STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345293	A. BUILDING _____ B. WING _____	06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

(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 observation, record review and interviews with staff, the facility failed to accurately code catheter use (section H) on the Minimum Data Set (MDS) for 1 of 1 sampled resident (Resident #105), failed to accurately code bed mobility, toilet use and eating status	F 278	Richmond Pines Healthcare 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	6/30/16

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

Electronically Signed | 06/21/2016

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F 278	Continued From page 1 (section G) for 1 of 4 sample residents (#35) and failed to accurately code restraint use (section P) for 1 of 1 sampled resident (Resident #32). The findings included: 1. Resident #105 was discharged from the area hospital on 5/4/16 with a urinary catheter with an order for the urinary catheter to remain in place until further orders from the physician. She was admitted to the skilled facility on 5/4/16 with cumulative diagnoses of Lupus, Pressure Ulcers and Acute Renal Failure. The admission MDS dated 5/12/16 indicated Resident #105 had moderate cognitive impairment and required total assistance with toileting by two staff. She was coded as being incontinent of bladder and bowel and not coded as having a urinary catheter. On 6/1/16 at 1:00 PM, Resident #105 was sitting up in bed eating her lunch. A urinary catheter was draining urine to a collection bag by gravity secured the bed frame near the upper right side rail. A privacy cover over the urine collection bag was being utilized. Resident #105 stated the urinary catheter was placed while she was in the hospital and the physician was running additional test and the plan was for it to be discontinued as some point and she was to return home to the care of the family. In an another observation on 6/1/16 5:15 PM, the resident care guide for Resident # 105 in her room made no reference of a urinary catheter but fluid restrictions was noted at 800 milliliters every 24 hours. In an interview on 6/2/16 at 10:30 AM, the MDS nurse stated she did not see the urinary catheter when Resident #105 was admitted nor did she	F 278	compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Richmond Pines Healthcare and Rehabilitation Centers 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. Further5, Richmond Pines Healthcare 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 proceedings. What measures did the facility put in place for the resident affected: For resident #105,on 06/02/16 MDS Nurse submitted a corrected MDS to reflect the use of the urinary catheter. A urinary catheter care plan with interventions was implemented and resident care guide was updated to reflect the use of the urinary catheter. For resident #35 MDS was modified on 06/14/16 to reflect the resident as total assist. For resident #32,the Quarterly MDS dated 05/10/16 was modified to identify the use of padded side rails when in bed. What measures were put into place for residents having the potential to be affected:	

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F 278	Continued From page 2 see evidence of the urinary catheter in her admission orders or paperwork. She stated she failed to code the admission MDS accurately but submitted a corrected MDS this morning along with a urinary catheter care plan with interventions. The MDS nurse stated she also updated Resident # 105's resident care guide. In an interview on 6/2/16 at 11:00 AM, the administrator stated it was her expectation the MDS would have accurately coded the admission MDS to reflect Resident #105"s care needs. 2. Resident #35 was admitted to the facility on 4/16/2016 with diagnoses which included Quadriplegia, Congestive Heart Failure, Sepsis and Neuromuscular. The admission MDS (Minimum Data Set) dated 4/30/2016 indicated the resident was extensive assist with toilet use, eating and bed mobility. The most current MDS assessment dated 5/14/2016 indicated the resident was total dependence with toileting, eating and bed mobility. On 6/1/2016 at 10:00 AM, the MDS nurse was interviewed. She acknowledged that the resident's care did not worsened with bed mobility,toilet use and eating between the MDS assessments which was completed on 4/30/2016 and 5/14/2016. She added the resident was admitted as total dependent on staff with bed mobility, toilet use and eating and continued to be total dependent during his stay at the facility . She further added the admission MDS dated 4/30/2016 was inaccurately coded. On 6/2/2016 at 2:00 PM, the Director of	F 278	An audit for residents with catheters,residents requiring total assist and side rails will be completed before 6/30/16 by the Director of Nursing, Quality Assurance Nurse and MDS Nurse to ensure the MDS/Care Plan/Resident Care Guide reflects the needs of the resident. What systems were put into place to prevent the deficient practice from reoccurring: All new admissions will be reviewed by the Interdisciplinary Team within 24 hours of admission to ensure MDS/Care Plan and Resident Care Guide reflects the needs of the resident. Modifications will be completed at this time to ensure accurate MDS. How the facility will monitor systems put in place: The Director of Nursing or the Quality Assurance nurse will report to the Quality Assurance Performance Improvement Committee monthly through next annual survey any discrepancies identified and corrections made.	

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F 278	Continued From page 3	F 278		

Nursing(DON) was interviewed. She acknowledged the admission MDS dated 4/30/2016 was inaccurate. She added her expectation was for MDS nurse to accurately code the MDS information.

3. Resident #32 was admitted to the facility on 09/04/14 with diagnoses that included Restlessness and Agitation, Contracture, Failure to Thrive, Aphasia, Muscle Weakness, Cognitive Communication Deficit, Anxiety Disorder, Anemia, Diabetes Mellitus II, Depression and Hypertension.

Review of the Annual Minimum Data Set (MDS) dated on 08/10/15 indicated that the resident was coded as severely impaired for daily decision making. The resident was coded as bed rails used daily and trunk restraint when out of bed.

Review of the Annual MDS Care Assessment Area (CAA) for restraints dated on 08/10/15 read in part "resident has a seat belt and padded side rails for safety. Resident is coded as using daily bed rails and trunk restraint."

Observation was made on 05/31/16 at 6:30 AM of full padded side rails on the resident's bed.

Review of the Quarterly Minimum Data Set (MDS) dated 05/10/16 revealed that Section P (Restraints) was coded as bed rails not use in bed.

An interview was conducted with the MDS Coordinator on 06/01/16 at 9:20 AM. She stated

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F 278	Continued From page 4 it was her responsibility to complete section P (restraints) of the MDS and it should have been coded as a restraint. The MDS Coordinator further stated that it was an oversight and she will go back and correct the MDS to indicate that the full side rails were in use while the resident is bed. An interview was conducted with the Administrator on 06/02/16 at 5:30 PM. She stated that it is her expectation that the resident's MDS be coded accurately.	F 278		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental	F 285		6/30/16

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F 285	Continued From page 5 retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to renew the expired Preadmission Screening Resident Review (PASRR) for 1 of 1 (Resident #33) sampled resident. The findings included: Resident #33 was admitted to the facility on 5/5/2009 with multiple diagnoses including Hypertension, Hypothyroidism, Osteoporosis, Alzheimers Disease, Depression and Schizophrenia.. A review of the Preadmission Screening Resident Review (PASRR) Level II Determination Notification dated 5/1/2009 was conducted. The PASRR Number was noted to end in the letter B.	F 285	What measures did the facility put in place for the resident affected: A renewal application has been submitted and returned for resident #33. What measure was put into place for residents having the potential to be affected: An audit has been completed to identify those residents whose PASRR□s have to be renewed. Applications have been applied for where needed. What systems were put into place to prevent the deficient practice from reoccurring:	

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F 285	Continued From page 6 The PASRR Expiration Date was 5/1/2010. An interview was conducted with Social worker on 6/2/2016 at 3:00 PM. She stated the application for the renewal of the PASSR level II was late for Resident # 33. She added it was never renewed after 2010. The social worker added in the future the PASSR Level II application for the residents at the facility will be placed in a timely manner to make sure the application was not late. An interview was conducted with Administrator on 6/2/2016 at 4:11 PM. He stated the social worker did not submit a renewal application for PASSR Level II for resident #33 within reasonable time. He also stated his expectation was for the Social worker to submit the renewal application of the PASSR in a timely manner before the expiration date.	F 285	All new admissions will be reviewed by the Interdisciplinary Team within 24 hours of admission to identify those residents needing renewal of their PASRR□s by a certain date. A log for updates will be kept with the Social Worker and reviewed during the daily morning clinical meeting. How the facility will monitor the systems put in place: The Social Worker will be responsible for reporting on the status of the PASRR Log monthly through the next annual survey during our Quality Assurance Performance Improvement meeting.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to provide nail care to 1 of 3 sampled residents reviewed for activities of daily living (Resident #52). The findings included:	F 312	What measures did the facility put in place for the resident affected: On 06/02/16, resident #52 nails were cleaned and trimmed per the Charge Nurse. What measure was put into place for	6/30/16

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F 312	Continued From page 7 Resident # 52 was admitted to the facility on 12/7/2015 with diagnoses including Myocardial Infarction and Transient Cerebral Attack. A quarterly Minimum Data Set (MDS) dated 3/14/2016 revealed Resident # 52 had moderately impaired cognition and was able to make her needs known. The quarterly MDS further revealed Resident # 52 required extensive assistance for personal hygiene and was totally dependent on staff for bathing. Rejection of care was not noted during the assessment period. During an initial observation on 5/31/2016 at 2:28 PM Resident #52 was observed with all his fingernails extending approximately 1/4 of an inch beyond her fingertips. During an interview after this observation the resident stated he would like to have his fingernails trimmed. Subsequent observations on 6/1/2016 at 8:40 AM and 6/1/2016 at 4:37 PM revealed all his finger nails extended approximately 1/4 of an inch beyond her fingertips. An interview was conducted with Nurse Aide (NA) #1 on 6/2/2016 at 11:14 AM. NA #1 stated he typically cleaned and trimmed residents fingernails with their showers. NA #1 further stated he showered Resident # 52 in the morning and noticed his finger nails were long. He added he assumed the nurse was going to take care of the resident ' s finger nails because he was diabetic During an interview on 6/2/2016 at 11: 30 AM, Nurse #1 stated nurses and NAs were responsible for monitoring residents' fingernails and trimming and filing fingernails as necessary. Nurse #1 observed Resident # 52's fingernails at	F 312	residents having the potential to be affected: On 06/07/16 an audit was completed to assist in identifying residents in need of nail care (toes and feet). Those residents identified have been cleaned and trimmed and referred to podiatrist as needed. What systems were put into place to prevent the deficient practice from reoccurring: An in-service for nail care will be provided by the Staff Development Coordinator for all shifts.. An audit on nail care will be completed once weekly by the Director of Nursing, Staff Development Coordinator or RN Supervisor, and care issues given to the Administrator to review and follow-up as needed. Pretty Nails has been added to the activities calendar every other Wednesday beginning 06/29/16 and will include cleaning, trimming and painting as desired. How the facility will monitor the systems put in place: The Director of Nursing or the Staff Development Coordinator will present the audits monthly for the next 6 months to the Quality Assurance Performance Improvement Committee for review to ensure the Pretty Nails program is meeting its goal.	

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F 312	Continued From page 8 that time and agreed they needed to be trimmed. An interview with the Director of Nursing (DON) on 6/2/2016 at 12:05 PM revealed she expected the NAs to monitor residents' fingernails daily during routine care and trim as needed. She also added if a resident was diabetic she expected the NAs to notify the Nurse so they can trim the resident's finger nails.	F 312		
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 observation, record review and staff interviews, the facility failed to provide restorative nursing services for contracture management for 1 of 1 sampled resident reviewed for range of motion (Resident #32). The findings included: Resident #32 was admitted to the facility on 09/04/14 with diagnoses that included Restlessness and Agitation, Contracture, Failure to Thrive, Aphasia, Muscle Weakness, Cognitive Communication Deficit, Anxiety Disorder, Anemia, Diabetes Mellitus II, Depression and Hypertension.	F 318	What measures did the facility put in place for the resident affected: Effective 06/16/16 only one Restorative Aide will be allowed to be pulled to work on the floor as a CNA. If and when only one Restorative Aide is scheduled, the Restorative Aide cannot be pulled to work on the floor as a CNA. What measure was put into place for residents having the potential to be affected: All residents in the Restorative Program have the potential to have been affected. A review of the Restorative Program was	6/30/16

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F 318	Continued From page 9 Review of the Rehab Communication to Nursing (occupation therapy) form dated on 11/10/14 read in part "right functional hand splint x 2 hours a day." No physician's orders could be found regarding the splint. Review of the Quarterly Minimum Data Set (MDS) dated on 05/10/16 indicated that the resident was coded as severely impaired for daily decision making. The resident is coded as being total care for activities of daily (ADL), and coded as being impaired on one side and no behaviors were exhibited. Review of the care plan dated 05/13/16 read in part "Focus: Requires assistance/potential to restore or maintain maximum function of self-sufficiency for mobility characterized by the following functions; positioning, locomotion/ambulation related to: At risk for worsening of present contractures. At risk for development of further contractures. Cognitive impairment, loss of muscle strength & flexibility. Goal: Resident will not acquire further contractures by next review date. AEB (as evidenced by) tolerating hand splint wear daily with no pain or skin issues thru next review. Interventions: Splint/brace: right functional hand splint to be worn 2 hours daily as tolerated for 7 days a week. Ensure hand hygiene is done as needed prior to and after splint wear. (Reapply splints as needed and document non-compliance with wearing). Splint/brace: Monitor skin integrity under applied splint/brace daily. If resident did not participate in splint/brace program, document reason." Review of the restorative nursing documentation	F 318	completed on 6/16/16 by the Director of Nursing, MDS Nurse/Restorative Nurse and Administrator. Prior to 6/30/16 Physician Orders will be clarified for Restorative Nursing for those residents receiving Restorative Nursing. What systems were put into place to prevent the deficient practice from reoccurring: A part time Restorative Aide will be trained and added to the Restorative Program Staff prior to 6/30/16. Effective 06/16/16 only one Restorative Aide will be allowed to be pulled to work on the floor as a CNA. If and when only one Restorative Aide is scheduled, the Restorative Aide cannot be pulled to work on the floor as a CNA. How the facility will monitor the systems put in place: Monitoring of the Restorative Nursing Program has been added to the Quality Assurance Program and the MDS/Restorative Nurse or Assistant MDS Nurse will report to the Quality Assurance Performance Improvement Committee monthly on the status of those resident on the Restorative Program.	

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for March 2016 indicated that the resident did not have the splint applied on the following days: 03/01/16, 03/03/16, 03/04/16, 03/07/16, 03/08/16, 03/09/16, 03/10/16, 03/11/16, 03/12/16, 03/13/16, 03/16/16, 03/17/16, 03/18/16, 03/19/16, 03/20/16, 03/27/16 and 03/30/16.

Review of the restorative nursing documentation for April 2016 indicated that the resident did not have the splint applied on the following days: 04/02/16, 04/08/16, 04/12/16, 04/16/16, 04/17/16 and 04/26/16.

Review of the restorative nursing documentation for May 2016 indicated that the resident did not have the splint applied on the following days: 05/08/16, 05/14/16, 05/15/16, 05/16/16, 05/18/16, 05/19/16, 05/24/16, 05/26/16, 05/27/16, 05/28/16, 05/29/16, 05/30/16 and 05/31/16.

Observation was made on 06/01/16 as 10:00 AM of the resident sitting up in wheelchair with the splint on her right hand.

Observation was made on 06/01/16 as 12:50 PM of the resident sitting up in wheelchair in her room being fed by staff without splint on right hand. Resident #32 was observed holding her hand in a cupped position.

An interview was conducted with the Restorative Nursing Assistant #1 (RNA) on 06/01/16 at 1:30 PM. She stated that she applied the splint to the resident's right hand on 06/01/16 at 9:10 AM and removed it at 11:10 AM. The Restorative Nursing Assistant further stated that the splint is supposed to be applied to resident's right hand 2 hours a day, 7 days a week. The RNA further stated that the resident does not refuse the splint and when

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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 318	Continued From page 11	F 318		

the splint is applied it is documented in the computer. The RNA #1 stated that the blank spots on the restorative nursing sheets for Resident #32 indicated that the splint was not applied.

An interview was conducted with the Restorative Nursing Assistant #2 on 06/02/16 at 11:15 AM. She stated that she applied the splint to the resident's right hand on 06/02/16 at 6:40 AM and removed it at 8:40 AM. The Restorative Nursing Assistant (RNA) further stated that if they were short staffed on the floor the Restorative Nursing Assistant is pulled to the floor and the residents do not receive splinting or ambulation on that day. The RNA further stated that the resident does not refuse the splint. The RNA #2 stated that the blank spots on the restorative nursing sheets for Resident #32 indicated that the splint was not applied.

An interview was made with the Minimum Data Set Coordinator (MDS) on 06/02/16 at 11:25 AM revealed that she supervises the restorative program and when the facility was short staffed on the floor the RNA was pulled to the floor to help out and the Nursing Assistant on the floor is supposed to attempt to apply the splint on Resident #32. The MDS Coordinator further stated that the previous administrator would not hire additional staff to make sure the residents receive their restorative needs and the new administrator is in the process of hiring additional staff.

An interview was conducted with the Nursing Assistant #1 on 06/02/16 at 2:00 PM. She stated that she has never applied the splint to the resident's right hand. The NA further stated that

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	345293	A. BUILDING _____ B. WING _____	06/02/2016

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F 318	Continued From page 12 when they are short staffed the splint does not get applied to the resident's hand. An interview was conducted with the Nursing Assistant #2 on 06/02/16 at 5:00 PM. She stated that she has never applied the splint to the resident's right hand. The NA further stated that the splint is applied on 1st shift by the RNA. An interview was conducted with the Administrator on 06/02/16 at 5:30 PM. She stated it is her expectation that the Restorative Nursing Assistants will not be pulled from the restorative program to help out on the floor. The Administrator stated that she is in the process of hiring 6 additional Nursing Assistants.	F 318		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide continuous oxygen for 1 of 1 sampled residents. (Resident #101).	F 328	What measures did the facility put in place for the resident affected: Resident expired on 04/04/16.	6/30/16

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F 328	Continued From page 13 The findings included: Resident # 101 was admitted to the facility on 3/16/2016 with diagnoses of Coronary Artery Disease, Hypertension and End Stage Renal Failure. The admission Minimum Data Set (MDS) dated 3/24/2016 revealed Resident # 101 had no problem with her short or long term memory. The admission MDS further revealed Resident # 101 required extensive assistance for personal hygiene and was totally dependent on staff for toileting. Review of the physician note dated 3/24/2016 revealed the resident was receiving supplemental oxygen. Review of the resident's physician order for the month of March 2016 revealed continuous oxygen 2 liters per minute. Review of the resident's vital signs report for the month of March 2016 and April 2016 revealed there was no resident ' s oxygen saturations documented. During the interview with the Physician on 6/2/2016 at 10:00 AM, he stated the resident was on continuous supplemental oxygen according to the orders. During the interview with the Physician Assistance on 6/2/2016 at 3:00 PM, she stated per March 2016 physician orders, the resident was on continuous oxygen. During the interview with Director of Nursing (DON) on 6/2/2016 at 4:30 PM, she stated her expectations was for the staff to take regular	F 328	What measure was put into place for residents having the potential to be affected: An audit was completed on 06/06/16 to identify residents on 02 therapy with continuous 02 orders or as needed orders. Physicians will be contacted prior to 6/30/16 and 02 saturation levels will be written per physicians orders. What systems were put into place to prevent the deficient practice from reoccurring: All new admissions will be reviewed by the Interdisciplinary Team within 24 hours of admission to ensure orders for special services are documented as continuous or as needed and orders obtained for monitoring those needs will be obtained. How the facility will monitor the systems put in place: The Director of Nursing as head of the Interdisciplinary Team will report monthly through the next annual survey, to the Quality Assurance Performance Improvement Committee any problems associated with new admissions and physician orders.	

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F 328	Continued From page 14 resident's oxygen saturations in order to determine whether the resident needed the continuous supplemental oxygen.	F 328		
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to provide sufficient nursing staff to meet the needs in the area of restorative nursing for 1 of 1 sampled resident (Residents # 32). The findings included:	F 353	What measures did the facility put in place for the resident affected: Effective 06/16/16 only one Restorative Aide will be allowed to be pulled to work on the floor as a CNA. If and when only one Restorative Aide is scheduled, the Restorative Aide cannot be pulled to work	6/30/16

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F 353	Continued From page 15 This tag is cross referenced to F318. F-318 Based on observation, record review and staff interviews the facility failed to provide restorative nursing services for contracture management for 1 of 1 sampled resident reviewed for range of motion (Resident #32 An interview was conducted with the Restorative Nursing Assistant #1 (RNA) on 06/01/16 at 1:30 PM. She stated that the facility has been short staffed in the past few months and she was pulled to the floor a lot in the months of March 2016 through May 2016. She further stated that when she is pulled to the floor the resident does not get her splint applied. An interview was made with the Minimum Data Set Coordinator (MDS) on 06/02/16 at 11:25 AM revealed that she supervises the restorative program and when the facility was short staffed on the floor the RNA was pulled to the floor to help out. MDS Coordinator further stated that the previous administrator would not hire additional staff to make sure the residents receive their restorative needs and the new administrator is in the process of hiring additional staff. An interview was conducted with the Administrator on 06/02/16 at 5:30 PM. She stated it is her expectation that the Restorative Nursing Assistants will not be pulled from the restorative program to help out on the floor. The Administrator stated that she is in the process of hiring 6 additional Nursing Assistants.	F 353	on the floor as a CNA. What measure was put into place for residents having the potential to be affected: All residents in the Restorative Program have the potential to have been affected. A review of the Restorative Program was completed on 6/16/16 by the Director of Nursing, MDS Nurse/Restorative Nurse and Administrator. Prior to 6/30/16, Physician Orders for Restorative Nursing orders will be clarified and written per physician order. A part time Restorative Aide will be trained and added to the Restorative Program Staff prior to 6/30/16. What systems were put into place to prevent the deficient practice from reoccurring: Effective 06/16/16 only one Restorative Aide will be allowed to be pulled to work on the floor as a CNA. If and when only one Restorative Aide is scheduled, the Restorative Aide cannot be pulled to work on the floor as a CNA. Currently using agency CNA's until new staff are hired and trained. How the facility will monitor the systems put in place: Monitoring of the Restorative Nursing Program has been added to the Quality Assurance Program and the MDS/Restorative Nurse or Assistant MDS Nurse will report to the Quality Assurance	

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F 353	Continued From page 16	F 353	Performance Improvement Committee monthly on the status of those resident on the Restorative Program.	