

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/30/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>NHC HEALTHCARE, GLASGOW</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>109 HOMEWOOD BLVD.</b> <b>GLASGOW, KY 42141</b>		
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F 000	INITIAL COMMENTS  An Abbreviated Survey investigating complaint #KY21708 was conducted on 05/28/14 through 05/30/14 to determine the facility's compliance with Federal requirements. Complaint #KY21708 was substantiated with regulatory violations identified, with the highest Scope and Severity cited at a "G".  On 08/28/13, Occupational Therapy (OT) evaluated Resident #1 and made the recommendations for a gel cushion with a cut out for the resident's comfort and safety. On 05/04/14, staff removed Resident #1 from his/her wheelchair, and placed him/her in a wheelchair which enabled the resident to be able to remove the positioning device (a lap buddy). The resident removed the positioning device and had a fall. Nursing staff did not consult with Occupational Therapy prior to changing the resident's chair. The resident was transferred to the hospital and diagnosed with a fractured pelvis. Resident #1 returned to the facility with orders for bedrest. On 05/08/14, orders were received that Resident #1 could be up in wheelchair as tolerated.	F 000	The Plan of Correction is Submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct.		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE  A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical	F 274	NHC does assure that within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition.  Corrected Actions Accomplished For The Resident Found Have Been Affected By The Allegedly Dificient Practice. MDS Coordinator completed a significant change in status MDS assessment for Resident # 1 related to the revocation of Hospice. This was completed on June 4, 2014. How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Been Taken. Overseen by the Director of Nursing, all other resident that had or has hospice	6/5/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Admn.

(X6) DATE

6/11/14

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 274	<p>Continued From page 1</p> <p>interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy and procedure and Minimum Data Set (MDS) Schedule and review of the Resident Assessment Instrument (RAI) Guidelines, it was determined the facility failed to conduct a comprehensive assessment within fourteen (14) days of, or after for one (1) of five (5) sampled residents (Resident #1), who was discontinued from Hospice Services. Resident #1 was under Hospice care as of 06/22/13, related to End Stage Chronic Obstructive Pulmonary Disease and remained under Hospice care until 03/18/14. On 03/18/14, the resident's Hospice Services were discontinued, however, the facility failed to complete a Significant Change Minimum Data Set (MDS) assessment.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled "Resident Assessment Policy", dated 06/03/14, revealed the facility follows the assessment guidelines as set by the Resident Assessment Instrument (RAI) Manual.</p> <p>Review of the RAI Guidelines (Chapter 2: Assessments for the RAI), dated 04/12, revealed a Significant Change Assessment was required to be performed when a resident was receiving Hospice services and then decided to discontinue those services (known as revoking of Hospice</p>	F 274	<p>charts were reviewed by administrative nurses for revocation of Hospice Services and the need for significant change in status MDS assessment. One other resident had indicated the revocation of Hospice. The MDS Coordinator completed a significant change in status MDS assessment on the resident. This was completed on June 4, 2014.</p> <p>The Measures We Have Put In Place and Systematic Changes We Have Made To Ensure That The Practice Does Not Recur.</p> <p>The Director of Nursing and Nurse Educator conducted an in-service for the MDS coordinators and the Unit Managers reviewing the need to complete a change in status MDS within 14 days of a residents's revocation of Hospice services. This was completed on June 4, 2014.</p> <p>The Corrective Actions Will Be Monitored To Ensure the Practice Will Not Recur.</p> <p>The Director of Nursing will monitor the compliance of completing a significant change in status MDS within 14 days of a resident's revocation of Hospice services through the quality assurance process. Overseen by the Director of Nursing the records of hospice patients will be reviewed by administrative nurses for revocation of Hospice services to ensure that a significant change in status MDS has been completed when indicated. The monitor will be completed weekly times 6 weeks and then report the findings to the quality assurance committee. The monitor and in-service training will be continued as determined by the Director of Nursing or as directed by the Quality Assurance Committee.</p>		

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F 274	<p>Continued From page 2 care). The Assessment Reference Date must be within fourteen (14) days from the effective date of the Hospice election revocation.</p> <p>Record review revealed the facility admitted Resident #1 on 06/22/13 with diagnoses which included Terminal End Stage Chronic Obstructive Pulmonary Disease, Alzheimer's Dementia with Behavioral Disturbance, Psychosis, Anxiety, and Constipation.</p> <p>Observation of Resident #1, on 05/30/14 at 1:25 PM, revealed the resident sitting up in a wheelchair in the hallway, alert with rambling conversation with no concerns noted.</p> <p>Record review revealed Resident #1 was under the care of Hospice as of 06/22/13 related to Terminal End Stage Chronic Obstructive Pulmonary Disease and remained under Hospice care until 03/18/14.</p> <p>Review of a Physician's Order, dated 03/18/14, revealed the resident was to receive Palliative care and discontinue Hospice Care related to the resident no longer being terminal.</p> <p>Review of the facility's MDS Schedule revealed there was no Significant Change MDS assessment completed related to the revocation of Hospice Care on 03/18/14.</p> <p>Interview, on 05/30/14 at 4:10 PM, with Licensed Practical Nurse (LPN) #3 (MDS Coordinator) revealed she was unaware of the need to complete a Significant Change MDS assessment for Resident #1 related to Hospice care revocation. She stated she was unaware of the Resident Assessment Instrument (RAI)</p>	F 274			

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F 274	Continued From page 3 Guidelines related to Hospice implementation or revocation.  Interview with the Regional Nurse, on 05/30/14 at 5:47 PM, revealed the MDS Coordinator should have known to complete a Significant Change MDS assessment related to Resident #1 being discontinued from Hospice care.  Interview with the Administrator, on 05/30/14 at 5:55 PM, revealed he was not sure if the MDS Nurse should have been aware of the need to do a Significant Change MDS assessment related to the Hospice care revocation for Resident #1.	F 274			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	NHC does assure that the results of the assessment is used to develop, review and revise the residents's comprehensive plan of care.  Corrected Actions Accomplished For The Resident Found To Have BEen Affected By The Allegedly Deficient Practice.  The Occupational therapy department updated Resident #1's care plan to reflect the current seating for the resident which included a pommel gel cushion and a wheelchair with a rear dropped seat. This was completed June 11, 2014.  How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Been Taken. Overseen by the Director of Nursing, Administrative Nurses reviewed all other resident care plans to ensure their current seating was care planned. This was completed on June 11, 2014.  The Measure We Have Put In Place and Systematic Changes We Have Made To Ensure That The Practice Does Nor Recur.  The Director of Nursing and Nurse Educator conducted an in-service for all licensed nursing staff reviewing the care plan process and the need to ensure that seating is on the care plan. This was completed on June 4, 2014.	6/12/14	

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F 279	Continued From page 4  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedures, it was determined the facility failed to revise the care plan to include interventions for a gel cushion with a cut out for one (1) of five (5) sampled residents (Resident #1).  On 08/28/13, Occupational Therapy (OT) assessed Resident #1 for wheelchair positioning and safety. OT modified the resident's wheelchair by adding a gel cushion with a cut out. However, the care plan was not revised to include the modification of the wheelchair with the gel cushion.  The findings include:  Review of the facility's policy and procedure titled "Care Plan Development", dated 07/03/08, revealed when new problems arise they were to be added to the current plan even if the change in condition was not considered significant enough for a complete revision. Care plans were updated as needed.  Record review revealed the facility admitted Resident #1 on 06/22/13 with diagnoses which included End Stage Chronic Obstructive Pulmonary Disease.  Review of a Occupational Therapy Evaluation, dated 08/28/13, revealed Therapy conducted an assessment of Resident #1 for wheelchair positioning and safety. Review of an Occupation Therapy Discharge Summary, dated 08/30/13, revealed the resident's wheelchair cushion was	F 279	The Corrective Actions Will Be Monitored To Ensure The Practice Will Not Recur.  The Director of Nursing will monitor the compliance of cushions, wheelchairs and falls interventions being appropriate, in place for the resident and careplanned through the quality assurance process. . Overseen by the Director of Nursing, 10 residents' records will be reviewed by Administrative Nurses weekly times 6 and then report findings to the quality assurance committee. The monitor and in-service training will be continued as determined by the Director of Nursing or as directed by the Quality Assurance Committee.		

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F 279	Continued From page 5 modified to a gel cushion with cut out to promote a safe, upright and proper position when the resident was in the wheelchair. However, review of the Comprehensive Care Plan, dated 04/04/14, revealed there was no revision to the care plan to address OT's assessment and recommendation for the gel cushion to the wheelchair.  Observation of Resident #1, on 05/29/14 at 11:40 AM, revealed Resident #1 sitting in restorative dining with a foam cushion in the wheel chair which was not the cushion OT had recommended.  Interview, on 05/30/14 at 3:26 PM, with Licensed Practical Nurse (LPN) #3, Minimum Data Set (MDS) Coordinator, revealed the Interdisciplinary Team (IDT) was responsible for updating and implementing care plans. She stated she reviewed and revised the care plans quarterly and when a new MDS assessment when needed. Additionally, she stated she obtained the Physician's Orders written over the past twenty-four (24) hours and copied them for the Unit Manager. She stated the orders were taken to the IDT meeting every day so the care plans could be updated at that time.  Interview with the Regional Nurse, on 05/30/14 at 5:47 PM, revealed the care plan should have been updated related to the gel cushion the Occupational Therapist had recommended.	F 279			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	NHC does assure that the resident environment remains as free from accident hazards as is possible.  The Occupational Therapy Department evaluated resident # 1 to ensure that the patient was in the appropriate wheelchair and had the appropriate cushion. The care plan was updated to include a pommel gel cushion and a wheelchair with a rear dropped seat.	6/12/14	

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F 323	<p>Continued From page 6</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one (1) of five (5) sampled residents (Resident #1).</p> <p>Staff removed Resident #1 from his/her wheelchair with a gel cushion which had been assessed by Occupational Therapy (OT) for positioning and safety. The resident was placed in another wheelchair without the gel cushion. The staff failed to consult with OT and failed to supervise the resident while in the other chair to ensure the resident's safety. The resident's positioning device (lap buddy) was loose on his/her wheelchair due to the wheelchair being a different size which enabled the resident to remove the lap buddy. Resident #1 removed the lap buddy and had a fall which resulted in a fractured pelvis on 05/04/14. Resident #1 returned to the facility the same day on bedrest; and, on 05/08/14 the resident was able to be in the wheelchair as tolerated.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled "Incident and Accident Process", dated 03/01/01, revealed "Injury is defined for reporting purposes as:</p>	F 323	<p>The DON reviewed and updated the current care plan for Resident # 1 for falls interventions. All fall prevention interventions were verified by observation to be in place as care planned. This was completed on June 11, 2014.</p> <p>How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Ben Taken.</p> <p>Overseen by the Director of Nursing, Administrative Nurses reviewed all other resident's care plans , observed cushions, wheelchairs and falls interventions. The careplans were updated as needed to ensure that residents' cushions, wheelchairs and falls interventions were appropriate for the individual resident. This was completed on June 11, 2014.</p> <p>The Measure We Put In Place and Systematic Changes We Have Made To Ensure That The Practice Does Not Recur.</p> <p>The Director of Nursing and Nurse Educator conducted an in-service for all licensed nursing staff reviewing the care plan process and the need to ensure that all cushions, wheelchairs and fall interventions are appropriate and on the care plan. This was completed on June 4, 2014.</p> <p>The Corrective Actions Will Be Monitored To Ensure The Practice Will Not Recur.</p> <p>The Director of Nursing will monitor compliance of cushions, wheelchairs, and falls interventions are appropriate and in place for the resident and careplanned through the quality assurance process. Overseen by the Director of Nursing, 10 residents will be reviewed by Administrative Nurses for compliance of cushions, wheelchairs, and falls interventions care planned and implemented weekly times 6, and then report the findings to the quality assurance committee. The monitor and in-service training will be continued as determined by the Director of Nursing or as directed by the Quality Assurance Committee.</p>		

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F 323	<p>Continued From page 7</p> <p>A. Fracture or dislocation of bones and joints; B. Any condition requiring medical treatment outside the center that is inconsistent with the routine management of the patient's preexisting condition(s); C. Any event resulting in the patient's admission to the hospital."</p> <p>Review of the Patient Care Policies regarding Resident Rights, revised 03/06/13, revealed "Safety precautions are taken to prevent, whenever possible, patient accidents and infections."</p> <p>Record review revealed the facility admitted Resident #1 on 06/22/13 with diagnoses which included Alzheimer's Dementia, Anxiety, Unspecified Psychosis, and Chronic Obstructive Pulmonary Disease.</p> <p>Review of the Minimum Data Set (MDS) Assessment, dated 03/19/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3), which indicated the resident was not interviewable. He/She required extensive assistance of two (2) staff for transfers and bed mobility; and, was non-ambulatory.</p> <p>Review of the Comprehensive Care Plan, titled "Falls", dated 04/02/14, revealed the facility assessed and care planned Resident #1 to have a lap buddy while up in the wheel chair for positioning due to the resident's leaning forward. However, further review revealed there were no interventions to address the resident's gel cushion until 05/06/14; after the fall, when interventions were added to ensure the resident was in his/her wheelchair. Staff was to monitor</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>for self removal of the lap buddy; and, to ensure the cushion recommended by Occupational Therapy was in the wheel chair.</p> <p>Review of the Occupational Therapist (OT) Evaluation, dated 08/28/13, revealed the family requested the evaluation by OT for wheel chair positioning. OT completed the evaluation and determined Resident #1 was using a standard wheel chair with a cushion that was too large to fit the chair which caused the resident to sit in a posterior pelvic tilt with hips in extension and adduction. The cushion was changed to a pressure relieving cushion (gel cushion with cut out) to decrease pain and to promote an upright posture for Resident #1.</p> <p>Interview with the Therapy Program Director and Occupation Therapist, on 05/29/14 at 10:43 AM, revealed Resident #1 was evaluated for a wheelchair/and cushion per his/her family's request for positioning. They stated the resident had a standard one (1) inch foam cushion that he/she had when he/she was admitted to the facility. They stated after evaluating the resident they recommended a new cushion that would put the resident's pelvis and hips in a neutral and functional position. Further interview revealed the resident was having pain and the cushion helped place the resident's pelvis in a comfortable position.</p> <p>Review of the facility's Investigation Report, dated 05/04/14 at 10:25 AM, revealed Resident #1 was found on the floor with a skin tear and yelling for help. He/She had removed the lap buddy from the wheel chair that staff had changed him/her into, and attempted to self transfer. Resident #1 had sustained a skin tear to the right hand and</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>had pain in the right hip. The resident was transferred to the Emergency Room for evaluation on 05/04/14 at 11:14 AM. Documentation revealed the root cause of the fall was determined to be related to a trial assessment of a more comfortable wheel chair with a concave back and the trial was unsuccessful. The resident was moved back into his/her own wheel chair due to complaints of pain.</p> <p>Review of the Final X-ray Report, Emergency Room Report, and Nurse's Note, dated 05/04/14, revealed Resident #1 was seen in the Emergency Room and sent back to the facility with orders to follow up with the physician as needed. The facility received a phone call from the hospital and was made aware the resident had a fractured left superior pubic ramus (pelvis) and orders were received for bedrest until seen by physician. Further review of the physician's orders revealed on 05/08/14 orders were received that Resident #1 could be up in wheelchair as tolerated.</p> <p>Interview with Resident #1's daughter, on 05/30/14 at 3:36 PM, revealed the fall occurred on 05/04/14. She stated her other parent had gone into the facility two (2) days prior to visit the resident and he/she was in a wheel chair that wasn't his/hers and the special cushion that OT had recommended was missing as well. She stated her father told her the chair the resident was in was larger and the lap buddy did not fit properly. When he asked staff where the resident's wheel chair and cushion were, no one knew. Further interview revealed the resident's spouse explained to the staff that if the resident was not placed in his/her own wheel chair, he/she was going to fall. She further stated interview</p>	F 323			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/30/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>NHC HEALTHCARE, GLASGOW</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>109 HOMEWOOD BLVD. GLASGOW, KY 42141</b>		
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F 323	<p>Continued From page 10</p> <p>with the resident's spouse revealed he/she went through the wheel chair storage closet and found Resident #1's wheel chair that had his/her name on it. Additionally, another daughter came to visit Resident #1 and inquired as to why the resident was in a different wheel chair and was told it was because the resident was complaining of pain in his/her buttocks.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 05/29/14 at 3:46 PM, revealed on 05/01/14 or 05/02/14 a Certified Nurse Aide (CNA) came to her and asked if the resident could be switched out to a wheel chair with a rounded back as she thought it would be more comfortable for her. The LPN stated the resident was transferred to the other wheelchair, and at that time the resident did not attempt to remove the lap buddy from the new chair. She stated the lap buddy was looser but she was not aware of this resident ever trying to remove the lap buddy. She revealed the resident should have been evaluated before the wheelchair was changed.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 05/29/14 at 1:41 PM, revealed the resident was able to remove the lap buddy from the wheelchair Resident #1 was changed to because the wheelchair was not as wide as the other wheelchair so the lap buddy was loose.</p> <p>Interview with CNA #2, on 05/29/14 at 2:25 PM, revealed she was told in report from the midnight shift that Resident #1's chair had been changed for comfort to the resident's back. She stated she was unaware of any issues with the other chair and was not sure why it was changed. Additionally, she stated the lap buddy was loose in the new chair.</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER  <b>NHC HEALTHCARE, GLASGOW</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>109 HOMEWOOD BLVD. GLASGOW, KY 42141</b>		
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F 323	Continued From page 11  Interview with LPN #2, on 05/29/14 at 2:00 PM, revealed LPN #1 told her in morning report that a trial for a different wheel chair was initiated because Resident #1's old wheel chair was not as soft. The LPN stated the resident was able to move the lap buddy in the new wheelchair; however, she did not take any action to ensure the resident's safety.  Interview with Registered Nurse (RN) #1, on 05/29/14 at 3:22 PM, revealed there were no issues to warrant changing the wheelchair. She stated LPN #1 should have gotten an order for an evaluation from OT before changing the wheelchair or the cushion.  Interview with the Unit Manager (UM), on 05/29/14 at 10:00 AM, revealed staff tried a different wheelchair on 05/02/14 because the CNAs thought it might be more comfortable for the resident because it was softer. The UM stated the wheelchair the resident was in when OT assessed him/her was the resident's wheelchair and it was smaller in height and width. The UM stated the lap buddy was used as a positioning device for Resident #1.  Interview with the Administrator, on 05/30/14 at 5:55 PM, revealed he did not feel the Charge Nurse, who removed the resident's wheel chair and cushion, should have obtained an OT Consultation prior to removing the wheel chair and cushion OT had recommended.	F 323			