STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345350	A. BUILDING _____ B. WING _____	C 05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND TERRACE	2300 ABERDEEN BOULEVARD GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID# MHPG11.	F 000		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment.	F 640		5/25/18

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

Electronically Signed | 05/25/2018

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F 640	Continued From page 1 (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a Significant Change MDS (Minimum Data Set) assessment and failed to transmit Admission, Annual and Quarterly MDS assessments within the required time frame for 6 of 6 residents (Resident #33, #1, #2, #3, #4, and #19) reviewed for Resident Assessments. Findings included: 1. Resident #33 was admitted to the facility on 02/22/17 with multiple diagnoses that included diabetes, hypertension, depression, and dementia. A review of Resident #33's most recent MDS had an Assessment Reference Date (ARD) of 04/03/18 and was coded as a significant change assessment. The MDS was noted to be "in process." During an interview on 05/01/18 at 3:14 PM the	F 640	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction, and constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. AFFECTED RESIDENTS: Resident # 33 □ Significant change MDS assessment was completed and transmitted on 5/3/18. Resident # 1, Resident #2, Resident #4 □ Quarterly MDS assessment was transmitted on 5/1/18. Resident # 3 - Annual MDS assessment	

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F 640	Continued From page 2 MDS Nurse stated she was the one responsible for signing and transmitting completed MDS assessments. The MDS Nurse explained they were in the process of switching computer systems and each week she ran a submission report that indicated the MDS assessments ready to be signed and transmitted. She further explained when an MDS assessment was transmitted and approved by the Centers for Medicare & Medicaid Services (CMS) it would indicate "production accepted." She confirmed the significant change MDS for Resident #33 was not done due to an oversight and would need to be completed and transmitted. During an interview on 05/02/18 at 12:51 PM the Director of Nursing (DON) stated it was her expectation for MDS assessments to be completed and transmitted within the required time frames. 2. Resident #1 was admitted to the facility on 12/28/16 with multiple diagnoses that included heart failure, hypertension and diabetes. A review of Resident #1's most recent MDS had an ARD of 03/19/18 and was coded as a quarterly assessment. The MDS was noted to be "in process." During an interview on 05/01/18 at 3:14 PM the MDS Nurse stated she was the one responsible for signing and transmitting completed MDS assessments. The MDS Nurse explained they were in the process of switching computer systems and each week she ran a submission report that indicated the MDS assessments ready to be signed and transmitted. She further	F 640	was signed and transmitted on 5/1/18. Resident #19 □ Admission MDS was transmitted on 5/1/18. POTENTIALLY AFFECTED RESIDENTS: All residents have the potential to be affected by this deficient practice. MDS Coordinators completed audit of resident MDS assessments and transmission on 5/25/18. All resident MDS assessments have been completed and transmitted within the required time frame as of 5/25/18. The root cause analysis revealed that due to the facility is still in process of switching to a new Electronic Health Record (EHR) system, the report generated from the facility□'s new EHR system did not capture completed resident MDS assessments therefore completed assessments were not transmitted within the required time frame. The resident MDS significant change assessment that was not completed timely by the MDS Assessment Nurse. SYSTEM CHANGE: The MDS Coordinator and MDS Assessment Nurse were re-educated by Director of Nursing on 5/21/18 on timely completion and transmission of resident MDS significant change assessment. MDS Coordinator contacted MatrixCare□s	

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F 640	Continued From page 3 explained when an MDS assessment was transmitted and approved by CMS it would indicate "production accepted." She was unable to explain why Resident #1's quarterly MDS assessment dated 03/19/18 was showing as in process and confirmed the MDS assessment was completed and should have been transmitted. During an interview on 05/02/18 at 12:51 PM the Director of Nursing (DON) stated it was her expectation for MDS assessments to be completed and transmitted within the required time frames. 3. Resident #2 was admitted to the facility on 12/08/17 with multiple diagnoses that included diabetes, arthritis and Alzheimer's disease. A review of Resident #2's most recent MDS had an ARD of 03/19/18 and was coded as a quarterly assessment. The MDS was noted to be "finalized." During an interview on 05/01/18 at 3:14 PM the MDS Nurse stated she was the one responsible for signing and transmitting completed MDS assessments. The MDS Nurse explained they were in the process of switching computer systems and each week she ran a submission report that indicated the MDS assessments ready to be signed and transmitted. She further explained when an MDS assessment was transmitted and approved by CMS it would indicate "production accepted." She confirmed Resident #2's quarterly MDS assessment dated 03/19/18 was completed and should have been transmitted.	F 640	Project Manager on 5/2/18 for further assistance on generated the appropriate MDS Report that will capture completed resident MDS assessments and are ready for signature and transmission. MDS Coordinator will run esignatures by User Report weekly to ensure all completed resident MDS assessments are signed and transmitted timely. MONITORING: An audit tool was developed to monitor compliance with timely completion and transmission of resident MDS assessments. Director of Nursing or designee will audit completion and transmission of resident MDS assessments weekly x 4 weeks, q 2 weeks x 4 weeks, then q monthly x 3 months Ongoing audits will be determined based on results of prior audits. Audit tools will be reviewed weekly by Administrator and/or Director of Nursing and during monthly Quality Assurance and Performance Improvement Committee meeting. The Director of Nursing will be responsible for implementing the acceptable plan of correction as outlined above.	

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F 640	Continued From page 4	F 640		

During an interview on 05/02/18 at 12:51 PM the Director of Nursing (DON) stated it was her expectation for MDS assessments to be completed and transmitted within the required time frames.

4. Resident #3 was admitted to the facility on 05/18/15 with multiple diagnoses that included Alzheimer's disease.

A review of Resident #3's most recent MDS had an ARD of 03/20/18 and was coded as an annual assessment. The MDS was noted to be "validated."

During an interview on 05/01/18 at 3:14 PM the MDS Nurse stated she was the one responsible for signing and transmitting completed MDS assessments. The MDS Nurse explained they were in the process of switching computer systems and each week she ran a submission report that indicated the MDS assessments ready to be signed and transmitted. She further explained when an MDS assessment was transmitted and approved by CMS it would indicate "production accepted." She confirmed Resident #3's annual MDS assessment dated 03/20/18 was completed and should have been signed and transmitted.

During an interview on 05/02/18 at 12:51 PM the Director of Nursing (DON) stated it was her expectation for MDS assessments to be completed and transmitted within the required time frames.

5. Resident #4 was admitted to the facility on

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F 640	Continued From page 5	F 640		

01/19/17 with multiple diagnoses that included hypertension, diabetes and dementia.

A review of Resident #4's most recent MDS had an ARD of 03/20/18 and was coded as a quarterly assessment. The MDS was noted to be "finalized."

During an interview on 05/01/18 at 3:14 PM the MDS Nurse stated she was the one responsible for signing and transmitting completed MDS assessments. The MDS Nurse explained they were in the process of switching computer systems and each week she ran a submission report that indicated the MDS assessments ready to be signed and transmitted. She further explained when an MDS assessment was transmitted and approved by CMS it would indicate "production accepted." She confirmed Resident #4's quarterly MDS assessment dated 03/20/18 was completed and should have been transmitted.

During an interview on 05/02/18 at 12:51 PM the Director of Nursing (DON) stated it was her expectation for MDS assessments to be completed and transmitted within the required time frames.

6. Resident #19 was admitted to the facility on 03/07/18 with multiple diagnoses that included hypertension and diabetes.

A review of Resident #19's most recent MDS assessments revealed a 5-day Prospective Payment System (PPS) assessment with an ARD of 03/14/18 and an admission MDS with an ARD of 03/14/18. The admission MDS was noted to

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F 640	Continued From page 6 be "in process." During an interview on 05/01/18 at 3:14 PM the MDS Nurse stated she was the one responsible for signing and transmitting completed MDS assessments. The MDS Nurse explained they were in the process of switching computer systems and each week she ran a submission report that indicated the MDS assessments ready to be signed and transmitted. She further explained when an MDS assessment was transmitted and approved by CMS it would indicate "production accepted." She stated due to Resident #19's insurance policy the PPS and admission MDS assessments were completed and transmitted separately. She confirmed the admission MDS dated 03/14/18 for Resident #19 was completed and should have been transmitted. During an interview on 05/02/18 at 12:51 PM the Director of Nursing (DON) stated it was her expectation for MDS assessments to be completed and transmitted within the required time frames.	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 resident	F 641	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance of state and	5/25/18

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F 641	Continued From page 7 (Resident #51) identified as PASRR Level II. Findings included: Resident #51 was admitted to the facility on 09/26/16 with multiple diagnoses that included bipolar disorder and anxiety. Review of the Annual MDS dated 03/12/18 revealed Resident #51 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and formulating a set of recommendations for services to help develop an individual's plan of care. Review of the Skilled Nursing Facility (SNF) Level II authorization dated 03/27/17 for Resident #51 indicated she was approved for a level II PASRR number with no expiration date. During an interview on 05/03/18 at 3:30 PM the MDS Nurse stated she was under the assumption that last year Resident #51 had received a lifetime PASRR that was not considered a Level II. The MDS Nurse reviewed the SNF Level II authorization dated 03/27/17 for Resident #51 and confirmed the approval indicated a Level II PASRR. During an interview on 05/03/18 at 6:09 PM the Admissions Coordinator confirmed the SNF Level II authorization dated 03/27/17 for Resident #51 was the most recent PASRR approval received. During an interview on 05/03/18 at 7:20 PM the	F 641	federal regulations as outlined. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction, and constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. AFFECTED RESIDENT: This deficient practice affected Resident # 51. Resident□s MDS Assessment has been modified on 5/18/18 to accurately code Level II PASARR on the assessment. This corrected MDS assessment was transmitted on 5/21/18. POTENTIALLY AFFECTED RESIDENTS: Residents with Level II PASRR are at risk to be potentially affected by this deficient practice. MDS Coordinators completed audit of residents with Level II PASRR on 5/18/18 to ensure Level II PASARR is accurately coded on resident□s MDS assessment. The root cause analysis revealed inaccurate coding of the Level II PASARR on resident□s MDS assessment was secondary to PASRR documentation was not available in resident□s chart during the period resident MDS Assessment was completed. SYSTEM CHANGE:	

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F 641	Continued From page 8 Administrator stated it was his expectation for MDS assessments to be accurately coded.	F 641	MDS Coordinator and MDS Assessment Nurse were re-educated by Director of Nursing on 5/21/18 on accurate coding of resident MDS assessments. Social Services Coordinator will start coding Level II PASRR on Section A of resident MDS assessment. The list of all current residents with Level II PASRR and the expiration date of the Level II PASARR will be added on the Resident Daily Census Report. Admissions Coordinator will update list when residents are discharged from the facility and when new residents are admitted to the facility with Level II PASRR. This will serve as notification for other members of the Interdisciplinary team (IDT) who may need this information for accurate completion of resident assessments. Admissions Coordinator will also enter the PASRR Level information on resident□s face sheet on admission. Social Services Coordinator will update the resident face sheet when PASRR Level II has been renewed. MONITORING: An audit tool has been developed to monitor compliance with accurate coding of Level II PASARR on resident MDS assessments.	

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F 641	Continued From page 9	F 641	MDS Coordinator and MDS Assessment Nurse will audit resident MDS Assessments for accurate coding of Level II PASARR weekly x 4 weeks, q other week x 2 weeks, then q monthly x 2 months. Ongoing audits will be determined based on results of prior audits. Audit tools will be reviewed weekly by Administrator and/or Director of Nursing and during monthly Quality Assurance and Performance Improvement Committee meeting. The Director of Nursing will be responsible for implementing the acceptable plan of correction as outlined above.	
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 700		5/25/18

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F 700	Continued From page 10 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to assess the need for side rails for 7 of 7 residents reviewed for side rails who were using ¼ side rails (Resident #232, #236, #39, #3, #17, #38, and #51). Findings Included: 1. Resident #232 was admitted to the facility on 04/05/18 with diagnoses that included pneumonia and partial intestinal obstruction. A review of the Admission Minimum Data Set (MDS) dated 04/12/18 revealed Resident #232 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. Bed rails were not coded under Section P0100A. A review of the medical record revealed Resident #232 had no side rail assessment. The following observations were conducted of Resident #232: On 04/30/18 at 11:45 AM Resident #232 was lying in bed and ¼ side rails were up on both sides of the bed. On 05/01/18 at 04:28 PM Resident #232 was resting in bed with eyes closed and ¼ side rails	F 700	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction, and constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. AFFECTED RESIDENTS: Residents # 232, 236, 39, 3, 17, 38, and 51 were affected by this deficient practice. Corrective actions for these residents includes Bed Rail Resident Assessment were completed on 5/2/18. Facility obtained Informed Consent for Bed Rails after providing the resident and responsible party the brochure from U.S. Department of Health and Human Services and Food and Drug Administration Center for Devices and Radiological Health on "A Guide to Bed Safety", and reviewing the risks and benefits of bed rails with resident and responsible party.	

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F 700	Continued From page 11 were up on both sides of the bed. On 05/03/18 at 09:25 AM Resident #232 was sitting up in bed feeding herself breakfast and ¼ side rail were up on both sides of the bed. On 05/02/18 at 3:15 PM an interview was conducted with the Nursing Supervisor (NS) who stated the facility did not conduct side rail assessments on residents. She stated she would speak with the Director of Nursing (DON) because no side rail assessments were conducted. On 5/2/18 at 4:05 PM an interview was conducted with the Administrator and DON who stated they were unaware side rail assessment were required and confirmed no side rail assessments had been completed. On 05/03/18 at 9:26 AM an interview was conducted with Resident #232 who stated she liked to have side rails on the bed because she was able to position herself in the bed by using the side rails. On 05/03/18 at 10:30 AM an interview was conducted with the DON who stated there was no rhyme or reason as why the nurse or nurse aide used side rails for the resident. The DON stated there was no formal guideline, procedure, or assessment for side rail use in the facility. The DON stated some families were old school and wanted side rails used for the resident. The DON stated some residents came to facility from the hospital and wanted to continue the use of side rails. The DON stated some staff used side rails for resident safety and further stated the facility had no formalized assessment developed and implemented for side rail use.	F 700	POTENTIALLY AFFECTED RESIDENTS: All residents have the potential to be affected by this deficient practice. Resident Bed Rail Assessments were completed on all current residents on 5/2/18 and 5/3/18. Informed Consent for Bed Rails were also obtained from residents and/or responsible party. Potential risks and benefits of the use of bed rails were discussed with resident and/or responsible party. CaroMont Regional Medical Center Maintenance Staff completed Bed Rail Audit on 5/18/18. The root cause analysis revealed, the facility failed to develop bed rail risk assessment based on bed rails definition of "adjustable metal or rigid plastic bars that attach to the bed in variable sizes". The facility failed to identify appropriate alternatives for beds that have bed rails of various sizes with bed controls attached to the bed. SYSTEM CHANGE: Staff in-service on appropriate use of bed rails, including alternatives prior to installation of bed rails was initiated on 5/2/18 and completed on 5/6/18. Any staff member on LOA or otherwise out will be educated prior to returning to assignment. Bed Rail Assessment Risk Form has been developed and will be completed on all	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 12 2. Resident #236 was admitted to the facility on 04/11/18 with diagnoses that included cerebral vascular accident and hemiplegia. A review of the Admission Minimum Data Set (MDS) dated 04/11/18 revealed Resident #236 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. Bed rails were not coded under Section P0100A. A review of the medical record revealed Resident #236 had no side rail assessment. An observation was conducted on 04/30/18 at 9:43 AM and revealed Resident #236 was observed lying in bed with the head of bed elevated and ¼ side rails were up on both sides of the bed. On 05/02/18 at 3:15 PM an interview was conducted with the Nursing Supervisor (NS) who stated the facility did not conduct side rail assessments on residents. She stated she would speak with the Director of Nursing (DON) because no side rail assessments were conducted. On 5/2/18 at 4:05 PM an interview was conducted with the Administrator and DON who stated they were unaware side rail assessment were required and confirmed no side rail assessments had been completed. On 05/03/18 at 10:04 AM an interview was conducted with Resident #236 who stated she like having side rails on her bed because they helped her with positioning in the bed.	F 700	new admissions and when residents are readmitted back to the facility. Current residents will also be assessed quarterly or when significant change has been identified, for use of bed rails utilizing the Bed Rail Assessment Risk Form. Individual bed rail evaluations will include data collection analysis and determination of potential alternative bed rail use. When bed rails are deemed necessary and appropriate, the facility will provide education to resident and/or resident□s representative pertaining to the risk and benefits of bed rail use. Informed Consent for Bed Rails Form has also been developed and will be completed and obtained from resident and/or responsible party when appropriate. The brochure A Guide to Bed Safety has been added in the Resident Admission Packet. The facility□'s Bed Rail Policy has been revised and updated. Employees will be provided education on Bed Rail Policy, namely risk identification and prevention of entrapment and other safety risks during orientation and ongoing programs. CaroMont Regional Medical Center Maintenance Staff will conduct inspection of all bed frames and bed rails quarterly as part of a regular maintenance program to identify areas of possible entrapment.	

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F 700	Continued From page 13 On 05/03/18 at 10:30 AM an interview was conducted with the DON who stated there was no rhyme or reason as why the nurse or nurse aide used side rails for the resident. The DON stated there was no formal guideline, procedure, or assessment for side rail use in the facility. The DON stated some families were old school and wanted side rails used for the resident. The DON stated some residents came to facility from the hospital and wanted to continue the use of side rails. The DON stated some staff used side rails for resident safety and stated the facility had no formalized assessment developed and implemented for side rail use. 3. Resident #39 was admitted to the facility 2/13/18 with diagnoses which included dementia with behavioral disturbances, syncope, diabetes and congestive heart failure. A review of the Admission Minimum Data Set dated 02/20/18 noted Resident #39 had severe cognitive impairment and required extensive assistance of staff for bed mobility and transfers. Bed rails were not coded under Section P0100a. A review of the medical record revealed Resident #39 had no side rail assessment. On 05/03/18 at 7:47 AM Resident #39 was observed, in his room, seated on the side of his bed. The bed was against the wall and a 1/4 side rail was observed in the upright position, towards the head of the bed. Resident #39 was observed holding onto the side rail for support while seated at the side of the bed.	F 700	The facility will purchase minimum of 36 new resident beds by 6/30/18. The facility will purchase the remainder 60 resident beds by end of 2019. MONITORING: An audit tool was developed to monitor compliance with completion of Bed Rail Risk Assessment. Assistant Clinical Nurse Managers will audit completion of Bed Rail Risk Assessment Form q week x 4 weeks, q 2 weeks x 2, q month x2 then quarterly x 2. Results of the quarterly inspection by CRMC Maintenance Staff will be discussed in the Safety Committee Meeting and during the Quality Assurance and Performance Improvement Meetings. Ongoing audits will be determined based on results of prior audits. Audit tools will be reviewed weekly by Administrator and/or Director of Nursing and during monthly Quality Assurance and Performance Improvement Committee meeting. The Facility Administrator and Director of Nursing will be responsible for implementing the acceptable POC and outlined above.	

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F 700	Continued From page 14 On 05/02/18 at 4:05 PM an interview was conducted with the Administrator and Director of Nursing and they both stated they were unaware side rail assessments were required and confirmed no side rail assessments had been completed. On 05/03/18 at 2:40 PM the nursing assistant care guide (used to know specific needs of individual residents) was reviewed and included an area under the category equipment to address the need for "side rails". The care guide for Resident #39 was blank beside the area for "side rails." On 05/03/18 at 2:42 PM Nursing Assistant #1 stated she routinely worked on the hall where Resident #39 resided and typically put 1/4 bed rails up on all of the residents to use when she assisted them with repositioning. Nursing Assistant #1 stated she was not aware of any systems in place to let staff know whether or not to use side rails for residents. 4. Resident #3 was admitted to the facility on 05/18/15 with multiple diagnoses that included Alzheimer's disease. A review of the annual Minimum Data Set (MDS) dated 03/20/18 revealed Resident #3 was severely impaired in cognition and required extensive to total staff assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. Bed rails were not coded as being used under Section P0100A. A review of the medical record revealed Resident #3 had no side rail assessment.	F 700		

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F 700	Continued From page 15 An observation on 04/30/18 at 2:50 PM revealed Resident #3 lying in bed with the bed pushed up against the wall and a ¼ side rail up on the opposite side of the bed. Observations of Resident #3's room on 05/01/18 at 3:15 PM and 05/02/18 at 8:45 AM revealed the bed against the wall with a ¼ side rail up on the opposite side of the bed. Resident #3 was unable to be interviewed due to cognition. An interview on 05/02/18 at 3:15 PM with the Nursing Supervisor (NS) revealed the facility did not conduct side rail assessments on residents. She stated she would speak with the Director of Nursing (DON) because no side rail assessments were conducted. An interview on 05/02/18 at 4:05 PM with the Administrator and DON revealed they were unaware side rail assessments were required and confirmed no side rail assessments had been completed. 5. Resident #17 was admitted to the facility on 12/04/15 with multiple diagnoses that included Alzheimer's disease. A review of the quarterly Minimum Data Set (MDS) dated 01/17/18 revealed Resident #17 was severely impaired in cognition and required total staff assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. Bed rails were not coded as being used under Section P0100A.	F 700		

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A review of the medical record revealed Resident #17 had no side rail assessment.

An observation of Resident #17's room on 04/30/18 at 2:50 PM revealed the bed pushed up against the wall with a ¼ side rail up on the opposite side of the bed. Observations of Resident #17's room on 05/01/18 at 2:38 PM and 05/02/18 at 11:01 AM revealed the bed against the wall with a ¼ side rail up on the opposite side of the bed.

Resident #17 was unable to be interviewed due to cognition.

An interview on 05/02/18 at 3:15 PM with the Nursing Supervisor (NS) revealed the facility did not conduct side rail assessments on residents. She stated she would speak with the Director of Nursing (DON) because no side rail assessments were conducted.

An interview on 05/02/18 at 4:05 PM with the Administrator and DON revealed they were unaware side rail assessments were required and confirmed no side rail assessments had been completed.

6. Resident #38 was admitted to the facility on 01/17/14 with multiple diagnoses that included Lewy body dementia, Alzheimer's disease and rheumatoid arthritis.

A review of the quarterly Minimum Data Set (MDS) dated 02/19/18 revealed Resident #38 was severely impaired in cognition and required total staff assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. Bed

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rails were not coded as being used under Section P0100A.

A review of the medical record revealed Resident #38 had no side rail assessment.

An observation of Resident #38's room on 05/01/18 at 12:07 PM revealed the bed pushed up against the wall with a ¼ side rail up on the opposite side of the bed. An observation of Resident #38's room on 05/02/18 at 12:10 PM revealed the bed against the wall with a ¼ side rail up on the opposite side of the bed.

Resident #38 was unable to be interviewed due to cognition.

An interview on 05/02/18 at 3:15 PM with the Nursing Supervisor (NS) revealed the facility did not conduct side rail assessments on residents. She stated she would speak with the Director of Nursing (DON) because no side rail assessments were conducted.

An interview on 05/02/18 at 4:05 PM with the Administrator and DON revealed they were unaware side rail assessments were required and confirmed no side rail assessments had been completed.

7. Resident #51 was admitted to the facility on 09/26/16 with multiple diagnoses that included dementia and arthritis.

A review of the annual Minimum Data Set (MDS) dated 03/12/18 revealed Resident #51 was severely impaired in cognition and required extensive staff assistance with bed mobility,

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F 700	Continued From page 18 transfers, dressing, toileting, and personal hygiene. Bed rails were not coded as being used under Section P0100A. A review of the medical record revealed Resident #51 had no side rail assessment. An observation on 04/30/18 at 2:24 PM revealed Resident #51 lying in bed with the bed pushed up against the wall and a ¼ side rail up on the opposite side of the bed. Observations of Resident #51's room on 05/01/18 at 2:40 PM and 05/02/18 at 10:11 AM revealed the bed against the wall with a ¼ side rail up on the opposite side of the bed. Resident #51 was unable to be interviewed due to cognition. An interview on 05/02/18 at 3:15 PM with the Nursing Supervisor (NS) revealed the facility did not conduct side rail assessments on residents. She stated she would speak with the Director of Nursing (DON) because no side rail assessments were conducted. An interview on 05/02/18 at 4:05 PM with the Administrator and DON revealed they were unaware side rail assessments were required and confirmed no side rail assessments had been completed.	F 700		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.	F 745		5/25/18

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F 745	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on medical record review and interviews the facility failed to obtain a psychiatric referral for 1 of 1 sampled residents reviewed for psychosocial needs. (Resident #39) The findings included: Resident #39 was admitted to the facility 02/13/18 with diagnoses which included dementia with behavioral disturbance and anxiety. Review of the admission Minimum Data Set dated 02/20/18 noted Resident #39 had severe cognitive impairment, behaviors which included verbal behaviors and rejection of care and was taking antipsychotic, anti-anxiety and hypnotic medications. The Care Area Assessment associated with the admission assessment included a review of behaviors and read, He has displayed behaviors as evidenced by yelling out and rejection of care. He has the following diagnoses: hypertension, anxiety, dementia, congestive heart failure, coronary artery disease and diabetes. Anxiety can cause resident to have feelings of apprehension, irritability and restlessness. Dementia can cause resident to have feelings of apprehension, irritability and restlessness. Dementia can cause resident to have mood changes, switching between emotions. Hypertension may attribute to personality changes and irritability. Changes in blood sugar levels can cause significant mood changes. Resident is at risk for further behavioral symptoms. Staff to encourage compliance and appropriate behavior. Staff to offer encouragement and support as needed.	F 745	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction, and constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. AFFECTED RESIDENT: This deficient practice affected Resident #39. Corrective action for this resident includes assessment and evaluation by Psychiatrist on 5/2/18. Psychiatrist will continue to follow resident and provide medically related and necessary intervention to attain or maintain the highest practicable physical, mental and psychosocial well-being. POTENTIALLY AFFECTED RESIDENTS: An audit of all current residents with physician ordered psychiatric services referrals and consult will be completed on or before 5/26/18, to assure all physician ordered psychiatric referrals or consults have been sent and received by the psychiatric provider. The root cause analysis revealed that the Social Services Coordinator failed to send the referral to the provider after physician	

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F 745	Continued From page 20 The admission care plan for Resident #39 dated 03/05/18 included the following problem areas and approaches: -Resident is prescribed a psychotropic medication for treatment of anxiety, insomnia and dementia with behaviors. Approaches to this problem area included, refer to psych services as indicated. -At risk for falls related to new admission, mental status, recent fall, history of previous falls, balance problem while standing and walking and psychoactive medications. After the fifth fall post admission, an approach was written to consult psych physician for behaviors and medication review. Review of physician orders for Resident #39 noted medications administered on a daily basis included Buspar (anti-anxiety) 7.5 milligrams three times a day, Trazadone (anti-depressant) 50 milligrams at bedtime and Zyprexa (anti-psychotic) 2.5 milligrams at bedtime. On 04/13/18 the physician ordered a psychiatric consult related to combative behaviors. Review of physician progress notes included a visit on 4/6/18 noting "patient has been intermittently refusing his medications" and "may need to adjust dosage if patient continues to be uncooperative and refuse medications." Review of the medical record of Resident #39 revealed the following nurses notes: 03/24/18-Patient refused all morning medication. Patient is cursing staff and other residents while in hallway. Increased combative behavior. 03/24/18-Patient refused blood sugar check. Patient states, I don't care if it's 500. 03/24/18-Patient refused 1:00 PM medication 03/28/18-Resident refused shower X 3 per nurse	F 745	order for psychiatric services was written and signed consent was obtained from resident□s responsible party. SYSTEM CHANGE: Administrator will utilize Just Culture and discuss appropriate work performance improvement efforts with Social Services Coordinator assigned to affected resident. Employee will return from FMLA on 6/21/18. A referral log has been developed to document and track psychiatric referrals and consults. Social Services Coordinators will maintain log and keep records of psychiatric referrals and consults. (See Attachment A) Social Services Coordinators and Assistant Clinical Nurse Managers were re-educated on 5/22/18 by Director of Nursing on the process of psychiatric referrals and consults. All other employees involved in the psychiatric referral process who are on LOA or otherwise out will be re-educated prior to returning to work. MONITORING: An audit tool was developed to monitor compliance with psychiatric referrals and consults. Director of Nursing or designee will conduct audits of referrals for completion and appropriate follow-up	

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F 745	Continued From page 21 and nursing assistant on hall. Resident became combative in shower room. 04/12/18-Nurse spoke to Responsible party and agreed for resident to be seen by psychiatrist. On 05/01/18 at 4:20 PM the nursing supervisor (on the unit Resident #39 resided) stated the psychiatrist or psychiatric nurse practitioner was in the facility once a week to assess residents. The nursing supervisor stated if there was a physician's order for a psychiatric referral it had to be communicated to the facility social worker so arrangements could be made for services. The nursing supervisor stated she knew the Responsible Party for Resident #39 signed the consent for psychiatric services but wasn't aware if the social worker had been in contact with the psychiatric services to arrange an assessment for Resident #39. On 05/01/18 at 5:08 PM Social Worker #1 stated she was covering for Social Worker #2 (who managed care for Resident #39) until she returned back to work on 05/03/18. Social Worker #1 stated she knew there had been a period of time when certain insurance coverage (like what Resident #39 had) was not covered for psychiatric service but knew that had changed in April and now psychiatric services would be covered. Social Worker #1 called the psychiatric practitioner's office to see if they had received the referral for services for Resident #39 and they reported they were not aware of the order dated 04/13/18 for a psychiatric consult. Social Worker #1 stated she could not explain what happened. On 05/02/18 at 9:05 AM the psychiatrist reported he was not aware of the 04/13/18 consult for services for Resident #39 until 05/01/18. The	F 745	weekly x (4) weeks, q 2 weeks x 2, then q monthly x 2. Ongoing audits will be determined based on results of prior audits. Audit tools will be reviewed weekly by Administrator and/or Director of Nursing and during monthly Quality Assurance and Performance Improvement Committee meeting. The Director of Nursing will be responsible for implementing the acceptable plan of correction as outlined above.	

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psychiatrist stated he could not explain what happened and was in the building to assess Resident #39.

On 05/02/18 at 10:45 AM the Nurse Practitioner (covering Resident #39) stated she expected physician orders to be followed; including orders for a psychiatric consult.

On 05/02/18 at 1:00 PM the Director of Nursing stated she expected physician orders to be followed and was not aware the 04/13/18 order for a psychiatric consult had not been communicated to the office of the psychiatrist.

On 05/03/18 at 2:00 PM Social Worker #2 stated she was dependent on nurses to provide her with orders for a psychiatric consult. Social Worker #2 stated the psychiatrist was not informed of the consult because she did not know about it and noted she could not explain what happened.

On 05/03/18 at 7:00 PM the Administrator stated there had been insurance coverage issues up until April but that had been resolved and psychiatric services should have been provided when ordered by the physician. The Administrator stated he could not explain what happened.