

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345502</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/02/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKE PARK NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 FAITH CHURCH ROAD</b> <b>INDIAN TRAIL, NC 28079</b>		
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F 000	INITIAL COMMENTS  A recertification and complaint survey was conducted from 09/25/2016 through 09/29/2016. Immediate Jeopardy was identified at:  CFR 483.25 at tag F323 at a scope and severity (J) CFR 483.75 at tag F490 at a scope and severity (J) CFR 483.75 at tag F520 at a scope and severity (J)  Tag F323 constituted Substandard Quality of Care.  Immediate Jeopardy began on 09/22/2016 and was removed on 09/29/2016. An extended survey was conducted on 09/29/2016.  Upon management review of F157 and F309, it was decided that these tags should be cited at the immediate jeopardy level. On 10/27/16 at 4:08 PM, the administrator was notified of the immediate Jeopardy at F157 and F309. The administrator provided a credible allegation of compliance on 10/31/16 at 6:04 PM. The credible allegation of compliance was validated on 11/2/16. The survey exit date was changed to 11/2/16.	F 000			
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in	F 157		11/21/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/21/2016

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

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F 157	<p>Continued From page 1</p> <p>injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews with resident, family, staff, physician assistant and physician, and record review, the facility failed to notify the resident's responsible party, the physician and the physician assistant of a resident's fall in the transportation van which resulted in a laceration at the back of the head for 1 (Resident #96) of 1 sampled resident.</p> <p>Immediate Jeopardy began on 9/22/16 when the</p>	F 157	<p>Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p>		

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F 157	<p>Continued From page 2</p> <p>physician or the physician assistant was not notified that Resident #96 and his wheelchair fell backwards in the transportation van and the resident sustained a laceration to the back of his head. The immediate jeopardy was removed on 11/2/16 when the facility's acceptable credible allegation of compliance was verified. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedure for notification of responsible party and physician of a resident's significant change in condition.</p> <p>Findings included: Resident #96 was admitted to the facility on 9/6/16 with diagnoses of pyogenic arthritis (infectious arthritis with pus formed), abnormal posture, muscle weakness, Guillain-Barre Syndrome (progressive muscle weakness and paralysis), scoliosis, chronic kidney disease, and infection of a shoulder surgical wound.</p> <p>During an interview on 9/26/16 at 11:28 AM, the resident revealed he fell backwards in the wheelchair while he was being transported from the dialysis center to the facility via the facility van. The resident stated he landed on the van floor and hit his head. He had a little cut on his head but he was okay.</p> <p>There were three handwritten statements dated 9/22/16 from the maintenance staff who was driving the van at the time of the accident. The three written statements included that the maintenance staff fell as he was pulling the resident from the lift to the van and the resident fell backwards on top of the maintenance staff and hit his head on the chair or the seat behind the driver seat. The maintenance staff asked the</p>	F 157	<p>Lake Park Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Park Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>F 157 - Notification Credible Allegation</p> <p>Lake Park was placed into Immediate Jeopardy at 4:08 pm, on October 27, 2016, related to an incident on the Lake Park van on September 22, 2016. The facility was placed into immediate jeopardy for F 157 Notification of Changes and F 309 Quality of Care.</p> <p>A. How the corrective action was accomplished for those residents found to have been affected by the deficient practice. Outcome.</p> <p>On 9/22/16, the maintenance worker and housekeeper assisted the resident back in to an upright position in the wheelchair on the van and returned to the facility without an assessment by a qualified medical professional, registered nurse, nurse practitioner, physician assistant, or</p>		

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F 157	<p>Continued From page 3</p> <p>resident if he was okay and the resident responded yes. The maintenance staff noticed a cut on the back of the resident's head, with no blood draining. They got back to the facility and got the resident off the van and took him to the DON (director of nursing) and told her what happened.</p> <p>An interview with the Physician Assistant (PA) was conducted on 9/26/16 at 5:30 PM. The PA said that she knew about the laceration today. She said if there was a fall with the resident hitting his head, she expected the facility to assess and do neurochecks. The staff were expected to call and notify her of the fall and about the resident hitting his head.</p> <p>On 9/27/16 at 9:20 AM, the resident's Medical Doctor (MD) was interviewed. The MD said he did not remember if he was notified about the resident's incident that happened last week in the van. He said he expected the staff to call him and let him know if there was head injury. He also expected the staff to assess the resident after a fall and do whatever was needed.</p> <p>On 9/26/16 at 3:55 pm, the resident was interviewed in the presence of the responsible party. The resident repeated the same description of the van incident on 9/22/16. The resident revealed he fell backwards in the wheelchair while he was being transported from the dialysis center to the facility via the facility van. The resident stated he landed on the van floor and hit his head. He had a little cut on his head but he was okay. The resident's responsible party said the facility called her and told her that the resident had a fall but they never told her exactly what happened. The resident told her what happened.</p> <p>Review of the " Progress Note " , written by the DON, dated 9/22/16 revealed the resident</p>	F 157	<p>medical doctor or notifying the facility.</p> <p>On 9/22/16, the maintenance worker immediately returned the resident to the facility and informed the director of nursing (DON).</p> <p>On 9/22/16, the DON immediately assessed the resident. The resident had no complaint of pain and exhibited normal behavior and activity. The resident had a small scratch on the back of his head with two drops of blood. The director of nursing left a voice message for the responsible party to return her call, but did not speak to, the responsible party (wife). The director of nursing sent a text message, but did not speak to the physician. The director of nursing notified the treatment nurse. The director of nursing performed a neuro check without negative findings. The director of nursing gave the neuro-check paperwork to the assistant director of nursing with verbal instructions to continue the neuro-checks through the night. The director of nursing did not notify the physician or the responsible party (wife). The neuro-checks were not performed through the night.</p> <p>On 9/22/16, the treatment nurse immediately initiated a treatment to the back of the resident's head. The treatment nurse left a message for the responsible party (wife). The responsible party (wife) returned the treatment nurse's call. The treatment nurse notified the resident's responsible party (wife) about the resident's head wound</p>		

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F 157	<p>Continued From page 4</p> <p>received a skin assessment and there was a laceration on the back of the head. Neurochecks were initiated and they were within normal limit at this time. Another " Progress Note " , written by Nurse #2, dated 9/22/16 revealed the resident received treatment to a small laceration to the back of the head. Per-wound area had slight erythema. The note indicated the physician was made aware and the responsible party was called and a message was left on the voice mail to return call.</p> <p>An interview was conducted with the director of nursing (DON) on 9/28/16 at 8:35 AM. When the resident arrived at the facility from dialysis, the maintenance staff brought the resident to the DON and told her what happened. The DON said she notified the Doctor by sending him a phone text message via the phone. The DON stated the MD never received the text and the MD did not know about the accident until 9/27/16. The DON did not follow up with the doctor to make sure he received the text.</p> <p>On 10/27/16 at 4:08 PM, the administrator was notified of the immediate Jeopardy. The administrator provided the following credible allegation of compliance on 10/31/16 at 6:04 PM:</p> <p>A. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Outcome.</p> <p>On 9/22/16, the maintenance worker and housekeeper (floor technician) assisted the resident back in to an upright position in the wheelchair on the van and returned to the facility without an assessment by a qualified medical professional, registered nurse, nurse practitioner, physician assistant, or medical doctor or notifying the facility.</p>	F 157	<p>and that an investigation was in progress relating to how the head wound happened. The treatment nurse did not notify the physician.</p> <p>On 9/22/16, the administrator and director of nursing interviewed the resident involved in the incident on the van. The resident gave an account of the events and incident.</p> <p>On 9/26/16 the DON notified the nurse practitioner (NP) of Resident #96's fall with laceration.</p> <p>On 9/26/16, the DON notified the responsible party of what happened during the 9/22/16 accident on the van when the resident fell backwards in his wheelchair causing a laceration (scratch) to the of his head.</p> <p>On 9/27/16, the DON talked to the attending physician regarding Resident #96's fall with laceration.</p> <p>B. How the facility identified other residents having the potential to be affected by the same deficient practice.</p> <p>On 10/20/16, an audit for the past 30 days of progress notes of 100% of residents was completed by the assistant director of nursing (ADON) to ensure the physician, nurse practitioner, and/or physician assistant has been notified of all falls including falls with injury.</p>		

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F 157	<p>Continued From page 5</p> <p>On 9/22/16, the maintenance worker immediately returned the resident to the facility and informed the director of nursing (DON).</p> <p>On 9/22/16, the DON immediately assessed the resident. The resident had no complaint of pain and exhibited normal behavior and activity. The resident had a small scratch on the back of his head with two drops of blood. The director of nursing left a voice message for the responsible party to return her call, but did not speak to, the responsible party. The director of nursing sent a text message, but did not speak to the physician. The director of nursing notified the treatment nurse. The director of nursing performed a neuro check without negative findings. The director of nursing gave the neuro-check paperwork to the assistant director of nursing with verbal instructions to continue the neuro-checks through the night. The director of nursing did not notify the physician or the responsible party. The neuro-checks were not performed through the night.</p> <p>On 9/22/16, the treatment nurse immediately initiated a treatment to the back of the resident's head. The treatment nurse left a message for the responsible party. The responsible party returned the treatment nurse's call. The treatment nurse notified the resident's responsible party about the resident's head wound and that an investigation was in progress relating to how the head wound happened. The treatment nurse did not notify the physician.</p> <p>On 9/22/16, the administrator and director of nursing interviewed the resident involved in the incident on the van. The resident gave an account of the events and incident.</p>	F 157	<p>On 10/27/16, an audit for the past 30 days of incident reports was completed by the ADON to ensure the responsible party has been notified of change in condition related to incident/accidents. All responsible parties had been notified of significant changes, incidents/accidents.</p> <p>On 10/31/16, an audit for the past 34 days of progress notes was completed by the DON, ADON, staff facilitator, administrator, facility consultant, and corporate clinical director to ensure the physician and/or nurse practitioner and responsible party are notified of significant changes in condition, including falls.</p> <p>C. Specific dates of the corrective actions.</p> <p>On 9/26/16, the DON notified the responsible party of what happened during the 9/22/16 accident on the van when the resident fell backwards in his wheelchair causing a laceration (scratch) to the of his head.</p> <p>On 9/26/16, the administrator and corporate clinical services director verbally instructed the DON she was not to communicate solely by text messages to the attending physician, nurse practitioner, and/or physician assistant when there is a resident incident/accident requiring physician notification.</p> <p>On 9/27/16, the administrator verified with the attending physician the DON would communicate a resident incident/accident,</p>		

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F 157	<p>Continued From page 6</p> <p>On 9/26/16 the DON notified the nurse practitioner (NP) of Resident #96's fall with laceration.</p> <p>On 9/26/16, the DON notified the responsible party of what happened during the 9/22/16 accident on the van when the resident fell backwards in his wheelchair causing a laceration (scratch) to the of his head.</p> <p>On 9/27/16, the DON talked to the attending physician regarding Resident #96's fall with laceration.</p> <p>B. How did the facility identify other residents having the potential to be affected by the same deficient practice.</p> <p>On 10/20/16, an audit for the past 30 days of progress notes of 100% of residents was completed by the assistant director of nursing (ADON) to ensure the physician, nurse practitioner, and/or physician assistant has been notified of all falls including falls with injury.</p> <p>On 10/27/16, an audit for the past 30 days of incident reports was completed by the ADON to ensure the responsible party has been notified of change in condition related to incident/accidents. All responsible parties had been notified of significant changes, incidents/accidents.</p> <p>On 10/31/16, an audit for the past 34 days of progress notes was completed by the DON, ADON, staff facilitator, administrator, facility consultant, and corporate clinical director to ensure the physician and/or nurse practitioner and responsible party are notified of significant</p>	F 157	<p>in addition to text messaging, by an in-person communication and/or phone call to the attending physician, nurse practitioner, and/or physician assistant.</p> <p>On 10/20/16, the DON began in-servicing all registered nurses (RNs) and licensed practical nurses (LPNs) on the importance of notifying the physician and/ or NP of all resident falls, including immediate notification regarding falls with injury. The in-service was completed 10/24/16. After 10/24/16, no RN or LPN was allowed to work until the in-service is completed. All RN and LPN new hires will receive the in-service during new employee orientation.</p> <p>On 10/28/16, the DON, ADON, staff facilitator, administrator, and corporate facility consultant, began in-servicing all RNs and LPNs on the requirement to contact the responsible party (RP) of any resident that has a fall to notify the RP of a change in condition. The in-service was completed 10/28/16 of all RNs and LPNs currently working. The in-services was changed and restarted on 10/31/16.</p> <p>On 10/31/16, the DON, ADON, staff facilitator, administrator, and department heads began in-servicing all staff on the importance of staff informing the nurse and the nurse notifying the physician, physician assistant, and/or nurse practitioner of a resident's change in condition (not just for falls). Also, the nurses must notify the resident's responsible party of a change in the</p>		

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F 157	<p>Continued From page 7</p> <p>changes in condition, including falls.</p> <p>C. Give specific dates of the corrective actions.</p> <p>On 9/26/16, the DON notified the responsible party of what happened during the 9/22/16 accident on the van when the resident fell backwards in his wheelchair causing a laceration (scratch) to the of his head.</p> <p>On 9/26/16, the administrator and corporate clinical services director verbally instructed the DON she was not to communicate solely by text messages to the attending physician, nurse practitioner, and/or physician assistant when there is a resident incident/accident requiring physician notification.</p> <p>On 9/27/16, the administrator verified with the attending physician the DON would communicate a resident incident/accident, in addition to text messaging, by an in-person communication and/or phone call to the attending physician, nurse practitioner, and/or physician assistant.</p> <p>On 10/20/16, the DON began in-servicing all registered nurses (RNs) and licensed practical nurses (LPNs) on the importance of notifying the physician and/ or NP of all resident falls, including immediate notification regarding falls with injury. The in-service was completed 10/24/16. After 10/24/16, no RN or LPN was allowed to work until the in-service is completed. All RN and LPN new hires will receive the in-service during new employee orientation.</p> <p>On 10/28/16, the DON, ADON, staff facilitator, administrator, and corporate facility consultant, began in-servicing all RNs and LPNs on the requirement to contact the responsible party (RP)</p>	F 157	<p>resident's condition with basic information. If the RP has additional questions, the nurse is to inform the DON or administrator for follow-up with the RP. The in-service was completed 11/01/16 of all staff working. After 11/01/16, no staff is allowed to work until the notification in-service is completed. All new hires will receive the notification in-service during new employee orientation.</p> <p>D. How the facility is monitoring systems to prevent recurrence.</p> <p>On 11/02/16, the ADON began auditing 100% of resident progress notes to ensure that the physician and/or NP and responsible party were notified of resident significant change in condition, including accidents, using the progress note audit tool. The audit will be completed by the DON, ADON, staff nurse, and/or corporate consultant 5x/week x 4 weeks, then weekly x 8 weeks, then monthly x 3 months.</p> <p>The monthly QI committee will review the results of the Progress Note Audit tool monthly x 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendation for monitoring for continued compliance. The administrator and/or DON will present the finding and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.</p>		



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F 157	<p>Continued From page 8</p> <p>of any resident that has a fall to notify the RP of a change in condition. The in-service was completed 10/28/16 of all RNs and LPNs currently working. The in-services was changed and restarted on 10/31/16.</p> <p>On 10/31/16, the DON, ADON, staff facilitator, administrator, and department heads began in-servicing all staff on the importance of staff informing the nurse and the nurse notifying the physician, physician assistant, and/or nurse practitioner of a resident's change in condition (not just for falls). Also, the nurses must notify the resident's responsible party of a change in the resident's condition with basic information. If the RP has additional questions, the nurse is to inform the DON or administrator for follow-up with the RP. The in-service was completed 11/01/16 of all staff working. After 11/01/16, no staff is allowed to work until the notification in-service is completed. All new hires will receive the notification in-service during new employee orientation.</p> <p>Based on interviews with resident, staff, physician assistant and physician, and record review, the facility failed to notify the physician or the physician assistant of a resident's fall in the transportation van which resulted in a laceration at the back of the head for 1 (Resident #96) of 1 sampled resident.</p> <p>Findings included: Resident #96 was admitted to the facility on 9/6/16 with diagnoses of pyogenic arthritis (infectious arthritis with pus formed), abnormal posture, muscle weakness, Guillain-Barre</p>	F 157			

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NAME OF PROVIDER OR SUPPLIER  <b>LAKE PARK NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 FAITH CHURCH ROAD</b> <b>INDIAN TRAIL, NC 28079</b>		
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F 157	<p>Continued From page 9</p> <p>Syndrome (progressive muscle weakness and paralysis), scoliosis, chronic kidney disease, and infection of a shoulder surgical wound.</p> <p>During an interview on 9/26/16 at 11:28 AM, the resident revealed he fell backwards in the wheelchair while he was being transported from the dialysis center to the facility via the facility van. The resident stated he landed on the van floor and hit his head. He had a little cut on his head but he was okay.</p> <p>There were three handwritten statements dated 9/22/16 from the maintenance staff who was driving the van at the time of the accident. The three written statements included that the maintenance staff fell as he was pulling the resident from the lift to the van and the resident fell backwards on top of the maintenance staff and hit his head on the chair or the seat behind the driver seat. The maintenance staff asked the resident if he was okay and the resident responded yes. The maintenance staff noticed a cut on the back of the resident's head, with no blood draining. They got back to the facility and got the resident off the van and took him to the DON (director of nursing) and told her what happened.</p> <p>An interview with the Physician Assistant (PA) was conducted on 9/26/16 at 5:30 PM. The PA said that she knew about the laceration today. She said if there was a fall with the resident hitting his head, she expected the facility to assess and do neurochecks. The staff were expected to call and notify her of the fall and about the resident hitting his head.</p> <p>On 9/27/16 at 9:20 AM, the resident's Medical Doctor (MD) was interviewed. The MD said he did not remember if he was notified about the resident's incident that happened last week in the</p>	F 157			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

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F 157	<p>Continued From page 10</p> <p>van. He said he expected the staff to call him and let him know if there was head injury. He also expected the staff to assess the resident after a fall and do whatever needed.</p> <p>An interview was conducted with the director of nursing (DON) on 9/28/16 at 8:35 AM. When the resident arrived at the facility from dialysis, the maintenance staff brought the resident to the DON and told her what happened. The DON said she notified the Doctor by sending him a phone text message via the phone. The DON stated the MD never received the text and the MD did not know about the accident until 9/27/16. The DON did not follow up with the doctor to make sure he received the text.</p> <p>The validation of the credible allegation was completed on 11/02/16 at 5:45 PM by doing the following:</p> <p>Inservice training material was reviewed which included:</p> <ul style="list-style-type: none"> <li>-Anytime a resident demonstrates a change in condition (changes in emotion, behavior, alertness, eating habit, talking, increased behaviors, sleeping, etc) or any time a resident acts different than normal tell the nurses what you saw/heard.</li> <li>-Nurses (Registered Nurses and Licensed Practical Nurses, not Medication Aides) must assess the resident's condition, document the assessment then notify the physician or nurse practitioner and the responsible party with the concern and assessment findings. If the resident has an incident/accident causing injury, notification must be done in person or via telephone in addition to the communication book. Follow-up until contact is made.</li> <li>-If an emergency call 911. If the responsible party</li> </ul>	F 157			

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F 157	Continued From page 11 has questions give basic information and let Director of Nursing/Administrator know a follow-up is needed.  Inservice records were reviewed with staffing schedules and all staff working in the facility since 11/01/16 had participated in the notification of change inservice training. The Staff Development Coordinator had working plans to inservice licensed staff that had not participated in the inservice prior to their return to work.  Staff representing all departments and all shifts were interviewed regarding the inservice training and demonstrated understanding and response in a situation involving a resident and notification of change.  Seven medical records of residents with incidents involving falls and pressure ulcer development were reviewed and timely notification had been made to the physician/nurse practitioner and the responsible party.  Audits were reviewed and included verification that notification of change had been made to the physician/nurse practitioner and responsible party.	F 157			
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		11/2/16	

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F 309	Continued From page 12  This REQUIREMENT is not met as evidenced by: Based on interviews with resident, staff, physician assistant and physician, and record review, the facility failed to get professional staff to assess the resident for possible injury after a fall in the transportation van and before moving and driving the resident to the facility for 1 (Resident #96) of 1 sampled resident with a van accident. Resident #96 sustained a laceration on the back of the head from the fall. The facility also failed to do neurochecks per nursing intervention.  Immediate Jeopardy began on 9/22/16 when the facility staff failed to get professional staff to assess Resident #96 for possible injury after a fall in the transportation van and before moving and driving the resident from the dialysis center to the facility. Resident #96 sustained a laceration to the back of his head. The facility failed to do neurochecks per nursing interventions to monitor the resident for brain injury. The immediate jeopardy was removed on 11/2/16 when the facility's acceptable credible allegation of compliance was verified. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedure for assessment and monitoring a resident's significant change in condition. Findings included: Resident #96 was admitted to the facility on 9/6/16 with diagnoses of pyogenic arthritis (infectious arthritis with pus formed), abnormal	F 309	F 309 Provide Care/Services for Highest Well Being  A. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Outcome.  On 9/22/16, the maintenance worker and housekeeper assisted the resident back in to an upright position in the wheelchair on the van and returned to the facility without an assessment by a qualified medical professional, registered nurse, nurse practitioner, physician assistant, or medical doctor.  On 9/22/16, the maintenance worker immediately returned the resident to the facility and informed the director of nursing.  On 9/22/16, the director of nursing immediately assessed the resident. The resident had no complaint of pain and exhibited normal behavior and activity. The resident had a small scratch on the back of his head with two drops of blood. The director of nursing left a message for, but did not speak to, the responsible party (wife). The DON sent a text message to the attending physician. The director of nursing notified the treatment nurse. The director of nursing performed a neurological check assessment without		

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F 309	<p>Continued From page 13</p> <p>posture, muscle weakness, Guillain-Barre Syndrome (progressive muscle weakness and paralysis), scoliosis, chronic kidney disease, and infection of a shoulder surgical wound. The resident was admitted to the facility for wound treatment and rehabilitation for his shoulder with a plan to return home.</p> <p>Review of the admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 9/13/16 revealed the resident had a Brief Interview of Mental Status (BIMS) score of 10 (score of 8-12 indicated the resident was cognitively moderately impaired). The resident required assistance of staff in activities of daily living (ADL). The resident was coded for impairment in the range of motion of both upper and lower extremities. The resident was coded as not steady and only able to stabilize with human assistance during transition and walking.</p> <p>Review of the resident's care plan of 9/26/16 revealed the resident was at risk for falls characterized by actual falls with injury. The resident had multiple risk factors related to impaired mobility. The goal was the resident will be free of falls through the next review. The interventions included for the staff to assist during transfer and mobility and provide frequent observation of the resident.</p> <p>During an interview on 9/26/16 at 11:28 AM, the resident revealed he fell backwards in the wheelchair while he was being transported from the dialysis center to the facility via the facility van. The resident stated he landed on the van floor and hit his head. He had a little cut on his head but he was okay.</p> <p>Review of a written statement by the</p>	F 309	<p>negative findings. The DON gave the neurological check paperwork to the ADON with verbal instructions to continue the neurological checks throughout the night. The DON did not speak to the responsible party (wife). The neurological checks were not performed through the night. There was no policy or standing order established at the time for neurological checks.</p> <p>On 9/22/16, the treatment nurse immediately initiated a treatment to the back of the resident's head in the presence of the DON, after assessing the resident's scalp. The treatment nurse left a message for the responsible party (wife) and the responsible party returned the call which was the first notification of the injury to the responsible party (wife) since the responsible party had not returned the call to the director of nursing. The treatment nurse did not notify the physician for additional assessment due to the injury presenting more like a scratch to the scalp.</p> <p>On 9/22/16, the administrator and director of nursing interviewed the resident involved in the incident on the van. The resident gave an account of the events and incident.</p> <p>On 9/26/16 the DON notified the nurse practitioner (NP) of Resident #96's fall with laceration. No new orders were received after the NP's assessment.</p> <p>On 9/27/16, the DON talked to the attending physician regarding Resident</p>		

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F 309	<p>Continued From page 14</p> <p>administrator dated 9/22/16 revealed she interviewed the resident regarding a reported fall. The resident told the administrator he fell straight back hitting his head on a raised area on the van floor. The resident said that the driver pulled to the side of the road and the two men (the maintenance staff and floor technician) picked him up and asked him if he was okay. He told them he was fine and to just take him back to the facility.</p> <p>There were three handwritten statements dated 9/22/16 from the maintenance staff who was driving the van at the time of the accident. The three written statements included that the maintenance staff fell as he was pulling the resident from the lift to the van and the resident fell backwards on top of the maintenance staff and hit his head on the chair or the seat behind the driver seat. The floor technician jumped on the lift and picked up the resident and the wheelchair off of the maintenance staff. The maintenance staff asked the resident if he was okay and the resident responded yes. The maintenance staff noticed a cut on the back of the resident's head, with no blood draining. The floor technician sat next to the resident as they left dialysis. They got back to the facility and got the resident off the van and took him to the director of nursing (DON) and told her what happened.</p> <p>On 9/26/16 at 1 PM, the Floor technician was interviewed regarding the van accident. The floor technician stated when the resident fell on top of the maintenance staff, he (floor technician) got on the van and lifted the resident wheelchair off the maintenance staff and asked the resident if he was okay. The resident said he was okay. They secured the resident wheelchair in the van and brought him to the facility.</p>	F 309	<p>#96's fall with laceration (scratch) to the scalp. No new orders were received after MD assessment. On 9/27/16, the DON also spoke with the responsible party (wife) about the incident/accident on the van.</p> <p>As of 9/28/16, Resident #96 has been transported by contracted van services. The contracted van services are trained in safe transfer, safe transport, and safe securement techniques and equipped with a cellular telephone. The drivers know to call 911 if professional staff are not available to assess a resident.</p> <p>B. How did the facility identify other residents having the potential to be affected by the same deficient practice.</p> <p>On 9/28/16 at 1:15 pm, the corporate vice president of operations removed the Lake Park van from Lake Park premises indefinitely. Effective 9/28/16, the residents are transported by contracted services.</p> <p>On 10/27/16, the DON, ADON, administrator, and corporate facility consultant performed a 100% audit of residents with a fall involving a head injury within the past 72 hours to ensure assessment with neuro-checks are being performed and the physician has been notified of the fall. The audit findings reveled two residents neurological checks needed to be restarted. The neurological checks were restarted for the two residents on 10/27/16.</p>		

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F 309	Continued From page 15 On 9/26/16 at 3:14 PM, the maintenance staff was interviewed, in the presence of the administrator, regarding the accident in the van on 9/22/16. He said when the resident fell on him, the resident might have hit his head on the seat or on the seat belt buckle lying on the passenger bench which might have caused the laceration on the resident's head. The maintenance staff said that the floor technician got on the van and got the wheelchair off of him. The maintenance staff said he asked the resident if he was okay, and the resident said yes. The maintenance staff said he tried to call the DON's cell phone. She did not answer and he did not leave a message or try to call someone else. He said he did not think about asking the dialysis center to assess the resident before driving back to the facility. When asked if he received any training on transporting resident via the van, he said that he never received any training from this facility but he received training from another facility. During the interview, the administrator stated that there was a facility policy against the employees using their personal cell phone while on duty. So the maintenance staff was afraid he would get in trouble if he used his personal phone. The administrator said there was no facility phone on the van at the time of the accident, but a facility phone was available if the driver asked for it. The maintenance staff was interviewed again via telephone on 9/27/16 at 6:38 PM. The maintenance staff said the DON asked him to go pick up the resident from the dialysis center and bring him to the facility via the facility van. The dialysis center was about 20 -25 minutes away from the facility. The maintenance staff said "we were right in front of the dialysis center. (The resident) said he was okay (after the resident	F 309	C. Give specific dates of the corrective actions.  On 10/20/16, the DON, ADON, staff facilitator, administrator, and corporate facility consultant, began in-servicing all RNs, LPNs, medication aides, nursing assistants, housekeepers, maintenance, dietary, administrative, activities, and therapy staff on the requirement to not move the resident after an incident/accident until a complete assessment has been completed by a nurse, nurse practitioner, physician assistant, or medical doctor. If no licensed professional is available, call 911. If the accident/incident happens outside the facility, the patient must still be assessed by a professional and if a licensed professional is not available, call 911. The in-service was completed 10/31/16 of all staff. After 11/1/16, no staff person is allowed to work until the in-service is completed. All new hires will receive the in-service during new employee orientation.  On 10/27/16, the DON, ADON, staff facilitator, administrator, and corporate facility consultant, began in-servicing all registered nurses (RNs) and licensed practical nurses (LPNs) on the importance of performing neurological assessments, including a neurological check schedule according to nursing standard of practice, when a resident has an accident/injury involving their head. The in-service was completed 10/28/16 of all RNs and LPNs		



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F 309	Continued From page 16 fell). I called from my phone (to let the facility know of the accident). (The) Receptionist could not find (the) DON. " The Maintenance staff said he drove the van to the facility. The maintenance staff stated he did not think of calling 911 or getting the dialysis center's professional staff to assess the resident because the resident said he was okay. An interview was conducted with the DON on 9/28/16 at 8:35 AM. When the resident arrived at the facility from dialysis, the maintenance staff brought the resident to the DON and told her what happened. The treatment nurse and the DON did a head to toe assessment. They noticed a scratch on him with no bleeding. There was some blood on the hair and that was how they knew there was a cut. There was no drip down of blood. They initiated neurochecks. They did not do range of motion. Then they used the slide board to put him in bed. The DON said she notified the Doctor by sending him a phone text message on the phone. The DON stated the MD never received the text and the MD did not know about accident until 9/27/16. Interview with the treatment nurse was conducted on 9/27/16 at 5:56 PM. This treatment nurse provided treatment for the resident's head laceration when he came back from dialysis on 9/22/16. The treatment nurse stated the resident appeared alert and oriented and he answered her questions appropriately. The treatment nurse said the laceration was not bleeding but had some redness. Review of the document titled "Neurological Observations " revealed neurochecks were initiated on 9/22/16 at 3:30 PM. The neurochecks were scheduled to be done every 30 minutes for 4 hours (from 3:30 PM till 7:30 PM on 9/22/16), every hour for 4 hours (from 8:30 PM till 11:30	F 309	currently working. After 10/28/16, no RN or LPN is allowed to work until the in-service is completed. All RN and LPN new hires will receive the neuro-check in-service during new employee orientation.  On 10/31/16, the DON, ADON, staff facilitator, administrator, and department heads began in-servicing all staff on the importance of staff informing the nurse and the nurse notifying the physician, physician assistant, and/or nurse practitioner of a resident's change in condition (not just for falls). Also, the nurses must assess the resident's condition, document the assessment, then notify the physician or nurse practitioner and resident's responsible party. To ensure proper assessment when a resident has an incident/accident causing injury, physician or nurse practitioner notification must be done in person or via telephone in addition to the communication book, including calling 911. The in-service will be completed 11/01/16 of all staff working. After 11/01/16, no staff is allowed to work until the notification/assessment in-service is completed. All new hires will receive the notification in-service during new employee orientation.  D. How the facility will monitor processes to prevent recurrence  On 11/02/16, the ADON began auditing 100% of resident progress notes to ensure that the physician and/or NP and		

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F 309	<p>Continued From page 17</p> <p>PM on 9/22/16), every 4 hours for 24 hours (from 3:30 AM on 9/23/16 till 3:30 AM 9/24/16), every shift starting on the 7:30 AM-3 PM shift on 9/24/16 and ending on the 3 PM-11 PM shift on 9/25/16. The neurochecks were done as scheduled on 9/22/16 at 3:30 PM, 4PM, 4:30 PM, and 5:00 PM and the neurochecks were within normal limits. Neurochecks were not documented as done on 9/22/16 at 5:30 PM, 6:00 PM, 6:30 PM, 7:00 PM, 7:30 PM, 8:30 PM, 9:30 PM, and 10:30 PM. Neurochecks were done as scheduled thereafter and they were within normal limits.</p> <p>The nurse that was on duty when the resident returned from dialysis (Nurse #5) on 9/22/16 was interviewed on 6:03 PM at 9/27/16. She said nothing was reported to her about the resident accident and the need to do neurochecks. The resident did not tell her about the incident when she went at 4:30 PM to do his accucheck. She did not do neurochecks on her shift (3PM-11 PM on 9/22/16).</p> <p>An interview with the Assistant Director of Nursing (ADON) on 11/2/16 at 2:25 PM revealed "We have always used the Neurological Observation Sheet to document neurochecks. We write the resident's name and date on the sheet and implement neurochecks immediately after a fall with a suspected head injury." The ADON provided the following documentation of the frequency of the neurochecks posted at the nurses' station and used in the facility until 10/27/16:</p> <p>Neurological Record Frequency: Every 30 minutes X 4 hours Every 1 hour X 4 hours Every 4 hours X 24 hours Every 8 hours X for remaining 72 hours or as ordered by the MD</p>	F 309	<p>responsible party were notified of resident significant change in condition, including accidents, using the progress note audit tool. The audit will be completed by the DON, ADON, staff nurse, and/or corporate consultant 5x/week x 4 weeks, then weekly x 8 weeks, then monthly x 3 months.</p> <p>The monthly QI committee will review the results of the Progress Note Audit tool monthly x 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendation for monitoring for continued compliance. The administrator and/or DON will present the finding and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.</p>		

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F 309	<p>Continued From page 18</p> <p>An interview with the DON on 11/2/16 at 2:37 PM revealed, "We have always used the Neurological Observation Sheet to document neuro checks. We used the parameters which were posted at the nurses' station (same as above) and that has been our practice for the five years I have worked at the facility. It was not a policy and not sure the origin of the parameters. Because it was not consistent with the standard of practice in the industry it was reviewed and revised by our medical director after the survey. Now we have new parameters for neurochecks which were put into place on 10/27/16 and include:</p> <p>Every 15 minutes X 1 hour Every 30 minutes X 2 hours Every hour X 4 hours Every 4 hours X 12 hours Then every shift till 72 hours. "</p> <p>An interview with the Physician Assistant (PA) was conducted on 9/26/16 at 5:30 PM. The PA said that she knew about the laceration today. She said if there was a fall with the resident hitting his head, she expected the facility to assess and do neurochecks. The staff were expected to call and notify her of the fall and about the resident hitting his head.</p> <p>On 9/27/16 at 9:20 AM, the resident's Medical Doctor (MD) was interviewed. The MD expected the staff to assess the resident after a fall and do whatever needed. They can do neurochecks and monitor for a change in mental status. If the injury was superficial and the resident did not have any loss of consciousness, then it was okay to keep the resident in the facility and monitor for changes. If the resident complained of headache, had symptoms or change in level of consciousness, then they needed to send him to</p>	F 309			

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F 309	<p>Continued From page 19</p> <p>the hospital. The MD was told that the floor technician and the maintenance staff picked up the resident and drove him back to the facility without assessment. The MD said the risk of serious harm to the resident from moving and driving him to the facility without assessment was low because the resident was alert and oriented with no changes in his level of consciousness. The MD said the resident could have intracranial bleeding, whip lash or neck injury/discomfort from the fall. The MD said the resident could have internal injuries without symptoms for a while. On 10/27/16 at 4:08 PM, the administrator was notified of the immediate Jeopardy. The administrator provided the following credible allegation of compliance on 10/31/16 at 6:04 PM:</p> <p>A. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Outcome.</p> <p>On 9/22/16, the maintenance worker and housekeeper (floor technician) assisted the resident back in to an upright position in the wheelchair on the van and returned to the facility without an assessment by a qualified medical professional, registered nurse, nurse practitioner, physician assistant, or medical doctor.</p> <p>On 9/22/16, the maintenance worker immediately returned the resident to the facility and informed the director of nursing.</p> <p>On 9/22/16, the director of nursing immediately assessed the resident. The resident had no complaint of pain and exhibited normal behavior and activity. The resident had a small scratch on the back of his head with two drops of blood. The director of nursing left a message for, but did not speak to, the responsible party. The DON sent a text message to the attending physician. The</p>	F 309			

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F 309	<p>Continued From page 20</p> <p>director of nursing notified the treatment nurse. The director of nursing performed a neurological check assessment without negative findings. The DON gave the neurological check paperwork to the ADON with verbal instructions to continue the neurological checks throughout the night. The DON did not speak to the responsible party. The neurological checks were not performed through the night. There was no policy or standing order established at the time for neurological checks. On 9/22/16, the treatment nurse immediately initiated a treatment to the back of the resident's head in the presence of the DON, after assessing the resident's scalp. The treatment nurse left a message for the responsible party and the responsible party returned the call which was the first notification of the injury to the responsible party since the responsible party had not returned the call to the director of nursing. The treatment nurse did not notify the physician for additional assessment due to the injury presenting more like a scratch to the scalp. On 9/22/16, the administrator and director of nursing interviewed the resident involved in the incident on the van. The resident gave an account of the events and incident. On 9/26/16 the DON notified the nurse practitioner (NP) of Resident #96's fall with laceration. No new orders were received after the NP ' s assessment. On 9/27/16, the DON talked to the attending physician regarding Resident #96's fall with laceration (scratch) to the scalp. No new orders were received after MD assessment. On 9/27/16, the DON also spoke with the responsible party about the incident/accident on the van.</p> <p>As of 9/28/16, Resident #96 has been transported by contracted van services. The contracted van</p>	F 309			

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F 309	<p>Continued From page 21</p> <p>services are trained in safe transfer, safe transport, and safe securement techniques and equipped with a cellular telephone. The drivers know to call 911 if professional staff are not available to assess a resident.</p> <p>B. How did the facility identify other residents having the potential to be affected by the same deficient practice.</p> <p>On 9/28/16 at 1:15 pm, the corporate vice president of operations removed the Lake Park van from Lake Park premises indefinitely. Effective 9/28/16, the residents are transported by contracted services.</p> <p>On 10/27/16, the DON, ADON, administrator, and corporate facility consultant performed a 100% audit of residents with a fall involving a head injury within the past 72 hours to ensure assessment with neuro-checks are being performed and the physician has been notified of the fall. The audit findings reveled two residents neurological checks needed to be restarted. The neurological checks were restarted for the two residents on 10/27/16.</p> <p>C. Give specific dates of the corrective actions.</p> <p>On 10/20/16, the DON, ADON, staff facilitator, administrator, and corporate facility consultant, began in-servicing all RNs, LPNs, medication aides, nursing assistants, housekeepers, maintenance, dietary, administrative, activities, and therapy staff on the requirement to not move the resident after an incident/accident until a complete assessment has been completed by a nurse, nurse practitioner, physician assistant, or medical doctor. If no licensed professional is</p>	F 309			

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F 309	<p>Continued From page 22</p> <p>available, call 911. If the accident/incident happens outside the facility, the patient must still be assessed by a professional and if a licensed professional is not available, call 911. The in-service was completed 10/31/16 of all staff. After 11/1/16, no staff person is allowed to work until the in-service is completed. All new hires will receive the in-service during new employee orientation.</p> <p>On 10/27/16, the DON, ADON, staff facilitator, administrator, and corporate facility consultant, began in-servicing all registered nurses (RNs) and licensed practical nurses (LPNs) on the importance of performing neurological assessments, including a neurological check schedule according to nursing standard of practice, when a resident has an accident/injury involving their head. The in-service was completed 10/28/16 of all RNs and LPNs currently working. After 10/28/16, no RN or LPN is allowed to work until the in-service is completed. All RN and LPN new hires will receive the neuro-check in-service during new employee orientation.</p> <p>On 10/31/16, the DON, ADON, staff facilitator, administrator, and department heads began in-servicing all staff on the importance of staff informing the nurse and the nurse notifying the physician, physician assistant, and/or nurse practitioner of a resident's change in condition (not just for falls). Also, the nurses must assess the resident's condition, document the assessment, then notify the physician or nurse practitioner and resident's responsible party. To ensure proper assessment when a resident has an incident/accident causing injury, physician or nurse practitioner notification must be done in</p>	F 309			

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F 309	<p>Continued From page 23</p> <p>person or via telephone in addition to the communication book, including calling 911. The in-service will be completed 11/01/16 of all staff working. After 11/01/16, no staff is allowed to work until the notification/assessment in-service is completed. All new hires will receive the notification in-service during new employee orientation.</p> <p>The validation of the credible allegation was completed on 11/02/16 at 5:45 PM by doing the following:</p> <p>Inservice training material was reviewed which included:</p> <ul style="list-style-type: none"> <li>-If a resident has a fall the staff member must immediately notify the licensed staff for assessment to be completed prior to moving the resident. If resident is out of facility with a staff member when fall occurs resident must still be assessed by a professional. If a licensed staff member is not present to assess you should call 911 to assess.</li> </ul> <p>Inservice records were reviewed with staffing schedules and all staff working in the facility since 11/01/16 had participated in the inservice training.</p> <p>Staff representing all departments and all shifts were interviewed regarding the inservice training and demonstrated understanding and response in a situation involving assessment of a resident after a fall.</p> <p>Six medical records of residents with incidents involving falls were reviewed and documentation of a physical assessment had been completed by</p>	F 309			



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F 309	Continued From page 24 a licensed nurse. Neuro checks were implemented for residents with a suspected injury and completed consistent with parameters implemented by the medical director. Two of the six residents were interviewable and verified a licensed nurse had assessed them after a recent fall.	F 309			
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 adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews with resident, family, facility staff, physician assistant and physician, and record review, the facility failed to transport a resident from the dialysis center to the facility in a safe manner with trained staff. The resident fell in the van and sustained a laceration in the back of the head. This is evident in 1 of 2 sampled resident (Resident # 96). Immediate Jeopardy began on 9/22/16 when Resident #96 and his wheelchair fell backwards in the transportation van and the resident sustained a laceration to the back of his head. The immediate jeopardy was removed on 9/29/16	F 323	F 323 Free of Accidents  On 9/22/16, the maintenance worker and housekeeper assisted the Resident #96 back in to an upright position in the wheelchair on the van and returned to the facility. On 9/22/16, the maintenance worker immediately returned the resident to the facility and informed the director of nursing (DON).  On 9/22/16, the DON immediately assessed the resident #96. The resident	11/2/16	

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F 323	<p>Continued From page 25</p> <p>at 3 PM when the facility's acceptable credible allegation of compliance was verified. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedure for residents' transportation to appointments and other activities.</p> <p>Findings included:</p> <p>Resident #96 was admitted to the facility on 9/6/16 with diagnoses of pyogenic arthritis (infectious arthritis with pus formed), abnormal posture, muscle weakness, Guillain-Barre Syndrome (progressive muscle weakness and paralysis), scoliosis, chronic kidney disease, and infection of a shoulder surgical wound. The resident was admitted to the facility for wound treatment and rehabilitation for his shoulder with a plan to return home.</p> <p>Review of the admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 9/13/16 revealed the resident had a Brief Interview of Mental Status (BIMS) score of 10 (score of 8-12 indicated the resident was cognitively moderately impaired). According to the MDS, the resident had no symptoms of delirium and did not have behaviors. The resident required assistance of staff in activities of daily living (ADL). The resident was coded for impairment in the range of motion of both upper and lower extremities. The resident was coded as not steady and only able to stabilize with human assistance during transition and walking.</p> <p>The resident Care Area Assessment (CAA) for falls of 9/19/16 revealed the resident was at risk</p>	F 323	<p>had no complaint of pain and exhibited normal behavior and activity. The resident had a small scratch on the back of his head with two drops of blood. The director of nursing left a message for the responsible party. The director of nursing notified the treatment nurse. On 9/22/16, the treatment nurse immediately initiated a treatment to the back of the resident's head and notified the resident's responsible party/wife. On 9/22/16, the assigned second shift nurse assessed resident # 96 during medication administration for pain without negative findings. Resident #96 denied pain or discomfort and ate dinner as usual.</p> <p>On 9/22/2016, the administrator stopped all facility transports with the facility van and secured the van keys.</p> <p>On 9/23/2016, the corporate facility consultant and the corporate clinical director reviewed the appointment book to verify outside transportation had been arranged for Resident #96's appointments through 9/27/2016.</p> <p>On 9/23/2016, the corporate facility consultant and the corporate clinical director reviewed the appointment book to identify residents requiring transports 9/23/2016 - 9/27/2016 and verified transportation was scheduled to be provided by an outside transportation company.</p> <p>On 9/26/2016, the administrator reviewed the appointment book for all currently</p>		

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F 323	<p>Continued From page 26</p> <p>of falls related to impaired balance and mobility. The CAA indicated the resident had difficulty maintaining sitting balance and had impaired balance during transfer. The risk factors included neuromuscular and functional (impairment), loss of arm or leg movement, incontinence, arthritis, cognitive impairment, infection and pain. Care plan considerations included to minimize risks of falls and to proceed to care plan.</p> <p>Review of the PPS (prospective payment system) 14-day MDS with ARD of 9/20/16 revealed the resident BIMS was 14 (score of 13-15 indicated the resident was cognitively intact).</p> <p>Review of the resident's care plan of 9/26/16 revealed the resident was at risk for falls characterized by actual falls with injury. The resident had multiple risk factors related to impaired mobility. The goal was the resident will be free of falls through the next review. The interventions included for the staff to assist during transfer and mobility and provide frequent observation of the resident.</p> <p>An interview was conducted on 9/29/16 at 1 PM with the social worker who did the assessments of the cognitive pattern of the resident on the MDS of 9/13/16 and 9/20/16. The social worker stated the resident's cognition had improved since admission and that she believed that his assessment of BIMS 14 on the MDS of 9/20/16 was accurate. The resident was alert, oriented and credible. When the resident comes back from dialysis, he is tired and has trouble focusing and concentrating.</p> <p>During an interview on 9/26/16 at 11:28 AM, the resident revealed he had an accident in the van</p>	F 323	<p>scheduled appointments and verified transportation will be provided by an outside transportation company.</p> <p>On 9/27/2016, the facility administrator and the corporate vice president of operations determined the facility van will remain out of service indefinitely.</p> <p>On 9/28/2016, the corporate vice president of operations removed the van from facility premises.</p> <p>On 9/28/2016, the administrator and the outside transportation services added an addendum to each of the three outside service's contract. The addendum included that transport staff have been trained in safe transfer, transport, and securement while transporting resident in vans.</p> <p>On 9/28/2016, the administrator and DON were in-serviced by the corporate vice president of operations related to ensuring the resident environment remains free of hazard, ensuring staff are trained and performance monitored prior to delegating a task, and ensuring assigned tasks are within the staff's scope of practice.</p> <p>On 9/29/2016, the corporate clinical director completed an audit of a resident transport to ensure the resident was being transported by a contracted outside transportation agency and safe securement of the wheelchair. Beginning 10/24/2016, the administrator, DON, ADON, corporate facility consultant,</p>		

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F 323	<p>Continued From page 27</p> <p>last week. The resident revealed there were two facility staff members on the van during transport. The resident revealed the driver did not know exactly how to tie down the wheelchair in the van, and the driver and the other person with him did not tie down the front wheels of the wheelchair correctly. When the van turned on highway 74, it accelerated to merge into traffic, the wheelchair flipped backwards, and the resident stated he landed on the van floor and hit his head. He had a little cut on his head but he was okay.</p> <p>On 9/26/16 at 3:55 PM, the resident was interviewed again with a family member present. The resident revealed (referring to the van accident on 9/22/16), the van turned on highway 74 and had to accelerate to merge into traffic when the wheelchair tilted backwards and he fell backwards on the van floor. When asked where he thought he hit his head, he said on the curb (a raised area in the back of the van) in the back of the van. The resident said one of the staff was training the other on how to secure the wheelchair and they did not know what they were doing. The family member said the facility never told her what happened but the resident told her that he fell backwards in the van as it accelerated into highway 74 to merge into traffic and the wheelchair tilted backwards and the resident fell on the floor.</p> <p>Review of a written statement by the administrator dated 9/22/16 revealed she interviewed the resident regarding a reported fall. The resident told the administrator he was picked up at the dialysis center by two men. The resident stated on their way back to the facility on highway 74, the van accelerated and the resident fell straight back hitting his head on a raised area</p>	F 323	<p>and/or the corporate clinical director will begin auditing the outside transportation services using the Transportation Audit tool. The audit will be completed weekly x 12 weeks, then monthly x 3 months.</p> <p>On 10/21/2016, an in-service was initiated for all staff related to not completing tasks that are not within their scope of practice and reporting to the administrator when asked to perform a task the staff person is not trained to perform. The in-service will be completed by 10/24/2016. No staff will be allowed to work a shift until they complete the in-service. All new hires will receive the in-service during new employee orientation.</p> <p>Beginning 10/24/2016, the administrator, DON, ADON, corporate facility consultant, and/or the corporate clinical director began auditing the outside transportation services for safe securement of the wheelchair using the Transportation Audit tool. The audit will be completed weekly x 12 weeks, then monthly x 3 months.</p> <p>The monthly QI committee will review the results of the Transportation Audit tool monthly x 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendation for monitoring for continued compliance. The administrator and/or DON will present the finding and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations</p>		

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F 323	<p>Continued From page 28</p> <p>on the van floor. The resident said that the driver pulled to the side of the road and the two men picked him up and asked him if he was okay. He told them he was fine and to just take him back to the facility.</p> <p>Review of a written statement by the director of nursing (DON) dated 9/22/16 at 4 PM revealed that both the administrator and the DON interviewed the resident together. The resident said that the accident happened when the van pulled out onto highway 74 and it accelerated and the resident did not. The resident told the administrator and the DON that when the van accelerated, he fell backwards and hit his head on the curved area at the door in the back. The resident noted that one staff member was being trained by the other.</p> <p>Review of an accident report prepared by the DON and dated 9/22/16 revealed the resident's wheelchair tilted backwards while being transported from the van lift to inside the van. Staff caught the resident and returned him to an upright position. The staff reported that the van was stationary at the time. Occipital (the back of the head) laceration was noted to be 0.5 centimeters (cm) by 0 cm. Under the section "Incident Description", the resident described that he fell backwards in the wheelchair in the van. The incident report indicated the resident was oriented to person, situation, place and time. The employee reported that the employee slipped and the wheelchair fell backwards on the employee's lap. The report revealed the physician was notified on 9/22/16 at 3:45 PM.</p> <p>There were three handwritten statements dated 9/22/16 from the maintenance staff who was</p>	F 323	and oversight.		

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F 323	<p>Continued From page 29</p> <p>driving the van at the time of the accident. The three written statements contained the following description of the accident of 9/22/16: the maintenance staff was picking the resident up from the dialysis center around 3:00 or 3:15 PM. The floor technician went with him. The van had a side entrance door with the lift. As the maintenance staff was putting the resident on the lift, the maintenance staff started backing into the van and the maintenance staff fell backwards. The resident and the wheelchair came back on top of the maintenance staff. The floor technician jumped on the lift and picked up the resident and the wheelchair off of the maintenance staff. The three written statements included that when the resident fell backward his head hit either the side of the chair in the back of the van, the corner of a chair or the seat behind the driver seat. The maintenance staff asked the resident if he was okay and the resident responded yes. The maintenance staff strapped the back wheels and the floor technician strapped the front wheels of the wheelchair to the floor tie down. The floor technician sat next to the resident as they left dialysis. The maintenance staff noticed a cut on the back of the resident's head, with no blood draining. They got back to the facility and got the resident off the van and took him to the DON (director of nursing) and told her what happened.</p> <p>A typed written statement from the floor technician dated 9/23/16 revealed that, on Thursday, 9/22/16, the resident was being transferred in his wheelchair from the van lift to inside the van. The maintenance staff slipped backwards, and the resident in the wheelchair tilted backwards and landed on top of the maintenance staff. The floor technician helped with bringing the resident back to a sitting</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>position. The resident repeatedly said he was okay. The resident seemed okay except for a small scratch on the back of his head. The resident bumped the back of his head on the back of the driver seat. Then they moved the resident in the wheelchair to the place to be strapped down in the van. The maintenance staff drove straight back to the facility while the floor technician sat next to the resident. The resident talked and seemed okay. The maintenance staff told the director of nursing what happened.</p> <p>On 9/26/16 at 1 PM, the Floor technician was interviewed regarding the van accident and also did a demonstration of how the resident and the wheelchair fell backwards in the van on 9/22/16. The floor technician revealed they were at the dialysis center picking up the resident. The floor technician stated he was on the ground operating the lift. The floor technician demonstrated with a wheelchair and a person sitting in the wheelchair how the maintenance staff placed the resident on the van lift, raised him to the van and walked backwards and parallel to the bench seat (perpendicular to the driver seat), with the wheelchair tilted on the rear two wheels only, to maneuver the wheelchair in the van. The floor technician described how the maintenance staff tripped as he was walking backwards (with the wheelchair on two wheels only) and fell on the floor and the resident with the wheelchair fell on top of him. The floor technician stated he got on the van and lifted the resident's wheelchair off the maintenance staff and asked the resident if he was okay. The resident said he was okay. They secured the resident's wheelchair in the van and brought him to the facility.</p> <p>On 9/26/16 at 3:14 PM, the maintenance staff</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>was interviewed and also did a demonstration of how the resident and the wheelchair fell backwards in the van on 9/22/16. The maintenance staff demonstrated using a wheelchair and a person sitting in the wheelchair. The maintenance staff said he was on the lift with the resident in the wheelchair. He backed the wheelchair into the van perpendicular to the bench seat. He tripped and fell backwards and the wheelchair fell on top of him. The resident might have hit his head on the seat or on the seat belt buckle lying on the passenger bench which might have caused the laceration on the resident's head. The maintenance staff said that the floor technician got on the van and got the wheelchair off of him. The maintenance staff denied tilting the wheelchair back on only two rear wheels to maneuver the wheelchair in the van. The maintenance staff said he asked the resident if he was okay, and the resident said yes. The maintenance staff said he tried to call the DON's cell phone. She did not answer and he did not leave a message or try to call someone else. He said he drove the resident back to the facility. When asked if he received any training on transporting residents via the van, he said that he never received any training from this facility but he received training from another facility. The floor technician joined the demonstration and the interview with the maintenance staff. The floor technician recanted his description of how the maintenance staff tilted the wheelchair on only the two back wheels and agreed with the maintenance staff demonstration and statement.</p> <p>On 9/28/16 at 10:24 AM, the floor technician was interviewed again. The floor technician said he could not see the maintenance staff fall or the resident fall from where he was standing on the</p>	F 323			



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F 323	<p>Continued From page 32</p> <p>ground. When asked why there were discrepancies between his description of what happened (on 9/26/16 at 1 PM), the resident description and the maintenance staff description, he said, "what happened is what I am describing now." Then the floor technician proceeded to describe what happened to match the description of the maintenance staff. When asked why he sat beside the resident on the way back, he said "I did not want any more accidents. " The floor technician said that he was never trained on safe transport of residents by the van, not even after the accident happened.</p> <p>The maintenance staff was interviewed again via telephone on 9/27/16 at 6:38 PM. The maintenance staff said the DON asked him to go pick up the resident from the dialysis center and bring him to the facility via the facility van. The maintenance staff stated he rode along with the previous driver but nobody gave him a skill test to make sure he knew how to transport residents safely in the facility van. The dialysis center was off highway 74. The maintenance staff said when the accident happened, the van was stationary. The dialysis center was about 20 -25 minutes away from the facility. The maintenance staff said " we were right in the front of the dialysis center. (The resident) said he was okay (after the resident fell). I called from my phone (to let the facility know of the accident). (The) Receptionist could not find (the) DON. " The Maintenance staff said he drove the van to the facility. When the maintenance staff was told the resident said the accident happened on highway 74, the staff maintenance staff said " We were definitely not on 74. "</p> <p>An interview with the administrator on 9/27/16 at</p>	F 323			

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F 323	<p>Continued From page 33</p> <p>8:45 AM was conducted. The administrator said there was no formal training for drivers before they drove the van. The administrator said the maintenance staff and the floor technician were never trained on how to transport residents in the facility's van. There was no policy on how to train staff on what to do with securing the wheelchair in the van. The administrator said that she asked the resident what happened and he told her a different story. She said that the resident told her that he fell backwards in his wheelchair when the van was turning on highway 74 when the driver had to accelerate to merge into traffic. The administrator said that the resident had periods of confusion so she did not believe he was accurately describing what happened. She had no reason to believe that the floor technician or the maintenance staff were not telling the truth.</p> <p>An interview with the administrator 9/27/16 at 10:22 AM revealed the facility had formal training for the van drivers. The administrator provided a transportation safety training test that was taken by the driver that left employment on 9/20/16.</p> <p>During an interview on 9/27/16 at 2:36 PM, the administrator confirmed again that the floor technician and the maintenance staff were not trained on van transportation of wheelchair bound residents. The maintenance staff was an employee of the facility and the floor technician was an employee of a contracted housekeeping company. The resident was transported to dialysis by a contracted transportation company on the morning of 9/22/16. The resident did not have anybody scheduled to pick him up from dialysis, therefore, the maintenance staff was asked to get the resident from dialysis. The floor technician and the maintenance staff never</p>	F 323			

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F 323	<p>Continued From page 34</p> <p>transported any residents of the facility before that date.</p> <p>Observation and demonstration of the van securement system was done on 9/28/16 at 10:10 AM. The floor technician and the maintenance staff were present, as well as the administrator and the corporate staff. The demonstration was done in the facility van. The wheelchair was raised via the lift with a surveyor and the maintenance staff on the lift. The maintenance staff secured the floor straps to the frame on the back of the wheelchair. The floor technician attached the straps to the loop attached to the front wheels instead of the wheelchair frame. When the wheelchair was pushed on from the back, the front wheels slightly raised up from floor.</p> <p>Review of the manufacturer's instructions of the securement system in the facility's van revealed the two front tie down straps should be attached to a solid frame close to the level of the seat.</p> <p>An interview with the Physician Assistant (PA) was conducted on 9/26/16 at 5:30 PM. The PA said that she learned about the van accident and the laceration today. The PA said staff told her today that the accident happened at the dialysis center when the maintenance staff fell and the resident fell on top of the maintenance staff. The PA said that the resident had problems with short term memory. The short term recall was not good. When she was told that the resident repeated the same description of the accident two times with the surveyors and one time with the family, she said "I would believe him."</p> <p>On 9/27/16 at 9:20 AM, the resident's Medical</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>Doctor (MD) was interviewed. He was oriented to self and place. When the MD was told that the resident repeated the same description of what happened on the van three separate times, the MD said, he would say the resident was not falsifying the facts. The MD said the resident goal was to go back home.</p> <p>Interview with the MD again on 9/27/16 at 10:15 AM revealed that he talked with the physical therapist and she told him that the resident was more confused when he was first admitted to the facility. He seemed to have improved cognition.</p> <p>On 9/28/16 at 11:16 AM, the physical therapist (PT) was interviewed. She said she was working with the resident on bed mobility and his slide board transfer. The PT saw him five times a week for therapy. The resident followed commands pretty well. He was improving and needing less help. He was oriented but the day he went to dialysis he was tired and lethargic. He was reliable and he can recall. On 9/22/16, the resident was already in the bed and he was lethargic and he did not want to get out of the bed so she worked with him on bed mobility. The PT saw a little blood on the pillow so she asked the resident what happened. The resident told her that the driver did not secure the strap tie down and when the van turned on highway 74, the van accelerated and the wheel chair fell backwards.</p> <p>Review of the PT notes of 9/22/16 revealed the resident stated he fell in the van, when they were coming back from dialysis. The resident told PT that the person who was bringing him back to the facility did not secure the strap and when the van accelerated, the resident fell backwards.</p>	F 323			

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F 323	<p>Continued From page 36</p> <p>Interview with the treatment nurse was conducted on 9/27/16 at 5:56 PM. This treatment nurse provided treatment for his head laceration when he came back from dialysis on 9/22/16. The resident did tell her that he fell in the van. He said something about falling on highway 74. He appeared alert and oriented. He answered her questions appropriately. The treatment nurse said "I would believe him." The laceration was not bleeding but had some redness.</p> <p>On 9/28/16 at 6:55 PM, a nursing assistant (NA # 1) that worked with the resident on the 11PM-7AM shift was interviewed. The NA stated the resident told her the accident happened on the van on the way coming back from dialysis. The NA stated the resident was credible.</p> <p>An interview was conducted with the DON on 9/28/16 at 8:35 AM. When the resident arrived at the facility from dialysis, the maintenance staff brought the resident to the DON and told her what happened.</p> <p>On 9/27/16 on 7:24 PM, the administrator, the DON, the regional vice president and the corporate consultants were interviewed. The DON said that the resident was at dialysis and he needed to be picked up. So she asked the maintenance staff to go in the van and pick the resident up. The administrator said she was made aware of the fall. She instructed the staff to assess the resident right away. She began an investigation and suspended the maintenance staff. Then she took the keys to the van and put it in her office. The van had not been used for transportation since the accident. The administrator said she went to interview the resident and he told her that the accident</p>	F 323			

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F 323	<p>Continued From page 37</p> <p>happened on highway 74. The administrator said she asked the maintenance staff to reenact what happened. This is when the administrator found out that the floor technician was with them when the accident happened. The administrator said that she wanted the van to be taken out of service and get checked out for the functionality of the safety tie down. The next day (9/23/16) the facility management interviewed the floor technician and asked him to do a demonstration of what happened.</p> <p>On 9/27/16 at 7:15 PM, the administrator was notified of the immediate Jeopardy. The administrator provided the following credible allegation of compliance on 9/28/16 at 6:55 PM: How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>On 9/22/16, the maintenance worker and floor technician assisted the resident back in to an upright position in the wheelchair on the van and returned to the facility.</p> <p>On 9/22/16, the maintenance worker immediately returned the resident to the facility and informed the director of nursing. The maintenance worker submitted a written statement and performed a reenactment prior to leaving on administrative suspension.</p> <p>On 9/22/16, the director of nursing immediately assessed the resident. The resident had no complaint of pain and exhibited normal behavior and activity. The resident had a small scratch on the back of his head with two drops of blood. The director of nursing left a message for the responsible party. The director of nursing notified the treatment nurse. The director of nursing performed a neurocheck without negative findings.</p>	F 323			

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F 323	<p>Continued From page 38</p> <p>On 9/22/16, the treatment nurse immediately initiated a treatment to the back of the resident's head and notified the resident's responsible party.</p> <p>On 9/22/16, the administrator and director of nursing interviewed the resident involved in the incident on the van. The resident gave an account of the events and incident.</p> <p>On 9/22/16, the administrator interviewed the maintenance worker, had the maintenance worker re-enact the event, and obtained a written statement from the maintenance worker. The maintenance worker verified there was no other resident on the van.</p> <p>On 9/22/16, the administrator stopped all facility transports with facility van and secured the van keys.</p> <p>How did the facility identify other residents having the potential to be affected by the same deficient practice.</p> <p>On 9/22/16, the administrator interviewed and verified with the maintenance worker and floor technician there was only the one resident on the 9/22/16 and furthermore they had not previously transported other residents.</p> <p>On 9/22/16, the administrator validated the facility's use of three outside transportation services. In the event the scheduled outside transportation service was unable to provide pick-up or return transportation, other outside transportation services will be contacted.</p> <p>On 9/23/16, the corporate facility consultant and corporate clinical director reviewed the appointment book to identify residents requiring transports 9/23/16 - 9/27/16 and verified transportation from an outside transportation company was scheduled. Appointments had been scheduled with an outside transportation providers.</p> <p>On 9/26/16, the administrator reviewed the</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>appointment book for all currently scheduled appointments and verified transportation will be provided by outside transportation providers. Specific dates of the corrective actions.</p> <p>On 9/22/16, the administrator collected the van keys and stopped all facility transports with facility van.</p> <p>On 9/22/16, the administrator verified there are three transport services used to provide transport services when needed.</p> <p>On 9/27/16, the facility administrator and Corporate Vice President of Operations determined the facility van will remain out of service indefinitely.</p> <p>On 9/28/16 at 1:15 PM, the Corporate Vice President of Operations removed the facility van from facility premises indefinitely. On 9/28/16, the administrator and the outside transportation services added an addendum to each of the three outside transportation service's contracts. The addendum included the outside transportation service had policies in place to ensure safety. In addition, the addendum included that transport staff have been trained in safe transfer, transport and securement while transporting residents in van.</p> <p>The validation of the credible allegation was completed on 9/29/16 at 3 PM by doing the following:</p> <p>Observation and demonstration on 9/27/16 at 12:05 PM were conducted. The resident arrived in the transportation van of a sister facility at 12:05 pm. The driver brought down the lift first and then he shook the wheelchair to demonstrate that it did not move and it was secure. The wheelchair did not move. The driver untied the straps and the resident was pushed to the lift facing the van door. The lift was lowered with the staff on the lift. Then the driver was asked to</p>	F 323			



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F 323	Continued From page 40 demonstrate how he secured the wheelchair. The driver put the wheelchair in place, pulled a strap anchored in the floor of the van and put it around the upper back frame of the wheelchair and hooked it back to the floor securement. Then he secured the front wheels to the frame of the wheelchair and tightened the straps and shook the wheelchair to make sure it did not move. On 9/29/16 at 11:55 AM, Resident #96 was observed being unloaded from the van at the facility. The resident was transported from dialysis to the facility. The van had the logo of one of the transportation company the facility contracted. The resident was in the wheelchair and the wheelchair had four point straps to the floor and seat belt across the resident. The driver unhooked the four point securement and then the seat belt and wheeled the resident out of the van backward. Interview with the administrator on 9/29/16 at 2:25 PM revealed she and the director of nursing received inservices about the ensuring the resident environment remains free of accident hazard and that the facility will ensure that staff are trained to perform the task that is asked of them. The facility provided a log of the QI meeting that happened on 9/28/16. The facility provided copies of the contracts of the three transportation company.	F 323			
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced	F 372		11/2/16	

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F 372	<p>Continued From page 41</p> <p>by: Based on observation, staff interview and documentation review, the nursing home failed to dispose of trash in the compactor and did not identify that liquid was dripping from the compactor onto the ground. The nursing home had one large compactor for the entire facility and one cardboard recycling container. Findings included:</p> <p>The compactor was observed in the presence of Dietary Aide #1 at 2:45 pm on 9/25/16 outside behind the kitchen. The door was not shut. It was left ajar, but the latch was not down. There was some brown water on the side of the dumpster with odor and numerous flies. The brown water was on the edge of the dumpster and dripping on the ground. When Dietary Aide #1 tried to close the dumpster door, the door pushed in. The door was closed and the employee latched the door with difficulty.</p> <p>The compactor was observed again at 11:36 am on 9/28/16 with the Corporate Dietary Consultant. The compactor door was not shut and the consultant was not able to shut it. There was constant dripping from the left side of the compactor about half way from the front of the compactor to the back. Liquid had pooled on the ground below the leak. Flies and ants were observed on and around the compactor. During the same observation a lot of trash was behind the cardboard container. Plastic wrapping, gloves, lids, yogurt cup and a straw was observed.</p> <p>On 9/28/16 at 7:58 PM, the Housekeeping Supervisor said the housekeeping service was not responsible for outside of the building and</p>	F 372	<p>F372 Dispose Garbage &amp; Refuse Properly</p> <p>On 9/28/16, the regional vice president ensured the floor technician removed the trash behind the dumpster area.</p> <p>On 9/29/16, the waste company replaced the leaking dumpster with a replacement dumpster which was free of leakage, as requested by the regional vice president.</p> <p>On 10/21/16, the director of nursing (DON) in-serviced the dietary staff on the importance of monitoring the dumpster area during garbage disposal and routinely in order to discover any leakage from the dumpster and to ensure trash and garbage are properly disposed of inside the dumpster/compactor.</p> <p>On 10/21/16 the dietary staff will begin monitoring the dumpster and the dumpster/compactor area during garbage disposal. Each staff member accessing the dumpster will report any observations of leakage to the dietary manager and/or the administrator immediately upon observation for correction. Dietary staff will immediately correct trash found outside of the dumpster/compactor.</p> <p>Starting 10/24/16, the dietary manager, cook, administrator, environmental services director, maintenance, floor technician, and/or corporate consultant will monitor the dumpster area 5x/week x 4 weeks, then weekly x 8 weeks, then</p>		

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F 372	Continued From page 42 that maintenance was responsible. On 9/29/16 at 8:25 AM the Corporate Dietary Consultant said she reported the condition of the compactor and surrounding area to the Administrator and the Regional Vice President (RVP). She said the Floor Tech from housekeeping cleaned up the trash behind the cardboard container. She provided a handwritten note that the RVP called the waste company at 11:55 AM on 9/28/16 and talked to their staff about removing the dumpster. She added that if she saw a problem she would tell the maintenance man. The Maintenance man was not available for interview. On 9/29/16 at 8:31 AM the Dietary Manager said if she saw a problem she would tell Maintenance or Housekeeping. She said, " It is everyone's responsibility if there is a problem. " On 9/29/16 at 8:31 a representative from the waste company was present and the representative said he was going to take a picture and send it to the owner and get direction on how to resolve the problem. He said the compactor had been repaired (welded) in the past.	F 372	monthly x 3 months and will record their observations on the Dumpster Area Audit tool and forward the completed tool to the administrator.  The monthly QI committee will review the results of the Dumpster Area Audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or dietary manager will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.		
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.  This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of facility records the nursing home administration	F 490	F 490 Effective Administration/Resident Well-Being	11/2/16	

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F 490	<p>Continued From page 43</p> <p>delegated a transportation task to the maintenance man who was not trained in van transport at the nursing home to pick up 1:2 sampled residents from dialysis and return the resident to the nursing home. Resident #96 Immediate Jeopardy began on 9/22/16 when the administrative staff member assigned the maintenance man to transport Resident #96 in the facility van from the dialysis center back to the facility. The employee had not been trained on safe transporting of a resident. The resident fell in the van and sustained a laceration in the back of his head. The immediate jeopardy was removed on 9/29/16 at 3 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedure for residents' transportation to appointments and other activities.</p> <p>Findings included: Cross refer to F323- Based on observation, interviews with resident, family, staff, physician assistant and physician, and record review, the facility failed to transport a resident in a safe manner with trained staff from the dialysis center to the facility. The resident fell in the van and sustained a laceration in the back of the head. This is evident in 1 of 2 sampled residents (Resident # 96).</p> <p>During an interview on 9/28/16 at 7:24pm, the administrator, the Director of Nursing (DON), the regional vice president and the corporate consultants were interviewed. The DON said the resident was at dialysis and he needed to be picked up. So she asked the maintenance staff to</p>	F 490	<p>On 9/22/16, the maintenance worker and housekeeper assisted the Resident #96 back in to an upright position in the wheelchair on the van and returned to the facility. On 9/22/16, the maintenance worker immediately returned the resident to the facility and informed the director of nursing (DON).</p> <p>On 9/22/16, the DON immediately assessed Resident #96. The resident had no complaint of pain and exhibited normal behavior and activity. The resident had a small scratch on the back of his head with two drops of blood. The DON left a message for the responsible party. The DON notified the treatment nurse. On 9/22/16, the treatment nurse immediately initiated a treatment to the back of the resident's head and notified the resident's responsible party/wife. On 9/22/16, the assigned second shift nurse assessed Resident #96 for pain during medication administration without negative findings. Resident #96 denied pain or discomfort and ate dinner as usual.</p> <p>On 9/22/16, the administrator stopped all facility transports with the facility van and secured the van keys.</p> <p>On 9/23/16, the corporate facility consultant and the corporate clinical director reviewed the appointment book to verify outside transportation had been arranged for Resident #96's appointments through 9/27/2016.</p>		

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F 490	<p>Continued From page 44</p> <p>go in the van and pick the resident up. The administrator said she was made aware of the fall. She instructed the staff to assess the resident right away. She began an investigation and suspended the maintenance staff. Then she took the keys to the van and put it in her office. The van has not been used for transportation since the accident. The administrator said she asked the maintenance staff to reenact what happened. This is when the administrator found out the floor technician was with the maintenance man when the accident happened. The administrator said that she wanted the van to be taken out of service and get checked out for the functionality of the safety tie downs. The next day (9/23/16) the facility management interviewed the floor technician and asked him to do a demonstration of what happened. The administrator at the time of the survey became employed in that role at the facility on 8/31/16 and the DON began her role on 2/19/16.</p> <p>The administrator was informed of immediate jeopardy on 9/27/16 at 7:15pm.</p> <p>How the corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>On 9/22/16, the maintenance worker and floor technician assisted the resident back in to an upright position in the wheelchair on the van and returned to the facility.</p> <p>On 9/22/16, the maintenance worker immediately returned the resident to the facility and informed the director of nursing. The maintenance worker submitted a written statement and performed a reenactment prior to leaving on administrative suspension.</p>	F 490	<p>On 9/23/16, the corporate facility consultant and the corporate clinical director reviewed the appointment book to identify residents requiring transports 9/23/2016 - 9/27/2016 and verified transportation from an outside transportation company was scheduled to transport the resident.</p> <p>On 9/26/16, the administrator reviewed the appointment book for all currently scheduled appointments and verified transportation will be provided by an outside transportation company.</p> <p>On 9/27/16, the facility administrator and the corporate vice president of operations determined the facility van will remain out of service indefinitely.</p> <p>On 9/28/16, the corporate vice president of operations removed the van from facility premises.</p> <p>On 9/28/16, the administrator and DON were in-serviced by the corporate vice president of operations related to ensuring the resident environment remains free of hazard, ensuring staff are trained and performance monitored prior to delegating a task, and ensuring assigned tasks are within the staff's scope of practice.</p> <p>On 9/28/16, the vice president of operations, vice president of clinical services, the corporate clinical director, and the corporate facility consultant began providing supervision and oversight to the</p>		

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F 490	<p>Continued From page 45</p> <p>On 9/22/16, the director of nursing immediately assessed the resident. The resident had no complaint of pain and exhibited normal behavior and activity. The resident had a small scratch on the back of his head with two drops of blood. The director of nursing left a message for the responsible party. The director of nursing notified the treatment nurse. The director of nursing performed a neuro check without negative findings.</p> <p>On 9/22/16, the treatment nurse immediately initiated a treatment to the back of the resident ' s head and notified the resident ' s responsible party/wife.</p> <p>On 9/22/16, the administrator and director of nursing interviewed the resident involved in the incident on the van. The resident gave an account of the events and incident.</p> <p>On 9/22/16, the administrator interviewed the maintenance worker, had the maintenance worker re-enact the event, and obtained a written statement from the maintenance worker. The maintenance worker verified there was no other resident on the van.</p> <p>On 9/22/16, the administrator stopped all facility transports with facility van and secured the van keys.</p> <p>On 9/28/16, the Vice President of Operations in-serviced the Administrator and Director of Nursing regarding administration ' s responsibility to ensure staff are appropriately trained and working within their scope of practice; the administrator and director of nursing must avoid inappropriate delegation of duties.</p> <p>How did the facility identify other residents having the potential to be affected by the same deficient practice?</p>	F 490	<p>facility's administration to ensure the facility will not assign duties to staff out of their scope of practice.</p> <p>Beginning 9/28/16, the regional vice president of operations, the corporate clinical director, and/or corporate facility consultant will visit the facility weekly x 8 weeks then every other week x 12 weeks, then monthly x 3 months.</p> <p>Beginning 10/24/16, the administrator, DON, ADON, corporate facility consultant, and/or corporate clinical director will begin auditing the outside transportation services using the transportation audit tool. The audit will be completed weekly x 12 weeks, then monthly x 3 months.</p> <p>The monthly QI committee will review the results of the Transportation Audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.</p>		

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F 490	<p>Continued From page 46</p> <p>On 9/22/16, the administrator interviewed and verified with the maintenance worker and floor technician there was only the one resident on the 9/22/16 and furthermore they had not previously transported other residents.</p> <p>On 9/22/16, the administrator validated the facility ' s use of three outside transportation services. In the event the scheduled outside transportation service is unable to provide pick-up or return transportation, other outside transportation services will be contacted.</p> <p>On 9/23/16, the corporate facility consultant and corporate clinical director reviewed the appointment book to identify residents requiring transports 9/23/16 - 9/27/16 and verified transportation from an outside transportation company was scheduled. Appointments had been scheduled with an outside transportation providers.</p> <p>On 9/26/16, the administrator reviewed the appointment book for all currently scheduled appointments and verified transportation will be provided by outside transportation providers.</p> <p>On 9/28/16, the Vice President of Operations in-serviced the Administrator and Director of Nursing regarding administration ' s responsibility to ensure staff are appropriately trained and working within their scope of practice; the administrator and director of nursing must avoid inappropriate delegation of duties.</p> <p>Give specific dates of the corrective actions.</p> <p>On 9/22/16, the administrator collected the van keys and stopped all facility transports with facility</p>	F 490			

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F 490	<p>Continued From page 47 van.</p> <p>On 9/22/16, the administrator verified there are three transport services used to provide transport services when needed.</p> <p>On 9/27/16, the Lake Park administrator and Corporate Vice President of Operations determined the Lake Park van will remain out of service indefinitely.</p> <p>On 9/28/16 at 1:15 pm, the Corporate Vice President of Operations removed the Lake Park van from Lake Park premises indefinitely.</p> <p>On 9/28/16, the administrator and the outside transportation services added an addendum to each of the three outside transportation service ' s contracts. The addendum includes the outside transportation service has policies in place to ensure safety. In addition, the addendum includes that transport staff have been trained in safe transfer, transport and securement while transporting residents in van.</p> <p>On 9/28/16, the Vice President of Operations in-serviced the Administrator and Director of Nursing regarding administration ' s responsibility to ensure staff are appropriately trained and working within their scope of practice; the administrator and director of nursing must avoid inappropriate delegation of duties.</p> <p>On 9/28/16, the Vice President of Operations, Clinical Director, and Facility Consultant began providing supervision and oversight to the facility ' s administration of the facility to ensure the administration would not assign duties to staff out of the scope of practice.</p> <p>The validation of the credible allegation was</p>	F 490			



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F 490	Continued From page 48 completed on 9/29/16 by 3pm An observation and demonstration on 9/27/16 at 12:05PM was conducted. A resident arrived in the transportation van of a sister facility. The driver demonstrated that the wheelchair and the resident was secured properly in the van. On 9/29/16 at 11:55 AM, Resident #96 was observed being unloaded from the van at the facility. The resident was transported from dialysis to the facility. The van had the logo of one of the transportation company the facility contracted. The resident was in the wheelchair and the wheelchair had four point straps to the floor and seat belt across the resident. The driver unhooked the four point securement and then the seat belt and wheeled the resident out of the van backward. Interview with the administrator on 9/29/16 at 2:25PM revealed she and the DON received in services about the ensuring the resident environment remains free of accident hazard and that the facility will ensure that staff re trained to perform the task that is asked of them. The facility provided a log of the QI (Quality Improvement) meeting that on 9/28/16. The facility provided copies of the contracts of the three transportation companies.	F 490			
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient	F 514		11/2/16	

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F 514	<p>Continued From page 49</p> <p>information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews and observation, the facility failed to update medication orders in the computerized record even though verbal orders had been received and medications had been discontinued. A medication order for Seroquel for Resident #60 appeared in the computerized record as an active medication even though it had been discontinued. A subsequent assessment and a psychiatric note inaccurately listed Seroquel as an active medication because the current medications were reviewed from the computer. A handwritten telephone order for loratadine for Resident #28 was not discontinued per order on the medication administration record. Inaccurate records affected 2 of 5 sampled residents reviewed for unnecessary medications (Residents #60 and #28.) Findings included:</p> <p>1. According to the March Medication Administration Record, Seroquel, (also known as Quetiapine Fumarate) was ordered for Resident #60 on 1/14/16. The order read, "Quetiapine Fumarate 25 mg (milligram) tab. Take ½ tablet 12.5 mg by mouth twice daily for behaviors." A telephone order dated 2/22/16 discontinued the morning dose and a telephone order dated 2/24/16 discontinued the evening dose.</p> <p>A Dyskinesia Identification System Condensed</p>	F 514	<p>F 514 Resident Records</p> <p>On 9/29/16, the assistant director of nursing (ADON) ensured Resident #28's Claritin medication was discontinued from the medication administration record (MAR).</p> <p>On 10/20/16, the ADON updated Resident #60's electronic health record in Point Click Care (PCC), showing the medication Seroquel was discontinued.</p> <p>On 10/20/16, the director of nursing (DON), ADON, staff nurse, and/or corporate consultant completed a 100% audit of each resident's orders for the past 30 days to ensure orders to discontinue medications were discontinued from the MAR and electronic health record in PCC.</p> <p>On 10/20/16, the DON began in-servicing 100% of licensed staff on correctly transcribing an order and ensuring the entire order is carried out, including if a medication is discontinued that it needs to be discontinued from the MAR and PCC correctly. This in-service will be completed by 10/24/16. No licensed practical nurse</p>		

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F 514	<p>Continued From page 50</p> <p>User Scale (DISCUS), an involuntary movement scale, dated 7/19/16 completed by Nurse #1 indicated Resident #60 was taking Seroquel and had no tardive dyskinesia.</p> <p>On 9/14/16 a psychiatric consult note indicated Resident #60 had no hallucinations. The note included several of her diagnoses and problems including dementia with behavior, mood disorder of manic type, psychosis, anxiety and insomnia. It indicated the resident was on Seroquel. The note was written by the Psychiatric Nurse Practitioner.</p> <p>On 9/26/16 at 12:09 PM, the computerized medication orders for Resident #60 were reviewed. Quetiapine Fumarate was ordered at 12.5 milligrams at bedtime for behaviors. The end date was indefinite.</p> <p>Observation of Resident #60 on 9/27/16 at 12:31PM and 3:44 PM in the day room revealed she was happy and had a pleasant affect.</p> <p>On 9/27/16 at 3:35 PM, Nurse #2 said a nurse should discontinue the order in the computer after being told it was discontinued. At 4:45 PM, the Director of Nursing said the nurses update the computer when they took the orders. If they cannot do it, then the night shift updated the computer.</p> <p>On 9/28/16 at 10:02 AM, the Director of Nursing said the floor nurse did the DISCUS. She said when the medication orders were written there was a pink copy that the night shift nurse was supposed to update in the computer. She said, "It is my expectation they update and make sure the computer is accurate."</p>	F 514	<p>(LPN) or registered nurse (RN) will be allowed to work after 10/24/16 until they complete the in-service. All LPN and RN new hires will receive in-service during new employee orientation.</p> <p>On 10/20/16, the DON, ADON, and staff nurse began auditing 100% of resident orders for discontinuing medications for accuracy using the Discontinued Medications Audit Tool. The audit will be completed by the DON, ADON, staff facilitator, treatment nurse, staff nurse, administrator, and/or facility consultant 5x/week x 4 weeks then weekly x 8 weeks then monthly x 3 months. Any negative findings will be corrected immediately and physician will be notified.</p> <p>The monthly QI committee will review the results of the Discontinued Medications Audit Tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.</p>		

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F 514	<p>Continued From page 51</p> <p>On 9/29/16 at 8:29 AM, the Psychiatric Nurse Practitioner was interviewed by telephone. He said he would have used the computer record to review the current medications that were listed in his note of 9/14/16.</p> <p>On 9/29/16 at 8:50 AM, Nurse #1 was interviewed. She said when she completed the DISCUS on 7/19/16 she would have reviewed the medications on the computer because she would have completed the form on the computer.</p> <p>Review of the March, April, May, June, July, August and September 2016 MARs did not indicate any administration of Seroquel.</p> <p>2. Review of the handwritten telephone orders for Resident #28 revealed an order dated 09/21/2016 to discontinue the Claritin. There was no indication on the handwritten telephone order to indicate the amount of the dose or the schedule of the Claritin to be discontinued. In an interview with Nurse #1 on 09/29/2016 at 10:00 AM, she stated she was the nurse who took the telephone order to discontinue the Claritin on 09/21/2016, and that she simply forgot to discontinue the Claritin on the medication administration record.</p> <p>In an interview with the director of nursing (DON) on 09/29/2016 at 11:13 AM, she stated that the facility used handwritten physician orders and telephone orders, and that the nurse who received a telephone order was expected to process the order, check it for accuracy with another nurse, then write the order on the medication administration record to ensure the order was completed and carried out by nursing staff. The DON also stated she expected for the night shift nurses to also check the orders for accuracy and to ensure that the order was placed</p>	F 514			

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F 514	Continued From page 52 into the electronic record. In an interview with the physician on 09/29/2016 at 1:10 PM, he stated that he relied on handwritten orders to ensure that residents received medications as ordered, or that medications were discontinued as ordered. He added that he expected the telephone orders to discontinue medications to be reflected accurately on the medication administration record.	F 514			
F 520 SS=J	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.	F 520		11/2/16	

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F 520	<p>Continued From page 53</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain compliance with administering the nursing home effectively (F 490); developing and implementing appropriate plans of action to correct identified quality deficiencies (F 520); assessing a resident immediately after an incident involving a head injury (F 309), and; maintaining accurate clinical records (F 514). These four regulations were also cited as deficiencies on 1/15/16 (490 &amp; 514), 2/15/16 (309, 490, 514 &amp; 520) and 3/14/16 (309, 490, 514 &amp; 520).</p> <p>Immediate Jeopardy began on 9/22/16 when administration authorized an employee who was not trained at the facility in van transportation to pick up Resident #96 from dialysis (F 490 and F 520). The resident's wheelchair fell backwards in the transportation van and the resident sustained a laceration to the back of his head. The immediate jeopardy was removed on 9/29/16 at 3:00 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor (F 520) and fully implement the new procedure for residents' transportation to appointments and other activities (F 490). The scope and severity of examples 3 &amp; 4 is at level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy). Findings included: This tag is cross referred to:</p>	F 520	<p>F 520 QAA Committee</p> <p>On 9/28/16, the facility Executive QI Committee held a meeting. The Medical Director, Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), MDS nurse, treatment nurse, staff facilitator, medical records, dietary manager, and/or housekeeping supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate.</p> <p>On 9/28/16, the corporate facility consultant in-serviced the facility administrator, director of nursing, MDS nurse, treatment nurse, maintenance director, dietary manager, and housekeeping supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identifying issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F 309 Necessary Care and Services, F490 Effective Administration, F 514 Maintaining Accurate Clinical Records, and F 520 Quality Assessment and Assurance Committee.</p> <p>As of 9/28/16, after the facility consultant in-service, the facility QI Committee will</p>		

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F 520	<p>Continued From page 54</p> <p>1) F 490: Administration</p> <p>During the complaint investigation dated 1/15/16, the recertification survey dated 2/15/16 and the subsequent revisit survey of 3/14/16, the nursing home was cited for failing to create and impose a culture that all residents would be protected from abuse and that staff would implement the facility's abuse policy and procedures to intervene, protect and immediately report abuse when witnessed. A combative resident experienced 2 episodes of physical abuse without immediate facility intervention, protection and implementation of abuse policies and procedures. This was cited at the immediate jeopardy level on two of the three surveys.</p> <p>On the current survey, the nursing home administration delegated a transportation task to an untrained staff member. The individual was assigned to pick up a resident from dialysis and return the resident to the nursing home.</p> <p>2) 520 Quality Assurance and Assessment</p> <p>During the recertification survey dated 2/15/16 and the subsequent revisit survey of 3/14/16, the nursing home's Quality Assessment and Assurance (QAA) committee was cited for failing to maintain implemented procedures and monitor the interventions that the committee put into place (F 223, F 226, F 490 &amp; F 514). This was cited at the immediate jeopardy level on one of the two surveys.</p> <p>On the current survey, the facility failed to maintain compliance with F 309, F 490, F 514 and F 520.</p> <p>On 9/27/16 at 7:15 PM, the administrator was</p>	F 520	<p>begin identifying other areas of quality concern through the QI review process, for example: review rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), resident council minutes, resident concern logs, pharmacy reports, and regional facility consultant recommendations.</p> <p>The facility's Executive QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of correction for identified facility concerns.</p> <p>Corrective action has been taken for the identified concerns related to F 309 Necessary Care and Services, F490 Effective Administration, F514 Maintaining Accurate Clinical Records, and F 520 Quality Assessment and Assurance Committee.</p> <p>The QI Committee will continue to meet at a minimum of monthly. The Executive QI Committee, including the Medical Director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring QI Committee and Executive QI Committee concerns are addressed through further training and/or other</p>		

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F 520	<p>Continued From page 55</p> <p>notified of the immediate jeopardy related to an incident on the facility van on September 22, 2016. Nursing home administration authorized the transport of the resident (F 490). Lack of effective nursing home administration was cited repeatedly on 2/15/16, 3/14/16 and on the current survey (F 520).</p> <p>The administrator provided the following credible allegation of compliance on 9/28/16 at 6:55 PM: A. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>On 9/22/16, the maintenance worker and Floor Technician assisted the resident back in to an upright position in the wheelchair on the van and returned to the facility.</p> <p>On 9/22/16, the maintenance worker immediately returned the resident to the facility and informed the director of nursing. The maintenance worker submitted a written statement and performed a reenactment prior to leaving on administrative suspension.</p> <p>On 9/22/16, the director of nursing immediately assessed the resident. The resident had no complaint of pain and exhibited normal behavior and activity. The resident had a small scratch on the back of his head with two drops of blood. The director of nursing left a message for the responsible party. The director of nursing notified the treatment nurse. The director of nursing performed a neuro check without negative findings.</p> <p>On 9/22/16, the treatment nurse immediately initiated a treatment to the back of the resident's head and notified the resident's responsible party/wife.</p> <p>On 9/22/16, the administrator and director of</p>	F 520	<p>interventions. The administrator, DON, and/or ADON will report back to the Executive QI Committee at the next scheduled meeting.</p>		



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F 520	<p>Continued From page 56</p> <p>nursing interviewed the resident involved in the incident on the van. The resident gave an account of the events and incident.</p> <p>On 9/22/16, the administrator interviewed the maintenance worker, had the maintenance worker re-enact the event, and obtained a written statement from the maintenance worker. The maintenance worker verified there was no other resident on the van.</p> <p>On 9/22/16, the administrator stopped all facility transports with facility van and secured the van keys.</p> <p>On 9/28/16, the Vice President of Operations in-serviced the Administrator and Director of Nursing regarding administration's responsibility to ensure staff are appropriately trained and working within their scope of practice; the administrator and director of nursing must avoid inappropriate delegation of duties.</p> <p>B. How did the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>On 9/22/16, the administrator interviewed and verified with the maintenance worker and floor technician there was only the one resident on the 9/22/16 and furthermore they had not previously transported other residents.</p> <p>On 9/22/16, the administrator validated the facility's use of three outside transportation services. In the event the scheduled outside transportation service is unable to provide pick-up or return transportation, other outside transportation services will be contacted.</p> <p>On 9/23/16, the corporate facility consultant and corporate clinical director reviewed the</p>	F 520			

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F 520	<p>Continued From page 57</p> <p>appointment book to identify residents requiring transports 9/23/16 - 9/27/16 and verified transportation from an outside transportation company was scheduled. Appointments had been scheduled with an outside transportation providers.</p> <p>On 9/26/16, the administrator reviewed the appointment book for all currently scheduled appointments and verified transportation will be provided by outside transportation providers.</p> <p>On 9/28/16, the Vice President of Operations in-serviced the Administrator and Director of Nursing regarding administration's responsibility to ensure staff are appropriately trained and working within their scope of practice; the administrator and director of nursing must avoid inappropriate delegation of duties.</p> <p>C. Give specific dates of the corrective actions.</p> <p>On 9/22/16, the administrator collected the van keys and stopped all facility transports with facility van.</p> <p>On 9/22/16, the administrator verified there are three transport services used to provide transport services when needed.</p> <p>On 9/27/16, the Lake Park administrator and Corporate Vice President of Operations determined the Lake Park van will remain out of service indefinitely.</p> <p>On 9/28/16 at 1:15 pm, the Corporate Vice President of Operations removed the Lake Park van from Lake Park premises indefinitely.</p>	F 520			

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F 520	<p>Continued From page 58</p> <p>On 9/28/16, the administrator and the outside transportation services added an addendum to each of the three outside transportation service ' s contracts. The addendum includes the outside transportation service has policies in place to ensure safety. In addition, the addendum includes that transport staff have been trained in safe transfer, transport and securement while transporting residents in van.</p> <p>On 9/28/16, the Vice President of Operations in-serviced the Administrator and Director of Nursing regarding administration's responsibility to ensure staff are appropriately trained and working within their scope of practice; the administrator and director of nursing must avoid inappropriate delegation of duties.</p> <p>On 9/28/16, the facility Executive QI Committee held a meeting. The Medical Director, Administrator, DON, QI nurse, MDS nurse, treatment nurse, staff facilitator, maintenance director, and housekeeping supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate.</p> <p>On 9/28/16, the regional facility consultant in-serviced the facility administrator, director of nursing, MDS nurse, treatment nurse, dietary manager, and housekeeping supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F 323 Accidents Hazards Supervision and F 490 Administration.</p> <p>As of 9/28/16, after the facility consultant in-service, the facility QI Committee will begin</p>	F 520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345502</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/02/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKE PARK NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 FAITH CHURCH ROAD</b> <b>INDIAN TRAIL, NC 28079</b>		
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F 520	<p>Continued From page 59</p> <p>identifying other areas of quality concern through the QI review process, for example: environment, behavioral management, review of Point Click Care (Electronic Medical Record) orders and activities of daily living, and regional facility consultant recommendations.</p> <p>Corrective action has been taken for the identified concerns related to F 323 Accidents Hazards Supervision and F 490 Administration as reflected in the plan of correction.</p> <p>The Executive QI Committee, including the Medical Director, will review compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.</p> <p>D. The alleged IJ removal date is 9/28/16. The validation of the credible allegation was completed on 9/29/16 at 3:00 PM by doing the following:</p> <p>On 9/29/16 at 11:55 AM, Resident #96 was observed being unloaded from the van at the facility. The resident was transported from dialysis to the facility. The van had the logo of a contracted transportation company. The resident was in the wheelchair and the wheelchair had four point straps to the floor and seat belt across the resident. The driver unhooked the four point securement and then the seat belt and wheeled the resident out of the van backward.</p> <p>Interview with the administrator on 9/29/16 at 2:25 PM revealed she and the Director of Nursing</p>	F 520			

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F 520	<p>Continued From page 60</p> <p>received in-services about ensuring the resident 's environment remains free of accident hazard and that the facility will ensure that staff are trained to perform the task that is asked of them. The facility provided a log of the QI meeting that happened on 9/28/16. The facility provided copies of the contracts of the three transportation companies.</p> <p>3) F 309 Acute Assessment</p> <p>During the recertification survey dated 2/15/16 and the subsequent revisit survey of 3/14/16, the nursing home was cited for failing to position a resident in her wheel chair with foot/leg support to prevent a decline in range of motion.</p> <p>On the current survey, the facility failed to get professional staff to assess a resident for possible injury after a fall in the transportation van before moving the resident and driving the resident to the facility. The resident sustained a laceration on the back of the head from the fall. The facility also failed to do neuro-checks per nursing intervention.</p> <p>4) F514: Accurate Records</p> <p>During the recertification survey dated 2/15/16 and the subsequent revisit survey of 3/14/16, the nursing home was cited for failing to transcribe a physician order for 3 months to the treatment record regarding the change of a resident's indwelling urinary catheter every 30 days and document the correct time of administration of an enteral feeding product for 2 of 31 medical records reviewed.</p> <p>On the current survey, the facility failed to update</p>	F 520			

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F 520	<p>Continued From page 61</p> <p>medication orders in the computerized record even though verbal orders had been received and medications had been discontinued. A medication order for Seroquel for Resident #60 appeared in the computerized record as an active medication even though it had been discontinued. A subsequent assessment and a psychiatric note inaccurately listed Seroquel as an active medication because the current medications were reviewed from the computer. A handwritten telephone order for loratadine for Resident #28 was not discontinued per order on the medication administration record.</p> <p>An interview was conducted on 9/29/16 at 5:10 PM with the Administrator and Director of Nursing. During the interviews, the Administrator reported the facility's QAA Committee met quarterly. The Administrator said the facility was aware of inaccurate record keeping regarding prior deficiencies and changing a resident's catheter. Corporate oversight was in progress related to medication and treatment administration records. The Administrator had concerns and noted trending with these records. She said the facility looked for patterns and trends and then decided whether to take the problem to QAA. The current Administrator had met with the previous Administrator and verified actions and tracking tools were validated. New areas not identified by the QAA committee were based on survey findings. They were unsure of the reason for duplication of orders in the computer system and handwritten orders. The Administrator said the Pharmacy has to be fully integrated to use the computer software system to produce medication administration records. Corporate oversight was in progress related to medication and treatment administration records.</p>	F 520			

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F 520	Continued From page 62 The Administrator stated the facility should have noted the root cause of the van incident because there was no backup plan for transportation. She said you have to know the root cause before can resolve problems.	F 520		