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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345348	A. BUILDING _____ B. WING _____	C 10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES NURSING & REHAB CENTER	523 COUNTRY CLUB DR FAYETTEVILLE, NC 28301

(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 000	INITIAL COMMENTS This 2567 was amended on 11/01/2013. Staff identifier numbers in tag F463 were changed as follows: NA#1 was changed to NA#5 NA#2 was changed to NA#6 NA#3 was changed to NA#7 NA#5 was changed to NA#8 NA#4 was changed to Nurse #2.	F 000	FILING THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE DEFICIENCIES, AS ALLEGED, DID IN FACT EXIST. THIS PLAN OF CORRECTION IS FILED AS EVIDENCE OF THE FACILITY'S DESIRE TO COMPLY WITH THE REQUIREMENTS.	
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	Resident #1 was noted to have swelling to her left leg on 9/17/13 (1030 PM). The nurse assessed the leg and called the on-call service. The on-call service paged the wrong provider and no return call was received. The PA-C was notified on 9/18/13 and ordered an x-ray. Investigation started. On 9/20/13 investigation revealed that the incident occurred on 9/16/13. Resident was admitted to a local hospital on 9/18/13 and had surgery on 9/19/13 to repair fractured hip. Resident was re-admitted to Whispering Pines Nursing and Rehabilitation Center on 10/1/13 under Hospice care and expired in facility on 10/4/13. CNA (NA #1) was terminated on 9/20/13 for failure to notify the nurse of an incident on 9/16/13 when it occurred. As all residents have the potential for a change in condition, the plan	9/18/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle H. Fontaine — TITLE: Executive Director — (X6) DATE: 11/12/13

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 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interviews, the facility failed to notify the physician for 1 of 2 residents (Resident #1) exhibiting signs and symptoms of acute changes in condition. Resident #1 was admitted to the hospital with a left femoral fracture on 9/18/2013. The Immediate Jeopardy began on 9/17/13 at the time the nurse aide allowed the resident to slip to the floor during care. The administrator was notified of the Immediate Jeopardy on 10/16/2013 at 5:35 pm. The Immediate Jeopardy was removed on 10/17/13 at 5:15 pm when the facility provided a Credible Allegation of Compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than minimal harm that is not immediate Jeopardy (D). The facility was in the process of full implementation and monitoring their corrective action. Findings included: Review of the facility policy on Acute Condition Changes revised April 2009 indicated "The nursing staff will contact the Physician based on the urgency of the situation. For emergencies, they will call or page the Physician and request a prompt response (within approximately one-half hour or less). The attending physician (or a practitioner providing backup coverage) will	F 157	established will address all residents in the facility. Each resident will continue to be monitored as of 10/4/13 through routine assessment and observation by the unit nurse and/or nursing supervisor. Should a resident experience an episodic event, it will be noted on the 24 hour report by the unit nurse or nursing supervisor and the acute assessment and charting process will begin and continue every shift for a minimum of 72 hours by the unit nurse or until resident episodic event resolves. Notification of physician and responsible party is part of episodic charting and will be documented. Beginning 10/16/13, any change in condition identified from the 24 hour report, the appropriate chart will be reviewed for evidence of assessment, treatment plan, monitoring of plan, appropriate notification of physician and responsible party. This monitoring will be completed by the DNS, Clinical Care Coordinator, Nurse Supervisor. All licensed nursing staff have been assigned on-line learning course "Effective Communication" (this is a repeat from the 1/30/13). This class includes the SBAR tool for communication with the physician. All nursing assistants were in-serviced by the DNS on 9/20/13 regarding the "STOP and WATCH" method of	10/4/13 10/16/13 10/4/13 9/20/13

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F 157	Continued From page 2 respond in a timely manner to notification of problems or changes in condition and status. The staff will notify the Medical Director for additional guidance and consultation if a timely response is not received." Resident #1 was admitted to the facility on 6/10/2005 with diagnoses which included Alzheimer's dementia and osteoarthritis. The most recent Minimum Data Set (MDS) dated 8/9/2013 indicated the resident was severely cognitively impaired. The same MDS assessment revealed the resident was totally dependent for transfers and required the assistance of one person. The assessment further indicated the resident required extensive assistance with dressing. The assessment indicated the resident was low risk for falls. A review of the facility September 2013 Accident log revealed Resident #1 had a fall on 9/16/2013. A review of the Incident/ Accident Report for Resident #1 dated 9/16/2013 completed by Nurse #1 indicated swelling was noted to the left thigh on 9/17/2013 at 10:30 pm. Review of the Incident/Accident Report indicated first aid was not administered. Review of the Witness Interview Form dated 9/18/2013 by Nurse #1 revealed she was notified by Nursing Assistant (NA) #3 on 9/17/2013 that Resident #1's left leg was swollen. Nurse #1's witness statement further revealed an assessment of the affected extremity had been conducted, and that the left leg was "edematous and abducted as opposed to the right leg. No s/sx (sign and symptom) of pain or discomfort upon	F 157	noticing a change in resident condition and alerting the nurse to that change. After the nurse addresses the issue on the STOP and WATCH the form is returned to the DNS and reviewed in the morning clinical meeting for monitoring follow-through. This information will be included as additional training in CNA orientation and annual re-orientation and has been added to the CNA skills checklist. The licensed nursing staff were in-serviced by the Corporate Director of Clinical Operations (DCO) or appropriate designee on regarding the following areas on 10/4/13: Resident Examination and Assessment; Acute/Episodic Documentation; SBAR; Hierarchy for Nurse Administration Contact; and Acute Condition Changes-Clinical Protocol. On 10/15/13, the DCO returned to provide a refresher course on the following topics: Documentation - General; Episodic/Event Charting; Notification of RP for Change in Resident Condition or Status. The *Hierarchy of Nurse Administration Contact* was in-serviced and initiated on 10/4/13. There have been no further situations regarding no physician notification due to the on-call service paging the wrong physician. Licensed nursing staff were re-inserviced by the Corporate Director of	10/4/13 10/15/13 10/7/13

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F 157	Continued From page 3 manipulation. Medical Doctor (MD) answering service was then called to advise of findings." Review of the Witness Interview Form by Nurse #1 did not reveal a date and time the answering service was notified. On 10/4/2013 at 11:39 am, during an interview Nurse #1 indicated she was notified by NA #3 on 9/17/2013 at 10:30 pm that Resident #1's left leg was swollen. She stated "The left leg was more swollen than the right and the left foot was more slanted. "Nurse #1 stated she placed a call to the answering service after leaving the resident 's room on 9/17/13 at 10:30 pm and informed the oncoming nurse (Nurse #2) that she had placed the call prior to leaving shift. Review of the local Physician Paging log undated revealed "Date 9/17/2013, time 12:12 am, Reason for call: possible leg fracture." A review of the facility 24 hour report dated 9/18/2013 revealed "no return call from MD related to left leg/knee for Resident #1." Review of a nurse's note by Nurse # 3 dated 9/18/2013 at 12:30 pm revealed "Left upper leg noted to be swollen, reddened and shorter than right leg. PA (Physician Assistant) notified at 10:15 am. Stat x-ray ordered. X-ray called in at 10:20 am. The X-ray company entered the facility at 10:45 am. PA notified of results. Order was given to send the resident to the hospital for evaluation of left displaced oblique fracture. EMS called at 12:15 pm. Vital signs were documented as prior to leaving 117/60-62-20-97 temp, with 97 % oxygen saturation on room air. EMS entered the facility at 12:32 pm and left at 12:40 pm."	F 157	Clinical Operations on 10/4/13 and 10/15/13 as to the standard criteria for monitoring resident's condition as listed, but not limited to Condition Changes, VS (TPR, BP, Pulse Ox) Level of Consciousness and Responsiveness; Level of Cognition. All licensed nursing staff have been re-inserviced by the Corporate Director of Clinical Operations on 10/4/13 and 10/15/13 with regards to Documentation Standards in acute/episodic charting, SBAR, reporting status changes to physician and RP to include additions of new medications. Any licensed staff nurse who has not been inserviced by the DNS or appropriate designee as of 10/17/13 will not be allowed to report for duty until training is complete. This information will be included as additional training in licensed nursing orientation and annual re-orientation and has been added to the licensed nurse skills checklist. 24 Hour reports will continue to be reviewed during morning meetings. Nurse's notes, for applicable residents, will be reviewed by DNS or designee to ensure timely notification was made according to *Acute Change in Condition-Clinical Protocol*. and *Hierarchy for Nurse Administration Contact* five times per week. *Quality Assurance of Acute Care Audits* will randomly be completed based on a	10/15/13 10/4/13

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F 157	Continued From page 4 Review of the hospital History and Physical dated 9/18/2013 revealed Resident #1 was admitted with a left proximal femoral fracture with displacement and left hip swelling. A review of the physician telephone order dated 10/1/2013 indicated "Hospice to evaluate and admit." A review of the Hospice Certification and Plan of Treatment revealed resident was admitted to services on 10/3/2013. A review of the Record of Death revealed resident expired 10/4/2013 at 10:05 pm. On 10/4/2013 at 09:02 am during an interview, Nurse #2 revealed she was informed by Nurse #1 that she had paged the on call physician to notify the doctor about swelling in Resident #1 left thigh. Nurse #2 further indicated swelling in an extremity is an abnormal finding and could indicate an injury. She stated she did not document her assessment of Resident #1's swollen leg in the nurse's notes. She further stated "Screaming is her normal baseline. So with her, you really wouldn't know if she is in pain. "Nurse #2 stated she did not make any further attempts to notify the physician during her shift from 11pm through 7am about the swelling in Resident #1's leg. She stated she documented the doctor's failure to return the call back to the facility on the 24 hour report and passed it on to the day shift nurse during the change of shift verbal report. During an interview on 10/4/2013 at 1:22 pm, Nurse # 3 revealed she was informed by Nurse #2 on 9/18/2013 of swelling to Resident #1's left	F 157	change mentioned on the 24 Hour report five times per week for two months, then once weekly for one month and then monthly thereafter. These audits will be reviewed by the ED and DNS weekly and findings will be brought to the monthly QA Committee by the DNS or appropriate designee and will be reviewed by the Committee monthly times 3 months followed by quarterly for 3 quarters and then as needed, for compliance with plan. Plan will be revised as needed with appropriate staff re-in-serviced to any changes. Policies, procedures and training will be reviewed as necessary.	

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F 157	Continued From page 5 thigh during the shift change report. She further revealed she was informed of the attempt to notify the physician the night before with no return call. She stated "I don't know why I did not attempt to call the doctor again." Nurse #3 revealed she assessed Resident #1's swelling to the left thigh at 8:00 am and obtained a set of vital signs. She further revealed she and the nursing assistant went back in the resident's room at 10:00 am and that the resident was not yelling out as she normally does. Nurse # 3 indicated she was aware that Resident #1 had episodes of vomiting and changes in appetite on 9/17/2013 and 9/18/2013. She further stated she thought it was just isolated incidents. In an interview on 10/4/2013 at 2:42 pm, the Director of Nursing (DON) stated she expected the nurse to attempt to call the doctor again if the doctor did not call back. The DON further indicated in the event of an emergency, she expected the nurse to call 911 and have the resident sent to the emergency room. On 10/16/2013 at 3:00 pm, during an interview, the attending physician stated "The nurses need to be sure to call when they notice the changes in the resident 's condition. "The attending physician stated in this case the wrong physician was paged but the nurse should have placed a call to the paging service again after 15 minutes of not receiving a call back from the on call physician. She further indicated the answering service was required then to call the on call physician directly. The attending physician further stated if the nurse assessed the resident 's leg with swelling and abduction, and the on call physician did not call back, she should have called 911 and sent the patient to the emergency room.	F 157		

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F 157	Continued From page 6 The facility provided the following Credible Allegation on October 17, 2013 at 5:15 pm: Credible Allegation of Compliance for F157: Resident #1 was noted to have swelling to her left leg on 09/17/13 (1030 PM). Investigation started. On 09/20/13 investigation revealed that the incident occurred on 09/16/13. Resident was admitted to a local hospital on 9/18/13 and had surgery on 9/19/13 to repair fractured hip. Resident was re-admitted to Whispering Pines Nursing and Rehabilitation Center on 10/1/13 under Hospice care and expired in the facility on 10/4/13. CNA (NA#1) was terminated on 9/20/13 for failure to notify the nurse of an incident on 09/16/13 when it occurred. As all residents have the potential for a change in condition, the plan established will address all residents in the facility. Each resident will continue to be monitored as of 10/4/13 through routine assessment and observation by the unit nurse and/or nursing supervisor. Should a resident experience an episodic event, it will be noted on the 24 hour report by the unit nurse or nursing supervisor and the acute assessment and charting process will begin and continue every shift for a minimum of 72 hours by the unit nurse or until resident episodic event resolves. Notification of physician and responsible party is part of episodic charting and will be documented. Beginning 10/16/13, any change in condition identified from the 24 hour report, the appropriate chart will be reviewed for evidence of assessment, treatment plan, monitoring of plan,	F 157		

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F 157	Continued From page 7	F 157		

appropriate notification of physician and responsible party. This monitoring will be completed by the DNS, Clinical Care Coordinator, Nurse Supervisor.

All licensed nursing staff have been assigned on-line learning course "Effective Communication" (this is a repeat from the 1/30/13). This class includes the SBAR tool for communication with the physician.

All nursing assistants were in-servived by the DNS on 9/20/13 regarding the "STOP and WATCH" method of noticing a change in resident condition and alerting the nurse to that change. After the nurse addresses the issue on the STOP and WATCH the form is returned to the DNS and reviewed in the morning clinical meeting for monitoring of follow-through. This information will be included as additional training in CNA orientation and annual re-orientation and has been added to the CNA skills checklist.

The licensed nursing staff were re-inserviced by the Corporate Director of Clinical Operations or appropriate designee on regarding the following areas on 10/4/13 and 10/15/13 157/Notification of Change; facility policy on Change in Resident status with includes notification of physician and responsible party; the Quality of Assurance of Acute Care and monitoring of follow-through.

Licensed nursing staff were re-inserviced by the Corporate Director of Clinical Operations on 10/4/13 and 10/15/13 as to the standard criteria for monitoring resident's condition as listed, but not limited to Condition Changes, VS (TPR, BP, Pulse Ox) Level of Consciousness and Responsiveness; Level of Cognition. All licensed

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F 157	Continued From page 8 nursing staff have been re-inserviced by the Corporate Director of Clinical Operations on 10/4/13 and 10/15/13 with regards to Documentation Standards in acute/episodic charting, SBAR, reporting status changes to physician and RP to include additions of new medications. Any licensed staff nurse who has not been inserviced by the DNS or appropriate designee as of 10/17/13 will not be allowed to report for duty until training is complete. This information will be included as additional training in licensed nursing orientation and annual re-orientation and has been added to the licensed nurse skills checklist. On 10/17/2013 at 5:15 pm, verification of the credible allegation was evidenced by interviews of direct care nursing staff and administrative staff related to notification of acute changes in condition. The nurses were aware of the hierarchy of change for all current residents with any acute changes in condition.	F 157		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interview, the facility failed to assess 1	F 309		

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F 309	Continued From page 9 of 2 residents (Resident #1) exhibiting signs and symptoms of acute changes in condition, nor timely assessment for immediate care. Resident #1 was admitted to the hospital with a left femoral fracture on 9/18/2013. The Immediate Jeopardy began on 9/17/13. The administrator was notified of the Immediate Jeopardy on 10/16/2013 at 5:35 pm.The Immediate Jeopardy was removed on 10/17/2013 at 5:15 pm when the facility provided a Credible Allegation of Compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than minimal that is not Immediate Jeopardy (D). The facility was in the process of full implementation and monitoring their corrective action. Findings included: Review of the facility policy on Acute Condition Changes revised April 2009 indicated "The nursing staff will contact the Physician based on the urgency of the situation. For emergencies, they will call or page the Physician and request a prompt response (within approximately one-half hour or less). The attending physician (or a practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition and status. The staff will notify the Medical Director for additional guidance and consultation if a timely response is not received." Resident #1 was admitted to the facility on 6/10/2005 with diagnoses which included Alzheimer's dementia and osteoarthritis. The most recent Minimum Data Set (MDS) dated 8/9/2013 indicated the resident was severely	F 309	FILING THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE DEFICIENCIES, AS ALLEGED, DID IN FACT EXIST. THIS PLAN OF CORRECTION IS FILED AS EVIDENCE OF THE FACILITY'S DESIRE TO COMPLY WITH THE REQUIREMENTS. Resident #1 was noted to have swelling to her left leg on 9/17/13 (1030 PM). The nurse assessed the leg and called the on-call service. The on-call service paged the wrong provider and no return call was received. The PA-C was notified on 9/18/13 and ordered an x-ray. Investigation started. On 9/20/13 investigation revealed that the incident occurred on 9/16/13. Resident was admitted to a local hospital on 9/18/13 and had surgery on 9/19/13 to repair fractured hip. Resident was re-admitted to Whispering Pines Nursing and Rehabilitation Center on 10/1/13 under Hospice care and expired in facility on 10/4/13. CNA (NA #1) was terminated on 9/20/13 for failure to notify the nurse of an incident on 9/16/13 when it occurred. As all residents have the potential for a change in condition, the plan	9/18/13 10/4/13

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F 309	Continued From page 10 cognitively impaired. The same MDS assessment revealed the resident was totally dependent for transfers and required the assistance of one person. The assessment further indicated the resident required extensive assistance with dressing. The MDS assessment indicated the resident was unsteady with surface to surface transfer. The same assessment further indicated resident had limited range of motion to both upper and lower extremities. A review of Resident #1 's nursing care plan last updated 8/9/2013 revealed the resident was at risk for falls. The care plan further indicated the resident was transferred with the mechanical lift. A review of the facility September 2013 Accident log revealed Resident #1 had a fall on 9/16/2013. The Incident/Accident report was completed by Nurse # 1 on 9/18/2013 after the resident was diagnosed with a left femoral fracture on 9/18/2013. During an interview on 10/3/2013 at 11:28 am, the Director of Nursing (DON) stated she had Nurse #1 to come in and complete an incident report for Resident #1 after the resident was diagnosed with the fracture because she had initially noticed the swelling and abduction the evening before. The DON further indicated the fall was not reported at the time of occurrence and the facility did not learn about the fall until days later. A review of a typed entry per the Director of Nursing dated 9/18/2013 at 10:00 am indicated "Called to resident's room to assess left leg abnormality. Noted the affected left lower extremity was shorter than unaffected extremity and the left lower extremity rotated. Nurse called attention to the left upper thigh area. Noted swelling, tightness and warmth. Resident appeared less responsive and was not exhibiting	F 309	established will address all residents in the facility. Each resident will continue to be monitored as of 10/4/13 through routine assessment and observation by the unit nurse and/or nursing supervisor. Should a resident experience an episodic event, it will be noted on the 24 hour report by the unit nurse or nursing supervisor and the acute assessment and charting process will begin and continue every shift for a minimum of 72 hours by the unit nurse or until resident episodic event resolves. Notification of physician and responsible party is part of episodic charting and will be documented. All licensed nursing staff have been assigned on-line learning course "Effective Communication" (this is a repeat from the 1/30/13). This class includes the SBAR tool for communication with the physician for completion of 10/15/13. The licensed nursing staff were in-serviced by the Corporate Director of Clinical Operations (DCO) or appropriate designee on regarding the following areas on 10/4/13: Resident Examination and Assessment; Acute/Episodic Documentation; SBAR; Hierarchy for Nurse Administration Contact; and Acute Condition Changes-Clinical Protocol. On 10/15/13, the DCO returned to provide a refresher	10/15/13 10/15/13

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	345348	A. BUILDING _____ B. WING _____	C 10/17/2013

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F 309	Continued From page 11 the normal behavior per resident which is yelling out when touched. Hip rocked. Resident moaned in discomfort. Instruction was given for nurse to update MD on the findings and to request in house X-ray." During an interview on 10/3/13 at 11:28 am, she stated, "It was a classic sign of a hip fracture. " Review of the Witness Interview Form dated 9/18/2013 by Nurse #1 revealed she was notified by NA #3 on 9/17/13 at 10:30 pm that Resident #1's left leg was swollen. Nurse #'1's witness statement further revealed an assessment of the affected extremity had been conducted, and that the left leg was "edematous and abducted as opposed to the right leg. No s/sx (sign and symptom) of pain or discomfort upon manipulation. MD (Medical Doctor) answering service was then called to advise of findings." Review of the Witness Interview Form did not reveal the date or time the answering service was notified. Review of the local Physician Paging log undated revealed one call "Date 9/17/2013, time 12:12 am, Reason for call: possible leg fracture." A review of a nurse's note by Nurse #3 dated 9/18/2013 at 12:30 pm revealed "Left upper leg noted to be swollen, reddened and shorter than right leg. PA (Physician Assistant) notified at 10:15 am. Stat x-ray ordered. X-ray called in at 10:20 am. X-ray company entered the facility at 10:45 am. PA notified of results. Order was given to send the resident to the hospital for evaluation of left displaced oblique fracture. EMS called at 12:15 pm. Vital signs prior to leaving 117/60-62-20-97 temp, with 97 % oxygen saturation on room air. EMS entered the facility at	F 309	course on the following topics: Documentation - General; Episodic/Event Charting; Notification of RP for Change in Resident Condition or Status. The *Hierarchy of Nurse Administration Contact* was in-serviced and initiated on 10/4/13. There have been no further situations regarding no physician notification due to the on-call service paging the wrong physician. Licensed nursing staff were re-inserviced by the Corporate Director of Clinical Operations on 10/4/13 and 10/15/13 as to the standard criteria for monitoring resident's condition as listed, but not limited to Condition Changes, VS (TPR, BP, Pulse Ox) Level of Consciousness and Responsiveness; Level of Cognition. All licensed nursing staff have been re-inserviced by the Corporate Director of Clinical Operations on 10/4/13 and 10/15/13 with regards to Documentation Standards in acute/episodic charting, SBAR, reporting status changes to physician and RP to include additions of new medications. Any licensed staff nurse who has not been inserviced by the DNS or appropriate designee as of 10/17/13 will not be allowed to report for duty until training is complete. This	10/4/13 10/17/13

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F 309	Continued From page 12 12:32 pm and left at 12:40 pm." Review of the nurse's note did not reveal first aid treatment or medication was administered. Review of a nurse's note by Nurse #1 dated 9/18/2013 at 4:55 pm revealed the following "Late entry for 9/17/2013- 3-11 shift (10:30 pm) CNA on duty notified this writer that resident leg "looked swollen" Upon assessment, resident leg/ hip appeared edematous, slightly abducted in comparison to right leg. Resident displayed no s/sx (sign and symptom) of pain or discomfort upon ROM (range of motion) of left leg. Resident noted to be lying on back at time of assessment. MD answering service called so that on call MD or PA on duty may be notified of findings and to seek further guidance. Information passed on to nurse of oncoming shift so that information of findings may be conveyed to on call MD or PA of information when call back received." Review of the nurse's note did not reveal first aid treatment or medication was administered. A review of the facility 24 hour report dated 9/18/2013 revealed "no return call from MD related to left leg/knee for Resident #1." Review of the Witness Interview Form by NA (Nursing Assistant) #1 dated 9/20/2013 indicated he sat the resident up on the side of the bed to pull her dress down and she slid to the floor. The Witness Interview Form further indicated NA #1 transferred Resident #1 into the chair with the assistance of NA #2 after the fall. There were no nurse 's notes in the medical record related to Resident #1 's status from 9/16/13 until 9/17/2013 at 10:30 pm. On 10/4/2013 at 09:02 am during an interview,	F 309	information will be included as additional training in licensed nursing orientation and annual re-orientation and has been added to the licensed nurse skills checklist. All nursing assistants were in-serviced by the DNS on 9/20/13 regarding the "STOP and WATCH" method of noticing a change in resident condition and alerting the nurse to that change. After the nurse addresses the issue on the STOP and WATCH the form is returned to the DNS and reviewed in the morning clinical meeting for monitoring follow-through. This information will be included as additional training in CNA orientation and annual re-orientation and has been added to the CNA skills checklist. 24 Hour reports will continue to be reviewed during morning meetings. Nurse's notes, for applicable residents, will be reviewed by DNS or designee to ensure timely notification was made according to *Acute Change in Condition-Clinical Protocol*. and *Hierarchy for Nurse Administration Contact* five times per week. *Quality Assurance of Acute Care Audits* will randomly be completed based on a change mentioned on the 24 Hour report five times per week for two months, then once weekly for one month and then monthly thereafter. These audits will be reviewed by the ED and DNS weekly and findings will be brought to	9/20/13 10/4/13 10/4/13

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F 309	Continued From page 13 Nurse #2 revealed she was informed by Nurse #1 that she had paged the on call physician to notify the doctor about swelling in Resident #1 left thigh. Nurse #2 further indicated swelling in an extremily is an abnormal finding and could indicate an injury. She stated she did not document her assessment of Resident #1's swollen leg in the nurse's notes. She added that she did not place the resident on acute charting report. She further stated "Screaming is her normal baseline. So with her, you really wouldn't know if she is in pain." Nurse #2 stated she did not make any further attempts to notify the physician during her shift from 11pm through 7am about the swelling in Resident #1's leg. She stated she documented the doctor's failure to return the call back to the facility on the 24 hour report and reported it on to the day shift nurse during the change of shift verbal report. In an interview on 10/4/2013 at 11:39 am, Nurse #1 indicated that NA #3 reported to her on 9/17/2013 that Resident #1's left leg looked swollen. She stated, "The left leg was more swollen than the right and the left foot was more slanted." Nurse #1 further indicated abduction is an abnormal finding that would indicate the need to notify the doctor and that further medical evaluation would be needed. Nurse #1 stated she did not place the resident on acute charting status for closer monitoring or implement precautions related to assessment of the abducted leg. On 10/14/2013 at 11:07 am, during an interview, NA (Nursing Assistant) #1 revealed he sat Resident #1 up on the side of the bed and tried to put her dress on her on 9/16/13 between 9 and 11 am. He stated the dress was too small and she slid off the bed. NA #1 further indicated "It was	F 309	the monthly QA Committee by the DNS or appropriate designee and will be reviewed by the Committee monthly times 3 months followed by quarterly for 3 quarters and then as needed, for compliance with plan. Plan will be revised as needed with appropriate staff re-in-serviced to any changes. Policies, procedures and training will be reviewed as necessary.	

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F 309	Continued From page 14 an accident and I feel bad about it." NA #1 further revealed that he always sat the resident up on the side of the bed to dress her. He stated he left the resident on the floor beside the bed while he went to the door and yelled down the hall for help. NA #1 stated he was not able to tell the nurse about the fall because she was off the floor to lunch but he had planned to tell her when she returned. He further stated he forgot to inform the nurse about the fall on 9/16/13. NA #1 stated the resident did not show any signs of pain before she was placed in the chair. During an interview on 10/4/2013 at 1:22 pm, Nurse # 3 revealed she was informed by Nurse #2 on 9/18/2013 of swelling to Resident #1's left thigh during the shift change report. She further revealed she was informed of the attempt to notify the physician the night before with no return call. She stated "I don't know why I did not attempt to call the doctor again. "Nurse #3 revealed she assessed Resident #1's swelling to the left thigh at 8:00 am and obtained a set of vital signs. She further revealed she and the nursing assistant went back in the resident's room at 10:00 am and that the resident was not yelling out as she normally does. Nurse # 3 indicated she was aware that Resident #1 had episodes of vomiting and changes in appetite on 9/17/2013 and 9/18/2013. She further stated she thought it was just isolated incidents. On 10/4/2013 at 2:05 pm during an interview, NA #4 indicated Resident #1 had a vomiting episode on 9/17/2013 after breakfast. She indicated Resident #1 normally had a good appetite. She further indicated Resident #1 exhibited additional changes to include decreased yelling and decreased appetite at lunch on 9/17/2013 which	F 309		

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F 309	Continued From page 15 was reported to Nurse #3. On 10/14/2013 at 11:48 am, In an interview with NA #2, she indicated she was called out of another resident 's room by NA #1 to assist with transferring Resident #1 into the gerichair. NA #2 further revealed that Resident # 1 was sitting on the bottom of the gerichair and the back of the chair was standing off the floor in the back. She indicated her immediate response was to help NA #1 to get the resident on up into the chair. NA #2 further stated NA #1 informed her not to tell anyone. NA #2 indicated this incident occurred on Monday 9/16/13. She further stated NA #1 was irrate and angry on the day of the fall. Review of a written statement undated by NA #3 revealed Resident #1 did not eat or drink during evening meal on 9/17/2013. The witness statement for NA #3 further indicated "I first checked her at 3:30 pm and she didn't seem like she felt good. Her eyes were fixed on the ceiling and she seemed to be out of it." NA #3's witness statement further revealed "I went in her room again on my last round which was 10:00 pm and I noticed her leg did not look right so I went and got the nurse." NA # 3 was not available during the investigation. She could not be reached at the telephone number provided by the facility on two attempts, 10/14/2013 at 11:00 am, and 10/14/2013 at 11:55am. Review of the hospital History and Physical dated 9/18/2013 revealed Resident #1 was admitted with a left proximal femoral fracture with displacement and left hip swelling. The history and physical further revealed a diagnosis of	F 309		

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F 309	Continued From page 16	F 309		

anemia, acute on chronic, "there is no external bleeding but may possibly be related to left hip injury intra compartmental bleeding. Patient will need a blood transfusion."

Review of the hospital Discharge summary dated 10/1/2013 revealed "drop in hemoglobin and hematocrit level could have been from the left hip fracture. She received a total of four units of packed red blood cells. She was found to have a hemoglobin level of 6.6 on admission." She was evaluated by cardiologist for preoperative risk assessment and had a 2D echocardiogram done which showed normal ejection fraction. The discharge summary further indicated multiple discussions with power of attorney confirming that the goal of care was comfort. Despite treatment, the patient continued to decline. The discharge summary further indicated resident was being discharged back to the skilled nursing facility with hospice services.

A review of the physician telephone order dated 10/1/2013 indicated "Hospice to evaluate and admit."

A review of the Hospice Certification and Plan of Treatment revealed resident was admitted to services on 10/3/2013.

A review of the record of death revealed resident expired 10/4/2013 at 10:05 pm.

On 10/16/2013 at 3:00 pm, during an interview, the attending physician stated "She lost a lot of blood." She further stated "The nurses need to be sure to call when they notice the changes in the resident's condition." She stated the low hematocrit and hemoglobin could be due to the

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F 309	Continued From page 17 delay in treatment from the time of the fall to the time of hospitalization. She further stated the resident never fully recovered from the hip fracture surgery and the goal became to keep the resident comfortable. She indicated the purpose of the surgery was to control the pain and the bleeding. The attending physician further stated if the nurse assessed the resident's leg with swelling and abduction, and the on call physician did not call back, she should have called 911 and sent the patient to the emergency room. The facility provided the following Credible Allegation on October 17, 2013 at 5:15 pm: Credible Allegation of Compliance for F309: Resident #1 was noted to have swelling to her left leg on 09/17/13 (1030 PM). Investigation started. On 09/20/13 investigation revealed that the incident occurred on 09/16/13. Resident was admitted to a local hospital on 9/18/13 and had surgery on 9/19/13 to repair the fractured hip. Resident was re-admitted to Whispering Pines Nursing and Rehabilitation Center on 10/1/13 under Hospice care and expired in the facility on 10/4/13. CNA (NA#1) was terminated on 9/20/13 for failure to notify the nurse of an incident on 09/16/13 when it occurred. As all residents have the potential for a change in condition, the plan established will address all residents in the facility. Each resident will continue to be monitored as of 10/4/13 through routine assessment and observation by the unit nurse and/or nursing supervisor. Should a resident experience an episodic event, it will be noted on the 24 hour report by the unit nurse or nursing supervisor and the acute assessment	F 309		

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F 309	Continued From page 18 and charting process will begin and continue every shift for a minimum of 72 hours by the unit nurse or until resident episodic event resolves. Notification of physician and responsible party is part of episodic charting and will be documented. All licensed nursing staff were assigned on-line learning course "Effective Communication " which includes the SBAR tool for communication to the physician for completion of 10/15/13. Licensed nursing staff and C.N.A.s have be re-inserviced by the DON or appropriate designee regarding the following ü Facility Policy on Change in Resident Status which includes notification of physician ü Quality Assurance of Acute Care ü Practice Guideline for Notification of Changes ü Documentation of Notification Licensed nursing staff were re-inserviced by the Corporate Director of Clinical Operations on 10/4 and 10/15 as to the standard criteria for monitoring resident ' s condition as listed below, but not limited to: Acute Condition Changes Clinical Protocol; VS (TPR, BP, Pulse Ox); Level of Consciousness and Responsiveness; Level of Cognition All licensed staff have been re-inserviced on Documentation Standards in acute/episodic charting, SBAR, reporting change in status to physician/RP to include additions of new medications by the Corporate Director of Clinical Operations on 10/4/13 and 10/15/13 Any licensed staff member who has not been inserviced as of 10/17/13 will not be allowed to report for duty until training is complete. This information will be included as additional training in licensed nursing orientation and annual re-orientation as shown on the licensed nurse	F 309		

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F 309	Continued From page 19 skills checklist. All nursing assistants were in-serviced by the DNS on 9/20/13 regarding the " STOP and WATCH " method of noticing a change in resident condition and alerting the nurse to that change. After the nurse addresses the issue on the STOP and WATCH the form is returned to the DON and reviewed in the morning clinical meeting to monitor for follow-through. This information will be included as additional training in CNA orientation and annual re-orientation and has been added to the CNA skills checklist. On 10/17/13 at 5:15 pm, verification of the credible allegation was evidenced by interviews of direct nursing care staff related to monitoring and reporting acute changes in condition. The direct nursing care staff was aware of the STOP and WATCH change alerting tool to be given to the nurses with a copy to be submitted to management. The Licensed Nurses were aware of Acute Changes Protocol to include vital signs with documentation of notification in the medical record.	F 309		
F 323 SS=J	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 prevent accidents. This REQUIREMENT is not met as evidenced	F 323		

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F 323	Continued From page 20 by: Based on record review, staff interviews and physician interview, the facility failed to assure that 1 of 5 residents reviewed for accidents (Resident #1) was properly supervised during routine care to prevent the resident from sliding to the floor and causing a fracture. The administrator was notified of the Immediate Jeopardy on 10/16/2013 at 5:35 pm. The Immediate Jeopardy began on 9/16/2013 at the time of the nurse aide allowed the resident to slip to the floor during care. The Immediate Jeopardy was removed on 10/17/13 at 5:15 pm when the facility provided a Credible Allegation of Compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than minimal harm that is not Immediate jeopardy (D). The facility was in the process of full implementation and monitoring their corrective action. Findings included: Resident #1 was admitted to the facility on 6/10/2005 with diagnoses which included Alzheimer's dementia and osteoarthritis. The most recent Minimum Data Set (MDS) dated 8/9/2013 indicated the resident was severely cognitively impaired. The same MDS assessment revealed the resident was totally dependent for transfers and required the assistance of one person. The assessment further indicated the resident required extensive assistance with dressing. The MDS assessment indicated the resident was unsteady with surface to surface transfer. The same assessment further indicated resident had limited range of motion to both upper and lower extremities.	F 323	On 9/17/13, the 3-11 CNA reported to the nurse that Resident #1's leg "looked swollen". The nurse assessed the leg and noted it to "appeared edematous, slightly abducted in comparison to the right leg". Resident was admitted to the hospital on 9/18/13. An incident report was completed and an investigation was initiated by the Director of Nursing Services immediately on 9/18/13 due to this being an injury of unknown origin. CNA involved in the incident was interviewed on 9/20/13 by the DON, and QCC and disciplinary action was initiated due to failure to notify the nurse of the incident. This failure of notification resulted in termination of employment on 9/20/13. On 9/18/13, nursing management reviewed Fall Risk Assessments for all current residents who had had a fall since 7/1/13 and all new admissions since 9/1/13 still residing in the facility. Any new fall prevention interventions were initiated and care planned. New admission residents will continue to be evaluated for fall risk upon admission and preventive interventions will be put into place for residents at risk. Residents at risk of falling will be identified at each nurse's station as a member of the Falling Leaf Club effective 9/23/13. All licensed nursing staff were in-serviced by the DON	9/18/13 9/18/13 9/20/13 9/18/13

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F 323	Continued From page 21 A review of Resident #1's nursing care plan last updated 8/9/2013 revealed the resident was at risk for falls. The goal stated for this problem was that the resident would have no falls over the next 90 days. Interventions listed for this problem included providing non restrictive side rails, giving the resident verbal reminders to use the call bell for assistance, providing an environment with adequate lighting that is free of glare, monitor the resident for at risk for behaviors which could lead to falls, keeping the resident in the geri-chair when out of bed, placing the call bell and other frequently used items within easy reach of the resident to prevent the resident from reaching for items. The care plan further indicated resident was transferred with the mechanical lift. A review of the facility September 2013 Accident log revealed Resident #1 had a fall on 9/16/2013. The Incident/Accident report was completed by Nurse #1 on 9/18/2013 after the resident was diagnosed with a left femoral fracture on 9/18/2013. During an interview on 10/3/2013 at 11:28 am, the Director of Nursing (DON) stated she had Nurse #1 to come in and complete an incident report for Resident #1 after the resident was diagnosed with the fracture because she had initially noticed the swelling and abduction the evening before. The DON further indicated the fall was not reported at the time of occurrence and the facility did not learn about the fall until days later. Review of the Witness Interview Form by NA (Nursing Assistant) #1 dated 9/20/2013 indicated he sat the resident up on the side of the bed to pull her dress down and she slid to the floor. The written witness statement further indicated NA #1	F 323	and Quality Care Coordinator regarding the policy for Acute Condition Changes/Clinical Protocol on 10/3/13 which address how to notify the physician. Transfer status of all residents were reviewed with the care plan updates and posted inside the resident closets on 9/23/13 for CNAs to easily access. New admits will continue to be assessed for care needs and Kardex and closet postings will be updated as needed by the IDT Team. Nursing staff, including CNAs, were in-serviced by the DON and Quality Care Coordinator on 9/23/13 regarding the following: Reporting Abuse to Facility Management (this policy includes injuries of unknown origin); Change in Resident Condition or Status; Repositioning; and the Falling Leaf Club. Staff were also in-serviced on the INTERACT STOP and WATCH communication tool on 9/20/13 by the DON. New employee Orientation Sheet was revised on 9/23/13 to include the Falling Leaf Club and STOP and WATCH tool to ensure all new employees will be trained. 9/20/13 on the Falls and Fall Risk Management policy and Fall Prevention Team Interventions by the DON and QCC.	10/3/13 9/23/13 9/23/13 9/20/13

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F 323	Continued From page 22 transferred Resident #1 into the chair with the assistance of NA #2 after the fall. On 10/14/2013 at 11:07 am, during an interview, NA (Nursing Assistant) #1 revealed he sat Resident #1 up on the side of the bed and tried to put her dress on her on 9/16/13 between 9 and 11am. He stated the dress was too small and she slid off the bed. NA #1 further indicated " It was an accident and I feel bad about it." NA #1 further revealed that he always sat the resident up on the side of the bed to dress her. He stated he left the resident on the floor beside the bed while he went to the door and yelled down the hall for help. NA #1 stated he was not able to tell the nurse about the fall because she was off the floor to lunch but he had planned to tell her when she returned. He further stated he forgot to inform the nurse about the fall on 9/16/13. NA #1 stated the resident did not show any signs of pain before she was placed in the chair. On 10/14/2013 at 11:48 am, in an interview with NA #2, she indicated she was called out of another resident ' s room by NA #1 to assist with transferring Resident #1 into the gerichair. NA #2 further revealed that Resident # 1 was sitting on the bottom of the gerichair and the back of the chair was standing off the floor in the back. She indicated her immediate response was to help NA #1 to get the resident on up into the chair. NA #2 further stated NA #1 informed her not to tell anyone. NA #2 indicated this incident occurred on Monday 9/16/13. She further stated NA #1 was irrate and angry on the day of the fall. Review of a nurse's note by Nurse #1 dated 9/18/2013 at 4:55 pm revealed the following "Late entry for 9/17/2013- 3-11 shift (10:30 pm)	F 323	Fall Prevention Team Interventions were posted at each nurse's station on 9/20/13 so that nurses would be able to immediately initiate interventions for falls. The DON and Quality Care Coordinator trained the CNAs on 9/18/13 regarding safety awareness of residents at risk of falls and on 9/20/13 regarding using the "buddy System" for transfers, turning and repositioning. All nursing staff were in-serviced on Repositioning; Lifting Machine, Using a Portable; and Safe Lifting and Movement of Residents on 9/23/13, also by the DON and QCC. What Constitutes as Fall was in-serviced on 10/16 and 10/17/13. Beginning on 9/20/13, "Transfer Audit Tool" and "Observation of Care" audits will be completed randomly for 8 weeks and then monthly thereafter. Audits will be reviewed each week for 8 weeks and additional training will be provided if indicated. These audits will be reviewed by the ED and DNS weekly and findings will be brought to the monthly QA Committee by the DNS or appropriate designee and will be reviewed by the Committee monthly times 3 months followed by quarterly for 3 quarters and then as needed, for compliance with plan. First QA meeting was held 9/20/13. Plan will be revised as needed with appropriate staff re-in-serviced to any changes. Policies, procedures and training will be reviewed as necessary.	9/20/13 10/17/13 9/20/13

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F 323	Continued From page 23 CNA on duty notified this writer that resident leg "looked swollen." Upon assessment, resident leg/ hip appeared edematous, slightly abducted in comparison to right leg. Resident displayed no s/sx (sign and symptom) of pain or discomfort upon ROM (range of motion) of left leg. Resident noted to be lying on back at time of assessment. MD answering service called so that on call MD or PA on duty may be notified of findings and to seek further guidance. Information passed on to nurse of oncoming shift so that information of findings may be conveyed to on call MD or PA of information when call back received." A review of the Incident/ Accident Report for Resident #1 dated 9/18/2013 completed by Nurse #1 indicated swelling was noted to the left thigh on 9/17/2013 at 10:30 pm. Review of the Incident/Accident Report indicated first aid was not administered. A review of a typed entry per the Director of Nursing dated 9/18/2013 at 10:00 am indicated "Called to resident's room to assess left leg abnormality. Noted the affected left lower extremity was shorter than unaffected extremity and the left lower extremity rotated. Nurse called attention to the left upper thigh area. Noted swelling, tightness and warmth. Resident appeared less responsive and was not exhibiting the normal behavior per resident which is yelling out when touched. Hip rocked. Resident moaned in discomfort. Instruction was given for nurse to update MD on the findings and to request in house X-ray." A review of a nurse's note by Nurse # 3 dated 9/18/2013 at 12:30 pm revealed "Left upper leg noted to be swollen, reddened and shorter than	F 323		

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right leg. PA (Physician Assistant) notified at 10:15 am. Stat x-ray ordered. X-ray called in at 10:20 am. X-ray company entered the facility at 10:45 am. PA notified of results. Order given to send the resident to the hospital for evaluation of left displaced oblique fracture. EMS called at 12:15 pm. Vital signs prior to leaving 117/60-62-20-97 temp, with 97 % oxygen saturation on room air. EMS entered the facility at 12:32 pm and left at 12:40 pm."

Review of the hospital History and Physical dated 9/18/2013 revealed Resident #1 was admitted with a left proximal femoral fracture with displacement and left hip swelling. The history and physical further revealed a diagnosis of anemia, acute on chronic, " there is no external bleeding but may possibly be related to left hip injury intra compartmental bleeding. Patient will need a blood transfusion."

Review of the hospital Discharge Summary dated 10/1/2013 revealed "drop in hemoglobin and hematocrit level could have been from the left hip fracture. She received a total of four units of packed red blood cells. She was found to have a hemoglobin level of 6.6 on admission. "She was evaluated by cardiologist for preoperative risk assessment and had a 2D echocardiogram done which showed normal ejection fraction. The discharge summary further indicated multiple discussions with power of attorney confirming that the goal of care was comfort. Despite treatment, the patient continued to decline. The discharge summary further indicated resident was being discharged back to the skilled nursing facility with hospice services.

A review of the physician telephone order dated

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F 323	Continued From page 25 10/1/2013 indicated "Hospice to evaluate and admit." A review of the Hospice Certification and Plan of Treatment revealed resident was admitted to services on 10/3/2013. A review of the Record of Death revealed resident expired 10/4/2013 at 10:05 pm. On 10/16/2013 at 3:00pm, during an interview, the attending physician stated "She never fully recovered from the hip fracture surgery and the goal became to keep the resident comfortable. " She indicated the purpose of the surgery was to control the pain and the bleeding. The facility provided the following Credible Allegation on October 17, 2013 at 5:15 pm: Credible Allegation of Compliance for F323: Resident #1 was noted to have swelling to her left leg on 09/17/13 (1030 PM). "The nurse assessed the leg and noted it to "appeared edematous, slightly abducted in comparison to the right leg" . Investigation started. On 09/20/13 investigation revealed that the incident occurred on 09/16/13. Resident was admitted to a local hospital on 9/18/13 and had surgery on 9/19/13 to repair fractured hip. Resident was re-admitted to Whispering Pines Nursing and Rehabilitation Center on 10/1/13 under Hospice care and expired in the facility on 10/4/13. CNA (NA#1) was terminated on 9/20/13 for failure to notify the nurse of an incident on 09/16/13 when it occurred.	F 323		

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An incident report was completed and an investigation was initiated by the Director of Nursing Services immediately on 9/18/13 due to this being an injury of unknown origin. CNA involved in the incident was interviewed on 9/20/13 by the DON, and QCC and disciplinary action was initiated due to failure to notify the nurse of the incident. This failure of notification resulted in termination of employment on 9/20/13.

On 9/18/13, nursing management reviewed Fall Risk Assessments for all current residents who had had a fall since 7/1/13 and all new admissions since 9/1/13 still residing in the facility. Any new fall prevention interventions were initiated and care planned. New admission residents will continue to be evaluated for fall risk upon admission and preventive interventions will be put into place for residents at risk. Residents at risk of falling will be identified at each nurse ' s station as a member of the Falling Leaf Club effective 9/23/13. All licensed nursing staff were in-serviced by the DON and Quality Care Coordinator regarding the policy for Acute Condition Changes/Clinical Protocol on 10/3/13 which address how to notify the physician. Transfer status of all residents were reviewed with the care plan updates and posted inside the resident closets on 9/23/13 for CNAs to easily access. New admits will continue to be assessed for care needs and Kardex and closet postings will be updated as needed by the IDT Team.

Nursing staff, including CNAs, were in-serviced by the DON and Quality Care Coordinator on 9/23/13 regarding the following: Reporting Abuse to Facility Management (this policy includes injuries of unknown origin); Change in Resident Condition or Status; Repositioning; and the

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Falling Leaf Club. Staff were also in-serviced on the INTERACT STOP and WATCH communication tool on 9/20/13 by the DON. New employee Orientation Sheet was revised on 9/23/13 to include the Falling Leaf Club and STOP and WATCH tool to ensure all new employees will be trained.

Fall IDT will continue to review all incidents of falls each morning in the stand-up meeting to initiate prevention interventions. Interventions will be added to the care plan. The Fall IDT began using the CCME Five Whys Worksheet on 9/18/13 to determine the root cause of the fall in order to initiate appropriate interventions. All licensed nursing staff was in-serviced on 9/20/13 on the Falls and Fall Risk Management policy and Fall Prevention Team Interventions by the DON and QCC. Fall Prevention Team Interventions were posted at each nurse's station on 9/20/13 so that nurses would be able to immediately initiate interventions for falls. The DON and Quality Care Coordinator trained the CNAs on 9/18/13 regarding safety awareness of residents at risk of falls and on 9/20/13 regarding using the "buddy System" for transfers, turning and repositioning. All nursing staff were in-serviced on Repositioning; Lifting Machine, Using a Portable; What Constitutes as Fall; and Safe Lifting and Movement of Residents on 9/23/13, also by the DON and QCC.

On 10/17/2013 at 5:15 pm, verification of the credible allegation was evidenced by interviews of direct nursing care staff related to safety awareness of residents at risk for falls. The direct care nursing staff was aware of what constitutes a fall, to look into the closets for the specific transfer need for the particular resident, and to

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F 323	Continued From page 28 use the buddy system for transfers.	F 323		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to maintain working call bell system for 1 (resident #3) of 6 residents reviewed for call bells. Findings include: Resident #3 was admitted to the facility on 6/15/106 with diagnoses including Osteoarthrosis, gout and contracture of the hands. The annual Minimum Data Set (MDS) dated 8/19/13 revealed the resident was cognitively intact. She required extensive assistance with bed mobility, dressing, toileting and total dependence with transfers, eating, and bathing. During an interview on 10/15/13 at 11:53 am the resident stated her call bell was not working. She reported that she had been aware of the malfunctioning call bell for one week. She stated the maintenance worker told her that the electrician had not come to correct the problem. She further stated that she had been calling out verbally to obtain assistance when needed. On 10/15/13 at 1:10 pm the Environmental	F 463	Resident #3 was put on 15 minute safety checks until her call light was fixed later that afternoon around 6:45 pm. Call lights for other residents were operating properly at that time. A back-up plan was written to detail steps to be taken in the event the call bell system is not functioning. The back-up plan is laminated and posted at each nurse's station for review. School bells are stored in the front medication room to be used in the event the call light system is nonfunctioning for a resident(s). Maintenance will be immediately notified of malfunctioning call lights. Resident(s) affected will be noted on the appropriate 24 hour report. On 10/17/13, in-servicing began for staff regarding the Back-up Plan if Call Light(s) Are Not Working (10/17/13). An audit of the call light system was conducted daily by the Environmental Director or designee beginning 10/16/13. These audits will be reviewed by the ED weekly and findings will be brought to the monthly QA Committee by the ED or appropriate designee and will be reviewed by the Committee monthly times 3 months followed by quarterly for 3 quarters and then as needed, for compliance with plan. First QA meeting was held 10/18/13. Plan	10/15/13 10/17/13 10/17/13 10/18/13

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F 463	Continued From page 29 Services (ES) Manager stated that he discovered the call bell malfunction during a routine inspection on 10/7/13. He reported he received an additional notification of the call bell not working on 10/11/13 from another staff member. He stated that the battery that controlled the wireless system for the resident's room and the next room was a specialty battery which was ordered but had not arrived. He stated when the call bell in the room was pressed a light outside the room should have illuminated. He stated the call bell also audibly alarmed at the nursing station. On 10/15/13 at 1:25 pm the DON and the ES Manager attempted to demonstrate the call bell alarm on the computer at the nursing station. The call system computer did not have an audible alert. The only notification of the call bell alert was a red block 1.5 inches square on the upper right hand side of the computer monitor screen. The DON indicated she had not been aware that Resident #3's call bell malfunctioned for more than a week. The DON stated that moving forward a staff member would maintain visual monitoring of the call bell computer screen to ensure the call bells were responded to even if the lights outside the rooms were not illuminating. She further stated that the staff member would notify the nursing staff of assistance needed through the overhead paging system. She also indicated the staff would monitor the rooms without functioning call bell lights every 15 minutes. On 10/15/13 at 1:55 pm the Administrator was present at the nursing station with the DON and the ES Manager. The Administrator stated the facility did not have a plan for the malfunctioning	F 463	will be revised as needed with appropriate staff re-in-serviced to any changes. Policies, procedures and training will be reviewed as necessary.	

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call light. She stated they did not currently have a paging system because the pagers were misplaced. The Administrator asked the ES Manager about the back up plan to which the ES Manager stated he told resident #3 that her call bell did not work. He also indicated that he had not reported it to the nursing staff.

During an interview on 10/16/13 at 2:14 pm nursing assistant (NA) #5 stated she knew to respond to a resident's room if the light outside the door was on. She further indicated that the only audible alarm was the bed or chair alarms. She stated the call bells did not make a noise to indicate resident needed assistance.

On 10/15/13 at 2:14 pm NA #6 stated she would know a resident needed assistance if the light outside the resident's door was on. She also stated that after a while it will alarm at the front desk and if someone was at the front desk then that person would use the overhead paging system to call the NA to the room in need of assistance.

On 10/15/13 at 2:20 pm NA #7 stated she would look for the light outside the door to be on to indicate the resident needed assistance. She stated if the call light was not working she would expect the resident to tell her. She stated she was aware that resident #3's call bell did not work but that it was fixed. She stated the ES Manager told her it was working.

On 10/16/13 at 8:44 am Nurse #2 reported that if a call bell is not working she would be informed by the prior shift. She stated she was not aware of a call bell problem until last night. She stated the resident would be put on every 15 minute

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F 463	Continued From page 31 checks. She stated that if the call light is malfunctioning she would check on the resident more frequently but would not do a written report of the checks. She reported they round on residents every two hours routinely when call bell are working. On 10/16/13 at 9:15 am NA #8 was feeding resident #3. NA #8 reported that this resident's call bell had not worked since last Thursday (10/10/13) and that she had reported it to the ES Manager. She stated she was aware of the light not working because resident #3 told her. She stated if the call light does not work they use 15 - 20 minute checks. During and interview with the Administrator on 10/16/13 at 11:25 am she reported that there needed to be an alternative system in place for the malfunctioning call bells. She stated the ES Manager could purchase anything that was needed to make the call system work properly. She stated there is a lot of activity in resident #3's room because of her room mate's family visits. She also stated that resident #3 was required to be fed so the staff was in there for about one hour to complete this task three times per day. The Administrator reported the call bell response time was being monitored due to information from the resident advisory committee. She stated call bell response time is already being monitored through the quality assurance committee	F 463		