STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	R-C 12/22/2017

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HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

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{F 282} SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to include in a care plan of a resident with a history of fall that the resident needed a full body lift for transfer and did not specify the type and size of the sling to use on the lift. The resident fell from the lift sling which resulted in a skin tear to his head, bruising to his head and right arm, a skin tear to his right knee and broken teeth for 1 of 5 residents sampled for transfer interventions on care plans (Resident #22). The facility also failed to apply a left hand splint as care planned for 1 of 4 residents sampled with limited range of motion/contractures (Resident #56). Findings included: 1. Resident #22 was admitted to the facility on 08/24/16 with diagnoses which included heart disease, depression and Alzheimer's disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 09/27/17 indicated Resident #22 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS further indicated Resident #22 was totally dependent on staff for	{F 282}	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F282 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; During the annual/follow-up survey ending 12/22/17, surveyors reviewed Resident #22 and Resident #56. Resident #22's Baseline Care Plan was reviewed and it was determined the facility did not have a process to capture the appropriate transfer status and failed to identify the specific sling type. As of the 11/28/17 regulatory requirements, the facility's Baseline Care Plan format was updated to	1/17/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/17/2018

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{F 282}	Continued From page 1 bed mobility and transfers. A review of a physical therapy initial assessment dated 08/25/16 indicated Resident #22 was 100 percent dependent on 1 or more persons for bed mobility and transfers. A review of a Care Area Assessment dated 09/04/16 indicated falls triggered and was addressed in the care plan. A review of an Initial Interdisciplinary Care Plan dated 08/25/16 indicated a potential for falls due to pain, generalized weakness, decreased mobility and a history of multiple fractures. There were no approaches or interventions to indicate Resident #22 was to be transferred with a full body lift and there was no indication of the type or size of sling to be used during the transfer. A review of a hospice and palliative care visit note, dated 11/19/16 at 2:17 PM, documented by Hospice Nurse #1 indicated Resident #22 fell from a full body lift. The notes revealed the sling type that was used to transfer Resident #22 in the total lift did not support his bottom and they would attempt to get a different type of sling for transfers. A review of an incident log dated 11/19/16 revealed Resident #22 was in a total body lift and 2 NAs were present. The document indicated Resident #22 slid out of the sling attached to the lift, onto the floor, bottom first and hit his head on a pole of the total body lift. The report further indicated a family member called a week later because they had noticed Resident #22 was missing 2 of his top front teeth that were broken with the roots still in place.	{F 282}	include transfer status and sling type. In addition, the Resident Profile utilized by Nursing Assistants for care has been updated to reflect the appropriate transfer status and sling type. Resident #56's Physician Orders were reviewed and it was determined the facility did not have an updated Resident Profile to reflect the application of the left wrist/hand splint, which was not applied in the morning and removed in the evening as ordered. The Resident Profile utilized by Nursing Assistants for care was updated to reflect the appropriate splint application schedule. Once identified during the survey, the sling was applied as ordered. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 1/3/18, a new Interdisciplinary Team (IDT) Rounds process was initiated. Members of the IDT included, a Physician, a representative from MDS, Social Worker, Clinical Nurse Supervisor, DON, Activity Representative, Dietitian, Informatics and Analytics Services (IAS), a representative from Therapy, and front-line Nursing Assistants. The IDT process included the development of the template for the IDT to utilize while performing the meetings with the residents present to ensure all pertinent information was captured. Physician orders, resident profile, and care plan were revised/updated to reflect current	

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{F 282}	Continued From page 2 A review of the Initial Interdisciplinary Care Plan dated 11/19/16 revealed Resident #22 had a fall during a transfer with a full body lift. A section labeled interventions had a hand written note that a new sling was ordered but there were still no approaches or interventions to use a full body lift for transfer or the type of sling or size of sling to be used. A review of a care plan with a revised date of 11/28/16 indicated Resident #22 was totally dependent for all activities of daily living and was to be transferred with a mechanical lift but had a recent fall from the lift. During an interview on 12/21/17 at 3:28 PM the Director of Nursing (DON) confirmed there was no transfer interventions or approaches on the initial interdisciplinary care plan prior to Resident #22's fall from the lift or after the fall from the lift until a new care plan was revised on 11/28/16. She explained she would want physical therapy and occupational therapy to screen a resident and make the safest recommendations for transfers and that should be care planned for staff to follow their recommendations. During an interview on 12/22/17 at 9:27 AM with the Administrator she stated it was her expectations to see a resident's transfer status on the care plan. She explained physical therapy or occupational therapy were involved in determining a resident's transfer status and once they made their determination there should be communication to nursing staff on how to provide the care. She further stated interim care plans could be updated as needed.	{F 282}	resident status, and any discrepancies were resolved prior to leaving the resident's room. In the event a piece of equipment/supply was not able to be fixed or obtained immediately, a work order was initiated. The resident profile for all residents was updated to reflect the specific needs of the resident, to include, but not limited to, transfer status, type/size of sling for residents transferred via Hoyer lift, and splint application. During the IDT rounds, the team was responsible for matching the Resident Profile with the Care Plan, and the Physician ensured all orders were entered appropriately. A member from IAS was included to verify the information was entered accurately since the Electronic Medical Record (EMR) is new to the facility. During the IDT rounds, the team Date certain: 1/12/18 Orientation for new teammates will include updating the resident profile, accessing the resident profile, and resident care plan implementation. Date certain 1/15/18 The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements Beginning 1/15/18, the Administrator selected a group of Leadership members as Zone Owners, to focus on monitoring the updates completed during IDT rounding to ensure continued compliance.	

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{F 282}	Continued From page 3 During an interview on 12/22/17 at 12:50 PM with a physical therapist she explained therapy staff screened every resident when they were admitted to the facility and made recommendations to staff for safe transfers. She stated Resident #22 was totally dependent on staff for everything and she would have expected for staff to include a total lift transfer as an intervention on his care plan. 2. Resident #56 was admitted to the facility on 07/28/16 with diagnosis that included progressive multiple sclerosis and spastic hemiplegia, a condition which can cause muscles on one side of the body to be in a constant state of contraction. Review of the activity of daily living (ADL) care plan updated on 01/03/17 addressed functional limitations with a goal to continue to participate in ADL with approaches that included a left hand splint to be applied every morning and removed every evening. During a review of the Resident #56's physician orders, an order dated 10/17/17 read: left wrist/hand orthosis applied in morning and remove in the evening. A review of the most recent minimum data set (MDS) assessment dated 10/18/17 coded Resident #56 as cognitively impaired, with a Brief Interview for Mental Status (BIMS) of 5 and as having functional impairment with limited range of motion (ROM) in the left hand. Review of the Nursing Assistant's (NAs) resident profile for Resident #56 noted a left wrist hand splint orthosis apply in the morning and remove in the evening.	{F 282}	Each Zone Owner has received a specific assignment of residents to monitor. The assignments include a back-up person to cover if the individual is out of the facility for the day. Zone owners were trained on accessing and utilizing the Resident Profile found on Care Tracker to ensure residents have appropriate slings and splints as outlined in the Resident Profile. Rounding assignments are quite extensive and include auditing of residents rights, physical environment, and individualized resident needs, amongst other areas. To monitor the IDT rounds, the facility will add a “Stand Down” meeting to provide findings of the Zone Owners of Resident Profiles and Care Plans that need to be updated. Any areas of discrepancy will be immediately addressed during the stand down meeting by the IDT. IDT Zone Owners will be required to complete rounds on their assigned residents Monday through Friday for 4 weeks and attend the stand down meeting each day. On the weekends for 4 weeks, the clinical supervisor and manager on duty will be responsible for auditing 100% of residents who require slings and splint application to determine the appropriate type and size of slings for residents transferred via Hoyer lift and splint application. Date Certain: 1/15/18 Service Line Nurse Educator and the Facility Educator provided in-services to MDS Coordinators, nursing staff and nursing assistants on the process flow expectations for verification of orders,	

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{F 282}	Continued From page 4 A review of the 12/2017 Medication Administration Record (MAR) for Resident #56 indicated a left hand splint to be donned in the morning and removed in the evening. Refusal of the hand splint was documented on the MAR for 12/6/17 and 12/19/17. Observations made of Resident #56 on 12/18/17 at 3:47 PM, 12/19/17 at 10:52 AM, 12/20/17 at 12:15 PM, 12/21/17 at 11:18 AM, and 12/22/17 at 9:00 AM revealed no left hand splint being worn. In an interview with Resident #56 on 12/18/17 at 3:15 pm, she stated she was not receiving any treatment for her left hand but would like to. An interview with NA #5 on 12/22/17 at 9:06 am, she stated Resident #56 used to have a splint but she hadn't seen it in a while and didn't know where it is was at this time. She reported the Resident didn't want to wear it most of the time. The NA explained if a resident had a splint ordered it would be on the resident profile to alert the NA's to it. If a resident refused to wear their splint it would be reported to the nurse because the nurses documented it on their MAR. During an interview with Nurse #3 on 12/22/17 at 9:15 am, he stated he had seen therapy work with Resident #56 many times but was not sure what they were doing for her left hand. A subsequent observation of Resident #56 on 12/22/17 at 1:15 pm revealed resident had a left hand splint was in place. A subsequent interview with NA #5 on 12/22/17 at 3:10 pm, revealed she had found the left hand splint for Resident #56 in the corner of her room	{F 282}	care plan updates, and care plan implementation. Any required staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. Date certain: 1/15/18 The IDT rounding team conducted 100% audit of matching the Resident Profiles, with the Care Plans, as the Physician ensured all orders were entered appropriately. MDS Coordinator or designee, will conduct weekly 100% audit of scheduled quarterly and annual care plans being conducted in resident's rooms to ensure Resident Profiles, Care Plans and Physician Orders match. Audits will continue for a period of 90 days, at which time the QAPI committee will determine if further auditing is needed. Any identified issues will be corrected at that time. Date certain: 1/12/18 Floor nurses will update the resident profile with any new orders. Clinical supervisors will be responsible for ensuring the floor nurse has updated the resident profiles appropriately upon start of their shift. The clinical supervisors will bring the 24-hour order report to morning stand-up and be prepared to discuss any updates. The MDS Coordinators will be responsible for verifying the resident profile was updated accurately and that the care plan is reflective of any changes. On weekends, the clinical supervisor will pull the 24-hour order report and ensure the resident profiles have been updated	

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{F 282}	Continued From page 5 under some things and had applied it to her left hand. In a subsequent interview with Nurse #3 on 12/22/17 at 3:46 pm, he reported that the nurses documented splint donning and doffing on the MAR. During an interview with the Occupational Therapist (OT) on 12/22/17 at 4:00 pm, she reported Resident #56 was on her caseload some time ago and a left hand splint was ordered. She didn't know the status of the hand splint since Resident #56 was not currently on her caseload. A telephone interview with Nurse #4 on 12/22/17 at 4:13 pm, revealed she worked on an as needed (PRN) basis at the facility and could not say if she has ever seen Resident #56 wear a left hand splint. She could not remember if she had documented splint placement on the MAR for Resident #56. An interview was conducted with the Director of Nursing (DON) on 12/22/17 at 6:29 pm. The DON stated her expectation regarding splints and positioning/mobility devices is that they would be applied and removed per physician orders and as directed by the care plan.	{F 282}	appropriately. Clinical supervisors are responsible for pulling the 72-hour order report on Monday mornings and following the normal process of bringing the report to morning stand-up meeting to give to MDS Coordinators. Date certain 1/17/18 IDT rounds will be conducted in resident rooms on a quarterly basis going forward, to be incorporated into the already existing schedule for care plans. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Date certain: 1/17/18. The title of the person responsible for implementing the acceptable plan of correction. The DON will have overall responsibility for oversight of the care plan process. MDS Coordinators will be responsible for ensuring the Resident Profile is reflective of changes made to a resident's care plan. MDS Coordinators will maintain the in-room assessments during care plan meetings which will allow the team to visualize any opportunities to enhance the residents' environment or plan of care. Date certain: 1/17/18	

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{F 520} SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality	{F 520}		1/17/18

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

Electronically Signed | 01/17/2018

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

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{F 520}	Continued From page 1 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor those interventions that the committee put into place on November 30, 2017 following a follow up and complaint survey and subsequently recited on December 22, 2017 on the current recertification survey. The repeat deficiency was in the areas of care plan implementation (F656). This deficiency was recited during the facility's current recertification survey. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 438.20 Resident Assessment: Based on record reviews and staff interviews the facility failed to include in a care plan of a resident with a history of fall that the resident needed a full body lift for transfer and did not specify the type and size of the sling to use on the lift. The resident fell from the lift sling which resulted in a skin tear to his head, bruising to his head and right arm, a skin tear to his right knee and broken teeth for 1 of 5 residents sampled for transfer interventions on care plans (Resident #22). The facility also failed to apply a left hand splint as care planned for 1 of 4 residents sampled with limited range of motion/contractures (Resident #56).	{F 520}	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F 520 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; During the survey ending 11/2/17, the facility received a citation related to not following a resident's plan of care. During the annual/follow-up survey ending 12/22/17, surveyors reviewed Resident #22 and Resident #56. Resident #22's Baseline Care Plan was reviewed and it was determined the facility did not have a process to capture the appropriate transfer status and failed to identify the specific sling type. As of the 11/28/17 regulatory requirements, the facility's Baseline Care Plan format was updated to include transfer status and sling type. In addition, the Resident Profile utilized by Nursing Assistants for care has been updated to reflect the appropriate transfer status and sling type.	

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{F 520}	Continued From page 2 During the follow up and complaint survey of 11/02/17 this regulation was cited for failure to apply a palm guard as directed by the care plan. During the current recertification survey this regulation was cited for failure to include in a care plan of resident with a history of fall that the resident needed a full body lift for transfer and did not specify the type and size of the sling to use on the lift and failed to apply a left hand splint as directed by the care plan. An interview was conducted with the Administrator on 12/22/17 at 6:23 PM. The Administrator stated that the Quality Assurance (QA) committee met monthly and included the Administrator, Medial Doctor (MD), attending physicians, Director of Nursing (DON), quality department, and all department heads. She added that since the last follow up complaint survey they have added additional members to the QA committee that included the Chief Medical Officer and Chief Nursing Executive. In addition to the new members of the committee they have also increased frequency of the meeting to include the most recent survey results and audits. The Administrator stated that the have essentially over hauled the wound program and the DON was observing every wound in the building and they had increased staffing on the weekend to make sure they were covering the wound protocol and to ensure that correct treatments were initiated. She added that the current wound nurse was also coming in on the weekends to help oversee the wound program. Another key element that the DON had initiated was a weekly interdisciplinary team (IDT) meeting and they discussed things like new admission, weights, wounds and etc. and then that all that information	{F 520}	Resident #56's Physician Orders were reviewed and it was determined the facility did not have an updated Resident Profile to reflect the application of the left wrist/hand splint, which was not applied in the morning and removed in the evening as ordered. The Resident Profile utilized by Nursing Assistants for care was updated to reflect the appropriate splint application schedule. Once identified, the sling was applied as ordered. The QAPI committee's plan of correction for monitoring care plans from the previous citation was very narrowly focused on palm guards and was not comprehensive to include splints, transfer status, and type of sling The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 1/3/18, a new Interdisciplinary Team (IDT) Rounds process was initiated. Members of the IDT included, a Physician, a representative from MDS, Social Worker, Clinical Nurse Supervisor, DON, Activity Representative, Dietitian, Informatics and Analytics Services (IAS), a representative from Therapy, and front-line Nursing Assistants. The IDT process included the development of the template for the IDT to utilize while performing the meetings with the residents present to ensure all pertinent information was captured. Physician orders, resident profile, and care plan	

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{F 520}	Continued From page 3 was rolled into the QA meeting. The Administrator stated that currently she believed that the only way for the facility to identify the resident's needs was to go room to room and have a comprehensive meeting with the entire IDT team and find out what we needed to do for each resident. She added that the leadership team was stable at the facility and they have recently hired an assistant director of nursing (ADON) which would complete the leadership team.	{F 520}	were revised/updated to reflect current resident status, and items identified as requiring a “fix” to meet the resident’s needs were resolved prior to leaving the resident’s room. In the event a piece of equipment/supply was not able to be fixed or obtained immediately, a work order was initiated. The resident profile for all residents was updated to reflect the specific needs of the resident, to include, but not limited to, transfer status, type/size of sling for residents transferred via hoyer lift, and splint application. During the IDT rounds, the team was responsible for matching the Resident Profile with the Care Plan, and the Physician ensured all orders were entered appropriately. A member from IAS was included to verify the information was entered accurately since the Electronic Medical Record (EMR) is new to the facility. During the IDT rounds, the team Date certain: 1/12/18 The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements Beginning 1/15/18, the Administrator selected a group of Leadership members as Zone Owners, to focus on monitoring the updates completed during IDT rounding to ensure continued compliance. Each Zone Owner has received a specific assignment of residents to monitor. The assignments include a back-up person to cover if the individual is out of the facility	

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{F 520}	Continued From page 4	{F 520}	for the day. Zone owners were trained on accessing and utilizing the Resident Profile found on Care Tracker to ensure residents have appropriate slings and splints as outlined in the Resident Profile. Rounding assignments are quite extensive and include auditing of residents rights, physical environment, and individualized resident needs, amongst other areas. To monitor the IDT rounds, the facility will add a “Stand Down” meeting to provide findings of the Zone Owners of Resident Profiles and Care Plans that need to be updated. Any areas of discrepancy will be immediately addressed during the stand down meeting by the IDT. IDT Zone Owners will be required to complete rounds on their assigned residents Monday through Friday for 4 weeks and attend the stand down meeting each day. On the weekends for 4 weeks, the clinical supervisor and manager on duty will be responsible for auditing 100% of residents who require slings and splint application to determine the appropriate type and size of slings for residents transferred via hoyer lift and splint application. Date Certain: 1/15/18 Service Line Nurse Educator and the Facility Educator provided in-services to MDS Coordinators, nursing staff and nursing assistants on the process flow expectations for verification of orders, care plan updates, and care plan implementation. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be	

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{F 520}	Continued From page 5	{F 520}	required to complete training prior to working a scheduled shift. Date certain: 1/15/18 The IDT rounding team conducted 100% audit of matching the Resident Profiles, with the Care Plans, as the Physician ensured all orders were entered appropriately. MDS Coordinator or designee, will conduct weekly 100% audit of scheduled quarterly and annual care plans being conducted in resident's rooms to ensure Resident Profiles, Care Plans and Physician Orders match. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Date certain: 1/12/18 Floor nurses will update the resident profile with any new orders. Clinical supervisors will be responsible for ensuring the floor nurse has updated the resident profiles appropriately upon start of their shift. The clinical supervisors will bring the 24-hour order report to morning stand-up and be prepared to discuss the updates. The MDS Coordinators will then be responsible to verify the resident profile was updates accurately and that the care plan is reflective of any changes. On weekends, the clinical supervisor will pull the 24-hour order report and ensure the resident profiles have been updated appropriately. Clinical supervisors are	

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{F 520}	Continued From page 6	{F 520}	responsible for pulling the 72-hour order report on Monday mornings and following the normal process of bringing the report to morning stand-up meeting to give to MDS Coordinators. Date certain 1/17/18 IDT rounds will be conducted in resident rooms on a quarterly basis going forward, to be incorporated into the already existing schedule for care plans. Date certain: 1/17/18. The title of the person responsible for implementing the acceptable plan of correction. The DON will have overall responsibility for oversight of the care plan process. MDS Coordinators will be responsible for ensuring the Resident Profile is reflective of changes made to a resident's care plan. MDS Coordinators will maintain the in-room assessments during care plan meetings which will allow the team to visualize any opportunities to enhance the residents' environment or plan of care. Date certain: 1/17/18	

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		1/17/18

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

Electronically Signed | 01/17/2018

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F 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to include in a care plan of a resident with a history of fall that the resident needed a full body lift for transfer and did not specify the type and size of the sling to use on the lift. The resident fell from the lift sling which resulted in a skin tear to his head, bruising to his head and right arm, a skin tear to his right knee and broken teeth for 1 of 5 residents sampled for transfer interventions on care plans (Resident #22). The facility also failed to apply a left hand splint as care planned for 1 of 4 residents sampled with limited range of motion/contractures (Resident #56). Findings included: 1. Resident #22 was admitted to the facility on 08/24/16 with diagnoses which included heart disease, depression and Alzheimer's disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 09/27/17 indicated Resident #22 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS further indicated Resident #22 was totally dependent on staff for bed mobility and transfers. A review of a physical therapy initial assessment dated 08/25/16 indicated Resident #22 was 100 percent dependent on 1 or more persons for bed mobility and transfers. A review of a Care Area Assessment dated	F 656	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F656 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; During the annual/follow-up survey ending 12/22/17, surveyors reviewed Resident #22 and Resident #56. Resident #22□s Baseline Care Plan was reviewed and it was determined the facility did not have a process to capture the appropriate transfer status and failed to identify the specific sling type/size. As of the 11/28/17 regulatory requirements, the facility□s Baseline Care Plan format was updated to include transfer status and sling type/size. In addition, the Resident Profile utilized by Nursing Assistants for care has been updated to reflect the appropriate transfer status and sling type/size.	

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F 656	Continued From page 2 09/04/16 indicated falls triggered and was addressed in the care plan. A review of an Initial Interdisciplinary Care Plan dated 08/25/16 indicated a potential for falls due to pain, generalized weakness, decreased mobility and a history of multiple fractures. There were no approaches or interventions to indicate Resident #22 was to be transferred with a full body lift and there was no indication of the type or size of sling to be used during the transfer. A review of a hospice and palliative care visit note, dated 11/19/16 at 2:17 PM, documented by Hospice Nurse #1 indicated Resident #22 fell from a full body lift. The notes revealed the sling type that was used to transfer Resident #22 in the total lift did not support his bottom and they would attempt to get a different type of sling for transfers. A review of an incident log dated 11/19/16 revealed Resident #22 was in a total body lift and 2 NAs were present. The document indicated Resident #22 slid out of the sling attached to the lift, onto the floor, bottom first and hit his head on a pole of the total body lift. The report further indicated a family member called a week later because they had noticed Resident #22 was missing 2 of his top front teeth that were broken with the roots still in place. A review of the Initial Interdisciplinary Care Plan dated 11/19/16 revealed Resident #22 had a fall during a transfer with a full body lift. A section labeled interventions had a hand written note that a new sling was ordered but there were still no approaches or interventions to use a full body lift for transfer or the type of sling or size of sling to	F 656	Resident #56□s Physician Orders were reviewed and it was determined the facility did not have an updated Resident Profile to reflect the application of the left wrist/hand splint, which was not applied in the morning and removed in the evening as ordered. The Resident Profile utilized by Nursing Assistants for care was updated to reflect the appropriate splint application schedule. Once identified during the survey, the sling was applied as ordered. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 1/3/18, a new Interdisciplinary Team (IDT) Rounds process was initiated. Members of the IDT included, a Physician, a representative from MDS, Social Worker, Clinical Nurse Supervisor, DON, Activity Representative, Dietitian, Informatics and Analytics Services (IAS), a representative from Therapy, and front-line Nursing Assistants. The IDT process included the development of the template for the IDT to utilize while performing the meetings with the residents present to ensure all pertinent information was captured. Physician orders, resident profile, and care plan were revised/updated to reflect current resident status, and any discrepancies were resolved prior to leaving the resident□s room. In the event a piece of equipment/supply was not able to be fixed or obtained immediately, a work order was initiated. The resident profile for all	

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F 656	Continued From page 3 be used. A review of a care plan with a revised date of 11/28/16 indicated Resident #22 was totally dependent for all activities of daily living and was to be transferred with a mechanical lift but had a recent fall from the lift. During an interview on 12/21/17 at 3:28 PM the Director of Nursing (DON) confirmed there was no transfer interventions or approaches on the initial interdisciplinary care plan prior to Resident #22's fall from the lift or after the fall from the lift until a new care plan was revised on 11/28/16. She explained she would want physical therapy and occupational therapy to screen a resident and make the safest recommendations for transfers and that should be care planned for staff to follow their recommendations. During an interview on 12/22/17 at 9:27 AM with the Administrator she stated it was her expectations to see a resident's transfer status on the care plan. She explained physical therapy or occupational therapy were involved in determining a resident's transfer status and once they made their determination there should be communication to nursing staff on how to provide the care. She further stated interim care plans could be updated as needed. During an interview on 12/22/17 at 12:50 PM with a physical therapist she explained therapy staff screened every resident when they were admitted to the facility and made recommendations to staff for safe transfers. She stated Resident #22 was totally dependent on staff for everything and she would have expected for staff to include a total lift transfer as an intervention on his care plan.	F 656	residents was updated to reflect the specific needs of the resident, to include, but not limited to, transfer status, type/size of sling for residents transferred via Hoyer lift, and splint application. During the IDT rounds, the team was responsible for matching the Resident Profile with the Care Plan, and the Physician ensured all orders were entered appropriately. A member from IAS was included to verify the information was entered accurately since the Electronic Medical Record (EMR) is new to the facility. During the IDT rounds, the team Date certain: 1/12/18 Orientation for new teammates will include updating the resident profile, accessing the resident profile, and resident care plan implementation. Date certain 1/15/18 The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements Beginning 1/15/18, the Administrator selected a group of Leadership members as Zone Owners, to focus on monitoring the updates completed during IDT rounding to ensure continued compliance. Each Zone Owner has received a specific assignment of residents to monitor. The assignments include a back-up person to cover if the individual is out of the facility for the day. Zone owners were trained on accessing and utilizing the Resident	

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F 656	Continued From page 4 2. Resident #56 was admitted to the facility on 07/28/16 with diagnosis that included progressive multiple sclerosis and spastic hemiplegia, a condition which can cause muscles on one side of the body to be in a constant state of contraction. Review of the activity of daily living (ADL) care plan updated on 01/03/17 addressed functional limitations with a goal to continue to participate in ADL with approaches that included a left hand splint to be applied every morning and removed every evening. During a review of the Resident #56's physician orders, an order dated 10/17/17 read: left wrist/hand orthosis applied in morning and remove in the evening. A review of the most recent minimum data set (MDS) assessment dated 10/18/17 coded Resident #56 as cognitively impaired, with a Brief Interview for Mental Status (BIMS) of 5 and as having functional impairment with limited range of motion (ROM) in the left hand. Review of the Nursing Assistant's (NAs) resident profile for Resident #56 noted a left wrist hand splint orthosis apply in the morning and remove in the evening. A review of the 12/2017 Medication Administration Record (MAR) for Resident #56 indicated a left hand splint to be donned in the morning and removed in the evening. Refusal of the hand splint was documented on the MAR for 12/6/17 and 12/19/17.	F 656	Profile found on Care Tracker to ensure residents have appropriate slings and splints as outlined in the Resident Profile. Rounding assignments are quite extensive and include auditing of residents rights, physical environment, and individualized resident needs, amongst other areas. To monitor the IDT rounds, the facility will add a Stand Down meeting to provide findings of the Zone Owners of Resident Profiles and Care Plans that need to be updated. Any areas of discrepancy will be immediately addressed during the stand down meeting by the IDT. IDT Zone Owners will be required to complete rounds on their assigned residents Monday through Friday for 4 weeks and attend the stand down meeting each day. On the weekends for 4 weeks, the clinical supervisor and manager on duty will be responsible for auditing 100% of residents who require slings and splint application to determine the appropriate type and size of slings for residents transferred via Hoyer lift and splint application. Date Certain: 1/15/18 Service Line Nurse Educator and the Facility Educator provided in-services to MDS Coordinators, nursing staff and nursing assistants on the process flow expectations for verification of orders, care plan updates, and care plan implementation. Any required staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. Date	

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F 656	Continued From page 5 Observations made of Resident #56 on 12/18/17 at 3:47 PM, 12/19/17 at 10:52 AM, 12/20/17 at 12:15 PM, 12/21/17 at 11:18 AM, and 12/22/17 at 9:00 AM revealed no left hand splint being worn. In an interview with Resident #56 on 12/18/17 at 3:15 pm, she stated she was not receiving any treatment for her left hand but would like to. An interview with NA #5 on 12/22/17 at 9:06 am, she stated Resident #56 used to have a splint but she hadn't seen it in a while and didn't know where it is was at this time. She reported the Resident didn't want to wear it most of the time. The NA explained if a resident had a splint ordered it would be on the resident profile to alert the NA's to it. If a resident refused to wear their splint it would be reported to the nurse because the nurses documented it on their MAR. During an interview with Nurse #3 on 12/22/17 at 9:15 am, he stated he had seen therapy work with Resident #56 many times but was not sure what they were doing for her left hand. A subsequent observation of Resident #56 on 12/22/17 at 1:15 pm revealed resident had a left hand splint was in place. A subsequent interview with NA #5 on 12/22/17 at 3:10 pm, revealed she had found the left hand splint for Resident #56 in the corner of her room under some things and had applied it to her left hand. In a subsequent interview with Nurse #3 on 12/22/17 at 3:46 pm, he reported that the nurses documented splint donning and doffing on the MAR.	F 656	certain: 1/15/18 The IDT rounding team conducted 100% audit of matching the Resident Profiles, with the Care Plans, as the Physician ensured all orders were entered appropriately. MDS Coordinator or designee, will conduct weekly 100% audit of scheduled quarterly and annual care plans being conducted in resident□s rooms to ensure Resident Profiles, Care Plans and Physician Orders match. Audits will continue for a period of 90 days, at which time the QAPI committee will determine if further auditing is needed. Any identified issues will be corrected at that time. Date certain: 1/12/18 Floor nurses will update the resident profile with any new orders. Clinical supervisors will be responsible for ensuring the floor nurse has updated the resident profiles appropriately upon start of their shift. The clinical supervisors will bring the 24-hour order report to morning stand-up and be prepared to discuss any updates. The MDS Coordinators will be responsible for verifying the resident profile was updated accurately and that the care plan is reflective of any changes. On weekends, the clinical supervisor will pull the 24-hour order report and ensure the resident profiles have been updated appropriately. Clinical supervisors are responsible for pulling the 72-hour order report on Monday mornings and following the normal process of bringing the report to morning stand-up meeting to give to MDS Coordinators. Date certain 1/17/18	

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F 656	Continued From page 6 During an interview with the Occupational Therapist (OT) on 12/22/17 at 4:00 pm, she reported Resident #56 was on her caseload some time ago and a left hand splint was ordered. She didn't know the status of the hand splint since Resident #56 was not currently on her caseload. A telephone interview with Nurse #4 on 12/22/17 at 4:13 pm, revealed she worked on an as needed (PRN) basis at the facility and could not say if she has ever seen Resident #56 wear a left hand splint. She could not remember if she had documented splint placement on the MAR for Resident #56. An interview was conducted with the Director of Nursing (DON) on 12/22/17 at 6:29 pm. The DON stated her expectation regarding splints and positioning/mobility devices is that they would be applied and removed per physician orders and as directed by the care plan.	F 656	IDT rounds will be conducted in resident rooms on a quarterly basis going forward, to be incorporated into the already existing schedule for care plans. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Date certain: 1/17/18. The title of the person responsible for implementing the acceptable plan of correction. The DON will have overall responsibility for oversight of the care plan process. MDS Coordinators will be responsible for ensuring the Resident Profile is reflective of changes made to a resident□s care plan. MDS Coordinators will maintain the in-room assessments during care plan meetings which will allow the team to visualize any opportunities to enhance the residents□ environment or plan of care. Date certain: 1/17/18	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and physician and staff interviews the facility failed to	F 677	DISCLAIMER: Preparation and/or execution of this Plan	1/17/18

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F 677	Continued From page 7 use soap and water or a perineal cleanser during incontinence care for 1 of 4 residents observed for incontinence care (Resident #22). Findings included: Resident #22 was admitted to the facility on 08/24/16 with diagnoses which included heart disease, depression and Alzheimer's disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 09/27/17 indicated Resident #22 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS further indicated Resident #22 was totally dependent on staff for toileting, hygiene and bathing and was always incontinent of bladder and bowel. During an observation of incontinence care on 12/22/17 at 11:32 AM Nurse Aide (NA) #3 and NA #4 entered Resident #22's room and raised his bed. NA #3 checked Resident #22's brief and stated he needed to be changed and NA #3 and NA #4 washed their hands and put on gloves. NA #3 ran water in a sink in Resident #22's room and stated it was warm and took a clean bath towel and placed one end of the towel under the faucet to wet one end with water while the other end was draped over the side of the sink and was dry. NA #3 then carried the towel to Resident #22's bed but did not put soap or a perineal cleanser on the wet end of the towel. Resident #22 was turned on his left side and NA #3 removed his brief which was wet and placed it into a clear plastic bag. NA #3 then used the wet end of the towel and wiped down between Resident #22's legs from front to back while he was still on his left side but did not separate his legs. NA #3 then wiped his buttocks with the same wet end of the	F 677	of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F677 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: During the annual/follow-up survey ending 12/22/17, a surveyor observed NA #3 failing to perform a basic nurse aide skill. The nurse aide made a personal choice to use water and not include soap or perineal cleaner, when performing perineal care for Resident #22. NA #4 was present and had an opportunity to ensure NA #3 was properly providing perineal care but failed to do so. NA #3 and NA #4 received inservice training on perineal care based on current policy. In addition, NA #3 and NA #4 were counseled as part of the progressive disciplinary process. Following this observation, Resident #22 received perineal care based on current policy. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Service Line Nurse Educator and the Facility Educator provided in-services to	

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F 677	Continued From page 8 towel. She then turned the towel to the dry end and wiped down his buttocks while he was still on his left side and then inside his legs again and placed the towel into a clear plastic bag. NA #3 then put a clean brief on Resident #22 and pulled his pants up. During an interview on 12/22/17 at 11:46 AM with NA #3 she confirmed she only used water to clean Resident #22 and had not used any soap or perineal cleanser. She stated there was periwash in Resident #22's closet and said she hadn't used it because she guessed she was a little nervous. She confirmed she did not open his legs or turn him during incontinence care because she cleaned him all from one side. She then stated she tried not to turn him too much because his legs were contracted and she did not want to hurt him. During an interview on 12/22/17 at 12:15 PM, the Director of Nursing (DON) stated it was her expectation for Nurse Aides to use soap and water during incontinence care and they should clean from front to back to prevent urinary tract infections. She stated use of only water during incontinence care was unacceptable. During an interview 12/22/17 at 3:40 PM with Resident #22's physician who was also the facility Medical Director he stated use of water only during incontinence care was unacceptable. He stated it was his expectations for procedures to be followed during incontinence care. During an interview on 12/22/17 at 2:59 PM, the Administrator confirmed she had been made aware by the DON of the incontinence care provided to Resident #22 She stated use of	F 677	nursing staff and nursing assistants on perineal care based on current policy. Competency was evaluated using a return demonstration on a mannequin as well as direct patient care observations. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. Date certain: 1/12/17 Orientation for new teammates will include training and competency related to peri-care. Date certain: 1/15/17 The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Service Line Nurse Educator and the Facility Educator will conduct weekly observations of the Nurse Aides providing perineal care to validate continued competency. Observations will be conducted on 5 CNAs on day shift per week, 3 CNAs on second shift, and 1 CNA on third shift for a period of 90 days. Any identified issues will be corrected at the time they are identified. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. The title of the person responsible for	

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F 677	Continued From page 9 water only during incontinence care should not have happened.	F 677	implementing the acceptable plan of correction. The DON will be responsible for oversight for this plan of correction. Date certain 1/17/18	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and physician and staff interviews the facility failed to safely transfer a resident with a total body lift and use the correct sling size to prevent the resident from sliding out of the sling onto the floor which resulted in a skin tear to his head, bruising to his head and right arm, a skin tear to his right knee and broken teeth and the facility failed to complete neurological assessments after the fall for 1 of 5 sampled residents for supervision to prevent accidents (Resident #22). Findings included: Resident #22 was admitted to the facility on 08/24/16 with diagnoses which included heart disease, depression and Alzheimer's disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 09/27/17 indicated Resident #22 had short term and long term memory problems	F 689	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F689 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: During the annual/follow-up survey ending 12/22/17, surveyors reviewed Resident #22 and determined the facility did not	1/17/18

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F 689	Continued From page 10 and was severely impaired in cognition for daily decision making. The MDS further indicated Resident #22 was totally dependent on staff for bed mobility and transfers. A review of a fall risk assessment dated 11/16/16 revealed Resident #22 had a total risk score of 20 which indicated he was high risk for falls. A review of a nurse's note dated 11/19/16 at 11:20 AM documented by Nurse #1 revealed Resident #22 was being transferred by a total body lift by 2 Nurse Aides (NAs) when Resident #22 slipped out of the sling and fell to the floor. The notes indicated Resident #22 hit his head on the bar of the lift and had a quarter size skin tear on top of his head and the area was cleaned with normal saline and a Mepilex (foam) border dressing was applied. The notes further indicated Resident #22 had his eyes open but was non-verbal with no grimacing. The notes revealed Resident #22 was assisted back to bed with the total body lift and the Nurse Practitioner (NP) and responsible party (RP) were notified. A review of a hospice on call note dated 11/19/16 at 12:01 PM indicated a report was received that staff were getting Resident #22 up with a total body lift and he fell out of the sling onto the floor. The notes further indicated Resident #22 hit his head and was having some bleeding from his head but he did not lose consciousness and a hospice nurse would make a visit to assess him. A review of a hospice and palliative care visit note dated 11/19/16 at 2:17 PM documented by Hospice Nurse #1 indicated a visit was made to the facility due to Resident #22 fell from a total lift. The notes revealed Resident #22 was alert but	F 689	have a process to capture the appropriate transfer status and failed to identify the specific sling type. Following a fall, vital signs were documented q shift for 72 hours per physician orders. However, neuro checks were not included as part of the documentation. The facility's policy at the time of the fall did not include that neuro checks should be conducted on a resident who fell. The falls policy has since been updated to include neuro checks for all unwitnessed falls and suspected head injuries following a fall. Transfer status and sling type are now included with the baseline/interim care plan completion within 24 hours of admission. The transfer status for Resident #22 and type of sling appropriate for transfers has been updated in the care plan and resident profile. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Falls policy has been updated to reflect the Medical Director's expectations in regards to neurological monitoring, post-fall. New parameters developed for documenting neuro checks after all unwitnessed and/or suspected head injury, post-fall. Date certain 1/12/18 Service Line Nurse Educator and the Facility Educator provided inservices to nursing staff related to the new parameters and documentation requirements in the EMR. Any nurses who do not receive training by the specified	

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nonverbal and was in no acute distress. The notes further indicated Resident #22 had a 3.0 centimeter (cm) length x 1.5 cm width x 0.5 cm depth skin tear on the top of his head, a 2.5 cm length x 3 cm width bruised knot on his parietal lobe (on the back of his head) and a 2.5 cm length x 3 cm width bruised knot on his occipital lobe (lower back of his head), a 4 cm length x 2 cm width bruise on his right arm and a 1 cm round skin tear on his right knee. The notes revealed the sling type that was used to transfer Resident #22 in the total lift did not support his bottom and they would attempt to get a different type of sling for transfers.

A review of a post fall risk assessment dated 11/19/16 revealed Resident #22 had a total risk score of 15 which indicated he was high risk for falls.

A review of an incident log dated 11/19/16 revealed Resident #22 was in a total body lift and 2 NAs were present. The document indicated Resident #22 slid out of the sling attached to the lift, onto the floor, bottom first and hit his head on a pole of the total body lift. The report further indicated a family member called a week later because they had noticed Resident #22 was missing 2 of his top front teeth that were broken with the roots still in place.

A review of a facility document titled Skilled Nursing Fall Investigation completed by Nurse #1 indicated Resident #22 had a fall on 11/19/16 at 11:20 AM in his room from a total body lift. A section labeled description of fall activity revealed Resident #22 slid onto the floor from a total body lift during transfer with 2 NAs present. The document further indicated Resident #22 had

date will not be allowed to work a shift until training/education has been completed. Date certain 1/17/18

On 12/21/17, MDS Coordinators and Nurse Supervisors conducted a facility-wide audit of residents transferred via lift to ensure proper slings were in place. This audit was utilized during the new Interdisciplinary Team (IDT) Rounds process, to observe that the appropriate transfer status was identified and the specific sling type was being utilized. On 1/3/18, a new Interdisciplinary Team (IDT) Rounds process was initiated. Members of the IDT included, a Physician, a representative from MDS, Social Worker, Clinical Nurse Supervisor, DON, Activity Representative, Dietician, Informatics and Analytics Services (IAS), a representative from Therapy, and front-line Nursing Assistants. The IDT process included the development of the template for the IDT to utilize while performing the meetings with the residents to ensure all pertinent information was covered. Physician orders, resident profile, and care plan were revised/updated to reflect current resident status, and any discrepancies were resolved prior to leaving the resident's room. In the event a piece of equipment/supply was not able to be fixed or obtained immediately, a work order was initiated. Another template was created to use for the Resident Profile outline to ensure each resident's profile contained the same information. During the IDT rounds, the team was responsible for matching the Resident Profile with the

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F 689	Continued From page 12 poor safety awareness and the injury type was reddened areas and abrasion at the top of his head. The document revealed the NP and RP were notified. The document further revealed a section labeled identification of cause of the fall indicated Resident #22 was assisted 100 percent by total body lift and he slipped out of the sling and hit his head. A section labeled immediate interventions indicated the NA's involved were instructed on patient safety. A review of an initial interdisciplinary care plan updated on 11/19/16 indicated no transfer method for Resident #22 however, hand written notes revealed he had a fall during transfer with a total body lift and a new total body sling was ordered. A review of a physician's order dated 11/19/16 at 3:58 PM indicated for Resident #22 to remain in bed until Monday 11/21/16. A review of a nurse's note summary dated 11/19/16 for the 3:00 PM to 11:00 PM shift documented by Nurse #2 indicated vital signs as follows: blood pressure 143/92, pulse 80, respirations 18, oxygen saturation percentage was 96 on room air and temperature 98.5 degrees Fahrenheit (F). The notes revealed Resident #22 was alert and responsive but there were no neurological assessments. A review of a nurse's note summary dated 11/19/16 for the 11:00 PM to 7:00 AM shift documented by Nurse #2 indicated Resident #22 rested during the shift but there were no neurological assessments. A review of a physician's order dated 11/20/16 at 3:00 AM indicated strict bed rest until new total	F 689	Care Plan, and the Physician ensured all orders were entered appropriately. A member from IAS was included to verify the information was entered accurately since the Electronic Medical Record (EMR) is new to the facility. Date certain: 1/12/18 The baseline care plan has been updated to reflect the new regulatory requirements, effective 11/28/17, with a specific section to identify the transfer status and sling type of all admissions. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Beginning 1/15/18, the Administrator selected a group of Leadership members as Zone Owners, to focus on monitoring the updates completed during IDT rounding, to ensure continued compliance. Zone owners were trained on accessing and utilizing the Resident Profile found on Care Tracker to ensure residents have appropriate slings as outlined in the Resident Profile. Rounding assignments are quite extensive and include auditing of residents rights, physical environment, and individualized resident needs, amongst other areas. To monitor the IDT rounds, the facility will add a “Stand Down” meeting to provide findings of the Zone Owners of Resident Profiles and Care Plans that need to be updated. Any areas of discrepancy will be	

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F 689	Continued From page 13 body lift sling arrived. A review of a nurse's note dated 11/20/16 at 10:00 AM documented by Nurse #1 indicated Resident #22 awakened to verbal stimuli. The notes revealed vital signs as follows: blood pressure 130/54, pulse 65, respirations 20, oxygen saturation percentage was 98 on room air and temperature 98.8 degrees F but there were no neurological assessments. A review of a nurse's note summary dated 11/20/16 for the 3:00 PM to 11:00 PM shift documented by Nurse #2 revealed vital signs as follows: blood pressure 117/65, pulse 75, respirations 18, oxygen saturation percentage 95 on room air and temperature 98.3 degrees F. The notes indicated Resident #22 had no pain or acute distress but there were no neurological assessments. A review of a nurse's note summary dated 11/20/16 for the 11:00 PM to 7:00 AM shift documented by Nurse #2 revealed vital signs as follows: blood pressure 120/60, pulse 60, respirations 18 oxygen saturation percentage 91 on room air and temperature 98.3 degrees F. The notes further revealed Resident #22 was in bed resting with eyes closed and his chest was noted to rise and fall with each breath but there were no neurological assessments. A review of a physician's order dated 11/21/16 at 5:10 PM indicated strict bed rest until Friday 11/25/16. A review of a nurse's note summary dated 11/21/16 for the 3:00 PM to 11:00 PM shift documented by Nurse #2 revealed vital signs as	F 689	immediately addressed during the stand down meeting by the IDT. Date Certain: 1/15/18 Service Line Nurse Educator and the Facility Educator provided in-services to nursing staff and nursing assistants on safe Hoyer lift transfers and how to identify the appropriate sling. All new orientees will receive the outlined education. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. Date certain 1/11/18 Observations on Hoyer lift transfers will be conducted on 5 CNAs on day shift per week, 3 CNAs on second shift, and 1 CNA on third shift for a period of 90 days. The IDT rounding team conducted 100% audit of matching the Resident Profiles, with the Care Plans, as the Physician ensured all orders were entered appropriately. Any identified issue was corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. The clinical supervisors will be responsible for bringing the completed baseline care plan to morning stand-up meeting for all new admissions to discuss with the IDT. A 100% audit will be	

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F 689	Continued From page 14 follows: blood pressure 119/58, pulse 81, respirations 18, oxygen saturation percentage 94 on room air and temperature 98 degrees F. The notes further revealed Resident #22 was alert and responsive but there were no neurological assessments. A review of a nurse's note dated 11/22/16 at 3:45 AM indicated Resident #22 was in bed resting with eyes closed. The notes revealed vital signs as follows: blood pressure 109/53, pulse 86, respirations 20, oxygen saturation percentage 94 on room air and temperature 98.7 degrees F but there were no neurological assessments. A review of a hospice note dated 11/25/16 indicated they were still working on getting a new sling for Resident #22 for transfers with the total lift. A review of a document titled Dental Emergency Report dated 12/02/16 revealed tooth concern was located at upper left and a handwritten note indicated roots were still intact but teeth were broken off. A review of a physician's order dated 12/02/16 indicated it was okay to get Resident #22 up to a broda chair (tilting and reclining chair) with a full body sling for a maximum of 4 hours a day. A review of an email dated 12/13/16 at 5:45 PM from a Social Worker to a former Administrator in part indicated a dentist saw Resident #22 on this date and Resident #22 was not in pain but had some decay from the missing teeth. The email indicated no medical interventions were planned but the dentist would see Resident #22 during the next visit in January 2017.	F 689	conducted of all baseline care plans for new admissions with a special focus on the transfer status and type of sling. According to the manufacturer's guidelines for the slings used within the facility, the weight of a resident determines which size of sling is most appropriate. The monthly weights spreadsheet populated by the registered dietitian has been formatted to automatically identify the most appropriate sling based off the resident's weight per the manufacturer's guidelines. Once the monthly weights are completed, the RD is responsible to complete the spreadsheet and send to the IDT. The clinical supervisors will then determine if a different size of sling is needed. If a new sling is needed based off the weight, the clinical supervisor will replace the sling and update the resident profile. MDS will be responsible for updating the care plan. Date certain 1/17/18 The title of the person responsible for implementing the acceptable plan of correction. DON will be responsible for implementing the acceptable plan of correction.	

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During an interview on 12/21/17 at 10:48 AM with Nurse #1 she stated NA #1 and NA #2 were transferring Resident #22 with a total body lift to get him up for lunch on 11/19/16 and she was called to the room. She explained when she walked into the room the total lift was beside the bed and Resident #22 was lying beside the bed on the floor. She stated she assessed him and recalled he had a bump on his head but did not recall skin tears and he did not seem to be in pain and did not lose consciousness. She explained after they took his vital signs they put the same sling under him he fell from and used the total body lift to transfer him back to bed. She further stated she called the hospice nurse, NP and RP to inform them of Resident #22's fall. She stated they used a standard sling for Resident #22 because that was the only size they had but after Resident #22 fell the hospice nurse ordered a longer sling for him. She explained when a resident had a fall and hit their head they were supposed to do neurological assessments (neuro checks) every 15 minutes for a period of time then every 30 minutes for a period of time then hourly and the standard time for post fall assessments was for 72 hours after the fall. She stated she could not remember doing neuro checks but she thought they checked on him during routine rounds.

During an interview on 12/21/17 at 11:10 AM, a Clinical Nurse Supervisor explained Resident #22 fell from a total body lift on Saturday 11/19/16 but she was not present in the facility. She stated it was reported to her on the following Monday 11/21/16 but she did not recall why it happened. She explained she recalled after the fall hospice decided to get a longer sling for him. She stated

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it was her expectation if a resident had a fall and bumped their head or if a fall was not witnessed nursing staff should perform neurological assessments for 72 hours after a fall. She explained neurological assessments were supposed to be documented on a specific form in the resident's medical record.

During an interview on 12/21/17 at 11:29 AM with NA #1 she explained she was called to Resident #22's room to assist NA #2 with transferring him from the bed to a broda chair. She stated NA #2 had already put the lift pad under him and he was sitting up in bed when she entered his room. She explained they hooked the straps of the sling to the hooks on the lift arm and raised him up off the bed. She further explained they were trying to turn the lift to position him over the chair but the wheels of the lift were caught on a power cord that was under his bed. She stated NA #2 went to the other side of the bed to pull the power cord away from the lift wheels but Resident #22's whole body jerked and before she knew it he fell through a hole in the sling. She described the sling as full length with a hole in it where his bottom was supposed to sit and the straps extended straight out to the sides where they were hooked onto the lift arms. She stated Resident #22 fell right through the hole in the sling. She explained she was not sure who had made the decision for that sling to be used but when she went into a resident's room and saw a lift sling there she thought that was the sling she was supposed to use for the resident. She stated she thought the sling Resident #22 had fallen from was too big for him and when he slid out of the sling he landed at the side of the lift and she did not recall he bumped his head on the lift. She explained during the transfer Resident #22

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had jerking movements of his whole body and the power cord was caught against the wheels of the lift and so they couldn't transfer him to the chair and she thought these things contributed to his fall from the lift sling. She stated after Resident #22 fell out of the sling they called for Nurse #1 and she came in and asked if he was in pain but he did not speak and did not making any noises so she turned him over and checked for bruises. She stated she thought they got a different sling to transfer him from the floor back to bed but that was difficult to remember.

During an interview on 12/21/17 at 12:03 PM, NA #2 explained she recalled when Resident #22 slid out of a lift sling on 11/19/16. She further explained she was standing next to the lift and NA #1 was on the other side of the lift and as they moved the lift there was a power cord under the bed and the legs of the lift were caught on it and they could not move the lift to lower Resident #22 into the chair or back over the bed. She stated she could not reach the power cord to move it from where she was standing because the legs of the lift were opened. She further stated she realized Resident #22 was sliding out of the lift sling to the floor but there was nothing they could do to stop him from falling and he fell between the bed and a nightstand next to his bed. She explained Resident #22 fell through a hole in the sling and after he landed on the floor the sling was still attached to the lift arms. She stated they could have saved him from falling if the power cord under the bed had not been in the way of moving the lift. She further stated he did not complain of pain when he fell but he was bleeding somewhere on his head and they called Nurse #1 to come to his room.

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During an interview on 12/21/17 at 12:17 PM the Director of Nursing (DON) confirmed she could not find documentation of neurological assessments or neurological flow sheets after Resident #22's fall on 11/19/16.

During an interview on 12/21/17 at 02:50 PM with Nurse #2 she confirmed she worked second and third shifts and it was reported to her during shift change on 11/19/16 that Resident #22 had fallen from a lift earlier that day. She explained the nurse who was assigned to the resident when a fall occurred was supposed to complete a packet of information regarding the fall and the packet contained a form for the documentation of neurological assessments. She stated she did not recall hearing in report that Resident #22 hit his head on the lift but if he had hit his head that would be a reason to do neurological assessments. She stated she did not recall doing neurological assessments after Resident #22 fell from the lift but she did recall family had requested a new sling after he slid out of the lift sling on 11/19/16.

During a follow up interview on 12/21/17 at 03:28 PM, the DON explained she was not employed in the facility when Resident #22 slid out of the lift sling on 11/19/16. She confirmed there was no transfer method on the initial interdisciplinary care plan but she would expect for physical therapy and occupation therapy to screen a resident and make the safest recommendations for transfer and she would expect for staff to follow the care plan according to their recommendations.

During an interview on 12/21/17 at 03:50 PM, the Corporate Nurse Consultant explained she had reviewed Resident #22's fall from the lift sling on

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11/19/16 and determined the wheels of the lift had lodged on a power cord under the resident's bed and Resident #22 had jerking movements during the transfer and drew his legs up and then he slid out from the lift sling. She further explained Resident #22 had an abrasion to the top of his head when he bumped his head on lift bar but there was no notation of missing teeth at time of the fall and he probably lost them during the fall but it was not noticed. She stated she had determined the possible causes of the fall were the power cord under the resident's bed caused the lift to become lodged and Resident #22's jerking movements and the lift sling did not support him when he drew his legs up. She explained after the fall a new lift sling was ordered for Resident #22 and the NAs were counseled.

During an interview on 12/21/17 at 4:01 PM, the Administrator stated she had just returned from a leave of absence when Resident #22 fell from the lift and did not participate in the post fall investigation.

During a follow up interview on 12/21/17 at 5:45 PM, the Corporate Nurse Consultant stated it was an expectation for nurses to do neuro checks for a resident after a fall when they had hit their head.

During an observation and interview on 12/22/17 08:46 AM with the wound/treatment nurse she stated Resident #22's sling was usually on the back of the bathroom door but when she looked in the bathroom there was no sling hanging on the back of the door. She then opened the closet door and pulled a blue full body sling that was made of a soft fabric from the top shelf and

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stated that was not the sling they currently used. She confirmed there was no size on any of the labels and an area was noted with white strings along the piping and she stated it looked like a label had been removed. She then called Nurse #1 to come to the room and Nurse #1 confirmed the sling was not the one staff currently used. She stated she was not sure where the sling that was supposed to be used to transfer Resident #22 was located and described it as a mesh sling with a hole in the center. The wound/treatment nurse then called NA #3 who was assigned to Resident #22 to come to the room and she confirmed the sling was not the correct sling to use for Resident #22's transfer. NA# 3 then went to the laundry and returned with another sling that was a lighter blue mess fabric with a hole in the middle and color coded straps at each corner and confirmed the sling was a large size and was the correct sling to use for Resident #22's transfers.

During an observation and interview on 12/22/17 at 09:20 AM with the DON she observed the blue sling the wound/treatment nurse had found in Resident #22's closet and stated she was not sure where that lift sling had come from. She explained it was possible family had brought it or it may have come from the hospital when Resident #22 was admitted to the facility. She stated she was not sure if that was the sling Resident #22 had fallen out of but stated it was her expectation for staff to use the sling assigned to Resident #22 and there should not have been any other slings in his room. She then removed the sling from Resident #22's room and stated she was going to return it to his family so it would not be used for him or for any other resident.

During an interview on 12/22/17 at 9:27 AM, the

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F 689	Continued From page 21 Administrator stated it was her expectation for 2 NAs to transfer Resident #22 safely with a lift. She stated she expected for NAs to use the sling that was assigned to him and if the sling did not look to be the correct size they should report it to the nurse to get the sling switched out for the correct size. During an interview on 12/22/17 at 12:50 PM with a Physical Therapist she explained therapy staff evaluated residents when they were admitted and made recommendations to staff for safe transfers of residents. She stated if a resident had a fall from a lift during a transfer the nurse was expected to assess the resident and request a therapy screen to evaluate the resident. She confirmed there was no referral for a therapy screen after Resident #22 fell from the lift. An attempt on 12/22/17 at 3:20 PM to contact Hospice Nurse #1 was unsuccessful. An attempt on 12/22/17 at 3:22 PM to contact Hospice Nurse #2 was unsuccessful. During an interview on 12/22/17 at 3:40 PM with Resident #22's physician who was also the facility Medical Director he stated it was his expectation for lifts to be functional and used by staff who were competent to use them. He further stated he expected for the proper equipment which included slings to be used and proper procedures should be followed.	F 689		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program.	F 865		1/17/18

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F 865	Continued From page 22 §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor those interventions that the committee put into place on November 30, 2017 following a follow up and complaint survey and subsequently recited on December 22, 2017 on the current recertification survey. The repeat deficiency was in the areas of care plan implementation (F656). This deficiency was recited during the facility's current recertification survey. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 438.20 Resident Assessment: Based on record	F 865	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F 865 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; During the survey ending 11/2/17, the facility received a citation related to not following a resident□'s plan of care. During the annual/follow-up survey ending	

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F 865	Continued From page 23 reviews and staff interviews the facility failed to include in a care plan of a resident with a history of fall that the resident needed a full body lift for transfer and did not specify the type and size of the sling to use on the lift. The resident fell from the lift sling which resulted in a skin tear to his head, bruising to his head and right arm, a skin tear to his right knee and broken teeth for 1 of 5 residents sampled for transfer interventions on care plans (Resident #22). The facility also failed to apply a left hand splint as care planned for 1 of 4 residents sampled with limited range of motion/contractures (Resident #56). During the follow up and complaint survey of 11/02/17 this regulation was cited for failure to apply a palm guard as directed by the care plan. During the current recertification survey this regulation was cited for failure to include in a care plan of resident with a history of fall that the resident needed a full body lift for transfer and did not specify the type and size of the sling to use on the lift and failed to apply a left hand splint as directed by the care plan. An interview was conducted with the Administrator on 12/22/17 at 6:23 PM. The Administrator stated that the Quality Assurance (QA) committee met monthly and included the Administrator, Medial Doctor (MD), attending physicians, Director of Nursing (DON), quality department, and all department heads. She added that since the last follow up complaint survey they have added additional members to the QA committee that included the Chief Medical Officer and Chief Nursing Executive. In addition to the new members of the committee they have also increased frequency of the meeting to	F 865	12/22/17, surveyors reviewed Resident #22 and Resident #56. Resident #22□s Baseline Care Plan was reviewed and it was determined the facility did not have a process to capture the appropriate transfer status and failed to identify the specific sling type/size. As of the 11/28/17 regulatory requirements, the facility□'s Baseline Care Plan format was updated to include transfer status and sling type/size. In addition, the Resident Profile utilized by Nursing Assistants for care has been updated to reflect the appropriate transfer status and sling type/size. Resident #56□s Physician Orders were reviewed and it was determined the facility did not have an updated Resident Profile to reflect the application of the left wrist/hand splint, which was not applied in the morning and removed in the evening as ordered. The Resident Profile utilized by Nursing Assistants for care was updated to reflect the appropriate splint application schedule. Once identified, the sling was applied as ordered. The QAPI committee□s plan of correction for monitoring care plans from the previous citation was very narrowly focused on palm guards and was not comprehensive to include splints, transfer status, and type/size of sling The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 1/3/18, a new Interdisciplinary Team	

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F 865	Continued From page 24 include the most recent survey results and audits. The Administrator stated that the have essentially over hauled the wound program and the DON was observing every wound in the building and they had increased staffing on the weekend to make sure they were covering the wound protocol and to ensure that correct treatments were initiated. She added that the current wound nurse was also coming in on the weekends to help oversee the wound program. Another key element that the DON had initiated was a weekly interdisciplinary team (IDT) meeting and they discussed things like new admission, weights, wounds and etc. and then that all that information was rolled into the QA meeting. The Administrator stated that currently she believed that the only way for the facility to identify the resident's needs was to go room to room and have a comprehensive meeting with the entire IDT team and find out what we needed to do for each resident. She added that the leadership team was stable at the facility and they have recently hired an assistant director of nursing (ADON) which would complete the leadership team.	F 865	(IDT) Rounds process was initiated. Members of the IDT included, a Physician, a representative from MDS, Social Worker, Clinical Nurse Supervisor, DON, Activity Representative, Dietitian, Informatics and Analytics Services (IAS), a representative from Therapy, and front-line Nursing Assistants. The IDT process included the development of the template for the IDT to utilize while performing the meetings with the residents present to ensure all pertinent information was captured. Physician orders, resident profile, and care plan were revised/updated to reflect current resident status, and items identified as requiring a fix to meet the resident□s needs were resolved prior to leaving the resident□s room. In the event a piece of equipment/supply was not able to be fixed or obtained immediately, a work order was initiated. The resident profile for all residents was updated to reflect the specific needs of the resident, to include, but not limited to, transfer status, type/size of sling for residents transferred via hoyer lift, and splint application. During the IDT rounds, the team was responsible for matching the Resident Profile with the Care Plan, and the Physician ensured all orders were entered appropriately. A member from IAS was included to verify the information was entered accurately since the Electronic Medical Record (EMR) is new to the facility. During the IDT rounds, the team Date certain: 1/12/18 The monitoring procedure to ensure that	

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the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

Beginning 1/15/18, the Administrator selected a group of Leadership members as Zone Owners, to focus on monitoring the updates completed during IDT rounding to ensure continued compliance. Each Zone Owner has received a specific assignment of residents to monitor. The assignments include a back-up person to cover if the individual is out of the facility for the day. Zone owners were trained on accessing and utilizing the Resident Profile found on Care Tracker to ensure residents have appropriate slings and splints as outlined in the Resident Profile. Rounding assignments are quite extensive and include auditing of residents rights, physical environment, and individualized resident needs, amongst other areas. To monitor the IDT rounds, the facility will add a Stand Down meeting to provide findings of the Zone Owners of Resident Profiles and Care Plans that need to be updated. Any areas of discrepancy will be immediately addressed during the stand down meeting by the IDT. IDT Zone Owners will be required to complete rounds on their assigned residents Monday through Friday for 4 weeks and attend the stand down meeting each day. On the weekends for 4 weeks, the clinical supervisor and manager on duty will be responsible for auditing 100% of residents who require slings and splint application to

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F 865	Continued From page 26	F 865	determine the appropriate type and size of slings for residents transferred via Hoyer lift and splint application. Date Certain: 1/15/18 Service Line Nurse Educator and the Facility Educator provided in-services to MDS Coordinators, nursing staff and nursing assistants on the process flow expectations for verification of orders, care plan updates, and care plan implementation. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. Date certain: 1/15/18 The IDT rounding team conducted 100% audit of matching the Resident Profiles, with the Care Plans, as the Physician ensured all orders were entered appropriately. MDS Coordinator or designee, will conduct weekly 100% audit of scheduled quarterly and annual care plans being conducted in resident□s rooms to ensure Resident Profiles, Care Plans and Physician Orders match. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Date certain: 1/12/18 Floor nurses will update the resident profile with any new orders. Clinical	

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F 865	Continued From page 27	F 865	supervisors will be responsible for ensuring the floor nurse has updated the resident profiles appropriately upon start of their shift. The clinical supervisors will bring the 24-hour order report to morning stand-up and be prepared to discuss the updates. The MDS Coordinators will then be responsible to verify the resident profile was updates accurately and that the care plan is reflective of any changes. On weekends, the clinical supervisor will pull the 24-hour order report and ensure the resident profiles have been updated appropriately. Clinical supervisors are responsible for pulling the 72-hour order report on Monday mornings and following the normal process of bringing the report to morning stand-up meeting to give to MDS Coordinators. Date certain 1/17/18 IDT rounds will be conducted in resident rooms on a quarterly basis going forward, to be incorporated into the already existing schedule for care plans. Date certain: 1/17/18. The title of the person responsible for implementing the acceptable plan of correction. The DON will have overall responsibility for oversight of the care plan process. MDS Coordinators will be responsible for ensuring the Resident Profile is reflective of changes made to a resident□s care plan. MDS Coordinators will maintain the in-room assessments during care plan meetings which will allow the team to visualize any opportunities to enhance the	

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F 865	Continued From page 28	F 865	residents□ environment or plan of care. Date certain: 1/17/18	