Hawaii Dept. of Health, Office of Hea Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125024	A. BUILDING: _____ B. WING _____	03/24/2017

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NUUANU HALE	2900 PALI HIGHWAY HONOLULU, HI 96817

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4 102	11-94.1-22(d) Medical record system (d) Records to be maintained and updated, as necessary, for the duration of each resident's stay shall also include: (1) Appropriate authorizations and consents for medical procedures; (2) Records of all periods, with physician orders, of use of physical or chemical restraints with justification and authorization for each and documentation of ongoing assessment of resident during use of restraints; (3) Copies of initial and periodic examinations and evaluations, as well as progress notes at appropriate intervals; (4) Regular review of an overall plan of care setting forth goals to be accomplished through individually designed activities, therapies, and treatments, and indicating which professional services or individual is responsible for providing the care or service; (5) Entries describing all care, treatments, medications, tests, immunizations, and all ancillary services provided; and (6) All physician's, physician assistant's, or APRN's orders completed with appropriate documentation (signature, title, and date). This Statute is not met as evidenced by: Based on observation, record review and interview the facility failed to maintain complete and accurate clinical documentation for 2 of 24 residents (Resident # 44 and Resident #36) in the Stage 2 sample.	4 102	**No resident harm occurred as a result of this practice.** **Corrective Actions Taken:** **DOH: 4 – 102** **Beginning in early March, the IDT began a review of Care Plans for all residents. The IDT has had ongoing Care Plan meetings at which care is reviewed and revised as indicated, and has involved residents as applicable, and resident representatives when they would attend.** **The Care Plan for Resident # 36 was reviewed and revised to address the skin assessment and documentation of the coccyx site was reviewed and corrected to reflect site condition.** **The Care Plan for Resident # 44 was reviewed and revised to address the neck wound and documentation regarding site care was entered.** **Corrective action was taken with the staff involved with the documentation of the skin assessment. As well, shift-to-shift education for all nursing staff regarding complete and valid documentation was provided.** **Identification of Other Residents Affected:** **The review of residents' individual Care Plans is a dynamic process completed by the IDT. Those residents with episodic Care Plan goals have been identified and the residents with long-term goals**	3/28/17

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/25/17

c: FP, w/attch, by KAB (K)

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4 102	Continued From page 1 Findings include: 2) On 3/22/2017 at 12:45 PM, Staff # 12 stated she was going to change Resident # 36's briefs. Observation noted the resident had a dressing on the resident's mid-coccyx area, which Staff # 3 said the nurse was going to change later. The staff said it was only on for protection and the resident no longer had an open area to there resident's buttocks. On 3/23/2017 at 8:45 AM, Staff # 2 said she just changed the foam dressing yesterday. She said, "it's for protection only" and would be changing it later. At 8:48 AM, during a concurrent record review with Staff # 1, they reviewed the physician orders and said, "Yeah, no more" for any type of dressing order to Resident #36's coccyx region. A review of the Body Audit form for 3/1/17 showed "old scab" and another note dated 3/4/17 stated "reddened." Yet, on 3/23/17 of the audit form, the comment by a licensed staff said, "None" for the 11-7 shift. However, at 8:57 AM, surveyor and Staff # 1 saw the resident's dressing was still intact and staff said it was a bordered foam dressing. The dressing had "3/22 protection only" handwritten on it. Staff # 1 was asked if the night shift nurse assessed and saw this because the documentation was "None" on the body audit form for that shift. When Staff # 1 was further queried, Staff # 1 nodded and agreed that it appeared the night shift nurse did not assess the resident and thus, the clinical documentation was inaccurate. There also was no order for the "protection only" dressing the staff used for the resident's coccyx area, which Staff # 1 confirmed was not obtained.	4 102	**involving care changes have also been identified.** **<u>Monitoring Systems to Ensure Deficient Practice Does Not Occur:</u>** **The facility continues to hold previously established regularly scheduled meetings, designed to address various aspects of care planning, medical record review for completion and validity, and revision as indicated of individual resident's care associated with specific care needs. These regular meetings: Behavior / Psychotropic medication evaluation, Care Planning review with resident and/or family, Skin and Infection assessment, and Weight management are all continuing on a weekly basis. These meetings will be facilitated by the D.O.N. going forward, until the review and revision process is firmly established into regular nursing practice. Nursing staff gather information from these topic-specific meetings, to use as indicated when revising individual resident's Care Plans and making an assessment of documented care provided for each resident.** **Care Plan education for all nursing staff is scheduled for early May 2017. The MDS Coordinator, Consultant, and D.O.N. will discuss a new Care Plan format, and coach the staff on identifying and documenting care challenges to be documented using the revised format. Skills development for Episodic Care Planning will also be provided during**	5/15/17

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4 102	Continued From page 2 2). On 03/22/17, Resident # 44 was observed to have gauze dressing with tape over it on the right side of her neck. During the medical record review of Resident # 44, no documentation could be found in record to state why resident had gauze dressing on the side of her neck. There was no care plan as to how to care for what was under the gauze dressing. Interview with Staff # 1 on 03/23/17, confirmed there was no documentation or care plan in place for care of the wound under the gauze dressing on Resident # 44. Staff # 1 was able to state that it was an access site used by QMC ER department to place a temporary pacemaker, and that the dressing remained intake as the resident's skin was fragile and they did not want to tear Resident # 44's skin by removing tape. Staff # 1 looked through the medical record of Resident # 44 and was unable to find any documentation or care plan for the care of this issue for Resident # 44. The facility failed to maintain a complete and accurate clinical record for Resident # 44 following an acute episode that required Resident # 44 to be sent to QMC ER department.	4 102	these educational sessions in May. Licensed staff meetings held April 2017 contained education regarding resident care planning and problem-identification using the "SBAR" format. The D.O.N. will provide further education for the nursing staff on medical record documentation: such as the documenting of care for Resident # 44 with the neck dressing wound care, using the SBAR format also in May. This education will provide the nursing staff with a framework from which they can assess the resident's care needs, unusual or unplanned situations arising, or care challenges they identify, and compose an approach to planning, executing, documenting, and reporting the care the individual resident receives. <u>System Changes and Monitoring Systems to Ensure Deficient Practice Does Not Occur:</u>	
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence,	4 115	As has been the practice in the recent past, facility leadership must remain actively involved in managing resident care. Going forward, the regularly scheduled care review meetings will be facilitated by the D.O.N. therefore giving leadership direct access to care planning review and revision. The Morning Meeting called by the Administrator, will provide a constant awareness of resident care challenges for the complete IDT so they may institute revisions for individual resident care	

F.102 as indicated, discuss challenges and provide input for the nursing team to establish care goals. The continuation of the regularly scheduled meetings will provide ongoing review of documented care provided to assess for completion and validity. The facility QAPI program will have a standing agenda item related to Care Plan review added to the meeting, to monitor the efficiency of the regularly scheduled care meetings.

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4 115	Continued From page 3 self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observation and staff interview the facility failed to ensure privacy while providing personal care for 1 of 22 residents (Resident # 50) in the Stage 2 resident sample. Findings include: On 03/24/2017 at 9:21 AM observed Staff # 12 blow drying Resident # 50's hair in front of the hallway TV just outside the resident's room. Queried Staff # 12 if the facility had a beauty shop area, and they stated "I wish." Inquired why the resident wasn't being groomed in their room and Staff # 12 stated that the resident didn't want to bother the other residents that shared the room. Inquired whether the practice of blow-drying residents hair in the hallway didn't disturb the acitivities of other residents sitting in the hallway. The Staff # 12 then stated that they would bring Resident # 50 to their room to finish blow-drying the resident's hair. The facility failed to provide personal privacy for R#50 during activities of personal hygiene and grooming.	4 115	**No resident harm occurred as a result of this practice.** **Corrective Actions Taken:** **DOH: 4 – 115** **The facility's Activities Department staff provide personnel for haircut / grooming for residents. These staff have been informed of the concern for privacy associated with the practice of providing personal care in public hallways, and the procedure and practice has been changed, such that private resident care will be planned and provided for residents in areas of the facility that can provide the resident with complete privacy.** **Identification of Other Residents Affected:** **The provision of hair grooming is provided to all residents who request this. The Activities staff will provide the same level of privacy for all residents.** **Monitoring Systems to Ensure Deficient Practice Does Not Occur:**	3/25/17
4 123	11-94.1-27(12) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or	4 123	**The Activities Director will ensure, through planning and monitoring, that the staff will provide personal care of this type, within the individual unit shower rooms.** **A schedule for hair grooming has been established so that the CNA staff working on the different units, will know of hair grooming planned in**	

4.115 that unit shower room, so as to eliminate the likelihood of personal care being planned for more than one resident at the same time

System Changes and Monitoring Systems to Ensure Deficient Practice Does Not Occur:

The establishment of a personal grooming schedule – haircutting, will allow both the CNA staff and the Activities staff the ability to plan use of the shower room, in which to provide privacy for all resident care. The personal grooming schedule will be monitored and maintained by the Activities Director, or designee, through collaboration with the Charge Nurse, who is aware of overall care needs of the residents.

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4 123	Continued From page 4 representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (12)The right to be fully informed in advance about care and treatment and of any changes in that care and treatment and the right to participate in planning care and treatment, unless adjudged incompetent or incapacitated; This Statute is not met as evidenced by: Based on record review and interview with staff members, the facility failed to revise care plans for 3 (Residents #47, #3 and R#48) of 17 sampled residents of the 21 residents included in the Stage 2 review. Findings include: 1) Resident #47 was admitted to the facility on 1/3/17 with diagnoses of acute hypoxic respiratory failure, generalized weakness, pneumonia, metastic breast cancer, major depression and urinary tract infection. Record review done on 3/23/17 at 10:00 AM found the "Body Audit Form" which documents on 1/14/17 Resident # 47 was found to have an "open area" to the right buttock. An interview and review of the audit form was done with Staff Member # 7. The staff member reported they were the staff member that documented the open area. The staff member further reported when there is a concern, the staff member will bring it to the attention of the licensed nurse. Further review found a physician's order dated 1/14/17 to "Cleanse/irrigate right buttock with normal saline. Apply skin sealant to skin. Apply Bacitracin to wound TID till healed." The	4 123	**No resident harm occurred as a result of this practice.** **Corrective Actions Taken:** **DOH: 4 – 123** **Beginning in early March, with the assistance of the MDS Consultant and the IDT, the team began a review of Care Plans for all residents, starting with those residents who would need MDS assessment data entered that month. The IDT has had ongoing Care Plan meetings at which care is reviewed and revised as indicated, and has involved residents as applicable, and resident representatives when they would attend. This will continue as a process to monitor long-term goals and episodic changes required in individual residents' care needs.** **The Care Plan and care for Resident # 3 was reviewed and revised to address the Mirtazapine medication being given.** **The documentation surrounding the skin condition of Resident # 47 was reviewed. Corrective action was taken with the staff involved, as well as shift-to-shift education for all nursing staff regarding effective and valid documentation.** **The D.O.N. met with the daughter of Resident # 48 to discuss the "suspected burn" and the facility Administrator met with the daughter some days later to further explain the medical condition and situation surrounding the "shingles"**	3/30/17

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4 123	Continued From page 5 diagnosis was excoriation. Further review found a care plan was developed for potential for skin breakdown related to generalized weakness (deconditioning) and unintentional weight loss. The care plan was not revised to include the treatment and further prevention of the excoriation to the right buttock. The progress note dated 1/14/17 at 2.40 PM documents the excoriation to the right buttock, 0.3 x 0.4 cm, the physician was notified and an order was made. An interview was conducted with Staff Member # 1 on 3/27/17 at 12:38 PM. The staff member confirmed a care plan was not developed to address Resident # 47's excoriation. The staff member reported the treatment for the excoriation could be added on to the existing care plan. Resident # 47's care plan was not revised to address treatment and further prevention of skin breakdown related to the excoriation to the right buttock. 2) Resident # 3 was admitted to the facility on 10/7/16 with diagnoses of sepsis secondary to left foot gangrene; diabetes mellitus, type II; peripheral arterial disease; CAD with prior CABG in 2012; left foot wound open; and diabetic neuropathy. Record review on 3/21/17 at 12:15 PM found a physician's order for mirtazapine (antidepressant) 7.5 mg., take one tab by mouth at bedtime with a diagnosis of anorexia. Further record review was done on 3/22/17 and 3/23/17 which found no documentation of a care plan for the use of mirtazapine. On the afternoon of 3/23/17 an interview and concurrent record review was done with Staff Member # 1. The	4 123	**diagnosis. At that meeting, the daughter stated "I am only going to trust what my Mom says because all my life I have listened to her and she says they burn her". Another meeting was held between the Resident # 48 daughter and the facility Administrator several days later, at which time the daughter expressed belief and understanding of the diagnosis and surrounding situation. The Care Plan for Resident # 48 had changed, the medications that were given had altered the condition, and the family members were not "infected" as was their initial concern.** **<u>Identification of Other Residents Affected:</u>** **The review of residents' individual Care Plans is a dynamic process completed by the IDT. Those residents with episodic Care Plan goals have been identified and the residents with long-term goals involving care changes have also been identified.** **<u>Monitoring Systems to Ensure Deficient Practice Does Not Occur:</u>** **The facility continues to hold previously established regularly scheduled meetings, designed to address various aspects of care planning, medical record review, and MDS accuracy and data. This input allows for the review and revision, as indicated, of individual resident's**	4/20/17

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4 123	Continued From page 6 staff member confirmed the facility did not develop a care plan for the use of mirtazapine as an appetite stimulant. The staff member acknowledged a care plan is indicated for the use of mirtazapine and stated a care plan will be developed. Resident # 3's care plan was not revised to include the use of mirtazapine as an appetite stimulant. 3) On 03/22/2017 at 1:03:13 PM, medical record review for Resident # 48 documented in the social services notes dated 01/10/2017. that the resident's daughter was upset that Resident # 48 had told them that they had been burnt by hot water when showered by staff on 01/05/2017 (Thurs) when the daughter visited the resident on Sunday. The daughter felt that nursing failed to inform the daughter of the resident burnt, and that nothing had been done for several days. Apparently, therapy staff reported "blisters" to nursing on 01/06/17 (Fri) and the daughter was upset that this had not reported to her. The Physician progress notes dated 01/06/2017 for Resident # 48 documented, "New chest rash," and the review of systems noted, "small water blisters."The physician assessment and plan included, "dermatitis". Ordered steroids..." On 01/10/2017 (Monday), Staff # 11 assessed Resident # 48's blisters and noted that the blisters were spreading over the resident's left shoulder. The blisters appeared similar to shingles, although no diagnosis was confirmed. Staff # 11 stated that the resident may have thought that they were burnt when showering, as when the water touched the blister it must of stung.	4 123	**care associated with specific care needs. These meetings: Behavior / Psychotropic medication evaluation, Care Planning review with resident and/or family representative, Skin and Infection assessment, and Weight management are all continuing on a weekly basis. These meetings will be facilitated by the D.O.N. going forward, until the review and revision process is firmly established in regular nursing practice. Nursing staff gather information from these topic-specific meetings, to use as indicated when revising individual resident's Care Plans.** **Care Plan education for all nursing staff is scheduled for early May 2017. The MDS Coordinator, Consultant, and D.O.N. will discuss a new Care Plan format, coach the staff on identifying and documenting care challenges which will be documented using the revised format. Skills development for Episodic Care Planning will also be provided during these educational sessions in May. Licensed staff meetings held April 2017 contained education regarding resident care planning and problem-identification using the "SBAR" format. The D.O.N. will provide further education for the nursing staff on medical record documentation using the SBAR format also in May. This education will provide the nursing staff with a framework from which they can look at the resident's care needs, unusual or unplanned situations arising, and care**	5/15/17 5/15/17

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4 123	Continued From page 7 The physician was alerted and the physician progress notes on 01/10/17 documented, "Chest lesions now with blistering." The review of systems included, "Central chest with more vesicles." The assessment and plan noted, "shingles". Ordered Valtrex. Neuropathy. gabapentin..." The physician progress note dated 02/21/17 documented, "Shingles resolved." On 03/22/2017 at 1:35 PM interviewed Staff # 1 and they stated that Resident # 48 never complains of pain. Queried Staff # 1 about partially lifted scab on resident's chest that could potentially be pulled off by bed sheet or clothing. According to Staff # 1 the scab area is where shingles started and went up towards the resident's neck area. There were no special treatment provided to the scab area as the shingles have resolved and only that area with dry scab left. The resident's care plan "#3 At risk for alteration in skin breakdown ...risk for friction and shear w/contributory diagnosis of CVA and Diabetes."The care plan goals were that resident will have no skin breakdown and will remain intact through next review. The care plan interventions included. "Provide good skin care, inspect daily during care, CNA to report if any concerns, showers every other day, use lotion to moisturize skin." On 03/22/2017 at 2:09 PM Staff # 1 approached surveyor and stated that they went to cover Resident # 48's scab with a band-aid so that it doesn't get caught in residents clothing or bed sheets. The resident's care plan "#3 At Risk for Alteration in Skin Breakdown," was not revised to include	4 123	**challenges they identify, and compose an approach to planning, executing, documenting, and reporting the care the individual resident needs or received. The facility Policy and Procedure for *Resident Change in Condition* was rewritten in January 2017, and education provided to all licensed staff, highlighting the obligation of the facility to notify family or representative of all significant changes in the resident's condition. The facility uses a brief version of the Care Plan that is held in the Medical record, which is referred to the "mini-care plan". This document was previously kept within a closed closet in the resident's room, and each resident had a "mini-care plan" for the nursing staff to refer to. Maintenance of the information on this document was previously the responsibility of the unlicensed and licensed staff. Currently this document is moved into a centrally located binder, held at the Nursing Station, onto which the licensed staff enter care changes and provide feedback to the unlicensed staff regarding those changes. Also within that binder now are ADL worksheets and skin assessment documents, so that the licensed staff are aware of current care needs and changes, and documentation surrounding care of each resident. This centrally located binder provides direct access to the residents' care needs for all nursing staff.**	3/25/17 4/30/17

4-123 System Changes and Monitoring Systems to Ensure Deficient Practice Does Not Occur:

As has been the practice in the recent past, facility leadership must remain actively involved in managing resident care. Going forward, the regularly scheduled care review meetings will be facilitated by the D.O.N. therefore giving leadership direct access to care planning review and revision. The Morning Meeting called by the Administrator, will provide a constant awareness of resident care challenges for the complete IDT so they may institute revisions for individual resident care as indicated, discuss challenges and provide input for the nursing team to establish care goals. The facility QAPI program will have a standing agenda item related to Care Plan review added to the meeting, to monitor the efficiency of the regularly scheduled care meetings.

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4 136	Continued From page 9 observed laying in bed watching a Japanese television station. The resident had both bilateral 3/4 metal side rails up. The resident had a care plan for risk for falls which noted the resident has a visual deficit, cognitive impairment, impaired functional limitation and her last fall occurred on 11/18/16. One of the interventions included having the bilateral 3/4 side rails up. A 10/31/16, a Physical Device Evaluation form noted the use of the two 3/4 metal side rails was started 5/25/16, and that the resident had cognitive deficit/dementia and a history of falls. The functional capacity for use of the side rail was that it facilitated turning from side to side and prevented the resident from rolling out of bed (history of falls from rolling out of bed). Of note, the January 2017 quarterly MDS assessment was not done and thus, Section P for Physical Restraint use had not been assessed since November 2016. Further, there was no documentation that a thorough assessment was done to rule out the potential risk for entrapment with the use of the long 3/4 length metal side rails for this cognitively impaired resident. On 3/23/2017 at 9:30 AM, Staff # 2 said the use of the resident's 3/4 metal side rails "is for positioning and safety." The staff said the resident "can hold onto rails especially when she watch TV. No, they cannot get out of bed, but one time they could. They gets restless too." Staff # 2 then said, "I don't think we have," when queried whether there was a risk assessment done for potential entrapment with the use of these types of metal rails. On 3/23/2017 at 9:35 AM, Staff # 1 confirmed for Resident # 32, who is cognitively impaired, they did not do a risk assessment for the potential for entrapment. Staff # 1 said, "Yeah, the space	4 136	**Monitoring Systems to Ensure Deficient Practice Does Not Occur:** **Many months ago, the facility realized the importance of using an appropriate bed-style, to ensure resident comfort, safety, and mobility. Within the next week, the facility will provide a new bed for every resident in the facility, to provide each resident with up-to-date compliant equipment. There will be a 100% replacement of the facility beds.** **The facility has also hired a MDS-certified Consultant on a full-time basis, who will work with our MDS Coordinator to build on her knowledge base, skills, and work to ensure our MDS documentation is within CMS guidelines.** **The IDT Morning Meeting has been adjusted, to include the discussion of residents who have been identified through Care Planning meetings, as those needing safety and mobility assistance. At this IDT meeting, the team will discuss those residents needing safety and mobility management, to ensure the need is valid and current.** **Education sessions for all licensed staff have been set, to review the Care Planning process, introduce a new revised Care Plan format, and work with all nursing staff to build their resident assessment skills to better identify those residents who require us to Care Plan their safety and provide them optimal mobility. Care Planning review for this group**	5/15/17

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AMENDED POC	125024	A. BUILDING: _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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4 136	Continued From page 10 between the side rails are large." On 3/23/2017 at 12:14 PM, Staff # 3 said Resident # 32 could get out of bed with the side rails up, "especially if the resident wants to go the bathroom." Record review also found for the resident's last fall on 11/8/16, the nursing entry stated the resident was found "in sitting position on right foot part of the bed...The resident probably slid herself toward the foot part of the bed and got down on the area with no sidereal. Body assessment was done and no signs of injury..." The last 11/2/16 IDT Care Conference Summary and the Resident Status Update noted for safety needs/interventions: 2 - 3/4 rails up for the resident. However, there was no risk assessment found regarding the potential for entrapment although the documented fall entry stated that, "the resident probably slid toward the foot part of the bed and got down on the area with no siderail." 3) On 03/21/2017 at 10:21 AM observed that Resident # 45's bed had metal bilateral side rails with a body pillow lying against the left side rail. On 03/22/2017 at 2:12 PM, Resident # 45's medical record review (MRR) found that the resident had a care plan "#2 At risk for Falls r/t [redacted] Pain; Poor safety awareness caused by cognitive impairment; Taking psychotropic med's; Hx falls;" dated 11/6/16. The interventions included, "2 (3/4) up rail for bed mobility & positioning." Also, the facility's, "Resident Admission Physician Orders" form documented "18) Positioning Device PRN SIDE RAIL (Full, half rail, one side): 2 (3/4) up side rail for mobility & transfer." The Physical Device Evaluation form documented, Devices: 3/4 side rails L/R Date: 11/02/16.	4 136	**of residents has been added to the facility QA program PIP.** **<u>System Changes and Monitoring Systems to Ensure Deficient Practice Does Not Occur:</u>** **Resident or family involvement in Care Planning will continue, so family is aware of changes in resident's condition, which might require safety or mobility management. With their involvement, they will be aware of care planning changes necessary, and have them provide suggestions for alternative plans to assist staff providing resident safety. Facility leadership drives the Morning Meeting, to ensure the IDT completes an ongoing review of those residents identified as having safety or mobility challenges, which will be discussed by the IDT.** **MDS Coordinator will head the process established for Care Planning review and assessment of residents identified in this group, so MDS documentation can be valid and current. QA program meets monthly, so the ongoing review of the residents needing safety management will be identified at this meeting: goals and objectives will be reviewed.**	

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4 136	Continued From page 11 On 03/23/2017 at 9:31 AM interviewed Staff # 14, and when asked why Resident # 45's side rails were kept up, and she stated, " To keep Resident # 45 from getting out of bed." According to Staff # 14 during the resident's previous admission, the resident would get out of bed and not use the call-light, so staff were instructed by Staff # 1 to keep the side rails up. Staff # 14 further commented that since Resident # 45 returned to the facility, the resident no longer exhibits those behaviors. On 03/23/2017 at 9:34 AM interviewed Staff # 1 regarding side rails for Resident # 45. According to Staff # 1, when the resident was readmitted to the facility in 11/2016, the resident no longer tried to get out of bed. When queried Staff # 1 if side rails are primarily used as a restraint, Staff #1 stated that Resident # 45 requested to have side rails up so that they didn't fall. Asked Staff # 1 for documentation on Resident # 45's request for side rails but Staff # 1 could not provide any and just smiled. Discussed with Staff # 1 that the staff did not want Resident # 45 to get out of bed without using the call-light, so side rails would be considered a restraint. The Staff # 1 did not comment. On 03/23/2017 at 10:57 AM interviewed Resident # 45 and when asked if they used the side rails, the resident stated that they didn't use them. Staff # 13 was present preparing the resident for lunch in bed and asked Staff # 13 why side rails were being used. Staff # 13 stated that Resident # 45 used to get out of bed, but no longer tries to get out of bed now. "I think they're currently evaluating the side rails because the resident had been asking to lower the right side rail as the resident was unable to reach the urinal through the side rail metal bars.	4 136		

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4 136	Continued From page 12 On 03/23/2017 at 1:12 PM observed that Resident # 45's right side rail was lowered. According to Staff # 13, they had lowered the right side rail because Resident # 45 got mad when they ' d spilled cup of water on themselves after reaching for it on the right side table. The resident used the call-light and complained to Staff # 13 when it happened. Staff # 13 lowered the right side rail and was making frequent checks on Resident # 45, and made Staff # 1 aware that Resident # 45 wanted their right side rail down. The right side rail was lowered but not all the way down. On 03/23/2017 at 1:37 PM, Staff # 1 informed surveyor that they were starting a side rail reduction plan today. Informed the staff member that side rails are being used as restraints and Staff # 1 stated that is why they will try the side rail reduction plan. The facility failed to thoroughly evaluate the potential for side rail entrapment for cognitively impaired residents, and failed to consider restraint reduction techniques as an alternative to the use of the metal side rails	4 136	**No resident harm occurred as a result of this practice.** **Corrective Actions Taken:** **DOH: 4 – 149** **The facility MDS Coordinator completed the RAI for Resident # 77 on March 23, 2017.** **The MDS process is complex, and early 2017, the facility management realized there needed to be further education and greater support for our MDS Coordinator to achieve compliance with MDS guidelines. Approximately 2 months ago, a certified MDS nurse Consultant was hired into a full-time position to support the education and development of our Coordinator.** **Identification of Other Residents Affected:** **There were no other outstanding "14-day Assessments" at this survey as evidenced by the record review completed during survey.**	3/25/17
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and	4 149	**Monitoring Systems to Ensure Deficient Practice Does Not Occur:** **The employment of the MDS-certified Consultant was the primary step taken to support appropriate and timely data entry into the MDS tool. In early 2017, the identified need for more MDS-capable staff to assure data validity and timely completion was evident.**	

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4 149	Continued From page 13 initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on record review and interview with staff members, the facility failed to ensure a comprehensive assessment was done within 14 calendar days after admission for 1 (Resident #77) of 17 sampled residents of the 21 residents in the Stage 2 review. Findings include: Cross Reference to F272. The record review found Resident #77 was admitted to the facility on 3/6/17 for hospice care. On the morning of 3/23/17, the record review found an admission comprehensive assessment was not done for this resident within 14 calendar days after admission. On 3/23/17 at 9:00 AM. An interview with staff members confirmed the admission assessment was not done.	4 149	**The facility management plans to add full-time nursing support for the MDS Coordinator to assist in data management, including timely reporting, which will occur at the completion of the Consultant's work about mid-year 2017.** **The MDS consultant is actively involved in building a process for data management and organization; educating our Coordinator on that process; and directing MDS completion in a timely fashion, to ensure "14-day assessments" are completed timely and contain assessment information from which staff will plan individualized resident care. Moving forward, the leadership calls the Morning Meeting, which is a daily IDT meeting held primarily to discuss care challenges as they arise, for individual residents, and the MDS Coordinator gathers assessment and Care Plan information at this meeting.** **<u>System Changes and Monitoring Systems to Ensure Deficient Practice Does Not Occur:</u>** **The MDS Coordinator and Consultant meet daily with the facility Director of Nursing Services who is also MDS knowledgeable, to advise on resident changes, and provide timely information for data input.** **The MDS Coordinator presents a daily status report, at the ongoing Morning Meeting, on current and outstanding data management.**	

4-149 The MDS Consultant is providing coaching and education for the Coordinator, on all aspects of the MDS process, which is discussed daily with the D.O.N. to ensure MDS process education is complete. A QA program PIP directed toward monitoring of MDS completion will be added to the monthly QA meeting agenda in April 2017.