STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345458	A. BUILDING _____ B. WING _____	C 03/30/2017

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TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 3/30/17. Event ID# C05D11	F 000		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, observations and record review the facility failed to provide a usable call bell for 1 of 1 sampled resident (#222). Findings included: Resident #222 was admitted on 03/21/17 with the diagnosis in part, of spinal cord injury cervical region, quadriparesis, fusion of spine of cervical region, and Stage 4 pressure ulcer. Record review of the admission assessment dated 03/21/17, revealed Resident #222 was independent to make decisions and her memory was intact. She was unable to move all extremities . On 03/29/2017 at 9:29 AM an observation revealed a push button call bell hanging above	F 246	Interventions for affected resident: Resident #222 was immediately assessed by the Director of Nursing and a flat call bell obtained on 3/29/17. Interventions for residents identified as having the potential to be affected: By 4/27/17, current facility residents will be audited by Nursing Management to ensure that they have a usable call bell in place. Systemic Change: By 4/27/17, the Staff Development Coordinator (SDC) will in-service Licensed Nurses on assessment of residents upon admission to ensure that they have a	4/27/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/20/2017

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F 246	Continued From page 1 her head, from a pole used to hang medication. She had no movement of her extremities. During an interview, Resident #222 indicated that she had not had a call bell she could use since her arrival. She yelled out to notify staff. The staff had told her they were getting her a call bell. On 03/29/2017 at 9:32 AM, Aide #1 indicated yesterday was her first day with Resident #222, and she had asked maintenance for the flat call bell. She indicated Resident #222 had no way to notify staff except to yell out. Aide #1 reported the resident had a soft voice and it was difficult to hear her. Aide #1 indicated the work request was in the work order book yesterday. She opened the work order log book and an observation revealed only blank pages. On 03/29/2017 at 9:39 AM, Nurse #1 indicated she had submitted a work order last week for the flat call bell and spoke to the maintenance assistant. On 03/29/2017 at 9:42 AM, the Maintenance Assistance (MA) indicated he removed the work order request every morning from the work order book. The MA also reported staff would report concerns to the maintenance department verbally without a written request. He indicated he was aware of Resident #222's need for a flat call bell and had informed the maintenance director last week. On 03/29/2017 at 9:52 AM, the Maintenance Director (MD) indicated the work orders were pulled by the maintenance assistant and he turned in the requests and then filed or threw them away. He was unable to find the request for Resident #222's flat call bell. He indicated most	F 246	usable call bell in place. Additionally, Nursing Management will review each new admission in the facility clinical meeting to ensure the resident has a usable call bell. This review will occur daily for a minimum of 12 weeks. By 4/27/17, the facility SDC will in-service facility staff on ensuring any work order requests is written in the work order book properly for Maintenance Department review. By 4/27/17, the Administrator will in-service the Maintenance Department on ensuring proper review, priority, and completion of work order requests. Weekly for 12 weeks, the Administrator will review submitted work orders with the Maintenance Department to ensure completion of work order request. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 246	Continued From page 2 of the time it was word of mouth. The MD reported, the MA told him yesterday evening that he needed a pancake call bell. The MD stated, he told the MA he did not have one and to look for one. The MD reported he ordered a pancake call bell through their corporate supply and it should be here 3/30/17. He indicated he had no proof he had ordered the flat call bell. He called corporate supply to obtain the confirmation document and they indicated he had not ordered a flat call bell. On 03/29/17 at 10:23 AM, the Director of Nursing (DON) observed Resident #222. The DON removed the call bell hanging from the medication pole and asked Resident #222 to move her hands. Resident #222 was unable to move. The DON assessed Resident #222's inability to move from her neck down and use the standard call bell button. The DON indicated she had no knowledge Resident #222 had no accessible call bell. Resident #222 indicated that she had not had a call bell since she arrived. The DON indicated she would get her a flat call bell immediately. The DON indicated she should have had a call bell the day she arrived and stated it was an education problem.	F 246		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		4/27/17

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F 281	Continued From page 3 Based on record review and staff interviews, the facility failed to transcribe a dietary order for fortified pudding onto the medication administration record (MAR) for one of two residents reviewed for dietary orders (Resident #26). Findings included: Resident #26 was admitted 04/06/12. Diagnoses included pneumonia, septicemia, anemia, and unspecified vitamin deficiency. A quarterly Minimum Data Set dated 02/15/17 indicated severe cognitive impairment. The resident required extensive assistance for all activities of daily living. The registered dietician wrote an order on 03/23/17 to "d/c [discontinue] House Shake, add fortified pudding bid [twice a day] at 10 a.m. and 2 p.m." The order was signed as transcribed with a time entered. The signature and time were illegible. The order had a notation to the side with initials and a date of 03/26/17. The initials were illegible. The MAR for March 2017 was reviewed. There was no entry present for "fortified pudding" and no documentation that the resident had received it since the date of ordering 03/23/17. The entry for "House Shake" was present with staff initials entered for dates from 03/01/17 through 03/30/17 to indicate it had been given. According to interviews with the DON and a medication nurse, initials on the MAR for dietary supplements only indicate they were offered but not necessarily consumed. In an interview with Nurse #3 on 03/30/17 at 1:00	F 281	Interventions for affected resident: The dietary order for fortified pudding was immediately added to the Medication Administration Record (MAR)on 3/30/17 for Resident #26. Interventions for residents identified as having the potential to be affected: By 4/27/17, the facility Director of Nursing and Dietician will review residents with dietary orders for supplements to ensure supplement orders are transcribed on the MAR as ordered. Systemic Change: By 4/27/17, the Staff Development Coordinator (SDC) will re-educate facility Licensed Nurses on ensuring transcription of dietary orders for supplements to the MAR. New dietary orders for supplements will be audited in the morning clinical meeting by Nursing Management to ensure supplements are transcribed to the MAR as ordered. This audit will occur daily for a minimum of 12 weeks. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the	

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F 281	Continued From page 4 p.m., he described the process of taking off diet orders. The nurse signed the new order and filled out a two-ply Diet Communication Form. The top white copy was taken to the Dietary Manager and the yellow copy remained in the chart as a record that the diet had been changed. In an interview with the Director of Nursing on 03/30/17 at 6:20 p.m., she confirmed the process of taking off orders and indicated that a second nurse was tasked with verifying that all orders written that day had been accurately transcribed. A second nurse had not identified the error.	F 281	audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: 1. Resident #119 was admitted on 1/16/15. The diagnoses included contracture of the joint, diabetes and hypertension. Review of the physician ' s order dated 6/24/16 revealed Resident #119 was to wear the left hand splint daily for 6 hours for hemiplegia 8:00 AM to 2:00 PM.	F 318	Interventions for affected resident: On 03/29/17, Resident #119 and Resident #61 assigned Licensed Nurse and Nurse Aide was re-educated on ensuring splint is applied as ordered. Resident #119 and Resident #61 will be re-evaluated by Therapy by 04/27/17.	4/27/17

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F 318	Continued From page 5 The Minimum Data Set (MDS) dated 3/2/17, indicated Resident #119 ' s cognition was intact and he required total care with activities of daily living. He was coded on the functional limitation in range of motion section with joint contracture. Review of the care plan dated 3/2/17 identified the problem as: contractures and arthritis. The goal included Resident #119 would remain free of complications related to arthritis, contractures of joints, stiffness, swelling or decline in mobility. The intervention included monitoring and documenting and reporting any signs and symptoms related to arthritis, joint pain and stiffness. Any decline in mobility, contracture formations and joint shape changes, creaking or clicking with joint movement or pain after exercise. The MAR documented the frequency of he splint application. During an observation on 3/28/17 at 8:30 AM, Resident #119 was seated at the hall at the nursing station without the left hand splint in place. During an observation on 3/28/17 at 9:00 AM, Resident #119 was seated in the hall in front of dining room without the left hand splint in place During an observation on 3/28/17 at 11:00 AM, Resident #119 was in the activity room without the left hand splint in place. Resident #119 stated the splint was not applied daily and he was unaware of who was responsible for applying the splint. During observation on 3/28/17 at 2:00 PM, Resident #119 was seated in the front door of his bed room without the left hand splint in place.	F 318	Interventions for residents identified as having the potential to be affected: By 04/27/17, all current residents with splinting orders will be re-evaluated by Therapy to ensure that they have the proper device and it is being worn properly. Systemic Change: By 04/27/17, the Staff Development Coordinator will provide re-education to facility Nursing Staff on ensuring splints are applied to residents as ordered. Nursing Management will observe three (3) residents per week for splint wear to ensure the splint is applied per order. This audit will be performed weekly for a minimum of 12 weeks. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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During an observation 3/28/17 at 3:30 PM, Resident #119 was seated in the hall in a common area without splint on left hand. Resident #119 ' s hand was slightly swollen. Resident reported staff did not put the splint on every day and staff needed to be reminded sometimes to put it on.

During an observation on 3/29/17 at 8:30 AM, Resident #119 was seated in the hall without left hand splint in place.

During an interview on 3/29/17 at 10:50 AM, Resident #119 was seated in hall at nursing station and stated they just put the splint on a few minutes ago. Resident #119 stated staff should not have to be reminded to put the splint on daily.

During an interview on 3/29/17 at 10:53 AM, NA #5 stated he just applied the splint at the request of the nurse. NA#5 reported that nursing was responsible for applying the splint.

During an interview on 3/29/17 at 2:26 PM, the Director of Nursing indicated splints should be applied in accordance to the orders.

Review of the March 2017 Medication Administration Record (MAR) revealed Nurse #3 documented the splint was applied and removed at the designated time.

During an interview on 3/29/17 at 2:34 PM, Nurse#3 indicated that nursing and the restorative/nursing assistants were responsible for applying the splint. He stated he would normally check to see if the RA/NA applied the splint, if not, he would put the splint on when doing med pass. Review of the medication record

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for 3/28/17 and 3/29/17, revealed the splints were documented as applied at 8:00 AM and removed at 2:00 PM. Nurse #3 had no direct response when asked did he applied and removed the splint at scheduled time. Nurse #3 indicated that he was not certain when the splints were actually applied but when he saw them he would sign off.

2. Resident #61 was admitted to the facility on 8/20/09. The cumulative diagnoses included neuromuscular dysfunction of bladder, cerebrovascular disease and hemiplegia.

Review of the physician ' s order dated 6/24/16 revealed Resident #61 was to wear the right hand splint daily for 6 hours for hemiplegia 8:00 AM to 2:00 PM.

The Minimum Data Set (MDS) dated 2/22/17, indicated Resident #61 had cognition impairment and required total assistance with activities of daily living. She was coded with contractures.

Review of the care plan dated 3/7/17 identified the problem as right hand contracture. The goal included Resident #61 would continue to wear splint to prevent contractures. The intervention included monitoring and documenting and reporting any signs and symptoms related to joint pain, stiffness. Report any decline in mobility, contracture formations and joint shape changes, creaking or clicking with joint movement or pain after exercise.

During an observation on 3/28/17 at 9:00 AM, Resident #61 was seated in hall at nurse ' s station without right hand splint in place.

During an observation on 3/28/17 at 11:00 AM,

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Resident #61 was seated in the activity room without right hand splint in place.

During an observation on 3/29/17 at 9:43 AM, Resident #61 was sleeping. The right hand splint was on the night stand.

During an observation on 3/29/17 at 10:00 AM, Resident #61 was sitting up in her room in the wheelchair without right hand splint.

During an interview on 3/29/17 at 10:53 AM, NA #5 stated he just applied the splint at the request of the nurse. NA#5 reported that nursing was responsible for applying the splint.

During an observation on 3/29/17 at 11:00 AM, Resident #61 was sitting in activity room watching movies with several other residents with blue splint on right hand.

During an interview on 3/29/17 at 2:26 PM, the Director of Nursing indicated splints should be applied in accordance to the orders.

Review of the March 2017 Medication Administration Record (MAR) revealed Nurse #3 documented the splint was applied and removed at the designated time.

During an interview on 3/29/17 at 2:34 PM, Nurse#3 indicated that nursing and the restorative/nursing assistants were responsible for applying the splint. He stated he would normally check to see if the RA/NA applied the splint, if not, he would put the splint on when doing med pass. Review of the medication record for 3/28/17 and 3/29/17, revealed the splints were documented as applied at 8:00AM and removed

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F 318	Continued From page 9 at 2:00PM. Nurse #3 had no direct response when asked did he applied and removed the splint at scheduled time. Nurse #3 indicated that he was not certain when the splints were actually applied but when he saw them he would sign off. During an interview on 3/29/17 at 2:43 PM, NA #6 stated Resident #61 should wear the right hand splint daily. NA#6 indicated she was uncertain who was responsible for the splint application since the duties changed from nursing assistant/restorative aide to nursing.	F 318		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		4/27/17

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F 323	Continued From page 10 (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to; a) identify a resident for risk of entrapment from side rails prior to and after installation, b) provide bed dimensions appropriate for the resident ' s size, and c) provide padded floor mats and maintain resident ' s bed in the lowest position for 1 of 1 sampled residents (#182). Findings included: Resident #182 was admitted on 2/6/17. Diagnoses included, in part, stroke with hemiplegia, functional quadriplegia and chronic left and right extremity impairment. A record review revealed a care plan was initiated on 2/6/17 for limited physical mobility related to stroke with left side hemiplegia and totally dependent on staff for all (ADLs) with interventions to include: assist bars for enabling, mats to floor, and bed in lowest position. The minimum data set (MDS) assessment dated 3/10/17 revealed the resident was cognitively impaired. He required an extensive assist to total dependence with one to two staff assist with all activities of daily living (ADLs). He had impairment to one side to the upper and lower extremities. a) An observation of Resident #182 on 3/28/17 at 10:35 am revealed the resident was lying in bed. The resident was nonverbal but alert. The bed was noted to have half side rails located on the	F 323	Interventions for affected resident: On 3/29/17, Resident # 182 was re-assessed by the facility Director of Nursing and provided an alternate mattress and low bed with quarter length side rails to aide with turning and repositioning. Fall mats were placed beside bed. Interventions for residents identified as having the potential to be affected: On 4/4/17, a facility wide audit of bed rails and bed mattresses was completed by the Administrator, Maintenance Director and Director of Nursing to ensure proper fit and assess for risk of entrapment. By 4/27/17, the facility Staff Development Coordinator (SDC) and Administrator will re-educate the Maintenance Staff and Nursing Staff on ensuring bed (rails) are assessed for risk of entrapment and bed is appropriate for the resident's size. Additionally, the SDC will re-educate Nursing Staff on ensuring care plan interventions are implemented. Systemic Change: All residents will continue to have siderail screens completed upon admission by the Licensed Nurse. Maintenance Staff will audit bed mattresses for proper fit on new	

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F 323	Continued From page 11 top of each side of the bed which were in the up position. The head of the bed was elevated and the lower knee area was elevated. (The side rails were constructed with a total of nine bars. The upper and lower sections of the side rail had 3.5 inch spaces in between the bars and the middle section had 2 inch spacing between the bars). An observation of Resident #182 on 3/29/17 at 10:05 am revealed Resident #182 moved around continuously on his bed. The half side rails were in the up position. Resident #182 was noted to be lying across the bed with his head up against the side rail and his legs over the side rails on the other side. The resident stuck his left foot through the 3.5 inch space between the bars and removed his foot. His movement was in a constant state. His foot went through the same space on the side rails multiple times during this observation. Resident #182 was observed scooting down toward the middle of the bed and continued to kick his legs. An observation with NA #1 on 3/29/17 at 10:30 am revealed Resident #182 lay across the bed and kicked his legs and stuck his foot through the 3.5 inch space on the side rail between the bars. His foot remained there for approximately one minute until he removed it and continued to kick about on the bed. During this observation, the resident kicked his foot through the space between the bars a second time. His foot remained through this space for approximately one minute. An interview with the family member (FM) on 3/29/17 at 10:35 am revealed she visited the resident every day and often he would be lying across the bed with his head up against the side	F 323	facility admissions. An audit of ten (10) resident beds (bed rails/mattresses) will be completed by the facility Director of Nursing and Maintenance Director weekly for a minimum of 12 weeks to evaluate the risk for entrapment and ensure bed is appropriate for resident's size. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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	345458	A. BUILDING _____ B. WING _____	C 03/30/2017

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rail and feet up on the side rail or hanging over the bed.

b) An interview with nursing assistant (NA) #1 on 3/29/17 at 10:20 am was conducted. NA #1 reported the resident was very restless and moved and kicked about all the time. NA #1 reported she had to make frequent checks on the resident due to his moving around. NA #1 reported the resident has had his leg stuck in the bottom of the bed between the mattress and foot board. NA #1 stated the staff raised the head of the bed and the knee area to help prevent him from scooting down. NA #1 reported she had noted the resident's leg up on the lock box/shelf that was on the wall, on and inside the spaces of the bedside rails, and dangling over the bed. NA #1 reported she told the nurse, but was unable to recall the name of the nurse.

A continuous observation of Resident #182 was done on 3/29/17 from 10:35 am to 10:50 am. Resident #182 was restless and moved around constantly. During the observation, he kicked his legs over the bed rails. He repositioned his body and laid across the bed with his head up against the side rail. The mattress was noted to have an approximate 5" gap between the end of the mattress and the foot board.

An interview with NA #3 on 3/30/17 at 2:55 pm revealed she frequently had to reposition Resident #182 due to his squirming around on the bed. He was usually lying across the bed or he would slide down the bed. NA #3 reported the resident would have his legs dangling over the bed or up on the side rails.

An interview was conducted with the Maintenance

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Director (MD) on 3/29/17 at 2:30 pm. The MD confirmed that the mattress did not fit the bed properly and it needed a bed extender between the mattress and foot board. The MD reported that he was not aware until today, 3/29/17.

An interview with the Director of Nursing (DON) on 3/29/17 at 2:50 pm was conducted. The DON revealed she was not aware of the resident ' s restlessness nor was she aware of the mattress not fitting the bed properly. The DON confirmed the resident needed a different bed and mattress. She also stated the resident should have padded floor mats and the bed in the lowest position.

An interview with the Unit Manager (UM) on 3/30/17 at 9:25 am revealed he had observed the resident frequently lying across the bed when he entered the room. The UM stated the resident was observed with his feet up on the side rail.

An interview with Nurse #2 on 3/30/17 at 9:45 am revealed the resident moved around a lot and required frequent repositioning. Nurse #2 stated every time he passed the resident ' s room, he had to check him and reposition him. Nurse #2 added, the aides would frequently ask to help reposition him as he would be lying across his bed or sliding down to the end of the bed. Nurse #2 stated Resident #182 ' s legs were always kicking around.

c) An observation of Resident #182 on 3/28/17 at 10:35 am revealed the bed was not in the lowest position and there were no padded floor mats on either side of the bed.

An observation of Resident #182 on 3/29/17 at 10:05 am revealed the bed was not in the lowest

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position and there were no padded floor mats on either side of the bed.

An interview with nursing assistant (NA) #1 on 3/29/17 at 10:20 am was conducted. NA #1 revealed the resident ' s bed was not put in the lowest position and there were no floor mats used for this resident.

An observation of Resident #182 with NA #1 on 3/29/17 at 10:30 am revealed the bed was not in the lowest position and there were no padded floor mats on either side of the bed.

An interview with the family member (FM) on 3/29/17 at 10:35 am revealed she visited the resident every day. The FM reported she had not seen the bed in a low position and she had not seen padded floor mats beside the bed.

An observation of Resident #182 on 3/30/17 at 9:00 am revealed the resident was located to a different room. He was in a different bed with smaller side rails, there was no space noted between the mattress and the foot board, there were padded floor mats on bilateral sides of the bed, and the bed was in the lowest position.

An interview with Nurse #2 on 3/30/17 at 9:45 am revealed he was not aware the resident needed floor mats or that the bed should be in the lowest position.

An interview with NA #3 on 3/30/17 at 2:55 pm revealed she did not know the bed was supposed to be in the lowest position and she was not aware floor mats were used for this resident until 3/30/17.

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F 323	Continued From page 15 An interview was conducted with the DON on 3/30/17 at 6:30 pm. The DON reported that her expectation of the staff was to make her aware of conditions that could put a resident at risk for getting hurt so she could put the necessary safety precautions in place.	F 323		
F 327 SS=D	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to limit fluids on meal trays as prescribed for one of two residents reviewed for diet orders (Resident #83.) Findings included: Resident #83 was admitted 07/28/14. Diagnoses included diabetes mellitus Type 2, end-stage renal disease, and hypertension. The resident received dialysis. The quarterly Minimum Data Set dated 02/21/17 documented that the resident was cognitively intact. He required extensive assistance for all activities of daily living except eating which needed supervision.	F 327	Interventions for affected resident: Resident # 83 diet and fluid restriction orders were immediately corrected on 3/30/17 by the facility Dietician . Interventions for residents identified as having the potential to be affected: By 04/27/17, the facility Dietician and Director of Nursing will audit all residents with fluid restriction orders to ensure orders have been communicated and implemented by the dietary department. Systemic Change:	4/27/17

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F 327	Continued From page 16 The registered dietician wrote an order for Resident #83 on 03/24/17 which read "Fluid restriction 2 L [liters]..Dietary provide 240 ml B/L/D [breakfast/lunch/dinner]. The order was signed as transcribed with no time entered. The signature was illegible. An observation of the breakfast dietary ticket for 03/30/17 showed that Resident #83 received a "regular diet" with "coffee, juice and whole milk" listed as the beverages. In an interview with Resident #83 on 03/30/17 at 9:23 a.m., he stated he did not know that his diet had been changed. He stated he was generally aware of limiting his fluids and salt intake. In an interview with Nurse #3 on 03/30/16 at 1:00 p.m., he described the process of taking off diet orders. The nurse signed the order and filled out a two-ply Diet Communication Form. The top white copy was taken to the Dietary Manager and the yellow copy remained in the chart as a record that the diet had been changed. There was a yellow copy of the Diet Communication Form present in the record to indicate that the fluid restriction had been communicated to the Dietary Manager. In an interview with the Dietary Manager on 03/30/17 at 1:30 p.m., she stated that she had not received a Diet Communication Form for Resident #83 for fluid restriction. Typically she would receive a new form and enter the diet change in the computer so the printed meal tickets would reflect what the Dietary Aides should serve the resident. She could not locate the white Diet Communication Form in her box of	F 327	By 4/27/17, the Staff Development Coordinator (SDC) will re-educate Licensed Nurses on use of 2 part dietary communication form for communicating any new diet or fluid orders. New dietary orders will be reviewed in the facility clinical meeting by Nursing Management to ensure communication of new dietary orders to the dietary department. This review will occur daily for a minimum of 12 weeks. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 327	Continued From page 17 entered orders. In an interview with the registered dietician on 03/30/17 at 1:59 p.m., she indicated that she wrote the new fluid restrictions based on consultation with the VA Medical Center where the resident received dialysis treatments. She reviewed the clinical status of dialysis residents monthly as they were considered high risk. She was not aware that the kitchen was not limiting fluids on Resident #83 ' s meal trays for the past six days. In an interview with the Director of Nursing on 03/30/17 at 2:00 p.m., she could not identify the signature of the nurse who signed the order. She confirmed the process of taking off orders and indicated that a second nurse was tasked with verifying that all orders written that day had been accurately transcribed. She acknowledged that the fluid restriction order for Resident #83 had not been transcribed despite the nurse signing off. A second nurse had not identified the error.	F 327		
F 367 SS=D	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by:	F 367		4/27/17

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F 367	Continued From page 18 Based on observation, record review and staff interviews, the facility failed to provide the prescribed renal diet as ordered for one of two residents reviewed for diet orders (Resident #83). Findings included: Resident #83 was admitted 07/28/14. Diagnoses included diabetes mellitus Type 2, end-stage renal disease, and hypertension. The resident received dialysis. The quarterly Minimum Data Set dated 02/21/17 documented that the resident was cognitively intact. He required extensive assistance for all activities of daily living except eating which needed supervision. The registered dietician wrote an order for Resident #83 on 03/24/17 which read "change diet to renal, regular texture." The order was signed as transcribed with no time entered. The signature was illegible. The order had a notation to the side with initials and a date of 03/27/17. The initials were illegible. An observation of the breakfast dietary ticket for 03/30/17 showed that Resident #83 received a "regular diet." In an interview with Resident #83 on 03/30/17 at 9:23 a.m., he stated he did not know that his diet had been changed. He stated he was generally aware of limiting his fluids and salt intake but could not identify a specific diet that was recommended. In an interview with Nurse #3 on 03/30/17 at 1:00 p.m., he described the process of taking off diet orders. The nurse signed the order and filled out a two-ply Diet Communication Form. The top	F 367	Interventions for affected resident: Resident # 83 diet and fluid restriction orders were immediately corrected on 3/30/17 by the facility Dietician . Interventions for residents identified as having the potential to be affected: By 04/27/17, the facility Dietician and Director of Nursing will audit all residents diet orders to ensure orders have been communicated and implemented by the dietary department. Systemic Change: By 4/27/17, the Staff Development Coordinator (SDC) will re-educated Licensed Nurses on use of 2 part dietary communication form for communicating any new diet or fluid orders. New dietary orders will be reviewed in the facility clinical meeting by Nursing Management to ensure communication of new dietary orders to the dietary department. This review will occur daily for a minimum of 12 weeks. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the	

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F 367	Continued From page 19 white copy was taken to the Dietary Manager and the yellow copy remained in the chart as a record that the diet had been changed. There was no yellow copy of the Diet Communication Form present in the record to indicate that the change in diet had been communicated to the Dietary Manager. In an interview with the Dietary Manager on 03/30/17 at 1:30 p.m., she stated that she had not received a Diet Communication Form for Resident #83 for the diet change. Typically she would receive a new form and enter the diet change in the computer so the printed meal tickets would reflect what the Dietary Aides should serve the resident. She could not locate the Diet Communication Form in her box of entered orders. In an interview with the registered dietician on 03/30/17 at 1:59 p.m., she indicated that she wrote the new diet order based on consultation with the VA Medical Center where the resident received dialysis treatments. She reviewed the clinical status of dialysis residents monthly as they were considered high risk. She was not aware that the resident had not been receiving the newly prescribed renal diet for the past six days. In an interview with the Director of Nursing on 03/30/17 at 2:00 p.m., she could not identify the signature of the nurse signing off the orders or the initials beside the date of 03/27/17. She confirmed the process of taking off orders and indicated that a second nurse was tasked with verifying that all orders written that day had been accurately transcribed. She acknowledged that the diet order for Resident #83 were not	F 367	audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 367	Continued From page 20 transcribed despite the nurse signing off. A second nurse had not identified the error.	F 367		
F 463 SS=D	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, a resident interview (Resident #222), staff interviews and medical record review, the facility failed to provide a resident with a means to contact the nurse's station for 24 hours for 1 of 1 sampled residents reviewed with the inability to use their call light. The findings included: Resident #222 was admitted on 03/21/17 with the diagnosis in part, of spinal cord injury cervical region, resulting in quadriparesis (inability to move including extremities). Record review of the admission assessment dated 03/21/17, revealed Resident #222 was independent to make decisions and her memory was intact. She was unable to move, including all extremities. On 03/29/2017 at 9:29 AM an observation revealed a push button call bell hanging above	F 463	Interventions for affected resident: Resident #222 was immediately assessed by the Director of Nursing and a flat call bell obtained on 3/29/17. Interventions for residents identified as having the potential to be affected: By 4/27/17, current facility residents will be audited by Nursing Management to ensure that they have a usable call bell in place. Systemic Change: By 4/27/17, the Staff Development Coordinator (SDC) will in-service Licensed Nurses on assessment of residents upon admission to ensure that they have a usable call bell in place. Additionally, Nursing Management will review each	4/27/17

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F 463	Continued From page 21 her head, from a pole used to hang medication. During an interview, Resident #222 indicated that she had not had a call bell she could use since her arrival. She yelled out to notify staff of her needs. On 03/29/2017 at 9:32 AM, Aide #1 indicated she had asked maintenance for the flat call bell for Resident #222 . On 03/29/2017 at 9:39 AM, Nurse #1 indicated she had submitted a work order last week for the flat call bell and spoke to the maintenance assistant. On 03/29/2017 at 9:42 AM, the Maintenance Assistance (MA) indicated he was aware of Resident #222's need for a flat call bell and had informed the maintenance director last week. On 03/29/2017 at 9:52 AM, the Maintenance Director (MD) indicated the MA told him yesterday evening that he needed a flat call bell. The MD stated, he told the MA he did not have one and to look for one. He then stated if it was that important he would go to the medical supply company and pick one up. On 03/29/17 at 10:23 AM, the Director of Nursing (DON) indicated she would get her a flat call bell immediately.	F 463	new admission in the facility clinical meeting to ensure the resident has a usable call bell. This review will occur daily for a minimum of 12 weeks. By 4/27/17, the facility SDC will in-service facility staff on ensuring any work order requests is written in the work order book for properly for Maintenance Department review. By 4/27/17, the Administrator will in-service the Maintenance Department on ensuring review, priority, and completion of work order requests. Weekly for 12 weeks, the Administrator will review submitted work orders with the Maintenance Department to ensure completion of work order request. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	