STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING ______ B. WING ______	C 05/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE RALEIGH, NC 27616

(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 280 SS=G	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update a care plan for a 1 of 3 sampled residents (Resident #5), high risk for falls; resulting in a fracture, once it was determined that she needed two staff to safely transfer her. The findings included: Resident #5 was admitted to the facility on 10/11/11 with the following diagnoses, senile dementia, functional quadriplegia, anxiety plus a history of falls and subdural hemorrhage. On 2/25/14 she was re-admitted to the facility after sustaining a fractured left tibia and fibula.	F 280	This Plan of Correction is the centerJ s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the	6/21/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 06/20/2014

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 280	Continued From page 1 Resident #5's chart was reviewed and revealed that a care plan was developed for her on 11/12/13 to address the potentials for falls due to short and long term memory deficits, visional deficits, use of anti-depressant and anti-hypertension medications as well as incontinence of bowel and bladder. She required assistance from staff for all transfers and with mobility. The written goal assured that she would not experience any injuries from falls through the next review. Approaches to be used included monitoring her condition that might warrant increased supervision and assistance. Both physical and occupational therapy referrals would be made as needed. A quarterly fall risk assessment, would be performed, per policy. An Initial Assessment report from physical therapy (PT) dated 11/27/13 revealed that Resident #5 needed to be evaluated due to a change in her abilities to transfer to/from her wheelchair and bed. A PT Daily Treatment Note on 12/4/13 recorded that a nurse aide reported to Physical Therapist (PT #1) that Resident #5 was inconsistent with transfers depending on level of alertness. She was unable to follow directions to weight bear on both feet. At times, she would thrust posteriorly and extended both knees, require total assist for transfer and bed positioning. During an observation it was noted that Resident #5 was able to stand up but unable to pivot and needed total assist for turning and for sitting to supine positions. A quarterly Minimum Data Set (MDS) performed on 12/6/13 determined that she was cognitively impaired and needed the extensive assistance of one person for bed mobility and the extensive assistance of two persons during transfers.	F 280	provisions of federal and state law. F280 Resident #5 has discharged from Universal Healthcare. Therefore, there are no direct interventions for resident #5 in regards to her care plan update. The Interdisciplinary team met on 6/18/2014 and 6/19/2014 to review the care plans and Kardex for the entire current census. This would ensure all resident had correct transfer information in accordance to safety and therapy recommendation. This Interdisciplinary team(IDT) consisted of the Director of Nursing, Rehab Director, Dietary Manager, Social worker Director, Unit Manager 1 and Unit Manager 2. The IDT reviewed care plans and kardex for the entire census as of 6/19/2014. Care plans and kardex were updated by the IDT to reflect the residentJ s transfer status as well as weight bearing status if needed on 6/18/2014 and on 6/19/2014. MDS, Unit managers and supervisors were trained on 6/20/2014 on how to correctly update transfer and weight bearing status on care plans. The Director of Nursing provided this training. The MDS nurse will update the residentJ s	

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F 280	Continued From page 2 Resident #5 was noted to be unsteady with her balance and non-ambulatory. She was assessed to have no limitations with range of motion on her upper and lower extremities. On the PT Therapist Progress and Discharge Summary, 12/11/13, PT #1 recorded that clinically, Resident #5 would require a two person transfer for safety of patient and staff from bed and/or wheelchair, due to her decreased stand tolerance. The Nursing Instructions report was revised on 2/25/14 to require a mechanical lift for mobility and two staff to assist with positioning. Her care plan was revised on 2/27/14 to include a floor mat while in bed as a new approach to prevent injuries from fall but did not include language about using two staff to transfer. On 5/29/14 at 9:25 am, Physical Therapist #1 (PT #1) was interviewed. She shared that she initially got involved with Resident #5 last year in November to help her with transfers from bed to the wheelchair. She stated that Resident #5 was dependent on staff for her mode of transfer and that two persons were required. Administrative staff #3 was interviewed on 5/29/14 at 10:08 am. She shared that she was a new employee and only became involved with Resident #5's care plan in February. She explained that the nurse who originally did the assessment was no longer employed at the facility, but the expectation would be for the care plan to be updated to reflect the changes that therapy had made, regarding a safer mode of transfer.	F 280	care plan as needed for changes and quarterly on mobility and transfers. Ongoing, care plans will be audited by the MDS nurse and rehab director at each residentJ s quarterly to ensure transfer information is correct over the next 12 months. New admissions will receive a temporary care plan noting weight bearing status and transfer methods. The MDS nurse will update weight bearing and transfer information onto the comprehensive care plan. Temporary care plans will be made by the admission nurse. All audit information will be taken to the quality assurance committee monthly for review over the next 6 months.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		6/21/14

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F 323	Continued From page 3 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 by: Based on record review, resident and staff interviews, the facility failed to safely transfer 2 of 3 residents (Residents #1 and #5) who required extensive assistance, resulting in a serious injury for Resident #5. The findings included: 1. Resident #5 was admitted to the facility on 10/11/11 with the following diagnoses, senile dementia, functional quadriplegia, anxiety plus a history of falls and subdural hemorrhage. On 2/25/14 she was re-admitted to the facility after sustaining a fractured left tibia and fibula. Resident #5's chart was reviewed and revealed that a care plan was developed for her on 11/12/13 to address the potentials for falls due to short and long term memory deficits, visional deficits, use of anti-depressant and anti-hypertension medications as well as incontinence of bowel and bladder. She required assistance from staff for all transfers and with mobility. The written goal assured that she would not experience any injuries from falls through the next review. Approaches to be used included monitoring her condition that might warrant increased supervision and assistance. Both physical and occupational therapy referrals would be made as needed. A quarterly fall risk	F 323	This Plan of Correction is the centerJ s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. As a result of the incident that occurred with resident #5, the dot system was implemented. This system was designed to inform nursing assistants of the residentJ s ability to transfer as a quick reference guide: Green dots symbolized independent, yellow dots symbolized minimal 1 person assist and red dots symbolized total dependence (sit to stand machine, hoyer, slide boards). The dots	

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F 323	Continued From page 4 assessment, would be performed, per policy. An Initial Assessment report from physical therapy (PT) dated 11/27/13 revealed that Resident #5 needed to be evaluated due to a change in her abilities to transfer to/from her wheelchair and bed. A PT Daily Treatment Note on 12/4/13 recorded that a nurse aide reported to Physical Therapist (PT #1) that Resident #5 was inconsistent with transfers depending on level of alertness. She was unable to follow directions to weight bear on both feet. At times, she would thrust posteriorly and extended both knees, require total assist for transfer and bed positioning. During an observation it was noted that Resident #5 was able to stand up but unable to pivot and needed total assist for turning and for sitting to supine positions. A quarterly Minimum Data Set (MDS) performed on 12/6/13 determined that she was cognitively impaired and needed the extensive assistance of one person for bed mobility and the extensive assistance of two persons during transfers. Resident #5 was noted to be unsteady with her balance and non-ambulatory. She was assessed to have no limitations with range of motion on her upper and lower extremities. On the PT Therapist Progress and Discharge Summary, 12/11/13, PT #1 recorded that clinically, Resident #5 would require a two person transfer for safety of patient and staff from bed and/or wheelchair, due to her decreased stand tolerance. The chart review did not contain an updated Kardex (nursing instructions form) or Care Plan, to reflect the change in transfer mode for Resident #5. A Physician Exam Summary on 2/3/14 remarked that Resident #5 needed maximum assistance for	F 323	were placed at the door by the residentJ s name outside of the room. Resident #5 has discharged from Universal Healthcare. There are no further direct interventions for resident #5 at this time. Prior to her discharge her Kardex reflected a hoyer transfer and a red dot were placed outside of her room. Kardex and care plans were reviewed for Resident #1 to ensure accurate transfer status, weight bearing and dot coding. This was done by the IDT on 6/18/2014 The Interdisciplinary team met on 6/18/2014 and reviewed the care plans and Kardex for 100% of the population which included the care plan and kardex for resident #1. This Interdisciplinary team(IDT) consisted of the Director of Nursing,Rehab Director, Dietary Manager, Social worker Director, Unit Manager 1 and Unit Manager 2. The IDT reviewed care plans and kardex for 100% of the census as of 6/18/2014 and 6/19/2014. Care plans and kardex were updated to reflect the residentJ s transfer status as well as weight bearing status. The IDT made updates to the kardex and door labels regarding the dot system as well to ensure that all residents had the appropriate color dots in accordance to their care plan and kardex on 6/18/2014 and on 6/19/2014	

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F 323	Continued From page 5 all of the activities of daily living. She was non-ambulatory and had a bed to chair existence. It was noted that she had been more confused recently. The musculoskeletal assessment indicated that she had partial limitations to her upper and lower motor abilities. On 2/22/14 at 12:09 am, Nurse #1 recorded in her notes that (on 2/21/14) at 7:00 pm, she was called to Resident #5's room by a nurse aide. Upon entering, she heard Resident #5 say, "My leg, it hurts." She found her lying in bed with left leg slightly swollen. The leg was turned outward in the shin area and a bruise was forming. The palpitation of the leg found a movable bump in the shin area. She noted that Resident #5 was lifting her leg to cross over the other leg, saying, "Please help me, my leg hurts." The left leg was immobilized and the nursing supervisor was notified. Her vital signs were recorded and a call was made to the physician's office. An order was written for an x-ray, then the family was notified. The x-ray was taken around 8:40 pm, with the results posting at 11:20 pm. A new order was made by the physician to send Resident #5 out to the emergency room. She was taken to the emergency room at 12:25 am. A Report of Resident Other Event (defined as an out of the ordinary occurrence), dated 2/21/14 was reviewed. Within the report, it mentioned that Resident #4 was lying in bed, saying "My leg." The left leg was noted with small amount of swelling to shin area and slight deformity of leg noted. Leg was turned outward at shin area with bruise forming. The event location took place in the resident's room with her sustaining a major injury. The report indicated that a new plan of care/intervention had been completed to prevent further events. The Hospital's Transfer Summary, dated 2/22/14	F 323	A new form titled Resident transfer/mobility status was also instituted for the current residents as of 6/19/2014. This form is a communication tool that will be used between therapy and nursing to communicate transfer needs and weight bearing status for new admissions and status changes, all supervisors have been trained to update the kardex and care plan to reflect the change in transfer needs and weight bearing status. All nursing assistants employed as of 6/19/2014 was in-serviced on the dot system. Original in-servicing on the dot system began on 2/25/2014 by the Staff development coordinator. Transfer training/ in-servicing was held again on 5/16 for nursing assistants by the rehab director and the staff development coordinator. On June 17th and 18th in-servicing was held with nursing assistants regarding the dot system, transfers, weight bearing status, reviewing kardex and the new resident transfer mobility status form. This in-service was given by the Director	

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F 323	Continued From page 6 was reviewed. It indicated that Resident #5 was brought to the emergency room with pain in her left leg following a fall. She was found to have a fracture of the tibia and fibula. On 2/22/14, her leg was surgically repaired, using an open reduction and internal fixation, but not placed in a cast. At the request of her family, she was placed on palliative care. She returned to the facility on 2/25/14. The Nursing Instructions report was revised on 2/25/14 to require a mechanical lift for mobility and two staff to assist with positioning. Her care plan was revised on 2/27/14 to include a floor mat while in bed as a new approach to prevent injuries from fall but did not include language about using two staff to transfer. A Physician's Monthly Note, 3/18/14, recorded that Resident #5 had remained stable since her return from the hospital and did not have complications due to her surgery. She was noted to have continual weight loss due to chronic diseases and expired at the facility a week later. On 5/28/14 at 4:08 pm, Administrative Staff #1 was interviewed. She commented that Resident #4 was injured during an event, sustaining a fracture, which prompted the facility to develop an Action Plan to prevent reoccurrence. She then explained that nurse aide #1 was transferring Resident #5 from her wheelchair to her bed, when her leg got caught in her recliner, thus fracturing her leg. She presented the Action Plan, 2/24/14, which revealed that Nurse Aide #1 was assigned to Resident #5 routinely, who had just received a new recliner chair, which was placed in her room, at bedside. She shared that there was about a space of 4 inches between the bed and recliner. She acknowledged that their Nursing Instructions report had still indicated that Resident #5 only	F 323	of Nursing and the Staff development coordinator. All new admissions will be audited over the next 30 days to ensure that all residents have care plans and kardex containing correct transfer and weight bearing information and each patient has transfer/ mobility status forms. This audit will be performed by the director of Nursing. Staff development or designee will observe 3 transfers weekly for accuracy times 2 months and then monthly for 12 months. All nursing assistants will receive dot and transfer training at orientation and quarterly by the rehab director and the staff development coordinator. Existing staff will receive quarterly training by the rehab director and staff development. Audits will be taken to the Quality Assurance Committee monthly for the duration of 12 months.	

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F 323	Continued From page 7 needed a one person transfer. It did not reflect that therapy no longer felt that Resident #5 was safe for a one person transfer, when she was evaluated in December, 2013. Recommendations followed and included: all nursing assistants were in-serviced on proper transfers and gait belt usage. They were also educated on when they should stop and re-evaluate a transfer technique needs and seek additional assistance or therapy advisement. A DOT system was developed and shared with all nursing assistants. Colored dots would be placed by the resident's door outside their door symbolizing their mode of transfer or need for additional help. A red dot meant that staff needed some mode of help to transfer the resident. The Nursing Instructions report should be checked to verify the mode of transfer. Nurse Aide #1 received follow up training on 2/22/14 and was required to be involved in all training, moving forward. Kardexes (nursing instructions reports) were reviewed to ensure that all residents have the correct transfer assist needs listed. Kardex would be completed on admission and updated with changes by Unit Managers, Therapy and Nursing Assistants. All rooms were checked for significant clutter on 2/24/14. All staff would check rooms daily for clutter. Staff would receive transfer training in orientation and quarterly. The Staff Development Coordinator, Therapy and Nursing would be responsible for training staff, with return demonstrations required. The Plans completion date was 3/7/14 and ongoing. Administrative staff #2 was interviewed on 5/28/14 at 4:20 pm. She explained that each	F 323		

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F 323	Continued From page 8 resident had a Nursing Instructions report completed at the time of admission, detailing the activities of daily living skills needed. However, the charge nurse usually revised the form, whenever a change occurred. She discussed that the facility had started to implement a new DOT system, about two months ago. It entailed placing a dot outside the resident's door, so that it was viewed before entering. A green not meant that the resident needed supervision by staff for transfers. A yellow dot meant that staff should be cautious and offer a 1 person assist. The red dot, meant that the staff should stop and get equipment or another person to help with transfer. On 5/29/14 at 9:25 am, Physical Therapist #1 (PT #1) was interviewed. She shared that she initially got involved with Resident #5 last year in November to help her with transfers from bed to the wheelchair. She stated that Resident #5 was dependent on staff for her mode of transfer and that two persons were required. A written statement from Nurse Aide #1, dated 2/21/14 was attached to the Action Plan. She indicated that she was putting Resident #5 back to bed when she noticed that her leg was caught between the chair and bed. She stated, "I get it out the best I could." I put her to bed and got the nurse. Nurse Aide #1 was interviewed on 5/28/14 at 6:23 pm. She stated that Resident #5 was her permanent assignment and she worked with her during the evenings. She shared that Resident #5 could not make her needs known and that she would usually have to transfer her from her bed to the wheelchair, when taking her down to dinner, or after dinner, transferring her back to bed. She stated that before the fracture, Resident #5	F 323		

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F 323	Continued From page 9 was not a two person transfer. The day of the incident she explained that Resident #5 was sitting in her wheelchair and she was getting ready to undress her for bed. She removed her shirt, placed her gown over her head, and then intended to transfer her bed, to remove her pants. She went on to explain how she set up the transfer that evening to the bed. Resident #5 was placed in her wheelchair, which was next to her bed, facing the new recliner. Nurse Aide #1 stood between the recliner and the wheelchair. She removed the leg rests off the wheelchair and noted that Resident #5's legs were still bent. Nurse Aide #1 commented that although Resident #5 was taller than her, she wasn't heavy to transfer because she had been losing weight. She stated that she always felt comfortable moving her. Nurse Aide #1 asked Resident #5 to place her arms around her and grab onto her gait belt, as the aide leaned forward. She held onto Resident #4, lifting her bottom off of the chair cushion and noticed that Resident #4 wasn't really grasping her waist so she was really doing all of the lifting. She shared that Resident #5 wasn't completely standing when she heard a funny noise. Then she turned, holding Resident #5, to put her to bed, continuing with her movements. Resident #5 did not cry out, but afterwards, Nurse Aide #1 could feel her bone moving, so she went to get the nurse, after she placed her in bed. She shared that while lifting Resident #5, she believed that the resident extended her left leg, which was not something that she usually did. When she heard the popping sound, she realized then that the knee was out, while she transferred her. She also commented that she felt that Resident #5's room was too crowded. Resident #5 was in an average size semi-private room,	F 323		

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F 323	Continued From page 10 placed near the window. Next to her bed, she remembered that the new recliner was placed, without removing the visitor chair, so the area seemed cluttered. A follow up conversation with Administrative Staff #1 took place on 5/29/14 at 12:15 pm. She stated that Nurse Aide #1 did not use the proper technique to transfer Resident #5. When she investigated the incident, Nurse Aide #1 was forthright and told her that she always transferred her independently. She also didn't place her gait belt on the residents. Administrative Staff #1 felt it was important to re-counsel Nurse Aide #1 on her techniques and pulled her from her assignments until she could get a transfer specialist like therapy to come in the following day and in-service and train her. Nurse Aide #1 had to do a return demonstration of transfer techniques with one physically dependent resident and one alert and oriented resident. They were satisfied that she could use the proper techniques before she was returned to the floor. Next, they went ahead and retrained all of the nursing assistants. Training on gait belt usage and transfers took place on 2/25/14-2/26/14 and 3/10/14-3/13/14. 2. Resident #1 was admitted to the facility on 4/11/14 and readmitted on 5/2/14 with multiple diagnoses including Right Total Knee Replacement, Fracture of the Right Femur, Muscle Weakness, Difficulty Walking, History of Falls, Anxiety and Depression. A review of the Minimum Data Set (MDS) dated 4/18/14 revealed resident #1 was assessed as needing extensive assistance with the staff providing weight bearing support during transfers. The resident was assessed as being cognitively intact.	F 323		

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	345529	A. BUILDING ______ B. WING ______	C 05/30/2014

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F 323	Continued From page 11 A review of the Hospital Discharge/Transfer Summary dated 5/2/14 revealed resident #1 was limited to toe-touch weight bearing on her right leg. A review of the Physician's orders revealed an order dated 5/2/14 which read " Toe-touch weight bearing on the right lower extremity. " A review of the Nursing Instructions Card for resident #1 was conducted. The special care instructions dated 5/2/14 stated the resident was touch toe weight bearing. A review of the Care Plans dated 4/25/14 revealed the resident was assessed as being at risk for falls related to de conditioning and weakness. The plan of care dated 5/9/14 indicated the resident experienced an assisted fall to the floor in the shower room. The resident was non weight bearing at that time. A review of the Report of Resident Fall dated 5/9/14 revealed resident #1 sustained an intercepted fall in which the resident was lowered to the floor by a staff member while in the shower room on 5/9/14. There was no injury observed. A review of a written statement from Nursing Assistant (NA) #2 dated 5/19/14 was conducted. NA #2 stated on 5/9/2014 she assisted resident #1 to the shower room for her scheduled shower. She had the resident stand and hold on to the rail. NA #2 took her shorts and underwear off of her right leg first. When she attempted to remove her shorts and underwear off of her left leg, the right leg became weak and she started to fall to the floor. NA #2 stated she caught her underneath	F 323		

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F 323	Continued From page 12	F 323		

her arms and assisted her to the floor.

An interview was conducted with NA #2 on 5/28/14 at 3:26 PM. NA #2 stated she took resident #1 to the shower room in her wheelchair. She assisted the resident to stand. The resident grabbed the safety rail and lifted her right leg. NA #2 removed her underwear and shorts from her right leg. The resident lifted her left leg and then began to fall. NA #2 stated she put her arms around the resident and assisted her to the floor. NA #2 stated she believed the resident was allowed to bear weight on her legs at the time of the fall on 5/9/14. NA #2 stated she had not been informed the resident was toe touch weight bearing on her right leg. NA #2 stated the Nursing Instructions Card was kept at the nurse's station. She stated she would review the Nursing Instructions Card for new admissions, readmissions and periodically for any changes in resident care.

An interview was conducted with resident #1 on 5/28/14 at 5:38 PM. The resident stated 5/9/14 was the first time NA #2 assisted her to the shower room. She stated she stood up, lifted her leg and fell. NA #2 caught her and assisted her to the floor. She was unsure if it was the left leg she lifted prior to the fall. The resident stated she hit her right knee on the floor when she fell.

An interview was conducted with Physical Therapist (PT) #2 on 5/29/14 at 9:26 AM. PT #2 stated resident #1 was toe touch weight bearing on her right leg at the time of the fall in the shower room. He stated toe touch weight bearing meant the resident would have been capable of sitting and resting her right foot on the floor with her toes touching the floor. PT #2 stated he

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F 323	Continued From page 13 expected the resident to be assisted by two staff members in the shower room. He stated the resident fell as a result of supporting her total body weight on her right leg when she lifted her left leg to remove her clothing. PT #2 stated once a resident has been evaluated by the physical therapy department, he would go and verbally communicate therapy instructions to the nurses and the nursing assistants. Therapy instructions included transfers and weight bearing status. An interview was conducted with Administrative Staff #1 on 5/29/14 at 11:15 AM. She stated she expected resident #1 to have been assisted by two staff members in the shower room. She stated NA #2 should have assisted the resident to a sitting position before removing her clothes from her left leg. She stated the physical therapists have routinely talked to the nurses and nursing assistants directly regarding therapy instructions for individual residents. Administrative Staff #1 stated an x-ray of the right leg was done on 5/9/14 and no further injury to the resident' s right leg was observed.	F 323		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment	F 520		6/21/14

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F 520	Continued From page 14 and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to put ongoing measures in place, through their quality assurance committee; to ensure that all residents determined high risk for falls, would have updated care plans which accurately record their ability to bear weight and safely transfer, in order to prevent falls. The findings included: 1. Resident #5 was admitted to the facility on 10/11/11 with the following diagnoses, senile dementia, functional quadriplegia, anxiety plus a history of falls and subdural hemorrhage. On 2/25/14 she was re-admitted to the facility after sustaining a fractured left tibia and fibula. Resident #5's chart was reviewed and revealed that a care plan was developed for her on 11/12/13 to address the potentials for falls due to short and long term memory deficits, visional deficits, use of anti-depressant and anti-hypertension medications as well as	F 520	This Plan of Correction is the centerJ s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F-520 The Quality assurance committee met on 6/19/2014 and reviewed current plans and process regarding	

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F 520	Continued From page 15 incontinence of bowel and bladder. She required assistance from staff for all transfers and with mobility. The written goal assured that she would not experience any injuries from falls through the next review. Approaches to be used included monitoring her condition that might warrant increased supervision and assistance. Both physical and occupational therapy referrals would be made as needed. A quarterly fall risk assessment, would be performed, per policy. A quarterly Minimum Data Set (MDS) performed on 12/6/13 determined that she was cognitively impaired and needed the extensive assistance of one person for bed mobility and the extensive assistance of two persons during transfers. Resident #5 was noted to be unsteady with her balance and non-ambulatory. She was assessed to have no limitations with range of motion on her upper and lower extremities. On the PT Therapist Progress and Discharge Summary, 12/11/13, PT #1 recorded that clinically, Resident #5 would require a two person transfer for safety of patient and staff from bed and/or wheelchair, due to her decreased stand tolerance. The chart review did not contain an updated Care Plan, to reflect the change in transfer mode for Resident #5. The Nurse's Notes were reviewed. Contained within the notes was an entry that stated on 2/21/14 at 7:00 pm, Resident #5's left tibia and fibula were fractured, when she was transferred independently by Nurse Aide #1. She was hospitalized, so that surgery could be performed and returned to the facility on 2/25/14. The Nursing Instructions report was revised on 2/25/14 to require a mechanical lift for mobility and two staff to assist with positioning. Her care	F 520	transfers and incidents. Processes in place for Resident #1 were discussed. Resident #5 has discharged from the facility. On 6/19/2014, the Quality Assurance Committee discussed recent training, and how all plans regarding transfers and weight bearing status would be monitored thru the committee. The Administrator designated program auditors. Quality Assurance Members present included: The Administrator, Director of Nursing, rehab Director, Dietary Manager, Social worker Director, Staff Development, MDS, Unit Manager 1 and Unit Manager 2 and Dr. James. Staff development and rehab a will perform transfer and dot training to staff on orientation and quarterly. Staff development and/or designee will monitor 3 transfers weekly for accuracy times 2 months and then monthly for 12 months. The MDS nurse will update the residentJ s care plan as needed for changes in mobility and transfers. Ongoing, care plans will be audited by the MDS nurse and rehab director at each residentJ s quarterly to ensure transfer	

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F 520	Continued From page 16 plan was revised on 2/27/14 to include a floor mat while in bed as a new approach to prevent injuries from fall but did not include language about using two staff to transfer. On 5/28/14 at 4:08 pm, Administrative Staff #1 was interviewed. She presented an Action Plan, 2/24/14, which demonstrated the corrective measures that the facility took to retrain staff and decluttering resident rooms to prevent falls. Recommendations followed and included: all nursing assistants were in-serviced on proper transfers and gait belt usage. They were also educated on when they should stop and re-evaluate a transfer technique needs and seek additional assistance or therapy advisement. Kardexes (nursing instructions reports) were reviewed to ensure that all residents have the correct transfer assist needs listed. Kardex would be completed on admission and updated with changes by Unit Managers, Therapy and Nursing Assistants. All rooms were checked for significant clutter on 2/24/14. All staff would check rooms daily for clutter. Staff would receive transfer training in orientation and quarterly. The Staff Development Coordinator, Therapy and Nursing would be responsible for training staff, with return demonstrations required. The Plans completion date was 3/7/14 and ongoing. Review of the Action Plan did not contain language about reviewing all care plans for residents placed at risk for falls, to ensure that they were updated and continually monitored for accuracy. It also did not contain language about monitoring care plans at the facility's quarterly Quality Assurance meetings. On 5/30/14 at 10:30 am, Adminstrative Staff #4	F 520	information is correct. All new admission care plans will be audited the day of the comprehensive care plan indefinitely. All audit information will be taken to the quality assurance committee monthly for review over the next 6 months. The quality assurance committee will review this plan monthly over the next 12 months. The quality assurance committee will continue to meet monthly and ensure that all plans are being monitored as proposed for effectiveness. Completion date is 6/21/2014	

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F 520	Continued From page 17 asked if the facilities measures to develop an Action Plan, to retrain staff on safe transfers and preventing falls, would qualify as past non-compliance. 2. Resident #1 was admitted to the facility on 4/11/14 and readmitted on 5/2/14 with multiple diagnoses including Right Total Knee Replacement, Fracture of the Right Femur, Muscle Weakness, Difficulty Walking, History of Falls, Anxiety and Depression. A review of the Minimum Data Set (MDS) dated 4/18/14 revealed resident #1 was assessed as needing extensive assistance with the staff providing weight bearing support during transfers. The resident was assessed as being cognitively intact. A review of the Nursing Instructions Card for resident #1 was conducted. The special care instructions dated 5/2/14 stated the resident was touch toe weight bearing. A review of the Care Plans dated 4/25/14 revealed the resident was assessed as being at risk for falls related to de conditioning and weakness. The plan of care dated 5/9/14 indicated the resident experienced an assisted fall to the floor in the shower room. The resident was toe touch weight bearing at that time. A review of the Report of Resident Fall dated 5/9/14 revealed resident #1 sustained an intercepted fall in which the resident was lowered to the floor by a staff member while in the shower room on 5/9/14. There was no injury observed. A review of the Action Plan, 2/24/14, did not contain language about reviewing all care plans	F 520		

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F 520	Continued From page 18 for residents placed at risk for falls, to ensure that they were updated and continually monitored for accuracy. It also did not contain language about monitoring care plans at the facility's quarterly Quality Assurance meetings. On 5/30/14 at 10:30 am, Adminstrative Staff #4 asked if the facilities measures to develop an Action Plan, to retrain staff on safe transfers and preventing falls, would qualify as past non-compliance.	F 520		