STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	C 11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE NURSING AND REHABILITATION CENTER	**711 SUSAN TART ROAD BOX 948 DUNN, NC 28334**

(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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, staff, resident and family interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) dental status of 2 of 2 sampled residents (Residents # 11 and 52), failed to accurately code range of motion (ROM) for 2 of 2 sampled	F 278	F278: Assessment/Accuracy/Coordination/Certified Cornerstone Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes	12/3/15

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

Electronically Signed | 11/24/2015

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F 278	Continued From page 1 residents (Residents #3 and #30) and failed to accurately code the urinary continence status for 1 of 1 sampled resident (Resident #50) whose MDS was reviewed. Findings included: 1. Resident #11 was admitted on 7/30/14 with diagnoses of Parkinson's disease. The 7/2/15 Annual MDS coded Resident #11 as cognitively intact. The MDS indicated Resident #11 had no dental problems. The section to signify edentulous was not marked. On 11/2/15 at 3:36 PM an observation was made. The resident had no teeth and was not using any dentures. Resident #11 stated he had no teeth and would like to have dentures. He stated he had not been seen by a dentist since admission to the nursing home. Resident #11 was interviewed on 11/4/15 at 3:37 PM. The resident stated although it had been probably 10 years since he ' d had any teeth or dentures, he would still like dentures. The MDS Nurse was interviewed on 11/5/15 at 12:07 PM. She reviewed the resident ' s annual MDS and stated if none of the above was checked, this meant Resident #11 had no dental problems. She stated while she had not completed this MDS, if the resident had no teeth, the MDS was inaccurate. 2. Resident #52 was readmitted on 1/26/15 with diagnoses that included hypertension Review of Resident #52 ' s Annual MDS, dated 4/24/15, indicated he was moderately cognitively impaired and had no dental problems including missing teeth. An observation was made on 11/3/15 at 8:41 AM. Resident #52 had no teeth. The resident's family member was interviewed on 11/4/15 at 12:33 PM. She stated it had been	F 278	this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Cornerstone Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cornerstone Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute resolution, formal appeal procedure and/ or any other administrative or legal proceeding. The Minimum Data Set (MDS) assessments for Residents #11, #52, #3, and #30 were reviewed and the appropriate modifications were made to include coding of dental status, range of motion and urinary continence to accurately reflect the resident□s current condition by the Facility Nurse Consultants, Director of Nursing, and the Assistant Director of Nursing initiated and completed on 11/18/15. Resident # 50 no longer resides in the facility, discharged on 9/22/15. A 100 % audit of the last completed MDS assessment for all residents to include Residents #11, #52, #3 and #30 was initiated on 11/12/15 by the Facility Nurse Consultants, Director of Nursing, Assistant Director of Nursing and the	

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F 278	Continued From page 2 years since Resident #52 had teeth or dentures. The MDS Nurse was interviewed on 11/5/15 at 12:07 PM. She reviewed the resident ' s annual MDS and stated if none of the above was checked, this meant Resident #11 had no dental problems. She stated the MDS was inaccurate. 3. Resident #3 was admitted on 1/9/14 with contractures of the hand and knee. An observation was made on 11/3/15 at 3:50 PM. Nursing Assistant #1 was unable to fully extend Resident #3 ' s right hand. A 7/19/15 Occupational Therapy (OT) plan of care included a medical history of contractures of the right hand and lower extremity for Resident #3. Review of the 9/5/15 quarterly MDS indicated Resident #3 had no impairment in functional ROM of the upper extremities. Active diagnoses included contracture of the hand joint. The MDS Nurse was interviewed on 11/5/15 at 12:07 PM. She reviewed the resident ' s 9/5/15 quarterly MDS and the OT plan of care and stated based on the information, the MDS was inaccurate. 4. Resident #30 was most recently readmitted on 8/5/15 with diagnoses that included contractures. An 8/5/15 Occupational Therapy (OT) plan of care indicated resident #30 presented with contractures to his bilateral upper and lower extremities. Observations on 9/3/15 and 9/4/15 indicated Resident #30 had contractures of his upper extremities. A 9/5/15 Significant Change in Status MDS indicated Resident #30 had impairment in functional range of motion on one side of his upper and lower extremities. The MDS Nurse was interviewed on 11/5/15 at	F 278	Quality Improvement Nurse to ensure the most recent MDS assessment accurately reflects the resident□s current condition to include coding of dental status, range of motion and urinary continence and completed by 12/3/15. For all areas of concern identified, a modification or significant correction of prior assessment (Quarterly/Comprehensive) was completed by the MDS Nurse and Quality Improvement Nurse as indicated by the RAI Manual by 12/3/15. In servicing was initiated for the Care Plan Team to include MDS Nurses, Activities, Social Services and Dietary on 11/18/15 by the Facility MDS Consultant regarding proper coding of the MDS assessments per the Resident Assessment Instrument (RAI) Manual to be completed by 11/25/15. The Care Plan Team to include MDS Nurses, Activities, Social Services and Dietary will also review a Teleconference on accurate MDS completion by 12/3/15. When coding the MDS assessment, the MDS Nurse and the Care Plan Team to include Activities, Social Services and Dietary will follow the instructions for proper coding found in the Resident Assessment Instrument (RAI) Manual and ensure that the assessment accurately reflects the resident□s current condition. An audit of 25% of completed Minimum Data Set (MDS) assessments will be conducted weekly x 4 weeks, then bi-weekly for 4 weeks then 10% monthly x 2 months by the Director of Nursing or the Assistant Director of Nursing to ensure compliance and accuracy of the MDS to	

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F 278	Continued From page 3 12:07 PM. She reviewed the resident ' s 9/5/15 quarterly MDS and the OT plan of care and stated based on the information, the MDS was inaccurate. 5. Resident # 50 was admitted to the facility on 6/14/2015 with diagnoses which included mood disorder,heart failure, Hyperlipidemia and muscle weakness. The admission MDS(Minimum Data Set)dated 6/21/2015 indicated the resident was always continent. The quarterly MDS assessment dated 9/8/2015 indicated the resident was always incontinent. On 11/4/2015 at 10:00 AM, the MDS nurse was interviewed. She acknowledged that the resident was admitted as always incontinent. She added the admission MDS dated 6/21/2015 and quarterly MDS dated 9/8/2015 should have both coded the resident as always incontinence. On 11/4/2015 at 11:00 AM, the Director of Nursing(DON) was interviewed. She reported Resident # 50 had been always incontinent since admission on 6/14/2015. DON acknowledged the admission MDS dated 6/21/2015 was inaccurate.	F 278	include coding for Dental, Range of Motion and Urinary Continence utilizing a MDS Audit Tool. All Identified areas of concern will be addressed immediately by the Director of Nursing or Assistant Director of Nursing through retraining and by modification or significant correction of the MDS Assessment by the MDS Nurse to accurately reflect the resident□s current condition. The results of the MDS Audit tool will be reviewed by the Administrator weekly. The Quality Improvement Executive Committee will review all audit results monthly x 4 months for further recommendations, take action as appropriate, and to monitor continued compliance.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		12/3/15

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F 279	Continued From page 4 assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to care plan interventions to prevent the development of contractures and to prevent the worsening of existing contractures for 1 of 2 sampled residents (Resident #3) reviewed for contractures. Findings included: Resident #3 was admitted on 1/9/14 with diagnoses that included dementia, arthritis multiple joints, hemiplegia and contractures of the hand and knee. A 7/19/15 Occupational Therapy (OT) Plan of Care (POC) indicated Resident #3 required skilled OT to provide an appropriate splint and educate nursing staff on the splints use to maintain joint integrity. Medical history included contracture of the right hand and lower extremity. The current level of function for Resident #3 was documented as the resident exhibited right upper stiffness with no splint. The goal of the splint was to prevent loss of range of motion on the right upper extremity with application of a hand	F 279	F 279: Develop Comprehensive Care Plans Cornerstone Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Cornerstone Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cornerstone Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute resolution, formal appeal procedure and/ or any other administrative or legal	

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F 279	Continued From page 5 roll in order to reduce further progressing/development of the contracture. Resident #3's 9/5/15 Quarterly Minimum Data Set (MDS) indicated Resident #3 was severely cognitively impaired. The resident required extensive to total dependence for all activities of daily living. The MDS noted the resident had no impairment in functional range of motion. Active diagnoses included contracture of the hand joint. Review of the care plan for Resident #3 indicated on 9/7/15, a care plan for the resident's contractures was noted as resolved. Under the description, the nurse had documented the resident's contractures were at risk for getting worse. The MDS nurse was interviewed on 11/5/15 at 12:07 PM. She stated residents were typically care planned for splinting and contractures. She stated contractures were still a problem for Resident #3 and her existing contractures had the potential to get worse. The MDS nurse stated the reason Resident #3's care plan for contractures was resolved was because she had been discharged from restorative nursing services. She stated she had not been aware of any interventions for prevention of worsening contractures.	F 279	proceeding. The care plan for resident # 3 was reviewed and updated on 11/4/15 by the Director of Nursing to reflect the resident□s contracture. A 100% audit of all residents care plans was initiated on 11/6/15 by the Director of Nursing and Quality Improvement Nurse including care plan for Resident # 3 to ensure comprehensive care plans have been developed per the comprehensive assessment to include any resident identified with contractures, completed by 11/25/15. The care plans were updated for any identified areas of concern by the Director of Nursing, Quality Improvement Nurse and Facility Nurse Consultant by 12/3/15. A 100% observation was completed on all residents to include Resident # 3 on 11/4/15 by the Director of Nursing, Assistant Director of Nursing, Treatment Nurse, Quality Improvement Nurse, and Staff Facilitator to ensure all residents to include resident #3 observed with contractures had care plan interventions to prevent the development of contractures and to prevent the worsening of existing contractures. The care plan was updated for any identified areas of concern during the audit by the Director of Nursing, Quality Improvement Nurse and the Facility Nurse Consultant by 12/3/15. The Care Plan Team to include the MDS Nurses, Director of Nursing, Activity Director, Dietary and Social Services were in-serviced on care planning requirements, per instructions provided in the RAI Manual on 11/20/15 by the Facility	

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F 279	Continued From page 6	F 279	MDS Consultant. When there is a newly identified or worsening contracture, the assigned nurse will initiate a referral to Therapy Services. The MDS Nurse will review all Therapy Referrals weekly x 8 weeks and monthly x 2 to identify any new contractures and to ensure the care plan is updated to reflect interventions to prevent the development of contractures and to prevent the worsening of existing contractures. The Director of Nursing will review all triggered Care Area Assessments on all subsequent comprehensive assessments, 24 hour reports, shift change notes, progress notes, current interventions, therapy referrals and physician telephone orders, or development of new or worsening contractures to ensure any newly identified area has been addressed on the resident care plan 5 x week for 4 weeks, then audit 10% of care plans weekly x 3 months and to ensure that care plans reflect the residents current medical, nursing, mental, and psychosocial needs utilizing a care plan audit tool. The MDS nurse will immediately update the care plan for all identified areas of concerns and the Administrator will provide retraining with the identified staff member. The results of the Care Plan Audit Tool will be reviewed by the Administrator weekly. The Quality Improvement Executive Committee will review all results of the care plan audit tool monthly x 4 months for any recommendations, take action as appropriate, and to monitor for continued compliance	

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F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to place interventions to reduce the risk of contractures worsening for 2 of 2 sampled residents (Residents # 3 and #30) who were observed with contracted hands. Findings included: 1. Resident #3 was admitted on 1/9/14 with diagnoses that included dementia, arthritis multiple joints, hemiplegia and contractures of the hand and knee. A 7/19/15 Occupational Therapy (OT) Plan of Care (POC) indicated Resident #3 required skilled OT to provide an appropriate splint and educate nursing staff on the splints use to maintain joint integrity. Medical history included contracture of the right hand and lower extremity. The current level of function for Resident #3 was documented as the resident exhibited right upper stiffness with no splint. The goal of the splint was to prevent loss of range of motion on the right upper extremity with application of a hand roll in order to reduce further progressing/development of the contracture. A physician's order dated 8/5/15 indicated Resident #3 had been discharged from therapy	F 318	F 318: Increase/Prevent Decrease in Range of Motion Cornerstone Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Cornerstone Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cornerstone Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute resolution, formal appeal procedure and/ or any other administrative or legal proceeding. On 11/ 4 /15, hand rolls were placed on	12/3/15

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F 318	Continued From page 8	F 318		

and restorative was initiated for services for contracture management. Review of Resident #3 physician ' s orders did not reveal an order to discontinue the splints.
Review of the August 2015 progress notes failed to reveal documentation that Resident #3 refused to wear the splint and did not document the splint was ineffective. There was no mention in the August 2015 progress notes of the splint application or the splint being discontinued.
Resident #3 ' s 9/5/15 Quarterly Minimum Data Set (MDS) indicated Resident #3 was severely cognitively impaired. The resident required extensive to total dependence for all activities of daily living. The MDS noted the resident had no impairment in functional range of motion. Active diagnoses included contracture of the hand joint.
The resident's care plan, reviewed on 9/16/15, indicated contractures were present and Resident #3 was at risk for fractures. Interventions to prevent fractures related to the contractures included mechanical lift for transfer and giving pain meds as needed. The care plan and the care guide for Resident #3 did not contain interventions for prevention of further contractures or for interventions to prevent skin breakdown in the contracted right hand.
Review of nurse's progress notes for September 2015 failed to mention the application of the splint or a hand roll in Resident #3 ' s right contracted hand. There was no documentation that indicated the splint had been discontinued.
Review of the October 2015 nurse's progress notes for Resident #3 failed to document any information regarding the application or discontinuation of the resident's splint. There was no documentation that indicated the resident refused the splints or was unable to tolerate the splints. There was no documentation that other resident #3 right hand by the Staff Facilitator. On 11/6/15, Resident #3 was referred to Physical Therapy and Occupational Therapy to evaluate contracted right hand by the Staff Facilitator. On 11/4/15, hand rolls were placed on Resident # 30 bilateral hands by the Staff Facilitator.
A 100 % audit of all residents to include Resident #3 and #30 was completed on 11/4/15 by the Assistant Director of Nursing, Staff Facilitator, Quality Improvement Nurse, and MDS Nurse to identify contractures and ensure proper interventions were in place to reduce the risk of contracture worsening. If there was no identified intervention noted for a contracture, the resident was referred to Physical Therapy for evaluation of the contracture, hand rolls were placed, splints were placed and/or restorative nursing was initiated by the Staff Facilitator by 12/3/15.
An In-Service was completed on 11/18/15 by the Facility Nurse Consultant to the Director of Nursing, Assistant Director of Nursing, MDS Nurse and the Staff Facilitator (Restorative Nurse) regarding: the facility must ensure that a resident with limited range of motion or contractures receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion or worsening of contractures. An In-Service was initiated on11/6/15 by the Director of Nursing and Assistant director of Nursing to all license nurses regarding: When a resident is observed to have a contracture

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F 318	Continued From page 9 interventions had been attempted in order to prevent progression of Resident #3 ' s contractures. The November 2015 physician's orders indicated Resident #3 was to receive range of motion (ROM) exercises to the left knee to decrease knee stiffness. There was no orders that revealed the resident ' s hand received ROM or splinting to prevent the progression of the contracture. An observation was made on 11/3/15 at 3:50 PM. The resident ' s right hand was clenched with her fingernails resting in the palm of her hand. Nursing Assistant (NA) #1 was in the room and demonstrated the resident ' s fingers could not be fully extended. The NA added at times, the resident would grimace in pain when the fingers were moved. When the NA tried to extend the resident's hand, a sweaty, musty smell was noted coming from the hand. The NA stated she typically tried to keep a rolled washcloth in the resident's hand. There was no reason given as to why there was not one in today. An observation was made on 11/4/15 at 8:30 AM. The resident's right hand was contracted. There was no splint or washcloth in the resident's hand to prevent the fingernails from resting in the resident ' s palm and to provide a better alignment of the hand. NA #2 was interviewed on 11/4/15 at 9:17 AM. The NA stated she had completed morning care that included washing the resident ' s right contracted hand. The NA stated prior to washing the resident ' s hand, she had observed an odor that came from Resident #3 ' s hand. NA #2 stated the odor was probably caused by Resident #3 holding her hand closed and causing the hand to sweat. The NA added washing the hand several times a day would probably eliminate the	F 318	of any kind, the resident must have an intervention implemented to prevent the contracture from worsening and to prevent skin breakdown. Examples of interventions to include, washcloths in hands, hand rolls, splints, pillows between knees, Physical Therapy Referrals, or restorative nursing. As a nurse, if you have any questions regarding an intervention, notify the Director of Nursing and/or Assistant Director of nursing. This in-service is to be completed by 12/03/15. The Quality Improvement Nurse, Staff Facilitator and/or the Treatment Nurse will observe all residents to include Resident # 3 and # 30 for new or worsening contractures and ensure that interventions for contractures are in place for any newly identified, worsening, or current contracted residents to include resident # 3 and # 30 utilizing a Monitoring Contracture Interventions tool 5 x week for 4 weeks, bi-weekly for 4 weeks, then weekly x 2 month. The Director of Nursing and/or the Assistant Director of Nursing will review all audits weekly x 8 weeks then monthly x 2 months for completion and to ensure all identified areas of concern were addressed. The Administrator will review all audit results weekly. The Quality Improvement Executive Committee will review all audit results monthly x 3 months for any recommendations, take actions as appropriate and to monitor continued compliance.	

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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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odor. She added she had previously used a wash cloth in other resident ' s contracted hands, but had not used one with Resident #3 since her care guide had not indicated a washcloth was to be used in the resident's contracted hand. The NA stated the resident's nails, while they were not digging into the resident's palm, were long and there was a potential for the nails to dig into the palm.

Nurse #2 was interviewed on 11/4/15 at 9:20 AM. She acknowledged Resident #4 ' s hands were contracted and a rolled washcloth could be used to keep the resident ' s palm dry. She added the resident's nails were long and there was a potential of her nails cutting into the skin. On observation, there were no wounds seen in the resident's hand. The nurse stated she was unaware why a washcloth had not been placed in the resident's hand this week.

The Director of Nursing (DON) was interviewed on 11/4/15 at 9:32 AM. The DON stated interventions to prevent the progression of contractures were dependent on the resident and each resident ' s tolerance of the intervention. The DON added she would have expected each intervention used and failure to be documented. She added the danger of a contracted hand being closed would be moisture and the risk of skin breakdown. The DON stated if an intervention was chosen, the intervention should appear on the care guide (a guide used by the NAs to care for residents). The DON stated she personally had previously tried to place a wash cloth in Resident #3 ' s hand and she did not keep it in her hand. The DON was unsure if she had documented the results of the intervention attempted.

The Restorative Aide (RA) was interviewed on 11/4/15 at 11:08 AM. The RA stated his training

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	345325	A. BUILDING _____ B. WING _____	C 11/05/2015

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for the position was received by the previous RA. He added he had been shown a few things such as how to put on splints, where to find his list of residents to be treated, their needs and where to chart. The RA stated Resident #3 was in the restorative feeding program, but was not on the splint list or the ROM list. He added when he first started working at the facility, Resident #3 had a splint. He added to the best of his memory she tolerated the splint and had not refused the splint.
On 11/4/15 at 11:31 AM, NA #2 was interviewed. She stated she had worked with Resident #3 for the last 3 to 4 months. NA #2 stated when she first started working with the resident, she received splinting services from the RA. She added Resident #3 had not seemed to mind the splint. NA #1 stated there had been times she had used a rolled wash cloth in Resident #3 ' s hand and the resident had not refused or shown signs of intolerance. The NA added the resident had not taken the wash cloth out and in fact, she did not think Resident #3 had the manual dexterity to remove a rolled wash cloth from her own hand.
Nurse #1 was interviewed on 11/4/15 at 11:33 AM. The nurse stated she cared for Resident #3 at least 3 to 4 days per week over the last 2 years. She stated a physician's order was needed to discontinue a splint. At one time, Resident #3 had a splint that was put on by the RA. The nurse stated she had not heard of discontinuation of the splint and had not seen an order to discontinue the splint. Nurse #1 stated the last time she remembered seeing Resident #3 use the splint was the last Monday in October 2015. Nurse #1 added she had not asked the RA about why the splint was not being placed and did not report the lack of splinting to the DON. She stated she did not ask anyone because the RA

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had a habit of picking up and dropping people daily and just thought Resident #3 was done with restorative.
The Physical Therapy Assistant (PTA) was interviewed on 11/4/15 at 11:56 AM. The PTA stated when a resident was discontinued from skilled therapy, the resident was then placed in a restorative program. She added a form was filled out that instructed staff on the resident ' s current level of functioning and instructions on what to do for the resident. Around July 2015, the PTA stated she had worked with the resident with stretching to achieve knee extension. The PTA stated if Resident #3 had not been able to tolerate a splint in her hand, a rolled wash cloth could be used. She added the purpose of using a rolled wash cloth in a contracted hand would be to prevent the nails from digging into the skin and to prevent the contracture from worsening.
An observation was made on 11/4/15 at 1:40 PM. Resident #3 was in bed with a rolled wash cloth observed in her contracted hand.
The Staff Facilitator (SF) was interviewed on 11/4/15 at 2:13 PM. She stated she was the nurse responsible for the restorative program. The SF stated splints were typically discontinued due to a lack of resident tolerance, the splint was broken, or it was not working for the intended purpose. If the splint was broken or not working, the resident was referred to therapy for re-evaluation on a case by case basis. The SF stated if a resident refused treatment, the aide or the nurse was expected to document the refusal. The SF had no knowledge of Resident #3 refusing treatment or not able to tolerate treatment.
Nurse #2 was interviewed on 11/5/15 at 10:27 AM. The nurse stated Resident #3 used to have splints, but she was unable to remember the last

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time the splints were used. The nurse stated Resident #3 had a contracture of her right hand. She added she typically used a rolled wash cloth in the resident ' s hand. Nurse #2 stated she was unaware the resident did not have a rolled wash cloth in her hand on Monday and Tuesday when she had been assigned to the resident. She stated she had no answer why there were no rolled wash cloths in the resident ' s hand.

2. Resident #30 was most recently readmitted on 8/5/15. Diagnoses included contracture of the knee and Parkinson's disease.
An 8/4/15 Nursing Admission and Re-entry assessment indicated Resident #30 had contractures bilateral upper extremities and right lower extremity.
An 8/5/15 Occupational Therapy Plan of Care indicated Resident #30 presented with contractures to bilateral upper and lower extremities. The therapist documented Resident #30 had hand splints. The therapist determined Resident #30 had no need for skilled therapy services.
A 9/5/15 Significant Change in Status Minimum Data Set (MDS) indicated Resident #30 had short and long term memory problems with severely impaired cognitive skills for daily decision making. The resident required total assistance of staff for completion of all activities of daily living. The MDS noted impairment in functional range of motion on one side of upper and lower extremities. Active diagnoses included hemiplegia or hemiparesis and contracture of multiple joints.
The care plan, with a 9/7/15, revision date indicated Resident #3 had multiple contractures and was at risk for fractures. The goal of being free from fracture included assistance with

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transfers using a mechanical lift and giving pain medication as ordered. There were no interventions to prevent further contractures or the current contractures from getting worse.
An observation was made on 11/3/15 at 3:40 PM. Resident #30 was lying in bed. His left hand was clenched shut with the nails touching the palms. There was no hand roll or splint observed in his contracted hand.
An observation was made on 11/4/15 at 8:30 AM. The resident was lying in bed. His left hand was contracted. There was no splint or washcloth in his hand.
Nurse #1 was interviewed on 11/4/15 at 9:30 AM. The nurse opened the resident ' s contracted hand and stated it smelled sweaty. Nurse #1 stated Resident #30 could not fully extend either his right or his left hand. She added that rolled washcloths in the resident's hand could help wick moisture away.
The Restorative Aide (RA) was interviewed on 11/4/15 at 11:14 AM. As a restorative aide, he stated he did not provide range of motion or splinting for Resident #30.
An interview was held with the Physical Therapy Assistant (PTA) on 11/4/15 at 12:05 PM. The PTA stated if a resident could not tolerate a splint, a rolled wash cloth could be used. The purpose would be to prevent the nails from digging into the skin and prevent the existing contractures from worsening.
Nurse #2 was interviewed on 11/5/15 at 10:30 AM. She stated Resident #30 previously had used splints, but when he was provided comfort care, the splints were discontinued. Normally, she added, Resident #30 had rolled wash cloths in his hand. She added she was unaware Resident #30 had not had rolled wash cloths in his hand.

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F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff and family interviews the facility failed to correctly reconcile ordered medications resulting in the omission of an ordered dose of Dilantin for 1 (Resident #119) of 5 residents reviewed for correct medication administration. Findings included: Resident #119 was admitted on 6/04/15 at 10:35 AM from another Skilled Nursing Facility (SNF) with diagnoses that included seizures. A review of the Nursing Admission and Re Entry Assessment dated 6/04/15 at 10:40 AM assessed the resident as requiring aid of staff with limited or extensive assistance for activities of daily living (ADL ' s). It further identified the resident could communicate her needs, had no visual or hearing deficit, and no behavioral interventions were needed. A review was conducted of the documents related to medication administration that were sent from the discharging facility. A copy of Resident #119 ' s medication administration record (MAR) was not included in the documents sent to the admitting facility. The discharging facility ' s instructions referenced: " review MAR for medications. " The discharging facility also included the FL2 form (a form intended to provide a summary of the patient ' s care) which also listed medications. The section of Resident #119 ' s FL2 titled " Medications - Name & Strength, Dosage and Route " did not list Dilantin as one of	F 333	F 333: Residents Free of Significant Med Errors Cornerstone Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Cornerstone Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cornerstone Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute resolution, formal appeal procedure and/ or any other administrative or legal proceeding. Resident # 119 no longer resides at the facility and was discharged on 6/23/15. A 100% audit of all current residents admitted from 6/4/15 □ 11/6/15 was initiated on 11/6/15 and completed on 11/12/15 by the Assistant Director of	12/3/15

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F 333	Continued From page 16 Resident #119 " s medications. Record review revealed the facility ' s Medication Administration Record (MAR) for Resident #119 dated 6/04/15 did not list Dilantin. Dilantin is an anticonvulsant used to treat or prevent seizures. Record review of the facility Nursing Progress Notes dated 6/05/15 at 7:46 AM, indicated the resident was not responding to verbal stimuli. The progress note stated, " Resident noted with eyes closed, breathing rapid at times, twitching noted in hands bilaterally, skin was warm to touch. " The progress note also stated the resident was sent out to the hospital. The progress note written on 6/05/15 at 4:53 PM stated the resident had returned to the facility. Review of the Patient Health Summary dated 6/05/15 from Resident #119 ' s hospital stay revealed no conclusive documentation that the resident had suffered a seizure. Record review revealed a physician ' s order for Resident #119 dated 6/05/15 at 4:00 PM for " Dilantin 100mg tablet give two tablets by mouth twice daily for seizure disorder. " Document review of Resident #119 ' s MAR for June 2015 revealed the addition on 6/05/15 of " Dilantin 100mg (milligrams) tablet give 2 to equal 200mg by mouth twice daily at 9:00 AM and 9:00 PM. " The first administration of Dilantin was indicated by licensed staff initials at 9:00 PM on 6/05/15. The MAR was initialed twice daily indicating the Dilantin was administered as ordered from 6/05/15 PM until the resident ' s discharge from the facility on 6/23/15. Interview on 11/03/15 at 11:30 AM with the Director of Nursing (DON) revealed the facility had not been aware that Resident #119 had been on Dilantin since January, 2015 until she had returned from the hospital Emergency Room (ER). She stated that when the resident returned	F 333	nursing to review all admission medications orders to ensure all medications were correctly reconciled onto the facility Medication Administration Record. Any negative findings were addressed by the Assistant Director of Nursing by 12/03/15. A 100% audit of all current residents physician orders from 10/9/15 to 11/9/15 was initiated on 11/9/15 and completed on 11/10/15 by the Facility Nurse Consultant to ensure all medications were properly transcribed to the residents current Medication Administration Record. Any negative findings were addressed by the Facility Nurse Consultant by 12/03/15. An in-service with all Licensed Nurses to include nurse # 3 was initiated by the Director of Nursing and the Assistant Director of Nursing on 11/4/15 regarding: When a resident is admitted from another facility, the nurse must review and follow the instructions from the Post-Discharge Plan of Care. The nurse must obtain a copy of the Medication Administration Record from the other facility, compare it to the discharge orders, verify the medications with the MD, document, and have a second nurse to verify the medication reconciliation. This in-service is to be completed by 11/20/15. An in-service with the Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse and the Staff Facilitator was completed by the Facility Nurse Consultant on 11/6/15 regarding: After the admission nurse completes the admission orders to include medications, the Assistant Director of Nursing, Quality	

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F 333	Continued From page 17 from the ER the family member who served as the resident ' s Responsible Party (RP) informed the facility that the resident should have been continued on Dilantin 200mg twice daily upon admission. The DON verified that she had reviewed the hospital labs for Resident #119 upon her return to the facility and was aware that her Dilantin level was low. The DON further stated once the facility became aware of their mistake in omitting Dilantin from the resident ' s MAR they immediately got an order from the facility physician for Resident #119 to receive Dilantin 200mg twice daily and for her Dilantin level to be rechecked in two days. Interview conducted on 11/03/15 at 12:15 PM with the nurse who admitted Resident #119 to the facility (Nurse #3) on 6/04/15 revealed she had not received a copy of the resident ' s MAR from the transferring facility. She stated " I did not get a copy of the MAR so I used the FL2 to reconcile the resident ' s admission medications. " When asked if she tried to obtain a copy of the resident ' s MAR from the transferring facility she stated " No, we use the FL2 to reconcile medications if the MAR is not available. " When asked if she discussed the resident ' s current medications with a family member who was present on admission she stated " No, I did not feel that was necessary since I had the FL2 which listed the resident ' s medications. " An additional interview conducted on 11/03/15 at 1:00 PM with the facility DON revealed she considered the FL2 to be an acceptable source of medication reconciliation for a newly admitted resident. When asked how she could be certain of when the medications were last administered since that information was not given on the FL2 she stated, " we assume when medications have been given based on whether they are ordered	F 333	Improvement Nurse or the Staff Facilitator will also review the admission transcription of orders and document on the Day of Admission Item Checklist/Audit. When there is a new admission, the admitting hall nurse will transcribe the medications from the transferring facilities Medication Administration Record or discharge orders and reconcile the medication orders with the attending physician. A second nurse will then review the approved admitting physician□s orders and compare to the Medication Administration Record to ensure all medications are reconciled correctly. Both nurses will sign the bottom of the transcribed Physician Orders validating all medications have been reviewed, reconciled and transcribed correctly. The Director of Nursing will review newly admitted residents physician orders and the transferring MARs, to ensure all admission orders have been reconciled correctly to the Medication Administration Record utilizing the Day of Admission Item Checklist/Audit for all admissions 5 x week for 4 weeks, then 10% of all admissions x 3 months. Any areas of concern will be addressed immediately by the Director of Nursing with re-training of the transcribing nurses and MD notification. The results of the Day of Admission Item Checklist/Audit tool will be reviewed with the Administrator weekly. The Quality Improvement Executive Committee will review all audit result information monthly x 3 months for any recommendations,	

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F 333	Continued From page 18 AM or PM. " She further stated the MAR was the preferable source for medication reconciliation when it was available. She stated " since the incident with Resident # 119 ' s missed Dilantin she no longer considered the FL2 to be a reliable source for admission medication reconciliation. She stated " the nurse should have called the transferring facility for a copy of the most recent MAR. " Interview conducted on 11/03/15 at 1:20 PM with Staff Development Coordinator (SDC) revealed the facility did not have a policy for medication reconciliation with new admissions. She stated " initially we get a group of documents from the transferring facility which usually includes some information about the resident ' s medications. We teach the admission staff to try to get the resident ' s most recent MAR if possible. " She further stated that if a MAR was not available " we tell the admission nurses to do the best they can with medication administration reconciliation and to call the physician if they have any discrepancies. " The SDC agreed that the system of using the FL2 for medication reconciliation without the input of a knowledgeable family member was not a dependable source for medication reconciliation. Interview conducted on 11/03/15 at 2:25 PM with the Facility Administrator (FA) revealed he did not consider the use of the FL2 as a document for reconciling a newly admitted resident ' s medications safe or acceptable. The FA stated he would be involved in reviewing the admission process to insure dependable sources were used in the process of medication reconciliation for newly admitted residents.	F 333	take action as appropriate, and to monitor continued compliance.	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS	F 412		12/3/15

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F 412	Continued From page 19 The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to offer 1 of 2 sampled residents reviewed for dental status (Resident #11) routine dental services. The resident expressed a desire for denture placement. Findings included: Resident #11 was admitted on 7/30/14 with diagnoses that included Parkinson's disease. The 7/30/14 Nursing Admission Assessment failed to address the resident's dental status. Review of the 7/2/15 Annual Minimum Data Set (MDS) coded Resident #11 as cognitively intact. The MDS did not identify Resident #11 as edentulous. Review of the resident ' s electronic medical record failed to reveal a dental examination had been conducted for Resident #11. During an observation and interview with Resident #11 on 11/2/15 at 3:36 PM, he stated he had no teeth, but would like to have dentures. He stated he had not been seen by a dentist since admission to the facility. The resident opened his mouth and no teeth were seen.	F 412	F 412: Routine/Emergency Dental Services Cornerstone Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Cornerstone Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cornerstone Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute resolution, formal appeal procedure and/ or any other administrative or legal	

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F 412	Continued From page 20 The Ward Secretary (WS) was interviewed on 11/4/15 at 3:11 PM. The WS stated she was responsible for scheduling dental appointments for residents. She added the facility currently had no dentist that examined residents in the facility. Residents, she added, were either taken to a local dentist or taken to the dental school for examination. The WS stated there was no policy or procedure in place to make sure residents were seen on a routine basis. She added dental appointments were only made when nursing informed her of a specific resident ' s need, a resident requested to be seen or the resident ' s family member requested a dental appointment. The WS stated she was unaware of any procedure or policy to ask alert and oriented residents if they wanted to be seen by a dentist. The WS identified Resident #11 as alert and oriented; able to make his wants and needs known. She added Resident /#11 had not been seen by a dentist in the last year. The WS stated she was unaware residents were eligible for routine dental examinations. With the WS present, Resident #11 was interviewed on 11/4/15 at 3:37 PM. Resident #11 stated he still wanted to see the dentist in order to obtain dentures. The Director of Nursing (DON) was interviewed on 11/5/15 at 11:13 AM. She stated the facility had no process in place to make sure residents were seen for routine dental examinations. The DON added residents were seen on a case by case basis. She stated she personally had discussed dentures and a dental visit with Resident #11, but the resident declined. The DON added she was sure there was no documentation of her discussion with the resident. The DON was unaware all residents were eligible for yearly, routine dental	F 412	proceeding. Resident #11 was seen by Denture Makers for his expressed desire of denture placement on 11/16/15. A 100% audit was initiated by the Admissions Coordinator on 11/6/15 to be completed by 12/3/15 to ensure all residents have had a dental consultation within the past 12 months. Any resident not seen by a dentist in the past year will be interviewed or the resident□s responsible party contacted by the Social Worker and the Admissions Coordinator and offered the service of a dental consult to include services for lost or damaged dentures by 11/25/15. Consultations will be scheduled accordingly by the Ward Secretary to be completed by 12/3/15. On 11/6/15, the Administrator and the Director of Nursing was in-serviced by the Facility Nurse Consultant regarding: The facility must ensure that services are available for residents to provide either by employing a staff dentist or through a contract service for routine dental visits. A contract arrangement with Long Term Care Professional Associates, Incorporated was made on 11/19/15 to provide in-house Dental Services by the Administrator. On 11/6/15, the Social Worker was in-serviced regarding: The Social Worker the process of maintaining individual resident information sheets on dental visits to ensure all residents are offered services yearly and as needed. If a resident indicates a dental concern or requests dental services, the nurse will assess the resident, contact the MD, and notify the Social Worker who will arrange	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	C 11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 412	Continued From page 21 examinations.	F 412	for an appointment for dental services. The Social Worker will maintain individual resident information sheets on dental visits to ensure all residents to include new admissions and Resident #11 are offered and arranged dental services yearly and as needed. The Director of Nursing or Assistant Director of Nursing will review the Resident Information Sheets weekly x 4 weeks, bi-weekly x 4 weeks then monthly x 2 months to ensure that all residents have been provided with routine dental services utilizing the Dental Audit tool. Any identified areas of concern will be addressed immediately by the Director of Nursing. The Administrator will review the Dental Audit Tool weekly. The Quality Improvement Executive Committee will review all Dental Audit Tool results monthly x 3 months for any recommendations, take action as appropriate, and to monitor for continued compliance.	