STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345309	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY	101 CAROLINE AVENUE WELDON, NC 27890

(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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		4/20/16

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

Electronically Signed | 04/15/2016

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F 156	Continued From page 1 funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to issue a letter of non-coverage 2 days prior to the Medicare A skilled services termination date for 3 of 3 residents (Residents #41, #67, and #68). Findings included: #1. Resident #41 was admitted to the facility on 12/30/2015 and was discharged on 1/19/2016. On 3/24/2016 at 12:07 PM, an interview was conducted with the Business Office Manager (BOM). The BOM stated she had not given resident #41 a non-coverage Medicare letter, with the right to appeal, prior to his discharge because she had been told she did not need to if the resident was going home on skilled services. She indicated resident #41's Medicare benefits ended on 1/18/2016 and because they ended, he was continuing his care at home. On 3/24/2016 at 12:15 PM, an interview was conducted with the Administrator, who stated the non-coverage letters should be sent out 2 days prior to coverage ending, so the resident has the right to appeal. #2. Resident #67 was admitted to the facility on 10/1/2015 and was discharged to home on 10/21/2015. On 3/24/2016 at 12:07 PM, an interview was conducted with the Business Office Manager (BOM). The BOM stated she had not given resident #67 a non-coverage Medicare letter, with the right to appeal, prior to his discharge because she had been told she did not need to if the resident was going home on skilled services. She	F 156	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected Residents #41, #67 and #68 have been discharged. Corrective Action for Resident Potentially Affected All residents with Medicare A skilled services that are being terminated from Medicare A coverage have the potential to be affected by this alleged deficient practice. Residents were reviewed by Administrator on 4/13/16 to ensure that Medicare Non-Coverage letters were sent 2 days prior to services being terminated since 3/24/16. 2 residents were discharged and noncovered Medicare A letters were provided. Systemic Changes An in-service was conducted on 3/31/16	

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F 156	Continued From page 3 indicated his Medicare benefits ended on 10/20/2016 and because they ended, he was continuing his care at home. On 3/24/2016 at 12:15 PM, an interview was conducted with the Administrator, who stated the non-coverage letters should be sent out 2 days prior to coverage ending, so the resident has the right to appeal. #3. Resident #68 was admitted to the facility on 2/2/2015 and was discharged on 2/19/2016. On 3/24/2016 at 12:07 PM, an interview was conducted with the Business Office Manager (BOM). The BOM stated she had not given resident #68 a non-coverage Medicare letter, with the right to appeal, prior to her discharge because she had been told she did not need to if the resident was going home on skilled services. She indicated resident # 68's Medicare benefits ended on 2/18/2016 and because they ended, she was continuing her care at home. On 3/24/2016 at 12:15 PM, an interview was conducted with the Administrator, who stated the non-coverage letters should be sent out 2 days prior to coverage ending, so the resident has the right to appeal.	F 156	by Business Office Consultant for the Business Office Manager. The in-service topics included: Discussed clarification of issuing noncovered letters for Medicare residents that are returning home from a Medicare A stay. When residents make a request to discharge and we would have continued to skill them of we stayed, a noncovered letter is not required. Anytime a cecision is made to no longer supply Medicare A benefits, either from reaching goals or not progressing with therapy or resolution of a skilled need, it is considered as no longer neeting criteria. Even if a resident decides at that point to leave the facility, a noncovered letter would be required. Continued services at home is not a determining factor for issuing a noncovered letter. Quality Assurance The Administrator will monitor this issue using the "Survey QA Tool for Issuing Medicare A Non-Coverage Letters ". The monitoring will include verifying that a Non-Coverage Letter was issued at least 2 days before termination of Medicare A skilled services. All residents with Medicare A termination of skilled services will be reviewed. This will be done weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and	

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F 156	Continued From page 4	F 156	Department Heads. Date of Compliance: April 20, 2016	
F 278 SS=E	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, interviews with residents	F 278	The statements made on this plan of	4/20/16

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F 278	Continued From page 5 and staff and review of records, the facility failed to accurately code the Minimum Data Set (MDS) for 3 of 15 sampled residents (Residents #25, #58 and #78 whose MDS was reviewed. Findings included: 1. Resident #58 was admitted on 2/10/16 with diagnoses that included a non-displaced fracture of the lateral malleolus. The 2/17/16 Admission MDS indicated Resident #58 was cognitively intact and required extensive assistance with most activities of daily living. Active diagnoses included a fracture. Resident #58 was coded as having no decreased range of motion in her lower extremities that included her ankle and foot. During an interview with the Physical Therapist on 3/23/16 at 4:06 PM, she stated the resident's fractured ankle prevented her from having full range of motion. The MDS nurse was interviewed on 3/23/16 at 3:20 PM. The MDS nurse acknowledged the resident had a fractured ankle. She then reviewed the resident's MDS and stated based on the definition in the Resident Assessment Instrument manual she had incorrectly coded Resident #58's range of motion. 2. A. Resident # 78 was re-admitted on 2/15/16 with diagnoses that included diabetes and hypertension. The 2/15/16 Admission MDS indicated Resident #78 was cognitively intact. He was coded on the MDS to reflect no dental problems. An observation and interview was held with Resident #78 on 3/23/16 at 12:05 PM. The resident was observed with no teeth on the top. On the bottom gum line, tooth fragments, some even with the gum line, black and white in color were observed. He stated his teeth had been in poor condition for some time.	F 278	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Residents Affected Resident #58□s MDS was modified on 3/23/16 to reflect that the Range Of Motion (ROM) is correctly reflective of the resident on the MDS. Resident #78□s MDS was modified to reflect that the resident A) had a dental condition of tooth fragments on 4/15/16 B) did not have delusions and was modified on 4/14/16 Resident #25□s MDS was modified on 4/16/16 to reflect no natural teeth or tooth fragments. Corrective Action for Resident Potentially Affected All residents without teeth or tooth fragments have the potential to be affected. Current resident□s dental status was reviewed by the MDS Nurse visually and manually inspecting by 4/13/16 to ensure that the dental section was coded correctly for the MDS done in the last 3 months for those residents. No other residents were identified as being	

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F 278	Continued From page 6 Nurse #3, Resident #78's primary day shift nurse was interviewed on 3/23/16 at 12:08 PM. She stated Resident #78 had no top teeth and only a few remaining teeth on the bottom. During an interview with the MDS nurse on 3/23/16 at 3:30 PM, she stated she obtained information for coding the MDS from assessments, progress notes, interviews and observations with the residents. After reviewing the coded MDS for 2/15/16, the MDS nurse made an observation of Resident #78 and stated he had no teeth on the top and broken fragments on the bottom. The MDS nurse stated based on her observation, the data entered on the resident's MDS was inaccurate. B. The 2/15/16 Admission MDS for Resident #78 coded him as cognitively intact and coded him as having delusions. The MDS nurse was interviewed on 3/23/16 at 3:30 PM. She stated she was unaware of any delusions for Resident #78, but added the behavior section of the MDS was coded by the Social Worker (SW). During an interview with the SW on 3/23/16 at 3:50 PM, she reviewed the entry for delusions for Resident #78 and acknowledged she had incorrectly coded his behaviors. The SW stated Resident #78 had no delusions.	F 278	coded incorrectly on their last MDS in the dental section. All residents with delusions coded on the MDS have the potential to be affected. Current residents coded for delusions/behaviors were reviewed by Social Services to ensure that the section E of the MDS was coded correctly for the MDS done in the last 3 months. 15 residents were identified as being coded incorrectly and their last MDS assessment was modified by 4/14/16 to correct the section E for delusions. All residents have the potential to be affected by incorrect ROM coding. Current residents ROM was reviewed by the MDS Nurse visually and manually inspecting by 4/14/16 to ensure that the ROM section was coded correctly for the MDS done in the last 3 months. 5 residents were identified as being coded incorrectly and their last MDS assessment was modified by 4/15/16 to correct the section. Systemic Changes An in-service was conducted on 3/29/16 by the MDS Consultant for the DON, MDS Nurse, and the Social Services. The in-service topics included Review of the RAI manual for the correct coding of Range of Motion of Upper and Lower extremities. It was also reviewed in the RAI manual for the correct coding of Section L and importance of coding the mouth and dental observations correctly. Also included was the Review of the RAI manual for the correct coding of Section E and importance of coding delusions correctly.	

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F 278	Continued From page 7 3. Resident #25 was readmitted 5/28/15 with cumulative diagnoses which included anemia, coronary artery disease, hypertension, gastroesophageal reflux disease, diabetes mellitus, dementia and seizures. On her most recent annual Minimum Data Set (MDS) of 3/2/16 she was coded as severely cognitively impaired with no behaviors noted. Her dental assessment was coded as having no missing teeth or tooth fragments. Resident #25 was observed 3/24/16 at 8:00 AM with her breakfast tray. There was chopped meat on the plate and the resident was rolling a piece of meat around in her mouth. No teeth were visible. An interview with Nursing Assistant (NA) #5 was conducted on 3/24/16 at 8:18 AM. She stated she was responsible for oral care of Resident #25 and would swab her mouth with a wash cloth and allow the resident to rinse. She stated Resident #25 does not wear dentures and had no natural teeth. An interview was conducted with NA #6 on 3/24/16 at 8:30 AM. She revealed Resident #25 had no natural teeth and used to wear dentures but when she started losing weight, they didn ' t fit well and her son had taken them home. An interview on 3/24/16 at 8:45 with the MDS Nurse revealed she was aware the resident had no natural teeth and interpreted the question in the Dental section of the MDS to mean if the resident had no teeth, she was to answer no. She stated she would review the Resident Assessment Instrument (RAI) manual to clarify. The corporate MDS consultant was interviewed at the same time and stated it was her understanding that if the resident did not have any teeth but was not experiencing any dental	F 278	Also reviewed that in PCC instructions for coding sections of the MDS are in the tools for each section to reference for coding. A second inservice was done on delusions with Social Services on 4/14/16 by the MDS Consultant. Quality Assurance The Director of Nursing or Support Nurse will monitor this issue using the "Survey QA Tool for Coding of Range of Motion, Delusions and Dental Conditions". The monitoring will include verifying that any assessment done for residents that delusions were coded correctly, that an oral visual inspection is done and coded correctly for each comprehensive assessment and that all residents Range of Motion is coded correctly for Upper and Lower Extremities. This will be done weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. Completion Date: April 20, 2016	

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F 278	Continued From page 8 problems, the question of no natural teeth or dental fragments should be answered with a no. She reviewed the RAI manual and stated it should be coded with a yes. In an interview on 3/24/16 at 11:02 AM with the Interim Director of Nursing, she indicated it was her expectation that the MDS be coded correctly for all residents.	F 278		
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 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: Resident #58 was admitted to the facility on 2/10/16 with diagnoses that included diabetes, hypertension, gastroesophageal reflux and	F 279	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	4/20/16

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F 279	Continued From page 9 depression. Her weight recorded on 2/11/16 was 180.8 pounds. The 2/17/16 Admission Minimum Data Set (MDS) indicated Resident #58 was cognitively intact. The resident required supervision with eating. The 2/24/16 nutritional assessment indicated Resident #58 was on a low concentrated sweet, cardiac, regular diet with thin liquids. The resident's weight was recorded as 172.5 pounds. No significant weight change was noted. The RD recommendations included encouraging meal intake. A 3/9/16 weight recorded for Resident #58 was 169.7 pounds. On 3/16/16 the physician ordered a diabetic bedtime snack. Review of the 3/22/16 care plan for Resident #58 identified the resident had a nutritional problem or a potential problem related to receiving a therapeutic diet. There was no care plan, with goals and interventions that addressed an actual significant weight loss. During an interview with the Dietary Manager (DM) on 3/24/16 at 8:36 AM, she stated she and the care plan team were responsible for care planning significant or desired weight loss. There was no reason why the resident ' s actual significant weight loss was not care planned. The facility's MDS nurse and the corporate MDS consultant were interviewed on 3/24/16 at 9:14 AM. The MDS consultant and the MDS nurse stated it was the responsibility of the MDS nurse and the DM to make sure significant weight loss was addressed on the care plan. On review of the care plan, they acknowledged Resident #58's significant weight loss had not been care planned.	F 279	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected Resident #58□s care plan for significant weight loss was updated on 3/24/16. Corrective Action for Resident Potentially Affected All residents with significant weight loss have the potential to be affected by this alleged deficient practice. Residents were reviewed by the dietician on 4/6/16 to ensure that all residents with significant weight loss was reflected in their care plan. 2 residents were found without a care plan update for significant weight loss and these care plans were corrected by 4/15/16. Systemic Changes An in-service was conducted on 3/29/16 by MDS Nurse Consultant. Those who attended were the Interdisciplinary Team including the Dietary Manager, Director of Nursing and MDS. The in-service topics included Identifying Significant Weight Loss, care planning significant weight loss so all staff can be aware of the weight loss and interventions to prevent further weight loss. All weight loss trigger alerts	

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F 279	Continued From page 10	F 279	in the Point Click Care Dashboard and the team will review these in the weekly weight meeting. There is also Monthly weight meeting to provide another opportunity for identifying significant weight loss. 5% weight change in 30 days, 7.5% weight change in 90 days and 10% in 180 days is considered significant weight loss. Quality Assurance The Director of Nursing or MDS will monitor this issue using the "Survey QA Tool for Care planning for Significant Weight Loss". The monitoring will include verifying that anyone with significant weight loss is documented as significant weight loss in their care plan. All residents who trigger for significant weight loss will be reviewed. This will be done weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. Date of Compliance: April 20, 2016	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		4/20/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident and family member interviews and record review, the facility failed to utilize the shoulder harness and lap belt to properly secure the resident into the wheelchair for 1 of 1 alert and oriented resident (Resident # 20) using the facility's transportation van which could have resulted in a high likelihood of serious bodily injury. Immediate Jeopardy began on 3/11/16 when Resident #20 was transported in the facility's transportation van without the use of a lap belt or shoulder strap to secure her in her wheelchair. The facility's Administrator was notified of the Immediate Jeopardy on 3/22/16 at 3:50 PM. The Immediate Jeopardy was abated on 3/23/16 at 3:15 PM when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure implementation of the change in process in providing transportation for appointments. Findings included: A Resident Securement User Instruction sheet with a revision in October 2010, sent to the facility by the corporate trainer on 3/22/16, after Immediate Jeopardy was called, indicated in part under Paragraph B, titled " Secure Passenger ", 1. Attach Lap Belts- to use the integrated	F 323	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected All company van transportations by any facility employee were suspended by the administrator on 3/19/2016 until another van driver can be hired and trained. Commercial transportation companies will be used to scheduled necessary transports for the facility. After review of the incident, it was decided that the employee would be removed from transportation duties permanently. A 24 hour report and 5 day report was submitted for neglect was submitted and was found substantiated and employee was terminated on 3/24/16. Corrective Action for Resident Potentially	

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F 323	Continued From page 12 stiffeners to feed belts through the openings between seat backs and bottoms, and/or armrests to ensure proper belt fit around occupant. Point a. On the aisle side, attach belt with female buckle to rear tie down pin connector; ensuring buckle rests on passenger's hip. Point b. Attach Shoulder Strap- Extend shoulder belt over passenger's shoulder and across upper torso and fasten pin connector onto lap belt. Note: Combination lap/shoulder belts serve as both window-side lap belt and shoulder belt. 3. Ensure belts are adjusted as firmly as possible, but consistent with user comfort. Resident #20 was admitted on 2/8/16 with diagnoses that included surgical aftercare, contusion of right lower leg, history of falling, dependence on supplemental oxygen due to respiratory issues, narcolepsy and anxiety. The 2/15/16 Admission Minimum Data Set (MDS) indicated Resident #20 was cognitively intact. The MDS also identified the resident required extensive assistance for bed mobility, transfer, walking in her room, toilet use and personal hygiene. She was coded as not steady and only able to stabilize with staff assistance when moving from a seated to a standing position, walking, turning around and facing the opposite direction while walking and surface to surface transfer. The MDS also indicted the resident required the use of a walker or wheelchair for mobility. Resident #20 was interviewed on 3/18/2016 at 1:00 PM. Resident #20 stated she was transported to the hospital in the facility van. She stated that she was transported with her wheelchair secured to the van but a seat belt was not put around her waist or upper torso to secure her to the wheel chair. Resident #20 stated that she was told by the van driver the seatbelt was	F 323	Affected All residents who have been transported by employee # 1 in the company van have the potential to be affected by this alleged practice. On 3/22/16 the Director of Nursing, Administrator, Social Services and Support Nurse interviewed alert and oriented patients who had been transported by employee # 1 from 2/2/16 to 3/22/16. 12 patients were transported. 4 residents were not able to be interviewed. 2 stated that they were not sure if the seatbelt was utilized. 5 stated they did not remember a seatbelt being used during transport 1 stated it was not used. Systemic Changes A new transportation aide will be hired and trained by the corporate van trainer prior to any patient being transported using the only facility owned van. This new employee and any other facility staff that may transport patients in the van will be trained. No employee who has not been trained by the corporate van trainer will be allowed to transport until this training (including the completion of a skills checklist) is complete. The van training will include proper securing of a wheelchair in the facility van and the utilization of seatbelts for all transports according to the manufacturer□s guidelines. If securing belts, hooks or seat belts are in disrepair the transportation will be rescheduled and the van will not be utilized until repairs can be made. The transportation checklist will also be utilized to remind staff to properly	

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F 323	Continued From page 13 broken. NA #3 was interviewed on 3/18/2016 at 2:15 PM. She stated that she did transport Resident #20 to the hospital and then back to the facility without the seat belt around her waist or her upper torso. She stated that she was already running late and she had to get the resident to the hospital for a scheduled surgery. She stated, " I understand that is not a good reason and I realize the seat belt should always be on. " The transport aide #3 stated that the seat belt was not broken and she would from now on transport all residents in the transport chair because it has a seat belt attached. Resident #20 was interviewed on 3/22/16 at 9:50 AM. She stated she had been transported by the facility's van twice in the last month; once for a physician's appointment and once to the hospital for a procedure. On both trips, the resident stated NA #3, the van driver, had secured her wheelchair to the floor of the van, but did not apply a seat belt across her upper torso and waist to secure her into the wheelchair. Resident #20 stated she was alarmed there was no seat belt and asked NA #3 why she had not placed a seat belt, adding NA #3 told her the van seat belt was broken. Per the facility's transportation log, the resident was transported to a physician's appointment on 3/3/16 and to the hospital for a procedure on 3/11/16. The Maintenance Supervisor (MS) was interviewed on 3/22/16 at 10:24 AM. The MS stated it was his responsibility to maintain service of the van. He added if there were any problems, these problems were communicated to him by NA #3, who drove the van. The MS added he had received no reports of the seat belts not working properly on the van. He added he completed a weekly safety check list in which the	F 323	secure the wheelchair and to use a seat belt. A van inspection will also be conducted by the corporate van trainer prior to any patient transport to ensure that all latches, hooks and belts are in proper working order. Investigations of all incidents involving transportation by the facility van will be completed by the Administrator and Director of Nursing as soon as the allegation or issue is identified. The investigation will include interviewing the resident involved, employee involved, other possible witnesses, and other potentially affected patients. During the investigation the employee will be notified promptly that they are suspended until the investigation is completed. Disciplinary actions will remain at the discretion of the administrator and will be dependent on the nature of the allegation and investigation findings. However, if the allegations are substantiated a 3 working day suspension will be implemented. Quality Assurance The Administrator or Director of Nursing will monitor this issue using the "Survey QA Tool for Safety for Resident while Transporting in Facility Van". The monitoring will include verifying by observation of at least two residents being secured and that seatbelts are being used ensuring that the resident and the chair are secured to the vehicle. The administrator will also interview two alert and oriented patients asking if the seat belt and securing straps were utilized. If	

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F 323	Continued From page 14 seat belts were checked for any problems. The MS added while checking the seat belts was part of the weekly check, no other staff person had specifically asked him to check the seatbelts related to any malfunction. Resident #20's family member was interviewed by phone on 3/22/16 at 10:57 AM. He stated while he did not observe how Resident #20 was transported to the hospital on 3/11/16, he was there when the driver, identified as NA #3, placed her in the van for the trip back to the facility. The family member stated the 4 harnesses were placed on the wheelchair to secure the wheelchair to the van floor, but NA #3 had not placed the seat belt around Resident #20's waist or upper torso. When NA #3 had been asked why she was not using the seat belt, the family member replied the NA told him the seat belt was broken and had been broken for a while. The family member was concerned if there had been a wreck, Resident #20 would have become a projectile, adding not using the seat belt was a very unsafe practice. The family member stated while he had no previous observations, his mother had relayed to him she had been transported before without NA #3 using the seatbelt. NA #3 was interviewed on 3/22/16 at 11:09 AM. She stated the last day she drove the van was on 3/18/16 and added she had been relieved of her duties as facility van driver because she had not secured Resident #20 into the van using a seat belt. She stated on 3/11/16, Resident #20 had a 6:30 AM hospital appointment. When she arrived at the facility at 6:15 AM, Resident #20 was not up or dressed. She stated after helping the resident to dress, they were running behind for the 6:30 AM appointment and she did not have time to place the seat belt. NA #3	F 323	errors are identified the employee will be suspended pending an investigation of the allegations. This will be done weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. Date of Compliance: April 20, 2016	

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acknowledged she had not placed the seat belt around Resident #20 for the return trip to the facility adding she had no excuse for not placing the seat belt on the return trip. She denied she had transported residents before 3/11/16 without a seat belt. NA #3 stated she had received training prior to driving the van from the previous van driver and the previous facility administrator. She added while both of these people had trained her to use the straps to secure the wheelchair to the floor of the van, they had not taught her how to use the seat belts. NA #3 stated another person had also trained her and made sure she could use both the straps to secure the wheelchair to the van floor and the seat belts correctly. NA #3 stated prior to transport she was not informed of any resident's diagnoses that would make them a higher fall risk. She stated she knew Resident #20 had a diagnosis of narcolepsy that would make her fall asleep quickly and added if she had fallen to sleep while not secured in her wheelchair with the seat belt, she could have fallen out of the wheelchair. She added she knew if there had been a wreck, Resident #20 could have been seriously injured without being secured with seatbelts. NA #3 added she knew seatbelts were legally required and stated she had no good excuse for not using the seatbelts. NA #3 stated when Resident #20 and the family member inquired about why the seat belt was not being used, she had not offered to hook the seatbelt and only pointed to the box where the seat belts were stored. She denied telling the resident and family member the seatbelt was broken.

At 11:28 AM on 3/22/16 an observation was made of NA #3 hooking a wheelchair to the van with a surveyor seated in the wheelchair. The wheelchair was secured to the van floor using a 4

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point strap restraint. She then took the part of the seatbelt, that was hanging from the left side of the van from near the ceiling that extended across the resident's lap, placing the upper torso strap under the arm of the chair so that both parts extended across the surveyor's lap. Both of the straps were twisted several times. The NA picked up another part of the seatbelt out of a box on the right floor of the van and hooked the hanging part that went across the resident's lap to the part taken from the box. The NA found it difficult to find the right slot in the floor into which to put the end of the seatbelt and acknowledged that was one reason why she had not used the seatbelt. The NA stated she was unsure if she had the right size part taken from the box and added she was unsure what the pieces in the box were used for. She stated since training back last June, no one had observed her securing a resident prior to transport. The NA added even during training, she had restrained her instructor and no one had ever observed her securing a resident in the van for transport. After the NA had completed securing the surveyor in the chair, the surveyor was able to slide down with the seatbelt ending up at mid abdominal area. The surveyor was able to almost able to stand up with the seat belt fastened.

The Administrator was interviewed on 3/22/16 at 12:34 PM. The Administrator stated she first became aware NA #3 was transporting residents without a seatbelt when the surveyor brought it to her attention on Friday, 3/18/16. She stated Resident #20, her family members or staff had not mentioned their concern about the lack of using a seatbelt to her before. On finding out NA #3 had not used the seatbelt during Resident #20's transport, the Administrator stated she immediately suspended the NA from transporting

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residents, filed a 24 hour report alleging resident neglect which had been faxed on 3/19/16 at 3:59 AM. Arrangements were made to use outside services for resident transportation. The Administrator stated she was unsure if other staff were qualified to use the van, but the van was parked and not being used. The Administrator stated she had expected NA #3 to have used the seatbelt since lack of a seatbelt could have caused endless dangers including resident injury.
The Business Office Manager (BOM) was interviewed on 3/22/16 at 12:51 PM. She reported there was no operator's manual for the lift, securing a wheelchair to the van floor or the use of the seatbelts in the van since the facility utilizes several different vans and several different lift systems. The BOM added the corporate trainer had received his training directly from the manufacturer and came to the facility to provide 1:1 training. She added if there was an issue and the van driver needed information on how to hook up something, the expectation was to call the corporate trainer.
The Director of Nursing (DON) was interviewed on 3/22/16 at 1:00 PM. She stated she first became aware NA #3 had been transporting residents without using a seatbelt on Friday, 3/18/16, when the surveyor and she spoke with NA #3. The NA admitted she had not used a seatbelt while transporting the resident for her 3/11/16 appointment. After the conversation, NA#3 went home and then the DON stated she called the NA back as part of the 24 hour investigation. The NA acknowledged she was in a rush, and had not wanted to be late to Resident #20's appointment and therefore she failed to use the seatbelt on Resident #20. For the trip back, there was no reason given by the NA for not using the seatbelt. Later that night, a 24 hour report

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was faxed and the NA was suspended for 3 days while a discussion was with the Corporate Risk Management and a nurse consultant to determine if NA #3 would be allowed back. The DON stated she had called NA #3 on Saturday night to tell her of her suspension, but since the NA had not called back, she was notified of the suspension on Sunday morning at 7:00 AM when she arrived for work. An administrative decision was made not to transport residents using the facility van and an outside transportation company would be used until someone could be hired and trained. The DON stated she was still investigating the concern of not using seat belts and had not talked to other alert and oriented residents the NA may have transported to see if NA #3 had used a seat belt while transporting other residents. The DON stated it would have been important to validate the NA's story that she had failed to use the seatbelt on other residents, but she had not done so because she had worked the 11 to 7 shift on Saturday night and failed to ask for assistance with the interviews. She stated she had accepted what the NA had told her about always using the seatbelt on all residents except Resident #20. She stated no one from the facility had interviewed Resident #20; adding the facility staff had heard from the surveyor on 3/18/16 that Resident #20 stated the seatbelt was broken.

The Administrator and the DON were notified of the Immediate Jeopardy on 3/22/16 at 3:50 PM.

On 3/23/16 at 3:15 PM, the facility provided the following credible allegation:

Corrective Action for Affected Residents

The nursing home investigated allegations that the facility van seatbelt was broken starting on 3/18/16 and ending 3/23/16. NA #3 was interviewed by the state surveyor and the Director

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of Nursing on 3/18/16 and confirmed that the seatbelt was not broken but that she did not utilize the seatbelt in the company van when transporting Resident #20. Resident #20 did not receive any physical injuries related to the event. On 3/18/16 the administrator observed the seat belt was in good repair and not broken. On 3/19/16 a 24 hour report of neglect was submitted by the Director of Nursing to the Healthcare Personnel Registry. A phone call was made on 3/19/16 to Employee #3 informing her that she needed to contact the Director of Nursing prior to returning to work. All company van transportations by any employee were suspended by the administrator on 3/19/2016 until another van driver can be hired and trained. Commercial transportation companies will be used to scheduled necessary transports for the facility. After review of the incident, it was decided that the employee would be removed from transportation duties permanently but would be allowed to continue employment as a nursing assistant. She returned to work on 3/22/16 but was dismissed early pending further investigation. Employee #3 was moved to the duties of transportation aide and central supply on 2/12/15. She received training from the corporate van trainer on 4/29/15 according to the sign and dated skilled checklist. Prior to the corporate training she was trained by the previous transportation aide and the administrator. Both had been trained by the corporate van trainer. They did not complete a skills checklist for this training. The corporate van trainer has received training directly from van products. He utilizes the training he received, manufacturer guidelines, and a skills checklist to educate. A skills validation is also completed where the staff member must demonstrate the skills appropriately. The only

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other employee who transports is the Social Worker. She was also trained and has a skills checklist dated 1/26/12 originally but received retraining in using the process outlined above on 4/29/15. She was re-educated by the corporate van trainer on 8/22/15 also. The transportation aides' direct supervisor is the Administrator.

Corrective Action for Potentially Affected Residents
All residents who have been transported by employee #3 in the company van have the potential to be affected by this alleged practice. On 3/22/16 the Director of Nursing, Administrator, Social Services and Support Nurse interviewed alert and oriented patients who had been transported by employee #3 from 2/2/16 to 3/22/16. 12 residents were transported. 4 residents were not able to be interviewed and 2 stated that they were not sure if the seatbelt was utilized. 5 stated they did not remember a seatbelt being used during transport 1 stated the seatbelt was not used.
Systematic Changes
A new transportation aide will be hired and trained by the corporate van trainer prior to any patient being transported using the only facility owned van. This new employee and any other facility staff that may transport patients in the van will be trained. No employee who has not been trained by the corporate van trainer will be allowed to transport until this training (including the completion of a skills checklist) is complete. The van training will include proper securing of a wheelchair in the facility van and the utilization of seatbelts for all transports according to the manufacturer ' s guidelines. If securing belts, hooks or seat belts are in disrepair the transportation will be rescheduled and the van will

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not be utilized until repairs can be made. The transportation checklist will also be utilized to remind staff to properly secure the wheelchair and to use a seat belt. A van inspection will also be conducted by the corporate van trainer prior to any patient transport to ensure that all latches, hooks and belts are in proper working order. Additionally, the skills checklist includes " secure resident for transport with approved system safety device " . This was updated on 3/23/16 to read: " secure resident for transport with approved system safety device which includes: using the seat belt to secure the person and using approved safety straps, belts and hooks to secure the chair."

Investigations of all incidents involving transportation by the facility van will be completed by the Administrator and Director of Nursing as soon as the allegation or issue is identified. The investigation will include interviewing the resident involved, employee involved, other possible witnesses, and other potentially affected patients. During the investigation the employee will be notified promptly that they are suspended until the investigation is completed. Disciplinary actions will remain at the discretion of the administrator and will be dependent on the nature of the allegation and investigation findings. However, if the allegations are substantiated a 3 working day suspension will be implemented.

The Credible Allegation was validated on 3/23/16 at 3:15 PM when the Administrator and the Director of Nursing validated they had been made aware the facility van was no longer to be used for resident transport. During an interview with Nurse #3, she validated all staff had been made aware the facility van would not be used for resident transportation and the facility would be using an outside transport agency when residents

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F 323	Continued From page 22 were scheduled for appointments.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews, the facility failed to place interventions to halt weight loss for 1 of 4 sampled residents (Resident #58) reviewed for weight loss. Findings included: Resident #58 was admitted to the facility on 2/10/16 with diagnoses that included history of a fracture, diabetes, chronic obstructive pulmonary disease, hypertension, gastroespohageal reflux disease and depression. The Nursing Admission Review, dated 2/10/16, identified Resident #58 had dentures and had no edema. The 2/10/16 Nutritional Risk Assessment indicated Resident #58 was independent with fluid intake, ate adequately, had no weight loss and had no risk factor for dehydration. Resident #58 ' s weight was recorded in the	F 325	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected Resident #58 interventions for significate weight loss were added on 3/24/16. Corrective Action for Resident Potentially	4/20/16

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F 325	Continued From page 23 electronic medical record on 2/11/16 as 180.8 pounds using a mechanical lift to weigh her. On 2/12/16, the resident was again weighed, using the mechanical lift with a result of 177 pounds. Review of physician ' s orders for 2/13/16 indicated Resident #58 was on a cardiac diet, regular texture with thin consistency liquids. The 2/17/16 Admission Minimum Data Set (MDS) indicated Resident #58 was cognitively intact with no rejection of care. She required supervision with eating. On 2/24/16, the nutritional assessment indicated Resident #58 received a low concentrated sweet, cardiac, regular diet with thin liquid. The Registered Dietician (RD) recorded Resident #58 ' s weight as 172.5 pounds. The RD documented the resident was on a therapeutic diet, had fair intake and recommended she be encouraged during meals to increase her intake. On 2/25/16, Resident #58 ' s weight was recorded as 171.4 pounds, using the mechanical lift. This weight reflected a 9.4 pound weight loss in 14 days. Review of the electronic medical record revealed no dietary reviews and review of the progress notes revealed no dietary progress notes had been written documenting review of Resident #58 ' s nutritional status. Review of the weight log for Resident #58, dated 3/9/16, while she was standing, indicated she weighed 169.7 pounds. On 3/16/16, the resident ' s weight was recorded as 166 pounds which equaled a total weight loss of 14.8 pounds in 34 days which exceeded 5% of her admission weight of 180.8 pounds. The physician ordered a diabetic bedtime snack. Review of the care plan, with a revision date of 3/22/16, indicated the resident had a nutritional	F 325	Affected All residents with significant weight loss have the potential to be affected by this alleged deficient practice. Residents were reviewed by the dietician on 4/6/16 to ensure that interventions were present for those residents with significant weight loss. All interventions will be updated by 4/20/16. Systemic Changes An in-service was conducted on 3/29/16 by MDS Nurse Consultant. Those who attended were the Dietary Manager, Director of Nursing and MDS. The in-service topics included Identifying Significant Weight Loss, documenting significant weight loss interventions so all staff can be aware of the weight loss. All significant weight loss triggers alerts in the Point Click Care Dashboard and the team will review these in the weekly weight meeting. There is also Monthly weight meeting to provide another opportunity for identifying significant weight loss. 5% weight change in 30 days, 7.5% weight change in 90 days and 10% in 180 days is considered significant weight loss. Quality Assurance The Director of Nursing or MDS will monitor this issue using the "Survey QA Tool for Interventions for Significant Weight Loss". The monitoring will include verifying that anyone with significant weight loss has interventions documented in the care plan or physician orders. All residents who trigger for significant weight loss will be reviewed. This will be done	

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F 325	Continued From page 24 problem or a potential problem related to receiving a therapeutic diet. Interventions used to maintain adequate nutrition as evidenced by a stable weight, no signs and symptoms of malnutrition and consuming at least 50% of at her meals daily for 90 days included: · Monitor/report to the physician as needed signs and symptoms of malnutrition including significant weight loss of 3 pounds in one week, greater than 5% in 1 month, greater than 7.5% in 3 months or greater than 10% in 6 months. · RD to evaluate and make diet change recommendations as needed. Resident #58 was interviewed at 11:30 AM on 3/23/16. She stated staff weighed her on a weekly basis and she was aware she had lost weight. The resident added she was fine with the weight loss, but the RD or the DM had not been in to discuss her weight loss or any interventions to prevent her weight loss. During an interview with the DM on 3/24/16 at 8:36 AM, she defined significant weight loss as a loss of 5% in 30 days, 7.5% in 3 months and 10% in 180 days. The DM added the RD was in the building twice monthly and during those visits reviewed residents who were new admissions, had pressure ulcers, those resident that received tube feedings or residents with weight loss or weight gain. The DM confirmed the RD ' s last visit to the facility was on 3/21/16. The DM stated any resident with a significant weight loss was reported to the RD for review. Additionally, it was her responsibility to alert the resident, the responsible party (RP) and the physician. The DM stated if significant weight loss was identified, supplements were started. All documentation of notification, interventions started and conversations with residents and RPs could be found in the dietary reviews or the dietary	F 325	weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. Completion date: April 20, 2016	

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progress notes. The DM stated she thought the resident ' s weight loss was due to edema that had been present on admission. She reviewed the dietary reviews and the dietary progress notes and confirmed she had no documentation regarding identification, notification of interested parties or interventions placed for Resident #58 ' s significant weight loss; adding she had no idea why there was no documentation.
The MDS nurse and the MDS consultant were interviewed on 3/24/16 at 9:14 AM. The MDS nurses stated nutritional and weight loss meetings were held weekly. Attendees included the MDS nurse and the DM. The MDS nurse produced the notes for the weekly nutritional meetings and review of those notes indicated the resident had been discussed on admission. Notes to the side of the resident ' s name indicated she had been identified with poor intake and the RD would review Resident #58 ' s nutritional needs. Review of the notes for Resident #58 on 3/2/16 indicated a diabetic snack had been added at bedtime. On 3/9/16 and 3/16/16, the action taken by the committee was to review the resident ' s food preferences. At 9:35 AM, the DM reported she had been unable to locate the food preference review that had been recommended by the weight loss team on 3/9/16 and 3/16/16.
On 3/24/16 at 10:00 AM, the RD was interviewed via phone. She acknowledged she was in the facility 1 to 2 times per month. On her visits, the DM has a referral list for her to review. The RD stated she would have expected to review any resident that had continued or significant weight loss so interventions could be initiated. The RD stated she had last been in the facility on 3/21/16 and confirmed Resident #58 had not been reviewed. The RD added the DM had not

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informed her of the resident ' s significant weight loss and she had been unaware.
Nurse #4 was interviewed on 3/24/16 at 10:30 AM. She confirmed she was the primary day shift nurse for Resident #58. The nurse stated Resident #58 looked as if she had lost weight since admission, but no one from the dietary department had confirmed the weight loss or relayed interventions to halt the weight loss.
During a 3/24/16 at 10:35 AM, with Resident #58 ' s RP, he stated having known the resident for such a long time, he could tell she had lost weight, but dietary staff had not discussed the weight loss with him.
At 10:50 AM on 3/24/16, the MDS consultant confirmed the resident ' s food preferences had been reviewed on admission, but the DM had not completed a review of the resident ' s food preferences as recommended by the weight loss committee on 3/9/16 and 3/16/16. The consultant added on admission, Resident #58 had been confused and may not have remembered speaking with the DM.
Nursing Assistant (NA) #4, who was Resident #58 ' s primary NA on day shift, was interviewed on 3/24/16 at 10:40 AM. The NA stated Resident #58 was alert and oriented. The NA stated the resident ' s appetite on admission was not too good and now it was much better. She stated she was unaware if the resident had weight loss. The NA added at times, the resident refused facility meals, but knew her RP would bring food when he came to visit. The NA reported she had weighed the resident on 3/23/16 and recorded a weight of 169 pounds.
On 3/24/16 at 11:13 AM the DM provided no answer why the likes and dislikes had not been updated or why the RD had not been consulted as indicated on the weekly weight reviews. She

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F 325	Continued From page 27 brought a handwritten piece of paper with the resident ' s name and some likes and dislikes and stated that had been completed on the day of admission. The Director of Nursing was interviewed on 3/23/16 at 10:23 AM. She stated she expected significant weight loss to be communicated to staff in order that the RD could re-evaluate residents and interventions be placed to halt the weight loss. She stated there had been a communication issue related to Resident #58 ' s significant weight loss.	F 325		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431		4/20/16

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F 431	Continued From page 28 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on manufacturer's recommendations, observation and staff interview the facility failed to secure a medication cart before leaving it unattended for 2 of 3 observations of medication administration and failed to date perishable medications when opened. Findings included: 1. Observations were made on 3/18/2016 at 5:00 PM to 5:30 PM of a nurse on the rehabilitation hall performing a medication administration pass. Nurse #2 prepared the medications to be given, entered room 213 and shut the door. Nurse #2 did not lock the medication cart before entering the room. Resident #47 was observed wheeling around the medication cart in a wheel chair in the hallway while Nurse #2 was in the room. Nurse #2 wheeled the medication cart to the doorway of room 207. Nurse #2 prepared medications to be given, and entered room 207 without locking the medication cart. Nurse #2 turned his back to the medication cart, spoke with the resident inside the room and gave her medications while in the room. Resident #47 was observed sitting in her wheelchair next to the	F 431	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected Inserviced Nurse #2 about the importance and safety for the residents to lock the cart anytime it is not in eyesight by turning turning head or stepping away. Resident #88 opened Xalatan eye gtts which were in a clear plastic bag labeled with Resident #88□s name were dated on 3/23/16 for the admission date of 3/18/16. One vial of Tuberculin PPD solution was discarded from the med room refrigerator and a new supply was ordered from the	

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F 431	Continued From page 29 medication cart in the hallway. An interview was conducted with the Interim Director of Nursing and the Administrator on 3/18/2016 at 5:30 PM. They both stated that the nurse should lock the medication cart while in the room administering medications. 2. Resident #88 was admitted 3/18/16 with diagnoses which included glaucoma. A review of her March orders revealed Xalatan Solution 0.005% instill one drop in both eyes at bedtime for glaucoma. The manufacturer ' s recommendations included: " Storage: Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks." Observation of the Rehab (200) hall medication cart on 3/23/16 at 11:45 AM revealed an opened bottle of Xalatan eye drops in a clear plastic bag labeled with Resident #88's name. The manufacturer's label was on the bottle with a label marked " Date opened____ " . There was no date written on that label. Nurse #4 was interviewed on 3/23/16 at 11:50 AM. She stated she did not give the first dose to Resident #88 but she knew she had recently been admitted. She stated the person giving the first dose should have written the date on the label. An interview with the Interim Director of Nursing (DON) was conducted on 3/24/16 at 7:41 AM. She stated it was her expectation that the nurse working on the medication cart should check for properly labeled medications. She further stated that eye drops, Spiriva inhalers and insulins should be dated by the nurse who first used them. 3. Observation of the medication storage room on 3/24/16 at 9:24 AM revealed an open vial of	F 431	pharmacy. Corrective Action for Resident Potentially Affected All residents who have medications with open dates required have the potential to be affected by this alleged deficient practice. All carts were reviewed by DON on 3/18/16, 3/19/16 and 3/21/16 and 3/28/16 to ensure that all meds requiring open dates had open dates on them and that all carts were locked when unattended. Systemic Changes An in-service was conducted on the 3/30/16 by the DON and Interim DON and on 4/12/16 by the Consulting Pharmacist. Those who attended were all RNs, LPNs, and Medication Aides and Med Techs, FT, PT, and PRN. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for temporary assignments. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed after 4/20/16. The in-service topics included a list of medications that needed open dates which included all medication multidose vials and carts must be locked when stepping away from the cart or the cart is out of direct eye sight. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees by way of Power Point for	

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F 431	Continued From page 30 Tubersol 5U/0.1 ml (a solution used to test for Tuberculosis) in the refrigerator. There was no date of opening recorded on the vial. The manufacturer's recommendations included: A vial of TUBERSOL® [Tuberculin Purified Protein Derivative (Mantoux)] which has been entered and in use for 30 days should be discarded because oxidation and degradation may have reduced the potency. Do not use after expiration date. On 3/24/16 at 9:25 AM the Medication Aide/Nursing Assistant #6 stated the vial should be dated when opened and discarded 30 days after that date. A second interview was conducted with the DON on 3/24/16 at 9:30 AM in the mediation storage room. She observed the undated bottle of Tubersol and stated it should be dated when opened. She discarded the undated vial. An interview was conducted with the Administrator on 3/24/16 at 9:41 AM. She stated it was her expectation that staff record the date opened on all medications requiring an opened by date.	F 431	Survey Citations and Corrections for 2016 and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing or Unit Manager will monitor this issue using the "Survey QA Tool for Storage and Labeling Medication". The monitoring will include verifying that all medications that need an open date applied or a vial that must be dated when opened has the open date present. All carts and medication refrigerators will be reviewed also reviewed will be the locking of unattended med carts. This will be done weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. Completion Date: April 20, 2016	
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490		4/20/16

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F 490	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to provide oversight for the transportation coordinator since the April 2015 training and failed to have manufacturer's instructions on site for the use of the resident securement system, including the use of a lap belt and shoulder strap which could have resulted in a high likelihood of serious bodily injury. Findings included: Immediate Jeopardy began on 3/11/16 when Resident #20 was transported on the facility van without the lap belt or the shoulder harness used to secure her in her wheelchair. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy on 3/22/16 at 3:50 PM. During an interview with Resident #20 on 3/18/2016 at 1:00 PM and 3/22/16 at 9:50 AM she stated on her 3/11/16 transport to the hospital, using the facility van, NA #3 failed to use the lap belt and shoulder strap to secure her in her wheelchair. She stated that she was told by the van driver the seatbelt was broken. The Maintenance Supervisor was interviewed on 3/22/16 at 10:24 AM. He stated the prior administrator had taught staff to transport residents safely in the van and had checked off their skills related to the use of the safety equipment. NA #3 was interviewed on 3/22/16 at 11:28 AM. She stated since her training by the corporate representative, she had received no oversight or skills check. The Administrator was interviewed on 3/22/16 at 12:34 PM. She stated staff who transported residents in the van were expected to follow	F 490	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected The nursing home investigated allegations that the facility van seatbelt was broken starting on 3/18/16 and ending 3/23/16. Employee # 1 was interviewed by the state surveyor and the Director of Nursing on 3/18/16 and confirmed that the seatbelt was not broken but that she did not utilize the seatbelt in the company van when transporting Resident # 1. Resident # 1 did not receive any physical injuries related to the event. On 3/18/16 the administrator observed the seat belt was in good repair and not broken. On 3/19/16 a 24 hour report of neglect was submitted by the Director of Nursing to the Healthcare Personnel Registry. A phone call was made on 3/19/16 to Employee #1 informing her that she needed to contact the Director of Nursing prior to returning to work. All company van transportations by any employee were suspended by the administrator on 3/19/2016 until another	

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F 490	Continued From page 32 protocol. She stated she had not observed NA #3 for skills competency in using the van's safety equipment. In review of her records, she could provide no evidence the NA had been observed since her previous training. The Immediate Jeopardy was removed on 3/23/16 at 3:15 PM when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure implementation of the change in process in providing transportation for appointments. Cross reference to F323. The facility policy and procedure for Resident Transportation, revised in June 2009 indicated all drivers would be responsible and held accountable in part to: · Operate motor vehicles in a safe manner at all times · Comply with all applicable state laws and regulations · Require all occupants to use seat belts at all times · Comply with organizational policy on transport of passengers The Transportation Coordinator job description, with a revision in June 2009, indicated the transportation coordinator had to have a wheelchair safety training and a skills checklist completed prior to transporting residents. Additionally, the transportation coordinator must have the ability to plan, organize and follow up on work assignments and must have the ability to make independent decisions and work well under pressure. The Administrator and the DON were notified of	F 490	van driver can be hired and trained. Commercial transportation companies will be used to scheduled necessary transports for the facility. After review of the incident, it was decided that the employee would be removed from transportation duties permanently. A 5 day report was submitted for neglect was submitted and was found substantiated and employee was terminated on 3/24/16. A new transportation aide will be hired and trained by the corporate van trainer prior to any patient being transported using the only facility owned van. Corrective Action for Resident Potentially Affected All residents who have been transported by employee # 1 in the company van have the potential to be affected by this alleged practice. On 3/22/16 the Director of Nursing, Administrator, Social Services and Support Nurse interviewed alert and oriented patients who had been transported by employee # 1 from 2/2/16 to 3/22/16. 12 patients were transported. 4 residents were not able to be interviewed. 2 stated that they were not sure if the seatbelt was utilized. 5 stated they did not remember a seatbelt being used during transport 1 stated it was not used. Systemic Changes On 3/23/16 the Administrator and Director of Nursing was educated by the regional director of operations on the following: A contract van company must be used anytime there is a vacancy in the	

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	345309	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 490	Continued From page 33 the Immediate Jeopardy on 3/22/16 at 3:50 PM. On 3/23/16 at 3:15 PM, the facility provided the following credible allegation: Corrective Action for Affected Residents The nursing home investigated allegations that the facility van seatbelt was broken starting on 3/18/16 and ending 3/23/16. NA #3 was interviewed by the state surveyor and the Director of Nursing on 3/18/16 and confirmed that the seatbelt was not broken but that she did not utilize the seatbelt in the company van when transporting Resident #20. Resident #20 did not receive any physical injuries related to the event. On 3/18/16 the administrator observed the seat belt was in good repair and not broken. On 3/19/16 a 24 hour report of neglect was submitted by the Director of Nursing to the Healthcare Personnel Registry. A phone call was made on 3/19/16 to NA #3 informing her that she needed to contact the Director of Nursing prior to returning to work. All company van transportations by any employee were suspended by the administrator on 3/19/2016 until another van driver can be hired and trained. Commercial transportation companies will be used to scheduled necessary transports for the facility. After review of the incident, it was decided that the employee would be removed from transportation duties permanently but would be allowed to continue employment as a nursing assistant. She returned to work on 3/22/16 but was dismissed early pending further investigation. NA #3 was moved to the duties of transportation aide and central supply on 2/12/15. She received training from the corporate van trainer on 4/29/15 according to the sign and dated skilled checklist. Prior to the corporate training she was trained by the previous transportation aide and the administrator. Both had been trained by the	F 490	transportation aide role unless another employee is available that has received the mandatory corporate van training can provide the transportation. No employee must transport a patient unless they have been trained by the corporate van trainer and a skills checklist is completed. The administrator and Director of Nursing will attend the van training on 4/13-4/16 to ensure proper knowledge of the system in order to verify that it is completed correctly. Investigations of all incidents involving transportation by the facility van will be completed by the Administrator and Director of Nursing as soon as the allegation or issue is identified. The investigation will include interviewing the resident involved, employee involved, other possible witnesses, and other potentially affected patients. During the investigation the employee will be notified promptly that they are suspended until the investigation is completed. Disciplinary actions will remain at the discretion of the administrator and will be dependent on the nature of the allegation and investigation findings. However, if the allegations are substantiated a 3 working day suspension will be implemented. Quality Assurance The Administrator or Director of Nursing will monitor this issue using the Patient Lift Safety Training form to document skills checks on all drivers every quarter. The form should be completed on all employees who transport patients and should be filed with Quality Assurance (QA) Minutes. The Director of Regional Operations (RDO) will audit the skills	

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F 490	Continued From page 34 corporate van trainer. They did not complete a skills checklist for this training. The corporate van trainer has been trained directly from van products. He utilizes the training he received, manufacturer guidelines, and a skills checklist to educate. A skills validation is also completed where the staff member must demonstrate the skills appropriately. The only other employee who transports is the Social Worker. She was also trained and has a skills checklist dated 1/26/12 originally but received retraining in using the process outlined above. She was reeducated by the corporate van trainer on 8/22/15 also. The transportation aides ' direct supervisor is the Administrator. Corrective Action for Potentially Affected Residents All residents who have been transported by NA #3 in the company van have the potential to be affected by this alleged practice. On 3/22/16 the Director of Nursing, Administrator, Social Services and Support Nurse interviewed alert and oriented patients who had been transported by NA #3 from 2/2/16 to 3/22/16. 12 patients were transported. 4 residents were not able to be interviewed. 2 stated that they were not sure if the seatbelt was utilized. 5 stated they did not remember a seatbelt being used during transport 1 stated it was not used. Systematic Changes On 3/23/16 the Administrator and Director of Nursing were educated by the regional director of operations on the following: A contract van company must be used anytime there is a vacancy in the transportation aide role unless another employee is available that has received the mandatory corporate van training can provide the transportation.	F 490	checks done at the facility monthly and file a report to be included in the QA minutes. Reports of quarterly skills checks and RDO monthly audit will be given to the Quarterly Quality of Life- QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. Date of Compliance: April 20, 2016	

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F 490	Continued From page 35	F 490		

No employee must transport a patient unless they have been trained by the corporate van trainer and a skills checklist is completed.
The administrator and Director of Nursing will attend the van training to ensure proper knowledge of the system in order to verify that it is completed correctly.
Investigations of all incidents involving transportation by the facility van will be completed by the Administrator and Director of Nursing as soon as the allegation or issue is identified. The investigation will include interviewing the resident involved, employee involved, other possible witnesses, and other potentially affected patients. During the investigation the employee will be notified promptly that they are suspended until the investigation is completed. Disciplinary actions will remain at the discretion of the administrator and will be dependent on the nature of the allegation and investigation findings. However, if the allegations are substantiated a 3 working day suspension will be implemented.
The Credible Allegation was validated on 3/23/16 at 3:15 PM when the Administrator and the Director of Nursing validated they had been made aware the facility van was no longer to be used for resident transport and that when the van returned to use, they would be expected to complete random audits to assure safety compliance. The Administrator stated the van keys were in her office and the van parked in the parking lot of the facility. During an interview with Nurse #3, she validated all staff had been made aware, by the Administrator and the Director of Nursing that the facility van would not be used for resident transportation and the facility would be using an outside transport agency when residents were scheduled for appointments.