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

PRINTED: 08/21/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 445406 | A. BUILDING _____<br>B. WING _____ | 07/29/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COMMUNITY CARE OF RUTHERFORD | 901 COUNTY FARM RD<br>MURFREESBORO, TN 37127 |

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| F 000 | INITIAL COMMENTS<br><br>AMENDED<br>The annual recertification survey and investigation of complaints #34525, #36461, #36491 and #36827 was conducted on 7/13 through 7/29/15, at Community Care of Rutherford County. The survey team identified Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause, serious injury, harm, impairment, or death to a resident) and Substandard Quality of Care related to a systemic problem with the use of restraints and failure to assess/reassess for the need of a restraint device, appropriateness of the restraint device, attempt restraint reduction, revising the care plan with current restraint information, and correctly apply restraint. Deficiencies were cited from the investigation of complaint #36461 at a harm level and deficiencies were cited from the investigation of complaint #36827.<br><br>A Full Extended survey was conducted 7/21-7/29/15.<br><br>The facility was cited an Immediate Jeopardy at F221-K, F272-K, F280-J, F490-K, F501-K, and F520-K.<br><br>The facility was cited for Substandard Quality of Care at F221-K.<br><br>The Administrator was informed of the Immediate Jeopardy on 7/21/15 at 2:40 PM in the conference room.<br><br>The Immediate Jeopardy was effective 5/4/15 | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charles W. [signature] TITLE: Administrator (X6) DATE: 10/2/15

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 000 | Continued From page 1<br>and was removed on 07/29/15.<br><br>An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received on 7/29/15 at 9:00 AM, and corrective actions were validated onsite by the surveyors on 7/29/15.<br><br>Non-compliance of the Immediate Jeopardy tags continues at a scope and severity of a "D" level for F280; at an "E" level for F221, F272, F490, F501, and F520 for monitoring the effectiveness of corrective actions to ensure sustained compliance of monitoring processes by the Quality Assurance Committee. | F 000 | | |
| F 221 SS=K | 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS<br><br>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of Lippincott Manual of Nursing Practice, 2014, Tenth Edition regarding standard for restraints, facility policy review, review of the restraint manufacturer's Application Instructions, the medical record, the facility investigations, interview, review of facility education forms, and observation, the facility failed to assess the need for the restraint; failed to determine the least restrictive restraint; failed to obtain consent for the restraint; failed to ensure the restraint was properly applied, and failed to monitor the resident in the restraint, to ensure the resident's | F 221 | Facility will ensure the resident is free from any physical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms.<br><br>All residents have the potential to be effected.<br><br>7/23/15 – Restraint Reduction Committee: New Committee meets weekly. DON is the Chairman. Members include: NHA, DON, MDS LN, Unit Managers, Wound Care Nurse, Central Supply, Restorative CNAs, Therapy, Social Service and Activities. The Medical Director will be an Ad Hoc member of the committee. The Committee will review weekly every restraint and all assistive devices that could also be a restraint. The review will be conducted for potential reduction, removal or validation of continued medical necessity.<br><br>**Resident #29**<br><br>7/31/15 – Seating in Broda chair with non-skid seating – no restraint. Chair is slightly reclined for | |

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| F 221 | Continued From page 2<br>safety for 12 (Resident #160, 29, 56, 63, 73, 78, 94, 109, 111, 117, 142, 158 ) of 13 residents reviewed with restraints. The failure of the facility to assess and reassess the need for restraints, determine the least restrictive restraint, follow the restraint manufacturer's application instructions and warnings, apply the restraint per the manufacturer's instructions, and monitor the resident while in the restraint placed Resident #160 in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident).<br><br>The Administrator was informed of the Immediate Jeopardy on 7/21/15 at 2:40 PM in the conference room.<br><br>The Immediate Jeopardy was effective 5/4/15 through 7/30/15.<br><br>A Full Extended Survey was conducted on 7/21-29/15.<br><br>An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received on 7/29/15 at 9:00 AM, and the corrective actions were validated by the surveyors on 7/29/15.<br><br>The findings included:<br><br>Review of Lippincott Manual of Nursing Practice, 2014, Tenth Edition, Chapter 9 revealed "[page] 191...These [restraint] guidelines must be met in any long-term care facility that participates in Medicare or Medicaid. However, these guidelines are useful for health care providers working with | F 221 | comfort except at meals. Continues sensor pad in bed. Will continue weekly Restraint Reduction Committee review.<br><br>8/5/15 – Morning QA Managers Meeting – observed on numerous occasions by 3-11 staff to be sitting toward front of the seat but no attempt to rise. Non-skid seating in place – continue to monitor.<br><br>8/5/15 – Restraint Reduction Committee review: Reassess current positioning - Staff report resident is more anxious in the afternoon. Committee will recommend an afternoon nap in bed after lunch to attempt to relax resident.<br><br>8/10/15 – Morning Managers Meeting – discussed related to resident preferred positioning at the front of the chair – observed at front of seat x 1 in previous 24 hours. No attempt to rise, chair assessed by Committee to continue to be the most appropriate seating for resident comfort. Family visited and ambulated with resident – safety maintained during visit.<br><br>8/12/15 – Restraint Reduction Committee review – resident was agitated x 1 (requiring medication intervention with positive results) since previous Committee review. Afternoon rest periods appear to decrease afternoon/evening anxiety. Confusion has increased this week. Not oriented to time or place – will incorporate additional afternoon activity time before or after nap. Activities notified. Care plan reviewed.<br><br>8/18/15 - Care plan updated. MAR updated for LN documentation. Assessment will continue for safe positioning without restraints. | |

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| F 221 | Continued From page 3<br>older adults in all settings. (a) The resident has the right to be free from any physical restraints imposed...for purposes of discipline or convenience and not required to treat the resident's medical condition. (b) Physical restraints are any manual method of physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the person cannot remove easily, which restricts freedom of movement or access to one's body (includes leg and arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, and geriatric chairs). (c) There must be a trial of less restrictive measures unless the physical restraint is necessary to provide life-saving treatment. (d) The resident or legal representative must consent to the use of restraints. (e) Residents who are restrained should be released, exercised, toileted, and checked for skin redness every 2 hours. (f) The need for restraints should be reevaluated periodically. (g) The specific facility will have to develop policies and procedures for the appropriate use of restraints... (h) Primary health care providers will have to write appropriate orders for restraints..."<br><br>Review of the facility policy, updated 2/4/14, "Restraint-Physical" revealed "Restraints should only be used for the safety and well-being of the resident(s) and only after all alternatives have been tried unsuccessfully and results are documented." Further review revealed "...Restraints will only be used in extreme circumstances and only with: 1) Documented behavior 2) Consent from resident's representative...All other non-restrictive alternatives have been tried and were unsuccessful...MD [Medical Doctor] orders MUST be written..." Further review revealed "...Orders | F 221 | **Resident #56**<br><br>7/31/15 – In care foam lounger for comfort and without restraint, incident or attempts to move unsafely out the chair. Will continue to be reviewed in the weekly Restraint Reduction Committee.<br><br>8/5/15 – Restraint Reduction Committee review: No safety concerns when in care foam lounger without harness restraint. Will discuss with family the end of reduction trial. Assessed for use of an electric low bed with upper rails and bolster pads (remove lower rails and bolsters). Recommendations will be discussed with family.<br><br>8/6/15 – DON met with family by phone related to RRC recommendations. Family agreed to continued care foam lounger without harness restraint. Agreed to removal of lower rails and bolster pads but continue upper rails and bolster pads. Discussed electric low bed – family agreed with the bed and continue the perimeter mattress. Consent updated by staff and signed, assessments completed to decrease restraints and change bed devices. Care plan updated, CNA care plan in resident's room and CNA kiosk in addition to LN MAR documentation updated.<br><br>8/10/15 – Daily QA Managers Meeting – review: no issues from restraint reduction in care foam lounger or removal of lower rails and bolsters.<br><br>8/11/15 – Daily QA Managers Meeting – review: no issues in chair or bed.<br><br>8/12/15 – Restraint Reduction Committee meeting review: Doing well in care foam lounger. Has sitter three times per week. Family came in today and requested lower rails and bolster pads be placed back on bed – no supportive of removal. Assessments will | |

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| F 221 | Continued From page 4<br>indicate the specific reason, type and period of time for the use of restraints. Restraints must be used only as a last resort, and the medical record must indicate the events leading to the necessity of the restraint. Their use is temporary and the resident will not be restrained for an indefinite amount of time...The attending physician must be notified of such use and the reason for the order. Consent for Restraint must be discussed with the responsible party...The resident placed in a restraint will be observed at least every thirty (30) minutes by Nursing personnel and documented. Reorders are issued only after a review of the resident's condition by...physician..." Further review revealed "...The opportunity for motion and exercise is provided for a period of not less then ten (10) minutes during every two (2) hours in which checks will be documented...Restrained residents must be repositioned at least every two (2) hours on all shifts...The need for restraints will be re-evaluated at least quarterly in the Fall Committee Meeting to determine their continued use. Every effort will be made to eliminate their use...The least restrictive must always be utilized..."<br><br>Review of the manufacturer's "...Application Instructions for the Posey Torso Support..." revealed "WARNING: ALWAYS Monitor patients per facility policy. Improper application or use of any restraint may result in serious injury or death." Further review revealed "Contraindications:...STOP USE AT ONCE: if the patient has a tendency to slide forward or down in the device..." Further review revealed "WARNING: Straps must ALWAYS be snug...If a patient's body weight becomes suspended off the chair, chest compressions and suffocation could result. Restraints with a pelvic piece may be | F 221 | be initiated – to be reviewed with MD for family request.<br><br>**Resident #63**<br><br>7/29/15 – Resident with Soft Posey belt in wheelchair with belt off at meal times. When restless the Merry Walker is offered with 1:1 contact guard assistance. Family does not support this level of restraint reduction. Will continue weekly Restraint Reduction Committee review.<br>8/5/15 – Morning QA Managers Meeting review: Order for restraint timed for update – refer to RRC today.<br><br>8/5/15 – Restraint Reduction Committee review: Staff report resident can apply seatbelt and take it off at will – however response when prompted in inconsistent due to confusion. Weakness has been noted when ambulating with Merry Walker – therapy screen with need for Part B therapy services for strengthening – awaiting family response to request. Psychotropic reduction initiated last week with decreased anxiousness and nervousness with improved cognition.<br><br>8/10/15 – Morning QA Managers Meeting review: intermittent anxiousness – improved with 1:1 Activity while in Merry Walker.<br><br>8/11/15 – Morning QA Managers Meeting review: Awake until early morning. Anxious in bed, Merry Walker and after snack. Asleep at 0100.<br><br>8/12/15 – Restraint Reduction Committee Review. When in wheelchair: alarming seat belt (resident does release the belt randomly and attempts to rise unassisted but due to cognition is unable to release on command or ambulate safely for more than a few | |

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| F 221 | Continued From page 5<br>necessary to reduce sliding down...Monitor per facility policy to ensure that the patient cannot slide down, or fall off the chair seat and become suspended..."<br><br>Review of the manufacturer's "...Application Instructions for the Posey Lap Belt/Padded Lap Belt..." revealed "WARNING: ALWAYS Monitor patients per facility policy. Improper application or use of any restraint may result in serious injury or death." Further review revealed "...Application Instructions: Position the patient as far back in the seat as possible, with the buttocks against the back of the chair...Bring the ends of the connecting straps down at a 45-degree angle between the seat and the wheelchair sides...Adjust the tightness of the slide buckles...Check that the straps are secure and will not change position, loosen, or tighten if the patient pulls on them, or if the chair is adjusted...The belt must be snug but not interfere with breathing...To check for proper fit, slide an open hand (flat) between the belt and the patient..." Further review revealed "...WARNING: Heed these warnings to reduce the risk of serious injury or death: There is a risk of chest compression or suffocation, if the patient's body weight is suspended off the chair seat...Monitor per facility policy to ensure that the patient cannot slide down, or fall off he chair seat and become suspended...STOP AT ONCE: if the patient has a tendency to slide forward or down in the device..."<br><br>Medical record review revealed Resident #160 was admitted to the facility on 3/30/15 with diagnoses including Fractured Neck of Femur, Fall, Dementia without Behavioral Disturbances, Blind both eyes, Difficulty Walking, Muscle Weakness, and Pelvis Joint Pain. | F 221 | steps safely). Belt is off at meals and during 1:1 encounters. Family is not supportive of current restraint reduction. Resident has bed sensor in bed which alarms randomly during the night with the resident attempting to exit the bed unassisted.<br><br>8/14/15 – Initiated B&B Program. Restraint Reduction Committee evaluation with recommendation to initiate trial bowel toileting "catch" or toileting assistance program in an effort to assist with unsafe ambulation due to frequent bowel toileting needs secondary to medical diagnosis and toileting habit changes.<br><br>**Resident #73**<br><br>7/29/15 – In wheelchair with seat belt. Belt is released during meals and 1:1 visits. Remains non-verbal with limited facial expressions. Family is supportive of reduction. There have been no attempts for the resident to stand unassisted. Will continue weekly Restraint Reduction Committee Review.<br><br>8/5/15 – Restraint Reduction Committee meeting – reviewed. Currently in restraint 2-3 hours per day. Continue to take rest periods with her husband everyday 1-5 pm and belt off during meals and 1:1 encounter. Will continue assessment.<br>8/6/15 – Morning QA Managers Meeting – review: Doing well with current restraint. DON met with family who is supportive of removing the seat belt as long as safety is maintained. Consent updated. Restraint assessment updated. Care plan, CNA information and LN documentation updated to reflect removal of belt restraint. Will refer to RRC for post removal safety assessment. | |

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| F 221 | Continued From page 6<br><br>Medical record review of the Admission Minimum Data Set (MDS) dated 4/6/15 revealed the resident had short and long term memory impairment, required extensive assistance of 1 person for bed mobility, toileting and hygiene; required extensive assistance of 2 persons for transfers, was frequently incontinent of bowel and bladder and had one fall without injury since admission.<br><br>Medical record review of the "ACKNOWLEDGEMENT OF RESTRAIN [restraint] POLICIES" (a form that is provided to the resident and or family upon admission to the facility) signed by the responsible party on 3/30/15 revealed "...If restraint use is deemed necessary the goal will be to use the least restrictive type of restraint for the shortest period of time possible...Every resident will be individually assessed regarding the need for appropriate safety measures and will be periodically reassessed..."<br><br>Medical record review of the "Restraint Assessment" dated 3/31/15 revealed Resident #160 was alert and oriented x (times) 2, had a fall in the past 12 months with a left hip fracture, a check mark beside gait/balance problems, and the "...Behavioral Problem was "removes clothing frequently"...Positioning Problems [was blank]...Reason for Restraint [was blank]..." Further review revealed the review date: "...3/31/15 no restraints needed..."<br><br>Medical record review of the Physician Telephone Order dated 4/9/15 revealed "...torso Posey positioner in w/c [wheelchair], check for placement q [every] 30 min [minutes] and | F 221 | 8/10/15 – Morning QA Manager's Meeting – review: Staff reports resident occasionally sits leaning slightly forward – no concerns related to safety. Will pass information to RRC.<br>8/11/15 – Morning QA Managers Meeting – review. Observed removing the table cloth from the dining tables. Staff state resident is cold natured so a sweater will be offered when resident leaves their room. Care plan and CNA care plan in resident's room and CNA kiosk updated to reflect resident preference.<br>8/12/15 – Restraint Reduction Committee meeting review: no problems with trying to get up from seat since restraint removed. Leans forward on table when in dayroom. Takes rest periods every afternoon with husband at bedside. Extended family expressed concern with resident positioning and restraint removal – DON will discuss concerns.<br><br>**Resident #78**<br><br>7/31/15 – Assessed for Velcro alarming seatbelt in wheelchair to be off at meal time and during family and 1:1 visits. Continue weekly Restraint Reduction Committee review.<br><br>8/5/15 – Morning QA Managers Meeting – review: Request RRC to review for possible Broda Peddler seating and remove the alarming seat belt.<br><br>8/5/15 – Restraint Reduction committee review: MD review for possible UTI - ordered urine C&S test. Family visited today to discuss change to Broda Peddler with alarming seatbelt to provide greater independence and safety without alarming seatbelt in addition to changes in behavior. Family did not support change in seating to promote independence because family felt resident is a "meddler" and leans | |

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| F 221 | Continued From page 7<br>release/reposition q 2 hours x 10 min..."<br><br>Medical record review of the "Informed Consent for Restraint Utilization," signed by the responsible party on 4/13/15, per nursing note review had verbal consent on 4/9/15, "...Consenting to the use of restraints described..." revealed "...Due to decreased safety awareness [with] unsteady gait, multiple attempts to get up unassisted...assessed and determined the torso Posey positioner vest necessary to protect [Resident #160] from physical harm..."<br><br>Medical record review of the "Restraint Assessment" revealed the facility failed to reassess Resident #160 after the assessment dated 3/31/15 for the restraint ordered on 4/9/15 for a "...torso Posey positioner in w/c..."<br><br>Review of the facility's Fall Investigation for Charge Nurse form with the date of the fall on 5/4/15 at 7:15 PM written by Licensed Practical Nurse (LPN) #1, revealed staff was present during the fall, a w/c or geri-chair was involved, a chair alarm was functioning properly, and an ordered restraint was in place and applied correctly. Further review revealed "...Did the resident remove the restraint?...Slid under restraint..." Further review revealed "...Description of incident: At approximately 715pm Resident was starting to slide down in w/c. This nurse pulled resident back up in w/c and went to get pads to put in...foam chair to transfer resident to...foam chair. On way back to the dayroom residents chair alarm started going off. Observed resident sliding down underneath Posey positioner onto the edge of the w/c. Able to assist resident safely to floor...assisted to...foam chair..." Further review revealed "...Conclusion: | F 221 | forward reaching for items. Family did agree for UA C&C to evaluate change in behavior. Will continue to follow for lab outcome.<br><br>8/7/15 – Morning QA Managers Meeting – review: Resident has been more active but quieter lately. Up in wheelchair with Velcro belt. Will unbuckle randomly but not when prompted.<br><br>8/10/15 – Morning QA Managers Meeting – review: No attempts to rise from seat during random opportunities when unbuckles the seat belt. Started on antibiotic for UTI.<br><br>8/11/15 – Morning QA Managers Meeting – review: Continue on antibiotic for UTI. No safety issues in wheelchair.<br><br>8/12/15 – Restraint Reduction Committee Review. When in wheelchair: Alarming seat belt (resident occasionally releases the belt when fidgeting but does not attempt to rise) with dump wheelchair seat due to resident persistent reaching and bending for items out of reach. Belt is off at meal times, during 1:1 encounter and when the family visits. Family is not supportive of current restraint reduction. Attended Happy Hour this week. Resident has sensor pad when in bed.<br><br>**Resident #94**<br><br>7/31/15 - Resident has abdominal binder to protect the integrity of the PEG tube. Resident remains without right hand mitten restraint. Assessments and care plans support the current restraint free status. Will continue weekly review by the Restraint Reduction Committee.<br><br>8/5/15 – Morning QA Managers Meeting – resident has made no attempt to remove PEG tube. | |

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| F 221 | Continued From page 8<br>Appropriate number of staff involved? Yes...Equipment use appropriate? Yes...Proper technique used? Yes...Resident unattended inappropriately? No..." Further review revealed "...Supervisor Report...New planned interventions: Staff training on correctly applying torso Posey positioner..."<br><br>Interview with LPN #1 on 7/14/15 at 3:17 PM in the conference room, after reading the Fall Investigation for Charge Nurse with the fall dated 5/4/15, confirmed LPN #1 was the nurse involved in the incident. When LPN #1 was asked to describe the event the LPN stated "...the resident was in the dayroom and slid down the w/c and the Posey was under the resident's breasts...I positioned resident up in w/c and posey was at lap, and I left resident and I went to get a pad for foam chair. I came back and resident is sliding out of w/c again with posey at breast area." When the LPN was asked if staff was present in the room with the resident while the LPN got the pads for the foam chair the LPN stated "...I left the resident unattended in the day room, no other staff was in the room..." When asked if this nurse reapplied the torso positioner after pulling resident up in the w/c prior to leaving the resident unattended the LPN stated "No." When LPN #1 was asked why the new intervention was to train staff on correctly applying the torso posey positioner the LPN stated "... was to compliance me [LPN #1] on appropriate application..." Further interview confirmed no other intervention other than the compliance.<br><br>Review of the facility staff education "Teachable Moment" form dated 5/5/15 signed by LPN #1 revealed the LPN was instructed by the Director of Nursing on the "...Related Procedure/Standard: | F 221 | 8/5/15 – Restraint Reduction Committee review: Activity reports resident made attempts to hit strings on guitar today during 1:1 session – a notable improved response to surroundings and staff encounter.<br><br>8/10/15 – Morning QA Managers Meeting - staff reports abdominal binder is effective in protection and positioning of the PEG tube.<br><br>8/12/15 – Restraint Reduction Committee review: Activity reports resident again responded to the guitar and appears to be listening to and enjoying music in the room. Activity recommends resident be out of the bed more since appears to be calmer with surroundings and external stimulation. Care plan updated for out of bed activity. Activity staff will continue to assess resident for response to various stimulation activities. Will continue to review during weekly RRC for four weeks to monitor tube and follow weekly improved interactions to surroundings.<br><br>8/17/15 MAR updated to document time spent out of **Resident #109**<br><br>7/31/15 – Exhibiting increased independence in ambulation, continues to carry cane when ambulating and is assisted with stand by assist ambulation or a chair when exhibiting unsteady gait. Remains at risk for falls due to episodic unsteady gait. Appears happier and engaged in friendly conversation with staff and other residents. Will continue to be reviewed weekly by the Restraint Reduction Committee.<br><br>8/4/15 – Fell in the dining room during lunch – Investigation and assessment – resident was attempting to rise, reach for health shake and pivot | |

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| F 221 | Continued From page 9<br>Posey not applied correctly...Content of Instruction- employee didn't ensure resident's restraint applied properly. It was too loose + [and] resident was able to get her arm beneath it + move it upward. Ensure she is seated back in w/c before applying posey..."<br><br>Medical record review of the Skilled Nursing Notes dated 5/8/15 revealed "...Resident in Rock & Roll [Rock-n-Go, a rocking wheelchair] chair @ [at] 4PM. Observed resident roll self to side bar of wall and pull self out of chair. Resident placed in w/c [with] torso positioner. @ approximately 830 PM this nurse was walking past dayroom. Observed resident down in w/c, posey restraint around neck..."<br><br>Review of the facility's Fall Investigation for Charge Nurse form with the date of the fall on 5/8/15 at 8:30 PM written by LPN #1, revealed a w/c or geri-chair was involved, and an ordered restraint was in place and applied correctly. Further review revealed "...Did the resident remove the restraint? was blank...Was a chair alarm involved? No..." Further review revealed "...Description of incident: Walked past dayroom observed resident down in w/c, posey torso restraint around neck...butt off of wheelchair. Undid restraint, lifted resident up in wheelchair x 2 assist...New Order 1) D/C [discontinue] soft torso positioner 2) soft posey belt in Rock & [and] Roll chair [with] pull alarm..." Further review revealed the "...Conclusion: Was appropriate number staff and equipment involved? Yes...Proper technique used? Yes...Resident left unattended inappropriately? No..." Further review revealed "...Supervisor Report...New planned intervention: posey belt in Rock-n-Go; cont [continue] pull alarm also..." Further review of the | F 221 | and lost balance. Footwear appropriate, area uncluttered, staff present – no injury. Ambulates with a safe gait otherwise.<br><br>8/5/15 – Restraint Reduction Committee meeting – Reviewed 8/4 fall. Resident is currently in therapy for balance strengthening. Staff will observe and offer assistance when rising from meals and ensure pathway is without clutter. Care plan and CNA care plan in resident's rooms and CNA kiosk updated. Will continue to assess and review next week.<br><br>8/10/15 – Morning QA Managers Meeting – review. Ambulating ad lib in facility without balance issues.<br><br>8/12/15 – Restraint Reduction Committee meeting – Ambulating without balance problems. Currently in therapy. Family notified of need for smaller shoes to assist in ambulation. Will continue to follow in committee until new shoes are evaluated.<br><br>**Resident #111**<br><br>7/31/15 – Continues in self-mobile wheel chair with non-skid seating material on a "dumped" (tilted) seat with a pull alarm to alert staff of unassisted transfer attempts. Additionally the wheelchair is fitted with anti-tippers due to resident persistence in pushing wheel chair backwards instead of forward. Bed room is modified with the head of the bed facility the doorway to provide a clutter-free walkway for the wheelchair. No change in cognition or participation in surroundings. Will continue in weekly review by the Restraint Reduction Committee.<br><br>8/5/15 – Morning QA Managers Meeting – review: observed sitting in chair without safety concerns.<br><br>8/5/15 – Restraint Reduction Committee Meeting - Continues in self-mobile wheel chair with non-skid | |

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| F 221 | Continued From page 10<br>Supervisor Report revealed in handwritten notes "...were arms beneath torso positioner? Yes...Had she had belt before? Yes but in w/c then, now Rock-n-Go..." Further review of the Supervisor Report revealed "...LPN #1: Resident was in w/c. Was in Rock-n-Go prior to dinner. She pulled herself up @ guardrail in Rock-n-Go. She was assisted to w/c [with] restraint..." Review of the Employee Statement written by Registered Nurse (RN) #3 of the 5/8/15 incident revealed "...The last time you saw resident before they fell? Time 450 PM...Location: In front dayroom (dayroom/dining room) on H + I (H hall and I hall) pulling self up out of Rock-n-Go by using rails on wall...Alarm sounding? Yes..." Further review of the Employee Statement revealed "...Describe...what you observed/saw/heard: walking down hallway observed resident in dayroom H + I in w/c had scooted self down so buttocks were off the seat of w/c. Torso posey positioner was still intact but was up around upper chest...With assist of two-release posey torso positioner and lifted back up into w/c-where she proceeded to...scoot downward in w/c...Sensor pad intact...Obtained Rock-n-Go + SWB [soft waist belt] + pull alarm for sitting position..."<br><br>Interview with LPN #1 on 7/14/15 at 3:17 PM in the conference room, after reading the investigation dated 5/8/15 confirmed she had written the investigation report and confirmed the resident had slid down the w/c wearing a torso positioner and the restraint was around Resident #160's neck.<br><br>Medical record review of the Physician Telephone Orders revealed the following: "...5/8/15...Trial period Rock in Go [with] pull alarm for restraint reduction... | F 221 | seating material on a "dumped" (tilted) seat with a pull alarm to alert staff of unassisted transfer attempts. Additionally the wheelchair is fitted with anti-tippers due to resident persistence in pushing wheel chair backwards instead of forward. No attempts stand without assistance. Care-giver states resident does not appear to need pull alarm in wheelchair – will continue assessment until next week.<br><br>8/6/15 Pull alarm in wheelchair discontinued.<br><br>8/10/15 – Morning Managers Meeting review – continues to position well without restraint.<br><br>8/12/15 – Restraint Reduction Committee meeting – Husband has been visiting more in the last week. Continue to position well in chair – family feels comfortable with current status.<br><br>**Resident #117**<br><br>7/31/15 – Has Torso Posey Positioner (yellow/Large) while in wheelchair with positioner removed from 7a-3p – there have been no incidents of unsafe transferring. Appears happy when self-propelling in the wheelchair attending activities without the Torso positioner. Appears to lean in the wheelchair when fatigued in the evening requiring positioner for torso support. Family supportive of reduction. Will continue weekly review by the Restraint Reduction Committee.<br><br>8/5/15 – Morning QA Managers Meeting – review: Doing well with current seating – upper torso balance in wheelchair. Staff report resident's balance in the evening continues to improve. No concerns when in bed. | |

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| F 221 | Continued From page 11<br>"...5/9/15...1) DC torso positioner in w/c...2) Soft posey belt in Rock-&-Go chair [with] pull alarm, check placement Q 30 min release et [and] reposition q 2 hrs [hours] x 10 min..."<br><br>Review of the medical record revealed the facility failed to obtain an Informed Consent for Restraint Utilization for the Rock-n-Go with a soft waist belt as indicated per facility policy. Further review revealed no assessment for the appropriateness of the restraint or alternatives per facility policy.<br><br>Medical record review of the Physician Telephone Orders dated 6/17/15 revealed "...Trial period [with] w/c + alarming seat belt..."<br><br>Medical record review of the "Restraint Assessment" revealed the facility failed to reassess Resident #160 after the assessment dated 3/31/15 for the restraint ordered on 6/17/15 for "...Trial period [with] w/c + alarming seat belt..." Further review revealed the facility included the "...Rock-n-Go chair [with] soft posey belt [with] trial period with w/c + alarming seat belt..." in the comment section of the assessment.<br><br>Review of the facility's Fall Investigation for Charge Nurse form with the date of the fall on 6/20/15 at 8:10 PM revealed a w/c or geri-chair was involved, the restraint was not in place, a restraint was ordered, a chair alarm was involved..."Did it [alarm] function properly? No...alarm did not sound Alarm not turned on..." Further review documented "...Description of Incident: ...resident on floor in dining room...transferred back to w/c...safety belt on and in place..." Further review revealed the "...Conclusion: Appropriate number of staff | F 221 | 8/5/15 – Restraint Reduction Committee meeting review: Unit Manager met with family – recommending Torso Posey be discontinued. Consent signed, assessment completed by committee. Care plan, LN documentation and CNA information in resident's rooms and CNA kiosks updated restraint free status.<br><br>8/10/15 – Morning QA Managers Meeting – review: Observed in wheelchair without balance issues.<br><br>8/12/15 – Restraint Reduction Committee meeting review: No leaning noted when seated in wheelchair, no attempts to exit bed. Appears happy and engaged in activities – singing and listening to music, watching TV and laughing with residents. Recommend sensor pad in bed be discontinues. Floor mats will continue when in bed.<br><br>8/13/15 Sensor pad alarm in bed discontinued.<br><br>**Resident #142**<br><br>7/31/15 – Ambulates at will daily with on-going monitoring for unsteady gait and needed additional assistance. Naps in common areas and utilizes a wheelchair occasionally when tired. Has not had a fall but remains at risk for falls. Continues on weekly review by the Restraint Reduction Committee.<br><br>8/5/15 – Morning QA Managers Meeting – review: Ambulating in the hall and room ad lib. Observed ambulation without shoes x 1 – easily redirected for appropriate footwear for ambulation.<br><br>8/10/15 – Morning QA Managers Meeting – review: Ambulating ad lib in hall with shoes.<br><br>8/12/15 – Restraint Reduction Committee review: Reported to be sleepy in the mornings and not | |

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| F 221 | Continued From page 12<br>involved? Yes...Equipment use appropriate? No...Proper technique used? Yes..." Further review revealed "...Supervisor Report...New Planned Interventions: trial period w/c [with] alarming seat belt. Inservice /re-educ [reeducate] to [check] alarm as well as connection on any resident [with] alarming seatbelt. Further review of the Supervisor report revealed in hand writing "...secured seatbelt but was unaware it was an alarming belt + did not make sure alarm was turned on..." Further review revealed "...Employee Statement of Incident...last time you saw resident before they fell? 8:00 PM...Location: Dayroom...Does resident have some kind of personal alarm? Yes...Was it sounding? No...What do you think could prevent this incident/could prevent similar incidences in the future? Double check the alarm. The buckle was on but I didn't check the alarm box..."<br><br>Medical record review of the Physician Telephone Orders revealed the following:<br>"...7/9/15...1) D/C [discontinue] alarming seat belt...2) begin soft posey [belt] while in w/c [wheelchair]. Apply 2 [hours], then release 10 min and reposition..."<br>"...7/10/15...D/C soft posey [belt]...Begin alarming seat belt [with] w/c..."<br>"...7/10/15...DC alarming seat belt to w/c...Apply SWB [soft waist belt] while in w/c. Check for placement q [every] 2 hours + release x 10 min..."<br>"...7/11/15...Start posey belt in Rock-n-Go chair...Check q 30 min + release q 2 hours + reposition x 10 min..."<br><br>Medical record review of the "Restraint Assessment" revealed the facility failed to reassess Resident #160 after the assessment dated 3/31/15. No assessment or reassessment | F 221 | sleeping through the night. Family and DON requested psychotropic review for possible GDR during psychiatrist visit today. Will initiate toileting plan to assist with toileting. Care plan and CNA care plan in resident's rooms and CNA kiosks updated.<br><br>**Resident #158**<br><br>7/31/15 – Self mobile in wheelchair with pull alarm to alert staff to unassisted transfer and anti-tippers to assist resident from pushing wheelchair backwards. Resident appears more cheerful, pleasant and has not attempted to rise from chair unassisted. Bolster to ½ side rails in bed – diagnosis of seizures and modified room to decrease clutter with sensor pad alarm in bed, non-skid socks and floor mats when in bed. Will continue weekly review by the Restraint Reduction Committee.<br><br>8/3/15 – QA Morning Manager Meeting review – new exit seeking behavior – intervention – outside activities will be scheduled and offered when he becomes combative with staff, is restless or exit seeking – care plans (Master and CNA) updated by MDS LN to include 1:1 activity in the Butterfly Garden.<br><br>8/5/15 – Restraint Reduction Committee Review: Due to exit seeking behavior and increased independence – Wander Guard bracelet applied to remind resident and staff to return to the Courtyard or Butterfly Garden for outside activity. Less agitation noticed. Will continue to observe.<br><br>8/10/15 – Morning QA Managers Meeting – No agitation or combative behavior. Daily outdoor activity available and encouraged; Wander Guard applied. | |

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| F 221 | Continued From page 13<br>was performed for the restraint ordered on 7/10/15 which states "...SWB [soft waist belt] while in w/c. Check for placement q [every] 2 hours + release x 10 min...", and on 7/11/15 for the ordered "...posey belt in Rock-n-Go chair...Check q 30 min + release q 2 hours + reposition x 10 min..."<br><br>Review of the medical record revealed the facility failed to obtain the Informed Consent for Restraint Utilization for the soft waist belt while in w/c on 7/9/15; alarming seat belt [with] w/c and the soft waist belt in w/c on 7/10/15; and the soft waist belt in the Rock-n-Go on 7/11/15 per facility policy. Further review revealed no assessment for the appropriateness of the restraints or alternatives per facility policy.<br><br>Review of the Nurses Notes dated 7/11/15 revealed "...2 PM...Observed in w/c [with] posey waist belt-Resident sliding down in w/c [with] posey belt across her arms...Initiated Rock-n-Go w/c [with] posey soft waist belt..."<br><br>Medical record review of the Physician Telephone Order dated 7/15/15 revealed "...D/C posey belt in Rock-n-Go. Res [Resident] to be in w/c [with] sensor pad + seatbelt. Check q 30 min + release q 2 [hours] x 10 min..."<br><br>Medical record review of the "Restraint Assessment" revealed the facility failed to reassess Resident #160 after the assessment dated 3/31/15 for the restraint ordered on 7/15/15 for "...Res [Resident] to be in w/c [with] sensor pad + seatbelt. Check q 30 min + release q 2 [hours] x 10 min..."<br><br>Observation of Resident #160 and/or interview | F 221 | 8/12/15 – Restraint Reduction Committee Meeting – Enjoys being outside; some agitation on 3 11- easily redirected; laughing more lately, decrease aggression on 7-3, moves easily about facility at will. Increased restlessness observed when needs toileting. Based on observation and staff interview a toileting plan was initiated. Care plan updated, CNA care plan and EHR (electronic health record) kiosk updated for assessment and documentation.<br><br>**Resident #160**<br><br>7/31/15 – Resident has a seatbelt with sensor pad when in the wheelchair without attempts for unsupervised transfer. Will be placed in bed for rest with resident's favorite stuffed animal when exhibits signs of fatigue and irritation. Will continue to review during the weekly Restraint Reduction Committee meeting<br><br>8/5/15 – Morning QA Managers Meeting – review: Follow-up appoint with MD Surgeon schedule for 8/21/15 to determine weight bearing status. No attempts to exit seat; longer shirts to cover the belt attempted however resident continues to prefer to "fidget" with the belt. Will refer to RRC.<br><br>8/5/15 – Restraint Reduction Committee review: Orthopedic appointment for 8/21/15 is to evaluate weight bearing status and initiate therapy services. Resident has made no attempts to get up from seat but does still fidget with seatbelt. Sensor pad in wheelchair has not sounded since application – no attempts to rise from chair.<br><br>8/7/15 – Morning QA Managers Meeting – review: Out of bed in wheelchair with seatbelt – no complaints of pain or positioning concerns. | |

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| F 221 | Continued From page 14<br>with staff revealed the following:<br>1. On 7/14/15 at 7:52 AM: Resident #160 was in the H hall and I hall dayroom/dining room in a reclined Rock-n-Go chair with a soft waist belt in place.<br><br>2. On 7/14/15 at 3:20 PM with LPN #1: Resident #160 was in the Rock-n-Go in the F hall and G hall dayroom/dining room with a soft waist belt in place.<br><br>3. On 7/15/15 at 7:37 AM: Resident #160 was in the H hall and I hall dayroom/dining room, with 15 other residents, in a reclined Rock-n-Go chair with a soft waist belt under her chin, both arms were under the soft waist belt with the right hand under her chin holding onto the top of belt, the resident had slid down in the chair, and no facility staff was present. The surveyor stayed with the resident. Observation at 7:39 AM revealed 2 nursing staff entering the H hall and I hall dayroom/dining room. Certified Nurse Aide (CNA) #3 did not see Resident #160 and left the dayroom. CNA #1 saw Resident #160 soft waist belt located under her chin and repositioned the belt to the waist area (without re-applying the straps) and left the dayroom. The surveyor stayed with the resident. Continued observation revealed Resident #160 took her right hand and pulled the soft waist belt up under her chin and both arms were under the belt. Continued observation at 7:42 AM revealed RN #1 entering the H hall and I hall dayroom/dining room, went to Resident #160, knelt down behind the chair and touched the restraint belt straps. Interview with RN #1 when asked if the soft waist belt was fastened appropriately, RN #1 stated "it should be tighter." Further interview revealed when RN #1 was informed of the soft waist belt under the resident's | F 221 | 8/10/15 – Morning QA Managers Meeting – review: No attempts to get up from wheelchair seat.<br><br>8/11/15 – Morning QA Managers Meeting – review: Unit staff request RRC to review related to removal of seatbelt since resident does not attempt to get up form seat but can unbuckle the seatbelt – only fidgets with the belt when released – unable to release when prompted.<br><br>8/12/15 – Restraint Reduction Committee meeting review: Resident is up in wheelchair daily with seatbelt and sensor pad-has made no attempts to get up from seat; staff has observed resident leaning forward with feet on wheelchair pedals – no attempts to self-propel. Continue rest periods daily after lunch. When in wheelchair, resident has a seat belt (can release but due to cognition is unable to release on command) with non-skid seat material and sensor pad. The seat belt is removed during meals and 1:1 encounter. When in bed the resident has a perimeter mattress with sensor pad to alert staff to unassisted/ unsafe transfer. Continues with limited weight bearing and remains at risk for falls. Due to s/p fracture, committee will continue current orders until orthopedic appointment on 8/21/15.<br><br>8/21/15 (on or about) - Resident has appointment with orthopedic surgeon. Anticipate resident will be released for weight bearing and Therapy services. Following Therapy evaluation the current restraint will be re-evaluated by the Restraint Reduction Committee for possible reduction and encouragement for increase ambulation.<br><br>---<br><br>7/30/15 – 8/18/15 – Unit Managers and MDS LN completed 100% device / alarm audit. RRC evaluated | |

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| F 221 | Continued From page 15<br>chin, CNA #1 repositioning the soft waist belt to the waist area without checking or re-applying the restraint straps and left the room leaving the resident unattended and if that was appropriate, RN #1 stated "No, it could have serious consequences." Observation and interview revealed CNA #1 re-entering the H hall and I hall dayroom/dining room and confirmed to RN #1 that CNA #1 had repositioned the soft waist belt and had then left the dayroom. The RN stated to CNA #1 "That could result in serious consequences, even death."<br><br>4. On 7/15/15 at 8:53 AM in front of the H hall and I hall nurses station, revealed Resident #160 in a reclined Rock-n-Go chair with a soft waist belt in place. Continued observation revealed the resident had both arms under the belt, the belt was loose, and the belt was positioned across the breast. The surveyor stayed with the resident until a nurse arrived. Observation and interview with RN #1 on 7/15/15 at 8:54 AM through 8:58 AM in front of the H hall and I hall nurses station, revealed Resident #160 had removed several types of restraints and the current restraint (soft waist belt) was "...not applied correctly, it was too loose..." Continued interview confirmed the resident was capable of self-propelling in a wheelchair, and the Rock-n-Go chair was reclined to prevent the resident from propelling. When RN #1 was asked if the belt was applied correctly the RN stated the "...soft posey belt was not applied correctly...belt was not appropriate for the resident..."<br><br>5. On 7/15/15 at 1:55 PM and at 2:50 PM: The resident was in a reclined Rock-n-Go chair in the in H hall and I hall dayroom/dining room with no staff present, no soft waist belt was on the | F 221 | each device to determine if it was a positioning device that could be a restraint for the individual resident. Assessments were completed as indicated to determine baseline for device reductions as indicated by resident activity, behavior, cognition and safety needs. Medical Director notified of results for discussion related to facility benchmark and current trends. Findings will be forwarded to QA Committee for establish action plan to achieve facility goals. DON will be responsible for communication action plan between RCC, QA and QAA committee in addition to documentation of the action plan, implementation and evaluation for full QAA review.<br>7/29/15 – Education LN has placed the Restraint inservice into the clinical staff (licensed nurses, CNAs and cross-trained staff including Therapists) orientation to be completed by all new clinical employees prior to working with residents. NHA will review orientation status in the morning QA Managers meeting to ensure training is completed during the orientation program. Education LN will conduct monthly staff meetings for three months to review current restraints, restraint application, observation, documentation and non-restraint alternatives. Restraints and assistive devices will be reviewed during orientation and at least quarterly thereafter as the facility will be restraint free.<br>8/4/15 – Mandatory Restraint Inservice for employees returning to work from extended LOA. Three part time clinical staff (licensed nurses, CNAs, cross-trained staff including Therapists) members and employees on FMLA will be inserviced by the Education LN prior to return to resident care.<br>8/6/15 – Mandatory All staff inservice conducted by Education LN, DON and NHA. Discussed current restraints, restraint application, observation and documentation along with facility goal to be a restraint free facility. | |

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| F 221 | Continued From page 16<br>resident. LPN #8 entered the H hall and I hall dayroom/dining room and stated the physician had changed the order to stop the soft waist belt and keep the Rock-n-Go.<br><br>Medical record review revealed no restraint assessment for the appropriateness of the restraint or alternative per facility policy.<br><br>Medical record review revealed an undated "Pre-Restraining Evaluation". Interview with MDS Coordinator #1 on 7/16/15 at 7:40 AM in the conference room confirmed the evaluation was not dated, had been completed after the 7/15/15 observations, and failed to identify recommendations and alternatives to restraints.<br><br>Interview with the Director of Nursing (DON) on 7/15/15 at 2:42: PM, in the Admissions Coordinator's office, confirmed, after the first incident on 5/4/15 at 7:15 PM, it was unsafe to leave the resident in a torso positioner, no new intervention was put in place, and the facility failed to follow the manufacturer's instructions. Further interview confirmed the torso positioner was still used on the 5/8/15 incident when the resident slid down the wheelchair again and the restraint was around the resident's neck. Further interview confirmed the soft waist belt was not appropriate for Resident #160. The DON confirmed the facility's failure to assess for the appropriateness of the restraints, the failure to assess for the least restrictive restraint, and the failure to obtain consent for the restraints as the restraints changed. The DON confirmed the facility had failed to monitored Resident #160 to ensure the resident's safety per facility policy.<br><br>Interview with MDS Coordinator #1 on 7/16/15 at | F 221 | 8/7/15 – QA Committee Meeting - Reviewed: New Restraint Policy, new Restraint Protocol, Restraint Audits, Restraint education audit, new restraint assessment forms (Pre-evaluation and Reduction)<br><br>7/23/15 – Restraint Reduction Committee: New Committee meets weekly and is a Sub-committee of the QAA Committee. DON is the Chairman. Members include: NHA, DON, MDS LN, Unit Managers, Wound Care Nurse, Central Supply, Restorative CNAs, Therapy, Social Service and Activities. The Medical Director will be an Ad Hoc member of the committee. The Committee will review weekly every restraint and all assistive devices that could also be a restraint.<br><br>The review will be conducted for potential reduction, removal or validation of continued medical necessity. Charts will be brought to the meeting by the Unit Managers for documentation review and to update the weekly committee meeting note. Committee Chairman (DON) will record minutes during the meeting. The minutes will be submitted to the QAA Committee for benchmark, trending, oversight, review and to determine programming and staff education needs. The nursing Home Administrator (NHA) will be responsible for QAA Committee oversight of the Restraint Reduction Committee activity. MD will review the committee minutes during weekly scheduled visits. Compliance Consultant will review weekly notes during scheduled monthly visits.<br><br>7/30/15 - Daily QA Managers Meeting (Monday – Friday). NHA will oversee and investigate concerns related to facility reports, communications and policies. | |

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| F 221 | Continued From page 17<br>7:40 AM in the payroll office confirmed the facility failed to follow the policy to complete a restraint assessment to determine the need for the restraint and the appropriateness of the restraints used.<br><br>Interview with the DON and Environmental Director, chairman of Falls Committee, on 7/20/15 at 9:00 AM and 10:45 AM in the conference room, confirmed LPN #1 failed to appropriately reapply the torso restraint after the first observation on 5/4/15 at 7:15 AM and left the resident unattended. Further interview confirmed LPN #1 had failed to accurately investigate when the LPN documented the proper technique was used and the resident was not left unattended. When the DON was asked about the two observations on 7/15/15, the DON stated an incident investigation would not have been completed since the resident had not been reported to be sliding out of the chair but would expect a nursing note. The DON confirmed neither event on 7/15/15 was documented in the nursing notes. The DON confirmed the facility failed to follow the manufacturer's instructions by discontinuing the torso positioner and the soft waist belt once the facility was aware the resident was sliding in the chairs.<br><br>Interview with LPN #1 on 7/14/15 at 3:17 PM in the conference room confirmed leaving the resident unattended on 5/4/15, and came back to the room to find Resident #160 had slid down the wheelchair again with the soft waist restraint in the breast area.<br><br>Medical record review revealed Resident #29 was admitted on 4/11/14, discharged on 05/30/15 for hospitalization and readmitted on 6/10/15 with | F 221 | Daily QA Managers Meeting attendees include but may not be limited to: NHA, DON, MDS LN, Infection Control/Staff Education, Wound Nurse, Unit Managers, Restorative, Medical Records, Therapy, Social Service, Activities, Housekeeping, Maintenance, Business Office and Payroll.<br><br>The following items will be reviewed daily: Change in Resident Condition, Significant Change in Resident Status, 24 Hour Report Information, New MD orders, Occurrence Reports, Clinical Progress Notes and Hospital Transfers in addition to Restraints, Infection Control and On-going Investigations.<br><br>Concerns discussed in the daily meeting will be assigned to staff for follow up and the DON as indicated to complete investigations. Information and findings from the areas discussed in the daily meeting will be reviewed in the meeting weekly until resolved or on-going as indicated. Staff education will be directed by information from the daily QA meeting in addition to on-going audits, scheduled monthly staff meetings and annual skills assessments.<br><br>Nursing Home Administrator will notify the Clinical Consultant of issues, concerns and investigations during the monthly visit to ensure a timely and comprehensive investigation with action plan is completed. Clinical Consultant will review daily, weekly and monthly QA and scheduled QA Committee and Sub Committee meeting minutes to ensure timely and comprehensive action plans are implemented, monitored and evaluated. Clinical Consultant will be on-site at least monthly and submit a written report to the QAA Committee for review and action as indicated. Medical Director will review consultant report monthly for timely response and needed intervention as indicated. | |

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| F 221 | Continued From page 18<br>diagnoses including Alzheimer's Disease, Aortic Valve Disorder, Chronic Systolic Heart Failure, Anemia and Malaise.<br><br>Medical record review of the Annual MDS dated 3/26/15 revealed Resident #29 to be severely cognitively impaired, and required extensive assistance of 1 for Activities of Daily Living (ADLs), and restraints in chair/out of bed were used daily.<br><br>Medical record review of "ACKNOWLEDGEMENT OF RESTRAIN [restraint] POLICIES" (a form that is provided to the resident and or family upon admission to the facility) signed by Resident #29's legal representative on 4/11/14 revealed "...if restraint use is deemed necessary the goal will be to use the least restrictive type of restraint for the shortest period of time possible...every resident will be individually assessed regarding the need for appropriate safety measures and will be periodically reassessed as their needs change throughout their stay..."<br><br>Medical record review of a Restraint Assessment dated 4/11/14 revealed "...7/24/14 Posey Torso dc'd [discontinued]. [Change] to Posey belt d/t [due to] pt removing..." Continued review revealed the review dates between 8/12/14 and 6/10/15, the resident continued to use a soft waist restraint and the facility failed to reassess for a least restrictive restraint per the facility policy.<br><br>Medical record review of the readmission Physician's Orders dated 6/10/15 revealed "...OOB [out of bed] in w/c daily; dump seat (a seat tilted downward) in w/c...use soft Posey belt in w/c prn [as needed] restlessness, agitation..." | F 221 | 8/7/15 – Monthly QA Committee Meeting - NHA or designee will summarize the daily Managers meetings for trends and education needs to be discussed in the Monthly QA meeting. Trend summaries and on-going or unresolved facility issues are discussed for resolution in the Monthly QA Committee Meeting. The QA Committee will meet 2 times per month for the first month (August – September) and then monthly thereafter.<br><br>Monthly QA Meeting attendees include but may not be limited to: NHA, DON, Department Managers, Wound Nurse, Infection Control Nurse and Staff Educator. The NHA will be the Chairman of the committee and responsible to ensure information is communicated between the QA Committee and the QAA Committee.<br><br>8/1/15 - The QAA Committee will meet quarterly. Items from the Monthly QA Committee Agenda will be reviewed by the full QAA Committee to ensure policy compliance, clinical best practice and staff education is monitored, implemented and evaluated on-going. The Clinical Consultant will review the QA and QAA Committee minutes during monthly visits to ensure compliance. Compliance issues or concerns will be discussed with the NHA for follow-up and resolution.<br><br>QAA Committee members include but may not be limited to: Medical Director, Nursing Home Administrator, DON, Department Managers (Social Service, Activity, Therapy, Nursing, Housekeeping, Maintenance), in addition to the wound Care Nurse, Staff Education Nurse, Infection Control Nurse and staff nurses and CNAs as available. | |

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| F 221 | Continued From page 19<br><br>Medical record review of an Informed Consent for Restraint Utilization dated 8/1/14 revealed "...physician and an interdisciplinary team of medical professionals have assessed and determined that the use of a Posey belt is necessary..."<br><br>Medical record review of a TAR (treatment administration record) dated June 2015 revealed "...When restless transfer to WC [wheelchair] with soft Posey belt d/t [due to] increased risk for fall/unsteady gait. Check q 30 min..."<br><br>Observation on 7/21/15 at 7:20 AM revealed the resident lying in bed with eyes closed. Continued observation revealed a wheelchair positioned near Resident #29's bed with a soft waist restraint lying in the seat.<br><br>Interview with the DON on 7/21/15 at 8:58 AM in the Admission Coordinators Office revealed, when questioned about the resident and use of the soft waist restraint stated, "...she's doing good in the Broda [a high back, reclining geriatric chair]...I haven't seen her in the w/c in a long time...we may need to reassess for its use..." Continued interview, when asked if the resident had not been in the wheelchair with the soft waist restraint in the month of June, explain the staff initials on the TAR, the DON stated "...it means they're aware of the order and monitoring of it ..." When asked if the staff initials could be interpreted as the restraint was in use, the DON stated "...oh I see what you mean...yes it could..." When asked if a complete restraint assessment or a reassessment for the least restrictive restraint had been completed in the past year, the DON stated "...no...we've not done that..." | F 221 | **#2• The independent contractor conducted training for all staff on the importance of preventing serious injuries and deaths from asphyxiation, suffocation, bed-rail entrapments and falls. Training was provided to facility personnel shall review the all types of restraints, including but not limited to, full bed rails, other types of bed rails used, trunk restraints, limb restraints, and chairs that may prevent rising. Training included manufacturer's instructions for all restraints in use at the facility; and included information on resident rights.** *The dates of training are provided in Independent Contractor's DPOC Final Report.*<br><br>• 2.1 Training was provided for all **active classifications** of Community Care of Rutherford County (CCRC) staff, agency personnel (none since before 2005) and contract service providers (therapy) on the importance of preventing serious injuries and deaths from asphyxiation, suffocation, bed-rail entrapments and falls. Training curriculum was customized to align with those items in use/in stock at CCRC.<br>o Responsible Party(ies): Vickie W. Harris, Independent Contractor<br>o Completion Date: September 15, 2015<br><br>• 2.2 Training was provided for all **active classifications** of licensed and/or certified CCRC staff, agency personnel (none since before 2005), contract service providers (therapy), social workers/designees and activity personnel on the types of restraints in use by CCRC at present, in stock and/or | |

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| F 221 | Continued From page 20<br><br>Interview with the DON on 7/21/15 at 10:04 in the conference room, when asked about restraint reassessment, the DON stated "...I would expect them to be done quarterly and documented in the interdisciplinary notes..."<br><br>Medical record review revealed Resident #56 was admitted to the facility on 11/18/08 and re-admitted on 3/9/09 with diagnoses including Depressive Disorder, Altered Mental Status, Delusional Disorder, Generalized Anxiety, Diabetes Mellitus Type II, and Dementia.<br><br>Medical record review of a Quarterly MDS dated 4/20/15 revealed the resident was severely cognitively impaired. Continued review revealed documentation under the restraint section, of a trunk restraint used less than daily, and a chair that prevented rising used less than daily.<br><br>Medical record review revealed a Restraint Assessment form with a review date of 5/24/12 documented "no restraints"; 6/24/13 documented "carafoam (padded foam chair with ottoman used for fall prevention) ottoman [with] 3 pt [point] pelvic positioner prn"; and 12/11/14 documented "...carefoam ottoman/lounger [with] 3 pt pelvic positioner release & [and] reposition q 2 [hours] x 10 min check q 30 minutes..."<br><br>Medical record review revealed Physicians Orders (recapitulation) for the months of 2/2015 through 7/2015, "...Padded side rails (4) up when in bed. Up OOB [out of bed] to carefoam lounger and put back to bed before 3 pm on shower days (M/W/F) [Monday, Wednesday, Friday] Carefoam lounger with 3 pt pelvic positioner. Release and reposition Q 2 hrs x 10 min. Check Q 30 min..." | F 221 | on the premises. The training included, at a minimum, a review of the manufacturer's instructions for use and where to source instructions for future reference.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Contractor<br><br>o Completion Date: September 15, 2015<br><br>• 2.3 Training was provided for **all active classifications** of CCRC staff, agency personnel (none since before 2005) and contract staff (therapy) on resident rights.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>**#3• The independent contractor ensured that staff was given education and training on restraint alternatives, including but not limited to, therapeutic interventions, environmental and equipment interventions, and the role of restorative programs.** *The dates of training are provided in Independent Contractor's DPOC Final Report.*<br><br>• 3.1 Education and training was provided for all **active classifications** of CCRC staff, agency personnel (none since before 2005) and contract service providers (therapy) on restraint alternatives available and used by the organization.<br><br>o Responsible Party(ies): Vickie W. Harris, IC | |

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| F 221 | Continued From page 21<br><br>Medical record review revealed a signed, but undated, Informed Consent for Restraint Utilization form for a 3 point pelvic harness restraint with the reason for the restraint documented as "...decreased safety awareness [secondary] dementia..."<br><br>Medical record review revealed no documented evidence the facility had assessed the resident for the restraint prior to restraint use or having had reassessed the resident for the need for continued use of the restraint or assessed the resident for restraint reduction.<br><br>Observation and interview on 7/20/15 at 3:45 PM in Resident #56's room, revealed the resident was lying in bed with four padded side rails in the raised position. Continued observation revealed a family member was present at the bedside. Continued observation revealed a foam recliner and ottoman in the room. When the family member was asked about the foam lounger in the room, the family member stated the resident was placed in the chair on the days she was scheduled for a shower. When asked, the family member confirmed the use of the pelvic restraint when the resident was in the foam lounger.<br><br>Interview with the DON on 7/21/15 at 10:30 AM in the conference room, confirmed the facility had failed to assess the resident for the need of restraints, the need for continued use of restraints, and for restraint reduction. Continued interview revealed the facility had failed to accurately complete the restraint consent form by leaving it undated and had failed to follow the facility restraint policy. | F 221 | o Completion Date: September 15, 2015<br><br>**#4• The independent contractor evaluated the systems and processes established by the facility and governing body to minimize the use of restraints. The independent contractor determined to what extent the nursing home seeks to involve, educate and train residents and family members on alternatives to restraints. The independent contractor validated via observation, record review and interview that restraints on all shifts if used are only to facilitate or support the resident's medical treatment, and not used to discipline residents, as staff convenience, or to prevent residents from wandering.** *The dates of evaluation, assessment, & validation of facility's & governing body's systems & processes are provided in Independent Contractor's DPOC Final Report.*<br><br>• 4.1 A facility assessment was completed to review all processes and systems related to restraint minimization. The assessment will include, but not be limited to:<br><br>o Leadership, staff and contractor interviews<br><br>o Policies and procedures<br><br>▪ Scope<br><br>▪ Execution<br><br>• New admits<br><br>• Current residents<br><br>o New orders | |

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| F 221 | Continued From page 22<br>Medical record review revealed Resident #63 was admitted to the facility on 4/20/09 with diagnosis including Depressive Disorder, Hypertension, Emphysema, Osteoporosis and Dementia.<br><br>Medical record review of the Annual MDS dated 4/28/15 revealed Resident #63 was unable to be severely cognitively impaired. Continued review of the MDS revealed the resident had trouble concentrating, trouble sleeping and poor appetite, wandering occurred daily and restraints were used daily while the resident was up in a chair or out of bed.<br><br>Medical record review of the 3/2015 through 7/2015 Physician's Orders revealed "...May be up in wc with soft posey belt. Release and reposition Q 2 hrs x 10 min. Check Q 30 min...Merry Walker (a standing walker with seat) to be used with staff 1:1 PRN for strengthening...Sensor pad alarm to bed to alert staff of unassisted rising..."<br><br>Medical record review of the Restraint Assessment dated 9/5/13 revealed none of the twenty-six assessment questions were completed. Continued review of the Review Dates: 6/3/14, 7/5/14, 8/5/14, 10/1/14, 11/5/14, 12/5/14, 1/5/15, 2/3/15, 3/14/15 and 4/8/15 revealed a soft belt restraint was in use with no documentation on the assessment for the reason a restraint was required.<br><br>Medical record review of Social Services Notes dated 5/26/14 revealed "Annual Assessment...is very resistant to the Torso-Posey that her daughter requested be on her at all times..."<br><br>Medical record review of Social Services Notes dated 8/21/14 revealed "Quarterly | F 221 | o Change orders<br>o Continuing orders<br>• Emergencies<br>o Training Curriculum – Restraints and resident rights<br>▪ Scope and content<br>▪ Stakeholders {includes employed staff, agency (none since before 2005), contractors (therapy), families and volunteers}<br>▪ Frequency<br>• CCRC Staff<br>o Onboarding<br>o Interim (as needed)<br>o Continuing (annual)<br>• Residents and Families<br>• Volunteers<br>▪ Staff returning from extended leave<br>▪ Agency and Contract Service Provider Staff<br>▪ Methods/Platforms<br>▪ Knowledge and/or competency verification | |

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| F 221 | Continued From page 23<br>Assessment...currently has soft-posey to prevent attempts to ambulate independently. This is at daughter's request..."<br><br>Medical record review of Social Services Notes dated 11/17/14 revealed "Quarterly Assessment...continues to reach behind her to take the soft-posey off..."<br><br>Medical record review of Social Service Notes dated 2/5/15 revealed "Quarterly Assessment...She is a wanderer and constantly ambulating around in her wheelchair...has a soft posey belt for safety. Staff walks her in her Merry Walker..."<br><br>Medical record review of Social Services Notes dated 4/28/15 revealed "Annual Assessment...continues to try to get out of her wheelchair...asks anyone she can to please get her out...does walk often in the Merry Walker with assist..."<br><br>Observation on 7/13/15 at 3:42 PM of Resident #63 on the H hall and I hall nurses station revealed the resident was up in the wheel chair with a soft belt restraint in place. The resident was asking staff members to take the soft belt restraint off so she can "get home."<br><br>Observation on 7/14/15 at 8:07 AM of the resident revealed the resident was up in the wheelchair with the soft belt restraint in place. Resident #63 was propelling herself with her feet, going from staff member to staff member asking them to take the belt off "so I can get on the road...I've got to get going." CNA # 2 readjusted the soft belt restraint and checked placement without removing the restraint. | F 221 | • Who does it?<br>• Documentation<br>• Follow-up<br>o Documentation<br>o Communication and Ongoing Involvement<br>▪ Staff<br>▪ Residents<br>▪ Family<br><br>Information collected in the above outlined baseline assessment was used to identify gaps and weaknesses, inform relevant opportunities for improvement and establish recommendations/specific actions to the facility Administrator and governing board.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>• 4.2 As part of the overall assessment (4.1) the involvement, education and training of residents and their families on alternatives to restraints was completed.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>• 4.3 Resident restraint use was validated on all shifts to insure utilization is to facilitate | |

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| F 221 | Continued From page 24<br><br>Observation on 7/20/15 at 2:00 PM of Resident #63 at the H hall and I hall nurses station revealed the resident was sitting in the wheelchair at the nurses station accompanied by a nurse. The soft belt restraint was not in place at the time of the observation.<br><br>Interview on 7/21/15 at 9:00 AM with Social Services Director #1 in the Social Services office revealed "She (the resident) is very confused and gets extremely anxious at times. The daughter wants us to have her mom in the belt restraint for her safety to prevent falls."<br><br>Interview on 7/21/15 at 10:10 AM with the DON in the Conference Room, in response to being asked about who makes the determination for use of restraints, stated "The nurse on the floor does. Sometimes the family requests one to be placed, like this one here (points to Resident # 63 chart). Her daughter insisted that her mother have it on and will not let us remove it. We have attempted a reduction with a Merry Walker, but the daughter just will not have it." When asked for the location of the restraint reassessment, the DON stated "I would expect them to be done quarterly and in the Interdisciplinary Notes."<br><br>Interview on 7/21/15 at 2:00 PM with the DON in the Admissions office stated "We did not reassess this resident's restraints because her daughter told us she wanted her mother in it."<br><br>Interview on 7/21/15 at 2:10 PM with MDS Coordinator #2 and the DON in the Admissions office, when asked about the Interdisciplinary Notes and Quarterly Assessments for Resident #63, MDS Coordinator #2 stated "I only document | F 221 | or support medical treatment and that none are in use for discipline, staff convenience or to prevent wandering. Validation was by way of observation, record review and interviews throughout the course of the Independent Consultant's engagement.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>**#5• The independent contractor determined what procedures are in place to assess the competency of staff who apply restraints; the frequency of observing and assessing the resident who is restrained; and how staff interact with the resident and attend to the resident's needs while he or she is restrained.** *The Independent Contractor's DPOC Final Report contains her findings and assessment of facility limited restraint use.*<br><br>• 5.1 As part of the overall facility assessment related to restraint minimization (4.1), the facility's procedures related to assessing staff competency in the application of restraints was evaluated.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>• 5.2 CCRC licensed and/or certified staff was evaluated as to the frequency of observation and assessment of residents | |

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| F 221 | Continued From page 25<br>on the Interdisciplinary Notes when there is a family meeting." When asked if 9/10/13 was the last family meeting, the MDS Coordinator stated "Yes." When asked where the quarterly restraint reassessment would be, the DON stated "I don't know."<br><br>Medical record review revealed Resident #73 was admitted to the facility on 1/9/13 with diagnoses including Alzheimer's Disease, Hypertension, Cerebral Vascular Accident, and Osteoarthritis.<br><br>Medical record review of a "Restraint Assessment" dated 1/23/14 revealed the resident had a "soft posey belt." Continued review revealed documentation in the comment section with a review date of 4/2/14, "restraint reduction @ each meal of soft Posey belt...at table [with] staff present, and a review date of 7/15/15, "soft Posey belt in w/c."<br><br>Medical record review of "Physician's Orders" (recapitulation) from 3/2015 through 7/2015, revealed an order for "...Posey belt off when at table during meals Posey belt in WC. Check Q 30 min and release and reposition Q 2 hrs x 10 min..."<br><br>Medical record review of "Informed Consent for Restraint Utilization" signed by the responsible party and dated 1/30/14 giving consent, revealed "...Due to Alzheimer's Disease, (Advance)...determined that the use of Soft Posey Belt in W/C is necessary to protect resident from physical harm..."<br><br>Medical record review revealed no documentation of restraint assessment prior to restraint reduction, no assessments for or attempts at | F 221 | who are restrained. This evaluation was completed in conjunction with 4.3.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>• 5.3. All classifications of CCRC staff, agency personnel (none since before 2005) and contract service providers (therapy) was evaluated as to how they interact with residents and attend to their needs while restrained. This was completed in conjunction with 4.3.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>**#6• The independent contractor is submitting to CMS and the State a copy of all training materials, and a written report summarizing the aforementioned components of the directed plan of correction, and how the administrator and governing body will ensure ongoing compliance with 42 CFR 483.13.**<br><br>• 6.1 At the completion of the Independent Consultant's role on September 15, 2015, a report is submitted to CMS and the State summarizing the above outlined directed plan of correction, its execution, findings and recommendations, and how the Administrator and governing body will ensure ongoing compliance with 42 CFR | |

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| F 221 | Continued From page 26<br>further restraint reduction, and no quarterly restraint reassessments having been completed, per facility policy.<br><br>Observation on 7/15/15 at 7:51 AM at the H hall and I hall nurses station, revealed Resident #73 was seated in a wheelchair and a soft belt restraint in place. Continued observation revealed the strap of the restraint on the right side of the chair was applied over the top of the chair arm.<br><br>Interview with CNA #12 on 7/15/15 at 7:52 AM at the H hall and I hall nurses station, confirmed the soft belt restraint was applied incorrectly "positioned at the breast up over the arm of the chair and should be between the seat close to hip bones."<br><br>Interview with the DON on 7/21/15 at 10:30 AM in the conference room, confirmed the facility had failed to assess the resident for the need of restraints, for the appropriateness of the restraint, for the need for continued use of restraints, and for further restraint reduction, per facility policy.<br><br>Medical record review revealed Resident #78 was admitted to the facility on 8/5/10 and readmitted on 7/9/13 with Recurrent Episode of Manic, Bipolar Affect, Psychosis, Anxiety, Depression, Lack of Coordination, Malaise and Fatigue, and Altered Mental Status.<br><br>Medical record review of the Annual MDS dated 6/5/15 revealed the resident was severely cognitively impaired. Continued review revealed the resident had a restraint used daily when in chair or out of bed.<br><br>Medical record review of a "Restraint | F 221 | 483.13. The report will include copies of all training materials and any other relevant documents.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 18, 2015 | |

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| F 221 | Continued From page 27<br>Assessment" dated 7/19/13 revealed the resident had no restraints at that time. Continued review revealed documentation in the comment section with a review date of 9/18/13, "alarming seatbelt in w/c." Continued review revealed a comment on 7/16/15, "cont. [with] alarming seat belt in w/c."<br><br>The Restraint Assessment dated 7/19/13 revealed no restraint was needed. The facility failed to complete a restraint assessment from 9/18/13 through 7/16/15.<br><br>Medical Record review of "Physician's Orders" (recapitulation) for 3/2015 through 7/2015 revealed an order for "...Alarming seat belt in WC. Check Q [every] 30 min and release and reposition Q 2 hrs x 10 min..."<br><br>Medical record review of a "Nurses Notes" with an entry date and time of 7/16/15 at 6:55 PM revealed, "...Spoke with daughter...regarding informed consent for alarming seat belt in w/c. Daughter stated she will be here tomorrow to sign consent... "<br><br>Medical record review of "Informed Consent for Restraint Utilization" signed by the responsible party giving consent, revealed "...Due to decreased cognition [with] [decreased] safety awareness....the use of an alarming seatbelt is necessary to protect from physical harm..." Continue review revealed the responsible party and witness signatures were undated.<br><br>Medical record review revealed no documentation of restraint assessment or reassessment having been completed and no documentation of attempted restraint reduction. | F 221 | | |

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| F 221 | Continued From page 28<br>Observation on 7/16/15 at 2:30 PM in the H hall and I hall dayroom/dining room, revealed the resident was seated in a wheelchair propelling herself back and forth with her feet. Continued observation revealed an alarming seat belt across her abdomen. Continued observation revealed the resident to be alert and pleasantly confused (confused or disoriented, but they aren't agitated about it).<br><br>Observation on 7/20/15 at 4:20 PM in the H hall and I hall dayroom/dining room, revealed the resident seated in a wheelchair with an alarming seat belt across the abdomen.<br><br>Interview with the DON on 7/21/15 at 10:30 AM in the conference room, confirmed the facility had failed, per facility policy, to assess the resident for the need of restraints, the need for continued use of restraints, and for restraint reduction. Continued interview revealed the facility had failed to accurately complete the restraint consent form by leaving it undated and had failed to follow the facility restraint policy.<br><br>Medical record review revealed Resident #94 was admitted 6/14/13 with diagnoses including Grand Mal Seizures, Cerebrovascular Accident, Left-Sided Hemiplegia, Blindness, Gastrostomy, and Muscle Weakness.<br><br>Medical record review of an Annual MDS dated 5/1/15 revealed Resident #94 was severely cognitively impaired and was totally dependent for all Activities of Daily Living. Continued review revealed the resident had a gastrostomy tube (g-tube/peg-tube) and had a limb restraint that was used daily. Continued review of the Care Area Assessment Summary revealed "...pulls his | F 221 | | |

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| F 221 | Continued From page 29<br>feeding tube (gastrostomy) out at times...hand mitt [mitten] on non-paralyzed hand at all times..."<br><br>Medical record review of an "ACKNOWLEDGEMENT OF RESTRAIN [restraint] POLICIES" (a form that is provided to the resident and or family upon admission to the facility) signed by the resident on 6/14/13, revealed "...if restraint use is deemed necessary the goal will be to use the least restrictive type of restraint for the shortest period of time possible...every resident will be individually assessed regarding the need for appropriate safety measures and will be periodically reassessed as their needs change throughout their stay..."<br><br>Medical record review of a Restraint Assessment with original date of 6/18/13 revealed "...type of restraint...R [right] hand mitt [mitten]..." Continued review revealed assessment review dates from 10/11/13 through 1/15/15 of continued use of a right hand mitten and no reassessment for the continued need of a restraint.<br><br>Medical record review of a Restraint Assessment dated 4/7/15 revealed "...Reason for Restraint...pulling peg-tube [gastrostomy]..." Continued review revealed "...Review dates...4/7/15 Rt [right] hand mitten to prevent resident from pulling on g-tube [gastrostomy]..." and no documentation that a reassessment had been completed for the continued need of a restraint.<br><br>Medical record review of the Physician's Orders dated 7/1-7/31/15 revealed "...Mitt to Rt hand to prevent him pulling feeding tube [gastrostomy] out..." | F 221 | | |

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| F 221 | Continued From page 30<br><br>Medical record review revealed no documentation of consent for the right hand mitten restraint.<br><br>Medical record review of a nurse note dated 5/7/15 at 6:00 AM "...R [right] hand mitten on for protection of tube. Prevent pulling out G-tube [gastrostomy]..." Continued review of nurses notes from 7/19/14 to 5/7/15 revealed no documentation of Resident #94 pulling out the gastrostomy tube.<br><br>Medical record review of a TAR dated 6/2015 revealed "...Mitt to rt hand to prevent him pulling feeding tube out. Check for safety q 30 min, release x 10 min (minimum for repositioning) Q 2 hrs..." Continued review revealed no documentation for the 11P-7A shift.<br><br>Observation on 7/20/15 at 1:34 PM revealed the resident lying in bed with a mitten on his right hand.<br><br>Interview with LPN #11 on 7/20/15 at 1:37 PM at F/G nurses station revealed "...he has a tendency to pull the G-tube [gastrostomy] out if he gets a chance to get a hold of it. He has pulled it out numerous times..."<br><br>Interview with the DON on 7/21/15 at 8:58 AM in the Admissions Coordinator Office, when asked if the restraint was to be checked every 30 minutes and released every 2 hours per the facility policy, the DON stated "...yes..." After reviewing the TAR, the DON was asked if there was documentation that the restraint had been monitored, she stated "...no documentation on 11/7 shift..." When asked if the resident had a complete restraint assessment and had been | F 221 | | |

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| F 221 | Continued From page 31<br>reassessed at least quarterly for the least restrictive device, the DON stated "...no, he's not been reassessed...at one time I thought he had a binder...can't remember...he's probably had the mitten since 2013..."<br><br>Medical record review revealed Resident #109 was admitted to the facility on 7/23/12 with diagnoses including Dementia with Behaviors, Parkinson's Disease, Hypertension, Bi-Polar Disorder and Glaucoma.<br><br>Review of the Quarterly MDS dated 4/3/15 documented the resident was independent for transfers and ambulation on and off the unit without supervision. His gait was not steady but he was able to stabilize without assistance. The resident used a wheelchair and a cane to assist with mobility and did not use any restraint devices. Continued review revealed the resident was severely cognitively impaired, and rejected care daily.<br><br>Review of an"ACKNOWLEDGEMENT OF RESTRAIN [restraint] POLICIES" (a form that is provided to the resident and or family upon admission to the facility) dated 7/23/12 and signed by the resident's family member revealed "...The intent of the restraint policy is for each person to reach his/her highest practicable well-being in an environment that prohibits the use of restraints... consent of the resident or legal representative...after a functional assessment...Every resident will be individually assessed regarding the need for appropriate safety measures and will be periodically reassessed as their needs change throughout their stay at our facility..." | F 221 | | |

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| F 221 | Continued From page 32<br>Observation on 7/13/15 at 11:17 AM in the H hall and I hall nurse station revealed a CNA taking Resident #109 to the H dayroom/dining room in a WC with a soft torso restraint velcroed to the WC. The resident was observed eating lunch with his left hand unassisted while still in the restraint.<br><br>Observation on 7/13/15 at 3:15 PM in the resident's room revealed the resident was seated in the wheelchair with a soft torso restraint velcroed to the WC leaning over attempting to pick up a cup that had fallen off of the over the bed table with water noted on the floor. There was a gap of approximately 5 inches between the resident's back and the back of the wheelchair. The surveyor notified CNA #2 the resident needed assistance. The CNA refilled the cup of water, cleaned up the water on the floor, and placed the over the bed table with the cup of water closer to the resident. The soft torso restraint was not adjusted.<br><br>Observation on 7/14/15 at 9:10 AM in the resident's room revealed the resident was seated in a wheel chair with a soft torso restraint velcroed to the WC watching TV.<br><br>Interview with LPN #9 on 7/15/15 at 8:00 AM at the H hall and I hall nurses station confirmed Resident #109 was in a restraint for multiple falls and an unsteady gait from Parkinson's disease. Continued interview confirmed the resident was being evaluated by physical therapy (PT) and he can ambulate with a cane and minimal assistance. When asked who placed the restraint on the resident the LPN stated, "...The CNA's place the resident in the restraint, and we all try to reposition him and release them every couple of hours but some days it just doesn't happen..." | F 221 | | |

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| F 221 | Continued From page 33<br><br>Observation on 7/15/15 at 9:12 AM in the resident's room revealed the resident was seated in the wheelchair in the soft torso restraint velcroed to the W/C (wheelchair) facing the window.<br><br>Observation on 7/15/15 at 12:45 PM revealed the resident had finished his lunch in the H hall and I hall dayroom/dining room and was assisted back into the WC and the soft torso restraint was placed by CNA #2. The resident was taken back to his room. Continued observation at 1:30 PM revealed the resident was taken to an activity in the main dining room in the WC with the soft torso restraint intact by an activities assistant and watched other resident's line dancing. The resident remained in the restraint during the activity.<br><br>Observation on 7/15/15 at 3:15 PM revealed the resident was back in his room seated in the W/C with the soft torso restraint in place.<br><br>Interview with CNA #2 on 7/15/15 at 3:20 PM at the H hall and I hall nurses station confirmed the soft torso restraint on Resident #109 had not been released since 12:45 PM.<br><br>Interview with the Physical Therapy Assistant (PTA) on 7/16/15 at 10:50 AM at the H/I nurses station confirmed he worked with the resident regularly. Continued interview confirmed the resident was ambulatory and walked unassisted on 7/15/15 during therapy and to breakfast on 7/16/15. Continued interview confirmed the resident had an abnormal gait and ambulated better without an assistive device although he did have a claw cane. Continued interview with the | F 221 | | |

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| F 221 | Continued From page 34<br>PTA revealed the residents goal was to ambulate unassisted. The PTA stated the resident had a pattern of obtaining the goal rapidly and would then be discharged from PT services. Continued interview with the PTA stated the resident would fall, would be placed back in a restraint, re-evaluated by PT and placed back on PT services again until he ambulated unassisted again, and then was discharged from PT services. This had been a frequent pattern for the resident.<br><br>Medical record review of a physician's order dated 5/5/15 revealed "...WC [with] soft belt when out of bed..." Continued review revealed an order dated 5/8/15 to "...D/C soft belt in WC...Torso posey positioner in W/C [check] for placement [every] 30 minute's release [and] reposition X 10 min's [every] 2 [hours]..."<br><br>Medical record review of an Informed Consent for Restraint Utilization dated 12/21/14 revealed it was signed by the residents family member. There was no witness signature or date.<br><br>Medical record review of a Restraint Assessment dated 12/21/14 documented the resident was "...unsteady...takes short steps...steps on own feet...resistant [with] care [at times]..." Continued review revealed "Yes" was marked next to "Uncooperative". The facility documented the reason for a restraint was "...gait unsteady, staggers, uncooperative [with] assisted ambulation..." Continued review revealed the following: 12/21/14 Soft positioner in wheelchair when out of bed; 12/23/14 Torso positioner in wheelchair when out of bed; 1/10/15 Torso positioner in wheelchair when out of bed. Release and reposition every 2 hours for 10 minutes, | F 221 | | |

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| F 221 | Continued From page 35<br>check for placement every 30 minutes; 3/10/15 May ambulate independent. May use wheelchair as needed for unsteady gait; 4/20/15 No restraints; and 5/4/15 and 7/7/15 Soft positioner in wheelchair when out of bed.<br>Interview with RN#1 on 7/16/15 at 1:50 PM in the H hall and I hall nurses station confirmed there were no updated restraint assessments completed for the resident after 12/21/14. Continued interview confirmed there was no documentation prior to the 5/5/15 order to place a soft belt restraint when out of bed, or the 5/8/15 order for the torso positioner while in the W/C, that a less restrictive alternative was attempted prior to placing the restraint. Continued interview with the RN confirmed there was no documentation that the restraints had been checked every 30 minutes and released every 2 hours as per facility policy.<br><br>Observation and interview with the resident on 7/22/15 at 8:40 AM in the H hall and I hall dayroom/dining room revealed the resident was seated at the table eating breakfast unassisted. The claw cane was noted behind the resident by the wall. When the resident was asked how he was doing he stated, "They sprung me loose." When the resident was asked if he was walking on his own he smiled and stated "Yes."<br><br>Interview with the Medical Director on 7/22/15 at 1:45 PM by phone in the conference room confirmed Resident #109 had "...mental status changes from time to time and needed to be assessed more often..." When asked what behaviors the resident exhibited to indicate the use of a restraint the Medical Director stated, "... He is negative and more uncooperative..." | F 221 | | |

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| F 221 | Continued From page 36<br>Interview with the DON on 7/22/15 at 3:17 PM in the conference room confirmed a new restraint consent was not obtained from the family when the order dated 5/5/15 to place Resident #109 in a soft belt was written, or when the soft torso positioner was ordered on 5/8/15. Continued interview confirmed the consent dated 12/21/14 was not witnessed or dated by the facility. Continued interview confirmed a new consent should have been obtained each time a different restraint was placed on the resident. Continued interview with the DON confirmed there was no medical reason documented why the resident was placed in a restraint.<br><br>Medical record review revealed Resident #111 was admitted 8/6/12 with diagnoses including Dementia without Behavior Disturbances, Coronary Artery Disease, Anxiety, Obstructive Sleep Apnea and Constipation.<br><br>Medical record review of an Annual MDS dated 8/5/14 and a Quarterly MDS dated 4/10/15 revealed the resident was severely cognitively impaired and required extensive assistance of 2 people for transfers, and a trunk restraint in chair/out of bed was used.<br><br>Medical record review of an ""ACKNOWLEDGEMENT OF RESTRAIN [restraint] POLICIES" (a form that is provided to the resident and or family upon admission to the facility) dated 8/6/12 revealed "...if restraint use is deemed necessary the goal will be to use the least restrictive type of restraint for the shortest period of time possible...every resident will be individually assessed regarding the need for appropriate safety measures and will be periodically reassessed as their needs change | F 221 | | |

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| F 221 | Continued From page 37<br>throughout their stay..."<br><br>Medical record review of a Restraint Assessment dated 4/2/14 revealed "...inconsistent [with] cooperation, often resistant to care...Posey positioner when [up] in w/c..." Continued review revealed "...reason for restraint...hx [history] of falls, resident safety..." Continued review revealed review dates from 4/30/14 through 7/9/15 and no documentation of an assessment or reassessment for the continued use of the restraint or for a least restrictive restraint.<br><br>Medical record review of Physician's Orders dated 7/2015 revealed "...Continue with in WC [wheelchair], torso Posey positioner at all times. Check for placement q 30 min & release reposition q 2 hr x 10 min..."<br><br>Medical record review of a Restraint Consent dated 2/1/14 documented "...[Resident #111's] physician and an interdisciplinary team of medical professionals have assessed and determined that the use of restraint when up in w/c is necessary..." and did not identify the type of restraint to be used.<br><br>Observation on 7/16/15 at 1:18 PM revealed resident seated in a W/C in front of F hall and G hall nurses station with torso positioner applied.<br><br>Observation on 7/20/15 at 1:29 PM revealed the resident seated in a W/C in the common area near F hall and G hall nurses station. Continued observation revealed a torso positioner applied.<br><br>Observation on 7/20/15 at 3:55 PM on G hall revealed Resident #111 seated in a W/C with a torso positioner applied. | F 221 | | |

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| F 221 | Continued From page 38<br><br>Interview with the Director of Nursing on 7/21/15 at 8:58 AM in the Admission Coordinators Office, after review of a Restraint Assessment with an original date of 4/2/14, the DON confirmed the last attempted restraint reduction was in 1/2015. When asked if the resident had been reassessed for a least restrictive restraint per the facility policy, the DON stated "...no..." When asked if the consent for restraint was specific to what the resident had, the DON stated "...no, it is not..."<br><br>Medical record review revealed Resident #117 was admitted to the facility on 9/18/12 with Diabetes Mellitus, Dementia with Behavioral Disturbances, Depressive Disorder, Muscle Weakness, and Hypertension.<br><br>Medical record review of the Quarterly MDS dated 5/18/15 revealed the resident was severely cognitively impaired. Further review revealed the resident had a trunk restraint used daily when out of bed.<br><br>Medical record review of the Restraint Assessment dated 11/21/12 revealed the resident had no restraints upon admission to the facility. Continued review revealed a review date of 4/2/14 documented, "torso posey positioner in W/C [with] con't [continue] to [check] q 30 mins release reposition q 2 [hours] x 10 mins - remove when @ table for meals & reattach after meal completed...." Continued review revealed a review date of 1-4-15 documented, "...torso posey positioner to WC..." Continued review revealed a review date of 7/14/15 documented, "continues torso posey positioner to WC..." Continued review revealed a review date of 7/18/15 documented, "Restraint Reduction: torso posey to WC from 3p | F 221 | | |

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| F 221 | Continued From page 39<br>[PM] until Bedtime, off from 7a [AM]- 3p..."<br><br>Medical Record review of the Physician's Orders (recapitulation) from 2/2015 through 7/2015 revealed orders for "...torso posey positioner on @ all times when up OOB in WC. Check Q 30 min, release and reposition Q 2 hrs x 10 min. Off at all meal times when up to table only..."<br><br>Medical record review of a Physician Telephone Order dated 7/18/15 revealed an order for restraint reduction trial with the torso positioner to be off from 7:00 AM to 3:00 PM and on from 3:00 PM to bedtime.<br><br>Medical record review revealed an "Informed Consent for Restraint Utilization" signed by the responsible party and dated 2/12/14, consenting to the use of the restraint, "...Due to Dementia w/ [with] behavior...assessed and determined that the use of Torso Posey while in W/C is necessary to protect resident from physical harm..." Continue review revealed there was no witness signature.<br><br>Medical record review revealed no documented evidence of a restraint assessment having been completed prior to the restraint reduction trial on 7/18/15 and no documentation of quarterly re-evaluation, per facility policy, of the continued need and appropriateness of the restraint having been completed.<br><br>Observation on 7/16/15 at 2:12 PM in the J hall and K hall dayroom/dining room revealed the resident was seated in a wheelchair with a torso positioner restraint in place.<br>Observation during an ice cream social activity, on 7/20/15 at 2:20 PM in the main dining room | F 221 | | |

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| F 221 | Continued From page 40<br>revealed the resident was seated in a wheelchair, unrestrained, self-propelling back and forth with his feet.<br><br>Interview with the DON on 7/21/15 at 10:30 AM in the conference room, confirmed the facility had failed, per facility policy, to assess the resident for the appropriateness of the restraint, and for the least restrictive device and had failed to assess the resident prior to attempting restraint reduction trial. Continued interview confirmed the facility had failed to re-evaluate the need for restraints at least quarterly, per facility policy.<br><br>Medical record review revealed Resident #142 was admitted to the facility on 11/18/14 with diagnoses including Alzheimer's, Dementia without Behaviors, Malaise and Fatigue, and Delusional Disorder.<br><br>Review of the Quarterly MDS dated 4/21/15 documented the resident was ambulatory, was steady at all times, had no range of motion impairment and did not use any mobility devices. The resident did not have any behavior problems, had disorganized thinking, short and long term memory loss and wandered daily but was not an elopement risk. The resident had not had any falls since the previous assessment.<br><br>Observation on 7/13/15 at 3:10 PM in the hall by the front entry doors revealed the resident was ambulating quickly with a steady gait.<br><br>Observation on 7/14/15 at 10:05 AM in the conference room revealed the resident stopped at the door, was smiling, mumbled incomprehensible words, then ambulated down the hallway. Continued observations revealed the | F 221 | | |

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| F 221 | Continued From page 41<br>resident wandered most of the day in the hallways throughout the facility and to the H hall and I hall dayroom/dining room for meals.<br><br>Observation on 7/15/15 at 7:53 AM in the H hall and I hall dayroom/dining room revealed the resident was seated at the head of a table in a W/C with a soft lap belt restraint in place.<br><br>Interview with LPN #9 on 7/15/15 at 8:05 AM at the H hall and I hall nurses station stated the resident was placed in the W/C with a lap belt restraint by night shift as the resident did not sleep much during the night and her gait was unstable by early morning. Continued interview with the LPN, when asked if a restraint was the least restrictive alternative to help keep the resident safe the LPN stated, "She's undirectable-when she gets it in her mind to go somewhere she goes, whether its in a W/C or walking, I've had to chase her down she goes so fast."<br><br>Medical record review of a physician order dated 6/9/15 documented "...May wear a posey when in W/C due to stumbling [check] placement q 30 min/release & reposition x 10 minutes q 2 [hours]..."<br><br>Review of a Nurses Notes dated 7/15/15 at 5:30 AM documented "...Awake most of NOC [night] wandering around facility-took a 2 [hour] nap, then back up and around gait became unsteady was then assisted into W/C [with] soft belt..."<br><br>Review of a Restraint Assessment dated 11/8/14 documented the following:<br>Diagnosis: UTI [Urinary tract infection], Alzheimer's Advance, Frequent Falls | F 221 | | |

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| F 221 | Continued From page 42<br>Cognitive Status: Confusion/disoriented<br>Ability to Understand/Remember directions: Poor<br>Falls within past 12 months: Yes<br>Gait/Balance Problems: Unsteady Gait<br>Behavioral Problems: No<br>Reason for Restraint: no documentation present<br><br>Review Dates: 11/8/14, 2/8/15, 3/10/15, 4/8/15: no restraints<br>7/9/15 no documentation present<br><br>Medical record review for a signed restraint consent revealed no consent was present in the resident's chart.<br><br>Review of a TAR dated 6/2015 and 7/2015 revealed no documentation of restraint monitoring.<br><br>Interview with RN #1 on 7/16/15 at 1:50 PM at the H hall and I hall nurses station confirmed the restraint assessment for Resident #142 was incomplete and not up to date; there was no documentation the facility attempted a less restrictive alternative before placing the resident in a restraint; there was no signed restraint consent in the resident's chart; and there was no documentation the restraint was released every 2 hours per the physician's order and the facility policy. Continued interview with the RN confirmed the resident should have never been restrained and the RN stated, "...She shouldn't have had a restraint--period! She's very compliant and does not need a restraint..."<br><br>Medical record review revealed Resident #158 was admitted to the facility on 2/25/15 and readmitted 3/17/15, with diagnoses including Dementia with Behaviors, Anxiety, and | F 221 | | |

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| F 221 | Continued From page 43<br>Depression.<br><br>Medical record review of a Physician's Telephone Order dated 4/6/15, revealed "...Soft posey belt while up in Wheel chair..."<br><br>Medical record review revealed no Informed Consent for Restraint Utilization for Resident #158.<br><br>Observation on 7/14/15 at 4:30 PM at the F hall and G hall nurses station, revealed the resident sitting in a wheelchair in the common area with a soft waist belt in place.<br><br>Interview with LPN #11, the nurse who obtained the restraint order, on 7/15/15 at 10:08 AM in the Case Manager's Office, confirmed the LPN failed to obtain the Informed Consent.<br><br>An acceptable Allegation of Compliance removed the immediacy of the Immediate Jeopardy on 7/29/15.<br><br>The interventions put in place were evaluated by the survey team on 7/29/15, and verified the Allegation of Compliance by:<br><br>1. The facility re-assessed the 13 residents with restraints for appropriateness and for the least restrictive device.<br><br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a | F 221 | | |

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| F 221 | Continued From page 44<br>restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level, for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 221 | | |
| F 272 SS=K | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns; | F 272 | Facility will conduct initially and periodically a comprehensive, accurate, standardized assessment of a resident's needs.<br><br>All residents have the potential to be effected.<br><br>7/23/15 – **Restraint Reduction Committee:** New Committee meets weekly. DON is the Chairman. Members include: NHA, DON, MDS LN, Unit Managers, Wound Care Nurse, Central Supply, Restorative CNAs, Therapy, Social Service and Activities. The Medical Director will be an Ad Hoc member of the committee. The Committee will review weekly every restraint and all assistive devices that could also be a restraint. The review will be conducted for potential reduction, removal or validation of continued medical necessity. | |

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| F 272 | Continued From page 45<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of Lippincott Manual of Nursing Practice, 2014, Tenth Edition regarding standard for restraints, facility policy review, review of the restraint manufacturer's Application Instructions, the medical record, the facility investigations, interview, and observation, the facility failed to ensure the use for a restraint was assessed, determine the least restrictive restraint, and periodically reassess the need for the restraints to ensure the resident's safety for 11 (Resident #160, 29, 56, 63, 73, 78, 94, 109, 111, 117, 142) of 13 residents reviewed with restraints. The failure of the facility to properly assess and re-assess the need for restraints, determine the least restrictive restraint, following the restraint | F 272 | **Resident #29**<br><br>7/31/15 – Seating in Broda chair with non-skid seating – no restraint. Chair is slightly reclined for comfort except at meals. Continues sensor pad in bed. Will continue weekly Restraint Reduction Committee review.<br><br>8/5/15 – Morning QA Managers Meeting – observed on numerous occasions by 3-11 staff to be sitting toward front of the seat but no attempt to rise. Non-skid seating in place – continue to monitor.<br><br>8/5/15 – Restraint Reduction Committee review: Reassess current positioning - Staff report resident is more anxious in the afternoon. Committee will recommend an afternoon nap in bed after lunch to attempt to relax resident.<br><br>8/10/15 – Morning Managers Meeting – discussed related to resident preferred positioning at the front of the chair – observed at front of seat x 1 in previous 24 hours. No attempt to rise, chair assessed by Committee to continue to be the most appropriate seating for resident comfort. Family visited and ambulated with resident – safety maintained during visit.<br><br>8/12/15 – Restraint Reduction Committee review – resident was agitated x 1 (requiring medication intervention with positive results) since previous Committee review. Afternoon rest periods appear to decrease afternoon/evening anxiety. Confusion has increased this week. Not oriented to time or place – will incorporate additional afternoon activity time before or after nap. Activities notified. Care plan reviewed. Assessment updated to reflect current resident status and interventions. | |

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| F 272 | Continued From page 46<br>manufacturer's application instructions and warnings placed Resident #160 in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident).<br><br>The Administrator was informed of the Immediate Jeopardy on 7/21/15 at 2:40 PM in the conference room.<br><br>The Immediate Jeopardy was effective 5/4/15 through 7/30/15.<br><br>A Full Extended Survey was conducted on 7/21-29/15.<br><br>An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received on 7/29/15 at 9:00 AM, and the corrective actions were validated by the surveyors on 7/29/15.<br><br>The findings included:<br><br>Review of Lippincott Manual of Nursing Practice, 2014, Tenth Edition, Chapter 9 revealed "[page] 191...These [restraint] guidelines must be met in any long-term care facility that participates in Medicare or Medicaid. However, these guidelines are useful for health care providers working with older adults in all settings. (a) The resident has the right to be free from any physical restraints imposed...for purposes of discipline or convenience and not required to treat the resident's medical condition. (b) Physical restraints are any manual method of physical or mechanical device, material, or equipment | F 272 | 8/18/14 - Care plan updated. MAR updated for LN documentation. Assessment will continue for safe positioning without restraints.<br><br>**Resident #56**<br><br>7/31/15 – In care foam lounger for comfort – no restraint, incident or attempts to move unsafely out the chair. Will continue to be reviewed in the weekly Restraint Reduction Committee.<br><br>8/5/15 – Restraint Reduction Committee review: Assessment reviewed: No safety concerns when in care foam lounger without harness restraint. Will discuss with family the end of reduction trial. Assessed for use of an electric low bed with upper rails and bolster pads (remove lower rails and bolsters). Recommendations will be discussed with family.<br><br>8/6/15 – DON met with family by phone related to RRC recommendations. Family agreed to continued care foam lounger without harness restraint. Agreed to removal of lower rails and bolster pads but continue upper rails and bolster pads. Discussed electric low bed – family agreed with the bed and continue the perimeter mattress. Consent updated by staff and signed, assessments completed to decrease restraints and change bed devices. Care plan updated, CNA care plan in resident's room & CNA kiosk in addition to LN MAR documentation updated.<br><br>8/10/15 – Daily QA Managers Meeting – review: no issues from restraint reduction in care foam lounger or removal of lower rails and bolsters.<br><br>8/11/15 – Daily QA Managers Meeting – review: no issues in chair or bed. | |

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| F 272 | Continued From page 47<br>attached or adjacent to the resident's body that the person cannot remove easily, which restricts freedom of movement or access to one's body (includes leg and arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, and geriatric chairs). (c) There must be a trial of less restrictive measures unless the physical restraint is necessary to provide life-saving treatment. (d) The resident or legal representative must consent to the use of restraints. (e) Residents who are restrained should be released, exercised, toileted, and checked for skin redness every 2 hours. (f) The need for restraints should be reevaluated periodically. (g) The specific facility will have to develop policies and procedures for the appropriate use of restraints... (h) Primary health care providers will have to write appropriate orders for restraints..."<br><br>Review of the facility policy, updated 2/4/14, "Restraint-Physical" revealed "Restraints should only be used for the safety and well-being of the resident(s) and only after all alternatives have been tried unsuccessfully and results are documented." Further review revealed "...Restraints will only be used in extreme circumstances and only with: 1) Documented behavior 2) Consent from resident's representative...All other non-restrictive alternatives have been tried and were unsuccessful...MD [Medical Doctor] orders MUST be written..." Further review revealed "...Orders indicate the specific reason, type and period of time for the use of restraints. Restraints must be used only as a last resort, and the medical record must indicate the events leading to the necessity of the restraint. Their use is temporary and the resident will not be restrained for an indefinite amount of time...The attending physician must be | F 272 | 8/12/15 – Restraint Reduction Committee meeting review: Assessment reflects resident doing well in care foam lounger. Has sitter three times per week. Family came in today and requested lower rails and bolster pads be placed back on bed – not supportive of removal. Assessments will be reviewed with MD for family request.<br><br>**Resident #63**<br><br>7/29/15 – Resident with Soft Posey belt restraint in wheelchair per manufacturer's recommendations with belt off at meal times. When restless the Merry Walker is offered with 1:1 assistance per policy. Family does not support this level of restraint reduction. Will continue weekly restraint assessment and Restraint Reduction Committee review.<br><br>8/5/15 – Morning QA Managers Meeting review: Order for restraint timed for update – refer to RRC today.<br><br>8/5/15 – Restraint Reduction Committee review: Staff report resident can apply seatbelt and take it off at will – however response when prompted in inconsistent due to confusion- restraint assessment updated. Weakness has been noted when ambulating with Merry Walker – therapy screened resident for Part B therapy services for strengthening – awaiting family response to request. Psychotropic medication reduction initiated last week with goal of decreased anxiousness and nervousness and improved cognition.<br><br>8/10/15 – Morning QA Managers Meeting review: intermittent anxiousness – improved with 1:1 Activity while in Merry Walker. | |

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| F 272 | Continued From page 48<br>notified of such use and the reason for the order...The need for restraints will be re-evaluated at least quarterly in the Fall Committee Meeting to determine their continued use. Every effort will be made to eliminate their use...The least restrictive must always be utilized..."<br><br>Review of the manufacturer's "...Application Instructions for the Posey Torso Support..." and the "...Posey Lap Belt/Padded Lap Belt..." revealed "...Before Applying Any Restraint: Make a complete assessment of the patient to ensure restraint use is appropriate..."<br><br>Medical record review revealed Resident #160 was admitted to the facility on 3/30/15 with diagnoses including Fractured Neck of Femur, Fall, Dementia without Behavioral Disturbances, Blind both eyes, Difficulty Walking, Muscle Weakness, and Pelvis Joint Pain.<br><br>Medical record review of the Admission Minimum Data Set (MDS) dated 4/6/15 revealed the resident had short and long term memory impairment, required extensive assistance of 1 person for bed mobility, toileting and hygiene; required extensive assistance of 2 persons for transfers, was frequently incontinent of bowel and bladder and had one fall without injury since admission.<br><br>Medical record review of the "ACKNOWLEDGEMENT OF RESTRAIN [restraint] POLICIES" (a form that is provided to the resident and or family upon admission to the facility), signed by the responsible party on 3/30/15, revealed "...If restraint use is deemed necessary the goal will be to use the least | F 272 | 8/11/15 – Morning QA Managers Meeting review: Awake until early morning. Anxious in bed, Merry Walker and after snack. Asleep at 0100.<br><br>8/12/15 – Restraint Reduction Committee Review. Assessment completed: When in wheelchair: alarming seat belt restraint (resident does release the belt randomly and attempts to rise unassisted but due to cognition is unable to release on command or ambulate safely for more than a few steps safely). Belt is off at meals and during 1:1 encounters. Committee restraint assessment summary – current devices are the least restrictive restraint for this resident at this time due to poor safety awareness, unsteady gait and mental confusion. Family is not supportive of current restraint reduction. Resident has bed sensor in bed which alarms randomly during the night with the resident attempting to exit the bed unassisted. Will continue weekly restraint reduction assessment for both family education and resident safety with least restrictive device(s).<br><br>8/14/15 – Initiated B&B Program. Restraint Reduction Committee conducted assessment of bowel habits with recommendation to initiate trial bowel toileting "catch" or toileting assistance program in an effort to assist with unsafe ambulation due to frequent bowel toileting needs secondary to medical diagnosis and toileting habit changes.<br><br>**Resident #73**<br><br>7/29/15 – In wheelchair with seat belt restraint. Belt is released during meals and 1:1 visits. Remains non-verbal with limited facial expressions. Family is supportive of reduction. There have been no attempts for the resident to stand unassisted. Will | |

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| F 272 | Continued From page 49<br>restrictive type of restraint for the shortest period of time possible...Every resident will be individually assessed regarding the need for appropriate safety measures and will be periodically reassessed..."<br><br>Medical record review of the "Restraint Assessment" dated 3/31/15 revealed Resident #160 was alert and oriented x (times) 2, had a fall in the past 12 months with a left hip fracture, a check mark beside gait/balance problems, and "...Behavioral Problems...Removes clothing frequently...Positioning Problems [was blank]...Reason for Restraint [was blank]..." Further review documented the review date: "...3/31/15 no restraints needed..."<br><br>Medical record review of the Physician Telephone Order dated 4/9/15 revealed "...torso posey positioner in w/c [wheelchair], check for placement q [every] 30 min [minutes] and release/reposition q 2 hours x 10 min..."<br><br>Medical record review of the "Informed Consent for Restraint Utilization," signed by the responsible party on 4/13/15, per nursing note review had verbal consent on 4/9/15, "...Consenting to the use of restraints as described..." revealed "...Due to decreased safety awareness [with] unsteady gait, multiple attempts to get up unassisted...assessed and determined the torso posey positioner vest necessary to protect [Resident #160] from physical harm..."<br><br>Medical record review of the "Restraint Assessment" revealed no changes in the assessment from 3/31/15 for the 4/9/15 order for "...torso posey positioner in w/c, check for placement q 30 min [minutes] and | F 272 | continue weekly Restraint Reduction Committee Review.<br><br>8/5/15 – Restraint Reduction Committee meeting – reviewed and updated restraint assessment. Currently in restraint 2-3 hours per day. Continue to take rest periods with her husband everyday 1-5 pm and belt off during meals and 1:1 encounter. Will continue review next week for goal of restraint reduction in the mornings.<br><br>8/6/15 – Morning QA Managers Meeting – review: Doing well with current restraint reduction. DON met with family who is supportive of removing the seat belt as long as safety is maintained. Consent updated. Restraint assessment updated for removal for morning hours. Care plan, CNA care plan in resident's room & CNA kiosk and LN documentation updated to reflect removal of belt restraint. Will refer to RRC for post removal safety assessment.<br><br>8/10/15 – Morning QA Manager's Meeting – review: Staff reports resident occasionally sits leaning slightly forward – no concerns related to safety. Will pass information to RRC.<br>8/11/15 – Morning QA Managers Meeting – review. Observed removing the table cloth from the dining tables. Staff state resident is cold natured so a sweater will be offered when resident leaves their room. Care plan and CNA care plan in resident's room & CNA kiosk updated to reflect resident preference.<br>8/12/15 – Restraint Reduction Committee meeting review: Assessment updated - no restraint at this time – no observations of resident trying to get up from seat unassisted since restraint removed. Leans forward on table when in dayroom. Takes rest periods every afternoon with husband at bedside. | |

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| F 272 | Continued From page 50<br>release/reposition q 2 hours x 10 min..."<br><br>Review of the facility's Fall Investigation for Charge Nurse form with the date of the fall on 5/4/15 at 7:15 PM revealed a w/c or geri-chair (a reclining chair with wheels that is not self-propelled) was involved, a chair alarm was functioning properly, and an ordered restraint was in place and applied correctly. Further review revealed "...Did the resident remove the restraint?...Slid under restraint..." Further review revealed "...Description of incident: At approximately 715pm Resident was starting to slide down in w/c. This nurse pulled resident back up in w/c and went to get pads to put in...foam chair to transfer resident to...foam chair. On way back to the dayroom residents chair alarm started going off. Observed resident sliding down underneath posey positioner onto the edge of the w/c. Able to assist resident safely to floor...assisted to...foam chair..." Further review revealed "...Conclusion: Appropriate number of staff involved ? Yes...Equipment use appropriate? Yes...Proper technique used? Yes...Resident unattended inappropriately? No..." Further review documented "...Supervisor Report...New planned interventions: Staff training on correctly applying torso posey positioner..."<br><br>Medical record review of the Skilled Nursing Notes dated 5/8/15 revealed " ...Resident in Rock & Roll [Rock-n-Go, a rocking wheelchair] chair @ [at] 4PM. Observed resident roll self to side bar of wall and pull self out of chair. Resident placed in w/c [with] torso positioner. @ approximately 830 PM this nurse was walking past dayroom. Observed resident down in w/c, posey restraint around neck..." | F 272 | Extended family expressed concern with resident positioning and restraint removal – DON will discuss concerns. Will update assessment during committee meeting next week to review resident safety without restraint.<br><br>**Resident #78**<br><br>7/31/15 – Assessed for Velcro alarming seatbelt restraint in wheelchair to be off at meal time and during family and 1:1 visits. Continue weekly Restraint Reduction Committee review to ensure seatbelt is applied according to manufacturer recommendation and is the least restrictive device indicated based on assessment.<br><br>8/5/15 – Morning QA Managers Meeting – review: Request RRC to review for possible Broda Peddler seating and remove the alarming seat belt.<br><br>8/5/15 – Restraint Reduction committee review: Assessment updated. MD reviewed for possible UTI - ordered urine C&S test. Family visited today to discuss change to Broda Peddler with alarming seatbelt to provide greater independence and safety without alarming seatbelt in addition to changes in behavior. Family did not support change in seating to promote independence because family felt resident is a "meddler" and leans forward reaching for items. Family did agree for UA C&S to evaluate change in behavior. Will continue to follow for lab outcome and device application and use.<br><br>8/7/15 – Morning QA Managers Meeting – review: Resident has been more active but quieter lately. Up in wheelchair with Velcro belt. Will unbuckle randomly but not when prompted. | |

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| F 272 | Continued From page 51<br>Review of the facility's Fall Investigation for Charge Nurse form with the date of the fall on 5/8/15 at 8:30 PM revealed a w/c or geri-chair was involved, and an ordered restraint was in place and applied correctly, Further review documented "...Did the resident remove the restraint? was blank...Was a chair alarm involved? No..." Further revealed "...Description of incident: Walked past dayroom observed resident down in w/c, posey torso restraint around neck...butt off of wheelchair. Undid restraint, lifted resident up in wheelchair x 2 assist...New Order 1) D/C [discontinue] soft torso positioner 2) soft posey belt in Rock & [and] Roll chair [with] pull alarm..." Further review revealed the "...Conclusion: Was appropriate number staff and equipment involved? Yes...Proper technique used? Yes...Resident left unattended inappropriately? No..." Further review revealed "...Supervisor Report...New planned intervention: posey belt in Rock-n-Go; cont [continue] pull alarm also..." Further review of the Supervisor Report revealed in handwritten notes "...were arms beneath torso positioner? Yes...Had she had belt before? Yes but in w/c then, now Rock-n-Go..." Further review of the Supervisor Report revealed "...Licensed Practical Nurse (LPN) #1: Resident was in w/c. Was in Rock-n-Go prior to dinner. She pulled herself up @ guardrail in Rock-n-Go. She was assisted to w/c [with] restraint..." Review of the Employee Statement written by Registered Nurse (RN) #3 of the 5/8/15 incident revealed "...The last time you saw resident before they fell? Time 450 PM...Location: In front dayroom [dayroom/ diningroom] H + [and] I [Hall H and Hall I]...Describe...what you observed/saw/heard: walking down hallway observed resident in dayroom [dayroom/dining room] dining room H + I | F 272 | 8/10/15 – Morning QA Managers Meeting – review: No attempts to rise from seat during random opportunities when unbuckles the seat belt. Started on antibiotic for UTI.<br><br>8/11/15 – Morning QA Managers Meeting – review: Continue on antibiotic for UTI. No safety issues in wheelchair.<br><br>8/12/15 – Restraint Reduction Committee Review. Assessment completed with resident in wheelchair: Alarming seat belt applied according to manufacturer recommendation (resident occasionally releases the belt when fidgeting but does not attempt to rise) with dump wheelchair seat due to resident persistent reaching and bending for items out of reach. Belt is off at meal times, during 1:1 encounter and when the family visits. Family is not supportive of current restraint reduction. Attended Happy Hour this week. Resident has sensor pad when in bed. Will review next week for restraint assessment and reduction.<br><br>**Resident #94**<br><br>7/31/15 - Resident has abdominal binder to protect the integrity of the PEG tube – no restraint. Resident remains without right hand mitten restraint. Assessments and care plans support the current restraint free status. Will continue weekly review by the Restraint Reduction Committee to follow safety of PEG tube.<br><br>8/5/15 – Morning QA Managers Meeting – resident has made no attempt to remove PEG tube.<br><br>8/5/15 – Restraint Reduction Committee review: Assessment completed. Activity reports resident made attempts to hit strings on guitar today during 1:1 session – a notable improved response to surroundings and staff encounter. | |

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| F 272 | Continued From page 52<br>in w/c had scooted self down so buttocks were off the seat of w/c. Torso posey positioner was still intact but was up around upper chest...With assist of two-release posey torso positioner and lifted back up into w/c-where she proceeded to...scoot downward in w/c..."<br><br>Medical record review of the Physician Telephone Orders revealed the following:<br>"...5/8/15...Trial period Rock in Go [with] pull alarm for restraint reduction...<br>"...5/9/15...1) DC torso positioner in w/c...2) Soft posey belt in Rock-&-Go chair [with] pull alarm, check placement Q 30 min release et [and] reposition q 2 hrs [hours] x 10 min..."<br><br>Review of the medical record revealed the facility failed to assess for the appropriateness of the soft waist belt in the Rock-n-Go restraint or alternatives per facility policy.<br><br>Medical record review of the "Restraint Assessment" revealed no changes in the assessment from 3/31/15 for the 5/9/15 order for "...Soft posey belt in Rock-&-Go chair [with] pull alarm, check placement Q 30 min release et [and] reposition q 2 hrs [hours] x 10 min..."<br><br>Medical record review of the Physician Telephone Orders dated 6/17/15 revealed "...Trial period [with] w/c + alarming seat belt..."<br><br>Medical record review of the "Restraint Assessment" revealed no changes in the assessment from 3/31/15 for the 6/17/15 order for "...Trial period [with] w/c + alarming seat belt..."<br><br>Review of the medical record revealed the facility | F 272 | 8/10/15 – Morning QA Managers Meeting - staff reports abdominal binder is effective in protection and positioning of the PEG tube.<br><br>8/12/15 – Restraint Reduction Committee review: Assessment updated. Activity reports resident again responded to the guitar and appears to be listening to and enjoying music in the room. Activity recommends resident be out of the bed more since appears to be calmer with surroundings and external stimulation. Care plan updated for out of bed activity. Activity staff will continue to assess resident for response to various stimulation activities. Will continue to review during weekly RRC for four weeks to monitor tube and follow weekly improved interactions to surroundings.<br><br>8/17/15 MAR updated to document time spent out of bed.<br><br>**Resident #109**<br><br>7/31/15 – Exhibiting increased independence in ambulation, continues to carry cane when ambulating and is assisted with stand by assist ambulation or a chair when exhibiting unsteady gait – No restraint. Remains at risk for falls due to episodic unsteady gait. Appears happier and engaged in friendly conversation with staff and other residents. Will continue to be reviewed weekly by the Restraint Reduction Committee following restraint reduction.<br><br>8/4/15 – Fell in the dining room during lunch – Investigation and fall assessment updated – resident was attempting to rise, reach for health shake and pivot and lost balance. Footwear appropriate, area uncluttered, staff present – no injury. Ambulates with a safe gait otherwise. Will refer to Restraint Reduction Committee for review. | |

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| F 272 | Continued From page 53<br>failed to assess for the appropriateness of the alarming seat belt in w/c or alternatives per facility policy.<br><br>Review of the facility's Fall Investigation for Charge Nurse form with the date of the fall on 6/20/15 at 8:10 PM revealed a w/c or geri-chair was involved, the restraint was not in place, a restraint was ordered, a chair alarm was involved..."Did it [alarm] function properly? No...alarm did not sound Alarm not turned on..." Further review revealed "...Description of Incident: ...resident on floor in dining room...transferred back to w/c...safety belt on and in place..." Further review revealed the "...Conclusion: Appropriate number of staff involved? Yes...Equipment use appropriate? No...Proper technique used? Yes..." Further review revealed "...Supervisor Report...New Planned Interventions: trial period w/c [with] alarming seat belt. Inservice /re-educ [reeducate] to [check] alarm as well as connection on any resident [with] alarming seatbelt. Further review of the Supervisor report revealed in hand writing "...secured seatbelt but was unaware it was an alarming belt + did not make sure alarm was turned on..." Further review revealed "...Employee Statement of Incident...last time you saw resident before they fell? 8:00 PM...Location: Dayroom...Does resident have some kind of personal alarm? Yes...Was it sounding? No...What do you think could prevent this incident/could prevent similar incidences in the future? Double check the alarm. The buckle was on but I didn't check the alarm box..."<br><br>Medical record review of the Physician Telephone Orders revealed the following: "...7/9/15...1) D/C [discontinue] alarming seat | F 272 | 8/5/15 – Restraint Reduction Committee meeting – Reviewed 8/4 fall and investigation. Resident is currently in therapy for balance strengthening. Assessment updated - Staff will observe and offer assistance when rising from meals and ensure pathway is without clutter. Care plan and CNA care plan in resident's room & CNA kiosk updated. Will continue to assess for committee review next week.<br><br>8/10/15 – Morning QA Managers Meeting – review. Ambulating ad lib in facility without balance issues.<br><br>8/12/15 – Restraint Reduction Committee meeting – Assessment updated: Ambulating without balance problems. Currently in therapy. Family notified of need for smaller shoes to assist in safer ambulation. Will continue to follow in committee until new shoes are evaluated.<br><br>**Resident #111**<br><br>7/31/15 – Continues in self-mobile wheel chair with non-skid seating material on a "dumped" (tilted) seat with a pull alarm to alert staff of unassisted transfer attempts – No Restraint. Additionally the wheelchair is fitted with anti-tippers due to resident persistence in pushing wheel chair backwards instead of forward. Bed room is modified with the head of the bed facility the doorway to provide a clutter-free walkway for the wheelchair. No change in cognition or participation in surroundings. Will continue in weekly review by the Restraint Reduction Committee.<br><br>8/5/15 – Morning QA Managers Meeting – review: observed sitting in chair without observed safety concerns. | |

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| COMMUNITY CARE OF RUTHERFORD | 901 COUNTY FARM RD MURFREESBORO, TN 37127 |

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| F 272 | Continued From page 54<br>belt...2) begin soft posey [belt] while in w/c. Apply 2 [hours], then release 10 min and reposition..."<br>"...7/10/15...D/C soft posey [belt]...Begin alarming seat belt [with] w/c..."<br>"...7/10/15...DC alarming seat belt to w/c...Apply SWB [soft waist belt] while in w/c. Check for placement q [every] 2 hours + release x 10 min..."<br>"...7/11/15...Start posey belt in Rock-n-Go chair...Check q 30 min + release q 2 hours + reposition x 10 min..."<br><br>Medical record review of the "Restraint Assessment" revealed the facility failed to reassess Resident #160 after the assessment dated 3/31/15 for the restraint ordered on 7/10/15 for the "...SWB [soft waist belt] while in w/c. Check for placement q [every] 2 hours + release x 10 min...", and on 7/11/15 for the ordered "...posey belt in Rock-n-Go chair...Check q 30 min + release q 2 hours + reposition x 10 min..."<br><br>Review of the medical record revealed the facility failed to assess for the appropriateness of the restraints, soft waist belt in w/c on 7/9/15, alarming seat belt on 7/10/15, soft waist belt in w/c or Rock-n-Go chair on 7/10-11/15, or alternatives per facility policy.<br><br>Review of the Nurses Notes dated 7/11/15 revealed "...2 PM...Observed in w/c [with] posey waist belt-Resident sliding down in w/c [with] posey belt across her arms...Initiated Rock-n-Go w/c [with] posey soft waist belt..."<br><br>Medical record review of the Physician Telephone Order dated 7/15/15 revealed "...D/C posey belt in Rock-n-Go. Res [Resident] to be in w/c [with] sensor pad + seatbelt. Check q 30 min + release q 2 [hours] x 10 min..." | F 272 | 8/5/15 – Restraint Reduction Committee Meeting – Assessment updated - Continues in self-mobile wheel chair with non-skid seating material on a "dumped" (tilted) seat with a pull alarm to alert staff of unassisted transfer attempts. Additionally the wheelchair is fitted with anti-tippers due to resident persistence in pushing wheel chair backwards instead of forward. No reported attempts to stand without assistance. Care-giver states resident does not appear to need pull alarm in wheelchair – will continue and reassess next week.<br><br>8/6/15 Pull alarm in wheelchair discontinued.<br><br>8/10/15 – Morning Managers Meeting review – continues to position well without restraint.<br><br>8/12/15 – Restraint Reduction Committee meeting – Assessment updated. Husband has been visiting more this review week. Continue to position well in chair - family feels comfortable with current status.<br><br>**Resident #117**<br><br>7/31/15 – Has Torso Posey Positioner (yellow/Large) Restraint while in wheelchair with positioner removed from 7a-3p. There have been no incidents of unsafe transferring. Appears happy when self-propelling in the wheelchair and attending activities without the Torso positioner. Assessment indicates resident tends to lean in the wheelchair when fatigued in the evening requiring positioner for torso support. Family supportive of reduction. Will continue weekly assessment and review by the Restraint Reduction Committee.<br>8/5/15 – Morning QA Managers Meeting – review: Doing well with current seating – upper torso balance in wheelchair. Staff report resident's balance in the evening continues to improve. No concerns when in bed. | |

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| F 272 | Continued From page 55<br><br>Medical record review of the "Restraint Assessment" revealed no changes in the assessment from 3/31/15 for the 7/15/15 order for "...Res [Resident] to be in w/c [with] sensor pad + seatbelt. Check q 30 min + release q 2 [hours] x 10 min..."<br><br>Review of the medical record revealed the facility failed to assess for the appropriateness of the w/c with seat belt or alternatives per facility policy.<br><br>Observation of Resident #160 and/or staff interview revealed the following:<br><br>1. On 7/14/15 at 7:52 AM: Resident #160 was in the H hall and I hall dayroom/dining room in a reclined Rock-n-Go chair with a soft waist belt in place.<br><br>2. On 7/14/15 at 3:20 PM with LPN #1: Resident #160 was in the Rock-n-Go in the F hall and G hall dayroom/dining room with a soft waist in place.<br><br>3. On 7/15/15 at 7:37 AM: Resident #160 was in the H hall and I hall dayroom/dining room, with 15 other residents, in a reclined Rock-n-Go chair with a soft waist belt under her chin, both arms were under the soft waist belt with the right hand under her chin holding onto the top of belt, the resident had slid down in the chair, and no facility staff was present. The surveyor stayed with the resident. Observation at 7:39 AM revealed 2 nursing staff entering the H hall and I hall dayroom/dining room. Certified Nurse Aide (CNA) #3 did not see Resident #160 and left the dayroom/dining room. CNA #1 saw Resident #160 soft waist belt located under her chin, | F 272 | 8/5/15 – Restraint Reduction Committee meeting review: Updated assessment indicates improved upper body strength throughout the day. Unit Manager met with family – recommending Torso Posey be discontinued. Consent signed, assessment completed by committee. Care plan, LN documentation and CNA care plan in resident's room & CNA kiosk updated to reflect restraint free status.<br><br>8/10/15 – Morning QA Managers Meeting – review: Observed in wheelchair without balance issues.<br><br>8/12/15 – Restraint Reduction Committee meeting review: No Restraint - No leaning noted when seated in wheelchair, no attempts to exit bed. Appears happy and engaged in activities – singing and listening to music, watching TV and laughing with residents. Recommend sensor pad in bed to discontinue. Floor mats will continue when in bed. Will assess and review next week in RRC to ensure appropriate position during morning and evening hours.<br><br>8/13/15 Sensor pad alarm in bed discontinued.<br><br>**Resident #142**<br><br>7/31/15 – Ambulates at will daily with on-going monitoring for unsteady gait and needed additional assistance. No Restraint. Naps in common areas and utilizes a wheelchair occasionally when tired. Has not had a fall but remains at risk for falls. Continues on weekly review by the Restraint Reduction Committee.<br><br>8/5/15 – Morning QA Managers Meeting – review: Ambulating in the hall and room ad lib. Observed ambulation without shoes x 1 – easily redirected for appropriate footwear for ambulation. | |

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| F 272 | Continued From page 56<br>repositioned the belt to the waist area (without re-applying the straps) and left the dayroom. The surveyor stayed with the resident. Continued observation revealed Resident #160 took her right hand and pulled the soft waist belt up under her chin and both arms were under the belt. Continued observation at 7:42 AM revealed Registered Nurse (RN) #1 entering the H hall and I hall dayroom/dining room, went to Resident #160, knelt down behind the chair and touched the restraint belt straps. Interview with RN #1 when asked if the soft waist belt was fastened appropriately, RN #1 stated "it should be tighter." Further interview with RN #1 when asked if it would be appropriate for staff to see the soft waist belt under the resident's chin, reposition the soft waist belt to the waist area without checking or re-applying the restraint straps and leaving the room with the resident unattended, the RN #1 stated, "No, it could have serious consequences." Observation and interview revealed CNA #1 re-entering the H hall and I hall dayroom/dining room and demonstrated to RN #1 how CNA #1 had repositioned the soft waist belt and stated then "...left the dayroom..." the RN stated to CNA #1 "That could result in serious consequences, even death."<br><br>4. On 7/15/15 at 8:53 AM in front of the H hall and I hall nurses station, revealed Resident #160 in a reclined Rock-n-Go chair with a soft waist belt in place. Continued observation revealed the resident had both arms under the belt, the belt was loose, and the belt was positioned across the breast. The surveyor stayed with the resident until a nurse arrived. Observation and interview with RN #1 on 7/15/15 at 8:54 AM through 8:58 AM in front of the H hall and I hall nurses station, revealed Resident #160 had removed several | F 272 | 8/10/15 – Morning QA Managers Meeting – review: Ambulating ad lib in hall with shoes.<br><br>8/12/15 – Restraint Reduction Committee review: Reported to be sleepy in the mornings and not sleeping through the night. Family and DON requested psychotropic review for possible GDR during psychiatrist visit today. Will initiate toileting plan to assist with toileting. Care plan and CNA information and documentation updated. Will continue for another week for assessment update and RRC review.<br><br>**Resident #160**<br><br>7/31/15 – Resident has a seatbelt restraint with sensor pad when in the wheelchair applied according to manufacturer's application instructions without attempts for unsupervised transfer. Will be placed in bed for rest with resident's favorite stuffed animal when exhibits signs of fatigue and irritation. Will continue weekly assessment and review during the weekly Restraint Reduction Committee meeting<br><br>8/5/15 – Morning QA Managers Meeting – review: Follow-up appoint with MD Surgeon schedule for 8/21/15 to determine weight bearing status. No attempts to exit seat; longer shirts to cover the belt attempted however resident continues to prefer to "fidget" with the belt. Will refer to RRC.<br><br>8/5/15 – Restraint Reduction Committee review: Orthopedic appointment for 8/21/15 is to evaluate weight bearing status and initiate therapy services. Assessment updated. Resident has made no attempts to get up from seat. Does still fidget with seatbelt. Sensor pad in wheelchair has not sounded since application – no attempts to rise from chair. | |

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| F 272 | Continued From page 57<br>types of restraints and the current restraint (soft waist belt) was "...not applied correctly, it was too loose..." Continued interview confirmed the resident was capable of self-propelling in a wheelchair, and the Rock-n-Go chair was reclined to prevent the resident from propelling. When RN #1 was asked if the belt was applied correctly the RN stated the "...soft posey belt was not applied correctly...belt was not appropriate for the resident..."<br><br>5. On 7/15/15 at 1:55 PM and at 2:50 PM: The resident was in a reclined Rock-n-Go chair in the in H/I dayroom/dayroom with no staff present, no soft waist belt was on the resident. LPN #8 entered the H hall and I hall dayroom/dining room and stated the physician had changed the order to stop the soft waist belt and keep the Rock-n-Go.<br><br>Medical record review of the undated "Pre-Restraining Evaluation" and interview, with MDS Coordinator #1 on 7/16/15 at 7:40 AM in the conference room, confirmed the evaluation was not dated, had been completed after the 7/15/15 observations, and failed to identify recommendations and alternatives to restraints.<br><br>Interview with the Director of Nursing (DON) on 7/15/15 at 2:42: PM, in the Admissions Coordinator's office, confirmed, after the first incident on 5/4/15 at 7:15 PM, it was unsafe to leave the resident in a torso positioner. Further interview confirmed the torso positioner was still used on the 5/8/15 incident when the resident slid down the wheelchair again and the restraint was around the resident's neck. The DON confirmed the soft waist belt was not appropriate for Resident #160. The DON confirmed the facility's | F 272 | 8/7/15 – Morning QA Managers Meeting – review: Out of bed in wheelchair with seatbelt – no complaints of pain or positioning concerns.<br><br>8/10/15 – Morning QA Managers Meeting – review: No attempts to get up from wheelchair seat.<br><br>8/11/15 – Morning QA Managers Meeting – review: Unit staff request RRC to review related to removal of seatbelt since resident does not attempt to get up form seat but can unbuckle the seatbelt – only fidgets with the belt when released – unable to release when prompted.<br><br>8/12/15 – Restraint Reduction Committee meeting review: Assessment reviewed – resident appears a good candidate for restraint reduction. Resident is up in wheelchair daily with seatbelt and sensor pad-has made no attempts to get up from seat; staff has observed resident leaning forward with feet on wheelchair pedals – no attempts to self-propel. Continue rest periods daily after lunch. When in wheelchair, resident has a seat belt (can release but due to cognition is unable to release on command) with non-skid seat material and sensor pad. The seat belt is removed during meals and 1:1 encounter. When in bed the resident has a perimeter mattress with sensor pad to alert staff to unassisted/ unsafe transfer. Continues with limited weight bearing and remains at risk for falls. Although restraint reduction could be recommended based on assessment, the committee recommends continue restraint due to s/p fracture, committee will continue current orders until orthopedic appointment on 8/21/15.<br><br>8/21/15 - Resident has appointment with orthopedic surgeon. Anticipate resident will be released for weight bearing and Therapy services. Following Therapy evaluation the current restraint will be re- | |

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| F 272 | Continued From page 58<br>failure to assess for the appropriateness for any restraints and the failure to assess for the least restrictive restraint. The DON confirmed the facility had failed to keep Resident #160 monitored to ensure the resident's safety per facility policy.<br><br>Interview with the MDS Coordinator #1 on 7/16/15 at 7:40 AM in the payroll office confirmed the facility failed to follow the policy to complete a restraint assessment to determine the need for the restraint and the appropriateness of the restraints used.<br><br>Medical record review revealed Resident #29 was admitted on 4/11/14 and readmitted on 6/10/15 with diagnoses including Alzheimer's Disease, Aortic Valve Disorder, Chronic Systolic Heart Failure, Anemia and Malaise.<br><br>Medical record review of the Annual MDS dated 3/26/15 revealed Resident #29 to be severely cognitively impaired, and required extensive assistance of 1 for Activities of Daily Living (ADLs), and restraints in chair/out of bed were used daily.<br><br>Medical record review of "ACKNOWLEDGEMENT OF RESTRAIN [restraint] POLICIES" (a form that is provided to the resident and or family upon admission to the facility) signed by Resident #29's legal representative on 4/11/14 revealed "...if restraint use is deemed necessary the goal will be to use the least restrictive type of restraint for the shortest period of time possible...every resident will be individually assessed regarding the need for appropriate safety measures and will be periodically reassessed as their needs change | F 272 | evaluated by the Restraint Reduction Committee for possible reduction and encouragement for increase ambulation.<br><br>#2• **The independent contractor conducted training for all staff on the importance of preventing serious injuries and deaths from asphyxiation, suffocation, bed-rail entrapments and falls. Training was provided to facility personnel shall review the all types of restraints, including but not limited to, full bed rails, other types of bed rails used, trunk restraints, limb restraints, and chairs that may prevent rising. Training included manufacturer's instructions for all restraints in use at the facility; and included information on resident rights.** *The dates of training are provided in Independent Contractor's DPOC Final Report.*<br><br>• 2.1 Training was provided for all **active classifications** of Community Care of Rutherford County (CCRC) staff, agency personnel (none since before 2005) and contract service providers (therapy) on the importance of preventing serious injuries and deaths from asphyxiation, suffocation, bed-rail entrapments and falls. Training curriculum was customized to align with those items in use/in stock at CCRC.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Contractor<br><br>o Completion Date: September 15, 2015<br><br>• 2.2 Training was provided for all **active classifications** of licensed and/or certified | |

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| F 272 | Continued From page 59<br>throughout their stay..."<br><br>Medical record review of a Restraint Assessment dated 4/11/14 revealed "...4/15/14 Torso Posey belt...7/24/14 Posey Torso dc'd [discontinued]. [Change] to Posey belt d/t pt removing..." Continued review revealed the review dates between 8/12/14 and 6/10/15, the resident continued to use a soft waist restraint. Continued review revealed the facility failed to assess and/or reassess for a least restrictive restraint per the facility policy.<br><br>Medical record review of the readmission Physician's Orders dated 6/10/15 revealed "...OOB [out of bed] in w/c daily; dump seat (a seat tilted backward) in w/c...use soft Posey belt in w/c prn restlessness, agitation..."<br><br>Medical record review of an Informed Consent for Restraint Utilization dated 8/1/14 revealed "...physician and an interdisciplinary team of medical professionals have assessed and determined that the use of a Posey belt is necessary..."<br><br>Observation on 7/21/15 at 7:20 AM revealed the resident lying in bed with eyes closed. Continued observation revealed a wheelchair positioned near Resident #29's bed with a soft waist restraint lying in the seat.<br><br>Interview with the DON on 7/21/15 at 8:58 AM in the Admission Coordinators Office revealed, when questioned about the resident and use of the soft waist restraint, stated "...she's doing good in the Broda [a high back, reclining geriatric chair]...I haven't seen her in the w/c in a long time...we may need to reassess for its use..." | F 272 | CCRC staff, agency personnel (none since before 2005), contract service providers (therapy), social workers/designees and activity personnel on the types of restraints in use by CCRC at present, in stock and/or on the premises. The training included, at a minimum, a review of the manufacturer's instructions for use and where to source instructions for future reference.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Contractor<br><br>o Completion Date: September 15, 2015<br><br>• 2.3 Training was provided for **all active classifications** of CCRC staff, agency personnel (none since before 2005) and contract staff (therapy) on resident rights.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>**#3• The independent contractor ensured that staff was given education and training on restraint alternatives, including but not limited to, therapeutic interventions, environmental and equipment interventions, and the role of restorative programs.** *The dates of training are provided in Independent Contractor's DPOC Final Report.*<br><br>• 3.1 Education and training was provided for all **active classifications** of CCRC staff, agency personnel (none since before 2005) and contract service providers (therapy) on restraint alternatives available and used by the organization. | |

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| F 272 | Continued From page 60<br>When asked if a complete restraint assessment or a reassessment for the least restrictive restraint had been completed in the past year, the DON stated "...no...we've not done that..."<br><br>Interview with the DON on 7/21/15 at 10:04 in the conference room, when asked about restraint reassessment, the DON stated "...I would expect them to be done quarterly and documented in the interdisciplinary notes..."<br><br>Medical record review revealed Resident #56 was admitted to the facility on 11/18/08 and re-admitted on 3/9/09 with diagnoses including Depressive Disorder, Altered Mental Status, Delusional Disorder, Generalized Anxiety, Diabetes Mellitus Type II, and Dementia.<br><br>Medical record review of a Quarterly MDS dated 4/20/15 revealed the resident was severely cognitively impaired. Continued review revealed documentation under the restraint section of a trunk restraint used less than daily, and a chair that prevented rising used less than daily.<br><br>Further medical record review revealed a Restraint Assessment form dated 5-24-12, "no restraints", on 6/24/13 documented, "carafoam [Carefoam] ottoman [a padded foam chair used for fall prevention] [with] 3 pt [point] pelvic positioner prn [as needed", and on 12/11/14 documented, "carefoam ottoman/lounger [with] 3 pt pelvic positioner release & reposition q [every] 2 [hours] x [times] 10 min [minutes] q 30 minutes."<br><br>Further medical record review revealed Physicians Orders (recapitulation) for the month of 7/2015 documented "...Padded side rails (4) up | F 272 | o Responsible Party(ies): Vickie W. Harris, IC<br><br>o Completion Date: September 15, 2015<br><br>**#4• The independent contractor evaluated the systems and processes established by the facility and governing body to minimize the use of restraints. The independent contractor determined to what extent the nursing home seeks to involve, educate and train residents and family members on alternatives to restraints. The independent contractor validated via observation, record review and interview that restraints on all shifts if used are only to facilitate or support the resident's medical treatment, and not used to discipline residents, as staff convenience, or to prevent residents from wandering.** *The dates of evaluation, assessment, & validation of facility's & governing body's systems & processes are provided in Independent Contractor's DPOC Final Report.*<br><br>• 4.1 A facility assessment was completed to review all processes and systems related to restraint minimization. The assessment will include, but not be limited to:<br><br>o Leadership, staff and contractor interviews<br><br>o Policies and procedures<br><br>▪ Scope<br><br>▪ Execution<br><br>• New admits<br><br>• Current residents<br><br>o New orders | |

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| F 272 | Continued From page 61<br>when in bed. Up OOB [out of bed] to carefoam lounger and put back to bed before 3 pm on shower days (M/W/F) [Monday, Wednesday, Friday] Carefoam lounger with 3 pt pelvic positioner. Release and reposition Q 2 hrs x 10 min. Check Q 30 min..."<br><br>Further medical review revealed a signed, but undated Informed Consent for Restraint Utilization form for a 3 point pelvic harness.<br><br>Further medical record review revealed no documented evidence the facility had assessed/evaluated the resident for restraints prior to being placed in a restraint or having had reassessed/reevaluated the resident for the continued use of restraints.<br><br>Observation on 7/20/15 at 3:45 PM in Resident #56's room, revealed the resident was lying in bed with four padded side rails in the raised position. Continued observation revealed a family member was present at the bedside. Continued observation revealed a foam recliner and ottoman in the room.<br><br>Further observation on 7/24/15 at 10:56 AM in the resident's room revealed the resident seated in a foam lounger with feet resting on an ottoman and a 3 point restraint harness was in place.<br><br>Interview with the DON on 7/21/15 at 10:30 AM in the conference room, confirmed the facility had failed to complete a restraint assessment and quarterly reassessment for the use of restraints.<br><br>Medical record review revealed Resident #63 was admitted to the facility on 4/20/09 with diagnosis including Depressive Disorder, Hypertension, | F 272 | o Change orders<br>o Continuing orders<br>• Emergencies<br>o Training Curriculum – Restraints and resident rights<br>▪ Scope and content<br>▪ Stakeholders {includes employed staff, agency (none since before 2005), contractors (therapy), families and volunteers}<br>▪ Frequency<br>• CCRC Staff<br>o Onboarding<br>o Interim (as needed)<br>o Continuing (annual)<br>• Residents and Families<br>• Volunteers<br>▪ Staff returning from extended leave<br>▪ Agency and Contract Service Provider Staff | |

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| F 272 | Continued From page 62<br>Emphysema, Osteoporosis and Dementia.<br><br>Medical Record Review of the Annual MDS dated 4/28/15 revealed Resident #63 was severely cognitively impaired. Continued review of the MDS revealed the resident had trouble concentrating, trouble sleeping and poor appetite, wandering occurred daily and restraints were used daily while the resident was up in a chair or out of bed.<br><br>Medical record review of "ACKNOWLEDGEMENT OF RESTRAIN [restraint] POLICIES" (a form that is provided to the resident and or family upon admission to the facility) signed by Resident #63's legal representative on 1/31/14 revealed "...if restraint use is deemed necessary the goal will be to use the least restrictive type of restraint for the shortest period of time possible...every resident will be individually assessed regarding the need for appropriate safety measures and will be periodically reassessed as their needs change throughout their stay...".<br><br>Medical record review of the Restraint Assessment dated 9/5/13 revealed none of the twenty-six assessment questions were completed. Continued review revealed Review Dates of 5/2/14, 6/3/14, 7/5/14, 8/5/14, 10/1/14, 11/5/14, 12/5/14, 1/5/15, 2/3/15, 3/14/15 and 4/8/15 revealed a soft belt restraint was in use with no documentation on the assessment for the reason a restraint was required.<br><br>Medical record review of the Non-Skilled Monthly Assessment dated 3/5/15 revealed "... Restraint: Soft Posey Belt ..." with no documentation of the reason the restraint was required. | F 272 | ▪ Methods/Platforms<br>▪ Knowledge and/or competency verification<br>• Who does it?<br>• Documentation<br>• Follow-up<br>o Documentation<br>o Communication and Ongoing Involvement<br>▪ Staff<br>▪ Residents<br>▪ Family<br><br>Information collected in the above outlined baseline assessment was used to identify gaps and weaknesses, inform relevant opportunities for improvement and establish recommendations/specific actions to the facility Administrator and governing board.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>• 4.2 As part of the overall assessment (4.1) the involvement, education and training of residents and their families on alternatives to restraints was completed.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant | |

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| F 272 | Continued From page 63<br><br>Medical record review of the Non-Skilled Monthly Assessment dated 4/20/15 revealed "... Restraint: Posey Belt ..." with no documentation of the reason the restraint was required.<br><br>Medical record review of the Non-Skilled Monthly Assessment dated 7/8/15 revealed "... Restraint: Posey Belt ..." with no documentation of the reason the restraint was required.<br><br>Observation on 7/13/15 at 3:42 PM of Resident #63 on the H hall and I hall nurses station revealed the resident was up in the wheelchair with a soft belt restraint in place. The resident was asking staff members to take the soft belt restraint off so she can "get home."<br><br>Interview on 7/21/15 at 10:10 AM with the DON in the Conference Room, in response to being asked about who makes the determination for use of restraints, revealed "The nurse on the floor does. Sometimes the family requests one to be placed, like this one here (points to Resident # 63 chart). Her daughter insisted that her mother be in restraint and will not let us remove it. We have attempted a reduction with a Merry Walker, but the daughter just will not have it." When asked for the location of the restraint reassessment, the DON stated "I would expect them to be done quarterly and in the Interdisciplinary Notes."<br><br>Interview on 7/21/15 at 2:00 PM with the DON in the Admissions office revealed "We did not reassess this resident's restraints because her daughter told us she wanted her mother in it."<br><br>Interview on 7/21/15 at 2:10 PM with MDS Coordinator #2 and DON in the Admissions office, | F 272 | ○ Completion Date: September 15, 2015<br><br>• 4.3 Resident restraint use was validated on all shifts to insure utilization is to facilitate or support medical treatment and that none are in use for discipline, staff convenience or to prevent wandering. Validation was by way of observation, record review and interviews throughout the course of the Independent Consultant's engagement.<br><br>○ Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>○ Completion Date: September 15, 2015<br><br>#5• **The independent contractor determined what procedures are in place to assess the competency of staff who apply restraints; the frequency of observing and assessing the resident who is restrained; and how staff interact with the resident and attend to the resident's needs while he or she is restrained.** *The Independent Contractor's DPOC Final Report contains her findings and assessment of facility limited restraint use.*<br><br>• 5.1 As part of the overall facility assessment related to restraint minimization (4.1), the facility's procedures related to assessing staff competency in the application of restraints was evaluated.<br><br>○ Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>○ Completion Date: September 15, 2015 | |

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| F 272 | Continued From page 64<br>when asked about the Interdisciplinary Notes and Quarterly Assessments for Resident # 63, MDS Coordinator # 2 stated "I only document on the Interdisciplinary Notes when there is a family meeting." When asked if 9/10/13 was the last family meeting, MDS Coordinator # 2 stated "Yes." When asked where the quarterly restraint reassessment would be, the DON stated "I don't know."<br><br>Medical record review revealed Resident #73 was admitted to the facility on 1/9/13 with diagnoses including Alzheimer's Disease, Hypertension, Cerebral Vascular Accident, and Osteoarthritis.<br><br>Medical record review of a "Restraint Assessment" dated 1/23/14 revealed the resident had a "soft posey belt." Continued review revealed documentation in the comment section with a review date of 4/2/14," restraint reduction @ each meal of soft Posey belt...at table [with] staff present, and a review date of 7/5/15, "soft Posey belt in w/c."<br><br>Medical record review of "Physician's Orders" (recapitulation) from 3/2015 through 7/2015, revealed an order for "...Posey belt off when at table during meals Posey belt in WC [wheelchair]. Check Q 30 min and release and reposition Q 2 hrs x 10 min..."<br><br>Medical record review of "Informed Consent for Restraint Utilization" signed by the responsible party and dated 1/30/14 giving consent, revealed "...Due to Alzheimer's Disease, (Advance) ...determined that the use of Soft Posey Belt in W/C is necessary to protect resident from physical harm..." | F 272 | • 5.2 CCRC licensed and/or certified staff was evaluated as to the frequency of observation and assessment of residents who are restrained. This evaluation was completed in conjunction with 4.3.<br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>o Completion Date: September 15, 2015<br><br>• 5.3. All classifications of CCRC staff, agency personnel (none since before 2005) and contract service providers (therapy) was evaluated as to how they interact with residents and attend to their needs while restrained. This was completed in conjunction with 4.3.<br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>o Completion Date: September 15, 2015<br><br>**#6• The independent contractor is submitting to CMS and the State a copy of all training materials, and a written report summarizing the aforementioned components of the directed plan of correction, and how the administrator and governing body will ensure ongoing compliance with 42 CFR 483.13.**<br><br>• 6.1 At the completion of the Independent Consultant's role on September 15, 2015, a report is submitted to CMS and the State summarizing the above outlined directed plan of correction, its execution, findings and recommendations, and how the | |

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| F 272 | Continued From page 65<br>Medical record review revealed no documentation of restraint assessment prior to restraint reduction, no assessments for or attempts at further restraint reduction, and no quarterly restraint reassessments having been completed, per facility policy.<br><br>Observation on 7/21/15 at 7:53 AM in the I hall, revealed the resident seated in a wheelchair with a soft restraint belt around her abdomen, being transported in wheelchair by staff to her room.<br><br>Observation on 7/21/15 at 8:38 AM in the H hall and I hall dayroom/dining room revealed staff assisted resident with meal and the resident was not wearing a restraint.<br><br>Interview with the DON on 7/21/15 at 10:30 AM in the conference room, confirmed the facility had failed to assess the resident for the need of restraints, for the appropriateness of the restraint, for the need for continued use of restraints, and for further restraint reduction.<br><br>Medical record review revealed Resident #78 was admitted to the facility on 8/5/10 and readmitted on 7/9/13 with Recurrent Episode of Manic, Bipolar Affect, Psychosis, Anxiety, Depression, Lack of Coordination, Malaise and Fatigue, and Altered Mental Status.<br><br>Medical record review of the Annual MDS dated 6/5/15 revealed the resident is severely cognitively impaired. Continued review revealed the resident had a restraint used daily when in chair or out of bed.<br><br>Medical record review of a "Restraint Assessment " dated 7/19/13 revealed the resident had no | F 272 | Administrator and governing body will ensure ongoing compliance with 42 CFR 483.13. The report will include copies of all training materials and any other relevant documents.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 18, 2015<br><br>o<br><br>7/30/15 – 8/18/15 – Unit Managers and MDS LN completed 100% device / alarm audit. RRC evaluated each device to determine if it was a positioning device that could be a restraint for the individual resident. Assessments were completed to ensure device(s) were used according to manufacturer application instructions and warnings and as indicated to determine baseline for device reductions as indicated by resident activity, behavior, cognition and safety needs. Medical Director notified of results for discussion related to facility benchmark and current trends. Findings will be forwarded to QA Committee for establish action plan to achieve facility goals. DON will be responsible for communication action plan between RCC, QA and QAA committee in addition to documentation of the action plan, implementation and evaluation for full QAA review. Audit tool will be updated as MD orders impact the devices. MDS LN will review the audit tool during the RAI schedule for each resident and a comprehensive audit will be conducted annually for full QAA Committee review to determine use trend and compliance with facility goals.<br><br>7/29/15 – Education LN has placed the Restraint inservice into the clinical staff (to include licensed nurses, CNAs, cross-trained & Therapist) orientation | |

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| F 272 | Continued From page 66<br>restraints at that time. Continued review revealed documentation in the comment section with a review date of 9/18/13, "alarming seatbelt in w/c." Continued review revealed a comment on 7/16/15, "cont. [continued] [with] alarming seat belt in w/c."<br><br>The Restraint Assessment dated 7/19/13 revealed no restraint was needed. The facility failed to complete a restraint assessment from 9/18/13 through 7/16/15.<br><br>Medical Record review of "Physician's Orders" (recapitulation) for 03/2015-07/2015 revealed an order for "...Alarming seat belt in WC. Check Q 30 min and release and reposition Q 2 hrs x 10 min..."<br><br>Medical record review of "Informed Consent for Restraint Utilization" signed by the responsible party giving consent, revealed "...Due to decreased cognition [with] [decreased] safety awareness....the use of an alarming seatbelt is necessary to protect from physical harm..."<br><br>Medical record review revealed no documentation of restraint assessment or reassessment having been completed.<br><br>Observation on 7/16/15 at 2:30 PM in the H hall and I hall dayroom/dining room, revealed the resident was seated in a wheelchair propelling herself back and forth with her feet. Continued observation revealed an alarming seat belt across her abdomen. Continued observation revealed the resident to be alert and pleasantly confused.<br><br>Observation on 7/20/15 at 4:20 PM in the H hall andI hall dayroom/dining room, revealed the | F 272 | to be completed by all new clinical employees prior to working with residents. NHA will review orientation status in the morning QA Managers meeting to ensure training is completed during the orientation program. Education LN will conduct monthly staff meetings for three months to review current restraints, restraint application, observation, documentation and non-restraint alternatives. Restraints and assistive devices will be reviewed during orientation and at least quarterly thereafter as the facility will be restraint free.<br><br>8/4/15 – Mandatory Restraint Inservice for employees returning to work from extended LOA. Three part time clinical staff (licensed nurses, CNAs, cross-trained & Therapist) members and employees on FMLA will be inserviced by the Education LN prior to return to resident care.<br><br>8/6/15 – Mandatory All staff inservice conducted by Education LN, DON and NHA. Discussed current restraints, restraint application, observation and documentation along with facility goal to be a restraint free facility.<br><br>8/7/15 – QA Committee Meeting - Reviewed: New Restraint Policy, new Restraint Protocol, Restraint Audits, Restraint education audit, new restraint assessment forms (Pre-evaluation and Reduction)<br><br>7/23/15 – Restraint Reduction Committee: New Committee meets weekly and is a Sub-committee of the QAA Committee. DON is the Chairman. Members include: NHA, DON, MDS LN, Unit Managers, Wound Care Nurse, Central Supply, Restorative CNAs, Therapy, Social Service and Activities. The Medical Director will be an Ad Hoc member of the committee. The Committee will review weekly every restraint and all assistive devices | |

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| F 272 | Continued From page 67<br>resident seated in a wheelchair with an alarming seat belt across her abdomen.<br><br>Interview with the DON on 7/21/15 at 10:30 AM in the conference room, confirmed the facility had failed to assess the resident for the need of restraints, the need for continued use of restraints, and for restraint reduction.<br><br>Medical record review revealed Resident #94 was admitted 6/14/13 with diagnoses including Grand Mal Seizures, Cerebrovascular Accident, Left-Sided Hemiplegia, Blindness, Gastrostomy, and Muscle Weakness.<br><br>Medical record review of an Annual MDS dated 5/1/15 revealed Resident #94 was severely cognitively impaired and was total dependent for all Activities of Daily Living. Continued review revealed the resident had a gastrostomy tube and had a limb restraint that was used daily. Continued review of the Care Area Assessment Summary revealed "...pulls his feeding tube (gastrostomy (g-tube/peg tube)) out at times...hand mitt [mitten] on non-paralyzed hand at all times..."<br><br>Medical record review of an "ACKNOWLEDGEMENT OF RESTRAIN [restraint] POLICIES" (a form that is provided to the resident and or family upon admission to the facility), signed by the resident on 6/14/13, revealed "...if restraint use is deemed necessary the goal will be to use the least restrictive type of restraint for the shortest period of time possible...every resident will be individually assessed regarding the need for appropriate safety measures and will be periodically reassessed as their needs change throughout | F 272 | that could also be a restraint and a restraint assessment will be updated to direct the committee to the resident indicated and least restrictive device for resident safety. The committee will be responsible on-going selection of restraint / device, monitoring restraint/device application and use in according to manufacturer application instructions and warnings in addition to assessment for restraint reduction and management.<br><br>Each restraint review will be conducted for potential reduction, removal or validation of continued medical necessity. Charts will be brought to the meeting by the Unit Managers for documentation review and to update the weekly committee meeting note. Committee Chairman (DON) will record minutes during the meeting. The minutes will be submitted to the QAA Committee for benchmark, trending, oversight, review and to determine programming and staff education needs. The nursing Home Administrator (NHA) will be responsible for QAA Committee oversight of the Restraint Reduction Committee activity. MD will review the committee minutes during weekly scheduled visits. Compliance Consultant will review weekly notes during scheduled monthly visits.<br><br>7/30/15 - Daily QA Managers Meeting (Monday – Friday). NHA will oversee and investigate concerns related to facility reports, communications and policies.<br><br>Daily QA Managers Meeting attendees include but may not be limited to: NHA, DON, MDS LN, Infection Control/Staff Education, Wound Nurse, Unit Managers, Restorative, Medical Records, Therapy, Social Service, Activities, Housekeeping, Maintenance, Business Office and Payroll. | |

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| F 272 | Continued From page 68<br>their stay..."<br><br>Medical record review of a Restraint Assessment with original date of 6/18/13 revealed "...type of restraint...R [right] hand mitt..." Continued review revealed assessment review dates from 10/11/13 through 1/15/15 of continued use of a right hand mitten and no reassessment for the continued need of a restraint.<br><br>Medical record review of a Restraint Assessment dated 4/7/15 revealed "...Reason for Restraint...pulling peg-tube [same as gastrostomy tube]..." Continued review revealed "...Review dates...4/7/15 Rt [right] hand mitten to prevent resident from pulling on g-tube [gastrostomy]..." and no documentation that a reassessment had been completed for the continued need of a restraint.<br><br>Medical record review of the Physician's Orders dated 7/1-7/31/15 revealed "...Mitt to Rt hand to prevent him pulling feeding tube [gastrostomy] out..."<br><br>Observation on 7/20/15 at 1:34 PM revealed the resident lying in bed with a mitten on his right hand.<br><br>Interview with LPN #11 on 7/20/15 at 1:37 PM at F/G nurses station revealed "...he has a tendency to pull the G-tube [gastrostomy] out if he gets a chance to get a hold of it. He has pulled it out numerous times..."<br><br>Interview with the DON on 7/21/15 at 8:58 AM in the Admissions Coordinator Office, when asked if the resident had a complete restraint assessment and had been reassessed at least quarterly for | F 272 | The following items will be reviewed daily: Change in Resident Condition, Significant Change in Resident Status, 24 Hour Report Information, New MD orders, Occurrence Reports, Clinical Progress Notes and Hospital Transfers in addition to Restraints, Infection Control and On-going Investigations.<br><br>Concerns discussed in the daily meeting will be assigned to staff for follow up and the DON as indicated to complete investigations. Information and findings from the areas discussed in the daily meeting will be reviewed in the meeting weekly until resolved or on-going as indicated. Staff education will be directed by information from the daily QA meeting in addition to on-going audits, scheduled monthly staff meetings and annual skills assessments.<br><br>Nursing Home Administrator will notify the Clinical Consultant of issues, concerns and investigations during the monthly visit to ensure a timely and comprehensive investigation with action plan is completed. Clinical Consultant will review daily, weekly and monthly QA and scheduled QA Committee and Sub Committee meeting minutes to ensure timely and comprehensive action plans are implemented, monitored and evaluated. Clinical Consultant will be on-site at least monthly and submit a written report to the QAA Committee for review and action as indicated. Medical Director will review consultant report monthly for timely response and needed intervention as indicated.<br><br>8/7/15 – Monthly QA Committee Meeting - NHA or designee will summarize the daily Managers meetings for trends and education needs to be discussed in the Monthly QA meeting. Trend summaries and on-going or unresolved facility issues are discussed for resolution in the Monthly QA Committee Meeting. The QA Committee will meet 2 times per month for | |

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| F 272 | Continued From page 69<br>the least restrictive restraint, the DON stated "no, he's not been reassessed...at one time I thought he had a binder...can't remember...he's probably had the mitten since 2013..."<br><br>Medical record review revealed Resident #109 was admitted to the facility on 7/23/12 with diagnoses including Dementia with Behaviors, Parkinson's Disease, Hypertension, Bi-Polar Disorder and Glaucoma.<br><br>Review of the Quarterly MDS dated 4/3/15 documented the resident was independent for transfers and ambulation on and off the unit without supervision. His gait was not steady but he was able to stabilize without assistance. The resident used a wheelchair and a cane to assist with mobility and did not use any restraint devices. Continued review revealed the resident was severely cognitively impaired, and rejected care daily.<br><br>Review of an "ACKNOWLEDGEMENT OF RESTRAIN [restraint] POLICIES" (a form that is provided to the resident and or family upon admission to the facility), dated 7/23/12 by the resident's family member revealed "...The intent of the restraint policy is for each person to reach his/her highest practicable well-being in an environment that prohibits the use of restraints... consent of the resident or legal representative...after a functional assessment...Every resident will be individually assessed regarding the need for appropriate safety measures and will be periodically reassessed as their needs change throughout their stay at our facility..."<br><br>Observation on 7/13/15 at 11:17 AM in the H hall | F 272 | the first month (August – September) and then monthly thereafter.<br><br>Monthly QA Meeting attendees include but may not be limited to: NHA, DON, Department Managers, Wound Nurse, Infection Control Nurse and Staff Educator. The NHA will be the Chairman of the committee and responsible to ensure information is communicated between the QA Committee and the QAA Committee.<br><br>8/1/15 - The **QAA Committee** will meet quarterly. Items from the Monthly QA Committee Agenda will be reviewed by the full QAA Committee to ensure policy compliance, clinical best practice and staff education is monitored, implemented and evaluated on-going. The Clinical Consultant will review the QA and QAA Committee minutes during monthly visits to ensure compliance. Compliance issues or concerns will be discussed with the NHA for follow-up and resolution.<br><br>QAA Committee members include but may not be limited to: Medical Director, Nursing Home Administrator, DON, Department Managers (Social Service, Activity, Therapy, Nursing, Housekeeping, Maintenance), in addition to the wound Care Nurse, Staff Education Nurse, Infection Control Nurse and staff nurses and CNAs as available. | |

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| F 272 | Continued From page 70<br>and I hall nurse station revealed a CNA taking Resident #109 to the H dining room in a W/C with a soft torso restraint velcroed to the W/C. The resident was observed eating lunch with his left hand unassisted while still in the restraint.<br><br>Interview with LPN #9 on 7/15/15 at 8:00 AM at the H hall and I hall nurses station confirmed Resident #109 was in a restraint for multiple falls and an unsteady gait from Parkinson's disease. Continued interview confirmed the resident was being evaluated by PT (physical therapy) and he can ambulate with a cane with minimal assistance.<br><br>Medical record review of a Restraint Assessment dated 12/21/14 documented the following:<br>Diagnosis: Dementia without Behavior Disturbance, Hypertension, Anemia, Parkinson's and Deep Vein Thrombosis<br>Cognitive Status: Alert with confusion<br>Ability to Understand/Remember Directions: Fair<br>Falls within Past 12 Months: 2<br>Walker: Rolling and a Cane<br>Gait/Balance Problems: Unsteady, takes short steps, steps on own feet<br>Behavioral Problems: Resistant with care at times<br>Reason for Restraint: Gait unsteady, staggers, uncooperative with assisted ambulation<br><br>Review dates with comments: 12/21/14 Soft positioner in wheelchair when out of bed; 12/23/14 Torso positioner in wheelchair when out of bed; 1/10/15 Torso positioner in wheelchair when out of bed. Release and reposition every 2 hours for 10 minutes, check for placement every 30 minutes; 3/10/15 May ambulate independent. May use wheelchair as needed for unsteady gait; | F 272 | | |

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| F 272 | Continued From page 71<br>4/20/15 No restraints; 5/4/15 Soft positioner in wheelchair when out of bed; 7/8/15 Soft positioner in wheelchair when out of bed. Interview with RN #1 on 7/16/15 at 1:50 PM in the H hall and I hall nurses station confirmed there were no updated restraint assessments completed for Resident #109 after 12/21/14.<br><br>Medical record review revealed Resident #111 was admitted 8/6/12 with diagnoses including Dementia without Behavior Disturbances, Coronary Artery Disease, Anxiety, Obstructive Sleep Apnea and Constipation.<br><br>Medical record review of an "ACKNOWLEDGEMENT OF RESTRAIN [restraint] POLICIES" (a form that is provided to the resident and or family upon admission to the facility), dated 8/6/12 revealed "...if restraint use is deemed necessary the goal will be to use the least restrictive type of restraint for the shortest period of time possible...every resident will be individually assessed regarding the need for appropriate safety measures and will be periodically reassessed as their needs change throughout their stay..."<br><br>Medical record review of a Restraint Assessment dated 4/2/14 revealed "...inconsistent [with] cooperation, often resistant to care...Posey positioner when [up] in w/c..." Continued review revealed "...reason for restraint...hx [history] of falls, resident safety..." Continued review revealed review dates from 4/30/14 through 7/9/15 and no documentation of an assessment or reassessment for the continued use of the restraint or for a least restrictive restraint.<br><br>Medical record review of Physician's Orders | F 272 | | |

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| F 272 | Continued From page 72<br>dated 7/2015 revealed "...Continue with in WC, torso Posey positioner at all times. Check for placement q 30 min & release reposition q 2 hr x 10 min..."<br><br>Observation on 7/16/15 at 1:18 PM revealed resident seated in a W/C in front of F hall and G hall nurses station with torso positioner applied.<br><br>Observation on 7/20/15 at 1:29 PM revealed the resident seated in a W/C in the common area near F hall andG hall nurses station. Continued observation revealed a torso positioner applied.<br><br>Observation on 7/20/15 at 3:55 PM on G hall revealed Resident #111 seated in a W/C with a torso positioner applied.<br><br>Interview with the Director of Nursing on 7/21/15 at 8:58 AM in the Admission Coordinators Office, after review of a Restraint Assessment with an original date of 4/2/14, the DON confirmed the last attempted restraint reduction was in 01/2015. When asked if the resident had been reassessed for a least restrictive restraint quarterly per the facility policy, the DON stated "...no..."<br><br>Medical record review revealed Resident #117 was admitted to the facility on 9/18/12 with Diabetes Mellitus, Dementia with Behavioral Disturbances, Depressive Disorder, Muscle Weakness, and Hypertension.<br><br>Medical record review of the Quarterly MDS dated 5/18/15 revealed the resident was severely cognitively impaired. Further review revealed the resident had a trunk restraint used daily when out of bed. | F 272 | | |

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| F 272 | Continued From page 73<br>Medical record review of the Restraint Assessment dated 11/21/12 revealed the resident had no restraints upon admission to the facility. Continued review revealed a review date of 4/2/14 documented, " torso posey positioner in W/C [wheelchair] [with] con't [continue] to [check] q [every] 30 mins [minutes] release reposition q 2 [hours] x [times] 10 mins - remove when @ [at] table for meals & [and] reattach after meal completed..." Continued review revealed a review date of 1/4/15 documented, "torso posey positioner to WC [wheelchair] ..." Continued review revealed a review date of 7/14/15 documented, "continues torso posey positioner to WC..." Continued review revealed a review date of 7/18/15 documented, "Restraint Reduction: torso posey to WC from 3p [PM] until Bedtime, off from 7a [AM]- 3p..."<br><br>Medical Record review of the Physician's Orders (recapitulation) from 02/2015 through 07/2015 revealed orders for "...torso posey positioner on @ all times when up OOB [out of bed] in WC. Check Q [every] 30 min, release and reposition Q 2 hrs [hours] x 10 min. Off at all meal times when up to table only.<br><br>Medical record review of a Physician Telephone Order dated 7/18/15 revealed an order for restraint reduction trial with the torso positioner to be off from 7:00 AM to 3:00 PM and on from 3:00 PM to bedtime.<br><br>Medical record review revealed an "Informed Consent for Restraint Utilization," signed by the responsible party and dated 2/12/14, consenting to the use of the restraint, "...Due to Dementia w/ [with] behavior...assessed and determined that the use of Torso Posey while in W/C is necessary | F 272 | | |

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| F 272 | Continued From page 74<br>to protect resident from physical harm. Continue review revealed there was no witness signature.<br><br>Medical record review revealed no documented evidence of a restraint assessment having been completed prior to the restraint reduction trial on 7/18/15 and no documentation of quarterly re-evaluation of the continued need and appropriateness of the restraint having been completed.<br><br>Observation on 7/16/15 at 2:12 PM in the J hall and K hall dayroom/dining room revealed the resident was seated in a wheelchair with a torso positioner restraint on. Continued observation revealed the resident was pleasantly confused.<br><br>Observation during an ice cream social activity, on 7/20/15 at 2:20 PM in the main dining room revealed the resident was seated in a wheelchair, unrestrained, self-propelling back and forth with his feet.<br><br>Interview with the DON on 7/21/15 at 10:30 AM in the conference room, confirmed the facility had failed to assess the resident for the appropriateness of the restraint and for the least restrictive device and had failed to assess the resident prior to attempting restraint reduction trial. Continued interview confirmed the facility had failed to re-evaluate the need for restraints at least quarterly.<br><br>Medical record review revealed Resident #142 was admitted to the facility on 11/18/14 with diagnoses including Alzheimer's, Dementia without Behaviors, Malaise and Fatigue, and Delusional Disorder. | F 272 | | |

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| F 272 | Continued From page 75<br>Review of the Quarterly MDS dated 4/21/15 documented the resident was ambulatory, was steady at all times, had no range of motion impairment and did not use any mobility devices. The resident did not have any behavior problems, had disorganized thinking, short and long term memory loss and wandered daily but was not an elopement risk. The resident had not had any falls since the previous assessment.<br><br>Observation on 7/15/15 at 7:53 AM in the H hall and I hall dayroom/dining room revealed the resident was seated at the head of a table in a W/C with a soft lap belt restraint in place.<br><br>Medical record review of a physician order dated 6/9/15 documented "...May wear a posey when in W/C due to stumbling [check] placement q 30 min/release & reposition x 10 minutes q 2 [hours]..."<br><br>Review of a Restraint Assessment dated 11/8/14 documented the following:<br>Diagnosis: UTI [Urinary tract infection], Alzheimer's Advance, Frequent Falls<br>Cognitive Status: Confusion/disoriented<br>Ability to Understand/Remember directions: Poor<br>Falls within past 12 months: Yes<br>Gait/Balance Problems: Unsteady Gait<br>Behavioral Problems: No<br>Reason for Restraint: no documentation present<br><br>Review Dates with comments:<br><br>11/8/14, 2/8/15, 3/10/15, 4/8/15 no restraints<br>7/9/15 no documentation present<br><br>Interview with RN #1 on 7/16/15 at 1:50 PM at the | F 272 | | |

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| F 272 | Continued From page 76<br>H hall and I hall nurses station confirmed the restraint assessment for Resident #142 dated 11/8/14 was incomplete and there were no updated restraint assessments after 11/8/14.<br><br>The interventions put in place were evaluated by the survey team on 7/29/15, and verified the Allegation of Compliance by:<br><br>1. The facility re-assessed the 13 residents with restraints for appropriateness and for the least restrictive device.<br><br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 272 | | |

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| F 280 SS=J | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy and procedure review, review of the restraint manufacturer's Application Instructions, the medical record, the facility investigations, interview, and observation, the facility failed to revise the care plan to ensure the currently ordered restraint was addressed to ensure the resident's safety for 1 (Resident #160) of 13 residents reviewed with restraints. The failure of the facility to revise the care plan placed Resident #160 in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, | F 280 | Facility will ensure the comprehensive resident care plan is developed within 7 days after the completion of the comprehensive assessment and periodically reviewed and revised by a team of qualified persons after each assessment<br><br>All residents have the potential to be effected.<br><br>**Resident #160**<br><br>7/31/15 – Resident has a seatbelt restraint with sensor pad when in the wheelchair applied according to manufacturer's application instructions without attempts for unsupervised transfer. Will be placed in bed for rest with resident's favorite stuffed animal when exhibits signs of fatigue and irritation. Care plan was reviewed by the Restraint Reduction Committee and updated by the MDS LN to reflect resident current restraint and assistive devices. Education LN reviewed the CNA resident information and Electronic Health Record (EHR) documentation kiosk to ensure the current care plan is updated for review and documentation by the CNA. RCC and Unit Managers review the LN MAR documentation to ensure it accurately reflected the most recent assessment and care plan. RCC will continue weekly assessment, review and care plan update procedures during the weekly Restraint Reduction Committee meeting.<br><br>8/5/15 – Restraint Reduction Committee review: Orthopedic appointment for 8/21/15 is to evaluate weight bearing status and initiate therapy services. Assessment updated. Care plan reviewed without changes. Resident has made no attempts to get up from seat. Does still fidget with seatbelt. Sensor pad in wheelchair has not sounded since application – no attempts to rise from chair. | |

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| F 280 | Continued From page 78<br>impairment or death to a resident).<br><br>The Administrator was informed of the Immediate Jeopardy on 7/21/15 at 2:40 PM in the conference room.<br><br>The Immediate Jeopardy was effective 5/4/15 through 7/30/15.<br><br>A Full Extended Survey was conducted on 7/21-29/15.<br><br>An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received on 7/29/15 at 9:00 AM, and the corrective actions were validated by the surveyors on 7/29/15.<br><br>The findings included:<br><br>Review of the facility policy, updated 2/4/14, "Restraint-Physical" revealed "Restraints should only be used for the safety and well-being of the resident(s) and only after all alternatives have been tried unsuccessfully and results are documented." The nurse applying the restraint must update resident's care plan to indicate the continued use of a restraint has been reevaluated...The least restrictive must always be utilized..."<br><br>Review of the facility "...Care Planning Procedure..." revealed the "...Purpose: To ensure the care plans are accurate and timely updated and reviewed by all disciplines..." Further review revealed "...Purpose: Care plans will be modified as needed on printed care plan by hand as indicated...Any handwritten changes will be dated and initialed..." | F 280 | 8/12/15 – Restraint Reduction Committee meeting review: Assessment reviewed – resident appears a good candidate for restraint reduction. Resident is up in wheelchair daily with seatbelt and sensor pad-has made no attempts to get up from seat; staff has observed resident leaning forward with feet on wheelchair pedals – no attempts to self-propel. Continue rest periods daily after lunch. When in wheelchair, resident has a seat belt (can release but due to cognition is unable to release on command) with non-skid seat material and sensor pad. The seat belt is removed during meals and 1:1 encounter. When in bed the resident has a perimeter mattress with sensor pad to alert staff to unassisted/ unsafe transfer. Continues with limited weight bearing and remains at risk for falls. Although restraint reduction could be recommended based on assessment, the committee recommends continue restraint due to s/p fracture, committee will continue current orders until orthopedic appointment on 8/21/15. Care plan reviewed during committee meeting by the MDS LN to ensure it accurately reflects current restraint and device(s) interventions.<br><br>8/21/15 - Resident has appointment with orthopedic surgeon. Anticipate resident will be released for weight bearing and Therapy services. Following Therapy evaluation the current restraint will be re-evaluated by the Restraint Reduction Committee for possible reduction and encouragement for increase ambulation.<br><br>---<br><br>**#2• The independent contractor conducted training for all staff on the importance of preventing serious injuries and deaths from asphyxiation, suffocation, bed-rail entrapments and falls. Training was** | |

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| F 280 | Continued From page 79<br><br>Review of the restraint manufacturer's Application Instructions revealed "...Before Applying Any Restraint: A restraint must be used in accordance with the patient's individualized Care Plan..."<br><br>Medical record review revealed Resident #160 was admitted to the facility on 3/30/15 with diagnoses including Fractured Neck of Femur, Fall, Dementia without Behavioral Disturbances, Blind both eyes, Difficulty Walking, Muscle Weakness, and Pelvis Joint Pain.<br><br>Medical record review of the Admission Minimum Data Set (MDS) dated 4/6/15 revealed Resident #167 had short and long term memory impairment, required extensive assistance of 1 person for bed mobility, toileting and hygiene; required extensive assistance of 2 persons for transfers, was frequently incontinent of bowel and bladder and had one fall without injury since admission.<br><br>Medical record review of the Physician Telephone Orders dated 6/17/15 revealed "...Trial period [with] w/c [wheelchair] + [and] alarming seat belt..."<br><br>Medical record review of the "Restraint Assessment" dated 3/31/15 revealed Resident #160 information had not been revised since 3/31/15 and included the resident was alert and oriented x (times) 2, had a fall in the past 12 months with a left hip fracture, a check mark beside gait/balance problems, and "...Behavioral Problems...Removes clothing frequently...Positioning Problems [was blank]...Reason for Restraint [was blank]..." Further review documented the review dates: | F 280 | **provided to facility personnel shall review the all types of restraints, including but not limited to, full bed rails, other types of bed rails used, trunk restraints, limb restraints, and chairs that may prevent rising. Training included manufacturer's instructions for all restraints in use at the facility; and included information on resident rights.** *The dates of training are provided in Independent Contractor's DPOC Final Report.*<br><br>• 2.1 Training was provided for all **active classifications** of Community Care of Rutherford County (CCRC) staff, agency personnel (none since before 2005) and contract service providers (therapy) on the importance of preventing serious injuries and deaths from asphyxiation, suffocation, bed-rail entrapments and falls. Training curriculum was customized to align with those items in use/in stock at CCRC.<br>o Responsible Party(ies): Vickie W. Harris, Independent Contractor<br>o Completion Date: September 15, 2015<br><br>• 2.2 Training was provided for all **active classifications** of licensed and/or certified CCRC staff, agency personnel (none since before 2005), contract service providers (therapy), social workers/designees and activity personnel on the types of restraints in use by CCRC at present, in stock and/or on the premises. The training included, at a minimum, a review of the manufacturer's instructions for use and where to source instructions for future reference. | |

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| COMMUNITY CARE OF RUTHERFORD | 901 COUNTY FARM RD MURFREESBORO, TN 37127 |

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| F 280 | Continued From page 80<br>"...3/31/15 no restraints needed..." Further review revealed no changes in the assessment from 3/31/15 for the 6/17/15 order for "...Trial period [with] w/c + alarming seat belt..."<br><br>Review of the facility's Fall Investigation for Charge Nurse form with the date of the fall on 6/20/15 at 8:10 PM revealed a w/c or geri-chair were involved, the restraint was not in place, a restraint was ordered, a chair alarm was involved..."Did it [alarm] function properly? No...alarm did not sound Alarm not turned on..." Further review documented "...Description of Incident: ...resident on floor in dining room....transferred back to w/c...safety belt on and in place..." Further review revealed the "...Conclusion: Appropriate number of staff involved? Yes; Equipment use appropriate? NO; Proper technique used? Yes..." Further review revealed "...Supervisor Report...New Planned Interventions: trial period w/c [with] alarming seat belt. Inservice /re-educ [reeducate] to [check] alarm as well as connection on any resident [with] alarming seatbelt. Further review of the Supervisor report documented in hand writing "...secured seatbelt but was unaware it was an alarming belt + did not make sure alarm was turned on..." Further review revealed "...Employee Statement of Incident...last time you saw resident before they fell? 8:00 PM...Location: Dayroom...Does resident have some kind of personal alarm? Yes...Was it sounding? No...What do you think could prevent this incident/could prevent similar incidences in the future? Double check the alarm. The buckle was on but I didn't check the alarm box..."<br><br>Medical record review of the Physician Telephone Orders revealed the following: | F 280 | ○ Responsible Party(ies): Vickie W. Harris, Independent Contractor<br><br>○ Completion Date: September 15, 2015<br><br>• 2.3 Training was provided for **all active classifications** of CCRC staff, agency personnel (none since before 2005) and contract staff (therapy) on resident rights.<br><br>○ Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>○ Completion Date: September 15, 2015<br><br>#3• **The independent contractor ensured that staff was given education and training on restraint alternatives, including but not limited to, therapeutic interventions, environmental and equipment interventions, and the role of restorative programs.** *The dates of training are provided in Independent Contractor's DPOC Final Report.*<br><br>• 3.1 Education and training was provided for all **active classifications** of CCRC staff, agency personnel (none since before 2005) and contract service providers (therapy) on restraint alternatives available and used by the organization.<br><br>○ Responsible Party(ies): Vickie W. Harris, IC<br><br>○ Completion Date: September 15, 2015<br><br>#4• **The independent contractor evaluated the systems and processes established by the facility and governing body to minimize the use of** | |

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| F 280 | Continued From page 81<br>"...7/9/15...1) D/C [discontinue] alarming seat belt...2) begin soft posey [belt] while in w/c. Apply 2 [hours], then release 10 min and reposition..."<br>"...7/10/15...D/C soft posey [belt]...Begin alarming seat belt [with] w/c..."<br>"...7/10/15...DC alarming seat belt to w/c...Apply SWB [soft waist belt] while in w/c. Check for placement q [every] 2 hours + release x 10 min..."<br>"...7/11/15...Start posey belt in Rock-n-Go chair [a rocking wheelchair]...Check q 30 min + release q 2 hours + reposition x 10 min..."<br><br>Review of the Nurses Notes dated 7/11/15 revealed "...2 PM...Observed in w/c [with] posey waist belt-Resident sliding down in w/c [with] posey belt across her arms...Initiated Rock-n-Go w/c [with] posey soft waist belt..."<br><br>Medical record review of the Physician Telephone Order dated 7/15/15 revealed "...D/C posey belt in Rock-n-Go. Res [Resident] to be in w/c [with] sensor pad + seatbelt. Check q 30 min + release q 2 [hours] x 10 min..."<br><br>Medical record review of the "Restraint Assessment" revealed no changes in the assessment from 3/31/15 for the 7/15/15 order for "...Res [Resident] to be in w/c [with] sensor pad + seatbelt. Check q 30 min + release q 2 [hours] x 10 min..."<br><br>Medical record review of the care plan dated 3/31/15, updated 4/6/15, 4/22/15, 7/6/15, and 7/8/15, revealed the problem of "...at risk for falls r/t [related to] h/o [history of] falls, resulting in fx [fracture]..." Further review revealed the last entry was dated "...5/17/15 trial period w/c [with] alarming seat belt, ck [check] q 30 min, release/reposition (x 10 min) q 2 hrs [hours]..." | F 280 | **restraints. The independent contractor determined to what extent the nursing home seeks to involve, educate and train residents and family members on alternatives to restraints. The independent contractor validated via observation, record review and interview that restraints on all shifts if used are only to facilitate or support the resident's medical treatment, and not used to discipline residents, as staff convenience, or to prevent residents from wandering.** *The dates of evaluation, assessment, & validation of facility's & governing body's systems & processes are provided in Independent Contractor's DPOC Final Report.*<br><br>• 4.1 A facility assessment was completed to review all processes and systems related to restraint minimization. The assessment will include, but not be limited to:<br>o Leadership, staff and contractor interviews<br>o Policies and procedures<br>▪ Scope<br>▪ Execution<br>• New admits<br>• Current residents<br>o New orders<br>o Change orders<br>o Continuing orders<br>• Emergencies<br>o Training Curriculum – Restraints and resident rights | |

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| F 280 | Continued From page 82<br>Further review revealed the facility failed to revise the care plan 7/9/15 to "... D/C alarming seat belt...2) begin soft posey [belt] while in w/c. Apply 2 [hours], then release 10 min and reposition...", on 7/10/15 to "...D/C soft posey [belt]...Begin alarming seat belt [with] w/c...", on 7/10/15 to "...DC alarming seat belt to w/c...Apply SWB [soft waist belt] while in w/c. Check for placement q 2 hours + release x 10 min..." on 7/11/15 to "...Start posey belt in Rock-n-Go chair...Check q 30 min + release q 2 hours + reposition x 10 min...", on 7/15/15 "...D/C posey belt in Rock-n-Go. Res [Resident] to be in w/c [with] sensor pad + seatbelt. Check q 30 min + release q 2 [hours] x 10 min..."<br><br>Observation of Resident #160 and/or interview revealed the following:<br><br>1. On 7/14/15 at 7:52 AM: Resident #160 was in the H hall and I hall dayroom/dining room in a reclined Rock-n-Go chair with a soft waist belt in place.<br><br>2. On 7/14/15 at 3:20 PM with LPN #1: Resident #160 was in the Rock-n-Go in the F hall and G hall dayroom/dining room with a soft waist belt in place.<br><br>3. On 7/15/15 at 7:37 AM: Resident #160 was in the H hall and I hall dayroom/dining room, with 15 other residents, in a reclined Rock-n-Go chair with a soft waist belt under her chin, both arms were under the soft waist belt with the right hand under her chin holding onto the top of belt, the resident had slid down in the chair, and no facility staff was present. The surveyor stayed with the resident. Observation at 7:39 AM revealed 2 nursing staff entering the H hall and I hall | F 280 | ▪ Scope and content<br>▪ Stakeholders {includes employed staff, agency (none since before 2005), contractors (therapy), families and volunteers}<br>▪ Frequency<br>• CCRC Staff<br>o Onboarding<br>o Interim (as needed)<br>o Continuing (annual)<br>• Residents and Families<br>• Volunteers<br>▪ Staff returning from extended leave<br>▪ Agency and Contract Service Provider Staff<br>▪ Methods/Platforms<br>▪ Knowledge and/or competency verification<br>• Who does it?<br>• Documentation<br>• Follow-up<br>o Documentation | |

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| F 280 | Continued From page 83<br>dayroom/dining room. Certified Nurse Aide (CNA) #3 did not see Resident #160 and left the dayroom. CNA #1 saw Resident #160 soft waist belt located under her chin, repositioned the belt to the waist area (without re-applying the straps) and left the dayroom. The surveyor stayed with the resident. Continued observation revealed Resident #160 took her right hand and pulled the soft waist belt up under her chin and both arms were under the belt. Continued observation at 7:42 AM revealed Registered Nurse (RN) #1 entering the H hall and I hall dayroom/dining room, went to Resident #160, knelt down behind the chair and touched the restraint belt straps. Interview with RN #1 when asked if the soft waist belt was fastened appropriately, RN #1 stated "it should be tighter." Further interview with RN #1 when asked if it would be appropriate for staff to see the soft waist belt under the resident's chin, reposition the soft waist belt to the waist area without checking or re-applying the restraint straps and leaving the room with the resident unattended, the RN #1 stated, "No, it could have serious consequences." Observation and interview revealed CNA #1 re-entering the H hall and I hall dayroom/dining room and demonstrated to RN #1 how CNA #1 had repositioned the soft waist belt and stated then "...left the dayroom..." the RN stated to CNA #1 "That could result in serious consequences, even death."<br><br>4. On 7/15/15 at 8:53 AM in front of the H hall and I hall nurses station, revealed Resident #160 in a reclined Rock-n-Go chair with a soft waist belt in place. Continued observation revealed the resident had both arms under the belt, the belt was loose, and the belt was positioned across the breast. The surveyor stayed with the resident until a nurse arrived. Observation and interview with | F 280 | o Communication and Ongoing Involvement<br>▪ Staff<br>▪ Residents<br>▪ Family<br><br>Information collected in the above outlined baseline assessment was used to identify gaps and weaknesses, inform relevant opportunities for improvement and establish recommendations/specific actions to the facility Administrator and governing board.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>• 4.2 As part of the overall assessment (4.1) the involvement, education and training of residents and their families on alternatives to restraints was completed.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>• 4.3 Resident restraint use was validated on all shifts to insure utilization is to facilitate or support medical treatment and that none are in use for discipline, staff convenience or to prevent wandering. Validation was by way of observation, record review and interviews throughout | |

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| F 280 | Continued From page 84<br>RN #1 on 7/15/15 at 8:54 AM through 8:58 AM in front of the H hall and I hall nurses station, revealed Resident #160 had removed several types of restraints and the current restraint (soft waist belt) was "...not applied correctly, it was too loose..." Continued interview confirmed the resident was capable of self-propelling in a wheelchair, and the Rock-n-Go chair was reclined to prevent the resident from propelling. When RN #1 was asked if the belt was applied correctly the RN stated the "...soft posey belt was not applied correctly...belt was not appropriate for the resident..."<br><br>5. On 7/15/15 at 1:55 PM and at 2:50 PM: The resident was in a reclined Rock-n-Go chair in the in H hall and I hall dayroom/dining room with no staff present, no soft waist belt was on the resident. LPN #8 entered the H hall and I hall dayroom/dining room and stated the physician had changed the order to stop the soft waist belt and keep the Rock-n-Go.<br><br>Interview with the Director of Nursing (DON) on 7/15/15 at 2:42: PM, in the Admissions Coordinator's office, confirmed the facility failed to revise the care plan after 5/17/15 to reflect the restraint changes.<br><br>The interventions put in place were evaluated by the survey team on 7/29/15, and verified the Allegation of Compliance by:<br><br>1. The facility re-assessed the 13 residents with restraints for appropriateness and for the least restrictive device.<br><br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 | F 280 | the course of the Independent Consultant's engagement.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>#5• **The independent contractor determined what procedures are in place to assess the competency of staff who apply restraints; the frequency of observing and assessing the resident who is restrained; and how staff interact with the resident and attend to the resident's needs while he or she is restrained.** *The Independent Contractor's DPOC Final Report contains her findings and assessment of facility limited restraint use.*<br><br>• 5.1 As part of the overall facility assessment related to restraint minimization (4.1), the facility's procedures related to assessing staff competency in the application of restraints was evaluated.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>• 5.2 CCRC licensed and/or certified staff was evaluated as to the frequency of observation and assessment of residents who are restrained. This evaluation was completed in conjunction with 4.3.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015 | |

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| F 280 | Continued From page 85<br>AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 280 | • 5.3. All classifications of CCRC staff, agency personnel (none since before 2005) and contract service providers (therapy) was evaluated as to how they interact with residents and attend to their needs while restrained. This was completed in conjunction with 4.3.<br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>o Completion Date: September 15, 2015<br><br>**#6• The independent contractor is submitting to CMS and the State a copy of all training materials, and a written report summarizing the aforementioned components of the directed plan of correction, and how the administrator and governing body will ensure ongoing compliance with 42 CFR 483.13.**<br>• 6.1 At the completion of the Independent Consultant's role on September 15, 2015, a report is submitted to CMS and the State summarizing the above outlined directed plan of correction, its execution, findings and recommendations, and how the Administrator and governing body will ensure ongoing compliance with 42 CFR 483.13. The report will include copies of all training materials and any other relevant documents.<br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>o Completion Date: September 18, 2015 | |

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| F 280 | Continued From page 85<br>AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 280 | 7/30/15 – 8/18/15 – Unit Managers and MDS LN completed 100% device / alarm audit. RRC evaluated each device to determine if it was a positioning device that could be a restraint for the individual resident. Assessments were completed to ensure device(s) were used according to manufacturer application instructions and warnings and as indicated to determine baseline for device reductions as indicated by resident activity, behavior, cognition and safety needs. MDS LN reviewed 100% resident Care plans and revised as indicated to reflect residents' current devices. Medical Director notified of results for discussion related to facility benchmark and current trends. Findings will be forwarded to QA Committee for establish action plan to achieve facility goals. DON will be responsible for communication action plan between RCC, QA and QAA committee in addition to documentation of the action plan, implementation and evaluation for full QAA review. Audit tool will be updated as MD orders impact the devices. MDS LN will review the audit tool during the RAI schedule for each resident and will conduct a comprehensive QA audit at least annually for full QAA Committee review to determine use trend and compliance with RAI assessment and care planning requirements in addition to facility goals.<br><br>8/7/15 – QA Committee Meeting - Reviewed: New Restraint Policy, new Restraint Protocol, Restraint Audits, Restraint education audit, new restraint assessment forms (Pre-evaluation and Reduction)<br><br>7/23/15 – Restraint Reduction Committee: New Committee meets weekly and is a Sub-committee of the QAA Committee. DON is the Chairman. Members include: NHA, DON, MDS LN, Unit Managers, Wound Care Nurse, Central Supply, Restorative CNAs, Therapy, Social Service and Activities. The Medical Director will be an Ad Hoc | |

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| F 280 | Continued From page 85<br>AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 280 | member of the committee. The Committee will review weekly every restraint and all assistive devices that could also be a restraint and a restraint assessment will be updated to direct the committee to the restraint indicated and least restrictive device for resident safety. MDS LN will be responsible for reviewing the care plans and updating during the committee meeting to accurately reflect the current assessment, interventions and devices The committee will be responsible on-going selection of restraint / device, monitoring restraint/device application and use in according to manufacturer application instructions and warnings in addition to assessment for restraint reduction and management.<br><br>Each restraint assessment review will be conducted for potential reduction, removal or validation of continued medical necessity. MDS, Care plan and resident Chart will be brought to the meeting by the Unit Managers for documentation, MDS and care plan review/update and to update the weekly committee meeting note. Committee Chairman (DON) will record minutes during the meeting. The minutes will be submitted to the QAA Committee for benchmark, trending, oversight, review and to determine programming and staff education needs. The MDS LN will be responsible for updating the care plan as indicated to reflect current assessment. The nursing Home Administrator (NHA) will be responsible for QAA Committee oversight of the Restraint Reduction Committee activity. MD will review the committee minutes during weekly scheduled visits. Compliance Consultant will review weekly notes during scheduled monthly visits.<br><br>7/30/15 - Daily QA Managers Meeting (Monday – Friday). NHA will oversee and investigate concerns related to facility reports, communications and policies. | |

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| COMMUNITY CARE OF RUTHERFORD | 901 COUNTY FARM RD MURFREESBORO, TN 37127 |

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| F 280 | Continued From page 85<br>AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 280 | Daily QA Managers Meeting attendees include but may not be limited to: NHA, DON, MDS LN, Infection Control/Staff Education, Wound Nurse, Unit Managers, Restorative, Medical Records, Therapy, Social Service, Activities, Housekeeping, Maintenance, Business Office and Payroll.<br><br>The following items will be reviewed daily: Change in Resident Condition, Significant Change in Resident Status, 24 Hour Report Information, New MD orders, Occurrence Reports, Clinical Progress Notes and Hospital Transfers in addition to Restraints, Infection Control and On-going Investigations. Care plan updates will be discussed in the meeting for updates and accuracy.<br>Concerns discussed in the daily meeting will be assigned to staff for follow up and the DON as indicated to complete investigations. Information and findings from the areas discussed in the daily meeting will be reviewed in the meeting weekly until resolved or on-going as indicated. Staff education will be directed by information from the daily QA meeting in addition to on-going audits, scheduled monthly staff meetings and annual skills assessments.<br><br>Nursing Home Administrator will notify the Clinical Consultant of issues, concerns, QA audits and investigations during the monthly visit to ensure a timely and comprehensive investigation with action plan is completed.<br><br>Clinical Consultant will review daily, weekly and monthly QA and scheduled QA Committee and Sub Committee meeting minutes to ensure timely and comprehensive action plans are implemented, monitored and evaluated. Clinical Consultant will be on-site at least monthly and submit a written report to the QAA Committee for review and action as | |

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| F 280 | Continued From page 85<br>AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 280 | indicated. Medical Director will review consultant report monthly for timely response and needed intervention as indicated.<br><br>8/7/15 – Monthly QA Committee Meeting - NHA or designee will summarize the daily Managers meetings for trends and education needs to be discussed in the Monthly QA meeting. Trend summaries and on-going or unresolved facility issues are discussed for resolution in the Monthly QA Committee Meeting. The QA Committee will meet 2 times per month for the first month (August – September) and then monthly thereafter.<br><br>Monthly QA Meeting attendees include but may not be limited to: NHA, DON, Department Managers, Wound Nurse, Infection Control Nurse and Staff Educator. The NHA will be the Chairman of the committee and responsible to ensure information is communicated between the QA Committee and the QAA Committee.<br><br>8/1/15 - The QAA Committee will meet quarterly. Items from the Monthly QA Committee Agenda will be reviewed by the full QAA Committee to ensure policy compliance, clinical best practice and staff education is monitored, implemented and evaluated on-going. The Clinical Consultant will review the QA and QAA Committee minutes during monthly visits to ensure compliance. Compliance issues or concerns will be discussed with the NHA for follow-up and resolution.<br><br>QAA Committee members include but may not be limited to: Medical Director, Nursing Home Administrator, DON, Department Managers (Social Service, Activity, Therapy, Nursing, Housekeeping, Maintenance), in addition to the wound Care Nurse, Staff Education Nurse, Infection Control Nurse and staff nurses and CNAs as available. | |

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| F 280 | Continued From page 85<br>responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "D" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 280 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy review, medical record review, and interview, the facility failed to ensure | F 309 | Facility will ensure each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.<br><br>All residents have the potential to be effected.<br><br>**Resident # 76**<br><br>8/14/15 – No rash present - most recent rash identified on 6/17/15 – diagnosis was not confirmed – no scrape test was performed. | |

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| F 309 | Continued From page 86<br>care was provided to meet the needs of the residents to maintain their highest well being by failing to determine the source of scabies infestation and control the recurrence of scabies for 3 (#76, 81, 158) of 7 residents reviewed for scabies.<br><br>The findings included:<br><br>Review of the facility policy entitled "Infection Control Policy and Procedure for Scabies" implemented 6/3/14, revealed "...Residents with signs and symptoms of scabies:<br>1. Notify physician for treatment plan.<br>2. Place on contact isolation and follow facility's isolation precautions policy and procedure. Resident remains on contact isolation for forty-eight hours after last treatment dose. Staff is to wear gowns and gloves with all care and when cleaning room.<br>3. Soak nails in soap and water with all nails trimmed short and cleaned thoroughly before first treatment.<br>4. Bathe resident daily with thorough skin assessments following the first initial treatment dose until second dose is given.<br>5. Skin-to-skin contact should be avoided for at least 8 hours after treatment.<br>6. Any clothing worn by resident anytime during the three days prior to treatment must be laundered.<br>7. Dedicate the use of non-critical patient care equipment to resident.<br>Environmental Protocol:<br>1. All clothing except three days worth, stuffed animals, throw blankets, etc, should be placed in a sealed bag for 14 days...After 14 days those clothes can be laundered and returned to the resident's room. | F 309 | Weekly skin assessments are conducted by Licensed Nurse to observe for rash.<br><br>**Resident # 81**<br><br>8/14/15 — Eczema present: rash identified on 2/3/15 – diagnosis was not confirmed – no scrape test was performed. Weekly skin assessments are conducted by Licensed Nurse to observe for skin condition.<br><br>**Resident # 158**<br><br>8/14/15 – No rash present – most recent rash identified on 5/22/15. Scraping on 6/23/15 with positive diagnosis. Scraping on 7/21/15 with negative diagnosis. Weekly skin assessments are conducted by Licensed Nurse to observe for rash.<br><br>8/6/15 – Full staff inservice conducted by the Education LN, DON and NHA to review current Infection Control policy for Isolation, Infectious disease, scabies diagnosis, treatment and staff responsibility for self-reporting and personal protection.<br><br>8/7/15 – QA Committee meeting – review Infectious Disease Report – no active scabies at this time.<br><br>8/14/15 – LN and Nurse Manager conducted skin audit for three residents with rashes – no indication of infectious disease (scabies).<br><br>8/14/15 – 100% resident skin audit and chart documentation review conducted by Infection Control Nurse to evaluate current rashes and confirmed scabies diagnosis. There are currently | |

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| F 309 | Continued From page 87<br>2. Bed linens should be changed daily.<br>3. Resident's room should be cleaned per facility's contact isolation room cleaning policy. Upholstered furniture should be vacuumed twice daily.<br>4. Resident personal equipment should be cleaned per contact isolation guidelines and kept in resident room unless otherwise indicated..."<br><br>Medical record review revealed Resident #76 was admitted to the facility on 8/30/11, with diagnoses including Osteoarthritis, Dementia, Spinal Stenosis, Hypertension, and Cerebrovascular Accident.<br><br>Medical record review of the Quarterly MDS dated 6/9/15, revealed the resident was severely impaired cognitively; required extensive assistance with transfers, dressing, grooming, eating, and bathing; was frequently incontinent of bladder and occasionally incontinent of bowel; and used a wheelchair for mobility.<br><br>Medical record review of nursing notes dated 2/27/15, revealed the resident had raised red area on her chest and was started on NEEM (product intended for use as a pesticide to control insects on agricultural crops). Continued medical record review of nursing notes dated 6/15/15, revealed the resident had a rash on the neck and chest and was placed on contact isolation.<br><br>Medical record review of physician's notes dated 6/19/15, revealed "...the return of rash coming back from hospital of erythematous papules knees and abdomen; treated multiple times for scabies; start Triamcinolone cream..."<br><br>Medical record review of nursing notes dated | F 309 | two residents (on the same hall) who have had a previous scabies diagnosis confirmed with a skin scrape / smear.<br><br>8/14/15 - Following completion of Infectious Disease (scabies / rash) audit and review of MD notes (dermatology, PCP, Medical Director, hospitalist) it was determined that MD's were confirming diagnosis of scabies with rash present regardless of the appearance of the rash and without scraping or smear diagnosis. There were dermatologists that confirmed 100% rash observation as scabies even when the scrape / smear was negative. There were other consulting physicians who diagnosed the same residents during the rash to have dry skin, eczema or psoriasis. It was noted that the original skin rash appeared on the residents when they were on the same hall of the unit. Also noted the residents on this unit had drier skin collectively than residents on other units. Additionally it was documented that most rashes subsided when residents were transferred to another unit within the facility. Of further consideration - the treatment for scabies and subsequent daily baths causes dry skin and often rashes in individuals with sensitive skin. As a result of the comprehensive audit and investigation the Infection Control Policy and Procedure for Scabies was revised in the following areas:<br><br>1) Diagnosis will be confirmed with a skin scraping by the PCP or dermatologist will be consulted as indicated,<br><br>2) Resident will initially be treated environmentally (isolation, room disinfected, clothing laundered and personal items bagged), | |

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| F 309 | Continued From page 88<br>6/23/15, revealed resident was on contact isolation and had a rash over most of the body. Continued medical record review of nursing notes dated 6/30/15, revealed the resident was on contact isolation and was started on Ivermectin (specific anti-scabies medication). Further review of nursing notes dated 7/3/15, revealed the resident had a rash over the whole body, while a note dated 7/6/15, revealed the resident was on contact isolation. Continued medical record review of nursing notes dated 7/13/15, revealed the resident was continued on contact isolation for 48 hours after being treated with Ivermectin. Further medical record review of nursing notes dated 7/16/15, revealed the resident had been admitted to the hospital.<br><br>Interview with the Director of Nursing (DON) on 7/15/15, at 2:00 PM in the Case Management Office, revealed she had called the Health Department for suggestions on how to eradicate the scabies. Continued interview with the DON revealed a resident was admitted in 2013 who had a bad rash and was using a cream so this may have been the first case. Further interview with the DON revealed some dermatologists said the rashes were scabies and treated them accordingly, while other dermatologists felt the rashes were not scabies but treated the rashes as though they were scabies. Continued interview with the DON revealed the staff on F and G halls were all treated since F hall was the primary location of the cases of scabies. Further interview with the DON revealed NEEM worked for awhile then residents began developing a rash from the NEEM. Continued interview with the DON revealed one resident had her rash treated several times; was moved to another unit; and had not developed any more rashes. | F 309 | 3) Daily skin lotion baths (in addition to peri-care) instead of showers will be given for skin hydration for 5 days prior to initiation of scabies treatment (hydrocortisone cream will not be used),<br><br>4) Additionally the policy was updated with a preference for oral medication treatment rather than topical medication due to the frail and sensitive skin of the elderly population.<br><br>7/30/15 - Daily QA Managers Meeting (Monday – Friday). NHA will oversee and investigate concerns related to infection control reports, communications and policies.<br><br>Daily QA Managers Meeting attendees include but may not be limited to: NHA, DON, MDS LN, Infection Control/Staff Education, Wound Nurse, Unit Managers, Restorative, Medical Records, Therapy, Social Service, Activities, Housekeeping, Maintenance, Business Office and Payroll.<br><br>The following items will be reviewed daily: Change in Resident Condition, Significant Change in Resident Status, 24 Hour Report Information, New MD orders, Occurrence Reports, Clinical Progress Notes and Hospital Transfers in addition to Restraints, Infection Control and On-going Investigations. Care plan updates will be discussed in the meeting for updates and accuracy.<br><br>Concerns discussed in the daily meeting will be assigned to staff for follow up and the DON as indicated to complete investigations. Information and findings from the areas discussed in the daily meeting will be reviewed | |

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| F 309 | Continued From page 89<br><br>Interview with the Infection Control Nurse/Staff Development Coordinator (ICN) on 7/15/15, at 2:45 PM in the Case Management office, revealed she took over the position on 5/2/14. Continued interview with the ICN revealed only a couple of cases of rashes were confirmed as being scabies and the rest were classified as rashes. Further interview with the ICN revealed 7/2/14, residents on the F hall began to develop rashes. Continued interview with the ICN revealed the residents were treated and the rashes disappeared, only to reappear a couple of months later. Further interview with the ICN revealed one resident was moved from F hall to G hall; tested three times for scabies and was negative; but the resident's new roommate developed scabies. Continued interview with the ICN revealed a staff member had a rash which was seen by her peers but which she denied having to administration; she was given cream to use for herself and cream was also provided for family members; and the staff person had patient contact in the period when she supposedly had a rash. Further interview with the ICN revealed a spray was used to treat the furniture; all resident's clothing and belongings were bagged for 14 days; and belongings were not returned to the resident until 48 hours after the last treatment. Continued interview with the ICN revealed residents were showered daily whether the resident was on cream or pills; showers were started 12 hours after the resident took the pills or the cream was applied. Further interview with the ICN revealed the families were told of the situation and it was suggested they self-treat. Continued interview with the ICN revealed Maintenance inspected the F hall for possible sources of infestations and found nothing. | F 309 | in the meeting weekly until resolved or on-going as indicated. Staff education will be directed by information from the daily QA meeting in addition to on-going audits, scheduled monthly staff meetings and annual skills assessments.<br><br>Nursing Home Administrator will notify the Clinical Consultant of issues, concerns, QA audits and investigations during the monthly visit to ensure a timely and comprehensive investigation with action plan is completed.<br><br>Clinical Consultant will review daily, weekly and monthly QA and scheduled QA Committee and Sub Committee meeting minutes to ensure timely and comprehensive action plans are implemented, monitored and evaluated. Clinical Consultant will be on-site at least monthly and submit a written report to the QAA Committee for review and action as indicated. Medical Director will review consultant report monthly for timely response and needed intervention as indicated.<br><br>8/7/15 – Monthly QA Committee Meeting - NHA or designee will summarize the daily Managers meetings for trends and education needs to be discussed in the Monthly QA meeting. Trend summaries and on-going or unresolved facility issues are discussed for resolution in the Monthly QA Committee Meeting. The QA Committee will meet 2 times per month for the first month (August – September) and then monthly thereafter.<br><br>Monthly QA Meeting attendees include but may not be limited to: NHA, DON, Department Managers, Wound Nurse, Infection Control | |

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| F 309 | Continued From page 90<br><br>Interview with the ICN on 7/20/15, at 2:10 PM, in the conference room, revealed everything that could be gathered was put in plastic bags for the whole time the resident was in isolation, including blankets, comforters, clothes, stuffed animals, and underwear. Continued interview with the ICN revealed three sets of clothing were left out and these were laundered when the resident was off isolation. Further interview with the ICN revealed the curtains in the rooms were changed in the first 12 hour after treatment; again after the second treatment; and when the resident came off isolation. Continued interview with the ICN revealed each resident had two soft lap belts, one of which was bagged for 48 hours then changed out with the other one and laundered. Further interview with the ICN revealed linens were placed in a yellow isolation bag and washed separately from other linens. Continued interview with the ICN revealed mattresses were cleaned twice daily with hospital grade disinfectant. Continued interview with the ICN revealed the furniture in the room was cleaned with hospital grade disinfectant as well.<br><br>Interview with the Director of Environmental Services on 7/22/15, at 3:00 PM in the conference room, revealed residents who had unexplained rashes were treated as scabies and 1 resident had a confirmed case of scabies. Continued interview revealed all the resident's personal belongings were bagged for 14 days. Further interview revealed linens were treated as any contact isolation linens were treated. Continued interview revealed the ozone and chlorine bleach used in the laundry could be causing some rashes. Further interview revealed 12 hours after a resident was placed in isolation, | F 309 | Nurse and Staff Educator. The NHA will be the Chairman of the committee and responsible to ensure information is communicated between the QA Committee and the QAA Committee.<br><br>8/1/15 - The QAA Committee will meet quarterly. Items from the Monthly QA Committee Agenda will be reviewed by the full QAA Committee to ensure policy compliance, clinical best practice and staff education is monitored, implemented and evaluated on-going. The Clinical Consultant will review the QA and QAA Committee minutes during monthly visits to ensure compliance. Compliance issues or concerns will be discussed with the NHA for follow-up and resolution.<br><br>QAA Committee members include but may not be limited to: Medical Director, Nursing Home Administrator, DON, Department Managers (Social Service, Activity, Therapy, Nursing, Housekeeping, Maintenance), in addition to the wound Care Nurse, Staff Education Nurse, Infection Control Nurse and staff nurses and CNAs as available. | |

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| F 309 | Continued From page 91<br>the room was totally cleaned; curtains were changed; the mattress was cleaned with hospital grade disinfectant. Continued interview revealed some of the residents who had a diagnosis of scabies also had dementia so they were difficult to keep in isolation. Further interview revealed if a defect was found in the mattress then a clear cover was placed on it. Continued interview revealed residents with severe scabies were treated over and over again and may be the ones who were reinfecting other residents. Further interview revealed the same treatments were used over and over again since there were only three treatments available and the scabies could be becoming resistant to the treatment, and he had a concern for the resident's health since some of the treatments are pesticides. Continued interview revealed any time Dermatology heard there had been a case of scabies in a nursing home, then every rash they saw from the facility was scabies and often they didn't do a scraping or punch biopsy.<br><br>Interview with the Administrator on 7/22/15, at 4:00 PM, in the conference room, revealed all staff and residents were treated with Permethrin (body cream for scabies). Continued interview revealed confirmation was difficult since some dermatologists always say a rash is scabies while others rarely will state it is scabies. Further interview revealed NEEM oil was used for some time but it can cause dry itching. Continued interview revealed a staff member was suspected of having scabies; she was given treatment for herself and her family; she refused to treat her family; and she resigned in June 2015.<br><br>Medical record review revealed Resident #158 was admitted to the facility on 2/25/15 with | F 309 | | |

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| F 309 | Continued From page 92<br>diagnoses including Dementia, Depression, Cerebrovascular Accident with Hemiplegia, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, and Alcohol Cirrhosis of the Liver.<br><br>Medical record review of the Quarterly Minimum Data Set (MDS) dated 5/28/15 revealed Resident #158 had a score of 10/15 on the Brief Interview for Mental Status (BIMS) indicating he was moderately cognitively impaired; required assistance with transfers, dressing, and bathing; required extensive assistance with grooming; was independent with eating after setup; and was continent of bowel and bladder.<br><br>Medical record review of a physician's note dated 5/22/15, revealed "...NEEM oil (product intended for use as a pesticide to control insects on agricultural crops) applied to affected areas, upper left arm, left side of abdomen twice daily..."<br><br>Medical record review of nursing notes dated 5/23/15, revealed "...rash to left upper arm; raised red areas with scratch marks noted; NEEM oil/spray applied..." Continued medical record review of nursing notes dated 6/3/15, revealed "...NEEM oil treatment continues to right and left arm, abdomen, and side as rash continues..." Further medical record review of nursing notes dated 6/12/15, revealed "...rash continues to upper left arm, back of left arm, and left side. Continue with NEEM oil/enzyme spray. Dermatology appointment..."<br><br>Medical record review of physician orders from the dermatologist dated 6/23/15, revealed "...Ivermectin (specific anti-scabies medication) 3 milligrams (mg) take 6 tablets for 18 mg now and repeat in 2 weeks. Contact isolation. Showers | F 309 | | |

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| F 309 | Continued From page 93<br>daily for 1 week. Bag all clothes except 3 outfits and current soft Posey belt. Must sleep in bed while on contact isolation..."<br><br>Medical record review of nursing notes dated 6/24/15, revealed "...contact isolation for treatment of scabies. Rash to trunk area..." Continued medical record review of nursing notes dated 6/29/15, revealed "...rashes red and raised, inflamed..." Further medical record review of nursing notes dated 7/4/15, revealed "...rash to trunk, left side, abdomen, chest, and upper arms. Isolation d/c [discontinued]..." Continued medical record review of nursing notes dated 7/10/15, revealed "...Apply Permethrin (specific anti-scabies medication) 5% cream to all skin from top of head to soles of feet. Wash off after 18-24 hours. Repeat in one week..." Further medical record review of nursing notes dated 7/17/15, revealed "...This nurse asked Nurse Practitioner [NP] if contact isolation was needed. NP that d/t [due to] resident not having active scabies present no order for isolation was necessary..." Continued medical record review of nursing notes dated 7/17/15, revealed "... NP stated daughter called office multiple times insisting that topical treatment for scabies be called in to local pharmacy and she would pick up and bring to facility. NP stated multiple attempts were made to explain the facts of scabies and how the rash and itching can be present up to several months in some cases after scabies are no longer present..."<br><br>Observation of Resident #158 on 7/16/15, at 10:20 AM, on the F hall, revealed the resident seated in a wheelchair on F hall. Continued observation revealed excoriations on his arms which appeared to be healing. Further | F 309 | | |

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| F 309 | Continued From page 94<br>observation revealed the resident was not scratching any part of his body.<br><br>Observation of Resident #158 on 7/20/15, at 2:35 PM, on the F hall, revealed the resident seated in his wheelchair at the nurses' station, without noticeable lesions and/or scratching.<br><br>Medical record review of a note from the Dermatologist dated 7/21/15, revealed "...pt [patient] much improved and no longer itching. Few erythematous (red, irritated) scabbing papules on forearms, fingerpads, abdomen, belt line. Scabies smear negative. Resolving scabies with mild pruritis. Clobetasol [short term topical treatment for moderate to severe plaque type psoriasis of non-scalp regions excluding face] cream 0.05% BID [twice daily] x 2 [for two] weeks then take one week off may repeat cycle as needed. Will biopsy if rash still remains..."<br><br>Medical record review revealed Resident #81 was admitted to the facility on 11/01/12, with diagnoses including Parkinson's Disease, Irritable Bowel Syndrome, Hypertension, Dementia, Benign Prostatic Hypertrophy.<br><br>Medical record review of the Quarterly MDS dated 6/11/15, revealed the resident had a score of 7/15 on the BIMS, indicating he was moderately impaired cognitively; required extensive assistance with transfers, grooming, and bathing; was independent with eating after setup; was sometimes incontinent of bladder and always incontinent of bowel.<br><br>Medical record review of nursing notes dated 2/13/15 revealed Resident #81 had a rash to his thighs, left hip, left side, left abdomen. Continued | F 309 | | |

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| F 309 | Continued From page 95<br>medical record review of nursing notes dated 3/14/15, revealed Resident #81 had a rash on the left side of the back, right inner thigh, abdomen, right side which was treated with Hydrocortisone. Further medical record review of nursing notes dated 4/15/15, revealed the resident had a rash on his trunk, chest, side, and abdomen. Continued medical record review of nursing notes dated 4/17/15 - 4/20/15, revealed the resident was treated with NEEM daily. Further medical record review of nursing notes dated 4/29/15, revealed Resident #81 was placed on contact isolation and treated with Ivermectin.<br><br>Medical record review of physician's note dated 5/7/15, revealed "...confirmed scabies on arms, trunk, thighs..."<br><br>Medical record review of nursing notes dated 5/13/15, revealed the resident received Stromectal (anti-scabies medication) for his rash. Continued medical record review of nursing notes dated 5/21/15, revealed the resident was placed on Triamcinolone (medicating ointment) for a rash on his trunk, arms, back, and abdomen. Further medical record review of nursing notes dated 6/10/15, revealed the resident was be treated with NEEM. Continued medical record review of nursing notes dated 6/21/15, revealed the resident still had a rash on his trunk, arms, and back. Further medical record review of nursing notes dated 6/26/15, revealed the resident was ordered a dermatology consult and started on Stromectin (anti-scabies medication). Continued medical record review of nursing notes dated 7/3/15, revealed the resident was placed on contact isolation. Further medical record review of nursing notes dated 7/9/15, revealed the resident had a bilateral lower extremity rash, and on | F 309 | | |

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| F 309 | Continued From page 96<br>7/13/15, was placed on contact isolation. | F 309 | | |
| F 323 SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to ensure equipment was safe for resident use for 1 (Resident #10); failed to ensure residents were correctly placed in mechanical lifts for 2 (Resident #84, 26); failed to ensure belts were secured on a merry walker for 1 (Resident #18) of 4 residents reviewed for accidents with medical equipment; and failed to supervise a resident in a restraint to ensure safety which resulted in an injury for 1 (Resident #158) of 13 residents reviewed for restraints.<br><br>This failure resulted in actual HARM to Resident #10 who sustained a fall from a mechanical lift and suffered a head laceration.<br><br>The findings included:<br><br>Review of the facility policy entitled "Patient/Resident Transfer and Handling", undated, revealed "...the Prolift may be used for total care or non-weight bearing residents and it | F 323 | Facility will ensure the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>All residents have the potential to be effected.<br><br>**Resident # 10**<br><br>4/12/15 - Discharged from facility.<br><br>**Resident # 26**<br><br>5/21/15 – Discharged from facility.<br><br>4/14/15 – all old / frayed slings were removed by the Restorative and Central Supply.<br><br>**Resident #18**<br><br>7/16/15 – Merry walker discontinued.<br><br>**Resident # 84**<br><br>8/14/15 – Therapy rescreened resident for lift use.<br><br>3/3/15 – Fall Assessment updated and reviewed following assisted fall in stand-up lift. | |

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| F 323 | Continued From page 97<br>allows the resident to have a sitting position during transfer. All mechanical lift users are responsible to:<br>1. Inspect devices prior to use to insure equipment is in good repair and working order.<br>2. Insure slings are laundered when indicated.<br>3. Report maintenance and repair issue to DON when indicated.<br>4. Follow the guide lines exactly for using mechanical lifts..."<br>Continued review of the facility policy addendum dated 2/1/13, revealed "...Two or more people are required for the total dependent lift such as the Pro One lift..." Further review of the facility policy addendum dated 4/13/15, revealed "...It is the policy of... (named facility) to inspect the integrity of all lift pads prior to uses. Any frayed edges or stitching coming undone is to be reported immediately to supervisor and the pad is not to be used..." Continued review of the facility policy revealed the statement "...DO NOT LEAVE RESIDENT UNATTENDED..."<br><br>Medical record review revealed Resident #10 was admitted to the facility on 8/9/11, with diagnoses including Seizures, Deep Vein Thrombosis, Cerebrovascular Accident with Hemiplegia, Atrial Fibrillation, and Hypertension.<br><br>Medical record review of the Quarterly Minimum Data Set (MDS) dated 1/22/15, revealed the resident was severely impaired cognitively; was total dependence of two people for transfer, dressing, grooming, and bathing; required extensive assistance for eating; and was always incontinent of bowel and bladder.<br><br>Medical record review of nursing notes dated 4/12/15, at 8:30 AM, revealed "...Summoned to | F 323 | 3/3/15 – Fall Committee reviewed Lift and Fall assessments to determine Standing lift is appropriate with two (2) staff in attendance for safe transfer. Resident is alert and oriented x 3 however due to size and debility cannot assist with weight bearing during transfer with lift – completely dependent on arm strength, standing lift and staff assistance.<br><br>7/24/15 – H&I Pro Lift wheel locks repaired<br><br>7/24/15 – J&K Pro Lift - front wheel without tread is replaced.<br><br>7/22/15 – Staff Education Nurse directed clinical staff inservice which included all licensed nurses and all CNAs on all three shifts regarding use of patient lifts. This inservice was conducted by Restorative CNAs from 7/22/15 - 8/21/15 (See below).<br><br>8/6/15 – Staff Education Nurse conducted clinical staff inservice which included all licensed nurses and all CNAs on all three shifts for use of patient lifts and slings. 1) Slings and straps will be checked for fraying by laundry staff prior to placing on linen cart for use. 2) Nursing staff (LNs or CNAs) will check straps and slings for fraying when removed from linen storage and before placing under resident and when lifting but prior to moving resident from surface. 3) Frayed slings or faulty lift equipment will be taken out of use immediately and reported to Central Supply or Restorative when discovered. 4) Call maintenance immediately for a faulty lift and fill out work orders on lifts. 5) Change battery on lifts at the start of each shift. 6) Manufacturer Instructions for use on each lift are attached to | |

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| F 323 | Continued From page 98<br>room. Observed resident lying on floor between bed and bars of Pro 1 lift (mechanical lift). Resident was dressed in gown and was lying on left side with head lying on lt [left] bar of lift and feet were elevated above floor D/T [due to] contractures of [lower] extremities causing body to be in semi-fetal position which is resident's normal positioning. Blood was noted to back of head - Resident was saying "Oh, my head". On assessment laceration noted to [upper] center back of head. An abrasion was noted on posterior (L) [left] leg extending from ankle to knee approx. 2-3" wide. Pressure applied to laceration. Resident was left on left side with staff in attendance until emergency service arrived. 2 CNAs [Certified Nursing Aides] were using Pro 1 lift when strap on rt [right] side of lift [front side when facing handle] broke causing resident to fall. Emergency service notified and resident was transported to...(named hospital)..."<br><br>Review of the admission History and Physical from the hospital dated 4/12/15, revealed"...patient was in lift and the strap broke and the patient fell hitting the back of the head on the floor. There was bleeding of note from the scalp wound. The patient received 2 sutures to the posterior aspect of the scalp. A CT (computerized technology) of the head revealed scalp hematoma of overlying the left posterior superior calvarium..."<br><br>Review of the facility investigation of a statement from CNA #1 dated 4/12/15, revealed "...Had resident connected to Pro 1 lift. (named CNA) and I were in the process of transferring when pulling Pro 1 lift away from bed the lift pad strap broke (front strap on right side when facing handle of Pro 1) and resident fell out. Her head | F 323 | the lift for easy reference. 7) Restorative will check all lifts and slings weekly. 8) Maintenance will check all lifts monthly for maintenance needs. Lifts will be taken out of use until necessary maintenance has been completed.<br><br>8/7/15 – QA Committee Meeting review: Lifts and slings are checked weekly / monthly – staff to check for frayed areas prior to use.<br><br>8/11/15 – Restorative Meeting – Reviewed resident ambulation, therapy, dining, checking alarms, wheelchair tippers and rollbacks, splints/brace application; assisting techs, ROM/contractures related to current restraints and restraint reduction and documentation in addition to keeping lift/sling checks documented in a book for ease in tracking.<br><br>8/14 - 8/17/15 – 100% resident and documentation audit conducted to evaluate current resident lift use, appropriate lift equipment for resident and staff assistance needed to ensure safety during resident transfer.<br><br>8/14/15 – 8/20/15 – Therapy screens completed for all residents using lift to evaluate safe lift transfer.<br><br>7/22/15 - 8/21/15: Restorative staff completed lift training for 93.52% (101/108) clinical staff with documented skills return demonstration to validate staff knowledge of:<br><br>1) Recognizing sling integrity,<br>2) Lift equipment — manufacturer's instructions for use,<br>3) Manufacturer directions to "troubleshoot" in | |

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| F 323 | Continued From page 99<br>hit leg of Pro 1 and because her body twisted as going down she ended up hitting against siderail of bed with her lower left leg. Nurse came in and we left her in the position she was in (on her side) until EMTs (Emergency Medical Technicians) got here..." Continued review of the statement from CNA #1, in response to the question of what could prevent similar incidents in the future, revealed "...It would help if laundry would inspect straps after washing prior to putting out for use. The washing of slings is causing straps to thin out..."<br><br>Continued review of the facility investigation of a statement from CNA #4 dated 4/11/15, revealed "...(named CNA #1) and I was transferring (named Resident #10) from bed to chair. While in mid air the lift pad strap broken and fell to floor. Her head hit leg of lift. Her leg hit side rail..."<br><br>Further review of the facility investigation revealed an unsigned note dated 4/12/15, with a 1 marked over the 2, revealed "...I examined all lift slings I could find including in laundry. All appeared ok. Except for stand-up lift sling had some strings that are starting to come loose - the strap is reinforced however this needs to be stitched up. It is ok to use for now. Also on the stand up lift sling on F & G [F hall and G hall] has a small worn area on one of the green colored hoop of strap. We had difficulty getting H & I [H hall and I hall] pro 1 lift to lock (wheels). (named maintenance) looked at it. It is the design of the brake. This needs to be looked at. It will lock if you can get the brake to go all way down when pushed on. Also Pro 1 lift on J & K one front wheel has no tread on it..."<br><br>Interview with the DON on 7/15/15, at 2:00 PM, in | F 323 | emergency,<br>4) Requirement for battery charge and<br>5) Correct positioning of furniture prior to transfer so resident experiences a limited lateral move rather than equipment pivot or move across room.<br><br>As of 8/21/15 101/108 retrained - (Of the remaining 9: two on vacation are scheduled for 8/24 training; one out of country; two on FMLA; and two have not responded to text communication. Retraining will occur upon returning to work & before providing resident care).<br><br>8/14/15 – Staff Education LN, Unit Managers, Restorative, Central Supply and the Fall Committee will monitor restraint use and staff compliance weekly for two weeks and quarterly thereafter to ensure lift and staff education competence.<br><br>7/29/15 – Education LN has placed the Restraint inservice into the clinical staff (licensed nurses, CNAs and cross-trained staff including Therapists) orientation to be completed by all new clinical employees prior to working with residents. NHA will review orientation status in the morning QA Managers meeting to ensure training is completed during the orientation program. Education LN will conduct monthly staff meetings for three months to review current restraints, restraint application, observation, documentation and non-restraint | |

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| F 323 | Continued From page 100<br>the Case Management office, revealed Resident #10's CNA had dressed her and placed the sling of the Pro 1 lift under her. Continued interview revealed 2 other CNAs went in to get the resident up in the chair. Further interview revealed the CNAs had cleared the bed with the sling and were moving the legs of the lift out from under the bed. Continued interview revealed at that point the strap on the lift broke and the resident fell on the floor. Further interview revealed one strap was frayed but it was hidden by another piece of the sling. Continued interview revealed Restorative had removed the slings that appeared worn and frayed but left others in use that appeared to be intact, and confirmed the frayed strap was overlooked.<br><br>Medical record review revealed Resident #84 was admitted to the facility on 5/6/10, with diagnoses including Parkinson's Disease, Hypertension, Anxiety, Alcohol Withdrawal, and General Weakness.<br><br>Medical record review of the Quarterly MDS dated 5/8/15, revealed the resident was cognitively intact scoring 15/15 on the Brief Interview for Mental Status; required extensive assistance with transfers, dressing, bathing, and grooming; was continent of bowel and bladder; and utilized a wheelchair for mobility.<br><br>Review of a facility fall investigation dated 3/2/15, at 10:30 PM, revealed "...Tech reported standing lift battery went dead. Resident standing on lift over bed. Tech (Certified Nursing Aide) went to get new battery and help from another tech. Tech put battery in lift went down by self. Resident lost footing. Resident stated he was not touching the floor at any time. Resident stated tech did nothing | F 323 | alternatives. Restraints and assistive devices will be reviewed during orientation and at least quarterly thereafter as the facility will be restraint free.<br><br>8/4/15 – Mandatory Restraint Inservice for employees returning to work from extended LOA. Three part time clinical staff (licensed nurses, CNAs and cross-trained staff including Therapists) members and employees on FMLA will be inserviced by the Education LN prior to return to resident care.<br><br>8/6/15 – Mandatory All staff inservice conducted by Education LN, DON and NHA. Discussed current restraints, restraint application, observation and documentation along with facility goal to be a restraint free facility.<br><br>8/1/15 - Daily QA Managers Meeting (Monday – Friday). NHA will oversee and investigate concerns related to facility reports, communications and policies.<br><br>Daily QA Managers Meeting attendees include but may not be limited to: NHA, DON, MDS LN, Infection Control/Staff Education, Wound Nurse, Unit Managers, Restorative, Medical Records, Therapy, Social Service, Activities, Housekeeping, Maintenance, Business Office and Payroll.<br><br>The following items will be reviewed daily: Change in Resident Condition, Significant Change in Resident Status, 24 Hour Report Information, New MD orders, Occurrence Reports, Clinical Progress Notes and Hospital Transfers in addition to Restraints, Infection Control and On-going Investigations. | |

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| F 323 | Continued From page 101<br>wrong. Techs x [times]1 used lift to helped resident on lift so resident not come out of lift. Tech helped resident get footing and tech x 2 helped resident get back up in bed..."<br><br>Continued review of the facility investigation revealed an undated, unsigned note which stated the resident "...came into Falls Meeting for interview. Resident states lift stopped working while he was up in air. Battery stopped working before resident was up high enough to sit on the bed. CNA hit the button (manual) on the left and it lowered resident almost to floor - had him suspended off floor. His feet were still on platform. He states no part of his body touched the floor. States lift was beeping when she first started helping him..."<br><br>Further review of the facility investigation of a note written by CNA #5 dated 3/2/15, revealed "...I had him in the stand-up lift and I was putting him to bed. When I start the lift batteries to stop work on me and went got another that when lift when all the way down and I ask (CNA #6) and the when (named resident #84) lose his footing..."<br><br>Continued review of the facility investigation of an unsigned note dated 3/2/15, revealed "...(CNA #6) came to me at 11 PM and told me to ask (CNA #5) about named Resident #84. I went to investigate immediately. Talk with (CNA #5) about not telling me and reporting anything even when resident did not get hurt or not..."<br><br>Further review of the facility investigation of a note from CNA #6 dated 3/2/15, when asked to describe what he observed/saw/heard, revealed "...Residents was sitting on his ass..." | F 323 | Concerns discussed in the daily meeting will be assigned to staff for follow up and the DON as indicated to complete investigations. Information and findings from the areas discussed in the daily meeting will be reviewed in the meeting weekly until resolved or on-going as indicated. Staff education will be directed by information from the daily QA meeting in addition to on-going audits, scheduled monthly staff meetings and annual skills assessments.<br><br>Nursing Home Administrator will notify the Clinical Consultant of issues, concerns and investigations to ensure a timely and comprehensive investigation with action plan is completed. Additionally Clinical Consultant will review daily, weekly and monthly QA and scheduled meeting notes to ensure timely and comprehensive action plans are implemented, monitored and evaluated. Clinical Consultant will be on-site at least monthly.<br><br>8/1/15 – Monthly QA Committee Meeting - NHA or designee will summarize the daily Managers meetings for trends and education needs to be discussed in the Monthly QA meeting. Trend summaries and on-going or unresolved facility issues are discussed for resolution in the Monthly QA Committee Meeting.<br><br>The QA Committee will meet 2 times per month for the first month (August – September) and then monthly thereafter.<br><br>Monthly QA Meeting attendees include but may not be limited to: NHA, DON, Department Managers, Wound Nurse, Infection Control Nurse and Staff Educator. | |

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| F 323 | Continued From page 102<br>Continued review of the facility investigation of a note by the Director of Nursing (DON) dated 3/4/15, at 3:00 PM, revealed "...via (CNA #5) states she was transferring him from w/c [wheel chair] to the bed. Had moved the lift over the bed. When going down his foot slipped. His bottom went off the edge of the mattress and then down. Resident strapped in lift - says his bottom didn't hit the floor - it landed on the legs of lift (to the platform). Thighs were on the legs of Lift(where it opens and closes). States she went to get assist. Says pt (patient) was safe. Saw (CNA #6) and got another battery. Says she didn't think to get the nurse since he was still on lift and didn't think it was a fall..."<br><br>Interview with the DON on 7/15/15, at 2:00 PM, in the Case Management office, revealed Resident #84 was in the lift being transferred when the battery went dead. Further interview revealed the lift has an emergency button to lower the sling to the bed which the CNA should have used. Continued interview confirmed the CNA should not have left the resident alone in the lift while she went in search of a battery.<br><br>Medical record review revealed Resident #18 was admitted to the facility on 10/26/12, with diagnoses including Diabetes Mellitus, Dementia, Parkinson's Disease, Hypertension, Coronary Artery Bypass Graft, Congestive Heart Failure, Gastroesophageal Reflux Disease, and Atherosclerotic Cardiovascular Disease<br><br>Medical record review the Quarterly MDS dated 6/8/15, revealed the resident was severely impaired cognitively; required extensive assistance with transfers; was total dependence for dressing, eating, grooming, and bathing; was | F 323 | 8/1/15 - The QAA Committee will meet quarterly. Items from the Monthly QA Committee Agenda will be reviewed by the full QAA Committee to ensure policy compliance, clinical best practice and staff education is monitored, implemented and evaluated on-going. The Clinical Consultant will review the QA and QAA Committee minutes during monthly visits to ensure compliance. Compliance issues or concerns will be discussed with the NHA for follow-up and resolution.<br><br>QAA Committee members include but may not be limited to: Medical Director, Nursing Home Administrator, DON, Department Managers (Social Service, Activity, Therapy, Nursing, Housekeeping, Maintenance), in addition to the wound Care Nurse, Staff Education Nurse, Infection Control Nurse and staff nurses and CNAs as available. | |

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| F 323 | Continued From page 103<br>always incontinent of bowel and bladder; and used a wheelchair for mobility.<br><br>Review of the facility investigation of a statement by the Licensed Practical Nurse (LPN) #13 dated 5/20/15 revealed "...Resident was observed still in her merri walker (a standing walker with a seat) sitting on the floor with her hands on the bar and black strap on the floor. Resident on her buttocks. The clip to the black strap that connects to the seat was not buckled. Resident was assisted by staff into her wheelchair and clip alarm attached..."<br><br>Continued review of the facility investigation of the supervisor's report dated 5/21/15, revealed the resident was seen ½ hour earlier with strap in place. Further review revealed a concern if the buckle was completely snapped on the safety strap when the resident was placed in the merri walker and the CNA's comment was "...pulled it, it was secure but didn't actually look at buckle..."<br><br>Medical record review revealed Resident #26 was admitted to the facility on 10/17/14, with diagnoses including Failure to Thrive, Diabetes Mellitus, Dementia, Hypertension, Atrial Fibrillation, Gastroesophageal Reflux Disease, and Normal Pressure Hydrocephalus.<br><br>Medical record review of the 30 day MDS dated 3/13/15, revealed the resident was severely impaired cognitively; was total dependence for transfers, eating, grooming, and bathing; was always incontinent of bowel and bladder; and used a wheelchair (w/c) for mobility.<br><br>Review of the facility investigation dated 5/3/15 revealed "...observed resident attached to | F 323 | | |

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| F 323 | Continued From page 104<br>Vera-lift (mechanical lift) but feet off the lift. Lowered the resident to floor and then manually transferred to bed with 3 person assist. Checked res (resident) for any injuries with none noted..."<br><br>Continued review of the facility investigation of a note written by CNA #7 revealed "...I was getting resident ready for bed. I hooked up to vera lift and secured her in and her feet slipped so I called for other CNAs to help me lift her up. She needs to be either on a pro 1 lift or two people should be there to assist her on vera lift..."<br><br>Further review of the facility investigation of a note written by CNA #8 revealed "...I am in a resident's room and here my name being yelled. I go to see who it is. I got to resident's room and I see resident on vera lift with the Tech holding her up off the floor and the resident is slowly going to the floor. It took 3 techs and 2 nurses to get her off lift to the floor and then in the bed. Need a Pro 1 lift or 2 people with vera and her bed needs the brakes fixed..."<br><br>Continued review of the facility investigation of a note written by CNA #9 revealed "...around 8 PM I was getting things together to clean up an resident and put him to bed when CNA #8 came around looking for me. She told me they needed me in (room of Resident #26). I went in with her. Three other CNAs was already in there. (named Resident #26) was hooked up the vera lift, looked like she had slid down when I came in she was on the lift, with the sling around her, she was kind of on her knees. Her legs were bent under her. We unhooked her, moved her legs out in front of her, put a gait belt around her. CNA #8 and another CNA was on her sides of her holding the gait belt and I had a hold of her legs, we lifted her | F 323 | | |

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| F 323 | Continued From page 105<br>up and put her on the bed. CNA #7 and CNA #8 started to change her and I went to change my resident..."<br><br>Review of the facility policy Falls Management dated 1/22/10, revealed "...It is a standard of practice to identify those residents that are at risk for falling and provide prompt intervention to decrease the number of occurrences...Interventions...update care plan to reflect...resident specific interventions (alarms, devices, restraints)...Fall Committee QA [Auality Assurance] Audit will be conducted...to ensure timely update of interventions..."<br><br>Medical record review revealed Resident #158 was admitted to the facility on 2/25/15 and readmitted 3/17/15, with diagnoses including Dementia with Behaviors, Anxiety, and Depression.<br><br>Review of the manufacturer's "...Application Instructions for the Posey Lap Belt/Padded Lap Belt..." revealed "WARNING: ALWAYS Monitor patients per facility policy. Improper application or use of any restraint may result in serious injury or death." Further review revealed "...Application Instructions: Position the patient as far back in the seat as possible, with the buttocks against the back of the chair...Bring the ends of the connecting straps down at a 45-degree angle between the seat and the wheelchair sides...Adjust the tightness of the slide buckles...Check that the straps are secure and will not change position, loosen, or tighten if the patient pulls on them, or if the chair is adjusted...The belt must be snug but not interfere with breathing...To check for proper fit, slide an open hand (flat) between the belt and the | F 323 | | |

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| F 323 | Continued From page 106<br>patient..." Further review revealed "...WARNING: Heed these warnings to reduce the risk of serious injury or death: There is a risk of chest compression or suffocation, if the patient's body weight is suspended off the chair seat...Monitor per facility policy to ensure that the patient cannot slide down, or fall off he chair seat and become suspended...STOP AT ONCE: if the patient has a tendency to slide forward or down in the device..."<br><br>Medical record review of a Care Plan onset date 2/25/15 revealed "...I'm at risk for falls..."<br><br>Medical record review of a "Restraint Assessment" dated 2/25/15 revealed "...Review dates...2/26/15 no restraints at time..."<br><br>Medical record review of a Physician's Telephone Order dated 3/27/15, revealed "...due to recent fall...sensor pad in bed...pull alarm in wheel chair [w/c]..."<br><br>Medical record review of a Fall Risk Evaluation dated 4/3/15 revealed a history of falls, confined to chair, and at risk for falls.<br><br>Medical record review of a Skilled Nursing Notes dated 4/6/15 at 7:20 AM revealed "...res [resident] found on floor in front of bed..."<br><br>Medical record review of a Physician's Telephone Order dated 4/7/15 revealed "...use soft posey belt [restraint] while up in w/c d/t [due to] increase fall risk (res [resident] has had multiple attempts to get up out of w/c)..."<br><br>Medical record review of a Care Plan updated 4/7/15 revealed "...soft posey belt while up in chair...care foam lounger (a padded foam chair | F 323 | | |

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| F 323 | Continued From page 107<br>with ottoman for fall prevention) for sleep and place near nurses' station..."<br><br>Medical record review of a "Restraint Assessment" review date 4/7/15 revealed "...soft posey belt in w/c...alert confused...res unable to comprehend instr [instructions]...Falls within past 12 months: multiple... last fall 4/6/15...R [right] side paralysis...agitated at times...multiple attempts to get up out of w/c increase fall risk..."<br><br>Medical record review of a Skilled Nursing Notes dated 4/8/15 at 11:50 AM revealed "...Res up in w/c, soft posey belt on...continues to have multiple attempts of getting up OOB (out of bed) and w/c...shows s/s (signs and symptoms) of depression...loss of independence..."<br><br>Medical record review of a Skilled Nursing Notes dated 4/8/15 at 9:00 PM revealed "...Resident observed in room in w/c, resident sliding out of w/c with softy posey up to chest...w/c locked...helped resident to bed..."<br><br>Medical record review of an Incident/Change Screen Form dated 4/8/15 revealed "...Res slid partway out of w/c...posey on around chest...res is restless and frequently tries to get up out of...w/c...recommendation...keep in common areas when up in w/c..."<br><br>Review of facility documentation dated 4/8/15 revealed "New planned interventions "...resident to be in common area, not left unattended in his room..."<br><br>Medical record review of a 5 day MDS dated 4/9/15 revealed Resident #158 was severely impaired for daily decision making, required | F 323 | | |

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| F 323 | Continued From page 108<br>extensive assistance of 2 for Activities of Daily Living (ADL's), frequently incontinent, and physical restraints used daily in chair.<br><br>Medical record review of a Fall Risk Evaluation dated 4/9/15 revealed "...resident seen sliding down out of w/c with soft posey belt at chest..."<br><br>Review of facility documentation Falls/Incident Committee dated 4/9/15, revealed "...in wheelchair slid out...posey up to chest..."<br><br>Medical record review of a Skilled Nursing Notes dated 4/10/15 revealed "...restless pulling on clothes, diaper, posey, while in the w/c...slipped down in chair pulled posey up slipped under it...hips off w/c seat...we sat him in floor so we could get R arm out of posey...so he could be undone from w/c..."<br><br>Medical record review of a Physician's Telephone Order dated 4/10/15 revealed "...Care Foam Lounger while asleep in front of NS [Nurses Station] d/t multiple falls..."<br><br>Medical record review of an Incident/Change Screen Form dated 4/10/15 revealed "...slid down in w/c and slid posey over his head lowered to floor...in common area..."<br><br>Review of facility documentation Falls/Incident Committee dated 4/10/15 revealed "...sitting by nursing station [with] posey on sliding down in wheelchair under posey..."<br><br>Interview with LPN #1 on 7/15/15 at 4:15 PM at the F hall and G hall nurses station, revealed on 4/10/15 at 8:30 PM the resident was sitting at the nurses station, started pulling at the soft waist | F 323 | | |

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| F 323 | Continued From page 109<br>belt, pulled the belt over his head, and was slipping out of the wheelchair. Continued interview confirmed the soft waist belt was loose and the resident had been able to get the soft waist belt over his head.<br><br>Review of facility documentation dated 4/10/15 revealed "...Care Foam lounger at HS [hours of sleep] for sleep..."<br><br>Review of facility documentation dated 5/11/15 revealed "...Pull alarm in Care Foam Lounger..."<br><br>Medical record review of a Physician's Telephone Order dated 5/11/15 revealed "...Pull alarm in Care Foam Lounger..."<br><br>Medical record review of a Physician's Telephone Order dated 6/23/15 revealed "...Must sleep in bed while on contact isolation..."<br><br>Medical record review of a Skilled Nursing Notes dated 6/28/15 at 11:05 AM, revealed "...observed on floor in front of bathroom door...res yelled out as this nurse was walking by...resident assisted back into w/c...restraint secured...abrasion to left wrist...contact isolation confined to room [placed on isolation 6/23/15]..."<br><br>Review of facility documentation dated 6/28/15 revealed "...Does not like being in room..."<br><br>Medical record review of an Incident/Change Screen Form dated 6/28/15 at 11:05 AM, revealed "...Resident has order for posey belt in w/c...resident was in his w/c reported by nursing that he managed to get restraint belt over his head..." | F 323 | | |

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| F 323 | Continued From page 110<br>Review of facility documentation dated 6/29/15 revealed "...Hourly checks while on isolation..."<br><br>Medical record review of a Skilled Nursing Note dated 7/1/15 at 9:50 AM, revealed falls x 2 in 3 days...currently on Q [every] 1 hour staff checks to aide in preventing falls..."<br><br>Review of facility documentation Falls/Incident Committee dated 7/1/15 revealed "...got up from bed..."<br><br>Medical record review of a Skilled Nursing Notes dated 7/1/15 at 1:45 AM, revealed "...alarm went off. .standing on blue pad...went to floor..."<br><br>Medical record review of facility documentation dated 7/1/15 revealed "...no new intervention...continue 1 hour checks until isolation over..."<br><br>Medical record review of a Skilled Nursing Notes dated 7/9/15 at 10:05 PM, revealed "...resident bed alarm going off...heard resident fall...resident lying on floor...gash [cut] to forehead...R elbow skin tear R knuckle skin tear R back side abrasion L [left] forearm abrasion...c/o [complained] pain to head and back...send to ER [Emergency Room]..."<br><br>Medical record review of a Physician's Telephone Order dated 7/9/15 revealed "send to ER to Tx [treat] and eval [evaluation]..."<br><br>Medical record review of a Skilled Nursing Notes dated 7/10/15, revealed "...returned at 3:20 AM...durabond [skin glue] to R forehead laceration..." | F 323 | | |

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| F 323 | Continued From page 111<br>Observation and interview on 7/14/15 at 4:16 PM at the F hall and G hall dayroom/dining room, revealed Resident #158 sitting in a wheelchair. A soft waist belt was in place with the left strap over the arm of the w/c and attached to the kick spur of the w/c. Continued observation and interview with LPN #10 confirmed the soft waist restraint had not been applied correctly. Further observation and interview with Certified Nurse Aide (CNA) #6 and #11 on 7/14/15 at 4:17 PM at the F hall and G hall dayroom/dining room, confirmed the soft waist belt had not been applied correctly and CNA #6 reapplied the restraint. CNA #6 confirmed the soft waist restraint had been applied by CNA #11, who had been employed at the facility for "5 to 6 days."<br><br>Interview with LPN #10 on 7/15/15 at 4:08 PM at the F hall and G hall nurses station, revealed on 4/8/15 the resident slid down in the chair, the restraint at the chest area [pointing to the breast] and staff witnessed the resident attempting to get the soft waist belt loose/off. The resident often slid down in the W/C, staff placed the resident back in the w/c with the restraint in place after the incident, and the soft waist belt was used daily for Resident #158.<br><br>Interview with the DON on 7/15/15 at 9:24 AM through 10:08 AM in the Case Manager's Office, revealed on 4/8/15 at 8:15 PM Resident #158 was observed in his room by staff sliding out of the wheelchair, the soft belt was positioned at the resident's chest, the intervention was not to leave the resident unattended in his room and the resident was placed back in the restraint. Continued interview confirmed the resident was reviewed on 4/9/15 in a Falls Committee, no changes were made related to the resident's | F 323 | | |

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| F 323 | Continued From page 112<br>restraint, and no education had been provided to the staff. Continued interview revealed the resident had a second incident on 4/10/15 at 8:30 PM in the w/c, with the soft belt in place, at the F hall and G hall nurses station. The staff witnessed the resident loosen the soft waist belt and the resident slipped under the restraint. Further interview confirmed the resident was reviewed in the Falls Committee Meeting on 4/13/15, no changes were made to the restraint and no education related to the restraint had been provided to the staff. Continued interview revealed the resident had a third incident on 6/28/15 at 11:05 AM. The resident was left in the room unattended in the w/c with the soft waist belt in place, the resident exited the wheelchair, the soft belt still attached to the w/c, stood up and fell, the resident had been placed back in the w/c, the soft belt was reapplied and the resident was left in his room unattended. Continued interview confirmed the resident had been reviewed in Falls Committee on 6/29/15 no changes were made to the restraint and no education related to the restraint had been provided to the staff. Continued interview revealed on 7/1/15 at 1:45 AM the resident had been put to bed in his room, the resident exited the bed and fell. Continued interview confirmed the resident had not been placed in the Care Foam Lounger in the common area for sleep due to 10 days of isolation and no new interventions were put in place. Further interview revealed on 7/9/15 at 10:05 PM the resident had been put to bed in his room, the resident exited the bed and fell. Further interview confirmed the resident had not been placed in the Care Foam Lounger in the common area for sleep, the CNA failed to follow the Care Plan and the resident had been transported to the ER for treatment of a laceration. | F 323 | | |

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| COMMUNITY CARE OF RUTHERFORD | 901 COUNTY FARM RD MURFREESBORO, TN 37127 |

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| F 323 | Continued From page 113<br><br>Interview with LPN #2, the Staff Development Education Nurse, on 7/15/15 at 10:12 AM, in the Case Manager Office, revealed the LPN #2 did not provide any formal in-service on restraints at time of hire. Continued interview revealed new hire CNA's were given a skills checklist to be completed during orientation on floor with staff that included restraints. Continued interview revealed the CNA's were given an annual skills checklist and the licensed nurses on the floor "checked" the CNA's.<br><br>Interview with the DON on 7/15/15 at 10:15 AM in the Case Manager's Office, confirmed the resident had 3 incidents with a restraint. Continued interview confirmed no additional education had been given to the staff related to restraint application/use, and the restraint continued to be used for the resident. Further interview confirmed on 7/9/15 the facility failed to follow an intervention for a fall; the resident sustained an injury to the forehead, was transferred to the ER and had been treated with durabond for a laceration to the forehead. | F 323 | | |
| F 411 SS=D | 483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS<br><br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making | F 411 | Facility will assist residents in obtaining routine and 24-hour emergency dental care.<br><br>All residents have the potential to be effected.<br><br>**Resident # 50**<br><br>8/6/15 – All staff inservice – review staff responsibility and policies related to daily mouth care, oral/dental services needs in addition to SS responsibility to schedule appointments and establish transportation. | |

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| F 411 | Continued From page 114<br>appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, and interview, the facility failed to provide routine dental services for 1 (Resident #50) of 50 resident's reviewed.<br><br>The findings included:<br><br>Medical record review revealed Resident #50 was admitted to the facility on 4/14/10 with diagnoses including Diabetes Mellitus, Dysphagia, Alzheimer's Disease, Hypertension, and Congestive Heart Failure.<br><br>Medical record review of a Quarterly Minimum Data Set (MDS) dated 4/17/15, documented "...extensive assist of 1 person is required for teeth brushing..."<br><br>Interview with the resident on 7/13/15 at 3:50 PM in the resident's room, revealed the resident had not seen a dentist since admission and would like to see a dentist.<br><br>Medical record review of the Care Plan revised on 4/22/15, documented "...natural teeth some missing, assist with daily oral care..."<br><br>Medical record review of a Dietary Note dated 7/14/15 documented "...has natural teeth and does her own oral care with set up help and verbal reminder to brush..." | F 411 | 8/7/15 –QA Committee meeting – discussed dental concerns, mouth care and dental services contract for facility.<br><br>8/8- 8/16/15 – 100% Dental documentation and resident needs audit conducted by nursing and social service to determine resident need for dental service secondary to pain, desire, preference.<br><br>8/17/15 – SS contacted local dental college to investigate resident services to assist with dental care for those residents confined to bed and difficult to transport non-emergent for an off-site office visit.<br><br>8/17/15 – Dental concerns will be reported to the MD for evaluation and reported on the Nursing 24 hour report in the Morning QA Managers meeting to initiate a Dietary (CDM / RS) assessment and SLP screen prior to schedule of a dental appointment. Nursing will monitor for dental pain and report to the MD for diagnosis and treatment.<br><br>8/17/15 – Social Service (SS) will submit an article monthly in the facility/family/resident newsletter to inform of dental services available, process for requesting services, and payer options for dental services. Dental Check-Up "flyer" with SS contact information will be placed in the admission packet and discussed during the family/resident care plan meeting at least quarterly in addition to the monthly resident council meeting.<br><br>7/30/15 - Daily QA Managers Meeting (Monday – Friday). NHA will oversee and investigate | |

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| F 411 | Continued From page 115<br>Interview with Social Services on 7/15/15 at 3:32 PM in the MDS office, confirmed the facility did not offer routine services at this time and Resident #50 had not been offered dental services since admission.<br><br>Interview with the Administrator on 7/15/15 at 5:15 PM in the Business Office confirmed the facility did not currently have a contract with a dentist for routine visits. | F 411 | concerns related to reports, communications and policies.<br><br>Daily QA Managers Meeting attendees include but may not be limited to: NHA, DON, MDS LN, Infection Control/Staff Education, Wound Nurse, Unit Managers, Restorative, Medical Records, Therapy, Social Service, Activities, Housekeeping, Maintenance, Business Office and Payroll.<br><br>The following items will be reviewed daily: Change in Resident Condition, Significant Change in Resident Status, 24 Hour Report Information, New MD orders, Occurrence Reports, Clinical Progress Notes and Hospital Transfers in addition to Restraints, Infection Control, Dental service needs and On-going Investigations. Care plan updates will be discussed in the meeting for updates and accuracy.<br><br>Concerns discussed in the daily meeting will be assigned to staff for follow up and the DON as indicated to complete investigations. Information and findings from the areas discussed in the daily meeting will be reviewed in the meeting weekly until resolved or on-going as indicated. Staff education will be directed by information from the daily QA meeting in addition to on-going audits, scheduled monthly staff meetings and annual skills assessments.<br><br>Nursing Home Administrator will notify the Clinical Consultant of issues, concerns, QA audits and investigations during the monthly visit to ensure a timely and comprehensive investigation with action plan is completed.<br><br>Clinical Consultant will review daily, weekly and | |



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| F 411 | Continued From page 115<br>Interview with Social Services on 7/15/15 at 3:32 PM in the MDS office, confirmed the facility did not offer routine services at this time and Resident #50 had not been offered dental services since admission.<br><br>Interview with the Administrator on 7/15/15 at 5:15 PM in the Business Office confirmed the facility did not currently have a contract with a dentist for routine visits. | F 411 | monthly QA and scheduled QA Committee and Sub Committee meeting minutes to ensure timely and comprehensive action plans are implemented, monitored and evaluated. Clinical Consultant will be on-site at least monthly and submit a written report to the QAA Committee for review and action as indicated. Medical Director will review consultant report monthly for timely response and needed intervention as indicated.<br><br>8/7/15 – Monthly QA Committee Meeting - NHA or designee will summarize the daily Managers meetings for trends and education needs to be discussed in the Monthly QA meeting. Trend summaries and on-going or unresolved facility issues are discussed for resolution in the Monthly QA Committee Meeting. The QA Committee will meet 2 times per month for the first month (August – September) and then monthly thereafter.<br><br>Monthly QA Meeting attendees include but may not be limited to: NHA, DON, Department Managers, Wound Nurse, Infection Control Nurse and Staff Educator. The NHA will be the Chairman of the committee and responsible to ensure information is communicated between the QA Committee and the QAA Committee.<br><br>8/1/15 - The QAA Committee will meet quarterly. Items from the Monthly QA Committee Agenda will be reviewed by the full QAA Committee to ensure policy compliance, clinical best practice and staff education is monitored, implemented and evaluated on-going. The Clinical Consultant will review the QA and QAA Committee minutes during monthly | |



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| F 411 | Continued From page 115<br>Interview with Social Services on 7/15/15 at 3:32 PM in the MDS office, confirmed the facility did not offer routine services at this time and Resident #50 had not been offered dental services since admission.<br><br>Interview with the Administrator on 7/15/15 at 5:15 PM in the Business Office confirmed the facility did not currently have a contract with a dentist for routine visits. | F 411 | visits to ensure compliance. Compliance issues or concerns will be discussed with the NHA for follow-up and resolution.<br><br>QAA Committee members include but may not be limited to: Medical Director, Nursing Home Administrator, DON, Department Managers (Social Service, Activity, Therapy, Nursing, Housekeeping, Maintenance), in addition to the wound Care Nurse, Staff Education Nurse, Infection Control Nurse and staff nurses and CNAs as available. | |

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| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the | F 431 | Facility will verify the narcotic count before administration of narcotics.<br><br>All residents have the potential to be effected.<br><br>**Resident # 14**<br><br>7/29/15 – Accuracy of scheduled narcotic count (Hydrocodone/Apap Tab 7.5/325) confirmed by LN Manager.<br><br>**Resident # 25**<br><br>7/29/15 - Accuracy of scheduled narcotic count (Percocet 10/325) confirmed by LN Manager.<br><br>8/4/15 – Staff Education LN conducted 1:1 inservice with LN #8 to review policy and best practice for narcotic administration. LN # 8 will be observed by RN at least two times weekly for two weeks to ensure policy for narcotic administration is followed.<br><br>8/7/15 – QA Committee meeting review – Narcotic policy reviewed with recommendation to clarify narcotic administration with "step by step" guidelines. | |

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| F 431 | Continued From page 116<br>Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy, medical record review, observation, and interview, the facility failed to verify the narcotic count before administration of narcotics of 2 (Resident #14 and #25) of 7 residents reviewed for medication administration.<br><br>The findings included:<br><br>Review of a facility policy titled Administering Oral Medications revised 9/2003, revealed "...The purpose of this procedure is to provide...safe administration...For Narcotics...Check the narcotic record for the previous drug count and compare with supply on hand..."<br><br>Medical record review revealed Resident #14 was admitted to the facility on 4/1/09 with diagnoses including Multiple Sclerosis, Anxiety, and Depression.<br><br>Medical record review of the Physician's Orders dated July 2015, revealed "...Hydrocodone (narcotic)/Apap (acetaminophen) Tab [tablet] 7.5/325 give one tab by mouth three times a day..."<br><br>Medical record review revealed Resident #25 was admitted to the facility on 8/22/11 with diagnoses | F 431 | 8/15/15 – DON reviewed and revised Narcotic Count Policy to include "step by step" process for administration of narcotics during medication administration.<br><br>7/30/15 - Daily QA Managers Meeting (Monday – Friday). NHA will oversee and investigate concerns related to reports, communications and policies.<br><br>Daily QA Managers Meeting attendees include but may not be limited to: NHA, DON, MDS LN, Infection Control/Staff Education, Wound Nurse, Unit Managers, Restorative, Medical Records, Therapy, Social Service, Activities, Housekeeping, Maintenance, Business Office and Payroll.<br><br>The following items will be reviewed daily: Change in Resident Condition, Significant Change in Resident Status, 24 Hour Report Information, New MD orders, Occurrence Reports, Clinical Progress Notes and Hospital Transfers in addition to Restraints, Infection Control, Dental service needs, Narcotic administration audits and observation and any open / on-going Investigations.<br><br>Concerns discussed in the daily meeting will be assigned to staff for follow up and the DON as indicated to complete investigations. Information and findings from the areas discussed in the daily meeting will be reviewed in the meeting weekly until resolved or on-going as indicated. Staff education will be directed by information from the daily QA meeting in addition to on-going audits, scheduled monthly staff meetings and annual skills assessments. | |

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| F 431 | Continued From page 117<br>including Chronic Pain Syndrome.<br><br>Medical record review of a Physician's Orders dated July 2015, revealed "...Percocet 10/325 (narcotic) 1 po [by mouth] q [every] 4-6h [hour] PRN [as needed]..."<br><br>Observation of Licensed Practical Nurse (LPN) #8 on 7/13/15 between 2:30 PM and 2:35 PM in the I hallway, revealed LPN #8 administered scheduled narcotics to 2 residents (Resident #14 and #25) and failed to check the narcotic count record for accuracy or initial the sign out sheet for the narcotics removed for the residents.<br><br>Interview with LPN #8 on 7/13/15, at 2:36 PM in the I hallway, confirmed the LPN failed to check the narcotic record for drug count accuracy and failed to sign the narcotic's sign out sheet prior to administration. | F 431 | Nursing Home Administrator will notify the Clinical Consultant of issues, concerns, QA audits and investigations during the monthly visit to ensure a timely and comprehensive investigation with action plan is completed.<br><br>Clinical Consultant will review daily, weekly and monthly QA and scheduled QA Committee and Sub Committee meeting minutes to ensure timely and comprehensive action plans are implemented, monitored and evaluated. Clinical Consultant will be on-site at least monthly and submit a written report to the QAA Committee for review and action as indicated. Medical Director will review consultant report monthly for timely response and needed intervention as indicated.<br><br>8/7/15 – Monthly QA Committee Meeting - NHA or designee will summarize the daily Managers meetings for trends and education needs to be discussed in the Monthly QA meeting. Trend summaries and on-going or unresolved facility issues are discussed for resolution in the Monthly QA Committee Meeting. The QA Committee will meet 2 times per month for the first month (August – September) and then monthly thereafter.<br><br><u>Monthly QA Meeting attendees</u> include but may not be limited to: NHA, DON, Department Managers, Wound Nurse, Infection Control Nurse and Staff Educator. The NHA will be the Chairman of the committee and responsible to ensure information is communicated between the QA Committee and the QAA Committee. | |

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| F 431 | | F 431 | 8/1/15 - The QAA Committee will meet quarterly. Items from the Monthly QA Committee Agenda will be reviewed by the full QAA Committee to ensure policy compliance, clinical best practice and staff education is monitored, implemented and evaluated on-going. The Clinical Consultant will review the QA and QAA Committee minutes during monthly visits to ensure compliance. Compliance issues or concerns will be discussed with the NHA for follow-up and resolution.<br><br>QAA Committee members include but may not be limited to: Medical Director, Nursing Home Administrator, DON, Department Managers (Social Service, Activity, Therapy, Nursing, Housekeeping, Maintenance), in addition to the wound Care Nurse, Staff Education Nurse, Infection Control Nurse and staff nurses and CNAs as available. | |

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| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections. | F 441 | Facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection.<br><br>All residents have the potential to be effected.<br><br>**Resident # 158**<br><br>8/14/15 – No rash present – most recent rash identified on 5/22/15. Scraping on 6/23/15 with positive diagnosis. Scraping on 7/21/15 with negative diagnosis. Weekly skin assessments are conducted by Licensed Nurse to observe for rash. | |

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| F 441 | Continued From page 118<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy review, medical record review, observation, and interview, the facility failed to determine the cause of multiple cases of scabies and failed to eradicate recurrent infestations of scabies for 3 (#158, 81, 76) of 7 residents reviewed for infestation of scabies. The facility also failed to follow infection control practice for handwashing for 1 of 4 dining rooms observed.<br><br>The findings included:<br><br>Review of the facility policy entitled "Infection Control Policy and Procedure for Scabies" implemented 6/3/14, revealed "...Residents with | F 441 | **Resident # 81**<br><br>8/14/15 — Eczema present: rash identified on 2/3/15 – diagnosis was not confirmed – no scrape test was performed. Weekly skin assessments are conducted by Licensed Nurse to observe for skin condition.<br><br>**Resident # 76**<br><br>8/14/15 – No rash present - most recent rash identified on 6/17/15 – diagnosis was not confirmed – no scrape test was performed. Weekly skin assessments are conducted by Licensed Nurse to observe for rash.<br><br>8/17 – 8/18/15 – CDM conducted Dietary Department inservice for all three shifts to address proper food handling, glove use protocol and required handwashing.<br><br>8/14/15 - CDM or RD will conduct random infection control observation audits during meal service weekly. Education concerns will be addressed immediately and reported to the Infection Control Nurse if additional education is needed. Handwashing will continue to be included in orientation and mandatory inservice schedule.<br><br>8/6/15 – Full staff inservice conducted by the Education LN, DON and NHA to review current Infection Control policy for Isolation, Infectious disease, scabies diagnosis, treatment and staff responsibility for self-reporting and personal protection.<br><br>8/7/15 – QA Committee meeting – review Infectious Disease Report – no active scabies at | |

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| F 441 | Continued From page 119<br>signs and symptoms of scabies:<br>1. Notify physician for treatment plan.<br>2. Place on contact isolation and follow facility's isolation precautions policy and procedure. Resident remains on contact isolation for forty-eight hours after last treatment dose. Staff is to wear gowns and gloves with all care and when cleaning rooom.<br>3. Soak nails in soap and water with all nails trimmed short and cleaned thoroughly before first treatment.<br>4. Bathe resident daily with thorough skin assessments following the first initial treatment dose until second dose is given.<br>5. Skin-to-skin contact should be avoided for at least 8 hours after treatment.<br>6. Any clothing worn by resident anytime during the three days prior to treatment must be laundered.<br>7. Dedicate the use of non-critical patient care equipment to resident.<br>Environmental Protocol:<br>1. All clothing except three days worth, stuffed animals, throw blankets, etc, should be placed in a sealed bag for 14 days...After 14 days those clothes can be laundered and returned to the resident's room.<br>2. Bed linens should be changed daily.<br>3. Resident's room should be cleaned per facility's contact isolation room cleaning policy. Upholstered furniture should be vacuumed twice daily.<br>4. Resident personal equipment should be cleaned per contact isolation guidelines and kept in resident room unless otherwise indicated..."<br><br>Medical record review revealed Resident #158 was admitted to the facility on 2/25/15 with diagnoses including Dementia, Depression, | F 441 | this time. Reviewed reporting procedures. Meal service / infection control audits will be reviewed during monthly meeting.<br><br>8/14/15 – LN and Nurse Manager conducted skin audit for three residents with rashes – no indication of infectious disease (scabies).<br><br>8/14/15 – 8/17/15 – 100% resident skin audit and chart documentation review conducted by Infection Control Nurse to evaluate current rashes and confirmed scabies diagnosis. There are currently two residents (on the same hall) who have had a previous scabies diagnosis confirmed with a skin scrape / smear.<br><br>8/14/15 - Following completion of Infectious Disease (scabies / rash) audit and review of MD notes (dermatology, PCP, Medical Director, hospitalist) it was determined that MD's were confirming diagnosis of scabies with rash present regardless of the appearance of the rash and without scraping or smear diagnosis. There were dermatologists that confirmed rash observation as scabies even when the scrape / smear was negative. There were other consulting physicians who diagnosed the same residents during the rash to have dry skin, eczema or psoriasis. It was noted that the original skin rash appeared on the residents when they were on the same hall of the unit. Also noted the residents on this unit had drier skin collectively than residents on other units. Additionally it was documented that one resident's rash subsided when transferred to another unit within the facility. Of further consideration - the treatment for scabies and subsequent daily baths causes dry skin and often | |

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| F 441 | Continued From page 120<br>Cerebrovascular Accident with Hemiplegia, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, and Alcohol Cirrhosis of the Liver.<br><br>Medical record review of the Quarterly Minimum Data Set dated 5/28/15 revealed Resident #158 had a score of 10/15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment; required assistance with transfers, dressing, and bathing; required extensive assistance with grooming; was independent with eating after setup; and was continent of bowel and bladder.<br><br>Medical record review of a physician's note dated 5/22/15, revealed "...NEEM oil (product intended for use as a pesticide to control insects on agricultural crops) applied to affected areas, upper left arm, left side of abdomen twice daily..."<br><br>Medical record review of nursing notes dated 5/23/15, revealed "...rash to left upper arm; raised red areas with scratch marks noted; NEEM oil/spray applied..." Continued medical record review of nursing notes dated 6/3/15, revealed "...NEEM oil treatment continues to right and left arm, abdomen, and side as rash continues..." Further medical record review of nursing notes dated 6/12/15, revealed "...rash continues to upper left arm, back of left arm, and left side. Continue with NEEM oil/enzyme spray. Dermatology appointment..."<br><br>Medical record review of physician orders from the dermatologist dated 6/23/15, revealed "...Ivermectin (anti-scabies medication) 3 milligrams [mg] take 6 tablets for 18 mg now and repeat in 2 weeks. Contact isolation. Showers daily for 1 week. Bag all clothes except 3 outfits | F 441 | rashes in individuals with sensitive skin. As a result of the comprehensive audit and investigation the Infection Control Policy and Procedure for Scabies was revised in the following areas:<br><br>1) Diagnosis will be confirmed with a skin scraping by the PCP or dermatologist will be consulted as indicated,<br><br>2) Resident will initially be treated environmentally (isolation, room disinfected, clothing laundered and personal items bagged),<br><br>3) Daily skin lotion baths (in addition to peri-care) instead of showers will be given for skin hydration for 5 days prior to initiation of scabies treatment (hydrocortisone cream will not be used),<br><br>4) Additionally the policy was updated with a preference for oral medication treatment rather than topical medication due to the frail and sensitive skin of the elderly population.<br><br>7/30/15 - Daily QA Managers Meeting (Monday – Friday). NHA will oversee and investigate concerns related to infection control reports, communications and policies.<br><br>Daily QA Managers Meeting attendees include but may not be limited to: NHA, DON, MDS LN, Infection Control/Staff Education, Wound Nurse, Unit Managers, Restorative, Medical Records, Therapy, Social Service, Activities, Housekeeping, Maintenance, Business Office and Payroll.<br><br>The following items will be reviewed daily: Change in Resident Condition, Significant Change | |

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| F 441 | Continued From page 121<br>and current soft posey belt. Must sleep in bed while on contact isolation..."<br><br>Medical record review of nursing notes dated 6/24/15, revealed "...contact isolation for treatment of scabies. Rash to trunk area..." Continued medical record review of nursing notes dated 6/29/15, revealed "...rashes red and raised, inflamed..." Further medical record review of nursing notes dated 7/4/15, revealed "...rash to trunk, left side, abdomen, chest, and upper arms. Isolation d/c [discontinued]..." Continued medical record review of nursing notes dated 7/10/15, revealed "...Apply Permethrin (anti-scabies cream) 5% cream to all skin from top of head to soles of feet. Wash off after 18-24 hours. Repeat in one week..." Further medical record review of nursing notes dated 7/17/15, revealed "...This nurse asked Nurse Practitioner [NP] if contact isolation was needed. NP that d/t [due to] resident not having active scabies present no order for isolation was necessary..." Continued medical record review of nursing dated 7/17/15, revealed "...NP stated daughter called office multiple times insisting that topical treatment for scabies be called in to local pharmacy and she would pick up and bring to facility. NP stated multiple attempts were made to explain the facts of scabies and how the rash and itching can be present up to several months in some cases after scabies are no longer present..."<br><br>Observation of Resident #158 on 7/16/15, at 10:20 AM, on the F hall, revealed the resident seated in a wheelchair. Continued Continued observation revealed no evidence of a rash on the resident's arms or legs. Further observation revealed the resident was not scratching any part of his body. | F 441 | in Resident Status, 24 Hour Report Information, New MD orders, Occurrence Reports, Clinical Progress Notes and Hospital Transfers in addition to Restraints, Infection Control and On-going Investigations. Care plan updates will be discussed in the meeting for updates and accuracy.<br><br>Concerns discussed in the daily meeting will be assigned to staff for follow up and the DON as indicated to complete investigations. Information and findings from the areas discussed in the daily meeting will be reviewed in the meeting weekly until resolved or on-going as indicated. Staff education will be directed by information from the daily QA meeting in addition to on-going audits, scheduled monthly staff meetings and annual skills assessments.<br><br>Nursing Home Administrator will notify the Clinical Consultant of issues, concerns, QA audits and investigations during the monthly visit to ensure a timely and comprehensive investigation with action plan is completed.<br><br>Clinical Consultant will review daily, weekly and monthly QA and scheduled QA Committee and Sub Committee meeting minutes to ensure timely and comprehensive action plans are implemented, monitored and evaluated. Clinical Consultant will be on-site at least monthly and submit a written report to the QAA Committee for review and action as indicated. Medical Director will review consultant report monthly for timely response and needed intervention as indicated.<br><br>8/7/15 – Monthly QA Committee Meeting - NHA | |

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| F 441 | Continued From page 122<br><br>Observation of Resident #158 on 7/20/15, at 2:35 PM, on the F hall, revealed the resident seated in his wheelchair at the nurses' station, without noticeable lesions and/or scratching.<br><br>Medical record review of a note from the Dermatologist dated 7/21/15, revealed "...pt [patient] much improved and no longer itching. Few erythematous (red irritated) scabbing papules on forearms, fingerpads, abdomen, belt line. Scabies smear negative. Resolving scabies with mild pruritis. Clobetasol (short term topical treatment for moderate to severe plaque type psoriasis of non-scalp regions excluding face) cream 0.05% BID [twice daily] x 2 [for two] weeks then take one week off may repeat cycle as needed. Will biopsy if rash still remains..."<br><br>Medical record review revealed Resident #81 was admitted to the facility on 11/01/12, with diagnoses including Parkinson's Disease, Irritable Bowel Syndrome, Hypertension, Dementia, Benign Prostatic Hypertrophy.<br><br>Medical record review of the Quarterly MDS dated 6/11/15, revealed the resident had a score of 7/15 on the BIMS, indicating moderate cognitive impairment; required extensive assistance with transfers, grooming, and bathing; was independent with eating after setup; was sometimes incontinent of bladder and always incontinent of bowel.<br><br>Medical record review of nursing notes dated 2/13/15 revealed Resident #81 had a rash to his thighs, left hip, left side, left abdomen. Continued medical record review of nursing notes dated 3/14/15, revealed Resident #81 had a rash on the | F 441 | or designee will summarize the daily Managers meetings for trends and education needs to be discussed in the Monthly QA meeting. Trend summaries and on-going or unresolved facility issues are discussed for resolution in the Monthly QA Committee Meeting. The QA Committee will meet 2 times per month for the first month (August – September) and then monthly thereafter.<br><br>Monthly QA Meeting attendees include but may not be limited to: NHA, DON, Department Managers, Wound Nurse, Infection Control Nurse and Staff Educator. The NHA will be the Chairman of the committee and responsible to ensure information is communicated between the QA Committee and the QAA Committee.<br><br>8/1/15 - The QAA Committee will meet quarterly. Items from the Monthly QA Committee Agenda will be reviewed by the full QAA Committee to ensure policy compliance, clinical best practice and staff education is monitored, implemented and evaluated on-going. The Clinical Consultant will review the QA and QAA Committee minutes during monthly visits to ensure compliance. Compliance issues or concerns will be discussed with the NHA for follow-up and resolution.<br><br>QAA Committee members include but may not be limited to: Medical Director, Nursing Home Administrator, DON, Department Managers (Social Service, Activity, Therapy, Nursing, Housekeeping, Maintenance), in addition to the wound Care Nurse, Staff Education Nurse, Infection Control Nurse and staff nurses and CNAs as available. | |

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| F 441 | Continued From page 123<br>left side of the back, right inner thigh, abdomen, right side which was treated with Hydrocortisone. Further medical record review of nursing notes dated 4/15/15, revealed the resident had a rash on his trunk, chest, side, and abdomen. Continued medical record review of nursing notes dated 4/17/15 - 4/20/15, revealed the resident was treated with NEEM daily. Further medical record review of nursing notes dated 4/29/15, revealed Resident #81 was placed on contact isolation and treated with Ivermectin (anti-scabies medication).<br><br>Medical record review of physician's note dated 5/7/15, revealed "...confirmed scabies on arms, trunk, thighs..."<br><br>Medical record review of nursing notes dated 5/13/15, revealed the resident received Stromectal (anti-scabies medication) for his rash. Continued medical record review of nursing notes dated 5/21/15, revealed the resident was placed on triamcinolone (used to treat discomfort for various skin conditions) for a rash on his trunk, arms, back, and abdomen. Further medical record review of nursing notes dated 6/10/15, revealed the resident was be treated with NEEM. Continued medical record review of nursing notes dated 6/21/15, revealed the resident still had a rash on his trunk, arms, and back. Further medical record review of nursing notes dated 6/26/15, revealed the resident was ordered a dermatology consult and started on Stromectin. Continued medical record review of nursing notes dated 7/3/15, revealed the resident was placed on contact isolation. Further medical record review of nursing notes dated 7/9/15, revealed the resident had a bilateral lower extremity rash, and on 7/13/15, was placed on contact isolation. | F 441 | | |

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| F 441 | Continued From page 124<br><br>Medical record review revealed Resident #76 was admitted to the facility on 8/30/11, with diagnoses including Osteoarthritis, Dementia, Spinal Stenosis, Hypertension, and Cerebrovascular Accident.<br><br>Medical record review of the Quarterly MDS dated 6/9/15, revealed the resident was severely impaired cognitively; required extensive assistance with transfers, dressing, grooming, eating, and bathing; was frequently incontinent of bladder and occasionally incontinent of bowel; and used a wheelchair for mobility.<br><br>Medical record review of nursing notes dated 2/27/15, revealed the resident had raised red area on her chest and was started on NEEM. Continued medical record review of nursing notes dated 6/15/15, revealed the resident had a rash on the neck and chest and was placed on contact isolation.<br><br>Medical record review of physician's notes dated 6/19/15, revealed "...the return of rash coming back from hospital of erythematous papules knees and abdomen; treated multiple times for scabies; start Triamcinolone cream..."<br><br>Medical record review of nursing notes dated 6/23/15, revealed resident was on contact isolation and had a rash over most of the body. Continued medical record review of nursing notes dated 6/30/15, revealed the resident was on contact isolation and was started on Ivermectin. Further review of nursing notes dated 7/3/15, revealed the resident had a rash over the whole body, while a note dated 7/6/15, revealed the resident was on contact isolation. Continued | F 441 | | |

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| F 441 | Continued From page 125<br>medical record review of nursing notes dated 7/13/15, revealed the resident was continued on contact isolation for 48 hours after being treated with Ivermectin. Further medical record review of nursing notes dated 7/16/15, revealed the resident had been admitted to the hospital.<br><br>Interview with the Director of Nursing (DON) on 7/15/15, at 2:00 PM in the Case Management Office, revealed she had called the Health Department for suggestions on how to eradicate the scabies. Continued interview with the DON revealed a resident was admitted in 2013 who had a bad rash and was using a cream so this may have been the first case. Further interview with the DON revealed some dermatologists said the rashes were scabies and treated them accordingly, while other dermatologists felt the rashes were not scabies but treated the rashes as though they were scabies. Continued interview with the DON revealed the staff on F and G halls were all treated since F hall was the primary location of the cases of scabies. Further interview with the DON revealed NEEM worked for awhile then residents began developing a rash from the NEEM. Continued interview with the DON revealed one resident had her rash treated several times; was moved to another unit; and had not developed any more rashes.<br><br>Interview with the Infection Control Nurse/Staff Development Coordinator (ICN) on 7/15/15, at 2:45 PM in the Case Management office, revealed she took over the position on 5/2/14. Continued interview with the ICN revealed only a couple of cases of rashes were confirmed as being scabies and the rest were classified as rashes. Further interview with the ICN revealed 7/2/14, residents on the F hall began to develop | F 441 | | |

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| F 441 | Continued From page 126<br>rashes. Continued interview with the ICN revealed the residents were treated and the rashes disappeared, only to reappear a couple of months later. Further interview with the ICN revealed one resident was moved from the F hall to the G hall; tested three times for scabies and was negative; but the resident's new roommate developed scabies. Continued interview with the ICN revealed a staff member had a rash which was seen by her peers but which she denied having to administration; she was given cream to use for herself and cream was also provided for family members; and the staff person had patient contact in the period when she supposedly had a rash. Further interview with the ICN revealed a spray was used to treat the furniture; all resident's clothing and belongings were bagged for 14 days; and belongings were not returned to the resident until 48 hours after the last treatment. Continued interview with the ICN revealed residents were showered daily whether the resident was on cream or pills; showers were started 12 hours after the resident took the pills or the cream was applied. Further interview with the ICN revealed the families were told of the situation and it was suggested they self-treat. Continued interview with the DON revealed Maintenance inspected the F hall and found nothing.<br><br>Interview with the ICN on 7/20/15, at 2:10 PM, in the conference room, revealed everything that could be gathered was put in plastic bags for the whole time the resident was in isolation, including blankets, comforters, clothes, stuffed animals, and underwear. Continued interview with the ICN revealed three sets of clothing were left out and theses were laundered when the resident was off isolation. Further interview with the ICN revealed the curtains in the rooms were changed in the | F 441 | | |

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| F 441 | Continued From page 127<br>first 12 hour after treatment; again after the second treatment; and when the resident came off isolation. Continued interview with the ICN revealed each resident had two posey belts, one of which was bagged for 48 hours then changed out with the other one and laundered. Further interview with the ICN revealed linens were placed in a yellow isolation bag and washed separately from other linens. Continued interview with the ICN revealed mattresses were cleaned twice daily with hospital grade disinfectant. Continued interview with the ICN revealed the furniture in the room was cleaned with hospital grade disinfectant as well.<br><br>Interview with the Director of Environmental Services on 7/22/15, at 3:00 PM in the conference room, revealed residents who had unexplained rashes were treated as scabies and 1 resident had a confirmed case of scabies. Continued interview revealed all the resident's personal belongings were bagged for 14 days. Further interview revealed linens were treated as any contact isolation linens were treated. Continued interview revealed the ozone and chlorine bleach used in the laundry could be causing some rashes. Further interview revealed 12 hours after a resident was placed in isolation, the room was totally cleaned; curtains were changed; the mattress was cleaned with hospital grade disinfectant. Continued interview revealed some of the residents who had a diagnosis of scabies also had dementia so they were difficult to keep in isolation. Further interview revealed if a defect was found in the mattress then a clear cover was placed on it. Continued interview revealed residents with severe scabies were treated over and over again and may be the ones who are reinfecting other residents. Further | F 441 | | |

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| F 441 | Continued From page 128<br>interview revealed the same treatments were used over and over again since there were only three treatments available and the scabies could be becoming resistant to the treatment, and he had a concern for the resident's health since some of the treatments were pesticides. Continued interview revealed any time Dermatology heard there had been a case of scabies in a nursing home, then every rash they saw from the facility was scabies and often they didn't do a smear or punch biopsy.<br><br>Interview with the Administrator on 7/22/15, at 4:00 PM, in the conference room, revealed all staff and residents were treated with Permethrin. Continued interview revealed confirmation was difficult since some dermatologists always said a rash was scabies while others rarely would state it was scabies. Further interview revealed NEEM oil was used for some time but it can cause dry itching. Continued interview revealed a staff member was suspected of having scabies; she was given treatment for herself and her family; she refused to treat her family; and she resigned in June 2015.<br><br>Review of a facility policy titled Handwashing/Hand Hygiene revised 12/2006 revealed, "...The facility considers handwashing...the primary means to prevent the spread of infection...employees must wash their hands... after handling items potentially contaminated..."<br><br>Observation on 7/13/15 at 11:20 AM in the J hall and K hall dayroom/dining room, revealed Dietary Aide #1 picked up food debris from the floor and disposed of the debris in the trash. Continued observation revealed the Dietary Aide uncovered | F 441 | | |

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| F 441 | Continued From page 129<br>disposed of the debris in the trash. Continued observation revealed the Dietary Aide uncovered a tray of desserts, served the dessert to two residents and failed to wash the hands.<br><br>Interview with Dietary Aide #1 on 7/13/15 at 11:37 AM in the J hall and K hall dayroom/dining room, confirmed the Dietary Aide failed to wash the hands after touching the dirty floor and served food to 2 residents. | F 441 | | |
| F 490 SS=K | 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of Administrator Job Description, and interview, the facility failed to be administered in a manner to ensure the residents were evaluated for the need of restraints; failed to determine the least restrictive restraint; failed to obtain consent for the restraint; failed to ensure the restraint was properly applied, and failed to monitor the resident in the restraint, to ensure the resident's safety for 12 (Resident #160, 29, 56, 63, 73, 78, 94, 109, 111, 117, 142, 158) of 13 residents reviewed with restraints.<br><br>The failure of the facility to assess and reassess the need for restraints, determine the least restrictive restraint, follow the restraint manufacturer's application instructions and | F 490 | Facility will 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<br><br>All residents have the potential to be effected.<br><br>7/23/15 – **Restraint Reduction Committee:** New Committee meets weekly. DON is the Chairman. Members include: NHA, DON, MDS LN, Unit Managers, Wound Care Nurse, Central Supply, Restorative CNAs, Therapy, Social Service and Activities. The Medical Director will be an Ad Hoc member of the committee. The Committee will review weekly every restraint and all assistive devices that could also be a restraint. The review will be conducted for potential reduction, removal or validation of continued medical necessity.<br><br>**Resident #29**<br><br>7/31/15 – Seating in Broda chair with non-skid seating – no restraint. Chair is slightly reclined for comfort except at meals. Continues sensor pad in bed. Will continue weekly Restraint Reduction Committee review. | |

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| F 490 | Continued From page 130<br>warnings, apply the restraint per the manufacturer's instructions, and monitor the resident while in the restraint placed Resident #160 in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident).<br><br>The Administrator was informed of the Immediate Jeopardy on 7/21/15 at 2:40 PM in the conference room.<br><br>The Immediate Jeopardy was effective 5/4/15 through 7/30/15.<br><br>A Full Extended Survey was conducted on 7/21/15 to 7/29/15.<br><br>The facility was cited Substandard Quality of Care at F221-K.<br><br>An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received on 7/29/15 at 9:00 AM, and the corrective actions were validated by the surveyors on 7/29/15.<br><br>The findings included:<br><br>Review of the undated "Administrator" job description revealed "...General Purpose...to lead and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies, with focus on maintain excellent care for the residents..."<br><br>Interview with the Administrator on 7/22/15 at 3:53 PM in the conference room, confirmed the | F 490 | 8/5/15 – Morning QA Managers Meeting – observed on numerous occasions by 3-11 staff to be sitting toward front of the seat but no attempt to rise. Non-skid seating in place – continue to monitor.<br><br>8/5/15 – Restraint Reduction Committee review: Reassess current positioning - Staff report resident is more anxious in the afternoon. Committee will recommend an afternoon nap in bed after lunch to attempt to relax resident. Assessment will continue for safe positioning without restraints.<br><br>8/10/15 – Morning Managers Meeting – discussed related to resident preferred positioning at the front of the chair – observed at front of seat x 1 in previous 24 hours. No attempt to rise, chair assessed by Committee to continue to be the most appropriate seating for resident comfort. Family visited and ambulated with resident – safety maintained during visit.<br><br>8/12/15 – Restraint Reduction Committee review – resident was agitated x 1 (requiring medication intervention with positive results) since previous Committee review. Afternoon rest periods appear to decrease afternoon/evening anxiety. Confusion has increased this week. Not oriented to time or place – will incorporate additional afternoon activity time before or after nap. Activities notified. Care plan reviewed. Assessment updated to reflect current resident status and interventions. | |

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| F 490 | Continued From page 131<br>facility was aware of the physical restraints stating "...they flag on Quality Measures...it was brought up...maybe 2 months ago...10 to 12 people..." Continued interview with the Administrator confirmed he was unaware the current residents in physical restraints had not been assessed for the need of restraints, had not been assessed for the least restrictive restraint, did not have completed consents for the restraint. Continued interview revealed staff had not applied restraints per the manufacturer's instructions, and had failed to monitor the use of the restraint. Continued interview revealed, when the QA (Quality Assurance Committee) met and restraints were reviewed on the Quality Measures, the Committee had started an evaluation, but changed the focus to dehydration due to the Medical Director's request.<br><br>Refer to F221-K, F272-K, F280-J, F490-K, F501-K, and F520-K.<br><br>The interventions put in place were evaluated by the survey team on 7/29/15, and verified the Allegation of Compliance by:<br><br>1. The facility re-assessed the 13 residents with restraints for appropriateness and for the least restrictive device.<br><br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of | F 490 | 8/18/14 - Care plan updated. MAR updated for LN documentation. Assessment will continue for safe positioning without restraints.<br><br>**Resident #56**<br><br>7/31/15 – In care foam lounger for comfort – no restraint, incident or attempts to move unsafely out the chair. Will continue to be reviewed in the weekly Restraint Reduction Committee.<br><br>8/5/15 – Restraint Reduction Committee review: Assessment reviewed: No safety concerns when in care foam lounger without harness restraint. Will discuss with family the end of reduction trial. Assessed for use of an electric low bed with upper rails and bolster pads (remove lower rails and bolsters). Recommendations will be discussed with family.<br><br>8/6/15 – DON met with family by phone related to RRC recommendations. Family agreed to continued care foam lounger without harness restraint. Agreed to removal of lower rails and bolster pads but continue upper rails and bolster pads. Discussed electric low bed – family agreed with the bed and continue the perimeter mattress. Consent updated by staff and signed, assessments completed to decrease restraints and change bed devices. Care plan updated, CNA care plan in resident's room and CNA kiosk in addition to LN MAR documentation updated.<br><br>8/10/15 – Daily QA Managers Meeting – review: no issues from restraint reduction in care foam lounger or removal of lower rails and bolsters.<br><br>8/11/15 – Daily QA Managers Meeting – review: no issues in chair or bed. | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | 8/12/15 – Restraint Reduction Committee meeting review: Assessment reflects resident doing well in care foam lounger. Has sitter three times per week. Family came in today and requested lower rails and bolster pads be placed back on bed – not supportive of removal. Assessments will be reviewed with MD for family request.<br><br>**Resident #63**<br><br>7/29/15 – Resident with Soft Posey belt restraint in wheelchair per manufacturer's recommendations with belt off at meal times. When restless the Merry Walker is offered with 1:1 assistance per policy. Family does not support this level of restraint reduction. Will continue weekly restraint assessment and Restraint Reduction Committee review.<br><br>8/5/15 – Morning QA Managers Meeting review: Order for restraint timed for update – refer to RRC today.<br><br>8/5/15 – Restraint Reduction Committee review: Staff report resident can apply seatbelt and take it off at will – however response when prompted in inconsistent due to confusion- restraint assessment updated. Weakness has been noted when ambulating with Merry Walker – therapy screened resident for Part B therapy services for strengthening – awaiting family response to request. Psychotropic medication reduction initiated last week with goal of decreased anxiousness and nervousness and improved cognition.<br><br>8/10/15 – Morning QA Managers Meeting review: intermittent anxiousness – improved with 1:1 Activity while in Merry Walker. | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | 8/11/15 – Morning QA Managers Meeting review: Awake until early morning. Anxious in bed, Merry Walker and after snack. Asleep at 0100.<br><br>8/12/15 – Restraint Reduction Committee Review. Assessment completed: When in wheelchair: alarming seat belt restraint (resident does release the belt randomly and attempts to rise unassisted but due to cognition is unable to release on command or ambulate safely for more than a few steps safely). Belt is off at meals and during 1:1 encounters. Committee restraint assessment summary – current devices are the least restrictive restraint for this resident at this time due to poor safety awareness, unsteady gait and mental confusion. Family is not supportive of current restraint reduction. Resident has bed sensor in bed which alarms randomly during the night with the resident attempting to exit the bed unassisted. Will continue weekly restraint reduction assessment for both family education and resident safety with least restrictive device(s).<br><br>8/14/15 – Initiated B&B Program. Restraint Reduction Committee conducted assessment of bowel habits with recommendation to initiate trial bowel toileting "catch" or toileting assistance program in an effort to assist with unsafe ambulation due to frequent bowel toileting needs secondary to medical diagnosis and toileting habit changes.<br><br>**Resident #73**<br><br>7/29/15 – In wheelchair with seat belt restraint. Belt is released during meals and 1:1 visits. Remains non-verbal with limited facial | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | expressions. Family is supportive of reduction. There have been no attempts for the resident to stand unassisted. Will continue weekly Restraint Reduction Committee Review.<br><br>8/5/15 – Restraint Reduction Committee meeting – reviewed and updated restraint assessment. Currently in restraint 2-3 hours per day. Continue to take rest periods with her husband everyday 1-5 pm and belt off during meals and 1:1 encounter. Will continue review next week for goal of restraint reduction in the mornings.<br><br>8/6/15 – Morning QA Managers Meeting – review: Doing well with current restraint reduction. DON met with family who is supportive of removing the seat belt as long as safety is maintained. Consent updated. Restraint assessment updated for removal for morning hours. Care plan, CNA care plan in resident's room, CNA kiosk and LN documentation updated to reflect removal of belt restraint. Will refer to RRC for post removal safety assessment.<br><br>8/10/15 – Morning QA Manager's Meeting – review: Staff reports resident occasionally sits leaning slightly forward – no concerns related to safety. Will pass information to RRC.<br><br>8/11/15 – Morning QA Managers Meeting – review. Observed removing the table cloth from the dining tables. Staff state resident is cold natured so a sweater will be offered when resident leaves their room. Care plan and CNA care plan in resident's room and CNA kiosk updated to reflect resident preference. | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | 8/12/15 – Restraint Reduction Committee meeting review: Assessment updated - no restraint at this time – no observations of resident trying to get up from seat unassisted since restraint removed. Leans forward on table when in dayroom. Takes rest periods every afternoon with husband at bedside. Extended family expressed concern with resident positioning and restraint removal – DON will discuss concerns. Will update assessment during committee meeting next week to review resident safety without restraint.<br><br>**Resident #78**<br><br>7/31/15 – Assessed for Velcro alarming seatbelt restraint in wheelchair to be off at meal time and during family and 1:1 visits. Continue weekly Restraint Reduction Committee review to ensure seatbelt is applied according to manufacturer recommendation and is the least restrictive device indicated based on assessment.<br><br>8/5/15 – Morning QA Managers Meeting – review: Request RRC to review for possible Broda Peddler seating and remove the alarming seat belt.<br><br>8/5/15 – Restraint Reduction committee review: Assessment updated. MD reviewed for possible UTI - ordered urine C&S test. Family visited today to discuss change to Broda Peddler with alarming seatbelt to provide greater independence and safety without alarming seatbelt in addition to changes in behavior. Family did not support change in seating to promote independence because family felt resident is a "meddler" and leans forward reaching for items. Family did agree for UA C&S | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | to evaluate change in behavior. Will continue to follow for lab outcome and device application and use.<br><br>8/7/15 – Morning QA Managers Meeting – review: Resident has been more active but quieter lately. Up in wheelchair with Velcro belt. Will unbuckle randomly but not when prompted.<br><br>8/10/15 – Morning QA Managers Meeting – review: No attempts to rise from seat during random opportunities when unbuckles the seat belt. Started on antibiotic for UTI.<br><br>8/11/15 – Morning QA Managers Meeting – review: Continue on antibiotic for UTI. No safety issues in wheelchair.<br><br>8/12/15 – Restraint Reduction Committee Review. Assessment completed with resident in wheelchair: Alarming seat belt applied according to manufacturer recommendation (resident occasionally releases the belt when fidgeting but does not attempt to rise) with dump wheelchair seat due to resident persistent reaching and bending for items out of reach. Belt is off at meal times, during 1:1 encounter and when the family visits. Family is not supportive of current restraint reduction. Attended Happy Hour this week. Resident has sensor pad when in bed. Will review next week for restraint assessment and reduction.<br><br>**Resident #94**<br><br>7/31/15 - Resident has abdominal binder to protect the integrity of the PEG tube – no restraint. Resident remains without right hand mitten restraint. Assessments and care plans support the current restraint free status. Will | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | continue weekly review by the Restraint Reduction Committee to follow safety of PEG tube.<br><br>8/5/15 – Morning QA Managers Meeting – resident has made no attempt to remove PEG tube.<br><br>8/5/15 – Restraint Reduction Committee review: Assessment completed. Activity reports resident made attempts to hit strings on guitar today during 1:1 session – a notable improved response to surroundings and staff encounter.<br><br>8/10/15 – Morning QA Managers Meeting - staff reports abdominal binder is effective in protection and positioning of the PEG tube.<br><br>8/12/15 – Restraint Reduction Committee review: Assessment updated. Activity reports resident again responded to the guitar and appears to be listening to and enjoying music in the room. Activity recommends resident be out of the bed more since appears to be calmer with surroundings and external stimulation. Care plan updated for out of bed activity. Activity staff will continue to assess resident for response to various stimulation activities. Will continue to review during weekly RRC for four weeks to monitor tube and follow weekly improved interactions to surroundings.<br><br>8/17/15 MAR updated to document time spent out of bed.<br>**Resident #109**<br><br>7/31/15 – Exhibiting increased independence in ambulation, continues to carry cane when ambulating and is assisted with stand by assist ambulation or a chair when exhibiting unsteady | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | gait – No restraint. Remains at risk for falls due to episodic unsteady gait. Appears happier and engaged in friendly conversation with staff and other residents. Will continue to be reviewed weekly by the Restraint Reduction Committee following restraint reduction.<br><br>8/4/15 – Fell in the dining room during lunch – Investigation and fall assessment updated – resident was attempting to rise, reach for health shake and pivot and lost balance. Footwear appropriate, area uncluttered, staff present – no injury. Ambulates with a safe gait otherwise. Will refer to Restraint Reduction Committee for review.<br><br>8/5/15 – Restraint Reduction Committee meeting – Reviewed 8/4 fall and investigation. Resident is currently in therapy for balance strengthening. Assessment updated - Staff will observe and offer assistance when rising from meals and ensure pathway is without clutter. Care plan and CNA care plan in resident's room and CNA kiosk updated. Will continue to assess for committee review next week.<br><br>8/10/15 – Morning QA Managers Meeting – review. Ambulating ad lib in facility without balance issues.<br><br>8/12/15 – Restraint Reduction Committee meeting – Assessment updated: Ambulating without balance problems. Currently in therapy. Family notified of need for smaller shoes to assist in safer ambulation. Will continue to follow in committee until new shoes are evaluated. | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | **Resident #111**<br><br>7/31/15 – Continues in self-mobile wheel chair with non-skid seating material on a "dumped" (tilted) seat with a pull alarm to alert staff of unassisted transfer attempts – No Restraint. Additionally the wheelchair is fitted with anti-tippers due to resident persistence in pushing wheel chair backwards instead of forward. Bed room is modified with the head of the bed facility the doorway to provide a clutter-free walkway for the wheelchair. No change in cognition or participation in surroundings. Will continue in weekly review by the Restraint Reduction Committee.<br><br>8/5/15 – Morning QA Managers Meeting – review: observed sitting in chair without observed safety concerns.<br><br>8/5/15 – Restraint Reduction Committee Meeting – Assessment updated - Continues in self-mobile wheel chair with non-skid seating material on a "dumped" (tilted) seat with a pull alarm to alert staff of unassisted transfer attempts. Additionally the wheelchair is fitted with anti-tippers due to resident persistence in pushing wheel chair backwards instead of forward. No reported attempts to stand without assistance. Care-giver states resident does not appear to need pull alarm in wheelchair – will continue and reassess next week.<br><br>8/6/15 Pull alarm in wheelchair discontinued.<br><br>8/10/15 – Morning Managers Meeting review – continues to position well without restraint. | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | 8/12/15 – Restraint Reduction Committee meeting – Assessment updated. Husband has been visiting more this review week. Continue to position well in chair - family feels comfortable with current status.<br><br>**Resident #117**<br><br>7/31/15 – Has Torso Posey Positioner (yellow/Large) Restraint while in wheelchair with positioner removed from 7a-3p. There have been no incidents of unsafe transferring. Appears happy when self-propelling in the wheelchair and attending activities without the Torso positioner. Assessment indicates resident tends to lean in the wheelchair when fatigued in the evening requiring positioner for torso support. Family supportive of reduction. Will continue weekly assessment and review by the Restraint Reduction Committee.<br><br>8/5/15 – Morning QA Managers Meeting – review: Doing well with current seating – upper torso balance in wheelchair. Staff report resident's balance in the evening continues to improve. No concerns when in bed.<br><br>8/5/15 – Restraint Reduction Committee meeting review: Updated assessment indicates improved upper body strength throughout the day. Unit Manager met with family – recommending Torso Posey be discontinued. Consent signed, assessment completed by committee. Care plan, LN documentation and CNA care plan in resident's room and CNA kiosk updated to reflect restraint free status.<br><br>8/10/15 – Morning QA Managers Meeting – review: Observed in wheelchair without balance issues. | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | 8/12/15 – Restraint Reduction Committee meeting review: No Restraint - No leaning noted when seated in wheelchair, no attempts to exit bed. Appears happy and engaged in activities – singing and listening to music, watching TV and laughing with residents. Recommend sensor pad in bed to discontinue. Floor mats will continue when in bed. Will assess and review next week in RRC to ensure appropriate position during morning and evening hours.<br><br>8/13/15 Sensor pad alarm in bed discontinued.<br><br>**Resident #142**<br><br>7/31/15 – Ambulates at will daily with on-going monitoring for unsteady gait and needed additional assistance. No Restraint. Naps in common areas and utilizes a wheelchair occasionally when tired. Has not had a fall but remains at risk for falls. Continues on weekly review by the Restraint Reduction Committee.<br><br>8/5/15 – Morning QA Managers Meeting – review: Ambulating in the hall and room ad lib. Observed ambulation without shoes x 1 – easily redirected for appropriate footwear for ambulation.<br><br>8/10/15 – Morning QA Managers Meeting – review: Ambulating ad lib in hall with shoes.<br><br>8/12/15 – Restraint Reduction Committee review: Reported to be sleepy in the mornings and not sleeping through the night. Family and DON requested psychotropic review for possible GDR during psychiatrist visit today. Will initiate toileting plan to assist with toileting. Care plan and CNA care plan in resident's room and CNA | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | kiosk updated. Will continue for another week for assessment update and RRC review.<br><br>**Resident #160**<br><br>7/31/15 – Resident has a seatbelt restraint with sensor pad when in the wheelchair applied according to manufacturer's application instructions without attempts for unsupervised transfer. Will be placed in bed for rest with resident's favorite stuffed animal when exhibits signs of fatigue and irritation. Care plan was reviewed by the Restraint Reduction Committee and updated by the MDS LN to reflect resident current restraint and assistive devices. Education LN reviewed the CNA resident information and Electronic Health Record (EHR) documentation kiosk to ensure the current care plan is updated for review and documentation by the CNA. RCC and Unit Managers review the LN MAR documentation to ensure it accurately reflected the most recent assessment and care plan. RCC will continue weekly assessment, review and care plan update procedures during the weekly Restraint Reduction Committee meeting.<br><br>8/5/15 – Restraint Reduction Committee review: Orthopedic appointment for 8/21/15 is to evaluate weight bearing status and initiate therapy services. Assessment updated. Care plan reviewed without changes. Resident has made no attempts to get up from seat. Does still fidget with seatbelt. Sensor pad in wheelchair has not sounded since application – no attempts to rise from chair.<br><br>8/12/15 – Restraint Reduction Committee meeting review: Assessment reviewed – resident | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | appears a good candidate for restraint reduction. Resident is up in wheelchair daily with seatbelt and sensor pad-has made no attempts to get up from seat; staff has observed resident leaning forward with feet on wheelchair pedals – no attempts to self-propel. Continue rest periods daily after lunch. When in wheelchair, resident has a seat belt (can release but due to cognition is unable to release on command) with non-skid seat material and sensor pad. The seat belt is removed during meals and 1:1 encounter. When in bed the resident has a perimeter mattress with sensor pad to alert staff to unassisted/ unsafe transfer. Continues with limited weight bearing and remains at risk for falls. Although restraint reduction could be recommended based on assessment, the committee recommends continue restraint due to s/p fracture, committee will continue current orders until orthopedic appointment on 8/21/15. Care plan reviewed during committee meeting by the MDS LN to ensure it accurately reflects current restraint and device(s) interventions.<br><br>8/21/15 - Resident has appointment with orthopedic surgeon. Anticipate resident will be released for weight bearing and Therapy services. Following Therapy evaluation the current restraint will be re-evaluated by the Restraint Reduction Committee for possible reduction and encouragement for increase ambulation.<br><br>---<br><br>**#2• The independent contractor conducted training for all staff on the importance of preventing serious injuries and deaths from asphyxiation, suffocation,** | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | **bed-rail entrapments and falls. Training was provided to facility personnel shall review the all types of restraints, including but not limited to, full bed rails, other types of bed rails used, trunk restraints, limb restraints, and chairs that may prevent rising. Training included manufacturer's instructions for all restraints in use at the facility; and included information on resident rights.** *The dates of training are provided in Independent Contractor's DPOC Final Report.*<br><br>• 2.1 Training was provided for all **active classifications** of Community Care of Rutherford County (CCRC) staff, agency personnel (none since before 2005) and contract service providers (therapy) on the importance of preventing serious injuries and deaths from asphyxiation, suffocation, bed-rail entrapments and falls. Training curriculum was customized to align with those items in use/in stock at CCRC.<br>o Responsible Party(ies): Vickie W. Harris, Independent Contractor<br>o Completion Date: September 15, 2015<br>• 2.2 Training was provided for all **active classifications** of licensed and/or certified CCRC staff, agency personnel (none since before 2005), contract service providers (therapy), social workers/designees and activity personnel on the types of restraints in use by CCRC at present, in stock and/or on the premises. The training included, at a minimum, a review of the manufacturer's instructions for use and where to source instructions for future reference. | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | ○ Responsible Party(ies): Vickie W. Harris, Independent Contractor<br>○ Completion Date: September 15, 2015<br>• 2.3 Training was provided for **all active classifications** of CCRC staff, agency personnel (none since before 2005) and contract staff (therapy) on resident rights.<br>○ Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>○ Completion Date: September 15, 2015<br><br>#3• **The independent contractor ensured that staff was given education and training on restraint alternatives, including but not limited to, therapeutic interventions, environmental and equipment interventions, and the role of restorative programs.** *The dates of training are provided in Independent Contractor's DPOC Final Report.*<br>• 3.1 Education and training was provided for all **active classifications** of CCRC staff, agency personnel (none since before 2005) and contract service providers (therapy) on restraint alternatives available and used by the organization.<br>○ Responsible Party(ies): Vickie W. Harris, IC<br>○ Completion Date: September 15, 2015<br><br>#4• **The independent contractor evaluated the systems and processes established by the facility and governing body to minimize the use of** | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | **restraints. The independent contractor determined to what extent the nursing home seeks to involve, educate and train residents and family members on alternatives to restraints. The independent contractor validated via observation, record review and interview that restraints on all shifts if used are only to facilitate or support the resident's medical treatment, and not used to discipline residents, as staff convenience, or to prevent residents from wandering.** *The dates of evaluation, assessment, & validation of facility's & governing body's systems & processes are provided in Independent Contractor's DPOC Final Report.*<br><br>• 4.1 A facility assessment was completed to review all processes and systems related to restraint minimization. The assessment will include, but not be limited to:<br>o Leadership, staff and contractor interviews<br>o Policies and procedures<br>▪ Scope<br>▪ Execution<br>• New admits<br>• Current residents<br>o New orders<br>o Change orders<br>o Continuing orders<br>• Emergencies<br>o Training Curriculum – Restraints and resident rights | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | ▪ Scope and content<br>▪ Stakeholders {includes employed staff, agency (none since before 2005), contractors (therapy), families and volunteers}<br>▪ Frequency<br>• CCRC Staff<br>o Onboarding<br>o Interim (as needed)<br>o Continuing (annual)<br>• Residents and Families<br>• Volunteers<br>▪ Staff returning from extended leave<br>▪ Agency and Contract Service Provider Staff<br>▪ Methods/Platforms<br>▪ Knowledge and/or competency verification<br>• Who does it?<br>• Documentation<br>• Follow-up<br>o Documentation | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | o Communication and Ongoing Involvement<br>▪ Staff<br>▪ Residents<br>▪ Family<br><br>Information collected in the above outlined baseline assessment was used to identify gaps and weaknesses, inform relevant opportunities for improvement and establish recommendations/specific actions to the facility Administrator and governing board.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>• 4.2 As part of the overall assessment (4.1) the involvement, education and training of residents and their families on alternatives to restraints was completed.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>• 4.3 Resident restraint use was validated on all shifts to insure utilization is to facilitate or support medical treatment and that none are in use for discipline, staff convenience or to prevent wandering. Validation was by way of observation, record review and interviews throughout the course of the Independent Consultant's engagement. | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>**#5• The independent contractor determined what procedures are in place to assess the competency of staff who apply restraints; the frequency of observing and assessing the resident who is restrained; and how staff interact with the resident and attend to the resident's needs while he or she is restrained.** *The Independent Contractor's DPOC Final Report contains her findings and assessment of facility limited restraint use.*<br><br>• 5.1 As part of the overall facility assessment related to restraint minimization (4.1), the facility's procedures related to assessing staff competency in the application of restraints was evaluated.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015<br><br>• 5.2 CCRC licensed and/or certified staff was evaluated as to the frequency of observation and assessment of residents who are restrained. This evaluation was completed in conjunction with 4.3.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 15, 2015 | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | • 5.3. All classifications of CCRC staff, agency personnel (none since before 2005) and contract service providers (therapy) was evaluated as to how they interact with residents and attend to their needs while restrained. This was completed in conjunction with 4.3.<br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>o Completion Date: September 15, 2015<br><br>**#6• The independent contractor is submitting to CMS and the State a copy of all training materials, and a written report summarizing the aforementioned components of the directed plan of correction, and how the administrator and governing body will ensure ongoing compliance with 42 CFR 483.13.**<br><br>• 6.1 At the completion of the Independent Consultant's role on September 15, 2015, a report is submitted to CMS and the State summarizing the above outlined directed plan of correction, its execution, findings and recommendations, and how the Administrator and governing body will ensure ongoing compliance with 42 CFR 483.13. The report will include copies of all training materials and any other relevant documents.<br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>o Completion Date: September 18, 2015 | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | 7/30/15 – 8/18/15 – Unit Managers and MDS LN completed 100% device / alarm audit. RRC evaluated each device to determine if it was a positioning device that could be a restraint for the individual resident. Assessments were completed to ensure device(s) were used according to manufacturer application instructions and warnings and as indicated to determine baseline for device reductions as indicated by resident activity, behavior, cognition and safety needs. MDS LN reviewed 100% resident Care plans and revised as indicated to reflect residents' current devices. Medical Director notified of results for discussion related to facility benchmark and current trends. Findings will be forwarded to QA Committee for establish action plan to achieve facility goals. DON will be responsible for communication action plan between RCC, QA and QAA committee in addition to documentation of the action plan, implementation and evaluation for full QAA review. Audit tool will be updated as MD orders impact the devices. MDS LN will review the audit tool during the RAI schedule for each resident and will conduct a comprehensive QA audit at least annually for full QAA Committee review to determine use trend and compliance with RAI assessment and care planning requirements in addition to facility goals.<br><br>8/7/15 – QA Committee Meeting - Reviewed: New Restraint Policy, new Restraint Protocol, Restraint Audits, Restraint education audit, new restraint assessment forms (Pre-evaluation and Reduction)<br><br>7/23/15 – Restraint Reduction Committee: New Committee meets weekly and is a Sub-committee of the QAA Committee. DON is the Chairman. Members include: NHA, DON, MDS LN, Unit Managers, Wound Care Nurse, Central Supply, Restorative CNAs, Therapy, Social Service and | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | related to facility reports, communications and policies.<br><br>Daily QA Managers Meeting attendees include but may not be limited to: NHA, DON, MDS LN, Infection Control/Staff Education, Wound Nurse, Unit Managers, Restorative, Medical Records, Therapy, Social Service, Activities, Housekeeping, Maintenance, Business Office and Payroll.<br>The following items will be reviewed daily: Change in Resident Condition, Significant Change in Resident Status, 24 Hour Report Information, New MD orders, Occurrence Reports, Clinical Progress Notes and Hospital Transfers in addition to Restraints, Infection Control and On-going Investigations. Care plan updates will be discussed in the meeting for updates and accuracy.<br><br>Concerns discussed in the daily meeting will be assigned to staff for follow up and the DON as indicated to complete investigations. Information and findings from the areas discussed in the daily meeting will be reviewed in the meeting weekly until resolved or on-going as indicated. Staff education will be directed by information from the daily QA meeting in addition to on-going audits, scheduled monthly staff meetings and annual skills assessments.<br><br>Nursing Home Administrator will notify the Clinical Consultant of issues, concerns, QA audits and investigations during the monthly visit to ensure a timely and comprehensive investigation with action plan is completed.<br><br>Clinical Consultant will review daily, weekly and monthly QA and scheduled QA Committee and Sub Committee meeting minutes to ensure timely and comprehensive action plans are implemented, monitored and evaluated. Clinical Consultant will be | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | on-site at least monthly and submit a written report to the QAA Committee for review and action as indicated. Medical Director will review consultant report monthly for timely response and needed intervention as indicated.<br><br>8/7/15 – Monthly QA Committee Meeting - NHA or designee will summarize the daily Managers meetings for trends and education needs to be discussed in the Monthly QA meeting. Trend summaries and on-going or unresolved facility issues are discussed for resolution in the Monthly QA Committee Meeting. The QA Committee will meet 2 times per month for the first month (August – September) and then monthly thereafter.<br><br>Monthly QA Meeting attendees include but may not be limited to: NHA, DON, Department Managers, Wound Nurse, Infection Control Nurse and Staff Educator. The NHA will be the Chairman of the committee and responsible to ensure information is communicated between the QA Committee and the QAA Committee.<br><br>8/1/15 - The QAA Committee will meet quarterly. Items from the Monthly QA Committee Agenda will be reviewed by the full QAA Committee to ensure policy compliance, clinical best practice and staff education is monitored, implemented and evaluated on-going. The Clinical Consultant will review the QA and QAA Committee minutes during monthly visits to ensure compliance. Compliance issues or concerns will be discussed with the NHA for follow-up and resolution.<br><br>QAA Committee members include but may not be limited to: Medical Director, Nursing Home Administrator, DON, Department Managers (Social Service, Activity, Therapy, Nursing, Housekeeping, Maintenance), in addition to the wound Care Nurse, | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | Staff Education Nurse, Infection Control Nurse and staff nurses and CNAs as available.<br><br>7/30/15 – 8/18/15 – Unit Managers and MDS LN completed 100% device / alarm audit. RRC evaluated each device to determine if it was a positioning device that could be a restraint for the individual resident. Assessments were completed to ensure device(s) were used according to manufacturer application instructions and warnings and as indicated to determine baseline for device reductions as indicated by resident activity, behavior, cognition and safety needs. MDS LN reviewed 100% resident Careplans and revised as indicated to reflect residents' current devices. Medical Director notified of results for discussion related to facility benchmark and current trends. Findings will be forwarded to QA Committee for establish action plan to achieve facility goals. DON will be responsible for communication action plan between RCC, QA and QAA committee in addition to documentation of the action plan, implementation and evaluation for full QAA review. Audit tool will be updated as MD orders impact the devices. MDS LN will review the audit tool during the RAI schedule for each resident and will conduct a comprehensive QA audit at least annually for full QAA Committee review to determine use trend and compliance with RAI assessment and care planning requirements in addition to facility goals.<br><br>8/7/15 – QA Committee Meeting - Reviewed: New Restraint Policy, new Restraint Protocol, Restraint Audits, Restraint education audit, new restraint assessment forms (Pre-evaluation and Reduction) | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | current assessment. The nursing Home Administrator (NHA) will be responsible for QAA Committee oversight of the Restraint Reduction Committee activity.<br><br>MD will review the Restraint Reduction Committee minutes during weekly scheduled visits to ensure NHA takes action on areas of concern.<br><br>Compliance Consultant will review weekly notes during scheduled monthly visits and submit a written report to the QAA committee for MD review to ensure QAA benchmarks and facility goals are met.<br><br>7/30/15 - Daily QA Managers Meeting (Monday – Friday). NHA will oversee and investigate concerns related to facility reports, communications and policies.<br>Daily QA Managers Meeting attendees include but may not be limited to: NHA, DON, MDS LN, Infection Control/Staff Education, Wound Nurse, Unit Managers, Restorative, Medical Records, Therapy, Social Service, Activities, Housekeeping, Maintenance, Business Office and Payroll.<br><br>The following items will be reviewed daily: Change in Resident Condition, Significant Change in Resident Status, 24 Hour Report Information, New MD orders, Occurrence Reports, Clinical Progress Notes and Hospital Transfers in addition to Restraints, Infection Control and On-going Investigations. Care plan updates will be discussed in the meeting for updates and accuracy.<br><br>Concerns discussed in the daily meeting will be assigned to staff for follow up and the DON as | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | indicated to complete investigations. Information and findings from the areas discussed in the daily meeting will be reviewed in the meeting weekly until resolved or on-going as indicated. Staff education will be directed by information from the daily QA meeting in addition to on-going audits, scheduled monthly staff meetings and annual skills assessments.<br><br>Nursing Home Administrator will notify the Clinical Consultant of issues, concerns, QA audits and investigations during the monthly visit to ensure a timely and comprehensive investigation with action plan is completed.<br><br>Clinical Consultant will review daily, weekly and monthly QA and scheduled QA Committee and Sub Committee meeting minutes to ensure timely and comprehensive action plans are implemented, monitored and evaluated. Clinical Consultant will be on-site at least monthly and submit a written report to the QAA Committee for review and action as indicated. Areas of on-going non-compliance with be reviewed with the NHA. Medical Director will review consultant report monthly for timely response and needed intervention as indicated – areas of concern will be addressed with NHA for resolution.<br><br>8/7/15 – Monthly QA Committee Meeting - NHA or designee will summarize the daily Managers meetings for trends and education needs to be discussed in the Monthly QA meeting. Trend summaries and on-going or unresolved facility issues are discussed for resolution in the Monthly QA Committee Meeting. The QA Committee will meet 2 times per month for the first month (August – September) and then monthly thereafter. | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | Monthly QA Meeting attendees include but may not be limited to: NHA, DON, Department Managers, Wound Nurse, and Infection Control Nurse<br><br>**Resident #160**<br><br>7/31/15 – Resident has a seatbelt restraint with sensor pad when in the wheelchair applied according to manufacturer's application instructions without attempts for unsupervised transfer. Will be placed in bed for rest with resident's favorite stuffed animal when exhibits signs of fatigue and irritation. Careplan was reviewed by the Restraint Reduction Committee and updated by the MDS LN to reflect resident current restraint and assistive devices. Education LN reviewed the CNA resident information and Electronic Health Record (EHR) documentation kiosk to ensure the current care plan is updated for review and documentation by the CNA. RCC and Unit Managers review the LN MAR documentation to ensure it accurately reflected the most recent assessment and care plan. RCC will continue weekly assessment, review and care plan update procedures during the weekly Restraint Reduction Committee meeting.<br><br>8/5/15 – Restraint Reduction Committee review: Orthopedic appointment for 8/21/15 is to evaluate weight bearing status and initiate therapy services. Assessment updated. Care plan reviewed without changes. Resident has made no attempts to get up from seat. Does still fidget with seatbelt. Sensor pad in wheelchair has not sounded since application – no attempts to rise from chair. | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | 8/12/15 – Restraint Reduction Committee meeting review: Assessment reviewed – resident appears a good candidate for restraint reduction. Resident is up in wheelchair daily with seatbelt and sensor pad-has made no attempts to get up from seat; staff has observed resident leaning forward with feet on wheelchair pedals – no attempts to self-propel. Continue rest periods daily after lunch. When in wheelchair: Seat belt (resident can release but due to cognition is unable to release on command) with non-skid seat material and sensor pad. The seat belt is removed during meals and 1:1 encounter. When in bed the resident has a perimeter mattress with sensor pad to alert staff to unassisted/ unsafe transfer. Continues with limited weight bearing and remains at risk for falls. Although restraint reduction could be recommended based on assessment, the committee recommends continue restraint due to s/p fracture, committee will continue current orders until orthopedic appointment on 8/21/15. Care plan reviewed during committee meeting by the MDS LN to ensure it accurately reflects current restraint and device(s) interventions.<br><br>8/21/15 - Resident has appointment with orthopedic surgeon. Anticipate resident will be released for weight bearing and Therapy services. Following Therapy evaluation the current restraint will be re-evaluated by the Restraint Reduction Committee for possible reduction and encouragement for increase ambulation. | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | 7/30/15 – 8/18/15 – Unit Managers and MDS LN completed 100% device / alarm audit. RRC evaluated each device to determine if it was a positioning device that could be a restraint for the individual resident. Assessments were completed to ensure device(s) were used according to manufacturer application instructions and warnings and as indicated to determine baseline for device reductions as indicated by resident activity, behavior, cognition and safety needs. MDS LN reviewed 100% resident Careplans and revised as indicated to reflect residents' current devices. Medical Director notified of results for discussion related to facility benchmark and current trends. Findings will be forwarded to QA Committee for establish action plan to achieve facility goals. DON will be responsible for communication action plan between RCC, QA and QAA committee in addition to documentation of the action plan, implementation and evaluation for full QAA review. Audit tool will be updated as MD orders impact the devices. MDS LN will review the audit tool during the RAI schedule for each resident and will conduct a comprehensive QA audit at least annually for full QAA Committee review to determine use trend and compliance with RAI assessment and care planning requirements in addition to facility goals.<br><br>8/7/15 – QA Committee Meeting - Reviewed: New Restraint Policy, new Restraint Protocol, Restraint Audits, Restraint education audit, new restraint assessment forms (Pre-evaluation and Reduction) | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | 7/23/15 – Restraint Reduction Committee: New Committee meets weekly and is a Sub-committee of the QAA Committee. DON is the Chairman. Members include: NHA, DON, MDS LN, Unit Managers, Wound Care Nurse, Central Supply, Restorative CNAs, Therapy, Social Service and Activities. The Medical Director will be an Ad Hoc member of the committee. The Committee will review weekly every restraint and all assistive devices that could also be a restraint and a restraint assessment will be updated to direct the committee to the restraint indicated and least restrictive device for resident safety. MDS LN will be responsible for reviewing the careplans and updating during the committee meeting to accurately reflect the current assessment, interventions and devices The committee will be responsible on-going selection of restraint / device, monitoring restraint/device application and use in according to manufacturer application instructions and warnings in addition to assessment for restraint reduction and management.<br><br>Each restraint assessment review will be conducted for potential reduction, removal or validation of continued medical necessity. MDS, Care plan and resident Chart will be brought to the meeting by the Unit Managers for documentation, MDS and care plan review/update and to update the weekly committee meeting note. Committee Chairman (DON) will record minutes during the meeting. The minutes will be submitted to the QAA Committee for benchmark, trending, oversight, review and to determine programming and staff education needs. The MDS LN will be responsible for updating the care plan as indicated to reflect | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | current assessment. The nursing Home Administrator (NHA) will be responsible for QAA Committee oversight of the Restraint Reduction Committee activity. MD will review the committee minutes during weekly scheduled visits. Compliance Consultant will review weekly notes during scheduled monthly visits. Concerns will be discussed with the NHA during the compliance visit.<br><br>7/30/15 - Daily QA Managers Meeting (Monday – Friday). NHA will oversee and investigate concerns related to facility reports, communications and policies.<br><br>Daily QA Managers Meeting attendees include but may not be limited to: NHA, DON, MDS LN, Infection Control/Staff Education, Wound Nurse, Unit Managers, Restorative, Medical Records, Therapy, Social Service, Activities, Housekeeping, Maintenance, Business Office and Payroll.<br><br>The following items will be reviewed daily: Change in Resident Condition, Significant Change in Resident Status, 24 Hour Report Information, New MD orders, Occurrence Reports, Clinical Progress Notes and Hospital Transfers in addition to Restraints, Infection Control and On-going Investigations. Care plan updates will be discussed in the meeting for updates and accuracy.<br><br>Concerns discussed in the daily meeting will be assigned to staff for follow up and the DON as indicated to complete investigations. Information and findings from the areas discussed in the daily meeting will be reviewed in the meeting weekly until resolved or on-going as indicated. Staff education will be directed by information from the daily QA meeting in | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | addition to on-going audits, scheduled monthly staff meetings and annual skills assessments.<br><br>Nursing Home Administrator will notify the Clinical Consultant of issues, concerns, QA audits and investigations during the monthly visit to ensure a timely and comprehensive investigation with action plan is completed.<br><br>Clinical Consultant will review daily, weekly and monthly QA and scheduled QA Committee and Sub Committee meeting minutes to ensure timely and comprehensive action plans are implemented, monitored and evaluated. Clinical Consultant will be on-site at least monthly and submit a written report to the QAA Committee for review and action as indicated. Medical Director will review consultant report monthly for timely response and needed intervention as indicated.<br><br>8/7/15 – Monthly QA Committee Meeting - NHA or designee will summarize the daily Managers meetings for trends and education needs to be discussed in the Monthly QA meeting. Trend summaries and on-going or unresolved facility issues are discussed for resolution in the Monthly QA Committee Meeting. The QA Committee will meet 2 times per month for the first month (August – September) and then monthly thereafter.<br><br><u>Monthly QA Meeting attendees</u> include but may not be limited to: NHA, DON, Department Managers, Wound Nurse, Infection Control Nurse and Staff Educator. The NHA will be the Chairman of the committee and responsible to ensure information is communicated between the QA Committee and the QAA Committee. | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site. | F 490 | 8/1/15 - The QAA Committee will meet quarterly. Items from the Monthly QA Committee Agenda will be reviewed by the full QAA Committee to ensure policy compliance, clinical best practice and staff education is monitored, implemented and evaluated on-going. The Clinical Consultant will review the QA and QAA Committee minutes during monthly visits to ensure compliance. Compliance issues or concerns will be discussed with the NHA for follow-up and resolution.<br><br>QAA Committee members include but may not be limited to: Medical Director, Nursing Home Administrator, DON, Department Managers (Social Service, Activity, Therapy, Nursing, Housekeeping, Maintenance), in addition to the Wound Care Nurse, Staff Education Nurse, Infection Control Nurse and staff nurses and CNAs as available. | |

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| F 490 | Continued From page 132<br>residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 490 | | |
| F 501 SS=K | 483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR<br><br>The facility must designate a physician to serve as medical director.<br><br>The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a facility policy review, reference review of "Lippincott Manual of Nursing Practice," for restraint guidelines, review of a job description, medical record review, observation and interview, the facility failed to ensure the Medical Director assisted the facility with identifying, evaluating and addressing clinical concerns; failed to coordinate the medical care | F 501 | Facility will designate a physician to serve as medical director who is responsible for implementation for resident care policies; and the coordination of medical care in the facility.<br><br>All residents have the potential to be effected.<br><br>7/23/15 – Restraint Reduction Committee: New Committee meets weekly. DON is the Chairman. Members include: NHA, DON, MDS LN, Unit Managers, Wound Care Nurse, Central Supply, Restorative CNAs, Therapy, Social Service and Activities. The Medical Director will be an Ad Hoc member of the committee. The Committee will review weekly every restraint and all assistive devices that could also be a restraint. The review will be conducted for potential reduction, removal or validation of continued medical necessity. | |



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| F 501 | Continued From page 133<br>and failed to provide clinical guidance and oversight regarding the implementation of resident care policies and procedures that reflect the current standards of practice for the residents residing in the facility.<br><br>The facility failed to ensure the Medical Director assisted with addressing clinical concerns and provided guidance regarding care of the residents residing in the facility by failing to ensure there was an effective process that monitored and addressed the potential for adverse consequences related to physical restraint use; failed to ensure physical restraint consents were signed, dated and witnessed; failed to ensure physical restraint assessments and reassessments were completed for 12 (Residents # 160, 29, 56, 63, 73, 78, 94, 109, 111, 117, 142 and 158) of 13 residents; failed to ensure accuracy of care plans; failed to ensure care plans were revised with the current restraint information for 1 (Resident #160), thus resulting in an Immediate Jeopardy (IJ). An IJ is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death for the resident.<br><br>The facility failed to ensure the Medical Director provided clinical guidance and oversight regarding infection control concerns, specifically a scabies infestation affecting 3 (Resident # 76, # 81 and # 158) of 7 residents reviewed for scabies.<br><br>The findings included: | F 501 | **Resident #29**<br><br>7/31/15 – Seating in Broda chair with non-skid seating – no restraint. Chair is slightly reclined for comfort except at meals. Continues sensor pad in bed. Will continue weekly Restraint Reduction Committee review.<br><br>8/5/15 – Morning QA Managers Meeting – observed on numerous occasions by 3-11 staff to be sitting toward front of the seat but no attempt to rise. Non-skid seating in place – continue to monitor.<br><br>8/5/15 – Restraint Reduction Committee review: Reassess current positioning - Staff report resident is more anxious in the afternoon. Committee will recommend an afternoon nap in bed after lunch to attempt to relax resident. Assessment will continue for safe positioning without restraints.<br><br>8/10/15 – Morning Managers Meeting – discussed related to resident preferred positioning at the front of the chair – observed at front of seat x 1 in previous 24 hours. No attempt to rise, chair assessed by Committee to continue to be the most appropriate seating for resident comfort. Family visited and ambulated with resident – safety maintained during visit.<br><br>8/12/15 – Restraint Reduction Committee review – resident was agitated x 1 (requiring medication intervention with positive results) since previous Committee review. Afternoon rest periods appear to decrease afternoon/evening anxiety. Confusion has increased this week. Not oriented to time or place – will incorporate additional afternoon activity time before or after nap. Activities | |

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| F 501 | Continued From page 134<br><br>1. Review of the policy Medical Director Responsibilities revealed "The facility retains a physician designated as Medical Director, to coordinate the medical care provided by attending physicians, and to assist with development and implementation of resident care policies...3. Medical Director will serve on the facility's QA [Quality Assurance] Committee quarterly and assist with the identification, evaluation and resolution of medical and clinical concerns that affect resident care, medical care, quality of life, or are related to the provision of services by physicians and other licensed health care practitioners..."<br><br>2. Review of Lippincott Manual of Nursing Practice, 2014, Tenth Edition, Chapter 9 revealed "[page] 191...These [restraint] guidelines must be met in any long-term care facility that participates in Medicare or Medicaid. However, these guidelines are useful for health care providers working with older adults in all settings. (a) The resident has the right to be free from any physical restraints imposed...for purposes of discipline or convenience and not required to treat the resident's medical condition. (b) Physical restraints are any manual method of physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the person cannot remove easily, which restricts freedom of movement or access to one's body (includes leg and arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, and geriatric chairs). (c) There must be a trial of less restrictive measures unless the physical restraint is necessary to provide life-saving treatment. (d) The resident of legal representative must consent | F 501 | notified. Care plan reviewed. Assessment updated to reflect current resident status and interventions.<br><br>8/18/14 - Care plan updated. MAR updated for LN documentation. Assessment will continue for safe positioning without restraints.<br><br>**Resident #56**<br><br>7/31/15 – In care foam lounger for comfort – no restraint, incident or attempts to move unsafely out the chair. Will continue to be reviewed in the weekly Restraint Reduction Committee.<br><br>8/5/15 – Restraint Reduction Committee review: Assessment reviewed: No safety concerns when in care foam lounger without harness restraint. Will discuss with family the end of reduction trial. Assessed for use of an electric low bed with upper rails and bolster pads (remove lower rails and bolsters). Recommendations will be discussed with family.<br>8/6/15 – DON met with family by phone related to RRC recommendations. Family agreed to continued care foam lounger without harness restraint. Agreed to removal of lower rails and bolster pads but continue upper rails and bolster pads. Discussed electric low bed – family agreed with the bed and continue the perimeter mattress. Consent updated by staff and signed, assessments completed to decrease restraints and change bed devices. Care plan updated, CNA care plan in resident's room and CNA kiosk in addition to LN MAR documentation updated.<br><br>8/10/15 – Daily QA Managers Meeting – review: no issues from restraint reduction in care foam lounger or removal of lower rails and bolsters. | |

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| F 501 | Continued From page 135<br>to the use of restraints. (e) Residents who are restrained should be released, exercised, toileted, and checked for skin redness every 2 hours. (f) The need for restraints should be reevaluated periodically. (g) The specific facility will have to develop policies and procedures for the appropriate use of restraints and psychoactive drugs. (h) Primary health care providers will have to write appropriate orders for restraints..."<br><br>3. Review of the facility's "Restraints-Physical "policy updated 2/4/14 revealed "...Restraints will only be used in extreme circumstances and only with: 1. Documented behavior. 2. Consent from resident's representative 3. Physician and DON or designee. 4. All other non-restrictive alternatives have been tried and were unsuccessful (MD orders must be written)...5. Physical restraint shall not be used to limit the resident's mobility for the convenience if the staff... Written policies and procedures governing the use of restraints specify which staff member may authorize the use of restraints and clearly delineate the following: (a) Orders indicate the specific reason, type and period of time for the use of restraints. Restraints must be used only as a last resort, and the medical record must indicate the events leading up to the necessity of the restraint. (b) Their use is temporary, and the resident will not be restrained for an indefinite amount of time...The attending physician must be notified of such use and the reason for the order. Consent for Restraint must be discussed with the responsible party...(e) Reorders are issued only after a review of the resident's condition by his or her physician...10. The need for restraints will be evaluated at least quarterly in the Falls Committee Meeting to determine their continued use of a restraint has been reevaluated and that | F 501 | 8/11/15 – Daily QA Managers Meeting – review: no issues in chair or bed.<br><br>8/12/15 – Restraint Reduction Committee meeting review: Assessment reflects resident doing well in care foam lounger. Has sitter three times per week. Family came in today and requested lower rails and bolster pads be placed back on bed – not supportive of removal. Assessments will be reviewed with MD for family request.<br><br>**Resident #63**<br><br>7/29/15 – Resident with Soft Posey belt restraint in wheelchair per manufacturer's recommendations with belt off at meal times. When restless the Merry Walker is offered with 1:1 assistance per policy. Family does not support this level of restraint reduction. Will continue weekly restraint assessment and Restraint Reduction Committee review.<br><br>8/5/15 – Morning QA Managers Meeting review: Order for restraint timed for update – refer to RRC today.<br><br>8/5/15 – Restraint Reduction Committee review: Staff report resident can apply seatbelt and take it off at will – however response when prompted in inconsistent due to confusion- restraint assessment updated. Weakness has been noted when ambulating with Merry Walker – therapy screened resident for Part B therapy services for strengthening – awaiting family response to request. Psychotropic medication reduction initiated last week with goal of decreased anxiousness and nervousness and improved cognition. | |

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| F 501 | Continued From page 136<br>reorder from the physician is so noted..."<br><br>4. Interview on 7/22/15 at 1:45 PM with the Medical Director, by conference call revealed he participates in the QA process. When asked if the responsible party was notified upon the introduction of restraints, the Medical Director responded "Every time a restraint is introduced, the responsible party should be notified." Continued interview revealed, when asked if he receives regular reports from the facility regarding the type and number of restraints used in the facility, the Medical Director responded "No, I do not get regular reports about the use of restraints." Further interview revealed, when asked who determines what type of restraint was used, the Medical Director responded "They call with a recommendation. I have one person, Licensed Practical Nurse (LPN) # 4), who contacts me about orders. I find it easier to have only one or two people handling that." When asked if he knew how many residents in the facility were restrained, the Medical Director responded "No." When asked if he would be surprised to know that some residents had been utilizing the same type of restraint without any reassessments or an attempt at a reduction of restraints for the last 2 years, the Medical Director responded "Yes, that would surprise me and should not happen."<br><br>5. During an interview on 7/24/15 at 1:29 PM in the J Hall Private Dining Room, the Medical Director was asked what his role in the QA process was and what issues were addressed in QA meetings. The Medical Director stated "I attend the meetings and receive reports from individuals and provide input to what I think should be addressed. We talk about falls, wound | F 501 | 8/10/15 – Morning QA Managers Meeting review: intermittent anxiousness – improved with 1:1 Activity while in Merry Walker.<br><br>8/11/15 – Morning QA Managers Meeting review: Awake until early morning. Anxious in bed, Merry Walker and after snack. Asleep at 0100.<br><br>8/12/15 – Restraint Reduction Committee Review. Assessment completed: When in wheelchair: alarming seat belt restraint (resident does release the belt randomly and attempts to rise unassisted but due to cognition is unable to release on command or ambulate safely for more than a few steps safely). Belt is off at meals and during 1:1 encounters. Committee restraint assessment summary – current devices are the least restrictive restraint for this resident at this time due to poor safety awareness, unsteady gait and mental confusion. Family is not supportive of current restraint reduction. Resident has bed sensor in bed which alarms randomly during the night with the resident attempting to exit the bed unassisted.<br><br>Will continue weekly restraint reduction assessment for both family education and resident safety with least restrictive device(s).<br><br>8/14/15 – Initiated B&B Program. Restraint Reduction Committee conducted assessment of bowel habits with recommendation to initiate trial bowel toileting "catch" or toileting assistance program in an effort to assist with unsafe ambulation due to frequent bowel toileting needs secondary to medical diagnosis and toileting habit changes. | |

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| F 501 | Continued From page 137<br>care management, food temperatures, resident accounts. I'm not sure who determines what subjects are brought up or discussed." The Medical Director was asked if he had been notified about any issues regarding restraints. The Medical Director stated "No, not a particular issue." Continued interview revealed, when asked to describe the process of addressing and identified concerns, the Medical Director stated "We look at the policy first to see what we are committed to do in writing. If it is committed to paper, then that is what we are doing." The Medical Director was then provided a copy of the current physical restraint policy to read. The Medical Director stated "We haven't been writing the orders like this states." When asked if there had been any concerns or issues brought up in QA meetings but not addressed, the Medical Director responded "My concern is what's not being brought up. I wasn't aware of that issue, that there should be an assessment for restraints." Further interview of the Medical Director revealed "The rash we've had had been a frustrating issue. Sent them (the residents involved) and had deep tissue scraping. An employee got treated, their doctor cleared them but the family didn't get treated." | F 501 | **Resident #73**<br><br>7/29/15 – In wheelchair with seat belt restraint. Belt is released during meals and 1:1 visits. Remains non-verbal with limited facial expressions. Family is supportive of reduction. There have been no attempts for the resident to stand unassisted. Will continue weekly Restraint Reduction Committee Review.<br><br>8/5/15 – Restraint Reduction Committee meeting – reviewed and updated restraint assessment. Currently in restraint 2-3 hours per day. Continue to take rest periods with her husband everyday 1-5 pm and belt off during meals and 1:1 encounter. Will continue review next week for goal of restraint reduction in the mornings.<br><br>8/6/15 – Morning QA Managers Meeting – review: Doing well with current restraint reduction. DON met with family who is supportive of removing the seat belt as long as safety is maintained. Consent updated. Restraint assessment updated for removal for morning hours. Care plan, CNA care plan in resident's room and CNA kiosk and LN documentation updated to reflect removal of belt restraint. Will refer to RRC for post removal safety assessment.<br><br>8/10/15 – Morning QA Manager's Meeting – review: Staff reports resident occasionally sits leaning slightly forward – no concerns related to safety. Will pass information to RRC.<br><br>8/11/15 – Morning QA Managers Meeting – review. Observed removing the table cloth from the dining tables. Staff state resident is cold natured so a sweater will be offered when | |

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| F 501 | Continued From page 137<br>care management, food temperatures, resident accounts. I'm not sure who determines what subjects are brought up or discussed." The Medical Director was asked if he had been notified about any issues regarding restraints. The Medical Director stated "No, not a particular issue." Continued interview revealed, when asked to describe the process of addressing and identified concerns, the Medical Director stated "We look at the policy first to see what we are committed to do in writing. If it is committed to paper, then that is what we are doing." The Medical Director was then provided a copy of the current physical restraint policy to read. The Medical Director stated "We haven't been writing the orders like this states." When asked if there had been any concerns or issues brought up in QA meetings but not addressed, the Medical Director responded "My concern is what's not being brought up. I wasn't aware of that issue, that there should be an assessment for restraints." Further interview of the Medical Director revealed "The rash we've had had been a frustrating issue. Sent them (the residents involved) and had deep tissue scraping. An employee got treated, their doctor cleared them but the family didn't get treated." | F 501 | 8/12/15 – Restraint Reduction Committee meeting review: Assessment reviewed – resident appears a good candidate for restraint reduction. Resident is up in wheelchair daily with seatbelt and sensor pad-has made no attempts to get up from seat; staff has observed resident leaning forward with feet on wheelchair pedals – no attempts to self-propel. Continue rest periods daily after lunch. When in wheelchair: Seat belt (resident can release but due to cognition is unable to release on command) with non-skid seat material and sensor pad. The seat belt is removed during meals and 1:1 encounter. When in bed the resident has a perimeter mattress with sensor pad to alert staff to unassisted/ unsafe transfer. Continues with limited weight bearing and remains at risk for falls. Although restraint reduction could be recommended based on assessment, the committee recommends continue restraint due to s/p fracture, committee will continue current orders until orthopedic appointment on 8/21/15. Care plan reviewed during committee meeting by the MDS LN to ensure it accurately reflects current restraint and device(s) interventions.<br><br>8/21/15 - Resident has appointment with orthopedic surgeon. Anticipate resident will be released for weight bearing and Therapy services. Following Therapy evaluation the current restraint will be re-evaluated by the Restraint Reduction Committee for possible reduction and encouragement for increase ambulation. | |

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| F 501 | Continued From page 137<br>care management, food temperatures, resident accounts. I'm not sure who determines what subjects are brought up or discussed." The Medical Director was asked if he had been notified about any issues regarding restraints. The Medical Director stated "No, not a particular issue." Continued interview revealed, when asked to describe the process of addressing and identified concerns, the Medical Director stated "We look at the policy first to see what we are committed to do in writing. If it is committed to paper, then that is what we are doing." The Medical Director was then provided a copy of the current physical restraint policy to read. The Medical Director stated "We haven't been writing the orders like this states." When asked if there had been any concerns or issues brought up in QA meetings but not addressed, the Medical Director responded "My concern is what's not being brought up. I wasn't aware of that issue, that there should be an assessment for restraints." Further interview of the Medical Director revealed "The rash we've had had been a frustrating issue. Sent them (the residents involved) and had deep tissue scraping. An employee got treated, their doctor cleared them but the family didn't get treated." | F 501 | o Documentation<br>o Communication and Ongoing Involvement<br>▪ Staff<br>▪ Residents<br>▪ Family<br>Information collected in the above outlined baseline assessment was used to identify gaps and weaknesses, inform relevant opportunities for improvement and establish recommendations/specific actions to the facility Administrator and governing board.<br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>o Completion Date: September 15, 2015<br>• 4.2 As part of the overall assessment (4.1) the involvement, education and training of residents and their families on alternatives to restraints was completed.<br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>o Completion Date: September 15, 2015<br>• 4.3 Resident restraint use was validated on all shifts to insure utilization is to facilitate or support medical treatment and that none are in use for discipline, staff convenience or to prevent wandering. Validation was by way of observation, | |



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| F 501 | Continued From page 137<br>care management, food temperatures, resident accounts. I'm not sure who determines what subjects are brought up or discussed." The Medical Director was asked if he had been notified about any issues regarding restraints. The Medical Director stated "No, not a particular issue." Continued interview revealed, when asked to describe the process of addressing and identified concerns, the Medical Director stated "We look at the policy first to see what we are committed to do in writing. If it is committed to paper, then that is what we are doing." The Medical Director was then provided a copy of the current physical restraint policy to read. The Medical Director stated "We haven't been writing the orders like this states." When asked if there had been any concerns or issues brought up in QA meetings but not addressed, the Medical Director responded "My concern is what's not being brought up. I wasn't aware of that issue, that there should be an assessment for restraints." Further interview of the Medical Director revealed "The rash we've had had been a frustrating issue. Sent them (the residents involved) and had deep tissue scraping. An employee got treated, their doctor cleared them but the family didn't get treated." | F 501 | transfer. Will be placed in bed for rest with resident's favorite stuffed animal when exhibits signs of fatigue and irritation. Care plan was reviewed by the Restraint Reduction Committee and updated by the MDS LN to reflect resident current restraint and assistive devices. Education LN reviewed the CNA resident information and Electronic Health Record (EHR) documentation kiosk to ensure the current care plan is updated for review and documentation by the CNA. RCC and Unit Managers review the LN MAR documentation to ensure it accurately reflected the most recent assessment and care plan. RCC will continue weekly assessment, review and care plan update procedures during the weekly Restraint Reduction Committee meeting.<br><br>8/5/15 – Restraint Reduction Committee review: Orthopedic appointment for 8/21/15 is to evaluate weight bearing status and initiate therapy services. Assessment updated. Care plan reviewed without changes. Resident has made no attempts to get up from seat. Does still fidget with seatbelt. Sensor pad in wheelchair has not sounded since application – no attempts to rise from chair.<br><br>8/12/15 – Restraint Reduction Committee meeting review: Assessment reviewed – resident appears a good candidate for restraint reduction. Resident is up in wheelchair daily with seatbelt and sensor pad-has made no attempts to get up from seat; staff has observed resident leaning forward with feet on wheelchair pedals – no attempts to self-propel. Continue rest periods daily after lunch. When in wheelchair, resident has a seat belt (can release | |



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| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. | F 514 | Facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>All residents have the potential to be effected. | |



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| F 514 | Continued From page 138<br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy review, medical record review and interview, the facility failed to accurately monitor the restraints on the Treatment Administration Record (TAR) for 5 (Resident #29, 63, 94, 109, 142); failed to have witnessed and/or dated Informed Consent for Restraint Utilization forms for 4 (Resident #56, 78, 109, 142); and failed to accurately transcribe admission physician orders, failed to write a physician order with the medication dose for an anti-anxiety medication, and failed to have an accurate Medication Administration Record (MAR), for 1 (Resident #167) of 50 residents reviewed.<br><br>The findings included:<br><br>Review of a facility policy titled Charting and Documentation dated 5/26/09 revealed, "...All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record..observations, services performed, etc...include date, time...Licensed Nurse signature..."<br><br>Medical record review for Resident #29 revealed the resident was admitted on 4/11/14 and readmitted on 6/10/15 with diagnoses including | F 514 | **Resident #29**<br><br>8/5/15 – Restraint Reduction Committee review: Reassess current positioning - Staff report resident is more anxious in the afternoon. Committee will recommend an afternoon nap in bed after lunch to attempt to relax resident. Care plan updated for documentation. Resident is restraint free.<br><br>8/12/15 – Restraint Reduction Committee review – resident was agitated x 1 (requiring medication intervention with positive results) since previous Committee review. Afternoon rest periods appear to decrease afternoon/evening anxiety. Confusion has increased this week. Not oriented to time or place – will incorporate additional afternoon activity time before or after nap. Activities notified. Care plan reviewed. Assessment updated to reflect current resident status and interventions. Resident is restraint free.<br><br>**Resident #63**<br><br>8/5/15 – Restraint Reduction Committee review: Staff reports resident can apply seatbelt and take it off at will — however response when prompted in inconsistent due to confusion-restraint assessment updated. Weakness has been noted when ambulating with Merry Walker – therapy screened resident for Part B therapy services for strengthening – awaiting family response to request. Psychotropic medication reduction initiated last week with goal of decreased anxiousness and nervousness and improved cognition. CNA kiosk and LN MAR documentation reviewed for completion. | |

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| F 514 | Continued From page 139<br>Alzheimer's Disease, Aortic Valve Disorder, Chronic Systolic Heart Failure, Anemia and Malaise.<br><br>Medical record review of the Treatment Administration Record (TAR) dated 6/2015 revealed "...when restless transfer to WC [wheelchair] with soft Posey belt d/t [due to] increased risk for fall/unsteady gait. Check q [every] 30 min [minutes]..." with no documentation for 6/12/15 and 6/23/15 on 7A-3P shift.<br><br>Interview with the Director of Nursing (DON) on 7/21/15 at 8:58 AM in the Admission Coordinators Office revealed, when asked what her expectation was for documentation by the licensed staff on the treatment record and reviewing the 6/2015 treatment record, stated "...I expect them to initial everything that they're supposed to...several are not filled in..."<br><br>Medical record review revealed Resident #56 was admitted to the facility on 11/18/08 and readmitted on 3/9/09 with diagnoses including Depressive Disorder, Altered Mental Status, Delusional Disorder, Generalized Anxiety, Diabetes Mellitus II, and Dementia.<br><br>Medical record review of the Physician's Orders from 2/1/15 through 7/31/15 revealed an order for a Carefoam Lounger (a padded foam chair with ottoman) with 3 point pelvic positioner (a type of restraint in-between the upper thighs which comes up over the pelvis and across the lower abdomen), release and reposition every 2 hours for 10 minutes, and check every 30 minutes.<br><br>Medical record review of the Informed Consent for Restraint Utilization revealed three signatures | F 514 | 8/12/15 – Restraint Reduction Committee Review. Assessment completed: When in wheelchair: alarming seat belt restraint (resident does release the belt randomly and attempts to rise unassisted but due to cognition is unable to release on command or ambulate safely for more than a few steps safely). Belt is off at meals and during 1:1 encounters. Committee restraint assessment summary – current devices are the least restrictive restraint for this resident at this time due to poor safety awareness, unsteady gait and mental confusion. Family is not supportive of current restraint reduction. Resident has bed sensor in bed which alarms randomly during the night with the resident attempting to exit the bed unassisted. CNA kiosk and LN MAR documentation reviewed for completeness. Will continue weekly restraint reduction assessment for both family education and resident safety with least restrictive device(s).<br><br>**Resident #109**<br><br>8/5/15 – Restraint Reduction Committee meeting – Reviewed 8/4 fall and investigation. Resident is currently in therapy for balance strengthening. Assessment updated - Staff will observe and offer assistance when rising from meals and ensure pathway is without clutter. Care plan, CNA care plan in resident's room and CNA kiosk updated. Will continue to assess for committee review next week. Resident is restraint free.<br><br>8/12/15 – Restraint Reduction Committee meeting – Assessment updated: Ambulating without balance problems. Currently in therapy. | |

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| F 514 | Continued From page 140<br>of the responsible party and one witness signature. Further review revealed all signatures were undated and the areas on the form designated for documenting the date of signatures were left blank.<br><br>Interview with the Director of Nursing on 7/21/15 at 10:30 AM in the conference room, confirmed the documentation on the informed consent for restraints was incomplete and undated.<br><br>Medical record review revealed Resident # 63 was admitted to the facility on 4/20/09 with diagnosis including Depressive Disorder, Hypertension, Emphysema, Osteoporosis and Dementia.<br><br>Medical record review of the Restraint Assessment dated 9/5/13 revealed none of the twenty-six assessment questions were completed. Continued review of the Review Dates: 6/3/14, 7/5/14, 8/5/14, 10/1/14, 11/5/14, 12/5/14, 1/5/15, 2/3/15, 3/14/15 and 4/8/15 revealed a soft belt restraint was in use with no documentation on the assessment for the reason a restraint was required.<br><br>Medical record review of the February 2015 TAR revealed "... May be up in WC with soft posey belt. Release and reposition Q 2 hrs x 10 min. Check Q 30 min..." with no documentation on 3 PM-11 PM shift for 2/2/15.<br><br>Medical record review of the March 2015 TAR revealed "... May be up in WC with soft posey belt. Release and reposition Q 2 hrs x 10 min. Check Q 30 min..." with no documentation on 3 PM-11 PM shift for 3/8/15 and 3/14/15 and 11 PM-7 AM shift for 3/1/15 and 3/29/15. | F 514 | Family notified of need for smaller shoes to assist in safer ambulation. Will continue to follow in committee until new shoes are evaluated. Resident is restraint free.<br><br>**Resident #142**<br><br>8/12/15 – Restraint Reduction Committee review: Reported to be sleepy in the mornings and sleeping through the night. Family and DON requested psychotropic review for possible GDR during psychiatrist visit today. Will initiate toileting plan to assist with toileting. Care plan, CNA care plan in resident's room and CNA kiosk updated. Will continue for another week for assessment update and RRC review. Resident is restraint free<br><br>7/29/15 – LN documentation for restraints has been placed on the MAR. LN will document compliance with the MD Restraint on the MAR each shift. If there is a change in status to the resident, restraint, resident's response to the restraint or family concern related to the restraint the LN will document in the nursing notes and notify their supervisor. DON will be informed immediately of all changes in restraint use.<br>7/29/15 – Unit Managers / Weekend Supervisor/ designee will review restraint documentation daily to ensure it is complete. The documentation audits (restraint documentation education provided 7/26/15 and 7/27/15) are placed under the DON door daily. The DON/designee will review next work day for compliance and changes. LN will be re-educated immediately if documentation compliance is not 100%. | |

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| F 514 | Continued From page 141<br><br>Medical record review of the April 2015 TAR revealed "... May be up in WC with soft posey belt. Release and reposition Q 2 hrs x 10 min. Check Q 30 min..." with no documentation on 7 AM-3 PM shift for 4/9/15 and 4/22 /15 and 11 PM-7 AM shift for 4/11/15, 4/12/15 and 4/18/15.<br><br>Medical record review of the May 2015 TAR revealed "... May be up in WC with soft posey belt. Release and reposition Q 2 hrs x 10 min. Check Q 30 min..." with no documentation on 7 AM-3 PM shift for 5/6/15 and 5/10/15, 3 PM-11 PM shift for 5/1 and 2/15 and on 11 PM-7 AM shift for 5/2/15, 5/11/15, 5/24/15, 5/30/15 and 5/31/15.<br><br>Medical record review of the June 2015 TAR revealed "... May be up in WC with soft posey belt. Release and reposition Q 2 hrs x 10 min. Check Q 30 min..." with no documentation on 11 PM-7 AM shift for 6/6 and 7/15, 6/13/15, 6/17/15, 6/21/15 and 6/28/15.<br><br>Interview with the DON on 7/21/15 at 10:30 AM in the Conference Room, when asked what her expectation was for documentation on the treatment record, stated "I expect each box to be filled in with the nurses' initials." When shown the February, March, April, May and June 2015 TARs for the soft belt restraint and the areas without documentation, the DON stated "Those should all be filled in."<br><br>Medical record review revealed Resident #78 was admitted to the facility on 8/5/10 and readmitted on 7/9/13 with diagnoses including Manic with Recurrent Episode, Bipolar Affect, Psychosis, Anxiety, Depression, Lack of Coordination, | F 514 | 8/7/15 - QA Committee Meeting - Licensed Nurses reviewed changes in Restraint documentation location (from TAR to MAR). Discussed best practice for checking documentation prior to ending shift to ensure completeness.<br><br>**Resident #56**<br><br>8/5/15 - Restraint Reduction Committee review: Assessment reviewed: No safety concerns when in care foam lounger without harness restraint. Will discuss with family the end of reduction trial. Assessed for use of an electric low bed with upper rails and bolster pads (remove lower rails and bolsters). Recommendations will be discussed with family. Current signed consent will be updated when family is available for discussion.<br><br>8/6/15 - Phone discussion with family - verbal consent to remove lower rails and bolsters - DON signed for facility witness.<br><br>8/7/15 Family signed consent.<br><br>8/12/15 - Restraint Reduction Committee meeting review: Assessment reflects resident doing well in care foam lounger. Has sitter three times per week. Family came in today and requested lower rails and bolster pads be placed back on bed - not supportive of removal. Assessments will be reviewed with MD for family request. Consent will be revised by DON after MD talks with resident family.<br><br>**Resident #78** | |

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| F 514 | Continued From page 142<br>Malaise and Fatigue, and Altered Mental Status.<br><br>Medical record review of the Physician's Orders from 3/1/15 through 7/31/15 revealed an order for an alarming seat belt in wheelchair, check every 30 minutes and release and reposition every 2 hours for 10 minutes.<br><br>Medical record review of the Informed Consent for Restraint Utilization revealed the form was signed by the responsible party in 3 places and was also signed by a witness. Continued review revealed the areas on the form designated for the date of the signatures were blank for all 4 signatures.<br><br>Interview with the Director of Nursing on 7/21/15 at 10:30 AM in the conference room, confirmed the documentation on the informed consent for restraints was incomplete and undated.<br><br>Medical record review revealed Resident #109 was admitted to the facility on 7/23/12 with diagnoses including Dementia with Behaviors, Parkinson's Disease, Hypertension, Bi-Polar Disorder and Glaucoma.<br><br>Medical record review of a physician's order dated 5/5/15 revealed "...WC [with] soft belt when out of bed..." Continued review revealed an order dated 5/8/15 to "...D/C soft belt in WC...Torso posey positioner in W/C [check] for placement [every] 30 minute's release [and] reposition X [times] 10 min's every 2 [hours]..."<br><br>Medical record review of an Informed Consent for Restraint Utilization dated 12/21/14 revealed it was signed by the residents family member. There was no witness signature or date. | F 514 | 8/5/15 – Restraint Reduction committee review: Assessment updated. MD reviewed for possible UTI - ordered urine C&S test. Family visited today to discuss change to Broda Peddler with alarming seatbelt to provide greater independence and safety without alarming seatbelt in addition to changes in behavior. Family did not support change in seating to promote independence because family felt resident is a "meddler" and leans forward reaching for items. Family did agree for UA C&S to evaluate change in behavior. Will continue to follow for lab outcome and device application and use.<br><br>8/12/15 – Restraint Reduction Committee Review. Assessment completed with resident in wheelchair: Alarming seat belt applied according to manufacturer recommendation (resident occasionally releases the belt when fidgeting but does not attempt to rise) with dump wheelchair seat due to resident persistent reaching and bending for items out of reach. Belt is off at meal times, during 1:1 encounter and when the family visits. Family is not supportive of current restraint reduction. Attended Happy Hour this week. Resident has sensor pad when in bed. Will review next week for restraint assessment and reduction. Signed consent remains accurate.<br><br>**Resident #109**<br><br>8/5/15 – Restraint Reduction Committee meeting – Reviewed 8/4 fall and investigation. Resident is currently restraint free and in therapy for balance strengthening. Assessment updated - Staff will observe and offer assistance when rising from meals and ensure pathway is | |

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| F 514 | Continued From page 143<br><br>Medical record review of a Restraint Assessment dated 12/21/14 documented the reason for a restraint was "...gait unsteady, staggers, uncooperative [with] assisted ambulation..." Continued review revealed the following updates and comments: 5/4/15 Soft positioner in wheelchair when out of bed; and 7/8/15 Soft positioner in wheelchair when out of bed.<br><br>Review of a TAR dated 5/2015 documented an order dated 5/5/15 "...wheelchair [with] safety belt when out of bed..." Continued review revealed the facility documentated the resident was in a wheelchair with a safety belt on 5/5/15 3-11 PM shift and all 3 shifts on 3/6/15. Continued review revealed a new order dated 5/7/15 documented "...torso posey positioner in [wheelchair] check [every] 30 min & release [every] 2 [hours] [for] 10 min..." Continued review revealed the facility documented the resident was in his wheelchair with a torso posey positioner on every day on each shift with the exception of 5/24, 5/30 and 5/31/15 on the 11-7 AM shift.<br><br>Review of a TAR dated 6/2015 documented "...Torso Posey Positioner in wheelchair, check for placement every 30 minutes, release and reposition every 10 min every 2 hours..." Continued review revealed the facility documented the resident was in a torso posey positioner in the wheelchair every day on every shift with the exception of 6/30/15 on the 7-3 PM shift, 6/13/15 on 3-11 PM shift and 6/8, 6/9, 6/13, 6/21 and 6/28/15 on the 11-7 AM shift.<br><br>Review of a TAR dated 7/1-7/21/2015 documented "...Torso Posey Positioner in wheelchair, check for placement every 30 | F 514 | without clutter. Care plan, CNA care plan in resident's room and CNA kiosk updated. Will continue to assess for committee review next week.<br><br>8/12/15 – Restraint Reduction Committee meeting – Assessment updated: Ambulating without balance problems. Currently in therapy. Family notified of need for smaller shoes to assist in safer ambulation. Will continue to follow in committee until new shoes are evaluated.<br><br>**Resident #142**<br><br>8/12/15 – Restraint Reduction Committee review: Reported to be sleepy in the mornings and not sleeping through the night. Family and DON requested psychotropic review for possible GDR during psychiatrist visit today. Will initiate toileting plan to assist with toileting. Care plan, CNA care plan in resident's room and CNA kiosk updated. Will continue for another week for assessment update and RRC review. Resident is restraint free.<br><br>7/29/15 – Restraint Reduction Committee will review all residents with restraints and/or prior to a restraint order. Committee Chairman (DON) or committee designee will be responsible for communication related to the restraint, informing family of need for consent (in person or by phone) and signing the consent to complete the restraint order and prior to the application of a restraint. RRC will manage and update restraint consents as indicated by MD orders for restraints.<br><br>8/7/15 – QA Committee Meeting - Reviewed: New Restraint Policy, new Restraint Protocol, | |

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| F 514 | Continued From page 144<br>minutes, release and reposition every 10 min every 2 hours..." Continued review revealed the facility documented the resident was in a torso posey positioner in the wheelchair every day on every shift with the exception of 7/8/15 on 7-3 PM shift, and 7/18, 7/19 and 7/21/15 on 3-11 PM shift.<br><br>Interview with RN #1 on 7/16/15 at 1:50 PM in the H hall and I hall nurses station confirmed there were no updated restraint assessments completed for the resident after 12/21/14. Continued interview confirmed there was no documention prior to the 5/5/15 order to place a soft belt restraint when out of bed, or the 5/8/15 order for the torso positioner while in the WC that a less restrictive alternative was attempted prior to placing the restraint. Continued interview with the RN confirmed the documentation that the restraints had been checked every 30 minutes and released every 2 hours per the physician's order and the facility policy was inaccurate.<br><br>Interview with the DON on 7/22/15 at 3:17 PM in the conference room confirmed a new restraint consent was not obtained from the family when the order dated 5/5/15 to place Resident #109 in a soft belt was written, or when the soft torso positioner was ordered on 5/8/15. Continued interview confirmed the consent dated 12/21/14 was not witnessed or dated by the facility. Continued interview with the DON confirmed there was no medical reason documented why the resident was placed in a restraint.<br><br>Medical record review revealed Resident #142 was admitted to the facility on 11/18/14 with diagnoses including Alzheimer's, Dementia without Behaviors, Malaise and Fatigue, and | F 514 | Restraint Audits, Restraint education audit, new restraint assessment forms (Pre-evaluation and Reduction) and CNA kiosk and LN MAR documentation.<br><br>**Resident # 167**<br><br>7/25/15 – Licensed Nurse inservice conducted by DON and Staff Education LN to review MD order transcription policy and daily chart audit protocol to review MD orders for transcription accuracy.<br><br>8/4/15 – Policy dated 3/30/09, "Signing Off Physicians Orders Policy" was amended to include pharmacy responsibility for contacting the facility if two LN's have not signed new admission orders prior to fax to the pharmacy.<br><br>8/6 – 8/14/15 – 100% audit of all new admission orders from all admissions still in the building from May 2015 (10 charts) checked for medication transcription errors on admission.<br><br>8/15/15 – Policy and Procedure for Signing Off Physician's Orders revised to clarify LN and Pharmacy responsibility for ensure all new admission orders are checked and signed by two Licensed Nurses prior to being faxed to the pharmacy for dispensing medication. DON will monitor compliance through emails from the pharmacy when noncompliant orders are received and from new admission chart audits completed by the unit manager or weekend supervisor for all new admissions. | |

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| F 514 | Continued From page 145<br>Delusional Disorder.<br><br>Medical record review of a physician order dated 6/9/15 documented "...May wear a posey when in W/C due to stumbling [check] placement q 30 min/release & reposition x 10 minutes q 2 [hours]..."<br><br>Review of a Nurses Notes dated 7/15/15 at 5:30 AM documented "...Awake most of NOC [night] wandering around facility-took a 2 [hour] nap, then back up and around gait became unsteady was then assisted into W/C [with] soft belt..."<br><br>Review of a Restraint Assessment dated 11/8/14 revealed the Reason for the Restraint was left blank. A review date of 7/9/15 had no documentation present.<br><br>Medical record review for a signed restraint consent revealed no consent was present in the resident's chart.<br><br>Review of a TAR dated 6/2015 and 7/2015 revealed no documentation of restraint monitoring.<br><br>Interview with RN #1 on 7/16/15 at 1:50 PM at the H hall and I hall nurses station confirmed the restraint assessment for Resident #142 was incomplete and not up to date; there was no documentation the facility attempted a less restrictive alternative before placing the resident in a restraint; there was no signed restraint consent in the resident's chart; and there was no documentation the restraint was released every 2 hours per the physician's order and the facility policy. | F 514 | 7/23/15 – Restraint Reduction Committee: New Committee meets weekly and is a Sub-committee of the QAA Committee. DON is the Chairman. Members include: NHA, DON, MDS LN, Unit Managers, Wound Care Nurse, Central Supply, Restorative CNAs, Therapy, Social Service and Activities. The Medical Director will be an Ad Hoc member of the committee.<br><br>The Committee will review weekly every restraint and all assistive devices that could also be a restraint and a restraint assessment will be updated to direct the committee to the resident indicated and least restrictive device for resident safety. The committee will be responsible on-going selection of restraint / device, monitoring restraint/device application and use in according to manufacturer application instructions and warnings in addition to assessment for restraint reduction and management in addition to family and resident communication and ensuring signing consents are accurate, updated and signed by both the Responsible Party and the facility RCC committee member.<br><br>Each restraint review will be conducted for potential reduction, removal or validation of continued medical necessity. Charts will be brought to the meeting by the Unit Managers for CNA and LN documentation review and to update the weekly committee meeting note. Committee Chairman (DON) will record minutes during the meeting. The minutes will be submitted to the QAA Committee for benchmark, trending, oversight, review and to determine programming and staff education needs. The nursing Home Administrator (NHA) | |

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| F 514 | Continued From page 146<br>Interview with the DON on 7/22/15 at 3:17 PM in the conference room confirmed there was no medical reason documented why Resident #142 was placed in a restraint.<br><br>Review of the facility policy "Chart Policy for New Admissions" revealed "...Purpose: To ensure that Resident's chart is checked thoroughly for completion..." Further review revealed "...After Admissions Coordinator has written the admission orders, the Receiving Nurse will review those orders against the orders from the Hospital and provide a second signature. Orders will then be faxed to pharmacy...The Unit Supervisor/Designee will review the completed orders and completed records for accuracy and follow through..."<br><br>Review of the facility policy "...Signing Off Physician's Orders" dated 3/30/90, revealed "...two (2) licensed nurses sign on all orders. The first signature ensures the order is received and written on the order form correctly. The second signature ensures that the medication is on the MAR [Medication Administration Record], the order has been faxed to the pharmacy...This is to reduce the risk of medication errors..."<br><br>Review of the undated facility policy "Ordering and Receiving Medications From Provider Pharmacy," revealed the "...Policy: ...The facility maintains accurate records of medication order and receipt..." Further review revealed "...Procedure: When...faxing a medication order to the pharmacy, the following information is given: Resident's name...Complete order if a new medication or direction changes to a previous order..." | F 514 | will be responsible for QAA Committee oversight of the Restraint Reduction Committee activity. MD will review the committee minutes during weekly scheduled visits. Compliance Consultant will review weekly notes during scheduled monthly visits.<br><br>7/30/15 - Daily QA Managers Meeting (Monday – Friday). NHA will oversee and investigate concerns related to facility reports, communications and policies.<br><br>Daily QA Managers Meeting attendees include but may not be limited to: NHA, DON, MDS LN, Infection Control/Staff Education, Wound Nurse, Unit Managers, Restorative, Medical Records, Therapy, Social Service, Activities, Housekeeping, Maintenance, Business Office and Payroll.<br><br>The following items will be reviewed daily: Change in Resident Condition, Significant Change in Resident Status, 24 Hour Report Information, New MD orders, Occurrence Reports, Clinical Progress Notes and Hospital Transfers in addition to Restraints, Infection Control and On-going Investigations.<br><br>Concerns discussed in the daily meeting will be assigned to staff for follow up and the DON as indicated to complete investigations. Information and findings from the areas discussed in the daily meeting will be reviewed in the meeting weekly until resolved or on-going as indicated. Staff education will be directed by information from the daily QA meeting in addition to on-going audits, scheduled monthly staff meetings and annual skills assessments. | |

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| F 514 | Continued From page 147<br>Review of the facility policy, revised 4/2006, for "...Administering Medications..." revealed "...Any explanatory note on the reverse side of the MAR must be entered when drugs are withheld, refused, or given other than at scheduled times..."<br><br>Medical record review revealed Resident #167 was admitted to the facility on 6/27/15 with diagnoses including Acute Kidney Failure, Dementia with Behavioral Disturbances, Congestive Heart Failure, Altered Mental Status, and Diabetes Mellitus Type 2.<br><br>Medical record review of the [hospital] "Discharge Medications" revealed "...Xanax (anti-anxiety medication) 1 mg [milligram] oral three times a day as needed..."<br><br>Medical record review of the facility 6/27/15 admission physician order and the June 2015 MAR, transcribed from the hospital discharge medication, revealed "...Xanax 1 mg po [by mouth] TID [three times a day] PRN [as needed]..." Further review of the 6/27/15 facility admission orders revealed the orders the pharmacy was provided was "Xanax 1 mg po TID" (the PRN was not included) and the form was not signed by 2 facility staff, per facility policy.<br><br>Medical record review of the June 2015 MAR revealed the Xanax was administered 6/27/15 for increased crying/outburst; on 6/29/15 for anxiety, restless, can't sleep; and 6/30/15 had no documentation for the need of the medication, per facility policy.<br><br>Medical record review of the July 2015 Physician Orders revealed "...Xanax 1 mg by mouth three | F 514 | Nursing Home Administrator will notify the Clinical Consultant of issues, concerns and investigations during the monthly visit to ensure a timely and comprehensive investigation with action plan is completed. Clinical Consultant will review daily, weekly and monthly QA and scheduled QA Committee and Sub Committee meeting minutes to ensure timely and comprehensive action plans are implemented, monitored and evaluated. Clinical Consultant will be on-site at least monthly and submit a written report to the QAA Committee for review and action as indicated. Medical Director will review consultant report monthly for timely response and needed intervention as indicated.<br><br>8/7/15 – Monthly QA Committee Meeting - NHA or designee will summarize the daily Managers meetings for trends and education needs to be discussed in the Monthly QA meeting. Trend summaries and on-going or unresolved facility issues are discussed for resolution in the Monthly QA Committee Meeting. The QA Committee will meet 2 times per month for the first month (August – September) and then monthly thereafter.<br><br>Monthly QA Meeting attendees include but may not be limited to: NHA, DON, Department Managers, Wound Nurse, Infection Control Nurse and Staff Educator. The NHA will be the Chairman of the committee and responsible to ensure information is communicated between the QA Committee and the QAA Committee.<br><br>8/1/15 - The QAA Committee will meet quarterly. Items from the Monthly QA Committee Agenda will be reviewed by the full | |

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| F 514 | Continued From page 148<br>times a day..." was signed by two facility nurses on 7/1/15 and signed by the physician on 7/2/15.<br><br>Medical record review of the Physician Telephone Orders revealed the following:<br><br>On 7/2/15 at "...11:45...Xanax 0.5 mg P.O. [by mouth] TID..."<br><br>On 7/2/15 "...D/C [discontinue] Xanax PRN TID..." Further review revealed the PRN was crossed out and "error" was written beside it.<br><br>On 7/7/15 "...D/C Xanax 0.5 mg TID per family request..."<br><br>Medical record review of the Skilled Nurses Notes revealed the following:<br><br>On 7/2/15 at "...[2:45 PM]...D/C Xanax PRN..."<br><br>On 7/7/15 "...8:00 AM...Orders received for D/C Xanax 0.5 mg TID per family request. Xanax D/C from MAR..."<br><br>Medical record review of the July 2015 MAR, provided to the facility by the pharmacy, revealed the following:<br><br>1. "Xanax 1 mg give one tablet by mouth three times a day." Further review revealed next to the "three times a day" was handwritten "PRN." Further review revealed initials, indicating medication administration, on 7/1/15 and 7/2/15. Further review revealed no explanation for the administration on the MAR per facility policy. Further review revealed handwritten in was "order changed 070215." | F 514 | QAA Committee to ensure policy compliance, clinical best practice and staff education is monitored, implemented and evaluated on-going. The Clinical Consultant will review the QA and QAA Committee minutes during monthly visits to ensure compliance. Compliance issues or concerns will be discussed with the NHA for follow-up and resolution.<br><br>QAA Committee members include but may not be limited to: Medical Director, Nursing Home Administrator, DON, Department Managers (Social Service, Activity, Therapy, Nursing, Housekeeping, Maintenance), in addition to the wound Care Nurse, Staff Education Nurse, Infection Control Nurse and staff nurses and CNAs as available. | |

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| F 514 | Continued From page 149<br>2. Handwritten in was "Xanax 0.5 mg 1 p.o. TID" followed by "D/C 070215." Further review revealed no administration of the medication.<br><br>3. Handwritten in was "Xanax 0.5 mg 1 p.o. TID [administration times]...Morning...PC [after] lunch...bedtime...HS [Hour of Sleep]..." Further review revealed initials, indicating medication administration, on 7/3/15 morning; 7/4 and 7/5/15 morning, after lunch, HS; 7/6/15 the morning was circled indicating no administration, medication administration after lunch and HS; and 7/7/15 morning..." Further review documented "D/C 070715." Further review revealed no documentation on the back of the MAR, per facility policy, to explain why the 7/6/15 morning dose was not administered.<br><br>Interview with Licensed Practical Nurse (LPN) #2 on 7/16/15 at 1:11 PM in the conference room confirmed the facility sent the pharmacy the admission orders dated 6/27/15 with Xanax 1 mg p.o. TID with no PRN included in the order. Further interview confirmed the facility failed to follow the policy to have 2 nurses sign the pharmacy form prior to sending the form to the pharmacy. Further interview stated the 7/2/15 order for Xanax 0.5 mg po TID followed by the D/C Xanax TID order should have been clarified since the pharmacy had two TID orders [Xanax 1 mg po TID and Xanax 0.5 mg po TID]. Further interview confirmed the facility had made a transcription error upon admission, provided the pharmacy the wrong Xanax order, and failed to clarify the PRN admission order and the DC order.<br><br>Interview with LPN #2 and Registered Nurse (RN) #2 on 7/16/15 at 1:30 PM in the payroll office | F 514 | | |

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| F 514 | Continued From page 150<br>confirmed RN #2 had been the admitting nurse on 6/17/15. Further interview stated the DON was acting as the Admission Coordinator and had written the admission orders due to the admission was scheduled for Saturday. Further interview stated RN #2 compared the hospital orders with the pre-written facility orders and corrected the Xanax order by adding the "PRN." Further interview stated RN #2 was not aware why the pharmacy copy did not match the corrected copy and lacked the 2 nurse's signatures, per facility policy. Further interview stated the Unit Manager was the 3rd set of eyes to look at the hospital medication orders, facility admission orders and the MAR for accuracy and that the pharmacy page would have been removed at the time of the review. Further interview confirmed the facility failed to clarify the orders with pharmacy regarding the PRN status.<br><br>Interview with the DON on 7/21/15 at 8:00 AM in the conference room confirmed the facility failed to document the need for the Xanax administered 6/30/15, per facility policy, and would expect staff to document the need and effectiveness on the back of the MAR.<br><br>Interview with LPN #4 and the DON on 7/21/15 at 9:08 AM in the payroll office when asked which Xanax TID was D/C on 7/2/15, LPN #4 stated, "...I wrote D/C Xanax 1 mg TID PRN. I was not aware of the 0.5 mg TID order. I was reviewing the admission physician orders with Xanax 1 mg po TID PRN...I don't know who crossed out the PRN on the telephone order..."<br><br>Interview with LPN #4 and #5, and the DON, on 7/21/15 at 9:15 AM in the payroll office revealed LPN #5 had "...crossed out the PRN on the 7/2/15 | F 514 | | |

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| F 514 | Continued From page 151<br>order for DC Xanax PRN TID after reviewing the July 2015 Physician Orders and saw the order was Xanax 1 mg po TID..." Further interview with LPN #5 stated the LPN was not aware of the telephone order dated 7/2/15 at 11:45 AM for Xanax 0.5 mg TID.<br><br>Telephone interview with Pharmacy Technician #1, LPN #4 and #5, and the DON, on 7/21/15 at 9:18 AM in the payroll office when asked how the pharmacy determined which TID order to D/C on 7/2/15 the Pharmacy Technician stated, "...according to the computer the only Xanax order on record was 1 mg TID..." Further interview at 9:45 AM, with all the same people in the payroll office, revealed the 7/2/15 order for Xanax 0.5 mg TID was faxed from the facility to the pharmacy at 1:10 PM, was received by the pharmacy at 2:01 PM, and processed in the computer at 4:46 PM. Further interview stated the 7/2/15 order to D/C the Xanax PRN TID (the PRN crossed out with "error" written) was faxed from the facility to the pharmacy at 2:53 PM, received by the pharmacy at 3:45 PM, and processed in the computer at 5:04 PM. Further interview with Pharmacy Technician #1 stated she was referring us to the pharmacist that processed the orders.<br><br>Interview with RN #2 on 7/21/15 at 9:30 AM in the courtyard confirmed she verified the admission orders, sent the copy to pharmacy, then reviewed the orders again and noted the PRN error and wrote PRN on the physician copy and the MAR. Further interview stated "...what I should have done was to contact the pharmacy to clarify the 1 mg TID PRN order..." Continued interview with RN #2 confirmed the facility had administered Xanax 1 mg TID in July 2015 but failed to document the reason for administering the | F 514 | | |

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| F 514 | Continued From page 152<br>Xanax 1 mg TID in July 2015 but failed to document the reason for administering the medication on the MAR per facility policy.<br><br>Telephone interview with Pharmacist #1, Administrator, DON, LPN #4 and #5, on 7/21/15 at 10:15 AM in the payroll office, Pharmacist #1 stated she had processed the 7/2/15 telephone orders. Further interview stated "...In my professional opinion it was logical to D/C the Xanax 1 mg TID since it appeared there was a dose reduction to Xanax 0.5 mg TID..." When asked repeatedly of the two TID orders and the D/C order without specifying the dosage why the pharmacy would not call the facility to get clarification the Pharmacist repeated the same statement "...In my professional opinion it was logical to D/C the Xanax 1 mg TID since it appeared there was a dose reduction to Xanax 0.5 mg TID..." When asked if the pharmacy had a policy, procedure, protocol to address questionable orders the Pharmacist said they did but would refer the question to the pharmacy management.<br><br>Telephone interview with Pharmacist #2, Administrator, DON, LPN #4 and #5, on 7/21/15 at 12:45 PM in the payroll office, stated she had been in contact with the pharmacy management. Further interview stated "...processed orders would not show up in the history until the next day..." Further interview stated "...It was standard policy to D/C previous order..." Further interview stated "...due to this finding the pharmacy would review their policy and procedures..." | F 514 | | |
| F 520 SS=K | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS | F 520 | Facility will maintain a QAA Committee (DON, MD plus 3 other staff) to meet at least quarterly to identify issues requiring QAA activities and | |

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| F 520 | Continued From page 153<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy review, reference review of "Lippincott Manual of Nursing Practice," for restraint guidelines, medical record review, observation and interview, it was determined that the facility failed to ensure the Quality Assessment and Assurance Committee identified and put into place corrective action to ensure the facility restraint policy was followed, failed to ensure physician's orders were provided correctly, followed and monitored, failed to ensure staff was educated and knowledgeable in proper | F 520 | develop and implement appropriate Plans of Action to correct identified quality deficiencies<br><br>All residents have the potential to be effected.<br><br>7/23/15 – Restraint Reduction Committee: New Committee meets weekly. DON is the Chairman. Members include: NHA, DON, MDS LN, Unit Managers, Wound Care Nurse, Central Supply, Restorative CNAs, Therapy, Social Service and Activities. The Medical Director will be an Ad Hoc member of the committee. The Committee will review weekly every restraint and all assistive devices that could also be a restraint. The review will be conducted for potential reduction, removal or validation of continued medical necessity.<br><br>**Resident #160**<br><br>7/31/15 – Resident has a seatbelt restraint with sensor pad when in the wheelchair applied according to manufacturer's application instructions without attempts for unsupervised transfer. Will be placed in bed for rest with resident's favorite stuffed animal when exhibits signs of fatigue and irritation. Care plan was reviewed by the Restraint Reduction Committee and updated by the MDS LN to reflect resident current restraint and assistive devices. Education LN reviewed the CNA resident information and Electronic Health Record (EHR) documentation kiosk to ensure the current care plan is updated for review and documentation by the CNA. RCC and Unit Managers review the LN MAR documentation to ensure it accurately reflected the most recent assessment and care plan. RCC will continue weekly assessment, | |

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| F 520 | Continued From page 154<br>application and use of restraints, failed to ensure the resident care plans were updated to reflect the current use of restraints for 1 (Resident #160), failed to ensure the consent for restraints were obtained, restraint assessments/reassessments were completed to ensure the need for restraints, the appropriateness of the restraint, the least restrictive restraint, and restraint reduction for 12 ( Resident #160, 29, 56, 63, 73, 78, 94, 109, 111, 117, 142, 158) of 13 residents reviewed for restraints resulting in an Immediate Jeopardy to Resident #160; failed to ensure the safety and maintenance of equipment which resulted in Harm to Resident #10; failed to provide oversight of the infection control program which resulted in recurrent scabies infestation for 3 (Resident 81, 76, 158) of 7 residents reviewed for scabies.<br><br>The failure of the facility to assess and reassess the need for restraints, determine the least restrictive restraint, follow the restraint manufacturer's application instructions and warnings, apply the restraint per the manufacturer's instructions, and monitor the resident while in the restraint placed Resident #160 in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident).<br><br>The Administrator was informed of the Immediate Jeopardy on 7/21/15 at 2:40 PM in the conference room.<br><br>The Immediate Jeopardy was effective 5/4/15 through 7/30/15. | F 520 | review and care plan update procedures during the weekly Restraint Reduction Committee meeting.<br><br>8/5/15 – Restraint Reduction Committee review: Orthopedic appointment for 8/21/15 is to evaluate weight bearing status and initiate therapy services. Assessment updated. Care plan reviewed without changes. Resident has made no attempts to get up from seat. Does still fidget with seatbelt. Sensor pad in wheelchair has not sounded since application – no attempts to rise from chair.<br><br>8/12/15 – Restraint Reduction Committee meeting review: Assessment reviewed – resident appears a good candidate for restraint reduction. Resident is up in wheelchair daily with seatbelt and sensor pad-has made no attempts to get up from seat; staff has observed resident leaning forward with feet on wheelchair pedals – no attempts to self-propel. Continue rest periods daily after lunch. When in wheelchair, resident has a seat belt (can release but due to cognition is unable to release on command) with non-skid seat material and sensor pad. The seat belt is removed during meals and 1:1 encounter. When in bed the resident has a perimeter mattress with sensor pad to alert staff to unassisted/ unsafe transfer. Continues with limited weight bearing and remains at risk for falls. Although restraint reduction could be recommended based on assessment, the committee recommends continue restraint due to s/p fracture, committee will continue current orders until orthopedic appointment on 8/21/15. Care plan reviewed during committee meeting by the MDS | |

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| F 520 | Continued From page 155<br>A Full Extended Survey was conducted on 7/21-29/15.<br><br>An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received on 7/29/15 at 9:00 AM, and the corrective actions were validated by the surveyors on 7/29/15.<br><br>The findings included:<br><br>Review of the facility's "Restraints-Physical" policy updated 2/4/14 revealed "...Restraints will only be used in extreme circumstances and only with: 1. Documented behavior. 2. Consent from resident's representative 3. Physician and DON or designee. 4. All other non-restrictive alternatives have been tried and were unsuccessful (MD [Medical Doctor] orders must be written)... 5. Physical restraint shall not be used to limit the resident's mobility for the convenience if the staff...Written policies and procedures governing the use of restraints specify which staff member may authorize the use of restraints and clearly delineate the following: (a) Orders indicate the specific reason, type and period of time for the use of restraints. Restraints must be used only as a last resort, and the medical record must indicate the events leading up to the necessity of the restraint. (b) Their use is temporary, and the resident will not be restrained for an indefinite amount of time...The attending physician must be notified of such use and the reason for the order. Consent for Restraint must be discussed with the responsible party...(e) Reorders are issued only after a review of the resident ' s condition by his or her physician...10. The need for restraints will be evaluated at least quarterly in the Falls Committee Meeting to determine their continued | F 520 | LN to ensure it accurately reflects current restraint and device(s) interventions.<br><br>8/21/15 - Resident has appointment with orthopedic surgeon. Anticipate resident will be released for weight bearing and Therapy services. Following Therapy evaluation the current restraint will be re-evaluated by the Restraint Reduction Committee for possible reduction and encouragement for increase ambulation.<br><br>**Resident #29**<br><br>7/31/15 – Seating in Broda chair with non-skid seating – no restraint. Chair is slightly reclined for comfort except at meals. Continues sensor pad in bed. Will continue weekly Restraint Reduction Committee review.<br><br>8/5/15 – Morning QA Managers Meeting – observed on numerous occasions by 3-11 staff to be sitting toward front of the seat but no attempt to rise. Non-skid seating in place – continue to monitor.<br><br>8/5/15 – Restraint Reduction Committee review: Reassess current positioning - Staff report resident is more anxious in the afternoon. Committee will recommend an afternoon nap in bed after lunch to attempt to relax resident. Care plan updated for documentation. Assessment will continue for safe positioning without restraints.<br><br>8/10/15 – Morning Managers Meeting – discussed related to resident preferred positioning at the front of the chair – observed at front of seat x 1 in previous 24 hours. No attempt to rise, chair assessed by Committee to | |

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| F 520 | Continued From page 156<br>use of a restraint has been reevaluated and that reorder from the physician is so noted..."<br><br>Review of Lippincott Manual of Nursing Practice, 2014, Tenth Edition, Chapter 9 revealed "[page] 191...These [restraint] guidelines must be met in any long-term care facility that participates in Medicare or Medicaid. However, these guidelines are useful for health care providers working with older adults in all settings. (a) The resident has the right to be free from any physical restraints imposed...for purposes of discipline or convenience and not required to treat the resident's medical condition. (b) Physical restraints are any manual method of physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the person cannot remove easily, which restricts freedom of movement or access to one's body (includes leg and arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, and geriatric chairs). (c) There must be a trial of less restrictive measures unless the physical restraint is necessary to provide life-saving treatment. (d) The resident of legal representative must consent to the use of restraints. (e) Residents who are restrained should be released, exercised, toileted, and checked for skin redness every 2 hours. (f) The need for restraints should be reevaluated periodically. (g) The specific facility will have to develop policies and procedures for the appropriate use of restraints... (h) Primary health care providers will have to write appropriate orders for restraints..."<br><br>Interview with the Administrator on 7/22/15 at 3:53 PM in the conference room revealed the Director of Nurses (DON) was the chair of the Quality Assessment and Assurance (QAA) | F 520 | continue to be the most appropriate seating for resident comfort. Family visited and ambulated with resident – safety maintained during visit.<br><br>8/12/15 – Restraint Reduction Committee review – resident was agitated x 1 (requiring medication intervention with positive results) since previous Committee review. Afternoon rest periods appear to decrease afternoon/evening anxiety. Confusion has increased this week. Not oriented to time or place – will incorporate additional afternoon activity time before or after nap. Activities notified. Care plan reviewed. Assessment updated to reflect current resident status and interventions.<br><br>8/18/15 - Care plan updated. MAR updated for LN documentation. Assessment will continue for safe positioning without restraints.<br><br>**Resident #56**<br><br>7/31/15 – In care foam lounger for comfort – no restraint, incident or attempts to move unsafely out the chair. Will continue to be reviewed in the weekly Restraint Reduction Committee.<br><br>8/5/15 – Restraint Reduction Committee review: Assessment reviewed: No safety concerns when in care foam lounger without harness restraint. Will discuss with family the end of reduction trial. Assessed for use of an electric low bed with upper rails and bolster pads (remove lower rails and bolsters). Recommendations will be discussed with family.<br><br>8/6/15 – DON met with family by phone related to RRC recommendations. Family agreed to | |

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| F 520 | Continued From page 157<br>committee. Continued interview stated he was an attendee of the QAA meetings which were held more often than quarterly. When asked if the scabies infestation had been addressed in the QAA meetings, he replied it had been. When asked if restraints had been discussed in the QAA meeting, he responded it had, but not at every meeting; " we knew it triggered on the QM [Quality Measure] maybe 2 months ago...10-12 people, we had started an eval [evaluation]... [Medical Director] felt UTI's [urinary tract infections] and dehydration needed to be looked at...that took priority..." When asked if he was aware the facility had residents who'd had the same restraint for two years or more who had not been reassessed for continued restraint use and there had been no attempt at restraint reduction, he replied he was not aware.<br><br>Interview with the DON on 5/24/15 at 12:51 PM in the private dining room on J Hall, confirmed she was the chair of the QAA committee. When asked what issues were routinely discussed in the QAA meeting, she responded, "...UTI's, MDS [Minimum Data Set], pressure ulcers, infection control..." When asked if the committee discussed triggers on the QMs, she responded, "Yes, even [Medical Director] brought up hydration and we had a report that would pull up anyone who had not had at least 1000 cc [cubic centimeters]..." and the facility was now monitoring all residents hydration. When asked if restraints had been discussed in the committee, she replied, "Yes, it was brought up on the last QAA meeting...how we compared nationally...I don't remember the last time residents with restraints was brought to the meetings...I had discussed with restorative nursing that we needed to have a meeting to discuss restraints...I | F 520 | continued care foam lounger without harness restraint. Agreed to removal of lower rails and bolster pads but continue upper rails and bolster pads. Discussed electric low bed – family agreed with the bed and continue the perimeter mattress. Consent updated by staff and signed, assessments completed to decrease restraints and change bed devices. Care plan updated, CNA care plan in resident's room and CNA kiosk in addition to LN MAR documentation updated.<br><br>8/10/15 – Daily QA Managers Meeting – review: no issues from restraint reduction in care foam lounger or removal of lower rails and bolsters.<br><br>8/11/15 – Daily QA Managers Meeting – review: no issues in chair or bed.<br><br>8/12/15 – Restraint Reduction Committee meeting review: Assessment reflects resident doing well in care foam lounger. Has sitter three times per week. Family came in today and requested lower rails and bolster pads be placed back on bed – not supportive of removal. Assessments will be reviewed with MD for family request.<br><br>**Resident #63**<br><br>7/29/15 – Resident with Soft Posey belt restraint in wheelchair per manufacturer's recommendations with belt off at meal times. When restless the Merry Walker is offered with 1:1 assistance per policy. Family does not support this level of restraint reduction. Will continue weekly restraint assessment and Restraint Reduction Committee review. | |

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| F 520 | Continued From page 158<br>actually had planned a meeting about 2 weeks before you came...something happened and we didn't have the meeting..." When asked how long she had been aware of the restraints being a QAA issue, she replied, "...[former Assistant Director of Nurses] was pretty good about things and keeping it up...it wasn't until she left that I realized there was a problem...she did not bring restraints to the meeting..."<br><br>The facility has failed to develop a QAA program and a Quality Assurance Performance Improvement (QAPI) to address the use of restraints.<br><br>Refer to F221-K<br><br>The facility has failed to develop a QAA program and a QAPI system to address Resident Assessment.<br><br>Refer to F272-K<br><br>The facility has failed to develop a QAA program and a QAPI system to address Care Plan Revision.<br><br>Refer to F280-J<br><br>The facility has failed to develop a QAA program and a QAPI system to address Accident Hazards.<br><br>Refer to F323-G<br><br>The facility has failed to develop a QAA program and a QAPI system to address Infection Control.<br><br>Refer to F441-D | F 520 | 8/5/15 – Morning QA Managers Meeting review: Order for restraint timed for update – refer to RRC today.<br><br>8/5/15 – Restraint Reduction Committee review: Staff report resident can apply seatbelt and take it off at will – however response when prompted in inconsistent due to confusion- restraint assessment updated. Weakness has been noted when ambulating with Merry Walker – therapy screened resident for Part B therapy services for strengthening – awaiting family response to request. Psychotropic medication reduction initiated last week with goal of decreased anxiousness and nervousness and improved cognition.<br><br>8/10/15 – Morning QA Managers Meeting review: intermittent anxiousness – improved with 1:1 Activity while in Merry Walker.<br><br>8/11/15 – Morning QA Managers Meeting review: Awake until early morning. Anxious in bed, Merry Walker and after snack. Asleep at 0100.<br><br>8/12/15 – Restraint Reduction Committee Review. Assessment completed: When in wheelchair: alarming seat belt restraint (resident does release the belt randomly and attempts to rise unassisted but due to cognition is unable to release on command or ambulate safely for more than a few steps safely). Belt is off at meals and during 1:1 encounters. Committee restraint assessment summary – current devices are the least restrictive restraint for this resident at this time due to poor safety awareness, unsteady gait and mental confusion. | |

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| F 520 | Continued From page 159<br>The survey team identified systemic failures on the part of the Administration to ensure the residents were evaluated for the need of restraints; failed to determine the least restrictive restraint; failed to obtain consent for the restraint; failed to ensure the restraint was properly applied, and failed to monitor the resident in the restraint, to ensure the resident's safety for 12 (Resident #160, 29, 56, 63, 73, 78, 94, 109, 111, 117, 142, 158) of 13 residents reviewed with restraints. During survey the team identified concerns in the areas of F221, F272, F280, F323, F490, and F501. The facility has failed to develop a QAA program and a QAPI system to address Administration<br><br>Refer to F221-K, F272-K, F280-J, F323-G, F441-E, F490-K, F501-K<br><br>The survey team identified failures on the part of the facility to ensure the Medical Director assisted with addressing clinical concerns and provided guidance regarding care of the residents with restraints residing in the facility and regarding infection control concerns, specifically a scabies infestation. The facility has failed to develop a QAA program and a QAPI program to address the responsibilities of the Medical Director.<br><br>Refer to F221-K, F272-K, F280-J, F441-E<br><br>The interventions put in place were evaluated by the survey team on 7/29/15, and verified the Allegation of Compliance by:<br><br>1. The facility re-assessed the 13 residents with restraints for appropriateness and for the least restrictive device. | F 520 | Family is not supportive of current restraint reduction. Resident has bed sensor in bed which alarms randomly during the night with the resident attempting to exit the bed unassisted. Will continue weekly restraint reduction assessment for both family education and resident safety with least restrictive device(s).<br><br>8/14/15 – Initiated B&B Program. Restraint Reduction Committee conducted assessment of bowel habits with recommendation to initiate trial bowel toileting "catch" or toileting assistance program in an effort to assist with unsafe ambulation due to frequent bowel toileting needs secondary to medical diagnosis and toileting habit changes.<br><br>**Resident #73**<br><br>7/29/15 – In wheelchair with seat belt restraint. Belt is released during meals and 1:1 visits. Remains non-verbal with limited facial expressions. Family is supportive of reduction. There have been no attempts for the resident to stand unassisted. Will continue weekly Restraint Reduction Committee Review.<br><br>8/5/15 – Restraint Reduction Committee meeting – reviewed and updated restraint assessment. Currently in restraint 2-3 hours per day. Continue to take rest periods with her husband everyday 1-5 pm and belt off during meals and 1:1 encounter. Will continue review next week for goal of restraint reduction in the mornings.<br><br>8/6/15 – Morning QA Managers Meeting – review: Doing well with current restraint reduction. DON met with family who is | |

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | supportive of removing the seat belt as long as safety is maintained. Consent updated. Restraint assessment updated for removal for morning hours. Care plan, CNA care plan in resident's room, CNA kiosk and LN documentation updated to reflect removal of belt restraint. Will refer to RRC for post removal safety assessment.<br>8/10/15 – Morning QA Manager's Meeting – review: Staff reports resident occasionally sits leaning slightly forward – no concerns related to safety. Will pass information to RRC.<br><br>8/11/15 – Morning QA Managers Meeting – review. Observed removing the table cloth from the dining tables. Staff state resident is cold natured so a sweater will be offered when resident leaves their room. Care plan, CNA care plan in resident's room and CNA kiosk updated to reflect resident preference.<br><br>8/12/15 – Restraint Reduction Committee meeting review: Assessment updated - no restraint at this time – no observations of resident trying to get up from seat unassisted since restraint removed. Leans forward on table when in dayroom. Takes rest periods every afternoon with husband at bedside. Extended family expressed concern with resident positioning and restraint removal – DON will discuss concerns. Will update assessment during committee meeting next week to review resident safety without restraint.<br><br>**Resident #78**<br><br>7/31/15 – Assessed for Velcro alarming seatbelt restraint in wheelchair to be off at meal time and during family and 1:1 visits. Continue weekly | |

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | Restraint Reduction Committee review to ensure seatbelt is applied according to manufacturer recommendation and is the least restrictive device indicated based on assessment.<br><br>8/5/15 – Morning QA Managers Meeting – review: Request RRC to review for possible Broda Peddler seating and remove the alarming seat belt.<br><br>8/5/15 – Restraint Reduction committee review: Assessment updated. MD reviewed for possible UTI - ordered urine C&S test. Family visited today to discuss change to Broda Peddler with alarming seatbelt to provide greater independence and safety without alarming seatbelt in addition to changes in behavior.<br><br>Family did not support change in seating to promote independence because family felt resident is a "meddler" and leans forward reaching for items. Family did agree for UA C&S to evaluate change in behavior. Will continue to follow for lab outcome and device application and use.<br><br>8/7/15 – Morning QA Managers Meeting – review: Resident has been more active but quieter lately. Up in wheelchair with Velcro belt. Will unbuckle randomly but not when prompted.<br><br>8/10/15 – Morning QA Managers Meeting – review: No attempts to rise from seat during random opportunities when unbuckles the seat belt. Started on antibiotic for UTI.<br><br>8/11/15 – Morning QA Managers Meeting – review: Continue on antibiotic for UTI. No safety issues in wheelchair. | |

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| F 501 | Continued From page 137<br>care management, food temperatures, resident accounts. I'm not sure who determines what subjects are brought up or discussed." The Medical Director was asked if he had been notified about any issues regarding restraints. The Medical Director stated "No, not a particular issue." Continued interview revealed, when asked to describe the process of addressing and identified concerns, the Medical Director stated "We look at the policy first to see what we are committed to do in writing. If it is committed to paper, then that is what we are doing." The Medical Director was then provided a copy of the current physical restraint policy to read. The Medical Director stated "We haven't been writing the orders like this states." When asked if there had been any concerns or issues brought up in QA meetings but not addressed, the Medical Director responded "My concern is what's not being brought up. I wasn't aware of that issue, that there should be an assessment for restraints." Further interview of the Medical Director revealed "The rash we've had had been a frustrating issue. Sent them (the residents involved) and had deep tissue scraping. An employee got treated, their doctor cleared them but the family didn't get treated." | F 501 | 8/12/15 – Restraint Reduction Committee Review. Assessment completed with resident in wheelchair: Alarming seat belt applied according to manufacturer recommendation (resident occasionally releases the belt when fidgeting but does not attempt to rise) with dump wheelchair seat due to resident persistent reaching and bending for items out of reach. Belt is off at meal times, during 1:1 encounter and when the family visits. Family is not supportive of current restraint reduction. Attended Happy Hour this week. Resident has sensor pad when in bed. Will review next week for restraint assessment and reduction.<br><br>**Resident #94**<br><br>7/31/15 - Resident has abdominal binder to protect the integrity of the PEG tube – no restraint. Resident remains without right hand mitten restraint. Assessments and care plans support the current restraint free status. Will continue weekly review by the Restraint Reduction Committee to follow safety of PEG tube.<br><br>8/5/15 – Morning QA Managers Meeting – resident has made no attempt to remove PEG tube.<br><br>8/5/15 – Restraint Reduction Committee review: Assessment completed. Activity reports resident made attempts to hit strings on guitar today during 1:1 session – a notable improved response to surroundings and staff encounter.<br><br>8/10/15 – Morning QA Managers Meeting - staff reports abdominal binder is effective in protection and positioning of the PEG tube. | |



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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | 8/12/15 – Restraint Reduction Committee review: Assessment updated. Activity reports resident again responded to the guitar and appears to be listening to and enjoying music in the room. Activity recommends resident be out of the bed more since appears to be calmer with surroundings and external stimulation. Care plan updated for out of bed activity. Activity staff will continue to assess resident for response to various stimulation activities. Will continue to review during weekly RRC for four weeks to monitor tube and follow weekly improved interactions to surroundings.<br><br>8/17/15 MAR updated to document time spent out of bed.<br><br>**Resident #109**<br><br>7/31/15 – Exhibiting increased independence in ambulation, continues to carry cane when ambulating and is assisted with stand by assist ambulation or a chair when exhibiting unsteady gait – No restraint. Remains at risk for falls due to episodic unsteady gait. Appears happier and engaged in friendly conversation with staff and other residents. Will continue to be reviewed weekly by the Restraint Reduction Committee following restraint reduction.<br><br>8/4/15 – Fell in the dining room during lunch – Investigation and fall assessment updated – resident was attempting to rise, reach for health shake and pivot and lost balance. Footwear appropriate, area uncluttered, staff present – no injury. Ambulates with a safe gait otherwise. Will refer to Restraint Reduction Committee for review. | |

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | 8/5/15 – Restraint Reduction Committee meeting – Reviewed 8/4 fall and investigation. Resident is currently in therapy for balance strengthening. Assessment updated - Staff will observe and offer assistance when rising from meals and ensure pathway is without clutter. Care plan, CNA care plan in resident's room and CNA kiosk updated. Will continue to assess for committee review next week.<br><br>8/10/15 – Morning QA Managers Meeting – review. Ambulating ad lib in facility without balance issues.<br><br>8/12/15 – Restraint Reduction Committee meeting – Assessment updated: Ambulating without balance problems. Currently in therapy. Family notified of need for smaller shoes to assist in safer ambulation. Will continue to follow in committee until new shoes are evaluated.<br><br>**Resident #111**<br><br>7/31/15 – Continues in self-mobile wheel chair with non-skid seating material on a "dumped" (tilted) seat with a pull alarm to alert staff of unassisted transfer attempts – No Restraint. Additionally the wheelchair is fitted with anti-tippers due to resident persistence in pushing wheel chair backwards instead of forward. Bed room is modified with the head of the bed facility the doorway to provide a clutter-free walkway for the wheelchair. No change in cognition or participation in surroundings. Will continue in weekly review by the Restraint Reduction Committee. | |

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | 8/5/15 – Morning QA Managers Meeting – review: observed sitting in chair without observed safety concerns.<br>8/5/15 – Restraint Reduction Committee Meeting – Assessment updated - Continues in self-mobile wheel chair with non-skid seating material on a "dumped" (tilted) seat with a pull alarm to alert staff of unassisted transfer attempts. Additionally the wheelchair is fitted with anti-tippers due to resident persistence in pushing wheel chair backwards instead of forward. No reported attempts to stand without assistance. Care-giver states resident does not appear to need pull alarm in wheelchair – will continue and reassess next week.<br><br>8/6/15 Pull alarm in wheelchair discontinued.<br><br>8/10/15 – Morning Managers Meeting review – continues to position well without restraint.<br><br>8/12/15 – Restraint Reduction Committee meeting – Assessment updated. Husband has been visiting more this review week. Continue to position well in chair – family feels comfortable with current status.<br><br>**Resident #117**<br><br>7/31/15 – Has Torso Posey Positioner (yellow/Large) Restraint while in wheelchair with positioner removed from 7a-3p. There have been no incidents of unsafe transferring. Appears happy when self-propelling in the wheelchair and attending activities without the Torso positioner. Assessment indicates resident tends to lean in the wheelchair when fatigued in the evening requiring positioner for torso support. Family supportive of reduction. Will | |

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | continue weekly assessment and review by the Restraint Reduction Committee.<br><br>8/5/15 – Morning QA Managers Meeting – review: Doing well with current seating – upper torso balance in wheelchair. Staff report resident's balance in the evening continues to improve. No concerns when in bed.<br><br>8/5/15 – Restraint Reduction Committee meeting review: Updated assessment indicates improved upper body strength throughout the day. Unit Manager met with family – recommending Torso Posey be discontinued. Consent signed, assessment completed by committee. Care plan, LN documentation, CNA care plan in resident's room and CNA kiosk updated to reflect restraint free status.<br><br>8/10/15 – Morning QA Managers Meeting – review: Observed in wheelchair without balance issues.<br><br>8/12/15 – Restraint Reduction Committee meeting review: No Restraint - No leaning noted when seated in wheelchair, no attempts to exit bed. Appears happy and engaged in activities – singing and listening to music, watching TV and laughing with residents. Recommend sensor pad in bed to discontinue. Floor mats will continue when in bed. Will assess and review next week in RRC to ensure appropriate position during morning and evening hours.<br><br>8/13/15 Sensor pad alarm in bed discontinued. | |



161 F

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | **Resident #142**<br><br>7/31/15 – Ambulates at will daily with on-going monitoring for unsteady gait and needed additional assistance. No Restraint. Naps in common areas and utilizes a wheelchair occasionally when tired. Has not had a fall but remains at risk for falls. Continues on weekly review by the Restraint Reduction Committee.<br><br>8/5/15 – Morning QA Managers Meeting – review: Ambulating in the hall and room ad lib. Observed ambulation without shoes x 1 – easily redirected for appropriate footwear for ambulation.<br><br>8/10/15 – Morning QA Managers Meeting – review: Ambulating ad lib in hall with shoes.<br><br>8/12/15 – Restraint Reduction Committee review: Reported to be sleepy in the mornings and not sleeping through the night. Family and DON requested psychotropic review for possible GDR during psychiatrist visit today. Will initiate toileting plan to assist with toileting. Care plan, CNA care plan in resident's room and CNA kiosk updated. Will continue for another week for assessment update and RRC review.<br><br>**Resident #158**<br><br>7/31/15 – Self mobile in wheelchair with pull alarm to alert staff to unassisted transfer and anti-tippers to assist resident from pushing wheelchair backwards. Resident appears more cheerful, pleasant and has not attempted to rise from chair unassisted. Bolster to ½ side rails in bed – diagnosis of seizures and modified room to decrease clutter with sensor pad alarm in bed, non-skid socks and floor mats when in bed. Will | |



161 G

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | continue weekly review by the Restraint Reduction Committee.<br><br>8/3/15 – QA Morning Manager Meeting review – new exit seeking behavior – intervention – outside activities will be scheduled and offered when he becomes combative with staff, is restless or exit seeking – care plans (Master and CNA) updated by MDS LN to include 1:1 activity in the Butterfly Garden.<br><br>8/5/15 – Restraint Reduction Committee Review: Due to exit seeking behavior and increased independence – Wander Guard bracelet applied to remind resident and staff to return to the Courtyard or Butterfly Garden for outside activity. Less agitation noticed. Will continue to observe.<br><br>8/10/15 - Morning QA Managers Meeting – No agitation or combative behavior. Daily outdoor activity available and encouraged; Wander Guard applied.<br><br>8/12/15 – Restraint Reduction Committee Meeting – Enjoys being outside; some agitation on 3 11-easily redirected; laughing more lately, decrease aggression on 7-3, moves easily about facility at will. Increased restlessness observed when needs toileting. Based on observation and staff interview a toileting plan was initiated. Care plan updated, CNA care plan and EHR (electronic health record) kiosk updated for assessment and documentation.<br><br>7/30/15 – 8/18/15 – Unit Managers and MDS LN completed 100% device / alarm audit. RRC evaluated each device to determine if it was a | |



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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | positioning device that could be a restraint for the individual resident. Assessments were completed to ensure device(s) were used according to manufacturer application instructions and warnings and as indicated to determine baseline for device reductions as indicated by resident activity, behavior, cognition and safety needs. MDS LN reviewed 100% resident Care plans and revised as indicated to reflect residents' current devices. Medical Director notified of results for discussion related to facility benchmark and current trends. Findings will be forwarded to QA Committee for establish action plan to achieve facility goals. DON will be responsible for communication action plan between RCC, QA and QAA committee in addition to documentation of the action plan, implementation and evaluation for full QAA review. Audit tool will be updated as MD orders impact the devices. MDS LN will review the audit tool during the RAI schedule for each resident and will conduct a comprehensive QA audit at least annually for full QAA Committee review to determine use trend and compliance with RAI assessment and care planning requirements in addition to facility goals.<br><br>8/7/15 – QA Committee Meeting - Reviewed: New Restraint Policy, new Restraint Protocol, Restraint Audits, Restraint education audit, new restraint assessment forms (Pre-evaluation and Reduction)<br><br>7/23/15 – Restraint Reduction Committee: New Committee meets weekly and is a Sub-committee of the QAA Committee. DON is the Chairman. Members include: NHA, DON, MDS | |

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161 K

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161L

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16/M

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161N

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | when they were on the same hall of the unit. Also noted the residents on this unit had drier skin collectively than residents on other units. Additionally it was documented that most rashes subsided when residents were transferred to another unit within the facility. Of further consideration - the treatment for scabies and subsequent daily baths causes dry skin and often rashes in individuals with sensitive skin. As a result of the comprehensive audit and investigation the Infection Control Policy and Procedure for Scabies was revised in the following areas:<br><br>1) Diagnosis will be confirmed with a skin scraping by the PCP or dermatologist will be consulted as indicated,<br><br>2) Resident will initially be treated environmentally (isolation, room disinfected, clothing laundered and personal items bagged),<br><br>3) Daily skin lotion baths (in addition to peri-care) instead of showers will be given for skin hydration for 5 days prior to initiation of scabies treatment (hydrocortisone cream will not be used),<br><br>4) Additionally the policy was updated with a preference for oral medication treatment rather than topical medication due to the frail and sensitive skin of the elderly population.<br><br>7/30/15 – Daily QA Managers Meeting (Monday – Friday). NHA will oversee and investigate concerns related to facility reports, communications and policies. | |



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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | Daily QA Managers Meeting attendees include but may not be limited to: NHA, DON, MDS LN, Infection Control/Staff Education, Wound Nurse, Unit Managers, Restorative, Medical Records, Therapy, Social Service, Activities, Housekeeping, Maintenance, Accounts Payable, Business Office and Payroll.<br><br>The following items will be reviewed daily: Change in Resident Condition, Significant Change in Resident Status, 24 Hour Report Information, New MD orders, Occurrence Reports, Clinical Progress Notes and Hospital Transfers in addition to Restraints, Infection Control and On-going Investigations. Care plan updates will be discussed in the meeting for updates and accuracy.<br><br>Concerns discussed in the daily meeting will be assigned to staff for follow up and the DON as indicated to complete investigations. Information and findings from the areas discussed in the daily meeting will be reviewed in the meeting weekly until resolved or on-going as indicated. Staff education will be directed by information from the daily QA meeting in addition to on-going audits, scheduled monthly staff meetings and annual skills assessments.<br><br>Nursing Home Administrator will notify the Clinical Consultant of issues, concerns, QA audits and investigations during the monthly visit to ensure a timely and comprehensive investigation with action plan is completed.<br><br>Clinical Consultant will review daily, weekly and monthly QA and scheduled QA Committee and Sub Committee meeting minutes to ensure timely and comprehensive action plans are | |



161P

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | implemented, monitored and evaluated. Clinical Consultant will be on-site at least monthly and submit a written report to the QAA Committee for review and action as indicated. Areas of on-going non-compliance with be reviewed with the NHA. Medical Director will review consultant report monthly for timely response and needed intervention as indicated – areas of concern will be addressed with NHA for resolution.<br><br>8/7/15 – Monthly QA Committee Meeting - NHA or designee will summarize the daily Managers meetings for trends and education needs to be discussed in the Monthly QA meeting. Trend summaries and on-going or unresolved facility issues are discussed for resolution in the Monthly QA Committee Meeting. The QA Committee will meet 2 times per month for the first month (August – September) and then monthly thereafter.<br><br>Monthly QA Meeting attendees include but may not be limited to: NHA, DON, Department Managers, Wound Nurse, and Infection Control Nurse<br><br>**Resident #160**<br><br>7/31/15 – Resident has a seatbelt restraint with sensor pad when in the wheelchair applied according to manufacturer's application instructions without attempts for unsupervised transfer. Will be placed in bed for rest with resident's favorite stuffed animal when exhibits signs of fatigue and irritation. Care plan was reviewed by the Restraint Reduction Committee and updated by the MDS LN to reflect resident current restraint and assistive devices. Education LN reviewed the CNA resident | |



1610

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | information and Electronic Health Record (EHR) documentation kiosk to ensure the current care plan is updated for review and documentation by the CNA. RCC and Unit Managers review the LN MAR documentation to ensure it accurately reflected the most recent assessment and care plan. RCC will continue weekly assessment, review and care plan update procedures during the weekly Restraint Reduction Committee meeting.<br><br>8/5/15 – Restraint Reduction Committee review: Orthopedic appointment for 8/21/15 is to evaluate weight bearing status and initiate therapy services. Assessment updated. Care plan reviewed without changes. Resident has made no attempts to get up from seat. Does still fidget with seatbelt. Sensor pad in wheelchair has not sounded since application – no attempts to rise from chair.<br><br>8/12/15 – Restraint Reduction Committee meeting review: Assessment reviewed – resident appears a good candidate for restraint reduction. Resident is up in wheelchair daily with seatbelt and sensor pad-has made no attempts to get up from seat; staff has observed resident leaning forward with feet on wheelchair pedals – no attempts to self-propel. Continue rest periods daily after lunch. When in wheelchair, resident has a seat belt (can release but due to cognition is unable to release on command) with non-skid seat material and sensor pad. The seat belt is removed during meals and 1:1 encounter. When in bed the resident has a perimeter mattress with sensor pad to alert staff to unassisted/ unsafe transfer. Continues with limited weight bearing and | |



161R

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | remains at risk for falls. Although restraint reduction could be recommended based on assessment, the committee recommends continue restraint due to s/p fracture, committee will continue current orders until orthopedic appointment on 8/21/15. Care plan reviewed during committee meeting by the MDS LN to ensure it accurately reflects current restraint and device(s) interventions.<br><br>8/21/15 - Resident has appointment with orthopedic surgeon. Anticipate resident will be released for weight bearing and Therapy services. Following Therapy evaluation the current restraint will be re-evaluated by the Restraint Reduction Committee for possible reduction and encouragement for increase ambulation.<br><br>---<br><br>**#2• The independent contractor conducted training for all staff on the importance of preventing serious injuries and deaths from asphyxiation, suffocation, bed-rail entrapments and falls. Training was provided to facility personnel shall review the all types of restraints, including but not limited to, full bed rails, other types of bed rails used, trunk restraints, limb restraints, and chairs that may prevent rising. Training included manufacturer's instructions for all restraints in use at the facility; and included information on resident rights.** *The dates of training are provided in Independent Contractor's DPOC Final Report.*<br><br>• 2.1 Training was provided for all **active classifications** of Community Care of Rutherford County (CCRC) staff, agency personnel (none since before 2005) and | |



161S

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | contract service providers (therapy) on the importance of preventing serious injuries and deaths from asphyxiation, suffocation, bed-rail entrapments and falls. Training curriculum was customized to align with those items in use/in stock at CCRC.<br>o Responsible Party(ies): Vickie W. Harris, Independent Contractor<br>o Completion Date: September 15, 2015<br>• 2.2 Training was provided for all **active classifications** of licensed and/or certified CCRC staff, agency personnel (none since before 2005), contract service providers (therapy), social workers/designees and activity personnel on the types of restraints in use by CCRC at present, in stock and/or on the premises. The training included, at a minimum, a review of the manufacturer's instructions for use and where to source instructions for future reference.<br>o Responsible Party(ies): Vickie W. Harris, Independent Contractor<br>o Completion Date: September 15, 2015<br>• 2.3 Training was provided for **all active classifications** of CCRC staff, agency personnel (none since before 2005) and contract staff (therapy) on resident rights.<br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>o Completion Date: September 15, 2015 | |



161T

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | **#3• The independent contractor ensured that staff was given education and training on restraint alternatives, including but not limited to, therapeutic interventions, environmental and equipment interventions, and the role of restorative programs.** *The dates of training are provided in Independent Contractor's DPOC Final Report.*<br><br>• 3.1 Education and training was provided for all **active classifications** of CCRC staff, agency personnel (none since before 2005) and contract service providers (therapy) on restraint alternatives available and used by the organization.<br><br>o Responsible Party(ies): Vickie W. Harris, IC<br><br>o Completion Date: September 15, 2015<br><br>**#4• The independent contractor evaluated the systems and processes established by the facility and governing body to minimize the use of restraints. The independent contractor determined to what extent the nursing home seeks to involve, educate and train residents and family members on alternatives to restraints. The independent contractor validated via observation, record review and interview that restraints on all shifts if used are only to facilitate or support the resident's medical treatment, and not used to discipline residents, as staff convenience, or to prevent residents from wandering.** *The dates of evaluation, assessment, & validation of facility's & governing body's systems & processes are provided in Independent Contractor's DPOC Final Report.* | |



161U

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | • 4.1 A facility assessment was completed to review all processes and systems related to restraint minimization. The assessment will include, but not be limited to:<br>o Leadership, staff and contractor interviews<br>o Policies and procedures<br>▪ Scope<br>▪ Execution<br>• New admits<br>• Current residents<br>o New orders<br>o Change orders<br>o Continuing orders<br>• Emergencies<br>o Training Curriculum – Restraints and resident rights<br>▪ Scope and content<br>▪ Stakeholders {includes employed staff, agency (none since before 2005), contractors (therapy), families and volunteers}<br>▪ Frequency<br>• CCRC Staff<br>o Onboarding | |



161 V

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | o Interim (as needed)<br>o Continuing (annual)<br>• Residents and Families<br>• Volunteers<br>▪ Staff returning from extended leave<br>▪ Agency and Contract Service Provider Staff<br>▪ Methods/Platforms<br>▪ Knowledge and/or competency verification<br>• Who does it?<br>• Documentation<br>• Follow-up<br>o Documentation<br>o Communication and Ongoing Involvement<br>▪ Staff<br>▪ Residents<br>▪ Family<br>Information collected in the above outlined baseline assessment was used to identify gaps and weaknesses, inform relevant opportunities for improvement and establish recommendations/specific actions to the facility Administrator and governing board. | |



16/W

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | ○ Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>○ Completion Date: September 15, 2015<br>• 4.2 As part of the overall assessment (4.1) the involvement, education and training of residents and their families on alternatives to restraints was completed.<br>○ Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>○ Completion Date: September 15, 2015<br>• 4.3 Resident restraint use was validated on all shifts to insure utilization is to facilitate or support medical treatment and that none are in use for discipline, staff convenience or to prevent wandering. Validation was by way of observation, record review and interviews throughout the course of the Independent Consultant's engagement.<br>○ Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>○ Completion Date: September 15, 2015<br><br>**#5• The independent contractor determined what procedures are in place to assess the competency of staff who apply restraints; the frequency of observing and assessing the resident who is restrained; and how staff interact with the resident and attend to the resident's needs while he or she is** | |



161 X

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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | **restrained.** *The Independent Contractor's DPOC Final Report contains her findings and assessment of facility limited restraint use.*<br><br>• 5.1 As part of the overall facility assessment related to restraint minimization (4.1), the facility's procedures related to assessing staff competency in the application of restraints was evaluated.<br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>o Completion Date: September 15, 2015<br><br>• 5.2 CCRC licensed and/or certified staff was evaluated as to the frequency of observation and assessment of residents who are restrained. This evaluation was completed in conjunction with 4.3.<br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>o Completion Date: September 15, 2015<br><br>• 5.3. All classifications of CCRC staff, agency personnel (none since before 2005) and contract service providers (therapy) was evaluated as to how they interact with residents and attend to their needs while restrained. This was completed in conjunction with 4.3.<br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br>o Completion Date: September 15, 2015 | |



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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | **#6• The independent contractor is submitting to CMS and the State a copy of all training materials, and a written report summarizing the aforementioned components of the directed plan of correction, and how the administrator and governing body will ensure ongoing compliance with 42 CFR 483.13.**<br><br>• 6.1 At the completion of the Independent Consultant's role on September 15, 2015, a report is submitted to CMS and the State summarizing the above outlined directed plan of correction, its execution, findings and recommendations, and how the Administrator and governing body will ensure ongoing compliance with 42 CFR 483.13. The report will include copies of all training materials and any other relevant documents.<br><br>o Responsible Party(ies): Vickie W. Harris, Independent Consultant<br><br>o Completion Date: September 18, 2015<br><br>7/30/15 – 8/18/15 – Unit Managers and MDS LN completed 100% device / alarm audit. RRC evaluated each device to determine if it was a positioning device that could be a restraint for the individual resident. Assessments were completed to ensure device(s) were used according to manufacturer application instructions and warnings and as indicated to determine baseline for device reductions as indicated by resident activity, behavior, cognition and safety needs. MDS LN reviewed 100% resident Care plans and revised as indicated to reflect residents' current devices. | |



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| F 520 | Continued From page 160<br>2. Interviews with 20 nursing staff members selected from all units in the facility from the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. These interviews included verbal explanation of who was responsible to assess and re-assess the need for a restraint, how to assess and reassess the resident need for restraint, how to order a restraint, how to monitor a resident while in a restraint, the requirements for documentation of residents utilizing restraints, how and who was to revise the care plan for changes in restraint orders, and how to apply the restraint.<br><br>3. Interview with the Administrator and Director of Nurses outlined the governing body's plan for on-going supervision and follow-up with the facility which would be conducted in response to the Immediate Jeopardy, by which means communication was to occur; how frequently over-site was provided; and for what duration follow-up would be performed on-site.<br><br>Non-compliance continues at a "E" level for evaluation of the monitoring by the Quality Assurance Committee. The facility is required to submit a Plan of Correction. | F 520 | Medical Director notified of results for discussion related to facility benchmark and current trends. Findings will be forwarded to QA Committee for establish action plan to achieve facility goals. DON will be responsible for communication action plan between RCC, QA and QAA committee in addition to documentation of the action plan, implementation and evaluation for full QAA review. Audit tool will be updated as MD orders impact the devices. MDS LN will review the audit tool during the RAI schedule for each resident and will conduct a comprehensive QA audit at least annually for full QAA Committee review to determine use trend and compliance with RAI assessment and care planning requirements in addition to facility goals.<br><br>8/7/15 – QA Committee Meeting - Reviewed: New Restraint Policy, new Restraint Protocol, Restraint Audits, Restraint education audit, new restraint assessment forms (Pre-evaluation and Reduction)<br><br>7/23/15 – Restraint Reduction Committee: New Committee meets weekly and is a Sub-committee of the QAA Committee. DON is the Chairman. Members include: NHA, DON, MDS LN, Unit Managers, Wound Care Nurse, Central Supply, Restorative CNAs, Therapy, Social Service and Activities. The Medical Director will be an Ad Hoc member of the committee. The Committee will review weekly every restraint and all assistive devices that could also be a restraint and a restraint assessment will be updated to direct the committee to the restraint indicated and least restrictive device for resident safety. MDS LN will be responsible for reviewing | |



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

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