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	345006	A. BUILDING _____ B. WING _____	C 07/17/2018

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BLUMENTHAL NURSING & REHABILITATION CENTER	**3724 WIRELESS DRIVE GREENSBORO, NC 27455**

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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		8/13/18

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

Electronically Signed | 08/06/2018

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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 review, observation and staff interview, the facility failed to develop a comprehensive measurable care plan for Resident #7 that addressed a right-hand contracture in 1 of 2 residents reviewed for contractures. Findings included: Resident #7 was admitted to the facility on 9/8/17 with numerous diagnoses which included dementia, coronary artery disease and contracture of the right hand. Review of the annual Minimum Data Set (MDS) assessment dated 5/16/18 coded the Brief Interview for Mental Status (BIMS) a score of 3 (represented severe cognitive impairment) with range of motion limitation on one side of the upper extremity. Under Section (O) the MDS coded the number of days Resident #7 received passive range of motion and splint assistance was zero (O). Review of the Care Area Assessment (CAA) summary revealed Resident #7 had a right-hand contracture and the facility would proceed with developing a care plan to monitor skin integrity. Review of the care plan dated 5/23/18 revealed no written care plan to address the resident's right hand contracture. Interview on 7/16/18 at 4:20 PM with MDS coordinator #2 who stated the facility currently	F 656	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F656 ROOT CAUSE The alleged noncompliance resulted from, the facility failed to develop a comprehensive measurable for resident #7 that addressed a right hand contracture. MDS coordinator #2 indicated during an interview on 7/17/2018 that it was an oversight on her part. IMMEDIATE ACTION On 7/17/2017 comprehensive care plan for right hand contracture was developed for resident #7 by MDS Coordinator #2 IDENTIFICATION OF OTHERS On 7/18/18 MDS coordinator #1, MDS coordinator #2 and/or MDS coordinator #3 completed an audit of 100 percent of current residents in the facility to identify any other resident with a contracture without a comprehensive care plan in place. Six other residents were identified	

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F 656	Continued From page 2 does not have a restorative program and the care plan was not the best to meet the individual needs regarding splints or contracture. A second interview on 7/17/18 at 9:50 AM with MDS coordinator #2 who stated it was it oversight and a mistake for failure to develop a care plan to address the right-hand contracture. Interview on 7/17/18 at 11:48 AM with the Staff Development Coordinator who stated a care plan should have been written to address the resident's right hand contracture. Interview on 7/17/18 at 12 noon with the Administrator and the Regional Clinical Director was held. The administrator stated she expected a care plan to be developed but the facility had not.	F 656	with contractures without care plan in place. On 7/18/2018 comprehensive care plan was developed for each of the six identified residents and filled in individual resident's medical records. Findings of this audit was documented on contracture audit tool maintained in the facility compliance binder. SYSTEMIC CHANGES Effective 8/13/2018, MDS coordinator #1, MDS coordinator #2 and/or MDS coordinator #3 who complete MDS 3.0 assessment for any active resident in the facility is required to assess resident's extremities (both arms & both legs) to determine if a resident has any contracture. MDS coordinator #1, MDS coordinator #2 and/or MDS coordinator #3 will then develop a comprehensive person-centered care plan with measurable objectives and timeline that address identified contracture(s). On 8/6/2018 Regional reimbursement consultant from the management and consulting company that oversee the facility re-educated MDS coordinator #1, MDS coordinator #2, MDS coordinator #3, Director of Social services #1 &#2, Activity Director and Dietary Manager. This education emphasized on the importance of developing care plan that reflect resident's medical and clinical condition as indicated on the Care Area Assessment (CAA). Effective 8/13/2018; this education is added to new hires orientation education for MDS nurses, Director of Social Services, Activities Director, and Dietary Manager (DM) and	

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F 656	Continued From page 3	F 656	will be provided annually. MONITORING PROCESS Effective 8/13/2018, MDS Coordinator #1 will review section V of MDS 3.0 completed by the MDS coordinator #2 or MDS coordinator #3 or vice versa to ensure that any triggered Care area Assessment to include Contracture Care Area (CA) has a care plan developed or rationale indicated of the reason of otherwise if the care plan is not developed. . Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a “Care plan development monitoring tool” and filed in the facility compliance binder after proper follow up is done. This monitoring process will take place daily (Monday to Friday) for two weeks, weekly x 2 more weeks, then monthly x 3 months for the completed assessments or until the pattern of compliance is maintained. Effective 8/13/2018, MDS coordinator #1, MDS coordinator #2 and/or MDS coordinator #3 will monitor compliance by reviewing all new contractures in the daily clinical stand up meeting to ensure any new identified contracture has a developed person-centered care plan with measurable objectives and timelines. Any contracture identified without a care plan will be addressed promptly. Findings from this monitoring process will be documented on a “Stand up meeting form” and filed in the facility compliance binder after proper follow up is done. This monitoring process will take place daily	

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F 656	Continued From page 4	F 656	(Monday to Friday) for two weeks, weekly x 2 more weeks, then monthly x 3 months, or until the pattern of compliance is maintained. Effective 8/13/2018, MDS coordinator #1, MDS coordinator #2 and/or MDS coordinator #3 will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 8/13/2018, the center Executive Director and the Director of Nursing and MDS coordinators (#1, #2, & #3) will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance date 8/13/2018	
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	F 677		8/13/18

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F 677	Continued From page 5 by: Based on observation, record review and staff interview the facility failed to cut the fingernails on Resident #2 who was dependent on staff for care. This was evident in 1 of 1 resident reviewed for activities of daily living (ADL). Findings included: Resident #7 was admitted to the facility on 9/8/17 with numerous diagnoses which included dementia, coronary artery disease and contracture of the right hand. Review of the annual Minimum Data Set (MDS) assessment dated 5/16/18 coded the Brief Interview for Mental Status (BIMS) with a score of 3 (which represented severe cognitive impairment). Under Section (G) the MDS coded extensive assistance of one staff for personal hygiene and extensive assistance of 2 staff for bathing. Review of the care plan dated 5/23/18 revealed a problem for Resident #7 which required assistance of ADL related to decreased mobility. The goal was to have Resident #7's needs met daily. The approaches included the assistance of staff for bathing, grooming and other ADLS. Observation on 7/16/17 at 11:05 AM revealed Resident #7's fingernails on his left hand were long, jagged and extended approximately 1/16 inches from his fingertips. Observation on 7/16/18 at 11:45 AM revealed Resident #7's fingernails on his left hand remained unchanged. Interview on 7/16/18 at 12 noon with the Treatment Nurse who stated Resident #7 scratches himself and picks at his skin. The Treatment Nurse stated Resident #7 will get skin tears when he scratches himself. Observation	F 677	F677 ROOT CAUSE Director of Nursing, and the facility Executive Director discussed on 8/06/18 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged non-compliance resulted from failure by an employee to provide nail care to 1 of 1 identified residents; resident #7. Resident #7 is dependent on staff to carry out the activities of Daily living, specifically nail care. The root cause analysis added that the alleged noncompliance was caused by the employees' culture within the facility that include, but not limited to, lack of residents' centered care delivery culture, lack of good customer service, and lack of consistent staffing who provide care for residents in the facility to assure care is delivered to residents in the facility at all times. IMMEDIATE ACTION On 07/17/2018, Unit Coordinator #1 provided nail care by trimming and filling resident's #7 nails. IDENTIFICATION OF OTHERS 100% audit of all current residents in the facility was completed by the Unit Coordinator #1, #2 and #3. Director of Nursing, Assistant Director of Nursing, and/or Unit Manager on 8/02/18 & 8/03/18 to identify any other resident with any ADL care needs to include nails care. Two	

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F 677	Continued From page 6 now revealed Resident #7's fingernails on his left hand remained long. Observation on 7/16/18 at 3 PM revealed Resident #7's fingernails on his left hand remained long. Observation on 7/16/18 at 3:43 PM revealed Resident #7's fingernails on his left hand remained long. Observation on 7/17/18 at 9:45 AM revealed Resident #7's fingernails on his left hand remained long. Interview on 7/17/18 at 10:50 AM with Nursing Assistant (NA) #3 revealed tried in the past to cut his fingernails but they were too hard to cut and told Nurse #1. On 7/17/18 Nurse #1 could not be interviewed. Interview on 7/17/18 at 12 noon with the Administrator and the Regional Clinical Director was held. The Administrator stated she expected finger nails to be cut as needed.	F 677	other residents were identified with need for nail care. Nail care for identified residents provided by Unit Coordinator #2 and Unit Coordinator #3 on 8/3/2018. Findings of this audit is documented on the “ADL care audit tool” maintained in the facility compliance binder. SYSTEMATIC CHANGES Effective 8/13/18; all residents will receive the necessary services and care to maintain good grooming that includes, but not limited to, nail care during daily ADL care. The ADL care to include nail care will be provided by certified nursing assistance with an oversite of the licensed nurses, based on each resident’s plan of care, effective 8/13/18. Effective 8/13/2018, facility will establish consistent assignment for licensed nurses and nursing aides. This will aide on improving residents’ centered care delivery and customer centered approach. Staff members will be familiar with the residents under their care as the result each resident needs will be anticipated to include ADLs care specifically nail care. Effective 8/13/18 the facility will conduct an interdisciplinary monthly team building meeting that with include the department supervisors to discuss culture change initiatives to be implemented in the facility. These meetings will be held without affecting resident care activities. These meetings are intended to improve employee culture in the facility and hence improve quality of care to all our residents. On 8/06/2018; Chief Clinical officer from the consulting and Management Company contracted by the facility revised	

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F 677	Continued From page 7	F 677	a “bath/shower form” to include area for documentation for nail care. Facility nursing staff will utilize the revised shower sheet effective 8/13/2018. Effective 8/13/2018; certified nursing aide on duty will notify a licensed nurse on duty of any refusal of care specifically related to nail care promptly when it occurs. Licensed nurse will discuss with the resident to validate the refusal and document actions taken as appropriate. Completed bath/shower forms will be maintained in the residents’ shower books maintained at each nursing station effective 8/13/2018. Director of Nursing, Assistant Director of Nursing and/or Staff development coordinator will complete 100% re-education to all current nursing staff, to include full time, part time and as needed nursing staffs. This education will provide an emphasis on the importance to providing ADLs care for dependent residents. Nursing staff were also re-educated on how to access each resident plan of care to determine the assistance/services needed for ADL’s. Nurses on duty were re-educated to follow up with residents on shower days to make sure that nail care was provided. This education will be completed by 08/13/2018, any nursing staff not educated by 08/13/2018 will not be allowed to work until educated. This education will also be added to new hire process for all new nursing employees effective 08/13/2018 and will be provided annually. MONITORING PROCESS:	

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F 677	Continued From page 8	F 677	Effective 08/13/2018, the Director of Nursing, Assistant Director of Nursing and/or Unit Coordinator #1, #2, and/or #3 will complete the random audit of ten residents to ensure nail care is provided. Any negative finding will be corrected promptly. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on an “ADL care monitoring tool “and filed in the facility compliance binder after proper follow up is done. This monitoring process will take place daily (Monday through Friday) for two weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 8/13/2018, Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 8/13/2018, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial	

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F 677	Continued From page 9	F 677	compliance. Compliance date 8/13/2018	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to conduct ongoing assessments for Resident #5's pressure ulcer on the left thumb. This was evident in 1 of 3 residents reviewed for pressure sores. Findings included: Resident #5 was readmitted to the facility on 9/18/13 with cumulative diagnoses which included vascular dementia with dysphagia. Review of the wound assessment report revealed on 3/5/18 an unstagable left thumb pressure ulcer was identified. Continued record review revealed an ulcer wound assessment was completed on 4/10/18. Further review of the pressure ulcer assessment revealed there were no follow-up	F 686	F686 ROOT CAUSE Director of Nursing, and the facility Executive Director discussed on 8/06/18 to identify the root cause of this alleged noncompliance for resident #5. Root-cause analysis conducted revealed, the alleged non-compliance resulted from failure by the facility to maintain a sustainable systemic process that assure an ongoing assessment for residents with pressure ulcers. The root cause analysis added that the alleged noncompliance was also caused by the employees' culture within the facility that include, but not limited to, lack of residents' centered	8/13/18

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F 686	Continued From page 10 assessments until 4/26/18 (16 days later) when the Nurse Practitioner's progress notes indicated "left thumb pressure injury with yellow slough that measured 3 centimeters (cm) in length (L) X 2.1 cm in width (W) and depth (D) was undetermined due to yellow slough in wound bed. Continued record review revealed a wound assessment on 4/28/18. On 5/17/18 an assessment was completed 21 days from 4/26/18 and 19 days from 4/28/18. Record review revealed on 6/9/18 another wound assessment was completed which was 23 days from 5/17/18. Observation of the wound care on 7/16/18 at 12:35 PM performed by the Treatment Nurse and assisted by Nursing Assistant #4 revealed the wound measured 0.5 cm L X 1.0 cm W X 0.1 cm D. The previous Treatment Nurse was not available for interview during the survey. Interview on 7/17/18 at 9:41 AM with the current Treatment Nurse stated this was a recent position for her within the last month and was not sure about the missing wound assessments. Interview on 7/17/18 at 12 noon with the Administrator and the Regional Clinical Director was held. The Administrator stated she expected the facility staff to conduct weekly assessments and measurements of pressure ulcer.	F 686	care delivery culture, lack of good customer service, and lack of consistent staffing who provide care for residents in the facility to assure residents with pressure ulcers receive necessary services to include ongoing assessments and appropriate intervention. IMMEDIATE ACTION On 7/20/2018 the wound care assessment of Resident #5 pressure ulcer was completed by the facility wound care nurse. No deterioration of pressure ulcer noted. IDENTIFICATION OF OTHERS 100% skin audit of all current residents with pressure ulcers completed on 8/5/2018 and 8/6/2018 in facility by Unit Coordinator #1, Unit Coordinator #2, Unit Coordinator #3 and/or Wound care nurse to identify any other resident with pressure ulcer without ongoing assessment. No other residents were identified with pressure ulcers without ongoing assessment. Findings of this audit is documented in “pressure ulcer audit tool” maintained in the facility compliance binder. SYSTEMIC CHANGES Effective 8/13/2018; the facility has secured a contract with a licensed wound care company to provide necessary wound care related services for our residents on site in the facility. This group will visit the facility weekly and conduct ongoing assessment in conjunction with the facility assessments effective 8/13/18. Effective 8/13/2018; the facility will utilize	

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F 686	Continued From page 11	F 686	skin assessment schedule re-implemented to be used starting 8/13/2018;, the skin assessment schedule revised by the Chief Clinical Officer on 8/6/2018. Resident's weekly skin assessments schedule shown resident's assessment due between days of Sunday and Thursday, every week. This will allow monitoring of completion of scheduled assessments by members of nursing administration between week days Monday through Friday. Effective 8/13/2017, the Director of Nursing appointed a Unit Coordinator #1 to oversee the wound program in the facility to ensure ongoing assessments take place at all times. 100% in service education will be completed by the Director of Nursing, Assistant Director of nursing and/or Staff Development Coordinator to all licensed nurses by 8/13/2018, among the topics was the emphasis on completing weekly skin assessments per schedule, and ongoing assessment of residents with pressure ulcers. Any Licensed nursing staff not educated by 8/13/2016 will not be allowed to work until educated. This education will also be added to new hire process for all new licensed nurses effective 8/13/18 and also will be provided annually. MONITORING PROCESS Effective 8/13/2018, Director Of Nursing, Assistant Director Of Nursing and/or Unit coordinators (#1, #2, and #3) will review the completion of the prior day weekly skin assessment on daily clinical meeting to ensure its completion and proper follow	

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F 686	Continued From page 12	F 686	through. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a “Skin Assessment monitoring tool “and filed in the facility compliance binder after proper follow up is done. This monitoring process will take place daily (Monday through Friday) for two weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 8/13/2018, Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 8/13/2018, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance date 8/13/2018	
F 688	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		8/13/18

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F 688	Continued From page 13 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to apply a soft splint device or rolled gauze as recommended by the occupational therapist. This was evident in 1 of 2 residents reviewed with contractures. (Resident #7) Findings included: Resident #7 was admitted to the facility on 9/8/17 with numerous diagnoses which included dementia, coronary artery disease and contracture of the right hand. Review of the occupational therapy plan of care from 5/3/18 to the end of service on 5/16/18 revealed the right hand was initially fisted with fingers contracted. A palm guard orthosis (splint)was tried and discontinued during therapy course due to developing a skin tear. A gauze	F 688	F688 ROOT CAUSE Director of Nursing, and the facility Executive Director discussed on 8/06/18 to identify the root cause of this alleged noncompliance for resident #7. The alleged noncompliance resulted from the facility failure to apply a soft splint device or rolled gauze as recommended by the Occupational Therapist on Resident #7. Root-cause analysis conducted revealed, the alleged non-compliance resulted from communication failure between therapy department and nursing department. IMMEDIATE ACTION On 7/17/2018, Rolled gauze was applied to palm of Resident #7 by the facility	

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F 688	Continued From page 14 hand roll was to be used. Further record review revealed education to nursing staff was provided on 5/16/18 to allow for a smooth transition from therapy to nursing. Review of the annual Minimum Data Set (MDS) assessment dated 5/16/18 coded the Brief Interview for Mental Status (BIMS) with a score of 3 (represented severe cognitive impairment) with range of motion limitation on one side of the upper extremity. Under Section (O) the MDS coded the number of days resident received passive range of motion and splint assistance was zero (O). Review of the Care Area Assessment (CAA) summary revealed Resident #7 had a right-hand contracture and the facility would proceed with developing a care plan to monitor skin integrity. Review of the care plan dated 5/23/18 revealed no care plan to address the resident's right hand contracture. Interview on 7/16/18 at 10:52 AM with Certified Medication Aide #1 stated the facility did not have a restorative program but was told by the administrator this program would be restarted. Interview on 7/16/17 at 11:05 AM with Nurse #1 revealed previously Resident #7 had a splint that went in between his fingers and developed a wound and needed a softer splin. Nurse #1 was not sure why the gauze was not in his right hand. Observation at the time of the interview indicated there was no soft splint device nor roll gauze applied to the right hand. Observation on 7/16/18 at 11:45 AM revealed no soft splint device nor roll gauze was applied to the right hand. Observation on 7/16/18 at 3:00 PM revealed no soft splint device nor roll gauze was applied to the right hand.	F 688	designated licensed nurse. IDENTIFICATION OF OTHERS On 8/06/18, Director of Rehabilitation Services, Director of Nursing and/or Unit Coordinators (#1, #2, #3) completed 100% audit of current residents in the facility to identify any other resident with a contracture without proper intervention in place such as range of motion exercise or splint or brace device in place. No other resident identified without proper intervention in place. Findings of this audit was documented on contracture audit tool maintained in the facility compliance binder. SYSTEMIC CHANGES Effective 8/13/2018; the resident with devices necessary to manage contracture will be applied by a Restorative aide or nursing assistant on duty per resident's individual care plan. Effective 8/13/2017, the Director of Nursing appointed a Unit Coordinator #1 to oversee the restorative and contracture management program in the facility to ensure proper coordination and communication between therapy department and nursing department. Unit Coordinator #1 will ensure that any resident with ordered splint is transcribed and communicated to nursing team timely. 100% in service education will be completed by the Director of Nursing, Director of Rehabilitation services, Assistant Director of nursing and/or Staff Development Coordinator to all nursing staff and rehabilitation department by 8/13/2018, among the topics was the	

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F 688	Continued From page 15 Observation on 7/16/18 at 3:43 PM revealed no soft splint device nor roll gauze was applied to the right hand. Observation on 7/17/18 at 9:45 AM revealed no soft splint device nor roll gauze was applied to the right hand. Interview on 7/17/18 at 11:48 AM with the Staff Development Coordinator stated nursing staff was expected to place a roll gauze into Resident #7 contracted right hand. Interview on 7/16/18 at 5:30 PM with the Administrator revealed she was unable to locate additional information to clarify and validate Resident #7 had a splint device or rolled gauze was applied as recommended by the Occupational Therapist (OT). Interview on 7/16/18 at 5:36 PM with the Regional Clinical Director (RCD) stated he was unable to locate additional information to clarify that Resident #7 had a splint device or rolled gauze applied as recommended by OT. Interview on 7/17/18 at 12 noon with the Administrator and RCD was held. The administrator stated she expected the rolled gauze to be placed in the resident's contracted right hand.	F 688	emphasis on contracture management, communication between therapy and nursing and the role of the Unit Coordinator #1, to ensure each resident's intervention related to contracture is implemented appropriately. Any nursing staff and/or therapy staff not educated by 8/13/2016 will not be allowed to work until educated. This education will also be added to new hire process for all new nursing staff & therapy staff effective 8/13/18 and also will be provided annually. MONITORING PROCESS The Director of Nursing and Unit Coordinators will monitor compliance by reviewing all residents with splints to ensure they are properly applied per resident's plan of care. This monitoring process will take place daily for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Any negative finding identified will be addressed promptly. This audit will be reviewed and documented in clinical stand up meeting. The Director of Nursing Services will report the finding to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY Effective 8/13/2018, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure	

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F 688	Continued From page 16	F 688	implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance date 8/13/2018	
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. §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 interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the annual recertification and complaint survey of 3/15/2018. This was for one (1) recited deficiency which was originally cited during the annual recertification and complaint of 3/15/2018,	F 865	ROOT CAUSE Repeated citation caused by the facility failure to follow through with plan of action set forth on the previous surveys. The alleged noncompliance resulted from, the facility failed to develop a comprehensive measurable for resident #7 that addressed a right hand contracture. MDS coordinator #2 indicated during an	8/13/18

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F 865	Continued From page 17 were subsequently cited again during the complaint survey of 7/17/2018. The repeat deficiency was F656 (develop care plans). The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance program. Findings included: This tag is cross referred to: F656 Based on record review, observation and staff interview, the facility failed to develop a comprehensive measurable care plan for Resident #7 that addressed a right-hand contracture in 1 of 2 residents reviewed for contractures. During the recertification and complaint survey dated 3/15/2018 the facility was cited for F656, the facility failed to develop a resident centered care plan that identified the primary language for Resident #112 was Spanish. This was evident for 1 of 1 resident that was reviewed for communication. During an interview with the Administrator on 7/17/2018 at 1:15pm who stated an expectation that the facility complies with the regulation as it related to Quality Assurance Performance Improvement (QAPI), that the facility does not get repeated tags, identify issues and monitor the issues until compliant with the regulation.	F 865	interview on 7/17/2018 that it was an oversight on her part. IMMEDIATE ACTION On 7/17/2017 comprehensive care plan for right hand contracture was developed for resident #7 by MDS Coordinator #2 IDENTIFICATION OF OTHERS On 7/18/18 MDS coordinator #1, MDS coordinator #2 and/or MDS coordinator #3 completed an audit of 100 percent of current residents in the facility to identify any other resident with a contracture without a comprehensive care plan in place. Six other residents were identified with contractures without care plan in place. On 7/18/2018 comprehensive care plan was developed for each of the six identified residents and filled in individual resident's medical records. Findings of this audit was documented on contracture audit tool maintained in the facility compliance binder. SYSTEMIC CHANGES On 8/13/2018, Chief Clinical Officer completed re-training with the facility Administrator and the Director of Nursing, regarding the quality assurance performance improvement program (QAPI) process. This education will include how to identify quality deficiencies as well as ways to establish a system that will ensure consistent and measurable outcomes. The education will also cover methods on how to track and trend data, as well as best practices on root cause analysis.	

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F 865	Continued From page 18	F 865	Effective 08/13/2018, this plan of correction will be incorporated and discussed in the QAPI committees meeting by the Executive Director monthly until the next annual inspection. Any repeated citation in the following year will necessitate modification of this plan and extension of discussion during monthly QAPI meetings. F656: Effective 8/13/2018, MDS coordinator #1, MDS coordinator #2 and/or MDS coordinator #3 who complete MDS 3.0 assessment for any active resident in the facility is required to assess resident's extremities (both arms & both legs) to determine if a resident has any contracture. MDS coordinator #1, MDS coordinator #2 and/or MDS coordinator #3 will then develop a comprehensive person-centered care plan with measurable objectives and timeline that address identified contracture(s). On 8/6/2018 Regional reimbursement consultant from the management and consulting company that oversee the facility re-educated MDS coordinator #1, MDS coordinator #2, MDS coordinator #3, Director of Social services #1 &#2, Activity Director and Dietary Manager. This education emphasized on the importance of developing care plan that reflect resident's medical and clinical condition as indicated on the Care Area Assessment (CAA). Effective 8/13/2018; this education is added to new hires orientation education for MDS nurses,	

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F 865	Continued From page 19	F 865	Director of Social Services, Activities Director, and Dietary Manager (DM) and will be provided annually. MONITORING PROCESS Effective 8/13/2018 the facility will conduct a directed performance improvement plan overseen by the Contracted and management company, to ensure the facility systematically creates sustainable systemic process to avoid repeat regulatory deficiencies. This will be accomplished through monthly visit by the member of the management and consulting company for 3 months or until the pattern of compliance is maintained. F656: Effective 8/13/2018, MDS Coordinator #1 will review section V of MDS 3.0 completed by the MDS coordinator #2 or MDS coordinator #3 or vice versa to ensure that any triggered Care area Assessment to include Contracture Care Area (CA) has a care plan developed or rationale indicated of the reason of otherwise if the care plan is not developed. . Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a “Care plan development monitoring tool” and filed in the facility compliance binder after proper follow up is done. This monitoring process will take place daily (Monday to Friday) for two weeks, weekly x 2 more weeks, then monthly x 3 months for the completed assessments or until the pattern of compliance is maintained.	

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F 865	Continued From page 20	F 865	Effective 8/13/2018, MDS coordinator #1, MDS coordinator #2 and/or MDS coordinator #3 will monitor compliance by reviewing all new contractures in the daily clinical stand up meeting to ensure any new identified contracture has a developed person-centered care plan with measurable objectives and timelines. Any contracture identified without a care plan will be addressed promptly. Findings from this monitoring process will be documented on a “Stand up meeting form” and filed in the facility compliance binder after proper follow up is done. This monitoring process will take place daily (Monday to Friday) for two weeks, weekly x 2 more weeks, then monthly x 3 months, or until the pattern of compliance is maintained. Effective 8/13/2018, MDS coordinator #1, MDS coordinator #2 and/or MDS coordinator #3 will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 8/13/2018, the center Executive Director and the Director of Nursing and MDS coordinators (#1, #2, & #3) will be ultimately responsible to ensure	

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F 865	Continued From page 21	F 865	implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance date 8/13/2018	