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	345415	A. BUILDING _____ B. WING _____	R-C 03/14/2017

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PINEVILLE REHABILITATION AND LIVING CTR	1010 LAKEVIEW DRIVE PINEVILLE, NC 28134

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{F 000}	INITIAL COMMENTS A complaint investigation survey was conducted from 02/27/17 through 03/01/17. Immediate Jeopardy was identified at: CFR 483.10 and 483.12 at tag F221 at a scope and severity of J CFR 483.20 at tag F278 at a scope and severity of J CFR 483.25 at tag F323 at a scope and severity of J The tags F221 and F323 constituted Substandard Quality of Care. Immediate Jeopardy began on 02/16/2017 and it is ongoing. A partial extended survey was conducted The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation of compliance on 03/10/17. A revisit survey was conducted on 03/14/17 for verification of the facility's allegation of compliance and to determine the status of the ongoing Immediate Jeopardy. Immediate Jeopardy was removed on 03/14/17 at 12:50 PM. At the time of the exit on 03/14/17, the facility remained out of compliance at F 221, F 278, F 323 and F514 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of their correction actions.	{F 000}		
{F 221} SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	{F 221}		3/21/17

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

Electronically Signed | 03/16/2017

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{F 221}	Continued From page 1 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, medical doctor interview, staff interviews and record reviews the facility utilized a device without considering it to be a restraint and without a medical symptom. The Transfer Handle entrapped the resident and when	{F 221}	F Tag 221 Right To Be Free From Physical Restraints Corrective action that will be accomplished:	

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{F 221}	Continued From page 2 the resident was found, he was dead. This was for 1 of 1 sampled resident with a Transfer Handle (Resident #1). Immediate Jeopardy began on 02/16/17 when Resident #1 was found lying on his left side on the fall mat beside the low bed with his head entrapped in the Transfer Handle. When found by the staff the resident was dead. The immediate jeopardy is present and on-going. The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation of compliance (AOC) on 03/10/17. A revisit survey was conducted on 03/14/17 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following: - Systematic changes implemented on the use of bed accessories, the use of restraints, and the accurate coding of the minimum data set (MDS). - Evidence of staff in-servicing on the use of bed accessories, the use of restraints, and the accurate coding of the MDS. - Documentation of audits for the use of bed accessories, the use of restraints and the accurate coding of the MDS. Observations of residents bed and enviroment and interviews with staff present in the facility on 03/14/17, review of all documentation to support the AOC and interviews with the facility's Administrator and Director of Nursing provided sufficient evidence to support corrective action by	{F 221}	Resident #1 received physician order on 11/22/16 for Supportive devices, positioning bars on both sides of bed for assistance with positioning and trunk control. Resident #1 received physician clarification order on 12/6/16 that also states for Supportive devices, positioning bars on both sides for assistance with positioning and trunk control. The positioning bars are the transfer handles on Resident #1□s bed. The facility did not assess Resident #1□s need for the transfer handles prior to adding them to the resident□s bed on 12/6/16 or while they were in use on his bed from 12/06/16 to 2/16/17. Resident #1 was found lying on his left side on the fall mat beside the low bed with his head on the transfer handle on 02/16/2017. Resident assessed by LPN (Licensed Practical Nurse) to be absent of vital signs; resident was DNR (Do Not Resuscitate) and hospice and PCP (Primary Care Physician) immediately notified. Death Certificate signed by Medical Director on 03/06/2017 states cause of death: cardiac arrest, heart failure, and hypertension. The Director of Clinical Operations reviewed the Bed Safety policy education with the ADON (Assistant Director of Nursing) via telephone on 02/16/17. The ADON (Assistant Director of Nursing) then educated the Unit Manager on the Bed Safety policy on 2/16/17. The ADON (Assistant Director of Nursing) and Unit Manager then immediately reviewed all	

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{F 221}	Continued From page 3 the facility to remove the immediate jeopardy at F- 221 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of the corrective action. The Findings included: Resident #1 was initially admitted to the facility on 12/03/04 and expired in the facility on 02/16/17. Resident #1's diagnoses included blindness, cerebrovascular accident, right sided hemiplegia/hemiparesis, vascular dementia, history of convulsions, heart failure, and major depressive disorder. Review of Resident #1's most recent comprehensive minimum data set (MDS) dated 10/30/16 revealed that Resident #1 had long and short term memory problems and was moderately impaired for daily decision making. No behaviors were identified on the MDS. The MDS further revealed that Resident #1 required extensive assistance of 1 staff member for bed mobility and required extensive assistance of 2 staff members for transfers. The MDS stated that Resident #1 was 72 inches tall and weighed 198 pounds. No falls were identified since the prior MDS. The MDS also revealed that Resident #1 received hospice services and indicated no physical restraint was used while Resident #1 was in the bed. A fall care plan updated on 11/16/16 specified the resident was to have positioning bars for positioning and fall mats on both sides of the bed while in bed to avoid injury from a fall.	{F 221}	resident beds in the facility for use of physical restraints, including all bed rails and assistive devices/bed accessories including but not limited to side rails and halo bed rails to validate devices in use and any immediate concerns for safety. No immediate concerns were noted including no unacceptable spacing between rail and mattress during the audit on the evening of 02/16/17; this review was conducted by staff making direct observations of each resident□s bed and the assistive device/restraint which was in place on the bed. This was repeated on 3/8/17 after the training by the outside consultant was completed. That training is described below. On 2/28/17, Director of Operations conducted education/in-servicing to nursing management team (i.e. Director of Nursing, Assistant Director of Nursing, Nurse Supervisor) on use of the Device Decision Tree. The Device Decision Tree reviews the device ordered, if device prevents resident from performing an action that they are otherwise capable of performing, does device assist in the improvement of the resident□s functional status, and instruction to proceed to care plan. After the education/in-servicing was conducted by Director of Operations on 2/28/17, the nursing management team completed the Device Decision Tree evaluations. Another review was conducted again on 3/7/17 by nursing management team using the Pre restraint Assessment Tool.	

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{F 221}	Continued From page 4 Review of the cumulative physician orders for 02/01/17 through 02/28/17 revealed that on 11/22/16 a physician's order was written for "positioning bars on both sides of bed for assistance with positioning and trunk control." The facility was unable to locate the original order. Further review of the medical record revealed no diagnosis or medical symptom for use of the transfer handle and did not reveal a side rail assessment or a restraint enabler decision tree. Review of a nurse's note dated 02/16/17 at 11:32 PM read, "Resident #1 was observed not breathing at 5:15 PM. Skin color pale, Resident #1 was lying on his left side. Floor mats were in place, bed was in low position and head of bed was elevated between 45 and 90 degrees. Hospice nurse was notified. Family was notified and physician was notified." The note was signed by Nurse #1. Observations on 02/27/17 at 10:00 AM and again on 02/28/17 at 10:00 AM made of Resident #1's bed revealed a bed that was approximately 80 inches long and contained a Transfer Handle on each side of the bed. The transfer handle was approximately 18 inches from the top of the bed making the bottom of a pillow in line with the transfer handles. The transfer handle was a 24 inches by 4 inches wide by 24 inches tall metal rail and was perpendicular to the bed. When attached the vertical bar created 90 degree angle to a flat mattress. The transfer handle was attached to the bed frame per the manufacture instructions. Interview with the Assistant Director of Nursing	{F 221}	Training/in-servicing was completed by the Director of Operations on correct use of the tool on 2/28/17. The Pre restraint evaluation tool directs the staff to evaluate whether a bed accessory (including side rails and halos) is a restraint, this is based on the resident□s individualized assessment. The Pre restraint Assessment Tool is conducted to ensure all areas of resident□s physical, mental, emotional, environmental, and social well-being are addressed to identify the lease restrictive intervention. Each halo was assessed to determine whether it was a restraint based on individual assessment, meaning whether the halo restricted resident□s movement in or out of the bed. If the accessory was determined to be a restraint, the MDS (Minimum Data Set) was coded to reflect same and care plans updated accordingly by the MDS Coordinator by 3/8/17. Residents with assistive devices on their beds such as ¿ side rails and ¿ side rails and halos were safety-checked by nursing management team (Director of Nursing, Assistant Director of Nursing, Nurse Supervisor) on 2/17/17 and again on 3/8/17 with any need for adjusting or repair completed immediately. The safety check included ensuring that no gaps existed that could cause entrapment from being caught between the mattress and bed accessory or in the bed accessory itself with no immediate concerns noted. The resident□s bed accessory & devices including the halos, were assessed to determine if they meet the definition of a	

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{F 221}	Continued From page 5 (ADON) on 02/27/17 at 11:50 AM revealed that on 02/16/17 the Director of Nursing (DON) had been on vacation and she was working late that evening finishing up some paper work in the office. The ADON stated she had gone to get a chart and was walking down the hallway when she noted Nursing Assistant (NA) #2 summoning her to Resident #1's room. The ADON stated she put the chart down and ran to Resident #1's room. The ADON stated that when she entered Resident #1's room Nurse #1 informed her Resident #1 was a hospice patient and had a Do Not Resuscitate order in place and he had expired. The ADON stated when she entered Resident #1's room she saw Resident #1 lying on the floor with his head resting on the mattress and his chin "touching" the transfer handle. The ADON described the color of Resident #1 as a "little yellow." The ADON stated she directed the staff to lower Resident #1's head to the floor and then assist the body back into bed. The ADON stated she was unaware of how long the incident had been going on and she did not think staff knew she was there because she was working in an office with the door closed and had come out to obtain a chart and the staff saw her and summoned her so she just was really not clear on what happened but she had some "concerns with the way Resident #1 was positioned." Interview with the Administrator on 02/27/17 at 12:13 PM revealed that on 02/16/17 at approximately 5:30PM she got a phone call from the ADON and was informed that Resident #1 had expired. The initial call from the ADON was that the staff stated Resident #1's head was caught in the side rail, so the Administrator told the ADON that she would be on her way back to the facility. The Administrator stated she returned	{F 221}	restraint by the nursing management team (Director of Nursing, Assistant Director of Nursing, Nurse Supervisor). This task was completed after Administrator and nursing leadership team (leadership team consists of Director of Nursing, Assistant Director of Nursing, Nursing supervisor, and Minimum Data Set Coordinators) were in - serviced by outside RN consultant on 3/8/17. The training included: 1) the definition of a restraint as any device attached to or adjacent to the resident which limits the residents movement in or out of a bed based that on that resident□s individualized assessment; 2) coding that resident□s MDS for restraints where applicable; 3) conducting a safety assessment of the device for risk / benefit and least restrictive 4) ensuring an appropriate physician or therapy order is in place for the device; and 5) ensuring the clinical record reflects an underlying medical condition supporting the use of the restraint. If they did, the MDS (Minimum Data Set) for that resident was coded appropriately, and the care plan updated to reflect same by the MDS (Minimum Data Set) Coordinators. This was completed by 3/9/17. On 2/17/17, an assessment was performed by the Interdisciplinary Team on each resident with any assistive device, including side rails and halos. Based on that assessment, fourteen (14) residents based upon their current abilities and conditions were determined to be appropriate for change to alternative	

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{F 221}	Continued From page 6 to the facility around 8:00 PM and immediately started interviewing the staff. The Administrator stated that she went into Resident #1' s room and observed that Resident #1 did not have side rails he had assist bars that were 4 inches wide and the assist bars were not considered a side rail or a restraint. The Administrator stated that she observed Resident #1's body and did not see any bruising or discoloration, she stated he did have red bumps on his neck but that he had been shaved earlier in the day but nothing that had indicated he had got hung on the assist bar. The administrator stated that through her interviews she got the same story of what happened and even took it a step further and brought the staff to the desk and used charts to simulate what happened. The staff told her that Resident #1 was sitting on the fall mat with his shoulders leaning on the mattress, his head was lying on the mattress and his forehead and chin were touching the assist bar. The administrator stated she asked the staff what he looked like and they stated he was white as a ghost but did not see bluish color to him. The administrator stated at that time she had no reason to believe the assist bars had anything to do with his death. Interview with NA # 4 on 02/27/17 at 2:58 PM revealed that she routinely cared for Resident #1. NA #4 stated she had fed him breakfast and lunch on 02/16/17 and he was his usual self. NA #4 stated that Resident #1 was a "wiggler in bed and always leaned to the left side of the bed." NA #4 stated she frequently throughout her shift would have to reposition Resident #1 back to the middle of the bed. Interview with NA #2 on 02/27/17 at 3:05 PM revealed that she routinely took care of Resident	{F 221}	less restrictive bed accessory, such as assist bars or halos and those devices were ordered on 2/17/17 by the maintenance department for installation upon delivery. Delivery is expected by 03/10/17. On 3/8/17 after training by an outside consultant (as described herein), the IDT (Interdisciplinary Team) again assessed and reviewed each resident□s use of any bed accessory including but not limited to side rails and halos. Bed accessory is defined as any item e.g. fixtures such as handrails, grab bars, and devices/equipment such as transfer lifts, canes, and wheelchairs, etc. that is used by, or in the care of a resident to promote, supplement, or enhance the resident□s function or safety. The assessment of use on 03/08/17 included a review of the resident□s current clinical record, staff interviews regarding how /if resident used the accessory, and resident observation was performed by a licensed nurse. This has resulted in the removal of assistive devices for all but 12 residents. As of 3/8/17, upon arrival, any assistive device will be assessed by nursing management team (Director of Nursing, Assistant Director of Nursing, Nurse Supervisor, all whom received training by outside consultant on 3/8/17 using the pre-restraint assessment tool to determine if device is a restraint based upon the resident□s individualized assessment. If they are restraints, the MDS (Minimum Data Set) will be coded accordingly and the care plan updated MDS (Minimum Data Set) Coordinators. This will include the alternative devices for	

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{F 221}	Continued From page 7 #1 and Resident #1 quite often slid to the left side of the bed and she would have to straighten him back up. NA #2 stated that Resident #1 was a "busy body" and would scoot from the middle of the bed to that left side of the bed. NA #2 also stated that because Resident #1 had swallowing issues they had been advised to keep the head of his bed elevated. NA #2 stated that on 02/16/17 at approximately 5:15 PM-5:30 PM they were in the dining room and NA #1 had taken Resident #1's tray to his room to assist him with the meal. NA #2 stated that immediately NA #1 came running back into the dining room and stated "he is choking." NA #2 stated that all the staff jumped up and ran to Resident #1's room. NA #2 stated that when she entered Resident #2's rooms she could tell "he was dead, there was no movement, he was limp, and his face was completely white." NA #2 stated that Resident #1's bed was in low position and the head of the bed was elevated between 45 and 90 degrees and Resident #1's chin was "hooked" on the transfers handle with his neck between the mattress and the handle. NA #2 stated that Resident #1's body was lying parallel to the bed except his head which was "hooked" on the transfer handle. NA #2 stated the bar was tight against Resident #1's neck under his chin (pointed to the larynx area) and stated that they had to lower the head of the bed to remove Resident #1 from the transfer handle. NA #2 stated that after they removed Resident #1 from the transfer handle there was a red area on his neck under his chin (pointed to larynx area) where the transfer handle had been. Interview with Nurse #1 on 02/27/17 at 3:24 PM revealed that she was the nurse taking care of Resident #1 on 02/16/17. Nurse #1 stated she arrived for her shift at 3:00 PM and got report and	{F 221}	the 14 residents mentioned above. Resident #1 had a 24-inch-long x 4-inch-wide transfer handle attached to his bed which was not assessed by staff to determine if it was a physical restraint. The assessment as we described herein examines all bed devices, including transfer handles, to determine if they were restraints based upon the resident□s□ individualized assessment. Where they were determined to be a restraint the resident MDS and care plan was updated appropriately. As of 3/8/17 and going forward, any device determined to be ineffective or a safety issue by IDT (Interdisciplinary Team) shall be removed; the resident will then be assessed by the IDT (Interdisciplinary Team) for an alternative intervention. Resident care plans will be updated accordingly by the IDT and direct care staff will be informed via the care guide. All nursing staff have been trained on this by 3/9/17. Any nursing staff who was not present for training or are PRN will not be allowed to return to work and patient care until this training has been completed by them. Resident #1□s bed did not malfunction nor have a device failure; therefore, it was not necessary to take the bed out of service. The bed is not currently in use by any resident and will be assessed for accessory needs prior to placement of a resident; transfer handles were removed from the bed on 3/1/17. All residents in the facility with a bed	

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{F 221}	Continued From page 8 counted the medication cart and then walked down the hallway to check on her patients. Nurse #1 stated that at that time Resident #1 was in his bed in low position and the head of the bed was elevated and he was his "normal self." Nurse #1 she had come up the hall after ending her medication pass at around 4:30 PM and again looked in on Resident #1 and he was he was alive and well. Nurse #1 stated that after she completed her medication pass she had gone into the dining room to wait for the dinner tray so she could assist residents with the meal. Nurse #1 stated that at approximately 5:15 PM NA #1 took Resident #1's tray to his room to assist him with the meal. Nurse #1 stated that immediately NA #1 came running back to the dining room hollering for help. Nurse #1 stated that all the staff jumped up and ran to Resident #1's room. Nurse #1 stated she walked around the side of the bed and Resident #1 was lying on the floor parallel to the bed with his chin firmly between the transfer handles and his neck between the transfer handle and the mattress. Nurse #1 stated that she had summoned for the NA to get some help because she had no idea what to do. Nurse #1 stated that she did confirm that Resident #1 had expired with no respiration and had a Do Not Resuscitate order in place. The ADON advised them to place Resident #1 back in the bed and perform post mortem care. Nurse #1 also stated that they had to lower the head of the bed to remove Resident #1 from the transfer handle. Nurse #1 stated she had notified the hospice provider, the family, and the physician that Resident #1 had expired. Interview with NA #3 on 02/27/17 at 4:39 PM revealed that she routinely cared for Resident #1 and on 02/16/17 at approximately 3:45 PM she had provided incontinent care to Resident #1. NA	{F 221}	accessory or physical restraint were assessed using the Initial Assessment for Use of Physical Restraint tool by DON/Nursing Management team (includes ADON, Nursing Supervisor, and MDS coordinators) by 3/9/2017. This included the following elements: 1) assessing each bed accessory based upon the resident□s individualized resident assessment to determine whether it constitutes a restraint for that resident; 2) ensuring that all residents with any assistive device have been coded on the MDS as having a potential restraint; 3) ensuring that all residents with a restraint have the MDS coded as such; 4) ensuring a safety assessment for all such residents is completed and documented; 5) ensuring a physician order and/or physician/therapy order is in place for such device and 6) ensuring the clinical record contains documentation of a medical condition warranting the use of such device. A physician order for every resident with a bed accessory or physical restraint was obtained by nursing management team by 3/9/17 that includes use of device/accessory or physical restraint and presence of medical symptom/condition for device/accessory to assist with protecting the resident□s safety, and help the resident attain the highest level of his/her physical or psychological well-being. All residents in the facility with a bed accessory or physical restraint care plan shall be reviewed and updated by IDT by	

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{F 221}	Continued From page 9 #3 stated that when she entered his room he was lying on his side on the left side of the bed and she had to reposition him near the middle of the bed and after providing care and repositioning Resident #1 she had raised the head of his bed and ensured the bed was in low position and left the room. NA #3 stated that Resident #1 favored the left side of his bed and generally about 3 times during her shift she would have to go in and reposition Resident #1 near the middle of the bed but he would always scoot back to the left side. NA #2 stated that lately he would rest his head on the transfer handle that was attached to his bed and would often time throw his legs off the side of the bed. NA #3 stated that on 02/16/17 at approximately 5:15 PM the staff was in the dining room and NA #1 had taken Resident #1's tray to his room to assist him with the meal. NA #3 stated that immediately NA #1 came running back to the dining room and stated "Resident #1 is choking", so we all jumped up and ran to his room. NA #3 stated that when she entered his room she could tell Resident #1 was dead, she stated he was very pale and white in color. NA #3 stated Resident #1's body was lying on the floor on the fall mat and his chin was between the transfer handles with his neck between the handle and the mattress. NA #3 stated that there was a red line where the bar had been on Resident #1's neck under his chin (pointed to larynx area) and they had to lower the head of the bed to remove Resident #1 from the transfer handle. NA #3 stated that his bed was in the low position and the head of the bed was just as she had left it earlier after rendering care. NA #3 stated that after they removed Resident #1 from the transfers handle they assisted the body back into bed and post mortem care was provided.	{F 221}	3/9/17 to reflect use of bed accessory/restraint. A modification MDS (Minimum Data Set) will be completed by MDS (Minimum Data Set) team by 3/9/17 to reflect the use of bed accessory/restraint, and the MDS (Minimum Data Set) restraint information will be transferred to the resident□s care plan. A QAPI (Quality Assurance Performance Improvement) subcommittee was formed, this committee consulted with the Medical Director on 3/1/17 and again on 3/9/17 regarding all required components of the Credible Allegation, and the citations issued by North Carolina Department of Health. The subcommittee consists of Administrator, DON (Director of Nursing), ADON (Assistant Director of Nursing), MDS (Minimum Data Set) Coordinators. The Subcommittee shall meet monthly and as needed x 3 months to ensure the Credible Allegation, 2567 (upon receipt), and Plan of Correction is followed and the facility is in compliance. Identification of other residents: All residents with bed accessories determined to be a restraint based upon their individualized assessment are at risk for this alleged deficient practice. Measures for systemic change: Administrator and facility leadership team (leadership team consists of Director of Nursing, Assistant Director of Nursing, Nursing supervisor, and Minimum Data Set Coordinators) in serviced by outside	

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{F 221}	Continued From page 10 Interview with the Director of Maintenance on 02/28/17 at 10:00 AM revealed that on 01/04/17 he had ordered a new bed for the facility. On 01/11/17 the new bed arrived to the facility and on or around 01/16/17 he assembled the new bed which included the Transfer handles. The Director of Maintenance stated that the new bed had come with Transfer handles and he attached them to the bed per the manufacturer instructions and once the bed was assembled the bed was placed in an empty room until someone needed the bed. The Director of Maintenance stated that at some point Resident #1 needed a new bed and someone had grabbed the bed with the Transfer handles on it and assigned it to Resident #1. The Director of Maintenance stated he had no involvement in assigning Resident #1 to the bed with the Transfer Handles. The Director of Maintenance stated to his knowledge the beds were just switched and was not sure that there was anything wrong with the old bed. Interview with the hospice nurse on 02/28/17 at 11:06 AM revealed that she routinely visited Resident #1 but had no involvement in assigning a bed to Resident #1. The hospice nurse stated that the facility would handle any type of bed or device that was needed for the resident. The hospice nurse stated that when she would visit, Resident #1 was usually found him lying on his left side with his head resting on the top upper rail of the transfer handle. The hospice nurse stated that she would move him closer to the middle of the bed but Resident #1 would wiggle back to the left side of the bed. The hospice nurse stated she had no concerns with Resident #1's preferred position of resting his head on the transfer handle and if she would have had any concerns she would have immediately notified the facility staff.	{F 221}	Registered Nurse consultant on 3/8/17. The training included: 1) the definition of a restraint as any device attached to or adjacent to the resident which limits the residents movement in or out of a bed based that on that residents individualized assessment; 2) coding that resident□s MDS (Minimum Data Set) for restraints where applicable; 3) conducting a safety assessment of the device for risk / benefit and least restrictive 4) ensuring an appropriate physician or therapy order is in place for the device; and 5) ensuring the clinical record reflects an underlying medical condition supporting the use of the restraint. No nursing staff who was absent or PRN (pro re nata) staff will be allowed to return to the floor and resident care until this training has been completed. Then, all nursing staff shall be in serviced by Director of Nursing, Assistant Director of Nursing, or Nurse Supervisor by 3/9/17 on 1) the definition of a restraint as any device attached to or adjacent to the resident which limits the resident□s movement in or out of a bed based that on that resident□s individualized assessment; 2) coding that resident□s MDS (Minimum Data Set) for restraints where applicable; 3) conducting a safety assessment of the device for risk / benefit and least restrictive 4) ensuring an appropriate physician or therapy order is in place for the device; and 5) ensuring the clinical record reflect and underlying medical condition supporting the use of the restraint. No nursing staff who was	

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{F 221}	Continued From page 11 The hospice nurse stated that Resident #1 also seemed to be comfortable and obviously preferred the left side of bed. The hospice nurse stated she had visited with Resident #1 on 02/15/17 and he was his usual self. Interview with the Central Supply Clerk on 02/28/17 at 11:22 AM revealed that he had been out of work for medical reason from 12/08/16 and returned to work at the facility on 01/19/2017. The central Supply clerk stated that when he left on 12/08/16 Resident #1 had a different type of rail on his bed and when he returned to work at the facility on 01/19/17 he had the Transfer handles on his bed. The Central Supply clerk stated that Resident #1 was a "fidgety person in bed and would pull himself around to the left side of the bed a lot." Interview with Director of Nursing (DON) on 02/28/17 at 12:04 PM revealed that she was on vacation when Resident #1 expired and did not participate in any type of investigation associated with his death or the manner in which he was found. The DON stated that Resident #1 was a "busy body" in the bed and would pull on the other devices that they had in place for him. The DON stated that at one point Resident #1 was able to pull a device called a "Halo" out of the device that secured them to the bed. The DON stated that they had tried several different types of beds to find what would work best for Resident #1 "but we felt like the Transfers Handle that attached to the bed frame was sturdier and better for him." The DON stated that she believed that Resident #1 got the Transfer Handle a couple of months ago but could not recall for sure. Interview with NA #1 on 02/28/17 at 3:39 PM	{F 221}	absent or PRN (pro re nata) staff will be allowed to return to the floor and resident care until this training has been completed. All nursing staff shall be in-serviced by Director of Nursing, Assistant Director of Nursing, or Nurse Supervisor on completing Initial Assessment for Use of Physical Restraint and Side Rail Assessment prior to implementation of bed accessory to identify the least restrictive intervention by 3/9/17. No nursing staff who was absent or PRN (pro re nata) will be allowed to return to the floor and resident care until this training has been completed. Beginning on 3/8/17, nursing staff shall be in serviced by Director of Nursing or Assistant Director of Nursing upon hire on bed safety including the use of restraints. Beginning on 3/8/17, the IDT (Interdisciplinary Team) will complete Physical Restraint Reduction Evaluation Assessment for all residents with a bed accessory at least quarterly, annually, with any significant change, or as needed and update care plan accordingly. Beginning on 3/8/17, the IDT (Interdisciplinary Team) will complete Side Rail Assessment for all residents with a side rail at least quarterly, annually, with any significant change, or as needed and update care plan accordingly. Beginning on 3/9/17, the facility shall remove all bed accessories from a	

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{F 221}	Continued From page 12 revealed that she routinely cared for Resident #1 and on 02/16/17 at approximately 5:10 PM she was in the dining room and when the trays arrived she had taken Resident #1's tray down the hall to his room to assist him with the meal. NA #1 stated that when she entered the room she saw Resident #1's legs were outside of the bed. NA #1 stated when she got to the bedside she saw Resident #1 with his chin between the transfer handles and his neck between the handle and the mattress and it was purple in the area of his chin/neck (pointed to larynx area). NA #1 stated "I ran for help but I knew that he was already dead, he was making no noises, he was limp and very pale." NA #1 stated she ran and told Nurse #1 that "the rail is choking him come now." When asked to describe the choking NA #1 replied "the rail was in his neck, his neck was trapped in the rail, and he could not get out of the rail." NA #1 stated that the head of the bed was elevated and we had to lay the head of his bed flat to remove him from the transfer handle. NA #1 stated that when we removed Resident #1 from the transfer handle there was blueish/purplish bruise still present in the same area (points to larynx area) where the transfer handle had been. NA #1 stated that they were instructed to lower Resident #1 to the floor and then back to bed and perform post mortem care. On 02/28/17 at 4:20 PM in a follow up interview with the Administrator she stated that the assist rail was 4 inches wide and physically impossible to get your head stuck and the facility did not consider the transfer handle a restraint or a side rail. The Administrator stated she had not re-enacted the scene as Resident #1's body was still present in the facility at the time, however she used charts to simulate the scene. The	{F 221}	resident bed when resident discharges or is assigned a different bed. This will be handled by maintenance as directed by nursing staff. Administrator provided education/in-servicing on 3/9/17 to nursing staff, maintenance staff, and receptionist on procedure of notifying maintenance staff to remove all bed accessories from a resident bed when resident discharges or is assigned a different bed including week ends. No nursing, maintenance staff or receptionist who was absent or PRN (pro re nata) will be allowed to return to the floor and resident care until this training has been completed. How corrective actions will be monitored: The Director of Nursing, Assistant Director of Nursing, Nurse Manager, Maintenance Director, Assistant Maintenance Director, and/or Administrator will complete an audit to assure any accessory being added to a bed validating: the type of accessory being recommended, an Initial assessment for use of Physical Restraint tool has been completed for the accessory to determine restraint/ability to use, Physician order has been obtained, resident is aware of the accessory and can verbalize understanding of the accessory. This audit will be completed five (5) times a week for eight(8)weeks on all resident beds, including new admission and permanently discharged resident beds, to ensure that a bed accessory has not been added to a bed without going through the nursing assessment and approval process, and then continue three	

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{F 221}	Continued From page 13 Administrator failed to provide the written information surrounding the circumstances of the incident. In an interview with the Medical Director (MD) on 03/01/17 at 4:08 PM revealed that he did not recall writing the order for Resident #1 to have to have the Transfer Handles but could not deny it. The MD stated that he did not assess the need for devices like that the facility would handle that and notify him if they needed anything from him or needed an order. To his knowledge and recollection the MD stated he did not assess Resident #1 for any transfer handle or other device for his bed. The Administrator was notified of the immediate jeopardy on 02/28/17 at 4:20 PM.	{F 221}	(3) times a week for eights (8) weeks, one (1) time a week for four (4) weeks, and one (1) time a month for a minimum 6 months and will continue until the Quality Assurance/ Performance Improvement (QAPI) committee reviews and determines that the facility has maintained substantial compliance. The audits being completed for both F323 and F221, will be reviewed in a weekly Interdisciplinary Team meeting for an additional review opportunity for one (1) time a week for twelve (12) months; these weekly meetings and reviews will then be presented in the Monthly Medical Director report for review and determinations. The Monthly Medical Director reports will be submitted to the Quality Assurance Performance Implementation (QAPI) for monthly review for twelve (12) months, making any necessary recommendations. This process will allow multiple layers of Facility committees to have direct review and over-sight of bed accessories in use within the Facility for a minimum of twelve (12) months and will continue until the Quality Assurance/ Performance Improvement (QAPI) committee reviews and determines that the facility has met and maintained substantial compliance. The Quality Assurance Performance Improvement committee participation includes, but is not limited to, Administrator, Director of Nursing, Medical Director, Unit Management, Regional Clinical Director, Director of Social Services, Minimum Data Set	

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{F 221}	Continued From page 14	{F 221}	(MDS) Coordinator, Culinary Services Director, Maintenance Director, Admissions Coordinator, and Activity Director.	
{F 278} SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	{F 278}		3/21/17

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{F 278}	Continued From page 15 (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to accurately code the quarterly minimum data set assessment to reflect the use of a physical restraint and hospice service for 1 of 3 resident reviewed (Resident #1). Resident #1's chin was restrained between the two bars of a Transfer Handle that was attached to his bedframe and his neck was stuck between the Transfer Handle and the mattress. When the resident was found, he was deceased. Immediate Jeopardy began on 01/30/17 when the nursing home failed to assess Resident #1 for the use of a device that met the definition of a restraint and had the effect of restraining the resident. On 2/16/17, Resident #1 was found lying on the left side of his body on a fall mat beside the low bed with his head entrapped in the Transfer Handle. When the resident was found by the staff, the resident was dead. See findings in 1.a. The immediate jeopardy is present and on-going. The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation of compliance (AOC) on 03/10/17. A revisit survey was conducted on 03/14/17 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following: - Systematic changes implemented on the use	{F 278}	F Tag 278 Assessment Accuracy /Coordination /Certified Corrective action that will be accomplished: Resident #1 received physician order on 11/22/16 for Supportive devices, positioning bars on both sides of bed for assistance with positioning and trunk control. Resident #1 received physician clarification order on 12/6/16 that also states for Supportive devices, positioning bars on both sides for assistance with positioning and trunk control. The positioning bars are the transfer handles on Resident #1 bed. The facility did not assess Resident #1□s need for the transfer handles prior to adding them to the resident□s bed on 12/6/16 or while they were in use on his bed from 12/06/16 to 2/16/17. Also, staff failed to assess the transfer handles as a physical restraint on Resident #1□s quarterly MDS (Minimum Data Set) of 1/30/17. Resident #1 was found lying on his left side on the fall mat beside the low bed with his head on the transfer handle on 02/16/2017. Resident assessed by LPN (Licensed Practical Nurse) to be absent of vital signs; resident was DNR (Do Not Resuscitate) and hospice and PCP (Primary Care Physician) immediately	

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{F 278}	Continued From page 16 of bed accessories, the use of restraints, and the accurate coding of the minimum data set (MDS). - Evidence of staff in-servicing on the use of bed accessories, the use of restraints, and the accurate coding of the MDS. - Documentation of audits for the use of bed accessories, the use of restraints and the accurate coding of the MDS. Observations of residents bed and enviroment and interviews with staff present in the facility on 03/14/17, review of all documentation to support the AOC and interviews with the facility's Administrator and Director of Nursing provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F- 278 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of the corrective action. The findings included: 1a. Resident #1 was initially admitted to the facility on 12/03/04. Resident #1's diagnoses included vascular dementia and heart failure. A fall care plan updated on 11/16/16 specified the resident was to have positioning bars for positioning and fall mats on both sides of the bed while in bed to avoid injury from a fall. Review of the cumulative physician orders for 02/01/17 through 02/28/17 revealed that on 11/22/16 a physician's order was written for "positioning bars on both sides of bed for	{F 278}	notified. Death Certificate signed by Medical Director on 03/06/2017 states cause of death: cardiac arrest, heart failure, and hypertension. Facility MDS (Minimum Data Set) Coordinator completed a modification to Resident #1 1/30/17 quarterly MDS for coding of P0100 on 3/9/17; transmission was completed on 3/9/17. Facility MDS (Minimum Data Set) Coordinator completed a modification to Resident #1 1/30/17 quarterly MDS (Minimum Data Set) for coding of J1400 on 3/1/17; transmission was completed on 3/9/17. 100% audit of all residents with bed accessories/restraints last MDS completed by 3/9/17 by facility MDS (Minimum Data Set) Coordinators on appropriate coding. Audit was completed based upon results of the Initial Assessment for Use of Physical Restraint tool for each individual resident. Of those identified, all were modified if appropriate by 3/9/17 by facility MDS (Minimum Data Set) Coordinators to reflect use of bed accessory/restraint. This was completed after the two (2) facility MDS (Minimum Data Set) Coordinators received education/in servicing from Director of Clinical Reimbursement on 3/7/17 on appropriately coding MDS (Minimum Data Set) Section P0100. 100% audit of all hospice residents last MDS (Minimum Data Set) completed on 3/1/17 by MDS (Minimum Data Set)	

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{F 278}	Continued From page 17 assistance with positioning and trunk control." Further review of the medical record revealed no diagnosis or medical symptom for use of the Transfer Handle and did not reveal a side rail assessment or a restraint enabler decision tree. In an interview with the Medical Director (MD) on 03/01/17 at 4:08 PM the MD revealed that he did not recall writing the order for Resident #1 to have to have the Transfer Handles but could not deny it. The MD stated that he did not assess the need for devices like that. The facility would handle that assessment and notify him if they needed anything from him or needed an order. To his knowledge and recollected the MD stated he did not assess Resident #1 for any Transfer Handle or other device for his bed. Observations on 02/27/17 at 10:00 AM and again on 02/28/17 at 10:00 AM made of Resident #1's bed revealed a bed that was approximately 80 inches long and contained a Transfer Handle on each side of the bed. The Transfer Handle was approximately 18 inches from the top of the bed making the bottom of a pillow in line with the Transfer Handles. The Transfer Handle was a tall metal rail that measured 4 inches wide by 24 inches tall and was perpendicular to the bed. When the Transfer Handle was attached to the bedframe, the vertical bar created a 90 degree angle to a flat mattress. The Transfer Handle was attached to the bed frame per the manufacturer's instructions and was not easily removed. Interview with the Central Supply Clerk on 02/28/17 at 11:22 AM revealed that he had been out of work from 12/08/16 and returned to work on 01/19/2017. The Central Supply Clerk stated that when he left on 12/08/16 Resident #1 had a	{F 278}	Coordinators on appropriate coding; audit was completed based upon review of all resident physician orders to determine if resident is under hospice care. This was completed after the two (2) facility MDS (Minimum Data Set) Coordinators received education/in-servicing from outside RN (Registered Nurse) consultant on 3/1/17 on appropriately coding MDS (Minimum Data Set) Section J1400. Identification of other residents: All residents who have a bed accessory/restraint are at risk for this alleged deficient practice. All residents who are under hospice care are at risk for this alleged deficient practice. Measures for systemic change: In-service by Director of Clinical Reimbursement on 3/7/17 to the facility□s two (2) MDS (Minimum Data Set) Coordinators on appropriately coding of MDS (Minimum Data Set) Section P0100 including definition of Physical Restraint which is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident□s body that the individual cannot remove easily which restricts freedom of movement or normal access to one□s body (e.g. leg restraints, arm restraints, hand mitts, soft tires or vests, lap cushions, and lap trays the resident cannot remove easily). If a device is coded as a restraint on Section P0100, a CAA (Care Area	

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{F 278}	Continued From page 18 different type of rail on his bed and when he returned to work at the facility on 01/19/17 he had the Transfer Handles on his bed. Review of Resident #1's most recent quarterly minimum data set (MDS) dated 01/30/17 revealed that Resident #1 had long and short term memory problems and was moderately impaired for daily decision making. The MDS also revealed that Resident #1 required extensive assistance of one person for bed mobility and required extensive assistance of two staff members for Transfer. The MDS further revealed that Resident #1 had no falls since the prior assessment, indicated no physical restraint (defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) was used in bed or chair. Interview with MDS Nurse on 03/01/17 at 10:30 AM revealed that she had completed the MDS dated 01/30/17 for Resident #1 and she had not coded any use of restraint because Resident #1 did not have a restraint. The MDS nurse stated he had no side rails, he only had Transfers Handles and those were used for positioning but were not a restraint. Interview with Nurse #1 on 02/27/17 at 3:24 PM revealed that she was the nurse taking care of Resident #1 on 02/16/17. Nurse #1 stated that at approximately 5:15 PM NA #1 requested her assistance. Nurse #1 stated she walked around the side of the bed and Resident #1 was laying on the floor parallel to the bed with his chin firmly between the Transfer Handle vertical rails and his	{F 278}	Assessment) and Care Plan shall be implemented. In-service by outside RN consultant on 3/1/17 to the two (2) facility MDS (Minimum Data Set) Coordinators received education/in-servicing from outside RN (Registered Nurse) consultant on 3/1/17 on appropriately coding MDS (Minimum Data Set) Section J1400 including definition of condition or chronic disease that may result in a life expectancy of less than 6 (six) months. If Section J1400 is coded on resident□s MDS (Minimum Data Set), a CAA (Care Area Assessment) and Care Plan shall be implemented. How corrective actions will be monitored: A nurse manager will conduct random audits of 10 MDS□s (Minimum Data Set) to ensure coding of J1400 and P0100 as appropriate. This audit will be completed five (5) times a week for eight (8) weeks, three (3) times a week for eights (8) weeks, one (1) time a week for four (4) weeks, and one (1) time a month for a minimum 6 months and will continue until the Quality Assurance/ Performance Improvement (QAPI) committee reviews and determines that the facility has met and maintained substantial compliance. The Quality Assurance Performance Improvement committee participation includes, but is not limited to, Administrator, Director of Nursing, Medical Director, Unit Management, Director of Social Services, Minimum Data Set (MDS) Coordinator, Regional Clinical	

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neck was between the Transfer Handle and the mattress. Nurse #1 stated that she confirmed Resident #1 had expired with no respiration and had a Do Not Resuscitate order in place. Nurse #1 also stated that they had to lower the head of the bed to remove Resident #1 from the Transfer Handle.

Interview with the Director of Nursing (DON) on 02/28/17 at 12:04 PM stated that Resident #1 was a "busy body" in the bed and would pull on the other devices that they had in place for him. The DON stated that at one point Resident #1 was able to pull a device called a "Halo Safety Ring" out of the post that secured it to the bed. The DON stated that they had tried several different types of beds to find what would work best for Resident #1 "but we felt like the Transfer Handle that attached to the bed frame was sturdier and better for him." The DON stated that she believed that Resident #1 got the Transfer Handle a couple of months ago. The DON also stated that residents with side rails were assessed using the side rail assessment located in the electronic medical record and other devices were assessed using the restraint enabler decision tree also located in the medical record. The DON stated that they did not consider the Transfer Handle a restraint for Resident #1.

On 02/28/17 at 4:20 PM in an interview with the Administrator she stated that the Transfer Handle was 4 inches wide and physically impossible to get your head stuck and the facility did not consider the Transfer Handle a restraint or a side rail. The Administrator stated that all residents with side rails were assessed for safety using the side rail assessment document located in the electronic medical record and that other devices

Director, Culinary Services Director, Maintenance Director, Admissions Coordinator, and Activity Director.

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were assessed using the restraint enabler decision tree. The Administrator stated that they always try to use the least restrictive device possible and they believed the Transfer Handle was appropriate for Resident #1. The Administrator stated that the Transfer Handle for Resident #1 was used for positioning.

The Administrator was notified of immediate jeopardy on 03/06/17 at 11:39 AM.

1.b. Review of a document titled, "Hospice and Palliative care Certification/Recertification Statement" that was found in the medical record read in part, "I have reviewed the above beneficiary's clinical circumstances and I certify that the beneficiary is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course." The document was signed by the hospice medical director on 01/04/17. The certification period was 01/18/17 to 04/17/17.

Review of Resident #1's most recent quarterly minimum data set (MDS) dated 01/30/17 revealed that Resident #1 had long and short term memory problems and was moderately impaired for daily decision making. The MDS also revealed that Resident #1 received hospice services, but did not indicate that Resident #1 had a life expectancy of less than 6 months to live (section J1400 of the MDS).

Interview with the MDS Nurse on 03/01/17 at 10:30 AM revealed that she had completed the MDS on Resident #1 dated 01/30/17 and that he was receiving hospice care during the assessment period. The MDS nurse stated that they never checked the prognosis of less than 6

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{F 278}	Continued From page 21 months to live (section J1400) on the MDS unless the physician wrote a note stating that they have 6 months or less to live. The MDS nurse stated that it was very rare for them to check that on the MDS in section J, because "doctors do not time frame how long someone has to live." In a follow up interview on 03/01/17 at 11:28 AM, the MDS nurse confirmed the assessment should have reflected that Resident #1 had a life expectancy of less than 6 months to live. Interview with Director of Nursing (DON) on 03/01/17 at 4:31 PM revealed that she expected the MDS to be completed accurately to reflect the resident status.	{F 278}		
{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.	{F 323}		3/21/17

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{F 323}	Continued From page 22 (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (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, staff interviews, and record reviews the facility failed to identify a Transfer Handle as an accident hazard for 1 of 1 residents (Resident #1) that resulted in a resident becoming entrapped in a Transfer Handle and when found by staff was dead. Immediate Jeopardy began on 02/16/17 when Resident #1 become entrapped in the Transfer Handle that was attached to his bed. When Resident #1 was found he was lying on his left side on the fall mat beside the low bed with his head entrapped in the transfer bar and was dead. The immediate jeopardy is present and on-going. The facility provided the State Agency and the Centers for Medicare and Medicaid with an acceptable allegation of compliance (AOC) on 03/10/17. A revisit survey was conducted on 03/14/17 to determine the status of the ongoing Immediate Jeopardy. The facility provided documentation for review of the following: - Systematic changes implemented on the use of bed accessories, the use of restraints, and the accurate coding of the minimum data set (MDS). - Evidence of staff in-servicing on the use of	{F 323}	F Tag 323 Free Of Accident Hazards/Supervision/Devices Corrective action that will be accomplished: Resident #1 received physician order on 11/22/16 for Supportive devices, positioning bars on both sides of bed for assistance with positioning and trunk control. Resident #1 received physician clarification order on 12/6/16 that also states for Supportive devices, positioning bars on both sides for assistance with positioning and trunk control. The positioning bars are the transfer handles on Resident #1□s bed. The facility did not assess Resident #1□s need for the transfer handles prior to adding them to the resident□s bed on 12/6/16 or while they were in use on his bed from 12/06/16 to 2/16/17. Resident #1 was found lying on his left side on the fall mat beside the low bed with his head on the transfer handle on 02/16/2017. Resident assessed by LPN (Licensed Practical Nurse) to be absent of vital signs; resident was DNR (Do Not Resuscitate) and hospice and PCP (Primary Care Physician) immediately notified. Death Certificate signed by	

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{F 323}	Continued From page 23 bed accessories, the use of restraints, and the accurate coding of the MDS. - Documentation of audits for the use of bed accessories, the use of restraints and the accurate coding of the MDS. Observations of residents bed and enviroment and interviews with staff present in the facility on 03/14/17, review of all documentation to support the AOC and interviews with the facility's Administrator and Director of Nursing provided sufficient evidence to support corrective action by the facility to remove the immediate jeopardy at F- 323 at a lower scope and severity of (D) isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility continues the process of monitoring the implementation of the corrective action. The Findings included: Review of facility policy titled "Bed Safety" revised December 2007 read in part, To try to prevent deaths/injuries from the beds and related equipment (including frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: identify additional safety measure for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g., altered mental status, restlessness, etc.) Resident #1 was initially admitted to the facility on 12/03/04 and expired in the facility on 02/16/17. Resident #1's diagnoses included blindness, cerebrovascular accident, right sided hemiplegia/hemiparesis, vascular dementia, history of convulsions, heart failure, and major	{F 323}	Medical Director on 03/06/2017 states cause of death: cardiac arrest, heart failure, and hypertension. The Director of Clinical Operations reviewed the Bed Safety policy education with the ADON (Assistant Director of Nursing) via telephone on 02/16/17. The ADON (Assistant Director of Nursing) then educated the Unit Manager on the Bed Safety policy on 2/16/17. The ADON (Assistant Director of Nursing) and Unit Manager then immediately reviewed all resident beds in the facility for use of physical restraints, including all bed rails and assistive devices/bed accessories including but not limited to side rails and halo bed rails to validate devices in use and any immediate concerns for safety. No immediate concerns were noted including no unacceptable spacing between rail and mattress during the audit on the evening of 02/16/17; this review was conducted by staff making direct observations of each resident□s bed and the assistive device/restraint which was in place on the bed. This was repeated on 3/8/17 after the training by the outside consultant was completed. That training is described below. On 2/28/17, Director of Operations conducted education/in-servicing to nursing management team (i.e. Director of Nursing, Assistant Director of Nursing, Nurse Supervisor) on use of the Device Decision Tree. The Device Decision Tree reviews the device ordered, if device prevents resident from performing an	

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{F 323}	Continued From page 24 depressive disorder. Review of Resident #1's most recent comprehensive minimum data set (MDS) dated 10/30/16 revealed that Resident #1 had long and short term memory problems and was moderately impaired for daily decision making. No behaviors were identified on the MDS. The MDS further revealed that Resident #1 required extensive assistance of 1 staff member for bed mobility and required extensive assistance of 2 staff members for transfers. The MDS stated that Resident #1 was 72 inches tall and weighed 198 pounds. No falls were identified since the prior MDS. The MDS also revealed that Resident #1 received hospice services and indicated no physical restraint was used while Resident #1 was in the bed. A fall care plan updated on 11/16/16 specified the resident was to have positioning bars for positioning and fall mats on both sides of the bed while in bed to avoid injury from a fall. Review of the cumulative physician orders for 02/01/17 through 02/28/17 revealed that on 11/22/16 a physician's order was written for "positioning bars on both sides of bed for assistance with positioning and trunk control." The facility was unable to locate the original order. Review of a nurse's note dated 02/16/17 at 11:32 PM read, "Resident #1 was observed not breathing at 5:15 PM. Skin color pale, Resident #1 was lying on his left side. Floor mats were in place, bed was in low position and head of bed was elevated between 45 and 90 degrees. Hospice nurse was notified. Family was notified	{F 323}	action that they are otherwise capable of performing, does device assist in the improvement of the resident□s functional status, and instruction to proceed to care plan. After the education/in-servicing was conducted by Director of Operations on 2/28/17, the nursing management team completed the Device Decision Tree evaluations. Another review was conducted again on 3/7/17 by nursing management team using the Pre restraint Assessment Tool. Training/in-servicing was completed by the Director of Operations on correct use of the tool on 2/28/17. The Pre restraint evaluation tool directs the staff to evaluate whether a bed accessory (including side rails and halos) is a restraint, this is based on the resident□s individualized assessment. The Pre restraint Assessment Tool is conducted to ensure all areas of resident□s physical, mental, emotional, environmental, and social well-being are addressed to identify the lease restrictive intervention. Each halo was assessed to determine whether it was a restraint based on individual assessment, meaning whether the halo restricted resident□s movement in or out of the bed. If the accessory was determined to be a restraint, the MDS (Minimum Data Set) was coded to reflect same and care plans updated accordingly by the MDS Coordinator by 3/8/17. Residents with assistive devices on their beds, such as side rails and halos, were safety-checked by nursing management	

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and physician was notified." The note was signed by Nurse #1.

Observations on 02/27/17 at 10:00 AM and again on 02/28/17 at 10:00 AM made of Resident #1's bed revealed a bed that was approximately 80 inches long and contained a Transfer Handle on each side of the bed. The transfer handle was approximately 18 inches from the top of the bed making the bottom of a pillow in line with the transfer handles. The transfer handle was a 24 inches by 4 inches wide by 24 inches tall metal rail and was perpendicular to the bed. When attached the vertical bar created 90 degree angle to a flat mattress. The transfer handle was attached to the bed frame per the manufacture instructions.

Interview with Nursing Assistant (NA) #2 on 02/27/17 at 3:05 PM revealed that she routinely took care of Resident #1 and Resident #1 quite often slid to the left side of the bed and she would have to straighten him back up. NA #2 stated that Resident #1 was a "busy body" and would scoot from the middle of the bed to that left side of the bed. NA #2 also stated that because Resident #1 had swallowing issues they had been advised to keep the head of his bed elevated. NA #2 stated that on 02/16/17 at approximately 5:15 PM-5:30 PM they were in the dining room and NA #1 had taken Resident #1's tray to his room to assist him with the meal. NA #2 stated that immediately NA #1 came running back into the dining room and stated "he is choking." NA #2 stated that all the staff jumped up and ran to Resident #1's room. NA #2 stated that when she entered Resident #1's rooms she could tell "he was dead, there was no movement, he was limp, and his face was completely white." NA #2 stated that Resident

team (Director of Nursing, Assistant Director of Nursing, Nurse Supervisor) on 2/17/17 and again on 3/8/17 with any need for adjusting or repair completed immediately. The safety check included ensuring that no gaps existed that could cause entrapment from being caught between the mattress and bed accessory or in the bed accessory itself with no immediate concerns noted. The resident□s bed accessory & devices including the halos, were assessed to determine if they meet the definition of a restraint by the nursing management team (Director of Nursing, Assistant Director of Nursing, Nurse Supervisor). This task was completed after Administrator and nursing leadership team (leadership team consists of Director of Nursing, Assistant Director of Nursing, Nursing supervisor, and Minimum Data Set Coordinators) were in-serviced by outside RN consultant on 3/8/17. The training included: 1) the definition of a restraint as any device attached to or adjacent to the resident which limits the residents movement in or out of a bed based that on that resident□s individualized assessment; 2) coding that resident□s MDS for restraints where applicable; 3) conducting a safety assessment of the device for risk / benefit and least restrictive 4) ensuring an appropriate physician or therapy order is in place for the device; and 5) ensuring the clinical record reflects an underlying medical condition supporting the use of the restraint. If they did, the MDS (Minimum Data Set) for that resident was

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{F 323}	Continued From page 26 #1's bed was in low position and the head of the bed was elevated between 45 and 90 degrees and Resident #1's chin was "hooked" on the transfers handle with his neck between the mattress and the handle. NA #2 stated that Resident #1's body was lying parallel to the bed except his head which was "hooked" on the transfer handle. NA #2 stated the bar was tight against Resident #1's neck under his chin (pointed to the larynx area) and stated that they had to lower the head of the bed to remove Resident #1 from the transfer handle. NA #2 stated that after they removed Resident #1 from the transfer handle there was a red area on his neck under his chin (pointed to larynx area) where the transfer handle had been. Interview with Nurse #1 on 02/27/17 at 3:24 PM revealed that she was the nurse taking care of Resident #1 on 02/16/17. Nurse #1 stated she arrived for her shift at 3:00 PM and got report and counted the medication cart and then walked down the hallway to check on her patients. Nurse #1 stated that at that time Resident #1 was in his bed in low position and the head of the bed was elevated and was his "normal self." Nurse #1 stated she had come up the hall after ending her medication pass at around 4:30 PM and again looked in on Resident #1 and he was he was alive and well. Nurse #1 stated that after she completed her medication pass she had gone into the dining room to wait for the dinner trays so she could assist residents with the meal. Nurse #1 stated that at approximately 5:15 PM NA #1 took Resident #1's tray to his room to assist him with the meal. Nurse #1 stated that immediately NA #1 came running back to the dining room hollering for help. Nurse #1 stated that all the staff jumped up and ran to Resident #1's room. Nurse	{F 323}	coded appropriately, and the care plan updated to reflect same by the MDS (Minimum Data Set) Coordinators. This was completed by 3/9/17. On 2/17/17, an assessment was performed by the Interdisciplinary Team on each resident with any assistive device, including side rails and halos. Based on that assessment, fourteen (14) residents based upon their current abilities and conditions were determined to be appropriate for change to alternative less restrictive bed accessory, such as assist bars or halos and those devices were ordered on 2/17/17 by the maintenance department for installation upon delivery. Delivery is expected by 03/10/17. On 3/8/17 after training by an outside consultant (as described herein), the IDT (Interdisciplinary Team) again assessed and reviewed each resident□s use of any bed accessory including but not limited to side rails and halos. Bed accessory is defined as any item e.g. fixtures such as handrails, grab bars, and devices/equipment such as transfer lifts, canes, and wheelchairs, etc. that is used by, or in the care of a resident to promote, supplement, or enhance the resident□s function or safety. The assessment of use on 03/08/17 included a review of the resident□s current clinical record, staff interviews regarding how /if resident used the accessory, and resident observation was performed by a licensed nurse. This has resulted in the removal of assistive devices for all but 12 residents. As of 3/8/17, upon arrival, any assistive device	

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{F 323}	Continued From page 27 #1 stated she walked around the side of the bed and Resident #1 was laying on the floor parallel to the bed with his chin firmly between the transfer handles and his neck between the transfer handle and the mattress. Nurse #1 stated that she had summoned the ADON because she had no idea what to do. Nurse #1 stated that she did confirm that Resident #1 had expired with no respiration and had a Do Not Resuscitate order in place. The ADON advised them to place Resident #1 back in the bed and perform post mortem care. Nurse #1 also stated that they had to lower the head of the bed to remove Resident #1 from the transfer handle. Nurse #1 stated she had notified the hospice provider, the family, and the physician that Resident #1 had expired. Interview with NA #3 on 02/27/17 at 4:39 PM revealed that she routinely cared for Resident #1 and on 02/16/17 at approximately 3:45 PM she had provided incontinent care to Resident #1. NA #3 stated that when she entered his room he was lying on his side on the left side of the bed and she had to reposition him near the middle of the bed and after providing care and repositioning Resident #1 she had raised the head of his bed and ensured the bed was in low position and left the room. NA #3 stated that Resident #1 favored the left side of his bed and generally about 3 times during her shift she would have to go in and reposition Resident #1 near the middle of the bed but he would always scoot to the left side. NA #2 stated that lately he would rest his head on the transfer handle that was attached to his bed and would often time throw his legs off the side of the bed. NA #3 stated that on 02/16/17 at approximately 5:15 PM the staff was in the dining room and NA #1 had taken Resident #1's tray to his room to assist him with the meal. NA #3	{F 323}	will be assessed by nursing management team (Director of Nursing, Assistant Director of Nursing, Nurse Supervisor, all whom received training by outside consultant on 3/8/17 using the pre-restraint assessment tool to determine if device is a restraint based upon the resident□s individualized assessment. If they are restraints, the MDS (Minimum Data Set) will be coded accordingly and the care plan updated MDS (Minimum Data Set) Coordinators. This will include the alternative devices for the 14 residents mentioned above. Resident #1 had a 24-inch-long x 4-inch-wide transfer handle attached to his bed which was not assessed by staff to determine if it was a physical restraint. The assessment as we described herein examines all bed devices, including transfer handles, to determine if they were restraints based upon the resident□s□ individualized assessment. Where they were determined to be a restraint the resident MDS and care plan was updated appropriately. As of 3/8/17 and going forward, any device determined to be ineffective or a safety issue by IDT (Interdisciplinary Team) shall be removed; the resident will then be assessed by the IDT (Interdisciplinary Team) for an alternative intervention. Resident care plans will be updated accordingly by the IDT and direct care staff will be informed via the care guide. All nursing staff have been trained on this by 3/9/17. Any nursing staff who was not present for training or are PRN	

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{F 323}	Continued From page 28 stated that immediately NA #1 came running back to the dining room and stated "Resident #1 is choking", so we all jumped up and ran to his room. NA #3 stated that when she entered his room she could tell Resident #1 was dead, she stated he was very pale and white in color. NA #3 stated Resident #1's body was lying on the floor on the fall mat and his chin was between the transfer handles with his neck between the handle and the mattress. NA #3 stated that there was a red line where the bar had been on Resident #1's neck under his chin (pointed to larynx area) and they had to lower the head of the bed to remove Resident #1 from the transfer handle. NA #3 stated that his bed was in the low position and the head of the bed was just as she had left it earlier after rendering care. Interview with the Director of Maintenance on 02/28/17 at 10:00 AM revealed that on 01/04/17 he had ordered a new bed for the facility. On 01/11/17 the new bed arrived to the facility and on or around 01/16/17 he assembled the new bed which included the Transfer handle. The Director of Maintenance stated that the new bed had come with Transfer handles and he attached them to the bed per the manufacturer instructions and once the bed was assembled the bed was placed in an empty room until someone needed the bed. The Director of Maintenance stated that at some point Resident #1 needed a new bed and someone has grabbed the bed with the Transfer handles on it and assigned it to Resident #1. The Director of Maintenance stated he had no involvement in assigning Resident #1 to the bed with the Transfer Handles. The Director of Maintenance stated to his knowledge the beds were just switched and was not sure that there was anything wrong with the old bed.	{F 323}	will not be allowed to return to work and patient care until this training has been completed by them. Resident #1□s bed did not malfunction nor have a device failure; therefore, it was not necessary to take the bed out of service. The bed is not currently in use by any resident and will be assessed for accessory needs prior to placement of a resident; transfer handles were removed from the bed on 3/1/17. All residents in the facility with a bed accessory or physical restraint were assessed using the Initial Assessment for Use of Physical Restraint tool by DON/Nursing Management team (includes ADON, Nursing Supervisor, and MDS coordinators) by 3/9/2017. This included the following elements: 1) assessing each bed accessory based upon the resident□s individualized resident assessment to determine whether it constitutes a restraint for that resident; 2) ensuring that all residents with any assistive device have been coded on the MDS as having a potential restraint; 3) ensuring that all residents with a restraint have the MDS coded as such; 4) ensuring a safety assessment for all such residents is completed and documented; 5) ensuring a physician order and/or physician/therapy order is in place for such device and 6) ensuring the clinical record contains documentation of a medical condition warranting the use of such device. A physician order for every resident with a	

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{F 323}	Continued From page 29 Interview with the hospice nurse on 02/28/17 at 11:06 AM revealed that she routinely visited Resident #1 but had no involvement in assigning a bed to Resident #1. The hospice nurse stated that when she would visit Resident #1 was usually found him lying on his left side with his head resting on the top upper rail of the transfer handle. The hospice nurse stated that she would move him closer to the middle of the bed but Resident #1 would wiggle back to the left side of the bed. The hospice nurse stated she had no concerns with Resident #1's preferred position of resting his head on the transfer handle and if she would have had any concerns she would have immediately notified the facility staff. The hospice nurse stated that Resident #1 also seemed to be comfortable and obviously preferred the left side of bed. The hospice nurse stated she had visited with Resident #1 on 02/15/17 and he was his usual self. Interview with NA #1 on 02/28/17 at 3:39 PM revealed that she routinely cared for Resident #1 and on 02/16/17 at approximately 5:10 PM she was in the dining room and when the trays arrived she had taken Resident #1's tray down the hall to his room to assist him with the meal. NA #1 stated that when she entered the room she saw Resident #1's legs were outside of the bed. Nurse #1 stated when she got to the bedside she saw Resident #1 with his chin between the transfer handle and his neck between the handle and the mattress and it was purple in the area of his neck under his chin (pointed to larynx area). NA #1 stated "I ran for help but I knew that he was already dead, he was making no noises, he was limp and very pale." NA #1 stated she ran and told Nurse #1 that "the rail is choking him come	{F 323}	bed accessory or physical restraint was obtained by nursing management team by 3/9/17 that includes use of device/accessory or physical restraint and presence of medical symptom/condition for device/accessory to assist with protecting the resident□s safety, and help the resident attain the highest level of his/her physical or psychological well-being. All residents in the facility with a bed accessory or physical restraint care plan shall be reviewed and updated by IDT by 3/9/17 to reflect use of bed accessory/restraint. A modification MDS (Minimum Data Set) will be completed by MDS (Minimum Data Set) team by 3/9/17 to reflect the use of bed accessory/restraint, and the MDS (Minimum Data Set) restraint information will be transferred to the resident□s care plan. A QAPI (Quality Assurance Performance Improvement) subcommittee was formed, this committee consulted with the Medical Director on 3/1/17 and again on 3/9/17 regarding all required components of the Credible Allegation, and the citations issued by North Carolina Department of Health. The subcommittee consists of Administrator, DON (Director of Nursing), ADON (Assistant Director of Nursing), MDS (Minimum Data Set) Coordinators. The Subcommittee shall meet monthly and as needed x 3 months to ensure the Credible Allegation, 2567 (upon receipt), and Plan of Correction is followed and the	

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{F 323}	Continued From page 30 now." When asked to describe the choking NA #1 replied "the rail was in his neck, his neck was trapped in the rail, and he could not get out of the rail." NA #1 stated that the head of the bed was elevated and we had to lay the head of his bed flat to remove him from the transfer handle. Na #1 stated that when we removed him from the transfer handle there was blueish/purplish bruise still present in the same area (points to larynx area) where the transfer handle had been. On 02/28/17 at 4:20 PM In an interview with the Administrator she stated that the assist rail was 4 inches wide and physically impossible to get your head stuck. The Administrator stated she had not re-enacted the scene as Resident #1's body was still present in the facility at the time, however she used charts to simulate the scene. The Administrator failed to provide the written information surrounding the circumstances of the incident. The Administrator was notified of Immediate Jeopardy on 02/28/17 at 4:20 PM.	{F 323}	facility is in compliance. F Tag 323 focuses on accident/hazards. As reflected above, the assessment we have described includes assessing not only if a device is a restraint but whether it is the least restrictive and poses any safety concerns. Identification of other residents: All residents with bed accessories determined to be a restraint based upon their individualized assessment are at risk for this alleged deficient practice. Measures for systemic change: Administrator and facility leadership team (leadership team consists of Director of Nursing, Assistant Director of Nursing, Nursing supervisor, and Minimum Data Set Coordinators) in serviced by outside Registered Nurse consultant on 3/8/17. The training included: 1) the definition of a restraint as any device attached to or adjacent to the resident which limits the residents movement in or out of a bed based that on that residents individualized assessment; 2) coding that resident□s MDS (Minimum Data Set) for restraints where applicable; 3) conducting a safety assessment of the device for risk / benefit and least restrictive 4) ensuring an appropriate physician or therapy order is in place for the device; and 5) ensuring the clinical record reflects an underlying medical condition supporting the use of the restraint. No nursing staff who was absent or PRN (pro re nata) staff will be allowed to return to the floor and resident	

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{F 323}	Continued From page 31	{F 323}	care until this training has been completed. Then, all nursing staff shall be in serviced by Director of Nursing, Assistant Director of Nursing, or Nurse Supervisor by 3/9/17 on 1) the definition of a restraint as any device attached to or adjacent to the resident which limits the resident□s movement in or out of a bed based that on that resident□s individualized assessment; 2) coding that resident□s MDS (Minimum Data Set) for restraints where applicable; 3) conducting a safety assessment of the device for risk / benefit and least restrictive 4) ensuring an appropriate physician or therapy order is in place for the device; and 5) ensuring the clinical record reflect and underlying medical condition supporting the use of the restraint. No nursing staff who was absent or PRN (pro re nata) staff will be allowed to return to the floor and resident care until this training has been completed. All nursing staff shall be in-serviced by Director of Nursing, Assistant Director of Nursing, or Nurse Supervisor on completing Initial Assessment for Use of Physical Restraint and Side Rail Assessment prior to implementation of bed accessory to identify the least restrictive intervention by 3/9/17. No nursing staff who was absent or PRN (pro re nata) will be allowed to return to the floor and resident care until this training has been completed. Beginning on 3/8/17, nursing staff shall be	

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{F 323}	Continued From page 32	{F 323}		

in serviced by Director of Nursing or Assistant Director of Nursing upon hire on bed safety including the use of restraints.

Beginning on 3/8/17, the IDT (Interdisciplinary Team) will complete Physical Restraint Reduction Evaluation Assessment for all residents with a bed accessory at least quarterly, annually, with any significant change, or as needed and update care plan accordingly.

Beginning on 3/8/17, the IDT (Interdisciplinary Team) will complete Side Rail Assessment for all residents with a side rail at least quarterly, annually, with any significant change, or as needed and update care plan accordingly.

Beginning on 3/9/17, the facility shall remove all bed accessories from a resident bed when resident discharges or is assigned a different bed. This will be handled by maintenance as directed by nursing staff. Administrator provided education/in-servicing on 3/9/17 to nursing staff, maintenance staff, and receptionist on procedure of notifying maintenance staff to remove all bed accessories from a resident bed when resident discharges or is assigned a different bed including week ends. No nursing, maintenance staff or receptionist who was absent or PRN (pro re nata) will be allowed to return to the floor and resident care until this training has been completed.

How corrective actions will be monitored: The Director of Nursing, Assistant

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{F 323}	Continued From page 33	{F 323}	Director of Nursing, and/or Nurse Manager will complete an audit to assure any accessory being added to a bed validating: the type of accessory being recommended, an Initial assessment for use of Physical Restraint tool has been completed for the accessory to determine restraint/ability to use, Physician order has been obtained, resident is aware of the accessory and can verbalize understanding of the accessory. This audit will be completed five (5) times a week for eight(8) weeks on all resident beds, including new admission and permanently discharged resident beds, to ensure that a bed accessory has not been added to a bed without going through the nursing assessment and approval process, and then continue three (3) times a week for eights (8) weeks, one (1) time a week for four (4) weeks, and one (1) time a month for a minimum 6 months and will continue until the Quality Assurance/ Performance Improvement (QAPI) committee reviews and determines that the facility has maintained substantial compliance. The audits being completed for both F323 and F221 will be reviewed in a weekly Interdisciplinary Team meeting for an additional review opportunity for one (1) time a week for twelve (12) months; these weekly meetings and reviews will then be presented in the Monthly Medical Director report for review and determinations. The Monthly Medical Director reports will be submitted to the Quality Assurance Performance Implementation (QAPI) for	

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{F 323}	Continued From page 34	{F 323}	monthly review for twelve (12) months, making any necessary recommendations. This process will allow multiple layers of Facility committees to have direct review and over-sight of bed accessories in use within the Facility for a minimum of twelve (12) months and will continue until the Quality Assurance/ Performance Improvement (QAPI) committee reviews and determines that the facility has met and maintained substantial compliance. The Quality Assurance Performance Improvement committee participation includes, but is not limited to, Administrator, Director of Nursing, Medical Director, Unit Management, Regional Clinical Services Director, Director of Social Services, Minimum Data Set (MDS) Coordinator, Culinary Services Director, Maintenance Director, Admissions Coordinator, and Activity Director.	
{F 514} SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	{F 514}		3/21/17

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{F 514}	Continued From page 35 (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to provide complete documentation of a significant event for 1 of 1 resident (Resident #1). The findings included: Review of a nurse's note dated 02/16/17 at 11:12 PM read, "Resident was observed not breathing at 5:15 PM. Skin color was pale, resident was lying on his left side. Floor mats were in place, bed in low position and head of bed elevated between 45 and 90 degrees. Hospice nurse notified. Resident family notified and the physician was notified." Signed by Nurse #1. There was no additional documentation in the	{F 514}	F Tag 514 Res Records □ complete/accurate/accessible Corrective action that will be accomplished: Resident #1 medical record was closed on 2/17/17 after Resident #1 was found lying on his left side on the fall mat beside the low bed with his head on the transfer handle on 02/16/2017. Resident assessed by LPN (Licensed Practical Nurse) to be absent of vital signs; resident was DNR (Do Not Resuscitate) and hospice and PCP (Primary Care Physician) immediately notified. Death Certificate signed by Medical Director on 03/06/2017	

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{F 514}	Continued From page 36 medical record about this event. Interview with Nurse #1 on 02/27/17 at 3:24 PM revealed that she was the nurse taking care of Resident #1 on 02/16/17 and that she wrote the nurse's note dated 02/16/17 at 11:12 PM. Nurse #1 stated that at approximately 5:15 PM on 02/16/17 she was summoned to Resident #1's room because he was reportedly choking. Nurse #1 stated she walked around the side of the bed and Resident #1 was lying on the floor parallel to the bed with his chin firmly between the transfer handles and his neck between the transfer handle and the mattress. Nurse #1 stated that she had summoned for the Nursing Assistant (NA) to get some help because she had no idea what to do. Nurse #1 stated that she did confirm that Resident #1 had expired with no respirations and had a Do Not Resuscitate order in place. Nurse #1 also stated she was told by the Assistant Director of Nursing (ADON) to only document that they found him unresponsive and to not document how he was found or any details of the event. Nurse #1 stated, "I documented what she told me to document." Interview with the ADON on 02/27/17 at 11:50 AM revealed that she was summoned to Resident #1's room by staff and when she entered Resident #1's room she was informed by Nurse #1 that Resident #1 was a hospice patient with a Do Not Resuscitate order in place and he had expired. The ADON stated she had some "concerns" with the way Resident #1 was positioned and she reached out to the Administrator. The ADON stated she did not recall instructing the staff what to document. Interview with the Administrator on 02/27/17 at	{F 514}	states cause of death: cardiac arrest, heart failure, and hypertension. 100% of all residents nursing notes of residents involved in a significant event within the last 30 (thirty) days were reviewed by the Director of Nursing by reading the nursing notes to ensure there is complete documentation of the incident by 3/9/17. The review by the Director of Nursing showed all significant events had complete documentation. This audit took place after the Director of Clinical Operations in - serviced the Director of Nursing, Assistant Director of Nursing, and Nurse Manager on 3/9/17 on completing documentation in the resident□s medical record on all observations and care provided to the resident, or any changes in the resident□s medical or mental condition. Identification of other residents: All residents are at risk for this alleged deficient practice. Measures for systemic change: Director of Clinical Operations in - serviced the Director of Nursing, Assistant Director of Nursing, and Nurse Manager on 3/9/17 on completing documentation in the resident□s medical record on all observations and care provided to the resident, or any changes in the resident□s medical or mental condition. Director of Nursing and Assistant Director of Nursing in-serviced all nursing staff on 3/9/17 on completing documentation in the resident□s medical record on all	

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{F 514}	Continued From page 37 12:13 PM revealed that during the investigation the staff had notified the Director of Operations that they were being instructed as to what to chart and what not to chart. The Administrator stated that the individual who allegedly instructed the employee what to document was given corrective action and was instructed that she could not do that, that the employee was free to document what they felt was necessary.	{F 514}	observations and care provided to the resident, or any changes in the resident□s medical or mental condition. No nursing staff who was absent or PRN (pro re nata) staff will be allowed to return to the floor and resident care until this in-servicing has been completed. How corrective actions will be monitored: The Director of Nursing, Assistant Director of Nursing, and/or Nurse Manager will review 10 random clinical records for documentation of any significant event to assure the clinical record contains complete documentation in the resident□s medical record on all observations and care provided to the resident, or any changes in the resident□s medical or mental condition. This audit will be completed five (5) times a week for eight weeks (8), five (5) times a week for eight (8) weeks, three (3) times a week for eights (8) weeks, one (1) time a week for four (4) weeks, and one (1) time a month for a minimum 6 months and will continue until the Quality Assurance/ Performance Improvement (QAPI) committee reviews and determines that the facility has maintained substantial compliance. The audits being completed for both F323 and F221 will be reviewed in a weekly Interdisciplinary Team meeting for an additional review opportunity for one (1) time a week for twelve (12) months; these weekly meetings and reviews will then be presented in the Monthly Medical Director report for review and determinations. The Monthly Medical Director reports will be	

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	345415	A. BUILDING _____ B. WING _____	R-C 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVILLE REHABILITATION AND LIVING CTR	1010 LAKEVIEW DRIVE PINEVILLE, NC 28134

(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 514}	Continued From page 38	{F 514}	submitted to the Quality Assurance/Performance Implementation (QAPI) for monthly review for twelve (12) months, making any necessary recommendations. This process will allow multiple layers of Facility committees to have direct review and over-sight of bed accessories in use within the Facility for a minimum of twelve (12) months and will continue until the Quality Assurance/ Performance Improvement (QAPI) committee reviews and determines that the facility has met and maintained substantial compliance. The Quality Assurance Performance Improvement committee participation includes, but is not limited to, Administrator, Director of Nursing, Medical Director, Unit Management, Regional Clinical Services Director, Director of Social Services, Minimum Data Set (MDS) Coordinator, Culinary Services Director, Maintenance Director, Admissions Coordinator, and Activity Director.	