45 day 90th day
12-2-17 12-31-17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/30/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED
Part 1	445410		10/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD MANOR	405 TIMES AVE LAFAYETTE, TN 37083

(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 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Austin
TITLE: Administrator
(X6) DATE: 11-9-17

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 225	Continued From page 1 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, interview, and observation, the facility failed to thoroughly investigate an allegation of verbal abuse for 1 resident (#45), and injury of unknown origin for 1 resident (#8) of 22 residents reviewed. The findings included: Review of facility policy, Abuse Policy, undated revealed "...The Administrator...shall conduct an investigation of any alleged abuse...All alleged violations...shall be reported to the state agency...Any...complaint...will be channeled	F 225		

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F 225	Continued From page 2 through the appropriate chain of command. The Administrator is designated as the person responsible for handling of complaints..." Medical record review revealed Resident #45 was admitted to the facility on 4/5/17 and readmitted on 6/12/17 with diagnoses including Cerebrovascular Disease, Repeated Falls, Osteoarthritis, and Pain. Medical record review of the Quarterly Minimum Data Set dated 9/18/17 revealed Resident #45 had a Brief Interview for Mental Status score of 13, indicating the resident was cognitively intact; the resident had no mood or behavior problems, and required extensive assistance of 2 persons for transfers and toileting. Interview and observation with Resident #45 on 10/17/17 at 9:23 AM in the resident's room revealed 3 "techs" (Certified Nursing Aides) (CNA) were "hateful" to the resident. Continued interview revealed the 3 techs talked "hatefully" to the resident when the resident requested assistance to the bathroom. Further interview revealed during the most recent event, Resident #45 turned on the call light to request assistance to the bathroom. When the tech responded, the resident had an incontinent episode. The tech told the resident, the resident needed to get up and go to the bathroom and stop being lazy. The resident informed the tech she was having pain in her leg making it difficult for her to get up. The tech responded "...the reason your leg is hurting is because you are lazy and won't get out of bed..." Continued interview revealed the resident could not recall the date or names of the CNAs however she pointed to an individual stating "there goes one of them right there." Observation	F 225	The Administrator will investigate and report any incidents of alleged or suspected abuse of any kind. Any incidents of alleged or suspected abuse of any kind will be thoroughly investigated for verbal, physical, sexual, neglect, or any form of abuse to determine if abuse did actually occur and to determine the outcome of the incident. All staff will be educated and inserviced regarding the need to report any instances of alleged or suspected abuse of any kind, and the results of any actual incidents of abuse. Any suspected incidents should be immediately reported to their supervisor and/or the Administrator. The Administrator will be responsible to ensure that all incidents of alleged or suspected abuse are thoroughly investigated and reported as such. In addition, the Quality Assurance Committee will review and monitor any incidents of alleged or suspected abuse.	12-2-17

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F 225	Continued From page 3 revealed CNA #1 had entered the room. Continued interview revealed the incidents caused Resident #45 to feel "sad." Interview with the Administrator on 10/17/17 at 9:23 AM in her office revealed the Administrator was aware of Resident #45's complaint. Continued interview revealed the Administrator was familiar with one event which occurred on 9/29/17 involving CNA #1, CNA #2, and Resident #45. Further interview revealed the Administrator was not aware of incidents between Resident #45 and a third unnamed CNA. Interview revealed Resident #45 had not talked with the Administrator about the complaint however the Administrator was made aware of the situation by a "nurse working the floor" at the time of the incident. Continued interview revealed the incident occurred when Resident #45 did not want to get up and the identified staff member was "encouraging" the resident to get up. The staff member called the resident "lazy" and the nurse on duty heard it. Interview revealed the Administrator stated she was unsure if the CNA actually called Resident #45 lazy to her face however the word lazy was used when the CNA relayed the incident to the nurse. Review of a Witness statement dated 9/29/17 and signed by Registered Nurse (RN) #1 revealed "Call light activated. Requests assistance with transfer from bed to chair...Resident previously refused assisted [assistance] from [CNA #1] ...the resident stated 'I don't like her. I don't want her in my room. She talks to me like a dog and wants me to do what she wants when she wants. I can't help I'm the way I am...This nurse notified [CNA #1] re: [regarding] resident comment. CNA responded	F 225		

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F 225	Continued From page 4 'Yeah, she's mad at me because I told her she can't be lazy. I tell her she has to get up to go to the bathroom'..." Interview with RN #1 on 10/17/17 at 3:00 PM at the old hall nurse's station confirmed the witness statement was correct. Interview with CNA #1 on 10/18/17 at 9:00 AM in the TV room revealed the CNA was familiar with Resident #45. Continued interview revealed the CNA recalled an incident involving Resident #45 in which the resident had "wet herself." Continued interview revealed the resident was "upset" with the CNA however the CNA stated she did not know why the resident was upset with her. Further interview revealed the CNA "encouraged" the resident to get up to go to the bathroom and the resident made the comment "I'm not lazy." Observation on 10/18/17 at 9:30 AM in the hallway entrance revealed mandatory reporting of abuse information was posted and accessible. Interview with the Director of Nursing (DON) on 10/18/17 at 10:00 AM and 1:40 PM in the DON's office revealed the DON was familiar with the incident and stated it occurred on 9/29/17. Continued interview revealed the DON did not witness the event but was told about it on 10/6/17. Further interview revealed the Administrator knew about the situation the week before 10/6/17. Interview with the DON revealed she met with CNA #1 on 10/9/17 however, the DON had no documentation of said meeting. Continued interview revealed when asked to define abuse the DON responded "yelling, talking hateful to a resident." Further interview revealed the DON did not know how to determine whether	F 225		

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F 225	Continued From page 5 or not verbal abuse had occurred in the situation. Continued interview revealed when asked what incidents should be reported the DON responded "I don't think I can answer that." Interview revealed the DON failed to investigate the allegation of abuse. Interview with the Administrator on 10/18/17 at 1:50 PM in the Administrator's office revealed the Administrator expected staff to report incidents of abuse to her. Continued interview revealed the expectation was to investigate and report to the state agency complaints of abuse. Continued interview revealed the Administrator was unable to produce evidence she talked with Resident #45 or the accused CNA regarding the incident. Interview confirmed the facility failed to thoroughly investigate and report an allegation of verbal abuse. Medical record review revealed Resident #8 was admitted to the facility on 8/24/17 with diagnoses including Atrial Fibrillation, Hypertension, Vascular Dementia with Behavioral Disturbances, Chronic Embolism and Thrombosis, Diabetes Mellitus Type 2, Foot Ulcer, History Bone Cancer Left Arm, Traumatic Subdural Hemorrhage, Edema, Depression, Pain, and Hemiplegia following Cerebral Infarction affecting Right Dominant Side. Medical record review of A Physician Telephone Order dated 9/21/17 revealed "...apply proactive island drsg [dressing] to L [Left] inner heel r/t [related to] popped blister. Cleanse [with] NS [Normal Saline], pat dry, apply skin prep peri-wound + [and] apply drsg. Change q [every] 3 days + PRN [as needed] until healed..." Medical record review of the Wound/Skin Report	F 225		

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F 225	Continued From page 6 form dated 9/27/17 revealed the "...Date of Onset 9/21/17...Site/Location...Left Heel blister DTI [Deep Tissue Injury]..." Continued review of the form revealed on 9/27/17 the Left Heel was "...Stage...Unstagable...Size in centimeters...4 x (by) 4 x 0..." Further review revealed no evaluation of the Left Heel site on 9/21/17, the date of onset. Interview with the Assistant Director of Nursing (ADON) on 10/18/17 at 8:30 AM in the lobby area revealed CNA #3 documented "...big blister..." on 9/20/17 at 12:50 AM on the CNA Skin Check Detail Report in the kiosk (computer). Continued interview revealed Licensed Practical Nurse (LPN) #3 was informed of the blister by CNA #3 and the LPN obtained a Physician Order to provide treatment on 9/21/17 at 6:00 AM. Continued interview confirmed the LPN failed to complete and document a wound assessment. Interview confirmed the ADON was not aware of the wound until 9/27/17 when she assessed it. Telephone interview with LPN #3 on 10/18/17 at 8:50 AM confirmed CNA #3 reported the blister to the LPN. Continued interview revealed the LPN assessed the wound site and informed the ADON to look at the blister. Further interview revealed the LPN was not sure how the blister developed. Interview confirmed the LPN thought she had written a nursing note about the blister. When informed there was no nursing note or skin assessment addressing the blister the LPN confirmed "...should have done a nursing note..." Interview with CNA #3 on 10/18/17 at 10:50 AM at the Corner Hall desk confirmed the CNA "...when helping resident to the bedside commode...saw resident's side of foot and asked to see foot then	F 225		

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F 225	Continued From page 7 saw blister..." Continued interview revealed the CNA saw "...blister was there and was real warm so I wrote it up in the kiosk [CNA Skin Check Detail Report] and then went to tell LPN #3..." Further interview revealed the CNA and LPN #3 went into Resident #8's room and the LPN looked at the resident's foot..." Interview with the DON on 10/18/17 at 11:50 AM in the Administrator's office, with the Administrator, ADON, and Director of Social Services and Activities present, when asked if the blister would be considered an injury of unknown origin the DON confirmed it was. When asked if the facility had completed an investigation regarding how the blister developed the DON confirmed the facility failed to investigate the cause of the blister. When the DON was asked what she expected nursing staff to do when the blister was observed the DON revealed she expected "...nurse to document what was found in the nursing notes, fill out an Incident/Accident Report form, notify the physician, responsible party, and DON, and to get a Physician Order if needed and provide treatment as ordered..." Further interview confirmed the facility failed to investigate the cause of the blister in order to prevent further blisters.	F 225	The facility will investigate all incidents of unknown origin to detemine the root cause and to ensure that no incidents of neglect have occurred. Any incident or occurrence of unknown origin will be treated as possible neglect or mistreatment until source or cause otherwise can be determined. All staff will be educated as to the necessity to treat all unknown incidents as suspect until cause is thoroughly investigated. The Administrator and the DON will monitor all incidents to ensure that a thorough investigation has been done and a reasonable cause has been determined. The Quality Assurance Committee will review and discuss all incidents to determine if proper procedures have been followed for investigation.	12-2-17
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of	F 226		

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F 226	Continued From page 8 resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and interview, the facility failed to develop policies and procedures to address abuse prevention. The findings included: Review of facility policy, Abuse Policy, undated revealed no policy or procedure that addressed prevention of abuse. Interview with the Administator on 10/18/17 at 1:50 PM in her office revealed the Administrator	F 226	The facility shall develop policies and procedures to address abuse prevention. All abuse policies and procedures shall include measures to address prevention of abuse. Staff shall be educated and inserviced regarding the changes and updates to the abuse policy which include the prevention of abuse.	12-2-1

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F 226	Continued From page 9 did not know prevention of abuse was required to be addressed in the policy. The Administrator confirmed the facility failed to develop policies and procedures to address abuse prevention.	F 226	The Administrator will ensure that all staff are routinely trained regarding abuse prevention. This will be done at least yearly.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 278		

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F 278	Continued From page 10 (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to accurately assess the toileting use for 1 resident (#25) of 22 residents reviewed. The findings included: Medical record review revealed Resident #25 was admitted to the facility on 9/6/17 with diagnoses including Dementia, Atrial Fibrillation, Maniac Episode, Severe with Psychotic Symptoms, Hypertensive Heart Disease, Anxiety Disorder, Major Depressive Disorder, Enlarged Prostate, Rheumatoid Arthritis, Hereditary and Idiopathic Neuropathy, Chronic Obstructive Pulmonary Disease, Gastro-Esophageal Reflux Disease, Sleep Apnea and Chronic Kidney Disease. Medical record review of the 5-day Minimum Data Set (MDS) dated 9/13/17 revealed Resident #25 had a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. Continued review revealed Resident #25 required limited physical assistance of one person for toileting. Medical record review of the 14-day MDS dated 9/19/17 revealed Resident #25 required extensive physical assistance of one person for toileting. Medical record review of the ADL [Activities of Daily Living] Self Performance and the ADL Detail Report for the 5-day MDS dated 9/13/17 revealed Resident #25 had documented the resident required extensive assistance of toilet use. Continued review revealed the resident had	F 278	The MDS of Resident #25 will accurately reflect the toileting status of the resident. The MDS of all patients will be reviewed to determine the correct status for ADLs. The MDS Coordinator will review all written and electronic documentation to accurately assess and document this information on the MDS. The Administrator and the DON will monitor the MDS to ensure all information is accurate. The Quality Assurance Team will review MDS information during their meetings to ensure compliance.	12-2-17

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F 278	Continued From page 11 documented the resident required extensive assistance of toilet use documented on the 14-day MDS dated 9/19/17. Interview with the Assistant Director of Nursing (ADON) on 10/18/17 at 11:20 AM in the sunroom revealed she was responsible for completing the 5-day and the 14-day MDS for Resident #25. Interview with the ADON confirmed the facility failed to accurately assess the toilet use for Resident #25 on the 5-day MDS.	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		

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	445410		10/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD MANOR	405 TIMES AVE LAFAYETTE, TN 37083

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F 280	Continued From page 12 (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 280		

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F 280	Continued From page 13 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the fall investigation, and interview, the facility failed to revise the care plan interventions after a fall for 2 residents (#7, #57), and failed to revise the care plan after a wound site was healed and when a new wound site developed for 1 resident (#8) of 22 residents reviewed. The findings included: Review of facility policy, Resident Fall Policy, undated revealed "...Add new intervention to the care plan...." Medical record review revealed Resident #7 was admitted to the facility on 3/21/16 with diagnoses including Multiple Fractures Post Traumatic Fall, Hemmorrhagic Event, Left Cerebral Vascular Accident with Right Sided Hemiparesis, Coronary Artery Disease, and Hypertension. Medical record review of the Nurse's Notes dated 11/29/16 revealed Resident #7 had a fall.	F 280		

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F 280	Continued From page 14 Review of the Incident/Accident Report form dated 11/29/16 revealed Resident #7 had a fall with intervention of instructing resident to use call light when needing help to get things off of the floor. Medical record review of the Care Plan dated 3/21/16, updated quarterly, revealed the interventions were not revised after the fall on 11/29/16 for Resident #7. Interview with Licensed Practical Nurse (LPN) #1 on 10/17/17 at 4:40 PM at the nurses station revealed "...They [nurses]...come up with intervention to prevent further falls, and then they care plan it..." Interview with Director of Nursing (DON) on 10/18/17 at 2:33 PM in the TV room when asked what the DON expected nurses to do after a resident had a fall revealed the DON expected "...The nurse taking care of the resident to update care plan immediately..." Further interview confirmed the facility failed to revise the Care Plan with the intervention after the fall on 11/29/16. Medical record review revealed Resident #57 was admitted to the facility on 10/4/17 with diagnoses including Transient Cerebral Ischemia Attack, Osteoporosis, Pneumonia, Hypertension, Chronic Obstructive Pulmonary Disease, Gastro-Esophageal Reflux Disease, Insomnia, Anxiety, Anemia, Vitamin D Defiency and Hyperlipidemia. Medical record review of a Nurses' Progress Note dated 10/10/17 revealed "...Housekeeper called this nurse to room, reports fall, pt [patient] reports	F 280	Resident #7 shall have her Care Plan revised to reflect all interventions for falls. All patients with falls shall have their care plan reviewed to ensure interventions have been added to the Care Plan for falls. All licensed staff shall be educated and inserviced to the need for revisions to each resident care plan following a fall to include interventions. The DON, ADON, and the Care Plan Nurse shall ensure that all Care Plans are being revised per the above standard. The QA team will also review Care Plans.	12-2-17
			Resident #57 shall have her Care Plan revised to include interventions after each fall. All patients with falls shall have their care plan revised after each fall to ensure new interventions have been put in place. All licensed staff shall be educated and inserviced to the need to implement new interventions after each new fall. The DON, ADON, and the Care Plan Nurse shall ensure that all Care Plans are being revised and updated following each new fall. The QA team will also review Care Plans.	12-2-17

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F 280	Continued From page 15 while ambulating [with] R/W [rolling walker] to BR [bathroom] lost balance and fell back onto floor, hit head lg [large] hematoma to L [left] posterior scalp..." Medical record review of a Physician's Order dated 10/10/17 revealed an order for a personal alarm due to a fall. Medical record review of the Care Plan dated 10/4/17 revealed no new intervention after the 10/10/17 fall. Medical record review of the 5-day Minimum Data Set (MDS) dated 10/11/17 revealed Resident #57 had a Brief Interview for Mental Status score of 10, indicating the resident had moderate cognitive impairment. Interview with the Assistant Director of Nursing (ADON) on 10/18/17 at 7:45 AM in the sunroom revealed "...it is the responsibility of the nurse assigned to the resident to update the Care Plan with interventions after a fall..." Interview with Registered Nurse #1 on 10/18/17 at 8:55 AM near room 23 revealed, after a fall the nurse was responsible for completing the fall check list which includes completing the fall risk assessment and updating the Care Plan with interventions. Interview with Licensed Practical Nurse (LPN) #1 on 10/18/17 at 9:27 AM in the sunroom revealed she completed the 10/10/17 incident report after Resident #57 fell. Continued interview with LPN #1 revealed the intervention put in place after the fall was a personal alarm. Interview with LPN #1 confirmed LPN #1 failed to update the Care Plan	F 280		

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F 280	Continued From page 16 to reflect the intervention of the personal alarm after the 10/10/17 fall. Medical record review revealed Resident #8 was admitted to the facility on 8/24/17 with diagnoses including Atrial Fibrillation, Hypertension, Vascular Dementia with Behavioral Disturbances, Chronic Embolism and Thrombosis, Hyperlipidemia, Diabetes Mellitus Type 2 and with Foot Ulcer, History Bone Cancer Left Arm, Traumatic Subdural Hemorrhage, Edema, Depression, Pain, and Hemiplegia following Cerebral Infarction affecting Right Dominant Side. Medical record review of a Physician Telephone Order dated 9/15/17 revealed the treatment to the right foot was discontinued because the site had healed. Medical record review of a Physician Telephone Order dated 9/21/17 at 6:00 AM revealed "...apply proactive island drsg [dressing] to L [Left] inner heel r/t [related to] popped blister. Cleanse [with] NS [Normal Saline], pat dry, apply skin prep peri-wound + [and] apply drsg. Change q [every] 3 days + PRN [as needed] until healed..." Medical record review of the Physician Telephone Orders revealed the following: 1. On 9/29/17 "...DC [discontinue] protective island drsg to L heel. 2. On 9/29/17 at 5:00 PM "...cleanse L heel [with] NS, Apply silvercel [ointment] secure [with] aquacel drsg. Change q other day..." 3. On 9/29/17 at 5:00 PM "...waffle boot (protective device) to L heel at HS [bedtime] Assure bl [bilateral] heels are afloat when abed..." 4. On 10/13/17 "...change dressing to left heel to: Cleanse [with] NS pat dry, apply Santyl ointment,	F 280		

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F 280	Continued From page 17 cover [with] aquacel foam dressing every other day..." Medical record review of the Care Plan with problem onset date of 5/19/17 and updated 8/24/17 revealed "...at risk altercation in skin integrity has DM [Diabetes Mellitus] ulcer to ball of right foot..." Continued review revealed the Care Plan was not revised/resolved after the right foot was healed and the treatment was discontinued on 9/15/17. Further review revealed the Care Plan was not revised to address the development of the left heel blister and any physician orders addressing the care of the blister. Interview with the Assistant Director of Nursing (ADON) on 10/18/17 at 7:37 AM in the sunroom confirmed the ADON and LPN #1 were responsible for the Care Plan. Continued interview revealed the ADON and LPN #1 were to update the Care Plan when orders were received. Further interview confirmed the Care Plan for skin integrity involving the right foot should have been resolved on 9/15/17 and the Care Plan should have addressed the left heel blister on 9/21/17. Interview with LPN #1 on 10/18/17 at 8:25 AM at the lobby desk confirmed "...I'm responsible to update the care plan and so is the ADON...." Interview confirmed the Care Plan was not revised after the healing of the right foot and after the development of the left heel blister. Interview with the DON on 10/18/17 at 11:50 AM in the Administrator's office, with the Administrator, ADON, and Director of Social Services and Activities present, confirmed the facility failed to revise the Care Plan after the right	F 280	Resident #8 shall have Care Plan revised to show that right foot is healed and to reflect the new blister on the left foot. All Care Plans shall be reviewed to ensure that revisions have been made to show healed areas and address any new open areas that are being treated. All licensed staff will be trained and educated as to the need to revise and update Care Plans for any treatments being done for patients or for areas that have been healed. The DON, ADON, and the Care Plan Nurse shall monitor and review Care Plans to determine their accuracy. Care Plans shall also be reviewed by the Quality Assurance Committee during their regular meetings.	12-2-17

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F 280	Continued From page 18 foot was healed on 9/15/17 and after the development of the left foot blister on 9/21/17.	F 280		
F 319 SS=D	483.40(b)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES 483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- (b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain psychiatric services as ordered for 1 resident (#8) of 22 residents reviewed. The findings included: Medical record review revealed Resident #8 was admitted to the facility on 8/24/17 with diagnoses including Atrial Fibrillation, Hypertension, Vascular Dementia with Behavioral Disturbances, Chronic Embolism and Thrombosis, Hyperlipidemia, Diabetes Mellitus Type 2 and with Foot Ulcer, History Bone Cancer Left Arm, Traumatic Subdural Hemorrhage, Edema, Depression, Pain, and Hemiplegia following Cerebral Infarction affecting Right Dominant Side. Medical record review of a Physician Telephone Order dated 9/14/17 revealed "...Psyc	F 319	Resident #8 shall have psychiatric services as ordered. All residents with orders for psychiatric services shall be seen by the appropriate professional. Licensed staff shall be educated and inserviced to the need to make sure physician's orders are followed to ensure appropriate treatment is rendered to all residents. The DON and the ADON shall monitor all patient records to ensure that all orders are being followed.	12-2-17

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F 319	Continued From page 19 [psychiatric] eval [evaluation] to treat as indicated..." Medical record review of the Nurse's Notes dated 9/14/17 revealed "...Psyc Services eval [and] tx [treat] ordered..." Medical record review revealed no documentation of psychiatric services provided as ordered. Interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 10/18/17 from 4:53 PM-6:00 PM in the DON's office confirmed no psychiatric service had been provided as ordered.	F 319		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with	F 323		

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F 323	Continued From page 20 the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on facility policy review, review of falls check list, medical record review, and interview, the facility failed to complete the Fall Risk Assessment after a fall for 2 residents (#57, #7); and failed to completely investigate the fall for 1 resident (#7) of 3 residents reviewed for falls. The findings included: Review of facility Resident Fall Policy, undated, revealed "...Complete a Fall Risk Assessment..." Review of Checklist for All Falls, undated, revealed "...Complete a Fall Risk Assessment..." Medical record review revealed Resident #57 was admitted to the facility on 10/4/17 with diagnoses including Transient Cerebral Ischemia Attack, Osteoporosis, Pneumonia, Hypertension, Chronic Obstructive Pulmonary Disease, Gastro-Esophageal Reflux Disease, Insomnia, Anxiety, Anemia, Vitamin D Defiency and Hyperlipidemia. Medical record review of Nurses' Progress Notes dated 10/10/17 revealed "...Housekeeper called this nurse to room, reports fall, pt [patient] reports while ambulating [with] R/W [rolling walker] to BR [bathroom] lost balance and fell back onto floor, hit head lg [large] hematoma to L [left] posterior scalp..."	F 323	Residents # 7 and #57 shall have Fall Risk Assessments completed after falls. Any resident having a fall shall have a Fall Risk Assessment completed and the fall shall be thoroughly investigated. Licensed staff shall be educated and inserviced regarding the need to complete a Fall Risk Assessment following a fall, and to thoroughly investigate each fall. The DON and the Administrator shall monitor each fall to ensure that all falls of any nature have been thoroughly investigated and a Fall Risk Assessment has been completed. All falls and the investigation of falls will be reviewed and discussed by the Quality Assurance Committee.	12-2-17

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F 323	Continued From page 21 Interview with Registered Nurse #1 on 10/18/17 at 8:55 AM near room 23 revealed, after a fall the nurse was responsible for completing the Fall Check List and Fall Risk Assessment. Interview with Licensed Practical Nurse (LPN) #1 on 10/18/17 at 9:27 AM in the sunroom confirmed she completed the 10/10/17 facility investigation report after Resident #57 fell. Continued interview with LPN #1 confirmed the facility failed to complete the Fall Risk Assessment for Resident #57 after a fall on 10/10/17. Medical record review revealed Resident #7 was admitted to the facility on 3/21/16 with diagnoses including Multiple Fractures Post Fall, Hemmorahgic Event, Left Cerebral Vascular Accident with Right Sided Hemiparesis, Coronary Artery Disease, and Hypertension. Medical record review of Nurse's Notes dated 11/29/16 revealed Resident #7 had a fall. Review of the the facility investigation report form dated 11/29/16 at 5:35 AM revealed "...Called into room by CNA [Certified Nurse Aide], found rsd [resident] in front of recliner on knees. Pt [patient] stated 'she didn't fall. was trying to pick up a blanket + [and] lost balance + eased self to floor'...Redness to knees from pressure noted..." Further review revealed the Body diagram marked redness to knees, and CNA #4 signed form under section for witness. Further review revealed no witness statements were included in the investigation. Further review of the facilit investigation form revealed the intervention listed to prevent recurrence was to "...instruct resident to use call light when needing help to get things out of the floor..."	F 323		

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F 323	Continued From page 22 Medical record review of the Nurse's Notes dated 8/2/17 revealed Resident #7 had a fall. Review of the facility investigation report form dated 8/2/17 with no time specified revealed "...was called to Magnolia DR [dining room] by CNA. Found resident sitting in floor. Asked pt, what happened + stated 'I lost my balance'...No injuries noted..." Continued review revealed the witnesses were the Director of Nursing and CNA #5. Further review of the investigation revealed no witness statements. Review of the facility investigation report form revealed no interventions listed to prevent reoccurrence. Medical record review of the Fall Risk Assessment forms dated 11/29/16 and 8/2/17 revealed the assessments were not completed after the falls. Medical record review of the Quarterly Minimum Data Set (MDS) dated 9/15/17 revealed Resident #7 had 1 fall since 6/15/17. Interview with LPN #1 and #2 on 10/17/17 at 4:57 PM in the nursing station revealed "...The Nurse taking care of the resident when the fall occurs is responsible for completing the Falls Risk Assessment form after each fall..." Further interview confirmed the Fall Risk Assessments were not completed after the falls on 11/29/16 and 8/2/17. Interview with Assistant Director of Nursing (ADON) on 10/18/17 at 7:54 AM in the sunroom revealed "...Nursing is responsible for completing a falls risk assessment..."	F 323		

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F 323	Continued From page 23 Interview with CNA #4 on 10/18/17 at 11:20 AM in the TV room when asked regarding Resident #7's incident on 11/29/16 revealed "...I heard the resident yelling for help and I ran into the room...I saw her on the floor on her knees facing the chair... I asked her (resident) what she was doing and she said...'I was trying to get back into my chair'..." Further interview revealed "...I noticed the call light on the chair but she [resident] didn't use it, she usually don't [does not] use her call light..." When asked if the CNA saw a blanket on the floor the CNA revealed "...I didn't see a blanket on the floor...she does keep one in the chair a lot but I didn't see it..." Interview with CNA #5 on 10/18/17 at 11:30 AM in the TV room revealed the CNA witnessed Resident #7's fall on 8/2/17 in the dining room. Further interview revealed "...I was in the dining room...when she (resident) fell..." Continued interview revealed "... the resident stood up, shuffled her feet sideways, and I believe she tripped over her bad leg/foot because she scoots it after a stroke she had..." Further interview revealed "...She [resident] fell back against the window and just kinda slid down to the floor...but she never hit her head..." When asked if any new intervention had been implemented the CNA revealed "...no...but we just keep her pathway as clear as possible..." Interview with the Director of Nursing (DON) on 10/18/2017 at 2:33 PM in the TV room revealed she "...expects nurses who are taking care of the residents when a fall occurs to complete the Fall Risk Assessment..." Continued interview confirmed the facility failed to complete the Fall Risk Assessments after a fall per facility policy. When asked if the DON felt the investigations	F 323		

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F 323	Continued From page 24 were complete for the 11/29/16 and 8/2/17 incidents the DON revealed "...No..." When asked who audits the Incident/Accident Report forms the DON revealed she "...waits for Medical Director to review the form and fax it back to the facility and then she gets the incident forms for review every week or so..." Interview revealed "...Then, at the end of the month if we feel there is an issue they are reviewed in QA [Quality Assurance] meeting..." Continued interview revealed "...I make decisions regarding who gets referrals to therapy after I get them back from the Medical Director and discuss it with the Administrator..." Further interview revealed a review of the Incident/Accident Report forms was not currently a designated task. Continued interview revealed, "...we do not have a designated person, MDS staff checks it sometimes and other people as well..." Further interview revealed "...everyone trys to help do this..." Interview confirmed the facility failed to completely investigate 2 incidents. When asked if she felt the investigations were complete and determined the root cause of the incidents the DON stated, "...No.." Interview confirmed the DON failed to complete the Fall Risk Assessment Report on 8/2/17.	F 323		
F 490 SS=D	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 490		

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F 490	Continued From page 25 Based on medical record review, review of facility investigations, and interview, the Administrator failed to administer the facility in a manner to ensure the facility completely investigated and/or investigated abuse, accidents, falls, and injury of unknown origin; failed to recognize verbal abuse; and failed to ensure care plans were revised timely with interventions after an incident. The findings included: Interview with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Quality Assurance Nurse, on 10/18/17 at 6:36 PM in the Administrator's office, revealed when asked if the facility was aware of and addressed the failure to completely investigate falls, abuse allegations, and injury of unknown origin, the Administrator stated "...they thought their investigations were complete and didn't realize there was a problem..." When asked if the root cause of the fall/injury of unknown origin were determined to prevent further incidents; if the witness statements were included, the environment at the time of the incident was addressed, resident and staff interviews were documented, staffing review, were part of the investigation the DON confirmed the facility did not have that information. Further interview confirmed the investigations were not complete. When asked if the facility followed-up to ensure the Fall Risk Assessment Report forms, wound assessments, and witness statements were completed as part of the investigation the Administrator confirmed "...we all are responsible..." Refer to F225, F323, F514.	F 490	The Administrator shall administer the facility in such a manner to ensure the facility completely investigates abuse, accidents, falls, and injury of unknown origin. Verbal abuse shall be recognized and care plans will be updated and revised timely after incidents. All areas of concern will be addressed to ensure the facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The Administrator will do a review of all areas of concern on a weekly basis to ensure the facility is compliant in all areas. The Board of Directors of Tri-Age Adventures, Inc. dba Knollwood Manor shall monitor the Administrator to ensure the duties are being adhered to.	12-2-17

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F 490	Continued From page 26 Interview when asked if the facility monitored the care plan revisions for timeliness and accuracy after an incident the DON confirmed they facility failed to monitor the care plan revision. Refer to F280.	F 490		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed	F 514		

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F 514	Continued From page 27 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain accurate and/or complete medical records for a skin assessment for 1 resident (#8) of 3 residents reviewed with skin issues; and failed to monitor behaviors for 1 resident (#25) using anti-psychotic medication, and failed to identify the behavior exhibited for 1 resident (#57) using anti-anxiety medication of 5 residents reviewed for medication. The findings included: Medical record review revealed Resident #8 was admitted to the facility on 8/24/17 with diagnoses including Atrial Fibrillation, Hypertension, Vascular Dementia with Behavioral Disturbances, Chronic Embolism and Thrombosis, Diabetes Mellitus Type 2 and with Foot Ulcer, History Bone Cancer Left Arm, Traumatic Subdural Hemorrhage, Edema, Depression, Pain, and Hemiplegia following Cerebral Infarction affecting Right Dominant Side. Medical record review of a Physician Telephone Order dated 9/21/17 at 6:00 AM revealed a treatment to the blister on the left heel. Medical record review of the Wound/Skin Report form dated 9/27/17 revealed the "...Date of Onset 9/21/17...Site/Location...Left Heel blister DTI [Deep Tissue Injury]..." Further review revealed no evaluation of the Left Heel site on 9/21/17, the date of onset.	F 514	Resident #8 shall have a Skin/ Wound Assessment completed to address the blister found by nursing staff on 9/20/17. All residents with wounds shall have a Skin/Wound Assessment completed upon discovering a skin/wound problem. Licensed nursing shall be educated and inserviced as to their responsibility and the requirement to complete a Skin/ Wound Assessment on any resident upon discovering a new condition. The DON and the ADON shall monitor all skin/wound problems to ensure Skin/Wound Assessments are being completed. The QA Committee shall review all skin and wound assessments and treatments during their meetings.	12-2-17

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F 514	Continued From page 28 Interview with the Assistant Director of Nursing (ADON) on 10/18/17 at 8:30 AM in the lobby area revealed Resident #8's Certified Nurse Aide (CNA) #3 documented "...big blister..." on 9/20/17 at 12:50 AM on the CNA Skin Check Detail Report in the kiosk (computer). Further interview revealed Licensed Practical Nurse (LPN) #3 was informed of the blister by CNA #3. Further interview confirmed the LPN failed to complete and document a wound assessment. Interview revealed the ADON was not aware of the wound until 9/27/17 when she assessed it. Telephone interview with LPN #3 on 10/18/17 at 8:50 AM confirmed CNA #3 reported the blister to the LPN. Further interview revealed the LPN assessed the wound site. When informed there was no skin assessment addressing the blister the LPN revealed "...should have done a nursing note..." Interview with the Director of Nursing (DON) on 10/18/17 at 11:50 AM in the Administrator's office, with the Administrator, ADON, and Director of Social Services and Activities present, confirmed the facility failed to complete a skin assessment on 9/21/17 for the blister. Medical record review revealed Resident #25 was admitted to the facility on 9/6/17 with diagnoses including Dementia, Atrial Fibrillation, Maniac Episode, Severe with Psychotic Symptoms, Hypertensive Heart Disease, Anxiety Disorder, Major Depressive Disorder, Enlarged Prostate, Rheumatoid Arthritis, Hereditary and Idiopathic Neuropathy, Chronic Obstructive Pulmonary Disease, Gastro-Esophageal Reflux Disease, Sleep Apnea and Chronic Kidney Disease.	F 514		

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F 514	Continued From page 29 Medical record review of the 30-day Minimum Data Set (MDS) dated 10/4/17 revealed Resident #25 had received antianxiety medication during the assessment look-back period. Medical record review of a Physician Order dated 9/6/17 revealed Lorazepam (antianxiety medication) 1mg (milligram) daily for anxiety. Medical record review of the September and October 2017 Medication Administration Record (MAR) revealed Resident #25 had received the medication daily as prescribed. Further review revealed no psychotropic drug monitoring for Lorazepam. Medical record review revealed Resident #57 was admitted to the facility on 10/4/17 with diagnoses including Transient Cerebral Ischemia Attack, Osteoporosis, Pneumonia, Hypertension, Chronic Obstructive Pulmonary Disease, Gastro-Esophageal Reflux Disease, Insomnia, Anxiety, Anemia, Vitamin D Deficiency and Hyperlipidemia. Medical record review of the 5-day MDS dated 10/11/17 revealed Resident #57 had received antianxiety medication during the assessment look-back period. Medical record review of a Physician Order dated 10/10/17 revealed Ativan (antianxiety medication) 0.5 mg daily for anxiety. Medical record review of the October 2017 MAR revealed Resident #57 had received the antianxiety medication daily as ordered. Further review revealed the facility failed to identify the behaviors for the use of Ativan.	F 514	Resident #25 shall have behavior monitoring done for the use of Lorazepam. All residents using Lorazepam shall have behavior monitoring done daily for the use of this psychotropic drug. All licensed nurses shall be educated and inserviced to the need for appropriate behavior monitoring on all residents taking psychotropic drugs. The DON and the ADON shall monitor psychotropic drug use and the behavior monitoring sheets for completion. The QA Committee shall review as well. Resident #57 shall have behavior monitoring done for the use of Ativan. All residents using Ativan shall have behavior monitoring done daily for the use of this drug. All licensed nurses shall be educated and inserviced to the need to complete behavior monitoring sheets on all patients taking Ativan. The DON and the ADON shall monitor charts for the completion of the behavior monitoring sheets for all residents taking Ativan. The QA Committee shall review as well.	12-2-17 12-2-17

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F 514	Continued From page 30	F 514		
	Interview with the Director of Nursing on 10/18/17 at 6:20 PM in her office confirmed the facility failed to monitor behaviors for Resident #25 who was prescribed antianxiety medication and the facility failed to identify the behavior exhibited for Resident #57 who was prescribed antianxiety medication.			
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		
	(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;			

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F 520	Continued From page 31 (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 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility incident investigation review, and interview, the facility Quality Assurance committee failed to identify and investigate verbal abuse, failed to have complete fall investigations, failure to complete wound assessment, failure to identify behavior to monitor for psychotropic medication, and the failure to monitor behavior for psychotropic medication. The findings included: Interview with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Quality Assurance (QA) Nurse, on 10/18/17 at 6:36 PM in the Administrator's office, when asked if the facility QA Committee was aware of and addressed the failure to completely investigate falls, abuse allegations, and injury of unknown origin, the Administrator stated "...they thought their investigations were complete and didn't realize there was a problem..." When asked if the root cause of the fall/injury of unknown origin were determined to prevent further incidents; if the witness statements were	F 520	The facility Quality Assurance Committee shall identify and correct quality deficiencies that exist and shall develop and implement plans of action to correct those deficiencies to include identifying and investigating verbal abuse, completely investigate falls,complete skin/wound assessments, complete behavior monitoring sheets, and identify behaviors that require monitoring. Care Plan revisions and timely updates will also be identified and plans to correct shall be implemented. All areas of quality will be addressed by the QA committee at each meeting to ensure that the facility is compliant in all areas; that the QA Committee is keeping the facility efficient and effective. All members of the QA Committee will be educated as to the responsibilities of the Committee and their duties to ensure the facility remain compliant. The Administrator and the Medical Director shall ensure that the QA Committee is fulfilling their mission	12-2-17

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F 520	Continued From page 32 included, the environment at the time of the incident was addressed, resident and staff interviews were documented, staffing review, were part of the investigation the DON confirmed the facility QA Committee did not have that information. Further interview confirmed the investigations were not complete. When asked if the facility QA committee followed-up to ensure the Fall Risk Assessment Report forms, wound assessments, and witness statements were completed and part of the investigation the Administrator revealed "...we all are responsible..." Refer to F225, F323, F514. Interview when asked if the facility QA Committee monitored the care plan revisions for timeliness and accuracy after an incident the DON confirmed the facility failed to monitor the care plan revision. Refer to F280.	F 520		