STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER ROAD ELIZABETHTOWN, NC 28337

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility instructed a resident to use her adult brief when she needed to use the bathroom for 1 of 1 residents observed for dignity (Resident #32). The findings included: Resident #32 was admitted to the facility on 01/12/16 with diagnoses which included cerebrovascular accident, muscle weakness and lack of coordination. A review of the quarterly Minimum Data Set (MDS) dated 07/14/16 indicated Resident #32 was cognitively intact, always continent of her bowels and bladder and was totally dependent on two staff for transfers and toileting. During an interview with Resident #32 on 09/26/16 at 4:46 p.m., Resident #32 stated she had been told by nursing assistants (NA ' s) to use her diaper (adult brief) when she called to go the bathroom. The resident stated she would much rather go to the bathroom and it made her feel terrible when she had to wet herself. During an interview with NA #1 on 09/30/16 at 9:20 a.m., NA #1 stated she could not toilet residents during meal times because of the risk of cross-contamination. NA #1 stated when Resident #32 had asked to use the bathroom, she had told the resident to use her diaper (adult brief) and she would change her later once the	F 241	Standard Disclaimer: This Plan of Correction is prepared as a necessary requirement for the continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). F241: It is the policy of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. In the case of Resident #32, after the surveyor made the DON aware of the alleged finding on 9/30/2016, the DON immediately (9/30/2016) educated NA #1 that the expectation of the nursing staff is to toilet a resident at the resident's request. Because all resident's that require assistance with toileting are potentially affected by the same alleged deficiency; on October 3, 2016 the nursing staff received in-service education on state and federal regulation regarding dignity and respect of individuality. A great emphasis	10/21/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/20/2016

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F 241	Continued From page 1 meal trays were off the hall. During an interview with the Administrator and the Director of Nursing (DON) on 09/30/16 at 9:53 a.m., the DON stated the expectation of the nursing staff was they toilet residents whenever they need to be toileted. The Administrator stated her expectation of the nursing staff and toileting residents was the same as the DON ' s.	F 241	was placed on toileting residents during mealtimes. All new nursing staff will receive the information during their hiring / orientation process. The QA Nurse reviewed the Nursing Assistant assignments for those residents that require assistance with toileting on 9/29/16. After having identified the residents that require assistance with toileting, the QA Nurse began conducting random checks once a week(with emphasis during meal times)on 10/03/16 to ensure toileting needs were being met. The monitoring will continue weekly x 4, then monthly or until resolved. It is important to note that we have not had any negative findings in this area since our monitoring began on 10/03/2016. If deficient practices are noted, they will be corrected immediately. The DON will monitor for compliance. Any discrepancies noted while conducting the random monitoring will be documented by the QA Nurse and submitted to the QAPI committee at the next meeting and quarterly thereafter for further review and/or corrective action(s). This Plan of Correction will be incorporated into the next QAPI meeting.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically	F 272		10/21/16

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F 272	Continued From page 2 a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by:	F 272		

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F 272	Continued From page 3 Based on record review, observations and staff interviews, the facility failed to comprehensively assess positioning needs to ensure the appropriate leg rests were attached to a specialty chair to prohibit legs and feet from suspending above the floor and failed to assess the need for a specialty chair for 2 of 2 residents reviewed (Resident's #98 and #82). Findings included: 1-A review of the medical record revealed Resident # 98 was admitted to the facility on 2/2/2015 with diagnoses which included Myocardial Infarction (heart attack) and left sided hemiparesis (paralysis). A review of the Minimum Data Set (MDS) dated 8/8/2016 indicated Resident #98 was severely cognitively impaired and required total assistance of 1 person with bed mobility, transfers, dressing and toileting. The MDS revealed the resident had impaired upper and lower extremity on the left side. The MDS also indicated Resident #98 had left arm/hand contracture and cervical neck contracture with splinting. A review of the Care Plan dated 8/8/2016 included Resident #98 ' s positioning needs and splint application for the left arm and positioning needs and splint application for the cervical spine/neck. An observation on 9/27/2016 at 10:27 AM revealed Resident #98 was seated in a specialty chair beside the nurse ' s station. Resident #98 was noted to have a left arm/hand contracture and the resident ' s head was leaning toward the right side. The specialty chair had 1 foot rest on the left side which was positioned against the left outer side of the chair with the foot rest in an upright position. Both of the resident ' s legs/feet were suspended approximately 6 inches above the floor. The resident ' s right foot/leg was	F 272	This Plan of Correction is prepared as a necessary requirement for the continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). F272: It is the policy of this facility to conduct initially and periodically a comprehensive and accurate assessment of each resident's functional capacity. In the case of Resident #98, the facility's Rehabilitation Director was notified on 9/29/16 of the surveyor's comments regarding the resident. The Rehab Director immediately placed a foot cradle on the residents chair to assist with his positioning while in the "specialty chair". On 10/03/16 the Physical Therapist assessed the resident and provided adaptive equipment which is attached to the lower part of the chair so that the resident is positioned more appropriately and correctly to interact with his environment. In the case of Resident #82, the Physical Therapist assessed the residents' "specialty chair" on 9/29/16 to determine the resident's positioning needs. The PT stated, "while the chair provides obvious comfort and support, the resident may gain therapeutic benefit by alternate positioning to improve posture. The resident was placed in a Geri-chair on 9/29/16. Resident is receiving Occupational therapy with the goals of Geri-chair positioning for improved sitting	

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F 272	Continued From page 4 observed to occasionally move and swing back and forth. The resident was observed in the same position on 9/27/2106 at 11:33 AM, 1:33 PM and 2:00 PM. An interview was conducted with the MDS nurse on 9/28/2016 at 10:30 AM. The MDS nurse reported she completed the assessment for Resident #98. The MDS nurse indicated the resident was up in the specialty chair almost every day. The MDS nurse stated she was unaware if the resident ' s chair had a positioning device for the legs or feet. The MDS nurse reported at the time of the assessment the resident ' s feet were not supported and they dangled above the floor. The MDS nurse stated she was not sure why she didn ' t address the need for positioning. An interview was conducted with the Nursing Assistant (NA) assigned to Resident #98 on 9/28/2016 at 11:14 AM. NA #9 reported the resident did not have any device for leg or foot positioning for the specialty chair which would prevent the resident ' s legs and feet from dangling. NA #9 stated Resident #98 ' s feet were always suspended approximately 6 inches from the floor when he was in the chair. NA #9 reported the resident was usually up in the chair daily. An interview was conducted with the Rehabilitation Department Director on 9/28/2016 at 2:16 PM. The Rehabilitation Director stated the current Therapy Department team had been in place in the facility since March 2016. The Rehabilitation Department Director stated they had not received a referral on Resident #98 for any positioning needs. The Rehabilitation Department Director was able to locate a referral from 2015 which referenced the need for splinting. There was no information located in	F 272	performance and safety / decrease tone in upper and lower extremities to a neutral position. Resident #82 is no longer in a "specialty chair". Exhibits for F272 attached to POC. Because all residents that require assistance with positioning may be potentially affected by this alleged deficiency; The MDS Coordinator, Therapists and Nurses have been educated on the definition of "specialty chair", so it will not be omitted from a resident assessment in the future. On 10/3/16,the physical therapist and/or occupational therapist began screening all current residents identified as having positioning needs. Residents will be screened for positioning needs by therapy upon admission, significant change in status and quarterly. (following the care planning schedule). The therapy department will communicate findings to the MDS Coordinator and care plans will be updated accordingly. The DON and/or designee will monitor for compliance through random chart audits for one month or until deficiency resolved. The DON and/or designee will document any discrepancies noted during random audits and will submit the documentation to the QAPI committee at the next meeting and quarterly thereafter, for further review and/or corrective action(s). This Plan of Correction will be	

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F 272	Continued From page 5 regard to the positioning needs of Resident #98 ' s legs or feet while in the specialty chair. The Rehabilitation Department Director stated she recalled seeing Resident #98 sitting in the chair and indicated he had positioning needs. An observation on 9/29/2016 at 10:00 AM revealed Resident #98 seated in the specialty chair beside the nurse ' s station. The specialty chair had 1 foot rest on the left side which was positioned against the left outer side of the chair with the foot rest in an upright position. Both of the resident ' s legs/feet were suspended approximately 6 inches above the floor. The resident ' s right foot/leg was observed to occasionally move and swing back and forth. The resident was observed in the same position on 9/29/2106 at 11:15 AM. An interview was conducted with NA #5 on 9/29/2016 at 11:25 AM. NA #5 indicated she was the NA usually assigned to Resident #98. The NA stated there was a left foot pedal on the chair and she had not seen the right one in at least 6 months. NA #5 reported she did not use the left pedal because the resident would not rest his foot on it. NA #5 stated the resident ' s feet dangled at least 6 inches from the chair and never reached the floor. An interview was conducted with Resident #98 ' s nurse (nurse #3) on 9/29/2016 at 11:45 AM. Nurse #3 reported Resident #98 was on her regular assignment and she was very familiar with his care. Nurse #3 stated no recollection of Resident #98 having foot rests on the specialty chair. Nurse #98 reported the resident ' s feet were suspended when he was in the chair, which was usually daily. An interview was conducted with the Director of Nursing (DON) on 9/29/2016 at 11:59 AM. The DON stated she was familiar with Resident #98	F 272	incorporated into the next QAPI meeting.	

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F 272	Continued From page 6 but did not recall the location of his feet while in the specialty chair. The DON stated the expectation was for comprehensive assessments to be completed so the resident ' s needs were addressed to enable proper care and treatment for his individual needs. 2. Resident #82 was admitted to the facility on 10/29/13 with diagnoses which included multi infarct dementia and mental retardation. A review of the quarterly Minimum Data Set (MDS) dated 07/05/16 indicated Resident #82 was severely cognitively impaired and was totally dependent on one staff member for all her Activities of Daily Living (ADL ' s). The MDS indicated the resident had no impairment in her bilateral upper and lower extremities. A review of Resident #82 ' s Care Plan revealed there was no Care Plan provided related to the resident ' s need for a specialty chair. During an observation of Resident #82 on 09/26/16 at 5:53 p.m., the resident was observed sitting in a two-piece specialty chair in her room. The resident ' s bottom was lower than her thighs which caused her legs to be raised in such a manner her knees were at the level of her abdomen. Subsequent observations on 09/27/16 at 11:37 a.m., 09/28/16 at 2:30 p.m. and 09/29/16 at 8:30 a.m. revealed the resident to be sitting in the specialty chair in the same position. An observation of the empty specialty chair on 09/28/16 at 3:45 p.m. revealed a chair and an ottoman which connected to each other by Velcro	F 272		

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F 272	Continued From page 7 strips. The seat of the chair contained a scooped-out area in which a person would be seated. During an interview with the Director of Nursing (DON) on 09/29/16 at 9:00 a.m., the DON stated Resident #82 was admitted in 2013 and had never had good posture. The DON stated the resident had not been able to adjust to any chair with a straight back such as a wheelchair, Geri chair or Broda chair. The DON stated the specialty chair in the resident ' s room was the only chair the resident had been comfortable in. During an interview with the MDS Coordinator on 09/29/16 at 2:04 p.m., the MDS Coordinator stated she did the MDS assessments and care plans. The MDS Coordinator stated she had felt the chair was more of a comfort chair than a specialty chair. The MDS Coordinator stated she should have assessed the resident ' s need for the specialty chair and care planned it. She stated she must have missed it. During an interview with the Administrator on 09/29/16 at 2:11 p.m., the Administrator stated when a resident needs a specialty item such as a chair it was her expectation the resident be assessed for it and care planned for it. During an interview with the DON on 09/29/16 at 2:18 p.m., the DON stated the expectation of the MD Coordinator was she assess residents with special needs and care plan those needs.	F 272		
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	F 279		10/26/16

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F 279	Continued From page 8 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: Based on observation, staff interviews and record review, the facility failed to develop a care plan that addressed a resident ' s need for a specialty chair and a resident ' s need for appropriate positioning in a specialty chair for 2 of 2 residents reviewed. (Resident #82 and #98). The findings included: 1. Resident #82 was admitted to the facility on 10/29/13 with diagnoses which included multi infarct dementia and mental retardation. A review of the quarterly Minimum Data Set (MDS) dated 07/05/16 indicated Resident #82 was severely cognitively impaired and was totally dependent on one staff member for all her Activities of Daily Living (ADL ' s). A review of Resident #82 ' s Care Plan revealed there was no Care Plan provided related to the resident ' s need for a specialty chair. During an observation of Resident #82 on 09/26/16 at 5:53 p.m., the resident was observed	F 279	This Plan of Correction is prepared as a necessary requirement for the continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). F279: It is the policy of this facility to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The care plans of Resident #98 and Resident #82 were updated and/or revised to reflect their current needs. Because all residents that require the use of a "specialty chair" and/or have positioning needs may be potentially affected by the alleged deficiency; The	

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F 279	Continued From page 9 sitting in a two-piece specialty chair in her room. The resident ' s bottom was lower than her thighs which caused her legs to be raised in such a manner her knees were at the level of her abdomen. Subsequent observations on 09/27/16 at 11:37 a.m., 09/28/16 at 2:30 p.m. and 09/29/16 at 8:30 a.m. revealed the resident to be sitting in the specialty chair in the same position. An observation of the empty specialty chair on 09/28/16 at 3:45 p.m. revealed a chair and an ottoman which connected to each other by Velcro strips. The seat of the chair contained a scooped-out area in which a person would be seated. During an interview with the Director of Nursing (DON) on 09/29/16 at 9:00 a.m., the DON stated Resident #82 was admitted in 2013 and had never had good posture. The DON stated the resident had not been able to adjust to any chair with a straight back such as a wheelchair, Geri chair or Broda chair. The DON stated the specialty chair in the resident ' s room was the only chair the resident had been comfortable in. During an interview with the MDS Coordinator on 09/29/16 at 2:04 p.m., the MDS Coordinator stated she did not recall when Resident #82 was placed in the specialty chair. The MDS Coordinator stated she did the MDS assessments and care planned what " spits out " on the Care Area Assessments (CAA ' s). The MDS Coordinator stated the specialty chair was not triggered and therefore not care planned. The MDS Coordinator stated she had felt the chair was more of a comfort chair than a specialty chair. The MDS Coordinator stated she should have care planned the specialty chair and stated she must have missed care planning it. During an interview with the Administrator on 09/29/16 at 2:11 p.m., the Administrator stated	F 279	MDS Coordinator, therapists and nurses were educated on the definition of a "specialty chair" so it will not be omitted in a resident's assessment. On 10/3/16, the rehab department began screening all current residents identified as having positioning needs. Residents will be screened for positioning needs by therapy upon admission, a significant change in status and according to the care planning schedule. The MDS Coordinator provides the rehab department with a monthly care planning / assessment calendar to ensure compliance. The Rehab Director will ensure communication with the MDS Coordinator so that care plans can be updated accordingly. The DON and/or designee will monitor for compliance through random chart audits examining rehab screenings and care plans for one month or until deficiency resolved. The DON and/or designee will document any discrepancies noted during random chart audits and will submit documentation the QAPI committee at the next meeting and quarterly thereafter for further review and/or corrective action(s). This plan of correction will be incorporated into the next QAPI meeting.	

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F 279	Continued From page 10	F 279		

when a resident needs a specialty item such as a chair it was her expectation the resident be assessed for it and care planned for it.
During an interview with the DON on 09/29/16 at 2:18 p.m., the DON stated the expectation of the MD Coordinator was she assess residents with special needs and care plan those needs.

2. A review of the medical record revealed Resident # 98 was admitted to the facility on 2/2/2015 with diagnoses which included Myocardial Infarction (heart attack) and left sided hemiparesis (paralysis). A review of the Minimum Data Set (MDS) dated 8/8/2016 indicated Resident #98 was severely cognitively impaired and required total assistance of 1 person with bed mobility, transfers, dressing and toileting. The MDS revealed the resident had impaired upper and lower extremity on the left side. The MDS also indicated Resident #98 had left arm/hand contracture and cervical neck contracture with splinting.
A review of the Care Plan dated 8/8/2016 included Resident #98 ' s positioning needs and splint application for the left arm and positioning needs and splint application for the cervical spine/neck. There was no mention of the resident ' s need for a specialty chair or the resident ' s lower extremity positioning needs.
An observation on 9/27/2016 at 10:27 AM revealed Resident #98 was seated in a specialty chair beside the nurse ' s station. The specialty chair had 1 foot rest on the left side which was positioned against the left outer side of the chair with the foot rest in an upright position. Both of the resident ' s legs/feet were suspended approximately 6 inches above the floor. The resident ' s right foot/leg was observed to occasionally move and swing back and forth. The

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11	F 279		

resident was observed in the same position on 9/27/2106 at 11:33 AM, 1:33 PM and 2:00 PM.
An interview was conducted with the MDS nurse on 9/28/2016 at 10:30 AM. The MDS nurse reported she completed the assessment for Resident #98. The MDS nurse reported she was responsible for the Care Plans. The MDS nurse indicated the resident was up in the specialty chair almost every day. The MDS nurse stated she was unaware if the resident ' s chair had a positioning device for the legs or feet. The MDS nurse reported at the time of the assessment the resident ' s feet were not supported and they dangled above the floor. The MDS nurse stated she was not sure why she didn ' t address the need for a specialty chair or lower extremity positioning needs for Resident #98 on his Care Plan.
An interview was conducted with the Nursing Assistant (NA) assigned to Resident #98 on 9/28/2016 at 11:14 AM. NA #9 reported the resident did not have any device for leg or foot positioning for the specialty chair which would prevent the resident ' s legs and feet from dangling. NA #9 stated Resident #98 ' s feet were always suspended approximately 6 inches from the floor when he was in the chair. NA #9 reported the resident was usually out of bed daily and always used the specialty chair.
An observation on 9/29/2016 at 10:00 AM revealed Resident #98 seated in the specialty chair beside the nurse ' s station. The specialty chair had 1 foot rest on the left side which was positioned against the left outer side of the chair with the foot rest in an upright position. Both of the resident ' s legs/feet were suspended approximately 6 inches above the floor. The resident ' s right foot/leg was observed to occasionally move and swing back and forth. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	09/29/2016

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F 279	Continued From page 12 resident was observed in the same position on 9/29/2106 at 11:15 AM. An interview was conducted with the Director of Nursing (DON) on 9/29/2016 at 11:59 AM. The DON stated she was familiar with Resident #98 but did not recall the location of his feet while in the specialty chair. The DON stated the expectation was for Care Plans to be accurate so the resident ' s individual care needs were available to staff to ensure proper care and treatment.	F 279		
F 323 SS=D	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 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and resident interviews, the facility failed to provide safe side rails for 3 of 4 residents with side rails (Residents #30, 95 and 71). Findings included: 1-Record review revealed Resident #30 was admitted to the facility on 2/25/2016 with cumulative diagnoses which included hemiplegia and Peripheral Vascular Disease. The Minimum Data Set (MDS) dated 7/4/2016 indicated the resident had no cognitive impairment and required extensive assistance of 1 person for bed mobility. The MDS indicated	F 323	This Plan of Correction is prepared as a necessary requirement for the continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). F323: It is the policy of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	10/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	09/29/2016

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F 323	Continued From page 13 side rails were not used. There was no Care Plan for side rails in the medical record. On 9/27/2016 at 9:52 AM, Resident #30 was interviewed in her room. The resident was observed lying in bed with full side rails on both sides of the bed. The rails were loose and could be moved away from the bed for a distance of 5 to 6 inches on each side. The rail on the right side of the bed measured 5 inches between the mattress and the rail. The resident stated the rails were not used for positioning as she was unable to position herself in bed without assistance. The resident stated she did not request the rails but they might prevent her from falling. The resident reported she had not fallen since admission to the facility. The resident stated the rails were very loose and occasionally a man came to her room and tightened them, but the rails were loose again " before he got out the door " . Further record review revealed a side rail assessment screen completed by the MDS nurse dated 7/14/2016. The screen listed the resident as non-ambulatory, unable to get in/out of bed, no history of falls and poor bed mobility, The assessment screen decision specified side rails were indicated for support and positioning and served as an enabler for the resident. An interview was conducted with the MDS nurse on 9/29/2016 at 2:42 PM. The MDS nurse stated she completed the side rail assessment for Resident #30. The MDS nurse stated the resident requested the rails and the resident used the rails for positioning. Section G of the MDS was reviewed with the MDS nurse. The MDS nurse reported the resident did require 1 person assist for bed mobility and stated the rails were probably an enabler for the staff and not the resident.	F 323	For residents #30, 95, and 71, the alleged unsafe side rails were immediately removed. Residents care plans were revised. All staff were re-educated on the "Side Rail" policy and how to assess the integrity of the side rails. 100% of all side rails were assessed in the facility for safety by the administrative nurses. No other side rails were found to be unsafe. It is important to note that no resident has sustained an injury from side rails at this facility. The facility currently has one resident that has a full length set of side rails with full length padded bolsters on each rail. Surveyors assessed the rails and bolsters while in facility and found them to be safe. All other side rails are quarter length and are not loose, shaky and meet the mattress. For the residents having the potential to be affected by the same alleged deficiency; On 10/03/16 the QA Nurse will use the "Side Rail Audit Sheet" to assess the side rails once a week for a month, then on a monthly basis. Any compromised rails will be removed. The rails will be replaced if resident uses for self - positioning. All staff have been re-educated on side rail safety so as to create an environment free of accidents and hazards. The DON and Administrator will monitor audits for compliance.	

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	345210	A. BUILDING _____ B. WING _____	09/29/2016

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F 323	Continued From page 14 On 9/29/2016 at 4:30 PM Resident #30 's bed was rechecked and the side rails were in the same position and condition as previously noted on 9/27/2016 at 9:52 AM. On 9/30/2016 at 10:00 AM there were no side rails on Resident #30 's bed. Resident #30 stated the rails were removed the night before. The resident reported it didn't matter to her if the rails were removed. 2. Resident #95 was admitted 5/16/2016 with diagnoses of traumatic brain bleed, stroke, hemiplegia and paraplegia. The admission Minimum Data Set (MDS) dated 5/22/2016 noted Resident #95 was cognitively intact and needed limited to total care for all Activities of Daily Living (ADLs) with the physical assistance of one to two persons. On 9/26/2016 at 4:00 PM, Resident #95 was interviewed in her room. The bed had full metal side rails on both sides of the bed. The rails were loose and could be pulled away from the bed for a distance of 4 inches on the side of the bed closest to the window, and a distance of 5 inches on the side of the bed closest to the door. There was a space between the mattress and the bed rail of 3 inches on the side closest to the window, and a space between the mattress and the bed rail of 3 inches on the side closest to the door. Resident #95 stated she would use the side rails to move herself around in bed, except the rails were so wobbly she had trouble holding on to them. Resident #95 stated she was paralyzed on one side of her body and needed help to get up or to have a bath.	F 323	Any discrepancies noted by the QA Nurse will be documented and submitted to the QAPI Committee at the next meeting and monthly thereafter for review and/or additional corrective action(s). Any trending noted by the committee will extend the monitoring. This plan of correction will be incorporated into the next QAPI meeting.	

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	345210	A. BUILDING _____ B. WING _____	09/29/2016

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F 323	Continued From page 15	F 323		

The MDS indicated side rails were not used and there was no care plan for side rails. There was a side rail assessment and a decision stating side rails were indicated and served as an enabler to promote independence.

A review of orders revealed on 6/9/2016: Resident uses side rails x 2 for turning and repositioning while in bed and to promote independence.

The September orders from pharmacy noted Resident uses side rails x 2 for turning and repositioning while in bed and to promote independence.

On 9/28/2016 2:30 PM, in an interview Resident #95 stated the side rail was loose on the side of the bed near the window, but the maintenance director had tightened the rail closest to the door. Resident #95 noted the side rail near the window was loose and she would have him fix it. Resident #95 stated she did not think the side rail prevented her from moving around in the bed.

On 9/30/2016 at 10:00 AM the side rails on Resident #95 's bed had been removed. Resident #95 stated she did not care if the rails were removed.

3. Resident #71 was admitted 2/14/2016 with diagnoses of A-fib, muscle weakness, history of embolism, stroke, fractured kneecap, bipolar disorder, diabetes, epilepsy and depression.

The annual Minimum Data Set (MDS) dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	09/29/2016

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F 323	Continued From page 16	F 323		

2/3/2016 noted Resident #71 to be cognitively impaired and needed extensive to total assistance for all Activities of Daily Living (ADLs), with the physical assistance of two persons. The Care Area Assessment (CAA) noted areas of falls and communication to be concerns. The MDS did not code Resident #71 as using a bed rail.

A side rail assessment was reviewed and revealed side rails were indicated and used as an enabler.

A physician order dated 7/5/2016 stated Resident uses side rails to assist with turning and repositioning and as an enabler to promote independence.

On 9/29/2016 at 4:00 PM, Resident #71 was observed in bed with full length side rails up on both sides of the bed. Resident #71 's bed was against the wall with a side rail up. The other side of the bed also had a full length side rail that was loose and would pull away from the bed a distance of 4 inches. There was a 2 ½ inch gap between the mattress and the rail.

On 9/29/2016 at 4:20 PM, in an interview, after the Administrator was informed of a concern regarding side rails being loose and not fitting the bed, the Administrator stated the facility is replacing beds in the building at the rate of 3 per month. The Administrator stated she thought an audit was completed monthly, and there had been no accidents concerning side rails.

On 9/30/2016 at 10:39 AM, in an interview, the Maintenance Director stated he completes the audits monthly. The Maintenance Director noted all side rails were removed after the survey the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 17	F 323		

previous year and were gradually added back, and sometimes, the family wanted the side rails on a resident ' s bed. The Maintenance Director indicated the side rails are all shaky and loose because they are worn out, and the long side rails are not made anymore. The Maintenance Director noted the last audit was 9/14/2016 and a review of that audit noted all rails were documented as safe. The Maintenance Director stated when he conducted the audit he would try to put his arm between the mattress and the rail and if it would go between the mattress and the rail he would document it as unsafe and replace it with another long rail that had been taken off of a bed in the past. The Maintenance Director stated the previous day the Administrator told him to remove all of the full length rails. The Maintenance Director stated the facility is ordering new beds at the rate of 2 per month, although 4 beds will be ordered in October. The Maintenance Director stated he attended Quality Assurance (QA) meetings and was asked about the audits and the rail replacements.

On 9/30/2016 at 11:46 AM, the Administrator stated her expectation was when the side rails were raised, the mattress and rails would meet, so there would be no entrapment issues.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 18	F 323		

2. Resident #95 was admitted 5/16/2016 with diagnoses of traumatic brain bleed, stroke, hemiplegia and paraplegia.

The admission Minimum Data Set (MDS) dated 5/22/2016 noted Resident #95 was cognitively intact and needed limited to total care for all Activities of Daily Living (ADLs) with the physical assistance of one to two persons.

On 9/26/2016 at 4:00 PM, Resident #95 was interviewed in her room. The bed had full metal side rails on both sides of the bed. The rails were loose and could be pulled away from the bed for a distance of 4 inches on the side of the bed closest to the window, and a distance of 5 inches on the side of the bed closest to the door. There was a space between the mattress and the bed rail of 3 inches on the side closest to the window, and a space between the mattress and the bed rail of 3 inches on the side closest to the door. Resident #95 stated she would use the side rails to move herself around in bed, except the rails were so wobbly she had trouble holding on to them. Resident #95 stated she was paralyzed on one side of her body and needed help to get up or to have a bath.

The MDS indicated side rails were not used and there was no care plan for side rails. There was a side rail assessment and a decision stating side rails were indicated and served as an enabler to promote independence.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	09/29/2016

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F 323	Continued From page 19	F 323		

A review of orders revealed on 6/9/2016: Resident uses side rails x 2 for turning and repositioning while in bed and to promote independence.

The September orders from pharmacy noted Resident uses side rails x 2 for turning and repositioning while in bed and to promote independence.

On 9/28/2016 2:30 PM, in an interview Resident #95 stated the side rail was loose on the side of the bed near the window, but the maintenance director had tightened the rail closest to the door. Resident #95 noted the side rail near the window was loose and she would have him fix it. Resident #95 stated she did not think the side rail prevented her from moving around in the bed.

On 9/30/2016 at 10:00 AM the side rails on Resident #95 's bed had been removed. Resident #95 stated she did not care if the rails were removed.

3. Resident #71 was admitted 2/14/2016 with diagnoses of A-fib, muscle weakness, history of embolism, stroke, fractured kneecap, bipolar disorder, diabetes, epilepsy and depression.

The annual Minimum Data Set (MDS) dated 2/3/2016 noted Resident #71 to be cognitively impaired and needed extensive to total assistance for all Activities of Daily Living (ADLs), with the physical assistance of two persons. The Care Area Assessment (CAA) noted areas of falls and communication to be concerns. The MDS did not code Resident #71 as using a bed rail.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	09/29/2016

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F 323	Continued From page 20	F 323		

A side rail assessment was reviewed and revealed side rails were indicated and used as an enabler.

A physician order dated 7/5/2016 stated Resident uses side rails to assist with turning and repositioning and as an enabler to promote independence.

On 9/29/2016 at 4:00 PM, Resident #71 was observed in bed with full length side rails up on both sides of the bed. Resident #71 's bed was against the wall with a side rail up. The other side of the bed also had a full length side rail that was loose and would pull away from the bed a distance of 4 inches. There was a 2 ½ inch gap between the mattress and the rail.

On 9/29/2016 at 4:20 PM, in an interview, after the Administrator was informed of a concern regarding side rails being loose and not fitting the bed, the Administrator stated the facility is replacing beds in the building at the rate of 3 per month. The Administrator stated she thought an audit was completed monthly, and there had been no accidents concerning side rails.

On 9/30/2016 at 10:39 AM, in an interview, the Maintenance Director stated he completes the audits monthly. The Maintenance Director noted all side rails were removed after the survey the previous year and were gradually added back, and sometimes, the family wanted the side rails on a resident ' s bed. The Maintenance Director indicated the side rails are all shaky and loose because they are worn out, and the long side rails are not made anymore. The Maintenance Director noted the last audit was 9/14/2016 and a

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	345210	A. BUILDING _____ B. WING _____	09/29/2016

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F 323	Continued From page 21 review of that audit noted all rails were documented as safe. The Maintenance Director stated when he conducted the audit he would try to put his arm between the mattress and the rail and if it would go between the mattress and the rail he would document it as unsafe and replace it with another long rail that had been taken off of a bed in the past. The Maintenance Director stated the previous day the Administrator told him to remove all of the full length rails. The Maintenance Director stated the facility is ordering new beds at the rate of 2 per month, although 4 beds will be ordered in October. The Maintenance Director stated he attended Quality Assurance (QA) meetings and was asked about the audits and the rail replacements. On 9/30/2016 at 11:46 AM, the Administrator stated her expectation was when the side rails were raised, the mattress and rails would meet, so there would be no entrapment issues.	F 323		
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	F 431		10/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	09/29/2016

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F 431	Continued From page 22 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, 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 observation, interview and record review the facility failed to ensure biologicals and supplements were not expired in one of two medication rooms (100 hall medication room) and 2 of three medication carts (200 and 400 medication carts). Findings included: On 9/29/2016 at 11:00 AM, the 200 hall cart was checked. There was a canister of Beneprotein supplement 8 oz. with a best by date of 29 August 2016. On 9/29/2016 at 11:00 AM, the 100/200 hall medication room was checked and the refrigerator contained one box of Tuberculin skin test. There was a vial inside labeled as Tuberculin	F 431	This Plan of Correction is prepared as a necessary requirement for the continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). F431: The items identified (Beneprotein & open vial of Tuberculin skin test) were destroyed immediately on 9/29/16. Immediately after the discovery on 9/29/16, each medication cart and medication rooms and storage areas were checked by administrative nursing staff to ensure all meds and/or biologicals were not expired. No other meds and/or biologicals were found to be expired or	

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	345210	A. BUILDING _____ B. WING _____	09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 23 skin test with no open date on the box or the open vial. On 9/29/2016 at 11:15 AM, the 400 hall medication cart was checked. There was a canister of Beneprotein supplement 8 oz. with a best by dated of 24 Jul 2016. On 9/29/2016 at 2:45 PM, in an interview, the Director of Nursing (DON) stated her expectation was that the medication carts, rooms and refrigerators would be audited on a regular basis by the staff and would be free of expired medications.	F 431	opened without being dated. Because all residents receiving medications and/or biologicals have the potential to be affected by this alleged deficiency, the following corrective actions were taken: All licensed nurses were re-educated on the policy and procedures of medication administration, with emphasis on checking the expiration dates and labeling open vials. The nurses were also instructed to check their med carts every day for expired and unlabeled meds. Any med and/or biological found to be expired will be destroyed immediately and the DON will be notified. The DON will bring the discrepancy to the next QA meeting for review and/or corrective actions. The DON and/or designee will check medication carts / medication rooms and all other medication storage areas on a weekly basis for 4 weeks, if no discrepancies found during this month long audit, the frequency will change to monthly audits. The Consultant Pharmacist checks the medication storage areas on a quarterly basis. F431 - Exhibits are attached to POC. The Administrator will monitor auditing for compliance. The DON and/or designee will document any discrepancies noted during audits	

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	345210	A. BUILDING _____ B. WING _____	09/29/2016

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F 431	Continued From page 24	F 431	performed and submit the documentation to the QAPI committee at the next meeting. QA will look at any discrepancies monthly for three months and quarterly thereafter or until resolved. This plan of correction will be incorporated into the next QAPI meeting.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520		10/26/16

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F 520	Continued From page 25 Based on observation, staff and resident interviews and record review, the facility Quality Assessment and Assurance (QAA) Committee failed to maintain and monitor interventions that were put into place 11/13/2015. These interventions were in an area originally cited in the recertification survey of 10/30/2015 and recited in the recertification survey of 9/29/2016. The deficiency was in the area of Accidents/Hazards. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective QAA program. Findings included: This citation is cross referenced to: F323 -Based on observations, record reviews and staff and resident interviews, the facility failed to provide safe side rails for seven of seven residents with side rails (Residents #13, 20, 32, 95, 31, 94 and 58). The facility was cited during the 10/30/2015 recertification survey F323 for failing to provide safe side rails. During the current survey, the facility continued to fail to provide safe side rails During an interview with the Administrator on 09/30/16 at 11:46 PM, the Administrator stated the QAA Committee met monthly and identified, developed and implemented plans of action to correct identified quality deficiencies. The Administrator stated a QAA meeting was held after the recertification survey of 10/30/2015 and discussed the action plan to correct the deficiency. The Administrator stated the Maintenance Director was properly in-serviced on the facility's expectations for safe side rails. The Administrator stated she thought the breakdown that caused the repeated deficiency was the	F 520	This Plan of Correction is prepared as a necessary requirement for the continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). F520: It is the policy of this facility to maintain a QAA committee consisting of the DON, MD, and at least three other members of the facility's staff. Corrective actions were taken for the residents identified in during this survey. Side rails were removed as described in statement of deficiency. For all residents that have the potential to be affected by this alleged deficiency, 100% of all side rails were assessed by the administrative nurses and were found to be safe. All staff were re-educated on the "Side Rail" policy and how to assess the integrity of the side rails. It is important to note that no residents were adversely affected by said practice as no injuries or accidents were noted. The facility currently has one resident that has a full length set of side rails with full length padded bolsters on each rail. Surveyors assessed the rails and bolsters while in facility and found them to be safe. All other side rails are quarter length and are not loose, shaky and meet the mattress.	

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F 520	Continued From page 26 Maintenance Directors perception of what was considered a safe space between the mattress and the side rails.	F 520	On 10/03/16 the QA Nurse will use the "Side Rail Audit Sheet" to assess the side rails once a week for a month, then on a monthly basis. Any compromised rails will be removed. The rails will be replaced if resident uses for self - positioning. On 10/4/16, the QAA committee has been in-serviced on the facility's QA policy, the QAPI Five Elements, QAPI Self - Assessment Tool, Guide for Developing Purpose, Guiding Principles and Scope for QAPI, Guide for Developing a QAPI plan, QAPI Leadership Rounding Guide, Measure/Indicator Development Worksheet, Measure/Indicator Collection and Monitoring Plan, Goal Setting, Prioritization for PIP's and the Five Why's for Root Cause Analysis. On 10/26/16, the QA Committee will have a QAPI training session from Kristine Williamson with our QIO, Alliant Quality. The Administrator will monitor QA meetings to ensure that each member of the QA Committee is knowledgeable about the issues we are reviewing and proactive in resolving issues that are brought to the QA meetings. The QA meetings will be monthly for six months and quarterly thereafter, however, if issues are noted to be of a severe nature, the monitoring will remain until the issue is resolved. The alleged deficiency will be incorporated into the next QA meeting and	

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F 520	Continued From page 27	F 520	along with the plan of correction.	