STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345222	A. BUILDING: ______ B. WING ______	9/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE DREXEL, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 247 483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE

A resident has the right to receive notice before the resident's room or roommate in the facility is changed.

This REQUIREMENT is not met as evidenced by:
Based on resident and staff interviews and record review, the facility failed to notify residents of a new roommate for 2 of 3 sampled residents (Resident #40 and #46).

The findings included:

1. The latest Minimum Data Set (MDS) for Resident #40 dated 08/28/2012 assessed the resident as severely cognitively impaired and unable to understand or make herself understood.

Interview with family member of resident #40 on 09/16/13 at 11:58 AM revealed resident and family were in resident 's bedroom when facility staff came into room and boxed up roommate's belongings. Family member stated resident immediately became very upset when seeing the staff and boxes. Resident #40's family member stated the roommate Resident #40 had before this roommate had died and Resident #40 had cried and shown signs of grieving for weeks afterward. The family member of Resident #40 felt she was crying at the sight of the staff boxing up her roommate's belongings because she believed this roommate had also died suddenly. The family member of Resident #40 stated they had not been told by staff about a new roommate and would have discussed the change with Resident #40 beforehand if they'd been told, alleviating her stress.

Review of Resident #40's medical record revealed no notification of roommate change.

Interview with the Social Worker (SW) on 09/19/13 at 3:15 PM revealed that she had not notified Resident #40 or the family of Resident #40 of the roommate change before the change occurred. SW stated she had begun to notify and document notification of all 4 resident parties involved in a room change this week, as the administrator had told her notification had to be done prior to room changes for all 4 parties earlier this week. Before this week, SW stated she had tried to notify all parties involved when able, but had only documented notification for the 2 residents who were actually making a room change.

Interview with the Administrator on 09/19/13 at 4:34 PM revealed she expected the social worker to give prior notification to residents and families of residents who are cognitively impaired before room changes are made in their rooms. The administrator stated she expected the SW to document the advanced notification in all 4 charts of residents impacted by each room change.

2. The latest Minimum Data Set (MDS) for Resident #46 dated 07/30/13 assessed the resident as cognitively intact and able to understand and make herself understood.

Interview with Resident #46 on 09/16/13 at 4:30 PM revealed she had recently eaten lunch in the dining room and returned her room to see belongings of her roommate had been moved out of the room. Resident #46

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

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 247	Continued From Page 1

stated she had felt very upset because she hadn't known the roommate was moving out and wanted to know ahead of time.

Review of Resident #46's medical record revealed no notification of roommate change.

Interview with the Social Worker (SW) on 09/19/13 at 3:15 PM revealed that she remembered notifying Resident #46 of the roommate change but had not documented the notification. SW stated she had begun to notify and document notification of all 4 resident parties involved in a room change this week, as the administrator had told her notification had to be done prior to room changes for all 4 parties earlier this week. Before this week, SW stated she had tried to notify all parties involved when able, but had only documented notification for the 2 residents who were actually making a room change.

Interview with the Administrator on 09/19/13 at 4:34 PM revealed she expected the social worker to give prior notification to residents and families of residents who are cognitively impaired before room changes are made in their rooms. The administrator stated she expected the SW to document the advanced notification in all 4 charts of residents impacted by each room change.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE DREXEL, NC 28619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to focus the attention on the group of residents eating lunch and failed to interact with a resident for 2 of 2 lunch meal observations (Resident #182). The findings included: Resident #182 was admitted to the facility on 09/09/13 with diagnoses that included dementia. There was no Minimum Data Set (MDS) information available for her. On 09/16/13 a continuous observation of the lunch meal was made in the Main Dining room lasting from 12:00 PM to 1:00 PM. The observations included a 4-person table that consisted of Resident #182. Resident #182 sat in the main dining room from 11:45 AM to 12:55 PM waiting for her food to be served. At 12:05 PM nurse aide #1 and nurse aide #3 seated themselves at the table with Resident #182. The nurse aides made no acknowledgement of the Resident or their presence at the table. The nurse aides did not offer the Resident a beverage while she waited for the food. During the continuous observation it was noted that the nurse aides did not initiate or attempt to make conversation with Resident #182. The nurse	F 241	This written plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal Law. Resident #182 has not experienced any negative outcomes. Nurse aide #1 and nurse aide #3 were re-educated on the correct way to interact with residents during meals. Nursing staff in-serviced by DON/Designee on dignity and respect of individuality related to meals including focusing attention on residents and interacting with residents in a manner to promote dignity and respect in full recognition of his or her individuality. DON/Designee conducts a dining observation audit five times weekly for one week, three times weekly for one week, once weekly for one week and then as needed ongoing. Results of the audits are reviewed quarterly to the Quality Assurance committee to ensure compliance. The Director of Nursing is responsible for monitoring compliance.	10/7/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melin Murray RN, LNHA
TITLE: Administrator
(X6) DATE: 10/10/13

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F 241	Continued From page 1 aides at times yawned and spoke to each other. Resident #182 fell asleep at various intervals and the nurse aides rested their heads in their hands propped on the table. At 12:55 PM Resident #182 was served her lunch meal and the nurse aides started making conversation and provided setup assistance. On 0919/13 at 12:30 PM nurse aide #3 was interviewed and reported that she was supposed to sit at the table and wait for the food to be served to the residents. She also reported that she did not know Resident #182's name. On 09/16/13 at 4:05 PM Resident #182 was interviewed in her room she said that since coming to the facility she had no visitors and no one to talk to. When asked if enjoyed eating in the dining room she said she did, but complained that she had to wait a long time for her food. She added that she did not know any of the people sitting with her at the table. On 09/19/13 a 2nd continuous observation of the lunch meal was made from 11:55 AM to 12:50 PM. The same lunch table was observed with Resident #182. At 12:02 PM nurse aide #1 and nurse aide #2 seated themselves at the table with the residents. Resident #182 sat at the table from 11:55 AM to 12:48 PM waiting for her food and had no interaction or acknowledgement from the nurse aides. Resident #182 was not offered a beverage while she waited for her food. The nurse aides sat at the table staring away from Resident #182 and did not speak to her. On 09/19/13 at 4:00 PM the Director of Nursing (DON) was interviewed and reported that staff are trained on dignity and respect. She explained	F 241		

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F 241	Continued From page 2 that she expected staff to talk with residents and attempt to keep conversation going when in a group setting such as the dining room. A description of the interactions observed between the nurse aides and Resident #182 during the lunch meals was reported to the DON and she stated that she would have expected the nurse aides to interact with the Resident. On 09/19/13 at 4:00 PM nurse aide #1 was interviewed and reported that she was assigned to assist residents with feeding in the main dining room and that she was supposed to sit at the table with the residents until their food was served. She explained that she was trained to offer beverages and talk to them about things "they wanted to talk about." She reported that it took awhile for the food to be served to that table and the residents seemed bored having to wait for their food. She offered no explanation why during the 2 days of observations she did not offer beverages or initiate conversation with Resident #182.	F 241		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record	F 242	It is the policy of this facility for the resident to have the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspect of his or her life that are significant to the resident. Some of the ways this has been accomplished for the named resident and other residents potentially affected by the cited deficiency is noted on the following pages.	

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F 242	Continued From page 3	F 242		

review the facility failed to allow residents the choice to eat in designated dining rooms with visitors for 3 of 5 sampled residents (Resident #70, #31 and #85) and failed to provide residents with the amount or type of baths/showers that they wanted each week for 2 of 4 residents sampled for choices (Resident #43 and #46).

1. A sign prominently displayed in the facility's dayroom dining area was observed on 9/16/13 at 11:35 AM that read:

"Family members and visitors due to lack of space please do not visit with residents in the dining area during meal times." Thank you.

a. Resident #70 was admitted to the facility on 08/21/13 with diagnoses that included sepsis, dementia, dehydration and others. The most recent Minimum Data Set (MDS) dated 08/30/13 specified the resident had severely impaired cognitive skills. On 09/16/13 at 11:30 AM Resident #70's family member was interviewed and reported that he could not visit with the resident any time day or night. The family member reported that the facility had a rule that prohibited families from being in the dining room for the breakfast, lunch and dinner meal. The family member explained that he was told this was the rule and no exceptions were allowed. He recalled an incident in which he was in the main dining room with Resident #70 waiting for the lunch meal to be served and was told by an unidentified staff member that he needed to leave. He added that he was not given a reason or given the choice to dine with Resident #70 in another location in the facility.

On 09/18/13 at 2:00 PM the Admissions Director

Plan of Correction (F 242):

All posted signs in the facility restricting visitors from the dining areas was removed on 9/20/13.
The admission form titled "Autumn Care of Drexel Policies" included with the Admission Packet was revised and no longer states that visitors are not allowed in the dining areas. This portion of the form has been omitted. — 9/20/13

Administrative staff, Nursing staff, and Dietary staff in-serviced on Self-Determination-Right to Make Choices including policy change which allows residents the choice to eat in designated dining rooms with visitors. — 10/17/13

The Social Worker/Designee conducts random resident and family interview three times weekly for one week, once weekly for one week, and then random as needed.
The results of the audits are reviewed quarterly to the Quality Assurance Committee.

The Social Worker is responsible for monitoring compliance.

Resident #70 expired on 9/24/13.

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F 242	Continued From page 4 was interviewed and reported that she was responsible for reviewing the facility's rules with residents and families. She confirmed that the facility did not allow families, guests or visitors to be in any of the 4 dining rooms while meals were being served. She stated that this rule had been in place since she was hired by the facility. She also explained that new admissions had to sign and date a form titled "Autumn Care Drexel Policies" stating they understood the dining rule. The Admissions Director reported that she told families the rule was in place because of lack of space in the dining areas to accommodate residents and their visitors. On 09/18/13 at 2:15 PM the Administrator was interviewed and reported that the facility had a rule prohibiting guests, families or visitors to be in the dining rooms while meals were served and that the rule had been in place "for years." She explained that the rule was implemented due to lack of space in the dining areas. She acknowledged that the facility would love to remodel to accommodate larger dining areas but that she had not developed a plan to create more space to allow residents the choice of eating with visitors. She stated that she would expect staff to offer visitors the option of dining in the resident's room, the conference room or the gazebo if a visitor expressed the desire to eat with a resident. b. Resident #31 was admitted to the facility on 08/07/13. Her most recent Minimum Data Set (MDS) dated 08/14/13 specified the resident had no cognitive impairment. On 09/16/13 at 3:00 PM Resident #31 was interviewed and reported that she could not have visitors any time day or night. She explained that her family could not eat with her in the dayroom. She added that the family	F 242	Resident #31 discharged home on 10/1/13.	

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F 242	Continued From page 5 had to leave if they came during meal times but that they could wait in a lounge while she ate her meal. She stated that she was there to "follow the rules" and had not asked anyone about being able to eat with her family when they visited during meal times. On 09/18/13 at 2:00 PM the Admissions Director was interviewed and reported that she was responsible for reviewing the facility's rules with residents and families. She confirmed that the facility did not allow families, guests or visitors to be in any of the 4 dining rooms while meals were being served. She stated that this rule had been in place since she was hired by the facility. She also explained that new admissions had to sign and date a form titled "Autumn Care Drexel Policies" stating they understood the dining rule. The Admissions Director reported that she told families the rule was in place because of lack of space in the dining areas to accommodate residents and their visitors. On 09/18/13 at 2:15 PM the Administrator was interviewed and reported that the facility had a rule prohibiting guests, families or visitors to be in the dining rooms while meals were served and that the rule had been in place "for years." She explained that the rule was implemented due to lack of space in the dining areas. She acknowledged that the facility would love to remodel to accommodate larger dining areas but that she had not developed a plan to create more space to allow residents the choice of eating with visitors. She stated that she would expect staff to offer visitors the option of dining in the resident's room, the conference room or the gazebo if a visitor expressed the desire to eat with a resident.	F 242		

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F 242	Continued From page 6 c. Resident #85 was admitted to the facility on 08/23/13 with diagnoses that included Alzheimer's disease and others. The most recent Minimum Data Set (MDS) dated 08/30/13 specified the resident had severely impaired cognitive skills. On 09/17/13 at 11:00 AM Resident #85's family member was interviewed and reported that she could not visit with the resident any time day or night. She explained that the facility had rules that did not allow families to eat with a resident in the dining room. She added that Resident #85 was in another facility and able to be in the dining room with Resident #85 for meals. She reported that she often visited during the lunch meal and had to say goodbye to Resident #85 just prior to her getting her lunch tray. She added that Resident #85 did not seem to understand and asked the family member to stay and eat with her. The family member explained that she was told there was not enough space in the dining room for every resident to have a visitor and she didn't want to "cause trouble" by asking for different arrangements. On 09/17/13 at 11:55 AM Resident #85's family member assisted her to the main dining room and told her goodbye. The resident asked the family member to stay and eat with her and the family member said she couldn't stay. On 09/18/13 at 2:00 PM the Admissions Director was interviewed and reported that she was responsible for reviewing the facility's rules with residents and families. She confirmed that the facility did not allow families, guests or visitors to be in any of the 4 dining rooms while meals were being served. She stated that this rule had been in place since she was hired by the facility. She	F 242	Resident #85's family was informed that it is the policy of this facility to allow residents the choice to eat in designated dining rooms with visitors.	10/8/13

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F 242	Continued From page 7 also explained that new admissions had to sign and date a form titled "Autumn Care Drexel Policies" stating they understood the dining rule. The Admissions Director reported that she told families the rule was in place because of lack of space in the dining areas to accommodate residents and their visitors. On 09/18/13 at 2:15 PM the Administrator was interviewed and reported that the facility had a rule prohibiting guests, families or visitors to be in the dining rooms while meals were served and that the rule had been in place "for years." She explained that the rule was implemented due to lack of space in the dining areas. She acknowledged that the facility would love to remodel to accommodate larger dining areas but that she had not developed a plan to create more space to allow residents the choice of eating with visitors. She stated that she would expect staff to offer visitors the option of dining in the resident's room, the conference room or the gazebo if a visitor expressed the desire to eat with a resident. d. On 09/19/13 at 5:35 PM the Resident Council President was interviewed and reported that there were rules in the facility that some residents found to be unfair. She explained that during the Resident Council Meeting, residents complained almost monthly that the facility did not allow visitors to be with the residents in dining rooms. She added that some residents believed that having their families visit was special and the families should be allowed in the dining rooms with them but that she told them that it was rule and they had to abide by it. She added that residents could eat in their rooms with their visitors. The Resident Council President stated that she had not shared any of these concerns	F 242	The Resident Council including the Resident Council President was informed during the monthly meeting on 10/7/13 that residents are allowed the choice to eat in designated dining rooms with visitors.	10/7/13

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F 242	Continued From page 8 with the facility because she felt all residents should follow the rules established by the facility whether they liked them or not. On 09/18/13 at 2:00 PM the Admissions Director was interviewed and reported that she was responsible for reviewing the facility's rules with residents and families. She confirmed that the facility did not allow families, guests or visitors to be in any of the 4 dining rooms while meals were being served. She stated that this rule had been in place since she was hired by the facility. She also explained that new admissions had to sign and date a form titled "Autumn Care Drexel Policies" stating they understood the dining rule. The Admissions Director reported that she told families the rule was in place because of lack of space in the dining areas to accommodate residents and their visitors. On 09/18/13 at 2:15 PM the Administrator was interviewed and reported that the facility had a rule prohibiting guests, families or visitors to be in the dining rooms while meals were served and that the rule had been in place "for years." She explained that the rule was implemented due to lack of space in the dining areas. She acknowledged that the facility would love to remodel to accommodate larger dining areas but that she had not developed a plan to create more space to allow residents the choice of eating with visitors. She stated that she would expect staff to offer visitors the option of dining in the resident's room, the conference room or the gazebo if a visitor expressed the desire to eat with a resident. The Administrator was unaware of the concerns that were being voiced during the Resident Council Meetings and added she would have expected the Resident Council President to alert	F 242		

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F 242	Continued From page 9 her to residents' concerns.	F 242		
	2. Resident #43 was admitted to the facility on 07/27/13 with diagnoses that included a fractured leg. The most recent Minimum Data Set (MDS) dated 08/03/13 specified the resident had no impaired cognition and required extensive assistance with bathing.			
	Resident #43's care plan dated 08/08/13 specified that she needed extensive assistance with bathing and she was to be bathed on a regular schedule.			
	On 09/16/13 at 3:00 PM Resident #43 was interviewed and reported that she was not allowed to choose the number of showers she would like to have a week. She stated that she was told she could have 2 showers a week but that she would prefer to have a shower daily. She added that she has not asked for more showers because she wanted to the follow the rules and felt that staff were too busy to give her showers every day.		Resident # 43 was interviewed by the Social Worker on 10/9/13. Bathing preferences and daily routine preferences were updated.	10/9/13
			All nursing staff named in the statement of deficiencies have received in-service training related to honoring resident preferences related to bathing and the right to make choices.	10/11/13
	On 09/18/13 at 10:56 AM nurse aide (NA) #8 was interviewed and reported that residents' bath frequency was scheduled based on the location of their room. NA #8 stated when residents changed rooms, their bath days were switched to the 2 days per week that were assigned to the new room.		Because all residents are potentially affected by the cited deficiency, all nursing staff received in-service training including honoring preferences related to bathing and the right to make choices related to their daily care and routines as well as procedure for obtaining resident preferences.	10/17/13
	On 09/18/13 at 11:10 AM NA #9 was interviewed and reported the facility maintained a shower schedule that was kept in a notebook at the nurse's station. She added that the shower schedule had not been changed since she started working at the facility about a year ago.		Social Worker/designee conducted resident interviews for all in-house residents to obtain bathing and daily routine preferences.	10/11/13
			To maintain compliance, a Bathing preferences/ daily routine preference questionnaire is completed upon admission and documented in the resident's medical record.	10/11/13

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F 242	Continued From page 10 Observations of the shower schedule notebook revealed each room was assigned two showers a week. NA #9 stated residents could have an extra shower if they had a reason. On 09/19/13 at 10:08 AM Nurse #1 was interviewed and reported the only time a resident's shower schedule was changed was when they were moved to a different room where the scheduled shower days were different. Nurse #1 stated the nurse aides on the floor consistently followed the shower schedule. She was unaware if anyone asked the resident's their bathing frequency preference. On 09/19/13 at 10:35 AM the Admissions Director was interviewed and revealed that she reviewed the shower schedule with new residents and families during admission process and asked residents and families at the end of the admission process if they had concerns. The Admissions Director stated she did not ask specifically about shower preferences/frequency during the admissions process. On 09/09/13 at 10:58 AM the Social Worker was interviewed and revealed during the admission process the hall nurse told the resident and family his assigned two shower days. On 09/19/13 at 11:09 AM the MDS Coordinator #1 was interviewed and revealed showers were set for twice weekly, based on room number. She stated if residents and families did not voice concerns then the schedule was followed for the convenience of staff and organization. Review of the admission packet for residents and their families did not reveal any information	F 242	Effective 10/11/13, a quality assurance program was implemented to ensure continued compliance. The Social Worker/designee conducts a Self-Determination/Right to Make Choices audit. The audit is conducted weekly and as needed to ensure compliance. Any deficiencies noted will be immediately corrected and findings reported to the quality assurance committee quarterly for further review or corrective action. The Social Worker is responsible for monitoring compliance.	10/11/13

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F 242	Continued From page 11 regarding preferences for frequency of showers would be honored by the facility.	F 242		
	3. Resident #46 was admitted on 06/15/11 with diagnoses including peripheral vascular disease, chronic obstructive pulmonary disease, dementia, and anemia. The latest quarterly Minimum Data Set (MDS) dated 07/30/13 assessed the resident as cognitively intact and able to understand and make herself understood.		Resident #46 was interviewed by the Social Worker on 10/9/13. Bathing preferences and daily routine preferences were updated.	10/9/13
			All nursing staff named in the statement of deficiencies have received in-service training related to honoring resident preferences related to bathing and the right to make choices.	10/11/13
	Interview with Resident #46 on 09/16/13 at 3:53 PM revealed each resident was told their scheduled two shower days per week. Resident #46 said she had never been asked if she wanted more than two showers weekly or what time of day she would prefer to shower. Resident #46 stated she wished she could have more than two showers a week. Resident #46 also stated she had enjoyed soaking in a tub-bath almost every day to relieve her joint pain when she lived at home but had been told she didn't have that option at the nursing home because there was no working bathtub..		Because all residents are potentially affected by the cited deficiency, all nursing staff received in-service training including honoring preferences related to bathing including honoring requests for tub baths.	10/17/13
			Two bathtubs accessible on three sides is provided at the facility.	10/10/13

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F 242	Continued From page 12 Interview with Nurse Aide #7 (NA) on 09/18/13 at 10:36 AM revealed each resident was scheduled to have two showers per week, based on their room number. NA #7 stated residents could take a shower but not a bath at the facility. NA #7 also stated when residents ask for a change in bathing schedule or frequency, she reminded them of their two scheduled shower days. Interview with NA #8 on 09/18/13 at 10:56 AM revealed residents' bath frequency was always 2 days weekly; the days scheduled based on the location of their room. NA #8 stated when residents change rooms, their bath days were switched to the 2 days per week that were bath days for their new room. NA #8 also stated that she didn't remember residents asking for more showers but she frequently reminded residents of their two shower days per week. Interview with NA #9 on 09/18/13 at 11:10 AM revealed shower schedule was kept in a notebook at the nurse's station and hasn't been changed since she started working at the facility about a year ago. NA #9 showed the notebook to this surveyor. The notebook included a list of rooms, divided by halls into shower days. Each room was assigned two shower days weekly. NA #9 stated residents could have an extra shower if the nursing supervisor told them they had a reason like a doctor's appointment the following day, but otherwise residents were told their schedule was two showers weekly. Interview with Nurse #1 on 09/19/13 at 10:08 AM revealed the only time a resident's shower schedule was changed was when they were moved to a different room where the scheduled shower days were different. Nurse #1 stated the	F 242		

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F 242	Continued From page 13 NAs on the floor consistently follow the shower schedule from the shower book that was located at the nurse's station. Interview with Nurse #2 on 09/19/13 at 10:16 AM revealed each resident receives two showers weekly. When asked about assessing for shower frequency preferences, Nurse #2 stated the resident or family was asked during admission by the admissions director if they have any concerns but are not asked specifically about shower frequency or type because they have a schedule in place. Nurse #2 stated she was not aware of any resident ever being asked if they would prefer a tub bath. Interview with admissions director on 09/19/13 at 10:35 AM revealed she went over the shower schedule with new residents and families during admission and asked residents and families at the end of the admission process if they had concerns. Admissions director stated she did not ask specifically about shower preferences during the admissions process. Interview with the previous admissions director on 9/19/13 at 10:54 AM revealed there was no assessment to discover residents' shower frequency preferences used during admissions. The previous admissions director stated residents and families were told about the existing schedule and if they do not initiate telling you a concern with the schedule, they were assigned according to the existing shower schedule. Interview with the social worker on 09/09/13 at 10:58 AM revealed during the admission process the hall nurse told the resident and family their assigned two shower days a week, based on	F 242		

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F 242	Continued From page 14 room number. Interview with Minimum Data Set (MDS) coordinator #1 on 09/19/13 at 11:09 AM revealed showers were set for twice weekly, based on room number. The MDS coordinator #1 stated if residents and families did not voice they prefered something different, the set schedule was followed for the convenience of staff and organization. The MDS coordinator #1 stated in the 17 years she has worked at the facility, she was not aware of any resident being offered a tub bath. Interview with MDS coordinator #2 on 09/19/13 at 11:26 AM revealed the basic shower schedule was set up according to room numbers. When asked about assessing for residents' shower frequency preferences, MDS coordinator #2 stated if residents or families had a problem with the shower schedule, they could express the concern to staff but they were not specifically asked about their shower preferences. MDS Coordinator #2 also stated she had worked for the facility for 17 years and was not aware of any resident ever being offered a tub bath. Review of the admission packet for residents and their families did not reveal any information preferences for frequency of showers or type of baths/showers.	F 242		
F 323 SS=E	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 adequate supervision and assistance devices to	F 323		

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F 323	Continued From page 15 prevent accidents.	F 323	It is the policy of this facility to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	
	This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interviews the facility failed to implement interventions to prevent repeated falls for 1 of 4 sampled residents. (Resident #81).		Some of the ways this has been accomplished with #81 includes adding a motion sensor chair alarm, review of the resident's fall history, and reviewing and updating the care plan.	9/20/13
	The findings included:		Because all residents are potentially affected by the cited deficiency, the Director of Nursing reviewed all current in-house fall/accident prevention interventions. No other residents were affected by the cited deficiency. All nursing staff in-serviced regarding state and federal requirements for minimizing hazards. Training included emphasis on importance of initiating new interventions after each fall or other accident, conducting a thorough post fall/ accident assessment and review of interventions to prevent falls/accidents. All staff named in the statement of deficiencies have received in-service training as described above.	10/17/13
	Resident #81 was admitted to the facility on 05/28/13 with diagnoses that included dementia (Alzheimer's type), urinary tract infection (UTI), osteoporosis, and hypertension. A quarterly Minimum Data Set (MDS) dated 06/04/13 specified Resident #81 required extensive assistance of 2 staff for physical assistance with Activities of Daily Living (ADLs) such as bed mobility, toileting, and transfers. The MDS also specified the resident was non-ambulatory and unable to self-propel her wheelchair without assistance. The resident's most recent MDS dated 08/17/13 revealed that the resident's short term memory was unable to be assessed, her long term memory was assessed as being impaired, and cognition was severely impaired related to decision making skills. The MDS specified the resident had fallen in the past 30 days.		Effective 10/11/13, a quality assurance program was implemented under the supervision of the Director of Nursing to monitor residents with falls or other accidents to ensure compliance. The Director of Nursing/Designee performs the following systemic changes: reviewing all post fall/accident assessments to ensure appropriate interventions are implemented after each fall/accident. Any deficiencies will be corrected immediately and the findings of the quality assurance check will be reported to the quality assurance committee quarterly fur further review or	10/11/13
	The resident's care plan to prevent falls was initiated 05/29/13 and updated on 08/23/13. The care plan goal was for the resident to experience no falls that resulted in injury and hospitalization. Current interventions listed on the care plan			

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included the following:

a) One full side rail used for bed mobility; turning and repositioning
b) Call bell within reach in room and encourage its use as needed
c) Keep pathways and common areas clear of clutter, trash, and furniture and well-lit as appropriate to prevent falls
d) Monitor position in bed/chair; reposition as needed to prevent falls or sliding to floor
e) Non-skid footwear for ambulation/transfers
f) Keep bed in lowest position
g) Out of bed (OOB) with walker and 2 person assist for all ambulation and transfers
h) Encourage to self-propel wheelchair as able
i) Frequent visual checks
j) Monitor risk for falling

On 07/19/13 at 3:15 PM a nursing entry specified Resident #81 was found in the floor, no injuries were noted and the resident was going to be monitored. A document titled "Event Investigation Follow-up" dated 08/22/13 was reviewed and revealed that the resident had an un-witnessed fall on 07/19/13. The document specified interventions to be implemented to prevent further reoccurrences included fall risk focus, frequent visual checks, and ensuring call bell is within reach.

On 07/28/13 at 10:45 AM a nursing entry specified Resident #81 was found in the floor, sustained a skin tear to her right elbow, and she had possibly hit her head. The resident was sent to the hospital for evaluation and was diagnosed with a UTI and was prescribed an antibiotic. She was transferred back to the facility the same day. A document titled "Event Investigation Follow-up"

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dated 08/22/13 was reviewed and revealed the resident had an un-witnessed fall on 07/28/13. The document specified interventions to be implemented included for staff to perform frequent visual checks and place call bell within reach of resident.

On 08/23/13 at 10:25 AM a nursing entry specified Resident #81 put to bed after her breakfast meal and was later found in the floor, unable to communicate to staff what had happened, had possibly hit her head, and there were no visual injuries. The resident was sent to the hospital for evaluation and was transferred back to the facility the same day. A document titled "Event Investigation Follow-up" dated 08/29/13 was reviewed. The document specified the resident had an un-witnessed fall on 08/23/13 and interventions to be implemented included continue frequent visual checks, place call bell within reach of resident, and review and update the care plan.

On 09/05/13 at 3:30 AM a nursing entry specified Resident #81 was found in the floor beside her bed, no injuries and/or no head injury were noted. A document titled "Event Investigation Follow-up" dated 009/06/13 was reviewed. The document specified the resident had an un-witnessed fall on 09/05/13 and interventions to be implemented included continue with current interventions and frequent visual checks.

On 09/05/13 at 10:30 PM a nursing entry specified Resident #81 was found in the floor in her room with increased confusion, and no new injuries were noted. A document titled "Event Investigation Follow-up" dated 09/06/13 was reviewed. The document specified the resident

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F 323	Continued From page 18 had an un-witnessed fall on 09/05/13 and interventions to be implemented included nurse would follow-up on results for urinalysis and check for possible UTI. On 09/16/13 at 7:00 PM a nursing entry specified Resident #81 was found in the floor, the staff would continue to give medications to treat the resident's infection and the resident would continue to be monitored for new infections. A document titled "Event Investigation Follow-up" dated 09/17/13 was reviewed. The document specified the resident had an un-witnessed fall on 09/16/13 and interventions to be implemented included continuing medications for the infection and to be monitored for new infections. On 09/17/13 at 2:45 PM Resident #81 was observed lying in her bed with the right sided bed rail in the upright position and the call bell was lying on the bed next to the resident within her reach. On 09/18/13 at 1:55 PM Resident #81 was observed in the doorway of another resident's room in her wheelchair and a staff member stating to the resident, "this is not your room". The staff member turned Resident #81's wheelchair around and wheeled her back to her room. On 09/18/13 at 4:00 PM Nursing Assistant (NA) #12 was interviewed. She stated she was unaware of the resident's recent falls and had been instructed to check on the resident more frequently. She further stated she was unaware of fall precautions and/or fall interventions for Resident #81. There was no source of documentation for frequent visual checks.	F 323		

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On 09/19/13 at 10:45 AM Resident #81 was observed self propelling her wheelchair in a hallway other than the hall of her room and going toward the dining/activity room with no staff members noted to be in the vicinity of the resident.

On 09/19/13 at 10:57 AM the Assistant Director of Nursing (ADON) was interviewed. She explained the facility utilized a fall committee that met daily to review falls to ensure appropriate interventions had been implemented to prevent reoccurrences. The ADON stated when a resident fell it was the responsibility of the nurse to implement an immediate intervention. She added the care plan was updated to reflect the changes in interventions to alert staff. The "Event Investigation Follow-up" document was reviewed with the ADON that specified the resident was to remain on frequent visual checks and ensure the resident's call bell was in reach. The ADON confirmed that these were the same interventions already in place for Resident #81 and no new interventions were implemented.

On 09/19/13 at 4:00 PM the Director of Nursing (DON) confirmed after Resident #81 experienced falls on 07/19/13, 07/28/13, 08/23/13, two falls on 09/05/13, and on 09/16/13 the staff failed to implement interventions to prevent the resident from experiencing further falls. The DON further stated that the current fall interventions were not effective in preventing the resident from falling.