STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425297	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLISTON HEALTHCARE AND REHAB LLC	5721 SPRINGFIELD HWY WILLISTON, SC 29853

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) 3.0 User's Manual, it was determined the facility failed to ensure staff accurately coded the Minimum Data Set (MDS) assessment for two (2) of twelve (12) sampled residents (Resident #12 and Resident #9) related to falls. Resident #9's Quarterly MDS dated [DATE] was coded incorrectly in three separate data fields under the Falls Section. Resident #12 sustained one (1) fall in the facility on 6/10/2020; however, the fall was not coded on the Quarterly MDS dated [DATE]. The findings include: Interview with MDS Coordinator #1, on 8/26/2020 at 11:02 a.m., revealed the facility did not have a policy to ensure MDS assessments were accurately coded. MDS Coordinator #1 stated the facility followed the RAI User's Manual to code assessments. Review of the CMS RAI 3.0 User's Manual, Version 1.17.1, dated October 2019, Chapter 3, pages J-27 through J-35, revealed the facility should code: -Item J1700A, Fall History on Admission/Entry or Reentry, as 1-Yes if the resident or family report, or transfer records or medical records documented a fall in the month preceding the resident's admission (A1600). -Item J1800, Any Falls since Admission/Entry or Reentry or Prior Assessment (OBRA) or Scheduled PPS, whichever was more recent, as 1-Yes if the resident had fallen since the last assessment then continue to item J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever was more recent. -Item J1900A, No Injury, the facility should code 0 for none, 1 for one and 2 for two or more falls. 1. Record review revealed the facility admitted Resident #9 on 2/1/19 with multiple diagnoses, which included hypertension, anxiety, constipation, type 2 diabetes, dementia, [MEDICAL CONDITIONS], abnormalities of gait and mobility, muscle weakness, [MEDICAL CONDITION], history of falling, gout, and [MEDICAL CONDITION]. Further record review of Nurse's Progress Notes, dated February 2020-August 2020, revealed the resident had only one fall during this period. Review of the Fall Incident Report, dated 8/15/2020, revealed Resident #9 stated he/she was pulling the privacy curtain and he/she fell to the floor. The resident was unable to elaborate further. Upon entering the room, Resident #9 was observed on his/her right lateral side in front of the closet after attempting to stand from wheelchair unassisted to pull the privacy curtain. Review of Nursing Progress Notes, dated 8/15/2020, revealed Resident #9 had a fall in her room on this date. Review of Resident #9's Quarterly MDS assessment, dated 6/1/2020, revealed item J1700 - Fall History on Entry or Reentry was blank; it should have been coded Yes or No; J -Did the resident have a fall in the last month prior to admission entry/or reentry or the prior assessment was coded 1 for yes and since the resident had no previous falls it should have been coded No; and J1900A - Number of falls since admission/entry or reentry or prior Assessment (OBRA or Scheduled PPS) whichever is more recent was coded as Yes and should have been coded No since the resident had no previous falls before the assessment. Interview with the Director of Nursing (DON) on 8/25/2020 at 1:53 p.m., revealed Resident #9 had no falls prior to 8/15/2020. The DON stated, I am not sure why it is coded on the MDS as such, it was coded wrong. 2. Review of Resident #12's clinical record, revealed the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Fall Incident Report, dated 6/10/2020, revealed the nurse found Resident #12 on the floor by the refrigerator and wheelchair in his/her room. The nurse assisted Resident #12 in his/her wheelchair, assessed for injuries, performed vital signs and notified the physician and family of the fall. The report stated that no injuries were noted, and that Resident #12 stated he/she tried to grab something off the top of the refrigerator and fell out of his/her wheelchair. Review of Resident #12's Quarterly Minimum Data Set (MDS) assessment, dated 6/14/2020, revealed item J1800 - Any Falls since Admission/Entry or Prior Assessment (OBRA or Scheduled PPS), whichever was more recent, was coded as No. The coding on J1800 should have been coded Yes since a fall occurred on 6/10/2020. Item J1900A- No Injury, was blank. The coding on J1900A should have been coded 1 since the fall on 6/10/2020 resulted in no injuries. Interview with the MDS Coordinator on 8/26/2020 at 11:02 a.m., revealed he/she has been employed with the facility for two (2) months and was hired after two (2) previous MDS Coordinators resigned. The MDS Coordinator stated that he/she was in the process of reviewing and correcting the errors on the previously submitted MDS assessments. Interview on 8/26/2020 at 11:22 a.m. with the Director of Nursing (DON) revealed that he/she began auditing the MDS assessments for accuracy in May or June 2020 with the assistance of a DON from a sister facility. Continued interview revealed that two (2) MDS Coordinators resigned. The MDS Coordinator that was completing the assessments during that time coded them incorrectly. Interview with the Administrator, on 8/26/2020 at 1:01 p.m., revealed he/she expected the MDS assessments to be submitted timely and coded accurately by the MDS Coordinator and to be audited for accurate coding and submission by the DON. Continued interview revealed that he/she would review the MDS assessment audits performed by the DON to ensure they were accurately coded. The Administrator verified Resident #9's and Resident #12's MDS assessments were not coded correctly for falls.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review. observation, and facility policy review, it was determined the facility failed to revise the care plan to reflect current falls interventions for one (1) of 12 sampled residents (Resident #12). Use of a cervical collar and floor mats were discontinued by the Physician; however, both interventions remained on the care plan. The findings include: Review of facility's policy titled, Care Plans, dated 6/2013, revealed care plans were developed by the Interdisciplinary Team to coordinate and communicate care approaches and goals for the resident. Review of the care plan process revealed the Minimum Data Set (MDS) Coordinator should oversee the committee and offer assistance in problem solving, as needed. The team should attempt to make care plans goals measurable, attainable, resident specific and easy to understand. Disciplines responsible for actions should be documented. Target dates for the accomplishment of goals may vary dependent on the nature of the problem. When a new approach is or goal is identified, the entry should be dated using the date the goal/approach is entered on the care plan. When problems, goals, or approaches identified in the care plan are resolved they should be discontinued from the care plan. Review of Resident #12's clinical record, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #12's Comprehensive Care Plan, no date, revealed the resident was at high risk for falls related to deconditioning, gait, balance problems, [DIAGNOSES REDACTED]. The goal was for the resident to remain free of falls, free of minor injury and would not sustain serious injury related to falls. The approaches directed staff to ensure the resident's call light was within reach and encourage the resident to use it for assistance as needed, c-collar (cervical collar) to neck at all times, consult pharmacist for medication review, fall mats to both sides of the bed, new signage in room to remind resident to call for assistance, Reacher within reach as tolerated, physical and occupational therapy as ordered, follow facility fall protocol, follow up with neurosurgeon as ordered, and ensure that the resident participates in activities that promote exercise, physical activity for strengthening and improved mobility and ensure the resident wore non-skid footwear when ambulating or

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

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) mobilizing in wheelchair. The care plan intervention dated 6/10/2020 stated not to place items on top of the refrigerator. Review of Resident #12's physician's orders [REDACTED]. Observation of Resident #12 on 8/23/2020 at 3:50 p.m., revealed he/she was lying in bed with fall mats on both sides of the bed. Observation on 8/24/2020 at 8/25/2020 at 11:10 a.m., revealed Resident #12 was sitting in his/her wheelchair; and fall mats were on the floor next to both sides of the bed. Interview with the Director of Nursing (DON) on 8/26/2020 at 10:27 a.m. revealed the nursing assistants were educated on the fall care planned interventions during the daily shift report and the nursing assistants' care plans were placed in the resident's closet The DON stated that he/she should have revised the falls interventions on Resident #12's care plan but he/she missed it. Interview on 8/26/2020 at 11:02 a.m. with the MDS Coordinator revealed he/she attended the interdisciplinary team (IDT) meetings in which incident reports were reviewed to determine the root cause of the fall and specific interventions were determined to prevent the resident's falls. The MDS Coordinator stated he/she updated the resident's care plan based on the decisions made in the IDT meetings. Further interview revealed he/she was in the process of reviewing and revising the care plans but was not responsible for the incorrect information on the care plans for Resident #12 and #18. Interview on 8/26/2020 at 1:01 p.m. with the Administrator, revealed he/she expected the MDS Coordinator to develop an individualized care plan and revise the care plans timely per the regulations. The Administrator also stated that the care plan for Resident #12 was not revised to the reflect the falls care planned interventions. Further interview revealed he/she had oversight of the care plans and reviewed care plan audits completed by the DON.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure interventions such as non-skid footwear and removal of mats on the floor that reduced maneuverability were implemented to prevent falls for one (1) of 3 (three) sampled residents who experienced falls (Resident #12). Resident #12 fell on [DATE] trying to get back in his/her wheelchair unassisted. Although the resident was non-compliant regarding asking for assistance, he/she was wearing sandals instead of non-skid footwear he/she should have been wearing. Observations during the survey revealed Resident #12 sitting his/her wheelchair wearing sandals instead of non-skid footwear and floor mats in place on the floor after they were discontinued. The findings include: Review of the facility's policy titled, Falls Management Program, not dated, revealed the purpose was to reduce falls and risk of injury from falls. First, a falls risk assessment would be completed on each resident upon admission, readmission, with a significant change, and at least quarterly. Second, a resident would be placed on the fall management program when the fall risk assessment score was 10 or higher. The fall management committee was an interdisciplinary committee which functioned as part of the Patient at Risk (PAR) meeting. During the weekly PAR meeting, the committee would do the following: review incident reports and investigations; review all new admits, readmits, and any significant changes; determine which residents should be placed on the fall management program; discuss each resident's risk factors based on history and declines; incidents, investigations and any other pertinent factors; develop interventions to decrease the risk for a fall or risk of reoccurrence; complete the fall management communication form and place with the resident's activities of daily living form and medication administration form to ensure the certified nursing assistants and nurses were aware of new interventions; review each resident on the program on a weekly basis during the PAR meeting; revise interventions as needed; institute a new intervention immediately if the resident has another incident; update the care plan to reflect each new intervention; and the resident would stay on the fall management program either without a fall in 30 days or longer if deemed necessary by the team. Review of Resident #12's clinical record, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #12's Quarterly Minimum Data Set (MDS) assessment, dated 6/14/2020, revealed Resident #12's cognition was intact with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Continued review of the MDS revealed the resident required the assistance of one (1) person for bed mobility, transfers, toileting, walking in room and corridor. Further review of the MDS revealed Resident #12 was assessed as occasionally incontinent of bladder. The MDS revealed Resident #12 used the wheelchair for mobility. Continued review of the MDS revealed Resident #12 had no falls prior to admission, since admission, or since the prior assessment. Review of Resident #12's comprehensive care plan, no date, revealed the resident was at high risk for falls related to deconditioning, gait, balance problems, [DIAGNOSES REDACTED]. The goal was for the resident to remain free of falls, free of minor injury and not to sustain serious injury related to falls. The approaches directed staff to be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed, c-collar (cervical collar) to neck at all times, consult pharmacist for medication review, fall mats to both sides of the bed, not place items on top of the refrigerator, new signage in room to remind the resident to call for assistance, the Reacher placed within the resident's reach as tolerated, physical and occupational therapy as ordered, follow facility fall protocol, follow up with neurosurgeon as ordered, and ensure the resident participated in activities that promoted exercise, physical activity for strengthening, improved mobility and ensure the resident wore non-skid footwear when ambulating or mobilizing in the wheelchair. Review of the Certified Nurse Assistant (CNA) care plan, dated 8/20/2020, revealed Resident #12 used a wheelchair for mobility, had a pressure reducing cushion in the wheelchair, was at risk for falls, transfer assist of one-person was needed, and tumbler mats (floor mats) were discontinued. However, the fall intervention for non-skid footwear when Resident #12 was ambulating in the wheelchair was not listed. Review of the Fall Incident Report, dated 6/15/2020, revealed Licensed Practical Nurse (LPN) #4 responded to Resident #12's call for help from his/her room and found him/her lying on the floor at 10:35 a.m. The nurse assessed the resident for injuries. Resident #12 complained of left knee, right shoulder and right side of his/her face pain. The report stated Resident #12's Physician and family were notified of the fall. The Physician ordered an x-ray of the left knee and right shoulder. Resident #12 stated that he/she fell trying to get back to his/her wheelchair and forgot to use the call light for assistance. The report revealed the resident was wearing improper footwear and ambulating without assistance. Continued review of the report revealed the intervention to prevent future falls and to ensure the resident's safety was for staff to reinforce use of the call light with the resident and move the resident to a room closer to the nurses' desk for frequent monitoring. Review of the radiology report, dated 6/15/2020, revealed a 22 millimeter (mm) of inferior displacement of the acromion and a [MEDICAL CONDITION] patella. Review of the physician's orders [REDACTED].#12 on 8/25/2020 at 11:10 a.m., revealed he/she was sitting in his/her wheelchair in his/her room and fall mats were on the floor next to both sides of the bed. Observation of Resident #12 on 8/25/2020 at 11:31 a.m., revealed he/she was propelling down the hallway in his/her wheelchair with sandals on. Interview with Resident #12 on 8/25/2020 at 11:31 a.m., revealed he/she had fallen a lot because he/she forgot to call for assistance. Resident #12 stated he/she doesn't have any other shoes to wear except the sandals and wore them while in the wheelchair, stating it was difficult to propel the wheelchair when he/she wore them. Interview with Resident #12 on 8/26/2020 at 9:00 a.m. revealed the staff removed the fall mats by his/her bed that morning and he/she was happy about it because he/she couldn't move around in his/her room with the mats on the floor. Interview with Certified Nursing Assistant (CNA) #2 on 8/26/2020 at 9:47 a.m., revealed the CNA assisted Resident #12 back to bed after his/her fall on 6/15/2020. Continued interview with CNA #2 revealed Resident #12 had sandals on and the fall mats were on the floor by the bed when he/she responded to the fall. The CNA stated Resident #12 was moved to a room closer to the nurses' station after the fall and the CNA was not educated to ensure he/she wore non-skid footwear when he/she was in the wheelchair. The CNA stated the nursing assistants rounded on him/her more frequently because he/she had fallen a lot in the last three (3) months trying to do things in his/her wheelchair in his/her room without requesting assistance. Interview with Licensed Practical Nurse (LPN) #4 on 8/26/2020 at 11:28 a.m., revealed he/she found Resident #12 on the floor by his/her wheelchair in his/her room on 6/15/2020. LPN #4 stated he/she assisted Resident #12 back to bed, assessed the resident for injuries and notified the Physician and family of the fall and complaint of pain. Continued interview revealed Resident #12 would not use her call light for assistance because he/she was confused at times and was progressively getting worse. LPN #4 stated the fall interventions in place now were not appropriate for Resident #12 because staff could not supervise him/her all the time and he/she wouldn't use her call light. Interview with the Director of Nursing (DON) on 8/26/2020 at 10:27 a.m., revealed fall interventions for Resident #12 were to remind him/her to call staff for assistance, signs posted in his/her room to remind to call staff for assistance and use of a low bed. Continued interview revealed Resident #12 was moved to a room closer to the nurses' station, staff removed clutter in his/her room and he/she removed the fall mats next to his/her bed today. The DON stated the Interdisciplinary Team (IDT) had discussed

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) placing a different type of cushion in his/her wheelchair seat but didn't implement it because Resident #12 wanted to get up out of the wheelchair. Further interview revealed Resident #12 wanted to wear the sandals; however, didn't have any other shoes.
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, record review and policy review, the facility failed to follow the Dietician's recommendation and a Physician's order for one (1) out of 12 sampled residents (Resident #29) to address weight loss. Resident #29 had a history of [REDACTED]. Findings Include: Review of a policy titled, Nursing Policy Manual no date, revealed the Physician retained control of the resident's medical plan of care, and was consulted when changes in condition occurred requiring an alteration to prescribe treatments. Such orders were often received by telephone. Physician's orders could be transmitted by facsimile machine or received by telephone, by a licensed nurse, or by another licensed or registered health care specialist in their own area of specialty. Further review of the Policy titled Nursing Policy Manual no date, revealed staff were to write the orders verbally given by the Physician on the orders sheet, read the order back to the Physician to ensure accuracy, then date and sign. The Physician should sign the order on his/her next visit to the facility. Staff should follow through with orders by contacting the pharmacy, lab, etc., and revise medication and treatments sheets as appropriate. Review of Resident #29's Quarterly Minimum Data Set ((MDS) dated [DATE] revealed an admission date of [DATE], under Section C - Cognition, the resident had a Brief Interview Mental Status (BIMS) score of two (2) indicating severe cognitive deficits. Review of Section G - Functional Status, revealed the resident was independent with meals but required staff supervision. Review of Section I - Active Diagnoses, revealed the resident was coded with [DIAGNOSES REDACTED]. Review of Section K- Nutrition, revealed Resident #29 weighed 153 pounds (lbs) with a height 68 inches and experienced a significant unplanned weight loss of five (5)% or more in the last month or 10% or more in the last six (6) months. Review of Resident #29's Dietary Notes dated 8/10/2020 revealed: Note Text: Current Body Weight (CBW): 151 pounds (lbs) (8/7/20). Resident with significant weight loss x (times) 80 days (-17.0%). Body Mass Index (BMI): 23, Within Normal Limits (WNL). Resident receives Consistent Carbohydrate Diet (CCD), Regular diet with finger foods with meals, strawberry Glucerna three times per day (TID) between meals, night time (HS) snack, and chocolate provided if resident consumes 50% or less of meal. Resident is also on the red napkin program to assist with increasing PO (oral) intakes. Current PO intakes are 50-75% mostly. Reviewed meds (medications). Reviewed progress notes. Resident's weight has been stable x 30 x 90 days. Current nutrition appropriate at this time. Review of Resident #29's weights from April 2020 -August 2020 revealed, the resident's weights remained between 151 lbs to 159 lbs with a Body Mass Index (BMI) of 23 (resident within a normal body weight range). Further review of the residents weights on a monthly basis from November 2019 - March 2020 revealed Resident #29 experienced a 37 pound weight loss during this timeframe. 8/7/2020 - 151.0 lbs 7/2/2020 - 152.6 lbs 6/1/2020 - 151.8 lbs 5/5/2020 - 153.0 lbs 4/7/2020 - 159.0 lbs 3/24/2020 - 165.0 lbs 2/6/2020 - 182.0 lbs 1/9/2020 - 177.2 lbs 12/14/2019 - 183.2 lbs 11/10/2019 - 188.0 lbs Review of the Physician's order dated 5/5/2020 for Resident #29, revealed the Physician prescribed a Consistent Carbohydrate Diet (CCD), regular texture with thin liquids, with finger foods added to the meal, and a Red Napkin program to help increase fluid intake. Review of Resident #29's lunch meal ticket for 8/25/2020, revealed the resident would be served, turkey and brown gravy, mashed potatoes and brown gravy, broccoli, peach cobbler and two (2) glasses of lemonade. Review of the breakfast meal ticket for 8/26/2020 revealed the resident was served scrambled eggs, grits, toast, cereal, banana, coffee and juice. Observation on 8/25/2020 at approximately 12:30 p.m. revealed Resident #29 was observed in his/her room with his/her lunch tray consisting of turkey with brown gravy, mashed potatoes with brown gravy, broccoli, peach cobbler and two (2) glasses of lemonade. The resident was observed eating the peach cobbler and then drinking one (1) of the glass of lemonade. The remaining meal sat on his/her tray. There were no finger foods observed on the tray. Observation of breakfast on 8/26/2020 at approximately 8:30 a.m. revealed Resident #29 was sitting up in his/her room with the breakfast tray in front of him/her. The meal consisted of grits, cereal, toast, scrambled eggs, a banana, coffee, milk and juice. The resident was observed eating the toast but did not finish the rest of the meal. During an interview on 8/25/2020 at 12:42 p.m. the Director of Nursing (DON) revealed Resident #29 preferred sweets over everything else, stating, We offered alternatives and he/she receives Glucerna several times during the shift; and will drink propel water which helps . I expect dietary to follow the Medical Director/Attending physician orders . I received the orders via e-mail from the Dietician; we discussed what's best for Resident #29, then the Medical Director is contacted and writes the order . Dietary is given the order right away via e-mail. During an interview on 8/25/2020 at 12:45 p.m. the Dietary Manager (DM) revealed Resident #29 did not get his/her finger foods for lunch on this date because the ham wasn't thawed out. The DM stated, I received the order from the Dietician via e-mail for finger foods a few months ago . I could have given him/her a Pimento cheese sandwich, but I didn't want him/her to get tired of eating them. During an on 8/25/20 at 2:24 p.m. the Registered Dietician (RD) revealed finger foods were recommended for Resident #29 on 5/13/2020. The RD stated, I spoke with the DON and we agreed that he/she would benefit weight wise if given finger foods . We wanted the weight to remain stable because he/she loves sweet stuff. The RD stated once the recommendation was made it was sent to the DON, then to the Medical Director who wrote the order; a copy was also sent to the Dietary Manager (DM). The RD stated, I expect the kitchen to follow my recommendations to ensure Resident #29 eats his/her meals and to prevent weight loss which has remain stable for the last several months. During an interview on 8/26/20 at 1:00 p.m. the Administrator stated, I expect dietary to follow any meal orders given for the residents. When the Certified Nursing Assistants (CNAs) look at the tray card and see the resident is not getting the meal ordered, they are expected to notify the kitchen immediately. The Facility failed to follow the Registered Dietician's recommendations and Physician orders for Finger Foods to prevent weight loss.