) stated, "All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law...Should a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse (including resident to resident abuse) be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident...The State licensing/certification agency responsible for surveying/licensing the facility...The local State Ombudsman...Adult Protective Services...Law

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F 226	Continued From page 21 enforcement officials...resident's Attending Physician...The facility Medical Director...The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation with five (5) working days of the occurrence of the incident..." These findings were reviewed with the administrator and director of nursing during a meeting on 3/1/17 at 2:10 p.m. 2. Facility staff failed to report an incident of sexual abuse that occurred on 02/15/2017 that involved Resident #2 and another resident in the facility to the Office of Licensure and Certification (OLC) within two hours of the occurrence per the facility policy. Resident #2 was originally admitted to the facility on 06/23/2015 and readmitted on 01/17/2017 with diagnoses including, but not limited to: Stroke, Atrial Fibrillation, Coronary Artery Disease with Bypass Surgery, Diabetes, Hypertension, Depression, and Vitamin D Deficiency. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/09/2016. Resident #2 was assessed as cognitively intact with a total cognitive score of 13 out of 15. Resident #2's clinical record was reviewed on	F 226		

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02/28/2017 at 3:10 p.m. A Nurse's Note dated 2/15/17 at 1720 (5:20 p.m.) included, "Staff member stated she witnessed resident pulling another resident in W/C (wheelchair) into room. Witnessed this resident (room #) inappropriately touching resident in W/C private area. Resident moved away to safe area by staff member. DON (director of nursing), administrator & (and) social worker notified via telephone. Call placed to Dr. (doctor) (Name). Order received to transport resident to ER (emergency room) for psych (psychiatric) eval (evaluation)." A note dated 2/15/17 at 1830 (6:30 p.m.), "Transported to (Hospital Initials) ER via (Transport Initials) 911. Report called to ER." A note dated 2/16/17 at 0227 (2:27 a.m.), "Resident returned to facility via stretcher..."

The Administrator and DON were asked for a copy of an Incident Report or investigation during a meeting with the survey team on 02/28/17 at approximately 5:30 p.m. A copy of this report was received on 03/01/2017 at approximately 7:45 a.m. The "Incident/Accident Report" dated "2/15/17 1720" (5:20 p.m.) included the following, "...CNA (certified nursing assistant) reported she witnessed this resident pulling a female resident in W/C into his room. States she witnessed male resident inappropriately touching female resident in W/C in private body part..." A witness statement from the CNA included the following, "...I, CNA (Name), saw (Name) Resident #2 pull (Name-female resident) into his room, by her wheelchair. They were facing each other. As I walked closer to see what was going on I saw (Name) Resident #2 reach his right hand out and touch (Name-female resident) private area [through her clothes]. I then went to remove (Name-female resident) from the room and

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immediately told the nurse."

Facility policy, "Reporting Abuse to State Agencies and Other Entities/Individuals" from the "Operational Policy and Procedure Manual for Long-Term Care...(Revised December 2009)" included the following: "Policy Statement - All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law. Policy Interpretation and Implementation - 1. Should a suspected violation or substantiated incident of...abuse (including resident to resident abuse) be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident: a. The State licensing/certification agency responsible for surveying/licensing the facility...2. Verbal/written notices to agencies will be made within twenty-four (2) hours of the occurrence of such incident and such notice may be submitted via special carrier, fax, e-mail, or by telephone..."

The Administrator was interviewed on 03/01/2017 at 2:00 p.m. regarding if the above noted incident had been reported to the Office of Licensure and Certification and if he had proof of a time stamp when the incident had been reported. The Administrator provided a copy of the Facility Reported Incident (FRI) that stated, "...Report date: February 16, 2017 Incident date: February 15, 2017..." A copy of the fax confirmation sheet included the following: "...ST. TIME 02/16 13:06 (1:06 p.m.)...RESULT OK." The Administrator was interviewed regarding if he was aware of the reporting time change from 24 hours to two hours. He stated, "I am." He then presented a

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copy of the facility policy where the reporting time had been changed as referenced above as (2).

Per documentation in the clinical record, the above mentioned incident occurred on 02/15/17 at 5:20 p.m. The incident was not reported to the Office of Licensure and Certification until 02/16/17 at 1:06 p.m. A time difference of almost twenty hours. The Administrator stated regarding the delay in reporting to the OLC, "I reported the incident the next day during the work day."

No further information was received prior to the exit conference on 03/01/2017.

3. For Resident # 6, the facility staff failed to implement their policy and procedure for the reporting and investigation an accident of unusual circumstances.

Resident # 6 in the survey sample, a 61 year-old female, was admitted to the facility on 4/27/15, and most recently readmitted on 9/21/15 with diagnoses that included hypertension, end stage renal disease, diabetes mellitus, seizure disorder, cerebrovascular accident, depression, gout, and hyperparathyroidism. According to the most recent Minimum Data Set, a Quarterly with an Assessment Reference Date of 1/20/17, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15.

Review of the Nurses Notes in the Resident # 6's

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clinical record revealed the following entries:

1/17/17 - 5:30 a.m. "Resident LOA (Leave of Absence) to dialysis."

1/17/17 - 5:45 a.m. "Transport driver returned to say resident had fallen out of wheelchair in van."

1/17/17 - 5:50 a.m. "Resident observed on floor of van. Resident assisted in to sitting position. Resident assessed for injury. NAI (No Additional Injuries) noted. (No) c/o (complaint of) pain/discomfort. Assisted x (times) 3 back into wheelchair. Resident stated she was OK. LOA to dialysis."

At approximately 10:00 a.m. on 2/28/17, the surveyor requested to see the Incident/Accident Report concerning the incident on 1/17/17. The report was provided by the Director of Nursing (DON). Review of the report noted the following entry under the question, "Describe exactly what happened and what were the causes...." The response to the question was as follows, "Resident LOA to dialysis. Transport driver returned in to facility and stated resident was leaning forward and fell out of chair. Resident assisted to sitting position. NAI noted." The Incident/Accident Report also included the following notation: "Resident fell in transport van, was not in facility."

During an end of day meeting at 5:00 p.m. on 2/28/17 that included the Administrator, DON, other administrative staff, and the survey team, the DON was asked to identify the staff member who had completed the Incident/Accident Report. The DON identified the staff member as LPN # 7 (Licensed Practical Nurse), and said she worked

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the third (11:00 p.m. - 7:00 a.m.) shift. The DON also offered to give the surveyor a copy of the Incident/Accident Report.

At 7:10 a.m. on 3/1/17, LPN # 7 was interviewed regarding the incident on 1/17/17. Asked if she knew exactly how resident # 6 fell, LPN # 7 indicated that she did not. When asked if Resident # 7 had a seat belt on her wheelchair and was it in use the day of the incident, LPN # 7 said, "Yes. When she left here she had her seat belt on." LPN # 7 went on to say that, "There is a chance she (Resident # 6) took it off herself."

At 1:45 p.m. on 3/1/17, the surveyor obtained the copy of the Incident/Accident Report that the DON had offered to provide. The report consisted of three pages. Asked if the incident had been reported to the State Agency, the DON indicated it had not. When asked if the three pages given the surveyor were the entire report, the DON said, "That is the sum total of the investigation."

Further review of the Incident/Accident Report revealed that the INVESTIGATE portion included the following directions, "Gather first impressions. List each staff member that was involved in this incident. List their location, and if they have knowledge of the incident. Knowledge would include witnessing the fall, being the first responder, being the last person to see the resident. What was the resident doing before the fall?"

The INVESTIGATE portion of the Incident/Accident Report was blank. There were no names of staff members listed, including LPN # 7, who said the resident had her seat belt on, or

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F 226	Continued From page 27 any of the staff members who assessed the resident and assisted her back into her wheelchair. The name of the van driver was not listed. There was no documentation to indicate the van company was notified of the incident. There were no written statements from any staff member that had knowledge of, or may have had knowledge of the incident, or who assessed and assisted the resident after the fall. During a meeting at 2:00 p.m. on 3/1/17 that included the Administrator, DON, other administrative staff and the survey team, the failure of the facility to implement their policy and procedure to report and investigate incidents and accidents, including the incident of 1/17/17 involving Resident # 6, was discussed.	F 226		
F 252 SS=D	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 252		4/10/17

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F 252	Continued From page 28 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure a wheelchair was in good condition for one of 18 residents in the survey sample. The covering on Resident #12's wheelchair arm cushions was cracked with foam exposed around the edges of both cushions. The findings include: Resident #12 was admitted to the facility on 12/9/15 with diagnoses that included dementia, chronic kidney disease, anemia, high blood pressure and cerebrovascular disease. The minimum data set (MDS) dated 2/17/17 assessed Resident #12 with moderately impaired cognitive skills. On 3/1/17 at 9:30 a.m. Resident #12 was observed in her wheelchair in the dining room. The cushions on both arm rests on the resident's wheelchair were cracked and separated around the edges from the frame. The right arm cushion was cracked and separated with yellow foam visible around the entire edge of the cushion. The left arm rest was deteriorated along the front edge of the cushion with yellow foam visible. On 3/1/17 at 11:00 a.m. the licensed practical nurse (LPN #5) caring for Resident #12 was	F 252	1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident #12 wheelchair arm rests were replaced with new arm rests 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: A. All residents wheelchair armrests have the potential to be affected by deficient practice. 100 % Audit of all residents wheelchair arm rests was completed and corrective action taken as indicated. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: A. Administrator will in-service by 03/24/2017 the Maintenance Director on Maintenance prevention program for wheelchair arm rests and overall wheelchair condition. B. The facility staff was in-serviced on submitting a maintenance request by	

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F 252	Continued From page 29 interviewed about the resident's arm rest cushions. LPN #5 stated maintenance usually repaired or replaced the cushions when needed. LPN #5 stated nurses were supposed to enter a work order for needed repairs. LPN #5 state she had not notice that Resident #5's arm rest cushions needed repair. These findings were reviewed with the administrator and director of nursing during a meeting on 3/1/17 at 2:10 p.m.	F 252	03/24/2017 for any resident equipment that needs repaired or any maintenance needs identified throughout the physical plant. C. The maintenance director will follow up on all maintenance requests received within 48 hours and report weekly to the Administrator on all maintenance requests received and status of repairs. 4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. Twenty wheelchair arm rest audits will be completed and repaired if required by the Maintenance Director 1 X week for 4 weeks, then monthly x 2 months. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. B. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy C. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly to review the need for continued intervention or amendment of plan.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment	F 278		4/10/17

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F 278	Continued From page 30 must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to ensure an accurate MDS (minimum data set) for one of 18 residents in the survey sample, Resident #4.	F 278	1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident # 4 quarterly MDS dated	

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F 278	Continued From page 31 Resident #4's quarterly MDS dated 02/03/2017 is inaccurate under J1800, Falls. Findings included: Resident #4 was originally admitted to the facility on 08/19/2010 and readmitted on 11/21/2016 with diagnoses including, but not limited to: Dementia, Vitamin D Deficiency, Congestive Heart Failure, Hypertension, Arthritis, Osteoporosis with Pathological Fractures , Atrial Fibrillation, Chronic Back Pain and Dysphagia. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 02/03/2017. Resident #4 was assessed as severely impaired in her cognitive skills with a total cognitive score of three out of 15. Resident #4's clinical record was reviewed on 02/28/17 at 9:45 a.m. A Nurse's Note dated 11/20/16 1745 (5:45 p.m.) included, "Resident observed in dining room on floor by CNA (certified nursing assistant). Resident on (L) (left) side with face to floor..." 1810 (6:10 p.m.) "To ER (emergency room)..." A SBAR Communication Form dated 11/20/16 stated, "...resident fell, lacerated forehead..." Resident #4's MDS with an ARD of 02/03/2017 under Section J - Health Conditions J1800: Falls since admit/reentry/prior asmt: any falls was answered "0. No." RN #1 (registered nurse) MDS nurse was interviewed on 02/28/2017 at 2:10 p.m. regarding why this question was answered "No" when this resident had a documented fall on 11/20/2016. RN #1 stated, "I will need to look at her chart and her MDS." At approximately 2:53	F 278	02/03/2017 Falls was corrected on 03/01/2017. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: A. All residents have the potential to be affected by this deficient practice. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: A. All residents that have had falls in the last 90 days will be audited to ensure MDS coding is accurate. B. The MDSC and interdisciplinary team were in-serviced by 03/24/2017 on the need to provide an accurate MDS medical record by reviewing the residents medical record, assessing the resident , speaking to the residents direct care givers and reviewing the RAI manual definitions before coding the MDS. 4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. Director of Nursing or designee will audit 3 recently completed MDS□s each week for 10 weeks and then monthly for 3 months to ensure that each section of the MDS has been coded correctly. B. Findings will be reported to the	

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F 278	Continued From page 32 p.m., RN #1 approached this surveyor and stated, "I will have to do a revision on the MDS to capture this fall." The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 02/28/17 at approximately 5:30 p.m. No further information was received by the survey team prior to the exit conference on 03/01/2017.	F 278	Nursing Home Administrator (NHA) immediately when policy is not adhered to. C. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy D. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly to review the need for continued intervention or amendment of plan.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (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	F 279		4/10/17

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F 279	Continued From page 33 care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 279		

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F 279	Continued From page 34 Based on, staff interview and clinical record review, the facility staff failed to develop comprehensive care plan for one of 18 residents, Resident #3. Resident #3 did not have a comprehensive care plan to include communication. Findings include: Resident #3 was admitted to the facility on 1/27/15 with a readmission on 11/16/15 with diagnoses including hard of hearing. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/23/16. Resident #3 was assessed as being moderately cognitively intact. Resident #3's electronic record was reviewed on 2/28/17 and evidenced, via comprehensive MDS dated 10/21/16, section "V" that Resident #3 had triggered for a care plan for communication due to hard of hearing under section "B" of the MDS. Review of Resident #3's care plan did not evidence a care plan to include communication. On 2/28/17 at 3:45 p.m. the MDS coordinator (identified as registered nurse, RN #1) was interviewed. RN #1 reviewed Resident #3's care plan and verbalized that she did not realize that a care plan for communication was not completed. On 2/28/17 at 5:30 p.m. the above finding was brought to the attention of the director of nursing and administrator during an end of day meeting.	F 279	1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident # 3 had communication needs added to the Comprehensive Care Plan on 03/01/2017. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: A. All residents have the potential to be affected by this deficient practice. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: A. All residents that have communication difficulties will be audited to assure Resident Care plan is place as a problem/need with appropriate interventions. B. MDSC, interdisciplinary team and all Licensed/Registered Nurses in-serviced by 03/24/2017 on the need to develop a comprehensive care plan to address all areas triggered from the MDS and specifically to provide a care plan for communication difficulties when appropriate (i.e., language barriers, hearing loss, etc.). 4. Monitoring of corrective action to ensure the deficient practice will not reoccur:	

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F 279	Continued From page 35 No further information was presented prior to exit conference on 3/1/17.	F 279	A. Director of Nursing/designee will audit 3 recently completed comprehensive care plans weekly x 10 and then monthly x 2 to ascertain that all areas triggered by the MDS have a comprehensive care plan developed and implemented. B. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. C. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy D. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly to review the need for continued intervention or amendment of plan.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.	F 280		4/10/17

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(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(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--

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F 280	Continued From page 37 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (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 observation, resident interview, staff interview and clinical record review, facility staff failed to review and revise a comprehensive care plan (CCP) for three of 18 residents in the survey sample, Residents #2, #4 and #5. 1. Facility staff failed to review and revise Resident #2's CCP regarding resident exhibiting inappropriate sexual behaviors and fluid restrictions.	F 280	1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident # 2, #4, and #5 Comprehensive Care Plan was reviewed and revised on 03/01/2017. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective	

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F 280	Continued From page 38 2. Facility staff failed to review and revise Resident #4's CCP for restorative nursing and a diagnosis of diabetes. 3. Resident #5's care plan was not revised to include problems, goals and/or interventions regarding use of an alarming seat belt. Findings included: 1. Facility staff failed to review and revise Resident #2's CCP regarding resident exhibiting inappropriate sexual behaviors and fluid restrictions. Resident #2 was originally admitted to the facility on 06/23/2015 and readmitted on 01/17/2017 with diagnoses including, but not limited to: Stroke, Atrial Fibrillation, Coronary Artery Disease with Bypass Surgery, Diabetes, Hypertension, Depression, and Vitamin D Deficiency. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/09/2016. Resident #2 was assessed as cognitively intact with a total cognitive score of 13 out of 15. Resident #2's CCP was reviewed on 02/28/17 at approximately 4:00 p.m. The care plan in Resident #2's thinned record included a problem dated 4/23/2016 "Resident Exhibiting Behaviors R/T (related to) Sexual Inapproiatness (sic)." Documentation on the care plan included, "...4/23/16 * 23 moved to West Wing * 15 minute checks 4/25/16 * T.C. (telephone call) to APS (adult protective services) APS reported to police." Goal and Target Date: "7/7/16, 9/22/16,	F 280	action taken: A. Residents with changes in condition including behavior changes, clinical condition changes, new physician orders, etc. have the potential to be affected by this deficient behavior. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: A. All residents that have inappropriate sexual behavior, fluid restrictions, restorative nursing, diagnosis of diabetes, and alarming seat belts will be audited to ensure residents Comprehensive Care Plan is accurate. B. MDSC, interdisciplinary team and licensed nurses in-serviced by 03/24/2017 on the need to revise/amend each resident care plan when there is a change in condition, new or worsening behaviors, new physician orders, etc. and to update the Nurse Aide plan of care with these changes. The licensed nurses are to revise the care plan at the time of the change in condition and it will be reviewed by the MDSC with 48 hours. The MDSC, interdisciplinary team and licensed nurses were educated on revising the care plan with interventions that address the root cause of the residents change in condition and to amend the care plan if interventions are not effective. C. The Director of Nursing or her designee will review the 24 hour report	

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F 280	Continued From page 39 12/15/16." Resident #2's current care plan included a problem dated 09/16/2016 "Resident with History of Exhibiting Innappropriate (sic) Sexual Behaviors." The only revision made to this problem was on "2-16-17 15 minute checks." Goal and Target Date: "12/15/16, 3/9/17, 03/22/17." Approaches were the same on both care plans except as noted above. Resident #2's Nutrition care plan originally dated 10/21/2015 included an added approach dated "1-31-17...Limit fluids: 2 liters (64 oz.) per day, 2000 ml (milliliters) fluid restriction 2/13/17..." The skin impairment problem dated 10/21/2015 included an approach of "...hydration cart..." The fluid volume problem dated 10/21/2015 included the following approaches, "...Monitor for S&S (signs and symptoms) of fluid volume overload, monitor daily intake, encourage fluid intake, hydration cart...keep resident's water pitcher within resident's reach & with fresh water at all times." Resident #2 was interviewed during the initial facility tour on 02/28/2017 at 7:50 a.m. Resident #2 was very verbal concerning his fluid restrictions. He stated, "I would rather be dead than thirsty." He had a water pitcher with a straw at his bedside during this interview. Resident #2 was observed several times throughout the survey and always had a water pitcher at his bedside. There were no updated approaches included on his care plan. The DON (director of nursing) was informed of the above during a meeting with the survey team on 02/28/2017 at approximately 5:30 p.m. She stated, "The MDS nurse updates the care plans."	F 280	Monday through Friday to identify any residents with a change in condition and then review the residents care plan to ascertain it was revised to reflect these changes 4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. Director of Nursing or designee will audit residents that have inappropriate sexual behavior, fluid restrictions, restorative nursing, diagnosis of diabetes, and alarming seat belts for 5 records X week for 3 months to ensure residents have accurate Comprehensive Care Plan. B. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. C. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy D. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly to review the need for continued intervention or amendment of plan.	

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No further information was received by the survey team prior to the exit conference on 03/01/2017.

2. Facility staff failed to review and revise Resident #4's CCP for restorative nursing and a diagnosis of diabetes.

Resident #4 was originally admitted to the facility on 08/19/2010 and readmitted on 11/21/2016 with diagnoses including, but not limited to: Dementia, Vitamin D Deficiency, Congestive Heart Failure, Hypertension, Arthritis, Osteoporosis with Pathological Fractures, Atrial Fibrillation, Chronic Back Pain and Dysphagia.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 02/03/2017. Resident #4 was assessed as severely impaired in her cognitive skills with a total cognitive score of three out of 15.

Resident #4's CCP was reviewed on 02/28/2017 at approximately 11:00 a.m. Her mobility care plan dated 10/07/2015 included an approach "...restorative nursing program for AROM (active range of motion) /ambulation, to/from bathroom & (and) to/from nurses station as tolerated 6X/week (six times per week)." The fall care plan dated 11/20/2016 included the following approaches, "Chair alarm to chair at all times. Common area when up to chair..."
The care plan included a problem of diabetes with a goal and approaches dated 10/07/2015.

Review of Resident #4's restorative sheets confirmed this resident had received restorative for eating and swallowing, but not for walking or

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ROM during December 2016, January and February 2017. LPN #3 (licensed practical nurse), restorative nurse was interviewed at 11:48 a.m. LPN #3 stated, "She gets restorative for eating and swallowing, but not ROM or ambulation because her daughter refuses. It remains on her care plan because we attempt or ask her everyday, but she doesn't do it. The daughter tells the aides not to do the ROM or ambulation. No it is not documented anywhere that the doctor was notified."

At 9:45 a.m. on 02/28/2017 Resident #4 was observed sitting up in a geri chair in her room. No alarm was observed. At 11:40 a.m., Other #1 accompanied this surveyor into Resident #4's room and verified no chair alarm was present. At 11:44 a.m., LPN #2 accompanied this surveyor into Resident #4's room and also verified no alarm was present on her chair and an alarm was not located in this resident's room. LPN #2 stated, "I will get one right away."

CNA #3 (certified nursing assistant) was interviewed regarding this resident's chair alarm at 2:56 p.m. CNA #3 stated, "To be honest, I forgot. I believe she used to have a different chair and I don't think the alarm was moved to the new chair."

RN #1 (registered nurse) MDS nurse was interviewed at 2:10 p.m. regarding Resident #4's CCP and the problem of diabetes. There is no record of a diagnosis of diabetes anywhere in the resident's clinical record except on her CCP. RN #1 stated, "I think she was diabetic when she first came here, but doesn't receive insulin. She is stable. I will look at these things and get back with you." At 2:15 p.m., Other #1 asked this

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surveyor to see Resident #4's CCP. Other #1 stated, "I don't know why she has a diabetes care plan." On 03/01/17 at 9:05 a.m. RN #1 stated regarding the diabetes on her CCP, "I got it from the prior care plan. I'm new to MDS. The old MDS nurse is working on the floor today and she doesn't know where she got it. I am DC'ing (discontinuing) this on his care plan. He does not have a diagnosis of diabetes."

The Administrator and DON were informed of the above during a meeting with the survey team on 03/01/17 at 2:15 p.m. No further information was received prior to the exit conference on 03/01/17.

3. Resident #5's care plan was not revised to include problems, goals and/or interventions regarding use of an alarming seat belt.

Resident #5 was admitted to the facility 11/2/16 with diagnoses that included pneumonia, high blood pressure, Alzheimer's, coronary artery disease, diabetes and history of stroke. The minimum data set (MDS) dated 1/27/17 assessed Resident #5 with severely impaired cognitive skills.

Resident #5 was observed on 2/28/17 at 9:35 a.m. in his wheelchair in the dining room. The resident had a seat belt buckled in place across his lap. Resident #5 was observed again on 2/28/17 at 10:05 a.m. in his wheelchair with a seat belt in place.

Resident #5's clinical record documented a physical therapy note dated 12/19/16 stating, "modified Pt's [patient's] w/c [wheelchair], lowered

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rear wheels for Pt safety as he has fallen multiple times recently and per pt's wifes request. Ordered seat belt alarm for Pt. trialed..." (sic) A physical therapy note dated 12/22/16 documented, "Pt demonstrated ability to unfasten seatbelt 3/3 trials..."

Nursing notes for Resident #5's documented the resident's ongoing use of the seat belt. Nursing notes documented the following.

2/17/17 - "...Safety belt intact, pulls apart activates alarm, reapplied..."
2/18/17 - "...Safety belt intact..."
2/19/17 - "...Safety belt intact..."
2/21/17 - "...Activating safety belt, reapplied..."
2/23/17 - "...Safety belt intact, Activated, discouraged, belt reapplied..."
2/25/17 - "...Resident [up] in w/c [wheelchair]...safety release belt intact..."
2/26/17 - "...Resident [up] in w/c...safety release belt intact..."

The resident's care plan (revised 2/9/17) made no mention of the resident's use of a seat belt. The plan listed the resident was at risk for falls due to weakness and a history of falls. The plan documented the resident fell on 12/8/16, 12/16/16, 1/18/17, 1/23/17, 2/4/17 and 2/10/17. Interventions for fall/injury prevention did not list the alarming seat belt used by the resident.

On 2/28/17 at 4:05 p.m. the licensed practical nurse (LPN #6) caring for Resident #5 was interviewed about the seat belt. LPN #6 stated therapy determined if a resident needed a seat belt. LPN #6 stated Resident #5 was able to release the seat belt and the belt was added as a safety measure due to the resident's attempts to

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F 280	Continued From page 44 get up without asking for assistance. LPN #6 stated, "He [Resident #5] takes it [seat belt] off all the time." LPN #6 stated the intent of the seat belt was to alert staff when the resident attempted to get out of the chair. LPN #6 stated the resident had been using the seat belt for "quite awhile." LPN #6 reviewed the resident's care plan and stated she did not see any entries on the care plan about the seat belt. LPN #6 stated the MDS coordinator was responsible for updating care plans. On 3/1/17 at 9:05 a.m. the registered nurse MDS coordinator (RN #1) was interviewed about Resident #5's care plan for the seat belt. RN #1 stated she reviewed Resident #5's clinical record and did not find a physician's order for the seat belt and the seat belt had not been added to the resident's care plan. RN #1 stated therapy evaluated the resident for the belt but did not advise nursing the belt was in use. These findings were reviewed with the administrator and director of nursing during a meeting on 3/1/17 at 2:10 p.m.	F 280		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.	F 309		4/10/17

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F 309	Continued From page 45 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on, staff interview and clinical record review, the facility staff failed to follow physician's orders for 2 of 18 Residents, (Resident # 3 and 7); failed to obtain an order for devices for one of 18 Resident's, (Resident # 5); and failed to complete an assessment for devices for two of 18 Resident's (Resident # 3 and 6). 1 A. Resident #3 physician order easy release lap belt was not in place. 1 B. Resident #3 did not have a assessment for a device that could be considered a restraint.	F 309	1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: A. A physician order to discontinue Resident # 3□s easy release belt was received on 03/01/2017. B. A physician order for Resident # 5□s easy release belt was received on 03/01/2017. The interdisciplinary team completed the Briggs pre-restraining assessment on 03/18/2017 and	

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F 309	Continued From page 46 2. The facility staff failed to follow the physician's order for Resident #7 regarding getting out of bed by lunchtime. 3. Resident #5 had a seat belt in use without a physician's order or plan of care for use of the belt. 4. Resident #6 did not have a assessment for a device that could be considered a restraint. Findings include: 1 A. Resident #3 physician order easy release lap belt was not in place. Resident #3 was admitted to the facility on 1/27/15 with a readmission on 11/16/15 with diagnoses including: Osteoporosis, history of falls. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/23/16. Resident #3 was assessed as being moderately cognitively intact. Resident #3's medical record was reviewed on 2/28/17 and evidenced a physician's order (on the current physician's order sheet, dated 2/7/17 with an original order date of 11/16/15) that read "EZ-RELEASE BELT WHILE UP IN WHEELCHAIR." Resident #3 was observed up in the wheelchair through out the day on 2/28/17 from 11:00 a.m. to 3:30 p.m. in Resident #3's room, out in the hallway and in the dining room during an activity	F 309	determined the resident was able to consistently release the belt on command and therefore the belt is not a restraint but rather positioning device. Resident #5□s care plan has been revised to address the use of the EZ seatbelt on 03/18/2017. C. The physician order for Resident #7 regarding time frame for getting out of bed was discontinued on 02/28/2017. The resident□s mobility needs have been added to the care plan on 02/28/2017. D. The interdisciplinary team completed the Briggs pre-restraining assessment for Resident #6 on 03/18/2017 and revised the care plan to address the use of this device. E. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: All Residents have the potential to be affected. F. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: The nursing staff has been inserviced on consistently implementing physician orders by referring to care plan, MAR□s, TAR;s, ADL records and the facility□s Physical Restraint policy and procedure to include: G. The Resident will be assessed by the	

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F 309	Continued From page 47 and without the EZ release belt in place. On 2/28/17 at 3:40 p.m. this surveyor asked license practical nurse (LPN #5) to observe Resident #3 without the lap belt. LPN #5 observed Resident #3 and proceeded to take Resident #3 back to Resident #3's room along with this surveyor. Once in Resident #3's room, the lap belt was found beside Resident #3's bed. LPN #5 did not know why the lap belt was not in place. LPN #5 then placed Resident #3's lap belt. During this time Resident #3 was asked if she could release the lap belt, Resident #3 verbalized that she could but did not demonstrate this to the surveyor. 1 B. Failed to obtain an assessment for a device that could be considered a restraint. Review of Resident #3's clinical record did not evidence an assessment for a device. On 2/28/17 at 3:50 p.m. LPN #5 was asked to review Resident #3's clinical record for a device assessment. LPN #5 reviewed the clinical record and could not evidence a device assessment. This surveyor asked LPN #5 how does the facility evidence that a lap belt is not considered a restraint. LPN #5 verbalized that she was new to the facility and was not sure of the answer. On 2/28/17 at 4:00 p.m. the assistant director of nursing (ADON) was interviewed regarding assessment for a device. The ADON verbalized that a specific assessment tool was not in place, but documentation should be done to indicate that the device is not considered a restraint.	F 309	Interdisciplinary Team using a Pre-restraining Assessment (Briggs form CFS 3-1) prior to the application of a restraint or device. H. The Licensed Nurse will contact the physician for an order prior to the application of a restraint or device. The order will state type of restraint, time period to be used, reason for use, medical diagnosis, and release and monitoring instructions. I. Prior to the application of the restraint, an informed consent (Briggs form CFS 3-4/2) is to be obtained from the Resident or Responsible Party. The clinical risk factors to be explained as well as the resident□s right to refuse. J. The Interdisciplinary Team will meet with the responsible party to discuss appropriate care of the resident. K. Residents who are using restraints or devices will be reviewed monthly and prn change in status by the Restraint Reduction Team. If the determination is made that the restraint may be reduced, the Physical Restraint Elimination Assessment will be completed (Briggs CFS 3-2). L. The Physical Restraint Elimination Assessment form will be completed and reviewed no less than quarterly to determine whether or not the restrained resident is a candidate for restraint reduction, less restrictive restraining measures or total restraint elimination. The Interdisciplinary summary is to be documented on the reverse side of the Physical Restraint Elimination Assessment.	

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F 309	Continued From page 48 On 2/28/17 at 4:15 p.m. the rehab director (other staff, OS #2) was interviewed regarding assessments for devices. OS #2 verbalized that the therapy department will assess and make a recommendation in regards to lap belts and if the lap belt can be released by the Resident then this would be documented in the clinical record. This surveyor then asked for help locating documentation of an assessment for Resident #3's lap belt. On 2/28/17 at 5:00 p.m. OS #2 verbalized that review of Resident #3's clinical record did not evidence that the therapy department was involved in an evaluation of Resident #3's lap belt and an assessment could not be found. On 2/28/17 at 5:25 p.m. the above finding was brought to the attention of the administrator and director of nursing (DON). The DON verbalized there should be an assessment and she would look for it. On 3/1/17 at 8:15 a.m. the DON verbalized that an assessment for Resident #3's lap belt was not found. No further information was presented prior to exit conference on 3/1/17. 2. Resident #7's physician's orders were not followed regarding getting out of bed by lunch time daily. Resident #7 was admitted to the facility on 3/31/15 with, but not limited to, the following diagnoses: sacral spina bifida (incomplete closure of the backbone and membranes around	F 309	M. The plan of care will include the reason for the restraint (problem), goals, and interventions used to reduce restraint usage. N. The Certified Nursing Assistants will have access to accurate information regarding the individual resident□s O. The Restraint Reduction Team (DNS or designee, therapist, Social Services, Charge Nurse, others as designated) will be active in the facility and meet no less than monthly to review Residents who are using restraints. 5. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. Director of Nursing or designee will audit residents that have residents that easy release alarm belts for 5 records X week for 3 months to ensure residents have accurate pre-restraining assessments and Comprehensive Care Plans. B. The Director of Nursing will monitor 5 residents per week for 3 months to ascertain that physician orders have been correctly transcribed, appropriate, and consistently implemented C. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. D. Failure to adhere to facility policy will be considered a violation. Violations will	

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F 309	Continued From page 49 the spinal cord) without hydrocephalus (accumulation of fluid on the brain), convulsions and neuromuscular dysfunction of the bladder. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/16/17 was a quarterly assessment. The resident was assessed as a ten (10) moderately impaired in decision-making skills. On 2/28/17 at approximately 8:00 a.m., Resident #7 was observed in her room and in bed. Resident #7's breakfast tray was sitting on her over bed table with approximately 50% of her meal consumed. On 2/28/17 at approximately 2:00 p.m., Resident #7 was observed in bed, a Certified Nursing Assistant, who will be identified as CNA #1 was providing incontinence care to the resident. On 2/28/17 at approximately 8:45 a.m., a review of the current, February 2017, Physician's Order Sheets (POS's) included the following orders: "03/31/15 Resident to be up by lunchtime every day." On 2/28/17 at approximately 2:38 p.m., CNA #1 was interviewed regarding the resident being in bed and not up as ordered by the physician. CNA #1 stated, "I don't get her up because of the area on her bottom. I keep her in bed so that it can heal." On 2/28/17 at approximately 2:38 p.m., the medication nurse, who was a licensed practical nurse and will be identified as LPN #1 was interviewed regarding the resident not being up as ordered by lunchtime. LPN #1 stated, "We don't get her up because of the area on her	F 309	result in disciplinary action in accordance with the facility progressive disciplinary policy E. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly to review the need for continued intervention or amendment of plan.	

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bottom." When interviewed and asked the reason staff could not get her up for lunch and then place the resident back in bed after lunch, LPN #1 stated, "There is no reason why we can't."

On 2/28/17 at approximately 5:22 p.m., the administrative staff was made aware of the above findings.

3. Resident #5 had a seat belt in use without a physician's order or plan of care for use of the belt.

Resident #5 was admitted to the facility 11/2/16 with diagnoses that included pneumonia, high blood pressure, Alzheimer's, coronary artery disease, diabetes and history of stroke. The minimum data set (MDS) dated 1/27/17 assessed Resident #5 with severely impaired cognitive skills.

Resident #5 was observed on 2/28/17 at 9:35 a.m. in his wheelchair in the dining room. The resident had a seat belt buckled in place across his lap. Resident #5 was observed again on 2/28/17 at 10:05 a.m. in his wheelchair with a seat belt in place.

Resident #5's clinical record documented a physical therapy note dated 12/19/16 stating, "modified Pt's [patient's] w/c [wheelchair], lowered rear wheels for Pt safety as he has fallen multiple times recently and per pt's wifes request. Ordered seat belt alarm for Pt. trialed..." (sic) A physical therapy note dated 12/22/16 documented, "Pt demonstrated ability to unfasten seatbelt 3/3 trials..."

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Nursing notes for Resident #5's documented the resident's ongoing use of the seat belt. Nursing notes documented the following.

2/17/17 - "...Safety belt intact, pulls apart activates alarm, reapplied..."
2/18/17 - "...Safety belt intact..."
2/19/17 - "...Safety belt intact..."
2/21/17 - "...Activating safety belt, reapplied..."
2/23/17 - "...Safety belt intact, Activated, discouraged, belt reapplied..."
2/25/17 - "...Resident [up] in w/c [wheelchair]...safety release belt intact..."
2/26/17 - "...Resident [up] in w/c...safety release belt intact..."

The resident's clinical record documented no physician's order for the seat belt. The resident's care plan (revised 2/9/17) made no mention of the resident's use of a seat belt. The plan listed the resident was at risk for falls due to weakness and a history of falls. The plan documented the resident fell on 12/8/16, 12/16/16, 1/18/17, 1/23/17, 2/4/17 and 2/10/17.

On 2/28/17 at 4:05 p.m. the licensed practical nurse (LPN #6) caring for Resident #5 was interviewed about the seat belt. LPN #6 stated therapy determined if a resident needed a seat belt. LPN #6 stated Resident #5 was able to release the seat belt and the belt was added as a safety measure due to the resident's attempts to get up without asking for assistance. LPN #6 stated, "He [Resident #5] takes it [seat belt] off all the time." LPN #6 stated the intent of the seat belt was to alert staff when the resident attempted to get out of his chair. LPN #6 stated the resident had been using the seat belt for "quite awhile." LPN #6 reviewed the resident's care plan and

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stated she did not see any entries on the care plan about the seat belt. LPN #6 stated the MDS coordinator was responsible for updating care plans.

On 2/28/17 at 4:30 p.m. the certified occupational therapy assistant (COTA) was interviewed about Resident #5's seat belt. The COTA stated the resident made improvements while in therapy and as the resident became stronger he made more attempts to get out of the wheelchair and did not ask for assistance. The COTA stated the alarm belt was applied to be a reminder for him to remain in his chair. The COTA stated Resident #5 was not able to safely stand, ambulate or transfer without assistance. On 2/28/17 at 4:35 p.m. the rehabilitation (rehab) director was interviewed about Resident #5's alarm belt use. The rehab director stated they evaluated the resident and determined he was able to remove the seat belt on his own. The rehab director stated use of the seat belt or any assistive devices required a physician's order. The rehab director stated she reviewed the record and did not see an order for the belt. The rehab director stated therapy performed evaluations regarding the use of assistive devices but nursing was responsible for getting the physician's order and developing a plan of care regarding their use. The rehab director stated Resident #5 was at times "impulsive," had speech and communication impairments and was not safe to get up without assistance.

On 3/1/17 at 9:05 a.m. the registered nurse MDS coordinator (RN #1) was interviewed about Resident #5's care plan for the seat belt. RN #1 stated she reviewed Resident #5's clinical record and did not find a physician's order for the seat

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belt and the seat belt had not been added to the resident's care plan. RN #1 stated therapy evaluated the resident for the belt but did not advise nursing the belt was in use.

These findings were reviewed with the administrator and director of nursing during a meeting on 3/1/17 at 2:10 p.m.

4. The facility staff failed to assess Resident # 6 for the use of an E-Z Release seat belt while in her wheelchair.

Resident # 6 in the survey sample, a 61 year-old female, was admitted to the facility on 4/27/15, and most recently readmitted on 9/21/15 with diagnoses that included hypertension, end stage renal disease, diabetes mellitus, seizure disorder, cerebrovascular accident, depression, gout, and hyperparathyroidism. According to the most recent Minimum Data Set, a Quarterly with an Assessment Reference Date of 1/20/17, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15.

Resident # 6 had a physician's order, dated 12/30/16 for an E-Z Release seat belt when in (wheel) chair, 7-3, 3-11, 11-7.

Resident # 6 was observed several times on both days of the survey seated in her wheelchair with the seat belt in place. The resident was able to remove the seat belt.

The resident's care plan, dated 10/27/16, included the following problem, "Resident with

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F 309	Continued From page 54 potential for alteration in skin integrity due to decreased mobility and history of diabetes." The goal for the problem was, "Resident will be without skin breakdown through next review." Included as an approach to the stated problem was, "E-Z Release belt to chair every day (when in chair)." The approach was added to the care plan on 12/30/16. A thorough review of Resident # 6's clinical record failed to reveal an assessment for the use of the seat belt, or a reason for the use of the seat belt. The lack of an assessment for the use of the seat belt by Resident # 6 was discussed during an end of day meeting at 5:00 p.m. on 2/28/17 that included the Administrator, Director of Nursing, other administrative staff, and the survey team.	F 309		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 314		4/10/17

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F 314	Continued From page 55 This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview and clinical record review, the facility staff failed to assess and provide treatments for the prevention of an unstageable pressure ulcer, which resulted in harm for one of eighteen residents in the survey sample, Resident #7. Resident #7 was not assessed or provided treatment to prevent the development of an unstageable pressure ulcer, which required debridement (surgical removal of necrotic tissue from a wound bed). The findings include: Resident #7 was admitted to the facility on 3/31/15 with, but not limited to, the following diagnoses: sacral spina bifida (incomplete closure of the backbone and membranes around the spinal cord) without hydrocephalus (accumulation of fluid on the brain), convulsions and neuromuscular dysfunction of the bladder. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/16/17 was a quarterly assessment. The resident was assessed as a ten (10) moderately impaired in decision-making skills. On 2/28/17 at approximately 8:00 a.m., Resident #7 was observed in her room and in bed. A resident interview was conducted with the resident's permission. During the interview, when asked if the staff provided care in a timely manner, Resident #7 stated, "sometimes I get help in a timely manner and sometimes I have to wait a long time before they (staff) lay me back	F 314	1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident #7 was assessed by the physician on 03/01/2017 with no negative outcome found. Resident is receiving appropriate wound care at this time and wound is healing. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: A. All residents have the potential to be affected by this alleged deficient practice. B. All residents had a complete head to toe body assessment completed by the DON/designee. No new areas were identified. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: A. LPN□s identified who failed to notify the Medical Doctor and Registered Nurse Wound Nurse of open area received disciplinary actions on reporting a resident□s change of condition on 3/3/17 and 3/13/17. B. The Director of Nursing will in service all nursing staff on the facility□s policy and procedure for skin and wound care to include:	

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F 314	Continued From page 56 down." On 2/28/17 at approximately 2:00 p.m., Resident #7's current, February 2017, Physician's Order Sheets (POS's) were reviewed to include the following orders: "12/28/16 Skin Assessment: Monitor and record one time a day every week on Monday during 7-3 (first) shift." On 2/28/17 at approximately 2:10 p.m., a Braden Scale (For predicting Pressure Sore Risk) form was reviewed to include the following: "Severe Risk: Total Score <9...High Risk: Total Score 10-12...Moderate Risk: Total score 13-14...Mild Risk: Total score 15-18...Dates of Assessments 10/21 and 1/10, the resident was assessed as being a 13 (Moderate risk)." On 2/28/17 at approximately 2:15 p.m., the Skin Assessments were reviewed in the clinical record. The Skin Assessments were reviewed to include the following: "Weekly Skin Assessment Record Instructions: To be completed by a licensed nurse. Circle each area of impaired skin integrity / wound location on the diagram and write a descriptive note for each wound. Use on Weekly Assessment box each week and indicate multiple areas of impaired skin integrity/ wounds on each diagram." The Weekly Assessments were performed on the following days... "2/6/17 Area mid-back tx (treat) with NS (normal saline) Apply hydrofera Blue and cover with coversite daily..." "2/13/17 Area to mid-back tx (treatment) in place. No new areas of impairment..."	F 314	a. How to report newly identified skin conditions (immediately to the charge nurse, physician and responsible party and documented in the red alert book) b. Review of the facility□s preventative skin protocols c. Proper use of low air loss beds and chair cushions d. Importance of using heel protectors/boots to float the heels of residents who are unable to independently reposition and residents with recent surgery that would predispose them to skin breakdown of the heels such as hip replacement e. turning & positioning guidelines f. Review of the intrinsic risks, skin condition, and other causal factors which place the resident at risk for developing pressure sores to include: i. Impaired/decreased mobility and functional abilities ii. Co-morbid conditions such as ESRD, thyroid disease or diabetes mellitus iii. Drugs such as steroids that affect wound healing iv. impaired diffuse or localized blood flow such as generalized atherosclerosis or lower extremity arterial insufficiency v. Resident refusal of some aspects of care and treatment vi. Cognitive impairment vii. Exposure of skin to urinary and fecal incontinence viii. Nutrition and hydration deficits ix. History of a healed ulcer x. diabetic neuropathy xi. Fragility g. Identification of which risk factors can	

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F 314	Continued From page 57 On 2/28/17 at approximately 2:25 p.m., a Progress Note from the wound doctor was reviewed to include the following: "2/14/17 Note: After initial visit today nursing staff notified me of new wounds. Pt (patient) with new wound left buttock 9 x 5 cm (centimeters) and right buttock 6 x 5 cm (centimeters) unstageable necrosis. No current dressing. Dressing to be applied is Santyl and dry dressing daily." A "Wound Care Specialist Evaluation note was reviewed to include the following: "2/21/17 Unstageable (Due to Necrosis) of the Left Buttock...Etiology: Pressure...MDS 3.0 Stage: Unstageable Necrosis...Objective: Manage Pain...Wound Size: 7 x 5 x 0.2 cm...Procedure: Surgical Excisional Debridement of (Site 2)..Indication: Remove necrotic tissue and establish the margins of viable tissue...Description: The wound was cleansed with normal saline and anesthesia was achieved using 1% lidocaine. Then with clean surgical technique, curette was used to surgically excise 17.5 cm (squared) of devitalized tissue and necrotic subcutaneous fat and surrounding connective tissues were removed at a depth of 0.3 cm and healthy bleeding tissue was observed. Hemostasis was achieved and a clean dressing was applied...." The same was performed on the right buttock. On 2/28/17 at approximately 2:38 p.m., the nurse on the unit, who was a licensed practical nurse and will be identified as LPN #1 was interviewed regarding the unstageable pressure areas found on the resident's buttocks. LPN #1 stated, "I did not see an area on her buttocks. We do the	F 314	be removed or modified h. Importance of proper nutrition and hydration for healthy skin i. Correct use of the Red Alert Book j. Proper technique for completing peri care and use of barrier creams k. Implementing the residents individualized plan of care l. Certified Nursing Assistants responsibility to notify the charge nurse immediately of any changes to skin integrity, compromised or missing dressing, drainage showing through the dressing, complaints of pain, etc. c. The licensed nurses will also be trained on the following: a. Review of facility□s skin and wound policy and procedure / Assessment " Use of the Braden risk assessment and interpreting the score of the assessment " identifying pre-existing signs of a potential deep tissue injury and situations/conditions that may contribute to the development of a deep tissue injury " assessing the resident with darkly pigmented skin and the need to focus more on bogginess, induration, coolness, or increased warmth as well as signs if discoloration " review of the weekly skin assessment process□ schedule, binder, proper documentation " how to properly complete and document a head to toe skin assessment " how to report newly identified skin conditions or worsening skin condition / use of the Red Alert Book " RD to be notified of all residents with	

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treatment on her mid-back and because the brief is so high we pull it (the brief) down. LPN #1 further stated, "I saw something on her buttocks but it looked like excoriation." When interviewed and asked if the physician was made aware, LPN #1 stated, "No."

On 2/28/17 at approximately 2:45 p.m., the Certified Nursing Assistant (CNA), who was caring for the resident and will be identified as CNA #1 was interviewed regarding the unstageable pressure areas on the resident's buttocks. CNA #1 stated "I saw the area on [Resident named] buttocks and I reported it to [Nurse named] and she [LPN #1] told me to put cream on it." CNA #1 stated, "I was already doing that."

On 2/28/17 at approximately 2:47 p.m., CNA # 1 was interviewed and asked if LPN #1 looked at the area after she was made aware, CNA #1 stated, "She looked at it but she just told me to put cream on it and that's what I did but it slowly got worse (sic)." When interviewed and asked when the pressure area was reported to LPN #1, CNA #1 stated, "it was around mid-January or towards the end of January."

On 2/28/17 at approximately 2:50 p.m.,the Assistant Director of Nursing (ADON) was interviewed regarding the pressure areas on the resident's buttocks being found at an unstageable. The ADON stated, "It was not reported until February 14, when the wound doctor looked at it. I informed the Director of Nursing (DON) and I gave her the names of all staff caring for her (the resident). The wound doctor and myself looked at it at the same time. The wound doctor cauterized the area and it's

altered skin integrity and to assess resident no less than monthly for nutritional needs and make recommendations to attending physician
b. Review of facility□s skin and wound policy and procedure / Treatment
" Proper way to transcribe treatment orders
" Assessment and treatment of pain prior to wound care treatments.
" How too correctly measure wounds and describe the wound□s characteristics (Only Interdisciplinary Team (IDT) will measure and stage wounds, if there is a noted change to the wound characteristics between IDT rounds notify the Wound Care Coordinator for reassessment/interventions.
" How to correctly stage pressure sores according to the NPUAP guidelines
" Proper technique for dressing change
" How to document wound characteristics, stage, size, etc.
" completing effective Weekly Interdisciplinary wound rounds to stage the wound; assess healing, nutrition, pain management; document wound characteristics; revise care plan as indicated; MD notification of non-healing after 10-14 days and/or changes in wound characteristics.
Factors affecting wound healing including nutritional considerations.
" Signs/symptoms of an infected wound&treatment of an infected wound
c. Documentation of Alterations in Skin Integrity
" documentation of treatments on the treatment administration record (TAR)

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F 314	Continued From page 59 healing now." A care plan (CP) revised on 1/19/17 was reviewed to include the following: "Problem Onset 10/21/16 Resident with self care deficit due to functional limitations r/t (related to) Spina Bifida, Is incontinent...Approaches: Observe skin daily during ADL (activities of daily living) care for changes, report changes observed in skin to nurse for follow up and treatment if needed / indicated..." On 2/28/17 at approximately 5:22 p.m., the administrative staff was made aware of the above findings. No further information was presented to this Surveyor during the course of the survey, regarding the wounds on the resident's buttocks being found at an unstageable pressure ulcer.	F 314	" Documentation of integrity of the wound dressing every shift by a licensed nurse on the treatment administration record " Documentation of pressure and non-pressure wounds on the weekly documentation record (Briggs form) " Weekly completion of the PUSH tool, interpreting the PUSH tool " how to update care plans to establish realistic goals and appropriate interventions to address potential for skin breakdown and existing pressure sores " pressure ulcer analysis of unavoidable pressure sores C. The Director of Nursing or designee will update the Comprehensive Care Plan and the C.N.A. care plan when an alteration in skin integrity is identified and when a wound treatment changes D. All new licensed nurses will be in-serviced on facility□s policy and procedure for skin and wound care as detailed above during orientation. 4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. The Director of Nursing/Designee will complete a skin integrity / pressure audit on 100% of the residents with alterations in skin integrity weekly for four weeks and then monthly for three months. The audit will ascertain that the weekly skin assessment was completed accurately; the resident□s individual risk factors for skin breakdown have been identified and	

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F 314	Continued From page 60	F 314	addressed on the care plan; that any changes in skin integrity were identified timely with attending physician and responsible party notified; that physician orders for treatment are in compliance with the facility□s treatment protocols and correctly transcribed; that treatments were completed and documented in accordance with the physician□s orders; that pain management was addressed prior to treatments being completed; that the pressure ulcer is staged correctly and the weekly documentation of wound characteristics is completed; the PUSH tool has been completed; the attending physician has been notified if there is no documented response/improvement to the ordered treatment within 2 weeks; nutritional supplements have been implemented in accordance with the facility□s skin and wound policy; the resident□s care plan addresses individual risk factors for skin breakdown and identifies measures to mitigate the risk factors; the resident is turned and positioned in accordance with their care plan; pressure reduction mattress and pressure reduction wheelchair cushion(if applicable) are in place. The results of this audit will be presented to the facility QAPI committee for review and further recommendations. B. The Director of Nursing/Designee will complete an audit of 20% of all residents at risk for skin breakdown weekly for four weeks and then monthly for two months to ascertain that these residents have appropriate interventions in place to prevent skin breakdown according to the	

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F 314	Continued From page 61	F 314	facility□s policy and procedure and that the weekly skin assessment has been completed timely and accurately. C. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. D. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. E. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly to review the need for continued intervention or amendment of plan.	
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (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. (1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 323		4/10/17

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F 323	Continued From page 62 (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and in the course of a complaint investigation, facility staff failed to provide supervision to prevent injuries for two of 18 residents (Residents #4 and #11), resulting in harm for one resident (Residents #4) and failed to properly assess residents for use of siderails for four of 18 residents in the survey sample, Residents #5, #8, #12 and #6. 1. Resident #4 was left unattended in the restorative dining room on 11/20/16 resulting in a fall from her wheelchair (w/c) resulting in harm to this resident. Resident #4 required sutures to a 12 cm (centimeter) laceration to the left side of her forehead resulting in harm. 2. Resident #11 was left unattended on two different occasions both resulting in falls with injuries. Resident #11 was left unattended during an activity on 12/23/2016 and while reaching for a bag of candy on the floor she fell from her chair and hit her head. Resident #11 was again left unattended in her room on 02/16/2017 and while reaching down to pick up her makeup brush from the floor, she fell out of the wheelchair and hit her head. Both falls resulted in emergency room visits. 3. Resident #5, with severe cognitive impairment	F 323	1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident #4 Physician has assessed and laceration has healed. No adverse effect noted. Resident #11 Physician has assessed with no adverse effect noted. Resident #5 POA spouse received education on the risk of side rail entrapment yet proceeded to sign against medical advice waiver to keep bed rails in place for mobility 03/08/2017. The resident□s care plan was updated to address the use of side rails and interventions to minimize the risk of entrapment. Resident #8 Bed Rails removed from bed after reassessing 03/01/2017. Resident #12 had chair alarm placed in chair on 03/01/2017 and bed rails removed after reassessing on 03/01/2017. The residents care plan was updated to reflect the use of the bed alarm.	

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F 323	Continued From page 63 and multiple falls from his bed, had bed side rails in use without an accurate assessment for safe use of the rails. 4. Resident #8, with severe cognitive impairment and poor safety awareness, had bed side rails in use without an accurate assessment for safe use of the rails. 5. Resident #12 did not have a chair alarm in use for fall prevention as required in her plan of care and had bed side rails in use without a completed assessment for safe use of the rails. 6. Resident #6 had an inaccurate and incomplete assessment for the use of bed siderails. Findings included: 1. Resident #4 was left unattended in the restorative dining room on 11/20/16 resulting in a fall from her wheelchair (w/c) resulting in harm to this resident. Resident #4 required sutures to a 12 cm (centimeter) laceration to the left side of her forehead resulting in harm. Resident #4 was originally admitted to the facility on 08/19/2010 and readmitted on 11/21/2016 with diagnoses including, but not limited to: Dementia, Vitamin D Deficiency, Congestive Heart Failure, Hypertension, Arthritis, Osteoporosis with Pathological Fractures , Atrial Fibrillation, Chronic Back Pain and Dysphagia. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 02/03/2017. Resident #4 was assessed as severely impaired in her cognitive	F 323	Resident #6 was reassessed for bed rails on 03/19/2017. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: A. All residents have the potential to be affected by deficient practice. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: A. Staff will be assigned to monitor each dining room for each meal. Staff have been instructed by the Director of Nursing that they cannot leave the dining room they are assigned to without another staff member replacing them first. B. Residents with chairs or bed alarms will have their care plan updated by the MDSC to reflect the alarm usage and the nurse aid plan of care will also be updated by the MDSC to reflect the alarm usage C. Residents will be assessed for the use of side rails using the Side Rail Assessment prior to using side rails. Grab bars as enablers or low beds with mats will be used as the first interventions as indicated. Half and full rails will not be utilized unless medically indicated and ordered by the resident□s attending physician. D. The nursing staff has been inserviced by the Director of Nursing on the following:	

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F 323	Continued From page 64 skills with a total cognitive score of three out of 15. During the review of Resident #4's clinical record on 02/28/17 at 9:45 a.m. a Nurse's Note dated 11/20/16 1745 (5:45 p.m.) included, "Resident observed in dining room on floor by CNA (certified nursing assistant). Resident on (L) (left) side with face to floor..." 1810 (6:10 p.m.) "To ER (emergency room)..." A SBAR Communication Form dated 11/20/16 stated, "...resident fell, lacerated forehead..." The Administrator and DON (director of nursing) were asked for an accident report or investigation on 02/28/17 at approximately 3:00 p.m. This surveyor received a copy of an incident/accident report dated 11-20-16 1745 (5:45 p.m.). Location of accident: "Feeders dining room." Describe what happened: "Resident sitting in w/c in dining room, leaned forward and fell out of chair." Injuries: "Laceration to forehead." Witness statement dated 11-21-16 at 2:46 p.m. signed by a CNA included the following: "I asked one of the CNA's who was going to the dining room, was not written on schedule aide said she would pass hall trays. I went to the dining room thought someone was in the feeding room, otherwise we are not to leave patients in room. While passing trays went down hall to drop a tray off immediately dropped the tray on nurse's station heard a patient yell help someone is on the floor. Found pt (patient) on floor face down laceration on head puddle of blood on floor wheelchair side parralell (sic) to table." (sic) A second witness statement dated 11/20/16 at 2nd shift (Dinner time) signed by a CNA included the following: "Resident was on the dinning (sic)	F 323	a. Bed rail use assessment and evaluation. b. Bed and bed rail safety. c. Risks and benefits of bed rail use. d. Alternatives to bed rail use. e. Functional Safety checks including side rail gap measurements. " Maintenance and environmental services staff will be provided education by the Administrator regarding the Bed Rail Usage policy and procedure per the FDA guidelines on: f. Installation g. Maintenance h. Functional safety checks including side rail gap measurements 4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. Director of Nursing/designee will audit X 5 residents per week X 4 weeks then X 5 residents for 2 months to ensure all residents with bed rails and chair alarms are per physician order and have the usage addressed on their plan of care and in the nurse aid care plan. The Director of Nursing/ designee will audit the dining rooms 5 x week for 4 weeks and then once weekly x 2 months to ascertain that appropriate supervision is in each dining room for all meals. B. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered	

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F 323	Continued From page 65 room floor as I walked by the feeder assisting dinning (sic) room door. A resident shouted 'help someone is on the floor.' Resident was bleeding from their head." A third witness statement, not dated or timed, signed by a CNA included, "I observe (Name) Resident #4 laying on the floor with the wheelchair turned to the left and was laying on the floor. When everyone started walking and sayed (sic) resident was on floor. I stop passing trays and ran to the seen. (sic) Previously resident has been noticed leaning toward right side a lot. Staff has straigthen (sic) her multiply (sic) times." The ER (emergency room) visit report included, "...Date: 11/20/2016...Physician Assessment: A 12 cm complex laceration of the brow. Plan: Repair here with sutures...Nursing Assessment Note: 18:30 (6:30 p.m.) Pt. presents to the ED after a fall occurred at the (facility name) where she is living. The fall was witnessed by a resident and related back to the nurse. The pt. was in the dining hall and they say that she fell forward out of her wheelchair and face first onto the ground. They deny any LOC (loss of consciousness). When I called and spoke to her nurse and asked who was supposed to be watching here (sic) and if she was left in the dining hall alone he stated, 'someone was supposed to be watching her but they were not and only the resident saw her fall.'...She has a good sized laceration in the middle of her forehead still actively bleeding...Her left eye is black and blue around the outside...She is currently in a C-collar...She has three quarter sized skin tears on her right upper arm..." Several CNA's were interviewed on 02/28/2017	F 323	to. C. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. D. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly to review the need for continued intervention or amendment of plan.	

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regarding residents in the restorative dining room. At 2:45 p.m., CNA #2 stated, "They are to never be left alone." At 2:56 p.m., CNA #3 stated, "No ma'am, they are never to be left alone. If you are in the big dining room you take them to the big dining room with you. Do not leave them alone." At 3:50 p.m., CNA #4 stated, "I was assigned to her hallway that day. I got her up for dinner and took her to the feeder dining room. The man at the end of her hall wanted a peanut butter and jelly sandwich and we were passing out trays. When I went to get the sandwich I saw her lying in the floor. No one was in there (meaning employees in the restorative dining room) when I found her. Someone is supposed to be in there all the time, actually I think two people."

LPN #4 was interviewed via phone at 4:02 p.m. LPN #4 stated, "I believe she fell in the dining room. She was leaning forward in her chair. I wasn't present when she fell. They came and got me right quick. She had a pretty bad skin tear. That's really all I remember."

The DON (director of nursing) was interviewed on 03/01/17 at 10:25 a.m. regarding when residents are present in the restorative dining room. The DON stated, "Yes, someone should be in the restorative dining room if residents are in there. It is staffed for safety in case of choking or falls. I don't know if there is a specific policy for this. It is just how we have always done it." The DON and Administrator were informed of possible harm during this interview.

No further information was received by the survey team prior to the exit on 03/01/2017.

This is a complaint deficiency.

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2. Resident #11 was left unattended on two different occasions both resulting in falls with injuries. Resident #11 was left unattended during an activity on 12/23/2016 and while reaching for a bag of candy on the floor she fell from her chair and hit her head. Resident #11 was again left unattended in her room on 02/16/2017 and while reaching down to pick up her makeup brush from the floor, she fell out of the wheelchair and hit her head. Both falls resulted in emergency room visits.

Resident #11 was admitted to the facility on 02/07/2016. Her diagnoses included, but were not limited to: Diabetes mellitus, hyperlipidemia, depression, osteoporosis, and hypothyroidism.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/30/2016. Resident #11 was assessed as having a cognitive summary score of "08"; indicating moderate impairment with her cognitive status.

On 02/28/2017, Resident #11 was observed sitting at the end of the hallway at the nurse's station. A golf ball size area was noted on her left forehead. The area was a fading bluish purple in color and was open on the very front of the swelling. A CNA (certified nursing assistant) in the hallway was asked about the area. She stated, "That was from a fall."

Prior to entering Phase 2 of the survey process a list of all falls for the last three months was requested and received. Resident #11 was on the list for three falls. The first on 12/09/2016

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with the explanation that Resident #11 had attempted to transfer herself after her ADL (activities of daily living) care and had fallen. The response to that fall was listed as, Transport to area of visibility when up in wheelchair. The second was on 12/23/2016. Resident #11 was reaching for a bag of candy on the floor and fell from her chair. The response was to educate activity staff to keep resident visible during activities. The third fall was on 02/16/2017. Resident #11 was in her room alone and was reaching for a makeup brush when she fell from her wheelchair. The response to that fall was to repair wheelchair brakes, apply dycem to her wheelchair cushion and do a trial with a reacher.

The clinical record and facility investigations were reviewed. The following information was gleaned:

"12/09/2016 This nurse was called to room...by another nurse. Resident was lying on floor in front of her w/c [wheelchair] on her back. Resident stated nothing was hurting her ROM [range of motion] to extremities per usual..." A review of the facility fall investigation stated that the facility staff would move the resident to areas of visibility when up in her wheelchair to prevent further falls.

"12/23/2016 Pt [patient] up in w/c in TV room on East Wing with other residents at activity. States she leaned forward in w/c to pick candy bag off of floor and she fell forward out of w/c - causing hematoma on L [left] forehead. Was lying in floor in front of w/c. Chkd [checked] over and assisted to w/c, then to bed. Pt continues to be awake and verbal...order received to send pt to ER to be evaluated d/t [due to] hematoma to head..." A

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review of the facility incident report was conducted. Steps to prevent reoccurrence for falls were listed as: "Have pt visible where staff can see her as much as possible."

The care plan was reviewed. The following intervention was added regarding falls on 01/19/2017: "DO NOT LEAVE RESIDENT ALONE IN ROOM DUE TO FALL; STAFF EDUCATE [SIC] NOT TO LEAVE IN ROOM ALONE. FREQUENT CHECKS TO ENSURE RESIDENT IS NOT IN ROOM ALONE."

"02/16/2017 Resident observed on floor in front of w/c laying on right side, alert and oriented to name, day and place...visible skin tear bilaterally to arms with minimal bleeding. Large raised area to left lateral forehead...sent to emergency department to rule out any type of injury..." The facility investigation was reviewed. Steps to prevent reoccurrence included adding dycem to the wheelchair seat, having maintenance check the wheelchair brakes and doing a trial with Resident #11 using a gripper to pick things up from the floor.

Emergency room notes were reviewed for the fall on 12/23/2016 and 02/16/2017. Resident #11 did not require any sutures to her head and her CT scans were negative during both visits.

On 03/01/2017 at approximately 9:15 a.m., this surveyor went to the west wing to interview staff regarding Resident #11's fall on 02/16/2017. The LPN (licensed practical nurse) in charge stated that the CNA (certified nursing assistant) who had gotten Resident #11 up that morning was "Off on her honeymoon." She stated, "I don't know why she left her but no one was in there when she fell

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out of the wheelchair."

The DON (director of nursing) was interviewed on 03/01/2017 regarding the entries on the care plan and the time line regarding the falls. She stated that the fall interventions dated 1/19/2017 were in place at the time of the fall on 02/16/2017 and should have been in place at the time of the fall on 12/23/2016.

On 03/01/2017 at approximately 11:10 a.m. the activity director was interviewed regarding the fall on 12/23/2016 during activities. She stated that she had not done activities that day, her assistant had conducted them while she did paperwork. The assistant was interviewed. She stated that she didn't recall the fall so she must not have witnessed it. She was asked if Residents were normally left alone during activities. She stated, "Not usually." The fall as described in the nurse's notes and the facility investigation were recanted with the activities assistant. "I must have been in the bathroom." The activities director came to the area where the activities assistant was being interviewed. She stated,"I just remembered...we were gathering the residents up for the activities at that time." The assistant stated, "That's right...we were...I wasn't in the bathroom...when we are getting the residents in there we don't always have someone in the room." The assistant was told that according to the facility investigation the fall had occurred at 11:50 a.m. She stated, "Okay that's it, we were transporting them to lunch after the activity then...there isn't someone in there all the time when we are doing that." The activity assistant was asked if she was aware that Resident #11 was care planned to not be left alone due to her fall history. She stated, "No, I didn't know that...she isn't usually in there

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for activities."

The maintenance director was interviewed on 03/01/2017 at approximately 11:20 a.m. regarding the brakes for Resident #11's wheelchair. He stated that he had checked them at the time he got the work order and there was nothing wrong with them.

The DON and the administrator were notified of the above information during a meeting on 03/01/2017 at approximately 2:10 p.m.

No further information was received prior to the exit conference on 03/01/2017.

3. Resident #5, with severe cognitive impairment and multiple falls from his bed, had bed side rails in use without an accurate assessment for safe use of the rails.

Resident #5 was admitted to the facility 11/2/16 with diagnoses that included pneumonia, high blood pressure, Alzheimer's, coronary artery disease, diabetes and history of stroke. The minimum data set (MDS) dated 1/27/17 assessed Resident #5 with severely impaired cognitive skills. This MDS assessed Resident #5 as requiring the extensive assistance of one person for bed mobility, transfers and toileting.

On 2/28/17 at 7:45 a.m. Resident #5 was observed in bed with side rails raised on both sides of his bed. The rails was approximately 1/2 length of the bedside. The rails covered the section of the bedside from approximately 12 inches from the head of the bed to the center of the bedside. A pressure activated alarm was in

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place on the bed. Resident #5 was observed again on 2/28/17 at 1:40 p.m. in bed with side rails raised on both sides of the bed and a bed alarm in place.

Resident #5's clinical record documented the resident had bilateral side rails in use on his bed since his admission to the facility on 11/2/16. A side rail assessment screening form dated 11/2/16 documented the resident had impaired safety awareness, a history of falls and marked the resident as a low risk for entrapment with a recommendation for 1/2 length bed rails to "assist [with] turning/repositioning." The record documented the resident had no falls in the facility until 12/8/16 when the resident slid out of his wheelchair. The resident had five additional falls with all of these five falls from the bed. The facility's fall/incident investigation forms documented the following falls from the resident's bed.

12/16/16 - "Found in room on floor sitting in the Doorway had stripped of [off] his shirt + had apparently climbed out of Bed; Bed alarm was in use but alarm was not loud enough to be heard from desk." This report listed the resident was confused, had a history of falls and required assistance for toileting/transfers.

1/18/17 - "Nurse alerted by CNA [certified nurses' aide] at 10:50 p.m. resident was sitting on the floor. Resident observed at foot of bed on left side...with his back against left side foot of bed between wall and bed. Stated he was 'going up there' when asked what happened...foot board applied to bed." This report documented, "Resident unaware of when his safety is at risk...Multiple attempts to ambulate from w/c

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[wheelchair] during the day. Fidgets constantly unable to make needs or wants known...Resident unable to determine what he wants or needs but will exhibit unsafe behaviors when he may be needing something..."

There was no re-assessment of Resident #5's side rail use following his falls from the bed on 12/6/16 and 1/18/17 until 1/21/17. This side rail assessment form was incomplete and inaccurate. The assessment criteria section of the 1/21/17 form listed the resident had altered safety awareness, a history of falls, poor bed mobility, was on medications requiring increased safety precautions and had a history of agitation. The section on the form for factors indicating a low entrapment risk erroneously indicated the resident had no falls and indicated the resident as unlikely to fall out of bed. The section for factors indicating a high risk for injury/entrapment inaccurately listed the resident as able to safely transfer from bed to wheelchair, as able to ambulate to and from the toilet without falling, as consistent with notifying staff of needs and as able to use his call bell. The form listed side rails were indicated to provide safety but listed no medical conditions addressed by use of the rails. This form listed the rails were indicated to serve as an enabler to promote independence and to prevent the resident from voluntarily getting out of bed. There was no mention on the form of the resident's recent unwitnessed falls from his bed on 12/16/16 and 1/18/17. A note written in the comment section stated, "IDT [interdisciplinary team] recommends 2 1/2 BSR [bed side rails] to aide [with] positioning + mobility." A physician's order dated 1/21/17 indicated use of the 1/2 length rails for positioning and mobility. There was no assessment or mention of the marked

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section on the form indicating the rails were used to keep the resident from getting out of bed.

Resident #5 experienced additional falls from his bed on 1/23/17, 2/4/17 and 2/10/17. The facility's investigation forms documented the following concerning these falls.

1/23/17 - "resident seen crossing the hall walking carry [carrying] diaper, resident got startled fell back against the wall and slid down...resident got up without help..."

2/4/17 - "CNA called to nurse accident in floor. Alarm not sounding, Res [resident] rolled up in blanket lying on right side in floor next to bed in fetal position, incont. [incontinent] of BM [bowel movement]...Alarm intact/on started to Alarm as we were working [with] resident...educated Res. to use call bell...gait weak/unsteady...confused Dementia..."

2/10/17 - "Resident observed sitting upright beside bed...Alarm did not sound...Resident wears glasses, needs assistance w/ ADL's [with activities of daily living] socks were not slip resistant, side rails was still in up position, call bell in reach, resident alert to name..."

Facility investigations made no mention of the resident's continued side rail use after the additional falls on 1/23/17, 2/4/17 and 2/10/17. The forms marked side rails were not a factor in the falls even though the falls were unwitnessed and the resident got out of the bed without assistance prior to falling.

Resident #5's care plan (revised 2/10/17) listed the resident was at risk for falls due to weakness,

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a history of falls and use of psychotropic medications. Interventions for fall/injury prevention included verbal reminders for resident not to ambulate/transfer without assistance, a toileting schedule, glasses on resident when awake, bed wheels locked at all times, low bed position, bed alarm and foot board on bed. The care plan listed use of bilateral 1/2 length bed rails as an intervention to prevent skin breakdown and improve mobility but included no problems, goals and/or interventions related to use of the side rails.

On 2/28/17 at 11:20 a.m. the licensed practical nurse (LPN #5) caring for Resident #5 was interviewed about his use of side rails. LPN #5 stated the floor nurses usually completed the side rail assessment forms to evaluate if the resident was safe to have bed rails. When asked about responses on Resident #5's assessment dated 1/21/17 and the recommendation to use rails, LPN #5 stated she basically looked to see if the resident used the rails. LPN #5 stated Resident #5 held the rail when they were moving him in bed or turning him. LPN #5 stated the resident was not safe to get out of bed on his own and required assistance for toileting.

On 2/28/17 at 2:20 p.m. the certified nurses' aide (CNA #5) caring for Resident #5 was interviewed. CNA #5 stated Resident #5 required the assistance of one person for transfer, bed mobility and toileting and the resident had a bed and chair alarm to alert staff if he got up unassisted. CNA #5 stated the side rails were raised when the resident was in bed and stated the resident held the rail when his brief was changed. CNA #5 stated the resident was not able to pull up on his own.

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On 2/28/17 at 3:00 p.m. the director of nursing (DON) was interviewed about Resident #5's use of side rails and the inaccurate, incomplete side rail assessment dated 1/21/17. The DON stated concerning the responses on the 1/21/17 assessment, "That's not right." The DON stated the responses concerning the resident's risk factors for entrapment and injury did not look correct. The DON stated, "That form is confusing. Maybe we need a new form." The DON stated Resident #5 was not safe to get up on his own. When asked about continued use of the rails after the resident had experienced multiple, unassisted, unwitnessed falls from the bed, the DON stated, "I need to watch him [Resident #5]." Concerning the addition of the foot board to the bed, the DON stated they added that "to keep him [Resident #5] from sliding out [of bed]."

On 2/28/17 at 3:25 p.m. the assistant director of nursing (ADON) was interviewed about Resident #5's side rail use and the risk assessment on 1/21/17. The ADON stated they completed the side rail assessments quarterly. The ADON stated the assessments were reviewed during their morning meeting with the interdisciplinary team. The ADON stated they usually looked to see if the residents were using the rails to increase their independence. When asked about the responses on Resident #5's assessment dated 1/21/17, the ADON stated the questions were not answered correctly. The ADON stated she had seen Resident #5 hold the rail to get to his bedside table and to get to his television remote. When asked about the resident falling after getting out of his bed with the side rails in place, the ADON stated, "I need to re-assess

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him." The ADON stated the responses on the 1/21/17 assessment were not answered correctly as the resident was unable to safely go to the bathroom and transfer on his own.

On 2/28/17 at 3:55 p.m. the administrator was interviewed about his knowledge of side rail use with Resident #5. The administrator stated the resident's wife wanted the side rails and the foot board was added to the resident's bed to assist with keeping him in bed. The administrator stated he was aware of the resident's fall history and interventions for Resident #5 included a low bed, alarms, the foot board and increased toileting.

On 2/28/17 at 5:00 p.m. the staff development coordinator (LPN #3) presented a copy of a corrected side rail risk assessment for Resident #5 dated 2/28/17. The form listed the resident had multiple factors indicating a high risk for injury/entrapment that included his inability to safely transfer, inability to ambulate without falling, inability to use call bell system, altered safety awareness and history of falls. This form documented rails were not indicated and were removed from use. LPN #3 was interviewed at this time about the 1/21/17 risk assessment. LPN #3 stated the nurses usually completed the risk assessment forms and mostly looked at the resident's use of the rails during turning and repositioning or when care was provided. LPN #3 stated the responses Resident #5's risk assessment were not accurate as the resident was not able to safely transfer and the resident had a history of getting up without calling for assistance. LPN #3 stated the risk assessment needed to include the resident's use of rails when unsupervised and take in to account the fall

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history and safety awareness.

These findings were reviewed with the administrator and director of nursing during a meeting on 3/1/17 at 2:10 p.m.

4. Resident #8, with severe cognitive impairment and poor safety awareness, had bed side rails in use without an accurate assessment for safe use of the rails.

Resident #8 was admitted to the facility on 3/30/16 with a re-admission on 7/31/16. Diagnoses for Resident #8 included advanced dementia, high blood pressure, anxiety, depression, osteoporosis and fractured femur. The minimum data set (MDS) dated 12/30/16 assessed Resident #8 with severely impaired cognitive skills. This MDS assessed Resident #8 as totally dependent upon one person for bed mobility, toileting and as totally dependent upon two people for transfers.

On 2/28/17 at 2:00 p.m. Resident #8 was observed in bed with side rails raised on both sides of her bed. The rails was approximately 1/2 length of the bedside. The rails covered the section of the bedside from approximately 12 inches from the head of the bed to the center of the bedside. A pressure activated alarm was in place on the bed. Resident #8 was observed again on 2/28/17 at 4:00 p.m. in bed with the side rails up. The resident was on her right side and mumbling.

Resident #8's clinical record documented a side rail risk assessment dated 12/28/16 indicating the resident was recommended to have 1/2 length

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bed side rails when in bed to aide in positioning and mobility. This assessment indicated the resident had only one out of four factors indicating a low risk of injury/entrapment and 5 of six factors indicating a high risk of injury/entrapment. The form listed side rails were indicated to provide safety but listed no medical conditions addressed by use of the rails. The form indicated the resident required 1/2 length rails instead of 1/4 length rails. The space for the resident's height and weight were blank. The clinical record documented the resident fell from her bed on 7/21/16 and fractured her femur but had experienced no further falls after a concave mattress and alarm were put in place.

The resident's care plan (revised 1/5/17) listed the resident was at risk of falls due to balance problems, poor safety awareness and weakness. Interventions for falls included verbal reminders for the resident to not ambulate on her own, scheduled toileting, call bell, low bed position and bed wheels locked. Side rail use was listed as an intervention for the prevention of skin breakdown and to aide in bed mobility.

On 2/28/17 at 3:00 p.m. the director of nursing (DON) was interviewed about how Resident #8 was safe to use side rails when her risk assessment indicated she was at high risk for injury/entrapment. The DON reviewed the form and stated the information entered did not look correct. The DON stated, "That form is confusing. Maybe we need a new form." The DON stated Resident #8 was totally dependent upon staff for bed mobility and transfers. The DON stated the resident held the rail when being turned or during incontinence care. The DON stated she needed to look at the residents to see

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how they were actually using the rails.

On 2/28/17 at 3:25 p.m. the assistant director of nursing (ADON) was interviewed and asked to explain the rationale for Resident #8 having side rails when the assessment indicated high risk factors for injury/entrapment. The ADON stated the nurses completed the risk assessments and looked to see if the resident was using the rails. When questioned about Resident #8's lack of low risk factors and 5 of six high risk factors for injury, the ADON stated she needed to re-assess Resident #8. The ADON stated Resident #8 mostly held the rail when she was turned and repositioned.

On 2/28/17 at 5:00 p.m. the staff development coordinator (LPN #3) presented a copy of a corrected side rail risk assessment for Resident #8 dated 2/28/17. The form listed the resident had multiple factors indicating a high risk of injury/entrapment that included her inability to safely transfer, inability to ambulate without falling, inability to use call bell system, altered safety awareness and history of falls. This form documented rails were not indicated and were removed from use. LPN #3 was interviewed at this time about Resident #8's side rail use/assessment. LPN #3 stated the nurses completing the risk assessment were looking only at the resident's use of the rail during care. LPN #3 stated Resident #8 was totally dependent upon staff members for transfers and bed mobility and did not self-initiate movement with the rails. LPN #3 stated the assessments should include the resident's use of the rail when unsupervised.

These findings were reviewed with the administrator and director of nursing during a

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meeting on 3/1/17 at 2:10 p.m.

5. Resident #12 did not have a chair alarm in use for fall prevention as required in her plan of care and had bed side rails in use without a completed assessment for safe use of the rails.

Resident #12 was admitted to the facility on 12/9/15 with diagnoses that included dementia, chronic kidney disease, anemia, high blood pressure and cerebrovascular disease. The minimum data set (MDS) dated 2/17/17 assessed Resident #12 with moderately impaired cognitive skills.

a) Resident #12 did not have a chair alarm in use for fall prevention as required in her plan of care.

On 3/1/17 at 9:30 a.m. Resident #12 was observed in her wheelchair in the dining room. There was no chair alarm in use at the time of this observation. On 3/1/17 at 9:45 a.m. Resident #12 was self-propelling in her wheelchair in the hallway going toward her room. There was no chair alarm in place on the resident's wheelchair.

Resident #12's clinical record documented a physician's order dated 12/9/15 for a chair alarm to be used when up in the wheelchair. Resident #12's care plan (revised 2/28/17) listed the resident had a potential for falls due to balance/gait problems. Included among interventions to prevent injury from falls was, "Alarm to bed/chair, tab alarm to chair, check every shift for function/placement."

On 3/1/17 at 9:50 a.m. the certified nurses' aide (CNA #6) caring for Resident#12 was interviewed

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about the missing chair alarm. CNA #6 stated she did not usually work the day shift so she was not sure if the resident required a chair alarm. Accompanied by CNA #6, Resident #12 was observed in her wheelchair without use of a chair alarm. CNA #6 went to Resident #12's room and stated the alarm was still on the resident's bed. On 3/1/17 at 9:55 a.m. CNA #6 stated she checked with the nurse and Resident #12 was supposed to have a chair alarm when up in the wheelchair.

On 3/1/17 at 10:30 a.m. the licensed practical nurse (LPN #5) caring for Resident #12 was interviewed about the alarm. LPN #5 stated Resident #12 was supposed to have a chair alarm in use when in her wheelchair.

These findings were reviewed with the administrator and director of nursing during a meeting on 3/1/17 at 2:10 p.m.

b) Resident #12 had bed side rails in use without a completed assessment for safe use of the rails.

On 2/28/17 at 7:30 a.m. Resident #12 was observed in bed with side rails raised on both sides of her bed. The rails was approximately 1/2 length of the bedside. The rails covered the section of the bedside from approximately 12 inches from the head of the bed to the center of the bedside.

Resident #5's clinical record documented a physician's order dated 12/9/15 for 1/2 length side rails to be used for bed mobility. The resident's plan of care (revised 2/28/17) listed the resident had a potential for falls due to balance/gait problems. The care plan listed the side rails were

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used when in bed to assist with the resident's mobility and to prevent skin breakdown.

The most recent side rail risk assessment dated 2/12/17 was incomplete. The form listed side rails were indicated to provide safety but listed no medical conditions addressed by use of the rails. The form indicated the resident needed 1/2 length rails instead of 1/4 length rails. The space on the form for height and weight was blank. The section for indicating current care plan interventions including a low bed and alarms was not completed.

On 3/1/17 at 10:30 a.m. the licensed practical nurse (LPN #5) caring for Resident #12 was interviewed about the side rails. LPN #5 stated Resident #12 used her rails to pull up in bed and to sit on the side of the bed. LPN #5 stated the resident required the assistance of one person for transfers and toileting but was able to move about and sit up with use of the side rails.

On 3/1/17 at 12:45 p.m. the licensed practical nurse staff development coordinator (LPN #3) was interviewed about the incomplete side rail risk assessment for Resident #12. LPN #3 stated the nurses were supposed to complete all sections of the form and include all safety interventions in place with the resident. LPN #3 stated some of the questions on the forms were confusing and the form may need to be modified to make it easier to complete.

These findings were reviewed with the administrator and director of nursing during a meeting on 3/1/17 at 2:10 p.m.

6. Resident # 6 had an inaccurate and

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incomplete assessment for the use of bed siderails.

Resident # 6 in the survey sample, a 61 year-old female, was admitted to the facility on 4/27/15, and most recently readmitted on 9/21/15 with diagnoses that included hypertension, end stage renal disease, diabetes mellitus, seizure disorder, cerebrovascular accident, depression, gout, and hyperparathyroidism. According to a Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/13/16, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 12 out of 15.

On the most recent Quarterly MDS with an ARD of 1/20/17, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15.

On both the Significant Change MDS and the most recent Quarterly MDS, the resident was assessed under Section G (Functional Status) as needing extensive assistance with one person physical assist for bed mobility and transfers..

The resident had the following physician's order, dated 12/16/16, "1/2 siderails X (times) 2 for positioning and mobility."

Resident # 6's care plan, dated 10/27/16, included the following problem, "Resident with mobility deficit due to functional limitations related to history of CVA (Cerebrovascular Accident), DM (Diabetes Mellitus), ERD (End Stage Renal Disease) with dialysis." The goal for the problem

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F 323	Continued From page 85 was, "Resident will maintain current level of mobility, out of bed daily to wheelchair, self propels, transfers." Added to the care plan on 12/16/16 as an approach to the stated problem was, "Bedrails up 1/2 X 2 when in bed for positioning/mobility." Review of a Side Rail Assessment Screen, dated 1/13/17, revealed inconsistent answers to questions as well as incomplete sections. The question "Resident has not fallen, or is unlikely to fall out of bed" was answered YES, while another question, "Resident has a history of falling our of bed, or the likelihood that such episodes will occur" was also answered YES. Under the Assessment Conclusions section, the statement "Side rails are indicated to provide safety related to these medical conditions" was blank. Neither response, YES or NO was selected, nor were any medical conditions listed. Under the Interventions for Care Plan, none of the listed interventions were selected, including low bed, padded floor mats next to bed, and personal alarm. On both days of the survey, the resident's bed was noted to be in the low position, there was a padded fall mat next to the bed, and there was a personal alarm attached to the bed. The lack of a complete and accurate assessment for the use of bed side rails by Resident # 6 was discussed during a at 2:00 p.m. on 3/1/17 that included the Administrator, DON, other administrative staff, and the survey team.	F 323		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		4/10/17

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F 332	Continued From page 86 (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, resident interview, staff interview and clinical record review, facility staff failed to ensure a medication error rate of less than five percent. Facility staff had a total of 29 medication opportunities with two administration errors for a total medication administration error rate of 6.89 % (percent). Findings included: Resident #18 was admitted to the facility on 11/02/2016 with diagnoses including, but not limited to: Chronic Venous Stasis, Congestive Heart Failure, Hypertension, Reflux Disease, Esophagitis, and Cardiac Pacemaker. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 02/10/2017. Resident #18 was assessed as severely impaired in his cognitive status with a total cognitive score of six out of 15. During the medication pass and pour observation on 02/28/17 at 8:30 a.m., Resident #18 received Milk of Magnesia (MOM) 1200 mg (milligrams) / 15 ml (milliliters) 30 ml by mouth and Miralax 17 Gms. (grams) mixed in four ounces of water by mouth. Resident #18 stated he had a bowel movement "last night."	F 332	1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident #18 Milk of Magnesia physician order has been discontinued as of 03/01/2017. Miralax has been given in 8 ounces of water as physician ordered as of 03/07/2017. No adverse effect 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: A. All residents have the potential to be affected by This deficient practice. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: A. All Licensed/Registered Nurses will be in-serviced by the Director of Nursing on strictly following physician orders for Medication Administration on 03/10/2017. The licensed nurses will be in-serviced on 03/21/2017 by the consultant pharmacist on the principles of safe medication administration.	

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F 332	Continued From page 87 At approximately 8:55 a.m., LPN #2 (licensed practical nurse) was interviewed regarding the MOM and Miralax administration. The physician order for MOM 1200 mg/15 ml was "Administer 30 ml (2 tablespoonfuls) by mouth one time a day if no bowel movement in 3 days." The physician order for Miralax Powder was "17 Gms (Mix in 8 oz. (ounces) of water) by mouth two times a day for constipation." LPN #2 stated, "He takes MOM everyday. I will hold if his bowels are loose. I will circle it." When informed the order was for every three days if no bowel movement, LPN #2 stated, "Oh, I didn't know that. He has received it everyday for at least this month." When informed the Miralax order was to mix in eight ounces of water, LPN #2 stated, "We used to have bigger cups. We need to get some more of those and keep them." Review of Resident #18's MAR (medication administration sheet) for February 2017 confirmed he had received MOM everyday for the month of February. The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 02/28/2017 at approximately 5:30 p.m. No further information was received by the survey team prior to the exit conference on 03/01/2017.	F 332	4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. DON/designee will conduct Medication pass audits x1 daily during business week for one month, then x2 weekly for 2 months, on all Nursing Staff who administer medications and the results reported at the monthly QAPI Meeting. B. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. C. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. D. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly to review the need for continued intervention or amendment of plan.	
F 333 SS=E	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant	F 333		4/10/17

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F 333	Continued From page 88 medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed, for one of 18 residents in the survey sample (Resident # 6), to administer a physician ordered medication to lower systolic blood pressure. Hydralazine, ordered for systolic blood pressure greater than 180, was not administered on any one of six days encompassing 21 episodes when Resident # 6's systolic blood pressure was greater than 180. The findings were: Resident # 6 in the survey sample, a 61 year-old female, was admitted to the facility on 4/27/15, and most recently readmitted on 9/21/15 with diagnoses that included hypertension, end stage renal disease, diabetes mellitus, seizure disorder, cerebrovascular accident, depression, gout, and hyperparathyroidism. According to the most recent Minimum Data Set, a Quarterly with an Assessment Reference Date of 1/20/17, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15. Resident # 6 had the following medication order, dated 5/21/16: Hydralazine tab 100 mg (milligrams) 1 tablet by mouth every six hours as needed for systolic blood pressure greater than 180. (NOTE: Hydralazine is an antihypertensive, direct-acting peripheral vasodilator used to treat essential hypertension; hypertensive	F 333	1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident #6: A physician□s clarification has been received to check the resident□s blood pressure at 0000, 0600, 1200, 1800 and administer hydralazine if blood pressure is greater than 180. This order has been transcribed to the residents MAR. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: A. All residents have the potential to be affected by deficient practice. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: A. The Director of Nursing in-serviced all Licensed Nurses on Facility policy and procedure for Medication Administration and strictly adhering to physician orders 03/24/2017. 4. Monitoring of corrective action to ensure the deficient practice will not	

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F 333	Continued From page 89 emergency/urgency. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 586.) (NOTE: Systolic pressure [the top number in a blood pressure reading] is the highest arterial blood pressure of a cardiac cycle. Ref. Langenscheidt's Medical Dictionary, Copyright 2002, page 684.) Review of the Nurses Notes in Resident # 6's clinical record revealed the following entry: 11/3/16 - 12:30 a.m. "Resident observed on floor beside bed...Resident assisted to bed. Will continue to monitor." Following the resident's fall, a Neurological Assessment Flowsheet was started. Review of the flowsheet revealed the following dates, times and systolic pressures greater than 180. 11/3/16: 1:00 a.m. - 199/101 1:15 a.m. - 198/93 1:30 a.m. - 192/99 2:00 a.m. - 187/100 2:30 a.m. - 191/100 3:30 a.m. - 189/106 4:30 a.m. - 189/105 5:00 a.m. - 192/106 11/4/16: 2:30 a.m. - 193/142 6:30 a.m. - 198/150 11/5/16: 6:30 p.m. - 186/101 10:30 p.m. - 192/101	F 333	reoccur: A. DON/ Designee will monitor a medication pass daily X 2 weeks then weekly X 4 then monthly X 3 to ensure no deficient practice occurs B. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. C. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. D. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly to review the need for continued intervention or amendment of plan.	

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Review of the Medication Administration Record (MAR) for the month of November 2016 found that Hydralazine was not administered during the entire month.

Review of the Nurses Notes in Resident # 6's clinical record revealed the following entry:

12/1/16 - 7:00 p.m. "Resident observed on floor beside bed...Assisted back to wheelchair...Will monitor."

Following the resident's fall, a Neurological Assessment Flowsheet was started. Review of the flowsheet revealed the following dates, times and systolic pressures greater than 180.

12/1/16:
7:30 p.m. - 181/105
7:45 p.m. - 182/116
8:00 p.m. - 183/117
9:00 p.m. - 189/102
10:00 p.m. - 181/101

12/2/16:
7:00 a.m. - 186/117

Review of the MAR for the month of December 2016 found that Hydralazine was not administered during the entire month.

Review of the Nurses Notes in Resident # 6's clinical record revealed the following entry:

1/9/17 - 9:40 a.m. "...Pt (Patient) was sitting in an upright position on floor in front of wheelchair...Neuro checks started."

A Neurological Assessment Flowsheet was

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F 333	Continued From page 91 started. Review of the flowsheet revealed the following date, times and systolic pressures greater than 180. 1/9/16: 7:30 a.m. - 186/92 7:45 a.m. - 190/80 8:00 a.m. - 186/100 Review of the MAR for the month of January 2017 found that Hydralazine was not administered during the entire month. The failure of the staff to administer Hydralazine to Resident # 6 for systolic blood pressure greater than 180 was discussed during a meeting at 2:00 p.m. on 3/1/17 that included the Administrator, Director of Nursing, other administrative staff, and the survey team.	F 333		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (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 (facility assessment implementation is Phase 2);	F 441		4/10/17

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F 441	Continued From page 92 (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 contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

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F 441	Continued From page 93 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 observations, staff interview and review of facility documents, the facility staff failed to follow proper handwashing procedures. A Certified Nursing Assistant was observed incorrectly drying her hands and turning off the water after washing her hands on two separate occasions. The findings were: At approximately 10:20 a.m. on 3/1/17, a staff member was observed transporting a resident by wheelchair from her room to the area directly across from the Nurses Station on the West Unit. The staff member, subsequently identified as CNA # 7 (Certified Nursing Assistant), then went the the Eye Wash Station on the unit which also had a handwashing sink. CNA # 7 washed her hands, turned off the water with her wet hand, and used a paper towel to dry her hands. At approximately 10:30 a.m. on 3/1/17, CNA # 7 was again observed transporting a resident by wheelchair from her room to the area directly across from the Nurses Station on the West Unit. CNA # 7 again went to the Eye Wash Station where she proceeded to wash her hands.	F 441	1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: A. No residents identified. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: A. All residents have the potential to to be affected by this alleged deficient practice. 3. Measures/systematic changes put in place to ensure that the deficient practice does not recur: " The identified CNA was given a teachable moment on facility Handwashing Procedures. " All nursing staff will be in-serviced by the Director of Nursing on facility Hand washing Policy by 03/24/2017. 4. Monitoring of corrective action to ensure the deficient practice will not recur:	

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F 441	Continued From page 94 As she did earlier, CNA # 7 washed her hands, turned off the water with her wet hand, and used a paper towel to dry her hands. During a meeting at 2:00 p.m. on 3/1/17 that included the Administrator, Director of Nursing (DON), other administrative staff, and the survey team, the manner in which CNA # 7 washed her hands was discussed. "That is unacceptable," the DON said. "Even I know that isn't right," the Administrator said. The surveyor requested and received a copy of the facility's handwashing policy. Review of the Handwashing/Hand Hygiene policy noted the following under Policy Interpretation and Implementation: "7. Use an alcohol based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents." The Washing Hands portion of the policy notes the following: "3. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel."	F 441	A. DON/Designee will audit 5 employees during rounds for correct hand washing weekly X 4 then monthly X 3 to ensure policy is adhered to. B. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. C. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. D. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly to review the need for continued intervention or amendment of plan.	
F 502 SS=D	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness	F 502		4/10/17

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	495302	A. BUILDING _____ B. WING _____	C 03/01/2017

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F 502	Continued From page 95 of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure physician's order laboratory services were obtained for one of eighteen Residents in the survey sample, Resident #7. Resident #7's physician's ordered Valproic Acid Serum Level was not obtained as ordered. The findings were: Resident #7 was admitted to the facility on 3/31/15 with, but not limited to, the following diagnoses: sacral spina bifida (incomplete closure of the backbone and membranes around the spinal cord) without hydrocephalus (accumulation of fluid on the brain), convulsions and neuromuscular dysfunction of the bladder. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/16/17 was a quarterly assessment. The resident was assessed as a ten (10) moderately impaired in decision-making skills. On 2/28/17 at approximately 8:45 a.m., a review of the current, February 2017, Physician's Order Sheets (POS's) included the following orders: "03/31/15 Valproic Acid Serum Level Every 6 Months." On 2/28/17 at approximately 9:00 a.m., The laboratory (lab) section of the clinical record was reviewed. The clinical record did not show documentation that the labs were obtained.	F 502	1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident #7 had a Physician order to obtain Valproic Acid Serum Level on 03/31/2015. The valproic acid level was drawn 11/14/2016 and the physician notified of the result on 11/15/2016. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: A. All residents have the potential to be affected by this alleged deficient practice. B. 100% audit of all residents Physician Orders to ensure all labs ordered have been properly placed in the lab book in the month they are due to be obtained on 03/20/2017. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: A. All Licensed nurses in-serviced on physician ordered lab procedures by 03/24/2017. B. All new Licensed Nurses will be in-serviced on facility□s policy for documenting physician ordered lab procedures.	

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F 502	Continued From page 96 On 2/28/17 at approximately 5:22 p.m., the administrative staff were made aware of the findings. A request was made to the administrative staff from this Surveyor to assist in locating the labs. On 3/1/17 at approximately 8:50 a.m., the medical records coordinator, who will be identified as Other Staff (OS #1) stated, "We do not have one (a lab) for the Valproic Acid Serum Level." On 3/1/17 at approximately 2:12 p.m., the administrative staff was made aware of the above findings.	F 502	4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. DON/Designee will audit 3 residents labs weekly X4 then monthly X 3 to ensure labs are obtained within the time frame they are ordered by the Physician. B. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. C. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. D. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly to review the need for continued intervention or amendment of plan.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 514		4/10/17

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F 514	Continued From page 97 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to ensure a complete and accurate clinical record for one of 18 residents in the survey sample, Resident #4. Resident #4's Fall Risk Assessment dated 1/29/17 was marked as zero for no falls in the past three months. Resident #4 has a documented fall on 11/20/2016. Findings included: Resident #4 was originally admitted to the facility	F 514	1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: Resident #4 A new Fall Risk Assessment has been correctly documented. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: A. All residents have the potential to be	

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F 514	Continued From page 98 on 08/19/2010 and readmitted on 11/21/2016 with diagnoses including, but not limited to: Dementia, Vitamin D Deficiency, Congestive Heart Failure, Hypertension, Arthritis, Osteoporosis with Pathological Fractures , Atrial Fibrillation, Chronic Back Pain and Dysphagia. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 02/03/2017. Resident #4 was assessed as severely impaired in her cognitive skills with a total cognitive score of three out of 15. Resident #4's clinical record was reviewed on 02/28/2017 at 9:45 a.m. A Nurse's Note dated 11/20/16 1745 (5:45 p.m.) included, "Resident observed in dining room on floor by CNA (certified nursing assistant). Resident on (L) (left) side with face to floor..." 1810 (6:10 p.m.) "To ER (emergency room)..." A SBAR Communication Form dated 11/20/16 stated, "...resident fell, lacerated forehead..." A "Fall Risk Assessment" dated 1/29/17 under "B. History of Falls (Past 3 months) was marked zero (0) meaning "No Falls in past 3 months." The correct answer should have been two meaning "1-2 Falls in past 3 months." LPN #2 (licensed practical nurse) was interviewed on 03/01/17 at 11:35 a.m. regarding the "Fall Risk Assessment." LPN #2 stated, "Yes, it should have been marked a two. I just wrote the wrong thing." The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 03/01/17 at approximately	F 514	affected by this deficient practice. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: A. All Licensed/Registered Nurses in-serviced by the Director of Nursing on correct documentation standards for the Fall Risk Assessment in the clinical record by 03/24/2017. 4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. DON/designee will conduct audit for 1 month of residents Fall Risk Assessments to ensure accuracy. The results will be reported at the monthly QAPI Meeting. B. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. C. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. D. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly to review the need for continued intervention or amendment of plan	

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F 514	Continued From page 99 2:15 p.m. No further information was received by the survey team prior to the exit conference on 03/01/2017.	F 514		