STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345163	A. BUILDING: _____ B. WING _____	2/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBRIDGE HEALTH AND REHABILTATION CENTER	211 MILTON BROWN HEIRS ROAD BOONE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to provide evidence a notice was sent to the resident/responsible party 2 days prior to Medicare benefits ending for 1 of 3 sampled residents (Residents #197).
The findings included:
Resident #197 was admitted to the facility on 09/09/13 with diagnoses of chronic obstructive pulmonary disease and non-Alzheimer's dementia.
Review of the SW #1 notes dated 07/09/14 revealed she was made aware that Resident #197's therapy services would end on 07/09/14. The note revealed SW #1 phoned Resident #197's responsible party to inform her of therapy services ending but she was not available. The note further revealed SW #1 mailed Resident #197's responsible party a written notice on 07/09/14, the day therapy services were ending.
An interview conducted on 02/26/15 at 12:05 PM with SW #1 revealed she did not keep a copy of the written notice when she sent them to the resident/responsible party nor did she follow up with the responsible party to see if they received the notice. She stated she was not aware written or verbal notices of ending Medicare Benefits had to be sent 2 days prior to services ending when she first started as the SW. She further stated the management company had sent in a consultant to train her on liability when she started the job but she was not aware she needed to follow up with the resident/responsible party that they received the letter or have a copy of the signed letter.
An interview was conducted on 02/27/25 at 12:15 PM with the Administrator. She stated it was her expectation residents/responsible party received a written or verbal notice that Medicare benefits were ending and that notice be signed and kept in the medical record.

F 280 483.20(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 resident and staff interviews and record reviews, the facility failed to include 2 of 2 residents

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sampled for care plan participation (Residents #50 and #64) in their care plan development and failed to revise the care plan to include a change in skin condition and treatment orders for 1 of 3 residents sampled for pressure sores (Resident #99).

The findings included:

1. Resident #50 was admitted to the facility on 10/31/13. Her diagnoses included muscle weakness, hypothyroidism, diabetes, cerebral vascular accident, coronary artery disease and anxiety disorder.

The care plan sign in sheet for review of the care plan noted that the responsible party and resident did not attend on 06/12/14. The sheet noted that the meeting held on 10/01/14 was attended by the responsible party but not the resident.

Her most recent Minimum Data Set (MDS), a significant change dated 12/10/14, coded her as having no cognitive impairments, having other behaviors, requiring extensive assistance with dressing, toileting and hygiene. The MDS coded her with little interest in doing things, having sleep issues, being nonambulatory, having impairment of range of motion on each side, receiving a therapeutic diet and receiving an antidepressant, hypnotic and anticoagulant.

There was no sign in sheet reflecting that a care plan meeting review was held following the significant change assessment.

On 02/17/15 at 10:49 AM, Resident #50 stated during interview that she was not invited to her care plan meetings and would like to know more about her disability.

On 02/24/15 at 9:57 AM, Resident #50 again stated during interview that she wanted to be included with her responsible party in care plan meetings. She further stated she could not recall ever attending a care plan meeting.

On 02/24/15 at 3:36 PM, Social Worker (SW) #2 stated that care plans were scheduled for every Tuesday and based on the schedule that the Minimum Data Set Coordinator developed. She stated that a letter was mailed to responsible parties alerting them of the date and time of the care plan. In addition, SW #2 stated that she set up care plan meetings extra if a need arose or was requested. She further stated that the letters were mailed to the responsible party unless a resident was their own responsible party. If a resident had a responsible party, SW #2 stated she asked the responsible party if they wished to have the resident involved in the care plan meeting. She stated there was no separate meeting to review the care plan or the results of the meeting with the resident if the resident was not present at the care plan meeting. In regards to Resident #50, SW #2 stated during the last care plan meeting the responsible party attended but not the resident. She thought the responsible party invited the resident.

On 02/24/15 at 3:55 PM MDS coordinator stated that she provided the schedule for care plan conferences to staff to mail to the residents' responsible parties. She stated she hoped that someone, such as she, the social

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worker or family would invite the resident but was not sure who took on that responsibility. Also MDS coordinator could not explain how the resident was involved in the care plan development.

2. Resident #64 was admitted to the facility on 09/09/08 with diagnosis including altered mental status, Parkinson's Disease, Panic disorder, bipolar, depression, and chronic pain. Her annual Minimum Data Set dated 01/01/15 coded her as being cognitively intact but having some impairment (scoring a 9 out of 15 on the Brief Interview for Mental Status).

There was no evidence in the medical record as to who attended care plan meeting in the past year. She had a responsible party.

On 02/17/15 at 11:55 AM, Resident #64 stated she was not involved in daily decisions about her care and had not been invited to care plan meetings.

On 02/24/15 at 3:36 PM, Social Worker (SW) #2 stated that care plans were scheduled for every Tuesday and based on the schedule that the Minimum Data Set Coordinator developed. She stated that a letter was mailed to responsible parties alerting them of the date and time of the care plan. In addition, SW #2 stated that she set up care plan meetings if the need arose or was requested. She further stated that the letters were mailed to the responsible party unless a resident was their own responsible party. If a resident had a responsible party, SW #2 stated she asked the responsible party if they wished to have the resident involved in the care plan meeting. She stated there was no separate meeting to review the care plan or the results of the meeting with the resident if the resident was not present at the care plan meeting.

On 02/24/15 at 3:55 PM MDS coordinator stated that she provided the schedule for care plan conferences to staff to mail to the residents' responsible parties. She stated she hoped that someone, such as she, the social worker or family would invite the resident but was not sure who took on that responsibility. She further stated that she had gone personally to talk with Resident #64 about concerns that her responsible party had brought up in care plan meetings. Also MDS coordinator could not explain how the resident was involved in the care plan development.

3. Resident #99 was admitted on 10/16/14 with diagnoses including chronic congestive heart failure and history of deep vein thrombosis of the left lower extremity. An admission Minimum Data Set dated 10/24/14 revealed Resident #99 was at risk for a pressure ulcer but did not have a pressure ulcer at the time of the assessment.

Review of a care plan dated 11/06/14 revealed Resident #99 had the potential for pressure ulcer development due to immobility. The goal was for Resident #99 to have intact skin, free of redness, blisters, or discoloration through the next review on 01/11/15. Interventions included to monitor nutritional status and document any changes in skin status.

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Review of a skin integrity report dated 01/08/15 revealed Resident #99 was readmitted to the facility on 01/08/15 with an unstageable pressure ulcer on her left heel.

Review of physician's orders revealed an order written by the Treatment Nurse on 01/08/15 to paint the pressure ulcer on Resident #99's left heel with betadine daily.

During an interview on 02/24/15 at 11:20 AM the MDS (Minimum Data Set) Coordinator confirmed there was a care plan meeting for Resident #55 on 01/19/15 which she attended in addition to the resident and a family member. The MDS Coordinator could not recall if the potential for pressure ulcer development care plan was reviewed during the meeting but stated the treatment nurse was expected to update care plans to include changes in skin condition and treatment orders.

An interview was conducted with the Treatment Nurse on 02/24/15 at 1:55 PM. The Treatment Nurse stated when there were changes in a resident's skin condition or treatment plan she updated the care plan. The Treatment Nurse confirmed she should have revised Resident #99's care plan on 01/08/15 to include the unstageable pressure ulcer on her left heel and daily treatment order. The Treatment Nurse could not explain why Resident #99's had not been revised.

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F 000	INITIAL COMMENTS 483.25 (F309) at J Immediate Jeopardy began on 11/15/14 when staff lowered Resident #24 to the floor during a transfer. Immediate jeopardy was removed on 02/27/15 at 11:35 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. 483.25 (F323) at J Immediate Jeopardy began on 11/15/14 when staff lowered Resident #24 to the floor during a transfer. Immediate jeopardy was removed on 02/27/15 at 11:35 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example 2 is at a scope and severity of D.	F 000		
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing	F 159		

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

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account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:

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Based on resident interviews, record reviews, and staff interviews, the facility failed to send quarterly statements to 5 of 5 alert and oriented residents sampled for facility management of funds. (Residents #7, #50, #68, #71,and #157).

The findings included:

1. Resident #50 was admitted to the facility on 10/31/13. Her diagnoses included muscle weakness, hypothyroidism, diabetes, cerebral vascular accident, coronary artery disease and anxiety disorder.

Her Minimum Data Set (MDS), a significant change dated 12/10/14, coded her as having no cognitive impairments, scoring 15 out of 15 on the Brief Interview for Mental Status.

On 02/17/15 at 11:04 AM she stated that she had a personal fund account managed by the facility but she never received a statement informing her of the balance.

On 02/19/15 at 3:24 PM Business Office Staff #1 stated resident fund statements were sent to responsible parties on a quarterly basis. If a resident was their own responsible party or did not have a responsible party then the statements were sent to the resident. Resident #50's quarterly statement were sent to her responsible party. She confirmed Resident #50 did not receive a quarterly account statement.

Follow up interview with Resident #50 on 02/24/15 at 9:57 AM revealed she wanted a statement informing her of how much money she had in her account.

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On 02/27/15 at 9:50 AM the Administrator stated that they were going to review each residents' cognition assessment and determine who should receive a copy of their own quarterly statements.

2. Resident #7 was readmitted to the facility on 08/04/14. Her diagnoses included congestive heart failure, diabetes and macular degeneration. Her quarterly Minimum Data Set dated 01/02/15 coded her as cognitively intact, scoring a 13 out of 15 on the Brief Interview for Mental Status.

On 02/17/15 at 10:57 AM Resident #7 stated the facility managed her personal funds account.

On 02/19/15 at 3:24 PM Business Office Staff #1 stated resident fund statements were sent to responsible parties on a quarterly basis. If a resident was their own responsible party or did not have a responsible party then the statements were sent to the resident. Resident #7's quarterly statements were sent to her family. Business Office Staff #1 confirmed Resident #7 did not receive quarterly account statements.

Upon follow up interview on 02/24/15 at 11:22 AM, Resident #7 stated she thought she had some money in her account but wanted to receive a statement informing her of the balance in addition to her family receiving the statement.

On 02/27/15 at 9:50 AM the Administrator stated that they were going to review each residents' cognition assessment and determine who should receive a copy of their quarterly statements.

3. Resident #68 was admitted to the facility on 07/09/10. His diagnoses included anemia, Parkinson's Disease and hypertension. His

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quarterly Minimum Data Set dated 12/16/14 coded him as being cognitively intact scoring a 15 out of 15 on the Brief Interview for Mental Status.

During interview on 02/16/15 at 2:19 PM he stated the facility managed a personal fund account for him but that he received no statement regarding the balance.

On 02/19/15 at 3:24 PM Business Office Staff #1 stated resident fund statements were sent to responsible parties on a quarterly basis. If a resident was their own responsible party or did not have a responsible party then the statements were sent to the resident. Resident #68's quarterly statements were sent to his family. Business Office Staff #1 confirmed Resident #68 did not receive quarterly account statements.

A follow up interview with Resident #68 on 02/24/15 at 10:08 AM revealed he wanted to receive a quarterly balance of his personal fund account.

On 02/27/15 at 9:50 AM the Administrator stated that they were going to review each residents' cognition assessment and determine who should receive a copy of their quarterly statements.

4. Resident #71 was admitted to the facility on 06/20/07. Her diagnoses included hypertension, peripheral vascular disease, anxiety and depression. Her quarterly Minimum Data Set dated 01/28/15 coded her as being cognitively intact scoring a 15 out of 15 on the Brief Interview for Mental Status.

On 02/17/15 at 1:36 PM she stated she had a personal fund account managed by the facility.

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F 159	Continued From page 5 On 02/19/15 at 3:24 PM Business Office Staff #1 stated resident fund statements were sent to responsible parties on a quarterly basis. If a resident was their own responsible party or did not have a responsible party then the statements were sent to the resident. Resident #71's quarterly statements were sent to her family. Business Office Staff #1 confirmed Resident #71 did not receive quarterly statements. Upon follow up interview on 02/24/15 at 10:08 AM, Resident #71 stated it was alright with her that her family received her personal fund statements. On 02/27/15 at 9:50 AM the Administrator stated that they were going to review each residents' cognition assessment and determine who should receive a copy of their quarterly statements. 5 Resident #157 was admitted to the facility on 04/08/14. Her diagnoses included anemia, diabetes, anxiety disorder and depression. Her most recent Minimum Data Set, an annual assessment dated 02/02/15 coded her as having no cognitive impairments, scoring a 15 out of 15 on the Brief Interview for Mental Status. On 02/16/15 at 2:22 PM, Resident #157 stated the facility managed her personal funds and she did not receive a statement quarterly informing her of her balance. On 02/19/15 at 3:24 PM Business Office Staff #1 stated resident fund statements were sent to responsible parties on a quarterly basis. If a resident was their own responsible party or did not have a responsible party then the statements	F 159		

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F 159	Continued From page 6 were sent to the resident. Resident #157's quarterly statement was sent to her family. Business Office Staff #1 confirmed Resident #157 did not receive quarterly account statements. On 02/24/15 at 11:23 AM, Resident #157 was interviewed again and stated that it was alright if her family received her statements. On 02/27/15 at 9:50 AM the Administrator stated that they were going to look at each residents' cognition assessment and determine who should receive a copy of their quarterly statements.	F 159		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain the dignity of residents during tray meal service for 5 of 8 residents sampled for dignity. Staff failed to knock on doors before entering residents' rooms with their meal tray (Resident #4 and #50) and staff stood over residents while feeding them (Residents #29, #56, and #106). The findings included: 1. Resident #56 was admitted to the facility on 10/01/14. Her diagnoses included severe acute	F 241		

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ischemic cardiovascular accident.

Her Minimum Data set dated 01/09/15 coded her as having long and short term memory impairment and severely impaired decision making skills. She was coded as requiring total assistance with eating.

On 02/16/15 at 11:25 AM, Nursing Assistant (NA) #3 was observed feeding Resident #56. NA #3 stood while Resident #56 was seated in her wheelchair and NA #3 bent over the resident with each bite as she fed Resident #56. She continued feeding Resident #56 while standing at 12:26 PM.

On 02/24/15 at 9:34 AM, NA #3 was interviewed. She stated she had been instructed to stand as she fed residents and not to sit in a chair or on the resident's bed.

On 02/19/15 at 5:24 PM Resident #56 was observed sitting in bed which was lowered to the floor. NA #9 was observed sitting in a chair by the bed, the tray in front of the NA. NA #9 would spoon up a bite of food, reach over, lean down and feed the resident each bite. She would hand the cup to Resident #56 and she drank from the cup independently.

NA #9 was interviewed on 02/19/15 at 5:41 PM. She related that this was the first time she had fed Resident #56 but that she often assisted with feeding residents at lunch time. She stated she did not think to raise the bed and position the food so she could see it. She stated she should have positioned the resident better.

On 02/24/15 at 2:22 PM the Director of Nursing

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and the Assistant Director of Nursing #2 were interviewed and stated that they expected staff to position themselves at eye level with the resident when they were feeding a resident during meals.

2. Resident #106 was admitted to the facility on 12/30/11 with diagnoses including Diabetes, Alzheimer's Disease, and esophageal reflux.

Her quarterly Minimum Data Set, a quarterly dated 01/12/15 coded that she was rarely or never understood and could not be assessed for memory impairments, but that she was coded for having severely impaired decision making skills and needing total assistance with feeding.

On 02/19/15 at 5:29 PM, Nurse Aide (NA) #7 was observed feeding Resident #106 while she was in bed. NA #7 was observed standing at bedside leaning over Resident #106 while he fed her each bite. NA #7's waist was at the same height as the resident's face. NA #7 finished feeding Resident #106 via standing at 5:52 PM.

On 02/19/15 at 5:52 PM NA #7 was interviewed. He stated that he had been employed at the facility approximately 3 months and normally always stood when he fed residents. He further stated he was trained to sit while he fed but sometimes could not locate a place to sit so he put the bed as high as it would go and fed her standing up.

Interview with the Director of Nursing and Assistant Director of Nursing #2 stated that they expected staff to feed residents at eye level.

3. Resident #50 was admitted to the facility on

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10/31/13. Her diagnoses included muscle weakness, hypothyroidism, diabetes, cerebral vascular accident, coronary artery disease and anxiety disorder.

Her Minimum Data Set (MDS), a significant change dated 12/10/14, coded her as having no cognitive impairments, scoring a 15 out of 15 on the Brief Interview for Mental Status.

On 02/19/15 at 5:19 PM Nurse Aide (NA) #7 did not knock on Resident #50's door before entering with the meal tray.

Interview with Resident #50 on 02/19/15 at 5:22 PM revealed she did not hear him knock and she did not like that he entered without knocking.

On 02/19/15 at 5:25 PM NA #7 was interviewed about knocking on resident doors, he stated that he did not knock on Resident #50's door because he forgot. He further stated he had been here 3 months and knew he was supposed to knock on the resident door before entering.

Interview with the Director of Nursing and Assistant Director of Nursing #2 on 02/24/15 at 2:26 PM revealed they expected staff to knock anytime they entered a resident's room.
4. Resident #29 was admitted to the facility on 12/26/12 with diagnoses which included high blood pressure, difficulty speaking, difficulty swallowing, anxiety, generalized muscle weakness, heart disease, right sided paralysis and a stroke.

A review of the most recent quarterly Minimum Data Set (MDS) dated 12/08/14 indicated short term and long term memory problems and severe

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impairment in cognition for daily decision making. The MDS also indicated Resident #29 was independent with eating and required set up help only.

During an observation on 02/19/15 at 5:35 PM Resident #29 was sitting in a wheelchair in her room with a meal tray in front of her on an overbed table. Resident #29 had a spoon in her left hand and was feeding herself small bites of food. At 5:47 PM Resident #29 laid the spoon on her plate and stopped feeding herself. At 5:52 PM Nurse Aide (NA) #10 walked into Resident #29's room and asked if she was still eating and then NA #10 picked up the spoon and started feeding Resident #29 while standing next to her and over her. NA #10 continued to feed Resident #29 while standing until 6:05 PM when Resident #29 started shaking her head and stated "no,no,no."

During an interview on 02/19/15 at 6:20 PM with NA #10 she stated sometimes Resident #29 fed herself and ate well but sometimes she didn't. She explained she tried to encourage Resident #29 to eat and offered her food to eat when she stopped eating. She stated it was her usual routine to stand next to Resident #29 where she could see her while she fed her. She further stated she had not had any in-services regarding sitting or standing while feeding residents and there was no policy that she was aware of.

During an interview on 02/24/15 at 2:22 PM the Director of Nursing and Assistant Director of Nursing #2 stated they expected staff to position themselves at eye level with the resident when they fed them during meals.

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5. Resident #4 was admitted to the facility on 11/06/14 with diagnoses of congestive heart failure, general weakness, high blood pressure and shortness of breath.

A review of the most recent quarterly Minimum Data Set (MDS) dated 01/27/15 indicated Resident #4 had short term and long term memory problems and was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #4 required extensive assistance by staff for activities of daily living.

During an observation on 02/19/15 at 6:09 PM Nurse Aide (NA) #10 entered Resident #4's room with a meal tray and did not knock before she entered the resident's room.

During an interview on 02/19/15 at 6:20 PM with NA #10 she confirmed she entered Resident #4's room with a meal tray without knocking and did not wait for permission to enter the room. She stated she knew she was supposed to knock, introduce herself and then go in. She further stated she tried to knock on resident's doors before she entered the room but when it got busy she just went on in the room without knocking.

During an interview on 02/24/15 at 2:26 PM with the Director of Nursing and Assistant Director of Nursing #2 they stated it was their expectation for staff to knock anytime they entered a resident's room.

During an interview on 02/26/14 at 12:04 PM with Resident #4 she stated she preferred for staff to knock on her door before they entered the room because she wanted to know who was coming into her room. She further stated she did not like

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F 241	Continued From page 12 it when staff just barged on in her room without letting her know they were coming in first.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain loose, cracked and broken vinyl panels on the exterior surface of resident closet doors on 7 of 36 rooms (Rooms 202, 212, 211, 303, 411, 414, and 416); failed to maintain wooden handrails which were pitted, scraped and missing varnish on 4 of 4 halls (Halls 100, 200, 300, and 400); and failed to repair and maintain wheelchairs for residents on 3 of 4 halls (Halls 200, 300, and 400). The findings included: 1. 0n 2/16/15 at 11:00 AM during the initial tour of the facility and again on 02/25/15 at 11:00 AM revealed the following observations were made of closet doors in resident rooms: Room 202- exterior panel on the front of the closet door was loose, cracked and frayed at the corners. Room 212- exterior panel on closet door was split open with sharp corners exposed to anyone moving by the door. Room 211- exterior panel on closet door loose, broken, and cracked. Room 303-exterior panel on closet door loose and cracked at the corners. Room 411- exterior panel on closet door broken	F 253		

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and frayed at the corners. Panel is loose and easily separated from door.
Room 414- exterior panel on closet door split in the middle and sharp edges protruding on each side of the split.
Room 416- exterior panel on closet door frayed at the corners and loosened from the door

A review of the maintenance logs for the past 30 days revealed no requests were identified for repair of closet doors in resident rooms.
Interview with the Maintenance Director (MD) on 02/25/15 at 10:30 AM regarding damaged closet doors in the resident rooms revealed, the MD indicated the outside vinyl covering would get moisture under them and split or come off completely. The maintenance director revealed the maintenance department was constantly trying to patch the doors, but they could not do much with them.

2. On 02/16/15 at 11:00 AM during the initial tour of the facility, and again on 02/25/15 at 11:00 AM the following observations were made of facility handrails:
100 Hall- wooden handrails in the hallway were observed with areas that was missing varnish that gave the wood a grainy, rough feel to touch. Other areas of the handrails were observed to be pitted and scraped.
200 Hall- wooden handrails in the hallway were observed with areas that was missing varnish that gave the wood a grainy, rough feel to touch. Other areas of the handrails were observed to be pitted and scraped. Residents were observed walking in the hallway and ambulating with wheelchairs by using the handrails for assistance.
300 Hall- wooden handrails in the hallway were observed with areas that was missing varnish that

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gave the wood a grainy, rough feel to touch. Other areas of the handrails were observed to be pitted and scraped. Residents were observed walking in the hallway and ambulating with wheelchairs by using the handrails for assistance.
400 Hall- wooden handrails in the hallway were observed with areas that was missing varnish that gave the wood a grainy, rough feel to touch. Other areas of the handrails were observed to be pitted and scraped.
A review of the maintenance logs for the past 30 days for Halls 200, 300, and 400 indicated no requests were identified for repair of handrails.
Interview with the Maintenance Director (MD) on 02/25/15 at 10:30 AM revealed that there were wooden handrails throughout the building and they were easily damaged when hit by wheelchairs causing splintering and damage to the handrails. He revealed the maintenance staff could sand the handrails one day and they would get hit by a wheelchair or cart and splinter, or be damaged before the next day. The MD stated this occurred frequently and the maintenance department could not stay ahead of the issue.

3. During the survey the following observations were made of resident wheel chairs:
a. 200 Hall- On 02/17/15 11:30 AM Resident #193 was observed sitting in his room in a wheelchair. The right padded armrest on the chair was missing exposing only a round stainless colored metal bar to rest right arm. The left armrest on the wheelchair was observed to be tattered and frayed exposing a cracked vinyl material to the resident's arm. Further observations of Resident #193 on 02/18/15 at 10:30 AM, 02/19/15 at 10:50 AM, 02/23/15 at 10:30 AM and 02/25/15 at 11:00 AM revealed he was seated in his wheelchair and the wheelchair's right armrest was missing and

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the left armrest was cracked and frayed.
b. 200 Hall- On 02/17/15 at 11:30 AM Resident #37 was observed sitting in a wheelchair in hallway. Wheelchair had a cracked and frayed left armrest that exposed the cracked vinyl material to resident's arm. Further observations of Resident #37 on 02/19/15 at 10:50 AM, and 02/23/15 at 10:30 AM revealed he was sitting in his wheelchair and the wheelchair's left armrest was cracked and frayed.
c. 300 Hall- On 02/17/15 at 11:30 AM Resident #84 was observed sitting in a wheelchair in his room. The wheelchair was observed to have torn, frayed, and cracked vinyl on right and left armrests exposing the resident's arms to the ragged vinyl surface of the armrests. Further observation of Resident #84 on 02/19/15 at 10:50 AM and 02/25/15 at 11:00 AM revealed he was sitting in his wheelchair and the wheelchair's left and right armrest was torn and cracked.
d. 400 Hall- On 02/17/15 at 11:30 AM Hall Resident #55 was observed in her room sitting in a wheelchair. Wheelchair was observed to have no armrest on left side exposing stainless colored metal bar to rest left arm. Right armrest was frayed exposing the tattered vinyl to the resident's arm. Further observations on 02/19/15 of Resident #55 at 10:50 AM and 02/25/15 at 11:00 AM revealed she was sitting in her wheelchair in her room. The wheelchair was missing the left armrest and the right armrest was frayed and cracked.

On 02/24/15 at 10:50 AM an interview was conducted with Nurse #3. She stated any maintenance issues that were brought to her attention she would call and report them to maintenance. Nurse #3 indicated there was a maintenance log that nurse aides were to use to

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log maintenance issues, but she also expected the nurse aides to let her know of any equipment or maintenance issues on her unit. She revealed she was not aware of any issues for wheelchairs on the 200 Hall at that time.

A review of the maintenance logs for the past 30 days for Halls 200, 300, and 400 indicated no requests for wheelchair repairs for the identified residents (Residents # 37, 55, 84, and 193).

On 02/25/15 at 10:30 AM an interview was conducted with the Maintenance Director (MD). He stated he had worked at the facility for 13 years. The MD indicated maintenance checks were done on facility equipment and furnishings on a weekly and monthly basis on a schedule. He also revealed facility maintenance was performed when issues were reported by staff or visitors. The maintenance director acknowledged there were logs on each hall that staff could list maintenance needs for repair and the maintenance department checked those logs each day. He stated staff could also call or verbally report maintenance issues that needed immediate attention.

On 02/25/15 at 11:35 AM the Maintenance Director again stated he was not aware of these particular issues with wheelchairs. He stated he believed therapy and nursing staff would have notified maintenance of the issues with the armrests.

On 02/27/15 at 9:40 AM an interview was conducted with the Administrator. The Administrator indicated it was her expectation that staff report any issues with the maintenance needs for the facility to the maintenance

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F 253	Continued From page 17 department, and those issues also be reported to her. She stated she expected any facility maintenance needs to be reported immediately.	F 253		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

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This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to comprehensively assess 10 of 33 residents sampled for assessments including residents' strengths and weaknesses, how the area impacted functionality and the analysis of the information determining the direction of the care plan. (Residents # 50,#56, #77, #92, #99, #55, #158, #107, #5, #29).
The findings included:

1. Resident #50 was admitted to the facility on 10/31/13. Her diagnoses included muscle weakness, hypothyroidism, diabetes, cerebral vascular accident, coronary artery disease and anxiety disorder.

Her Minimum Data Set (MDS), a significant change dated 12/10/14, coded her as having no cognitive impairments, having other behaviors, requiring extensive assistance with dressing, toileting and hygiene. The MDS coded her with little interest in doing things, having sleep issues, nonambulatory, having impairment of range of motion on each side, receiving a therapeutic diet and receiving an antidepressant, hypnotic and anticoagulant.

Review of the Care Area Assessments (CAA) dated 12/15/14 revealed a checklist but no analysis of the checked items or any analysis of how the checked items affected the resident's

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function or what direction the care plan would take. Examples as follows:
a. Cognition/Delirium checked that she had decreased ability to make herself understood, she had confusion, disorientation and forgetfulness, and the only comments made other than checking items on the form were that she made disruptive sounds on 12/04/14 and nurse aides stated she yelled out at night. Under care plan considerations was the statement that "will utilize Socially Disruptive Behavior care plan in hopes to reduce the number of outbursts" and referral to other disciplines stated "Staff to continue to encourage and support as tolerated by resident." This was written by the Social Worker #2.
b. Communication noted that this was an actual problem, and only checked item such as she had expressive communication, mental health problems, received anti anxiety antidepressant and hypnotic medication, had oral motor function, but failed to analyze any of the areas to describe how this affected her ability to communicate or be understood. This was completed by MDS Nurse.
c. Activities of Daily Living Skills (ADLs) was a checklist with the only additional information noted she had an actual problem with a decline in mobility and an occupational therapy referral was made. This was completed by MDS Nurse.
d. Psychosocial Wellbeing CAA was a checklist and the additional information note a potential problem with psychosocial wellbeing as she had the diagnoses of anxiety and depression. The only other analysis was noted that the facility will continue to utilize Depression care plan and staff will continue to encourage and support as tolerated by resident. This was written by Social Worker #2.
e. Behavioral Symptoms noted this was a potential problem as the resident had socially

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inappropriate behavior as indicated by yelling out according to the Flow sheets. In addition to the checklist, notes indicated that the facility will utilize Socially Inappropriate Behavior Care Plan in hopes of reducing number of outbursts and will continue to encourage and support as tolerated by resident. This was written by Social Worker #2.

On 02/17/15 at 10:43 AM, Resident #50 was interviewed. Due to her stroke, she had trouble forming words clearly and expressing herself clearly. Throughout the interview, Resident #50 expressed concern that staff did not take the time to understand her and figure out that she was alert, oriented and knew what was going on.

On 2/23/15 at 10:14 AM, an interview was conducted with the MDS coordinator, MDS nurse and Social Worker (SW) #2. During the interview it was revealed that MDS nurse started completing MDSs in September 2014 and SW #2 started the end of July 2014. MDS nurse stated that he just received a quick overview this month on how to complete a CAA analyze the information within the last week from the newly hired quality assurance (QA) nurse. MDS nurse stated that if he knew he was going to develop a care plan he just used the information from the checklist and was unaware he had to explain his analysis on the CAA. SW #2 stated she had never been trained on how to complete CAA and generally just put in the information from the brief interview for mental status. She further stated that the new QA nurse told her that training was coming in the future. The MDS Coordinator stated she always had trouble understanding the CAAs and has been overwhelmed with the new responsibilities she has taken on since becoming

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the coordinator.

On 02/27/15 at 9:50 AM, the Administrator stated that she had identified that CAAs were not being completed correctly so she brought in the QA nurse to assist with training the MDS staff.

2. Resident #56 was admitted to the facility on 10/01/14. Her diagnosis included severe acute ischemic cardiovascular accident, hypertension and history of cardiac arrest.

The admission Minimum Data Set (MDS) dated 10/8/14 noted that her short term memory and long term memory was not assessed as she was rarely or never understood but she was assessed with severely impaired decision making skills. She required total assistance with most activities of daily living skills, was nonambulatory and had falls in the 2 to 6 months prior to admission.

Review of the Care Area Assessment (CAA) for falls dated 10/12/14 revealed a checklist but no analysis of the checked items or any analysis of how the checked items affected the resident's function or what direction the care plan would take. The CAA noted that falls was a potential problem for Resident #56 due to hemiparesis from a recent stroke, impaired mobility, impaired balance, total assist with all ADLs and mobility, and possible poor awareness. Under care plan consideration was the comment that physical, occupational and speech therapies were working with Resident #56 to improve mobility, cognition and communication. This was signed by the MDS coordinator.

On 2/23/15 at 10:14 AM, an interview was conducted with the MDS coordinator, MDS nurse

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and Social Worker (SW) #2. During the interview it was revealed that MDS nurse started completing MDSs in September 2014 and SW #2 started the end of July 2014. MDS nurse stated that he just received a quick overview this month on how to complete a CAA analyze the information within the last week from the newly hired quality assurance (QA) nurse. MDS nurse stated that if he knew he was going to develop a care plan he just used the information from the checklist and was unaware he had to explain his analysis on the CAA. SW #2 stated she had never been trained on how to complete CAA and generally just put in the information from the brief interview for mental status. She further stated that the new QA nurse told her that training was coming in the future. The MDS Coordinator stated she used to do a summary of the triggered area but when the facility went to the point click care system she quit doing the summaries. She further stated she always had trouble understanding the CAAs and has been overwhelmed with the new responsibilities she has taken on since becoming the coordinator.

On 02/27/15 at 9:50 AM, the Administrator stated that she had identified that CAAs were not being completed correctly so she brought in the QA nurse to assist with training the MDS staff.

3. Resident #77 was admitted to the facility on 06/16/12 with diagnoses of dementia, depression, hypertension, muscle weakness and deep vein thrombosis and fractured hip.

The significant change Minimum Data Set (MDS) dated 06/28/14 coded her with long and short term memory problems and having severely impaired decision making skills. She required

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total assistance with all activities of daily living skills, rejected care 1-3 days in the previous 7 days and received a mechanical diet and weighed 120 pounds.

Review of the Care Area Assessment (CAA) for nutrition dated 06/27/14 revealed a checklist but no analysis of the checked items or any analysis of how the checked items affected the resident's function or what direction the care plan would take. In addition to the checklist, the CAA noted Resident #77 had an actual problem with nutrition, and required a no added salt diet due to hypertension and a pureed diet due to chewing difficulty. Under the impact of this problem and rationale for care planning, the CAA noted "stable weight +/- 5% Blood pressure will be within normal range. Resident will tolerate diet texture w/o (without) chewing or swallowing difficulty or signs of aspiration." This was signed as being completed by the Dietary Manager (DM).

Interview with the DM on 02/24/14 at 9:25 AM revealed when she completed a CAA she put the type of diet the resident was on and why they were getting that type of diet. She stated she tried to know what was going on with them such as how much feeding assistance they needed. She further stated that she was just learning how to complete the CAAs.

On 02/27/15 at 9:50 AM, the Administrator stated that she had identified that CAAs were not being completed correctly so she brought in the QA nurse to assist with training the MDS staff.

4. Resident #92 was admitted to the facility on 11/26/14 with diagnoses of pneumonia, urinary

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tract infection and thyroid disorder. The admission Minimum Data Set (MDS) dated 12/03/14 revealed Resident #92 was severely cognitively impaired. She required extensive assistance with bed mobility and dressing and limited assistance with transfers, toileting, personal hygiene and bathing.

Review of the Care Area Assessments (CAA) dated 12/03/14 revealed a checklist but no analysis of the checked items or any analysis of how the checked items affected Resident #92 ' s function or what direction the care plan would take. Examples as follows:
Cognitive Loss/Dementia checked that she had decreased ability to make herself understood or to understand others, and the only other comments other than checking items on the form were she had cognitive loss potentially due to recent medical conditions and did not have a diagnoses of dementia. This was written by Social Worker #1.
Communication checked that she had expressive communication, problems describing objects and events and receptive communication. The only other comment was she was able to make needs known, has some confusion, possibly due to infectious process. This was written by the MDS Coordinator.
Urinary incontinence was a checklist with the only additional comment of working with physical and occupational therapy to increase physical functioning, incontinence episodes should decrease. This was written by the MDS Coordinator.
Falls was a checklist with the only additional information of history of falls and physical and occupational to increase strength, endurance and safety awareness. This was written by the MDS

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Coordinator.
Pressure ulcers was a checklist with the only additional information of being at risk due to impaired mobility, occasional incontinence, infectious process and development of clostridium difficile, a bacterial infection.

An interview was conducted on 02/23/15 at 10:14 AM with the MDS Coordinator, MDS Nurse and Social Worker (SW) #2. During the interview it was revealed the MDS Nurse began working in the MDS office in 09/2014 and SW #2 began work at the facility in 07/2014. The MDS Nurse stated he received a quick overview this month, 2/2015, on how to complete a CAA analysis from the newly hired Quality Assurance Nurse (QA). The MDS Nurse stated if he knew he was going to develop a care plan he used the information from the checklist and was unaware he had to explain his analysis on the CAA. SW #2 stated she had never been trained on how to complete a CAA and generally put in the information from the brief interview for mental status. She further stated she had been informed by the QA Nurse she would be trained on how to complete a CAA. The MDS Coordinator stated she was aware an analysis and summary needed to be completed for the CAA but she had been overwhelmed by the amount of work she had to do when she took the MDS Coordinator position in 09/2014.

On 02/27/15 at 9:50 AM the Administrator stated she had identified CAAs were not being completed correctly and she brought in the QA Nurse to assist with training the MDS staff.

5. Resident #99 was admitted on 10/16/14 with

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diagnoses including chronic congestive heart failure and history of deep vein thrombosis of the left lower extremity.

Review of an admission Minimum Data Set (MDS) dated 10/24/14 revealed Resident #99 was at risk for a pressure ulcer but did not have a pressure ulcer at the time of the assessment. The Admission MDS noted Resident #99 was cognitively intact.

Review of the Care Area Assessment (CAA) for pressure ulcers dated 11/06/14 revealed checked items but no analysis of the checked items or any analysis of how they affected the resident ' s function or what direction the care plan would take. The checked items on the CAA summary for pressure ulcers noted pressure ulcers were a potential problem due to immobility, cognitive loss, and new admission status. Pain was checked in the area for conditions that increase the risk for pressure ulcer. There was no supporting documentation entered under any of the sections to indicate the reason the item(s) were checked. The CAA summary was checked to indicate that pressure ulcers would be addressed in the care plan with no further documentation noted.

An interview was conducted on 02/23/15 at 10:14 AM with the MDS Coordinator and the MDS Nurse. During the interview it was revealed the MDS Nurse began working in the MDS office in 09/2014 and he received a quick overview this month, 2/2015, on how to complete a CAA analysis from the newly hired Quality Assurance Nurse (QA). The MDS Nurse stated if he knew he was going to develop a care plan he used the information from the checklist and was unaware

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he had to explain his analysis on the CAA. The MDS Coordinator stated she was aware an analysis and summary needed to be completed for the CAA but she had been overwhelmed by the amount of work she had to do when she took the MDS Coordinator position in 09/2014.

On 02/27/15 at 9:50 AM the Administrator stated she had identified CAAs were not being completed correctly and she brought in the QA Nurse to assist with training the MDS staff.

6. Resident #55 was admitted on 02/25/11 with diagnoses including dementia, history of cerebrovascular accident (CVA), history of falls, anxiety, and depression.

A significant change Minimum Data Set (MDS) dated 09/10/14 revealed Resident #55 had short and long-term memory problems and severely impaired cognitive skills for daily decision making. The significant change MDS also stated Resident #55 required extensive assistance with transfers, had unclear speech, and was sometimes understood. In addition, inattention and disorganized thinking were continuously present and she was short tempered and easily annoyed 2 to 6 days during the 7 day assessment period. The significant change MDS revealed Resident #55 received an antidepressant daily during the 7 day assessment period and had no falls since her re-entry to the facility.

Review of the Care Area Assessments (CAA) dated 09/15/14 revealed checked items but no analysis of the checked items or any analysis of how they affected the resident ' s function or what direction the care plan would take. Examples were as follows:

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a. Cognitive Loss/Dementia triggered due to short and long-term memory loss. The checked items noted dementia, decreased ability to make herself understood, decline in activities of daily living, poor nutrition, and psychiatric or mood disorder. The only comments on the form were under the heading of " Nature of Problem/Condition " which stated Resident #55 had a diagnoses of Alzheimer ' s disease, senile dementia, and dementia unspecified with behavioral disturbances. The CAA summary was checked to indicate that cognitive loss/dementia would be addressed in the care plan with no further documentation noted.

b. Mood State triggered due to mood severity score. The checked items noted a relapse of underlying health problem, communication problems, psychiatric disorder, dementia, neurological disease, and pain. Comments on the form were under the heading of " Nature of Problem/Condition " which stated Resident #55 had a diagnosis of dementia with unspecified behavioral disturbance, unspecified psychosis, depressive disorder, anxiety state, unspecified psychotic condition, senile dementia uncomplicated, and Alzheimer ' s disease. The CAA summary was checked to indicate that mood state would be addressed in the care plan and the analysis was to encourage the resident to attend activities even if to observe and provide support and encouragement as tolerated by the resident.

c. Falls triggered due to balance problems during transition and antidepressant medications. The checked items noted difficulty maintaining sitting balance, impaired balance during transitions,

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antidepressants, arthritis, hip fracture, loss of arm or leg movement, incontinence, dementia, cognitive impairment, anxiety disorder, depression, and pain. Comments on the form were under the heading of " Nature of Problem/Condition " which stated Resident #55 had a history of falls, poor safety awareness, psychiatric diagnoses, dementia, medications, narcotics, and impaired mobility. The CAA summary was checked to indicate that falls would be addressed in the care plan and listed in the analysis block was for physical therapy, occupational therapy, speech therapy to evaluate and treat.

d. Psychotropic Drug Use triggered due to the use of antidepressant medications. The checked items noted antidepressant use with adverse consequences checked as anxiety, depression, decline in cognitive abilities, and disturbances of balance, gait, and positioning ability. Comments on the form were under the heading of " Nature of Problem/Condition " and listed Resident #55 ' s current antidepressant medication. The CAA summary was checked to indicate that psychotropic drug use would be addressed in the care plan and it was noted in the analysis block Resident #55 was taking more psych meds before discharge and changes had been made recently. Resident #55 received antidepressant medication daily and antianxiety medication as needed.

An interview was conducted on 02/23/15 at 10:14 AM with the MDS Coordinator, MDS Nurse and Social Worker (SW) #2. During the interview it was revealed the MDS Nurse began working in the MDS office in 09/2014 and SW #2 began work at the facility in 07/2014. The MDS Nurse

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stated he received a quick overview this month, 2/2015, on how to complete a CAA analysis from the newly hired Quality Assurance Nurse (QA). The MDS Nurse stated if he knew he was going to develop a care plan he used the information from the checklist and was unaware he had to explain his analysis on the CAA. SW #2 stated she had never been trained on how to complete a CAA and generally put in the information from the brief interview for mental status. She further stated she had been informed by the QA Nurse she would be trained on how to complete a CAA. The MDS Coordinator stated she was aware an analysis and summary needed to be completed for the CAA but she had been overwhelmed by the amount of work she had to do when she took the MDS Coordinator position in 09/2014.

On 02/27/15 at 9:50 AM the Administrator stated she had identified CAAs were not being completed correctly and she brought in the QA Nurse to assist with training the MDS staff.

7. Resident #158 was admitted to the facility on 05/13/14 with diagnoses that included but was not limited to depression, anxiety, dementia, psychosis, insomnia, and post-hip replacement. Review of the latest quarterly Minimum Data Set (MDS) dated 12/16/14 indicated she was cognitively intact, required limited assistance for most activities of daily living (ADL ' s), received scheduled pain medication and she indicated she had a pain severity score of 8 on a 1-10 scale. Resident #158 was revealed to always be continent of bowel and bladder. Resident #158 was revealed to take antidepressant, antianxiety, and hypnotic medications 7 days a week.

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Review of the Care Area Assessments (CAA) dated 11/07/14 revealed a checklist, but no analysis of the checked items or analysis of how the checked items affected Resident #158 ' s function, or what direction the care plan should follow. Examples are as follows:

ADL ' s checked that Resident #158 had physical limitations such as weakness, and was at risk for complications of immobility such as contractures, incontinence, and depression. These areas were checked with no additional information provided other than the checklist. This was written by the MDS Coordinator.

Psychosocial well-being checked that Resident #158 had health status factors that could inhibit social involvement that included decline in ADL ' s, mood or behavior problems, health problems, and communication issues. No further analysis of these issues was provided. This was written by the Activities Director.

Activities checked that Resident #158 had health issues that result in decreased participation in activity participation to include depression or anxiety, cognitive deficits, use of psychoactive medications, numerous treatments, and chronic health problems among other checked issues. No further analysis was provided. This was written by the Activities Director.

Falls checked that Resident #158 had difficulty maintaining balance, impaired balance during, transitions, psychotropic medications, cognitive impairment, and incontinence among other areas checked. Resident # 158 was not indicated on MDS to be incontinent. No further analysis was for falls was provided. This was written by the

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F 272	Continued From page 32 MDS Coordinator. Pressure sores checked risk factors as altered mental status, incontinence, antipsychotic medications, and functional limitation of range of motion among others. No further analysis of Resident #158 ' s risk factors were provided. This was written by the MDS Coordinator. An interview was conducted on 02/23/15 at 10:14 AM with the MDS Coordinator, MDS Nurse and Social Worker (SW) #2. During the interview it was revealed the MDS Nurse began working in the MDS office in 09/2014 and SW #2 began work at the facility in 07/2014. The MDS Nurse stated he received a quick overview this month, 02/2015, on how to complete a CAA analysis from the newly hired Quality Assurance Nurse (QA). The MDS Nurse stated if he knew he was going to develop a care plan he used the information from the checklist and was unaware he had to explain his analysis on the CAA. SW #2 stated she had never been trained on how to complete a CAA and generally put in the information from the brief interview for mental status. She further stated she had been informed by the QA Nurse she would be trained on how to complete a CAA. The MDS Coordinator stated she was aware an analysis and summary needed to be completed for the CAA but she had been overwhelmed by the amount of work she had to do when she took the MDS Coordinator position in 9/2014. On 02/27/15 at 9:50 AM the Administrator stated she had identified CAAs were not being completed correctly and she brought in the QA Nurse to assist with training the MDS staff.	F 272		

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F 272	Continued From page 33 8. Resident #107 was admitted to the facility on 07/31/14 with diagnoses including hypertension, dementia (non-Alzheimer's), anxiety disorder, and depression. The annual assessment Minimum Data Set (MDS) dated 01/13/15 coded Resident #107 as cognitively impaired. The MDS indicated she had one or more unhealed pressure ulcers and one stage IV pressure ulcer. Resident #107 required extensive assistance for bed mobility, transfers, dressing, toileting, and personal hygiene. She was coded as always incontinent of bowel and bladder. Review of the Care Area Assessment (CAA) dated 01/13/15 revealed the following areas were not analyzed with the MDS information to determine the resident's strengths, weaknesses and how her condition affected those areas as follows: a. Nutritional CAA: under nature of problem/condition was ideal body weight and regular diet; under other diseases and conditions that can affect appetite or nutritional needs, pressure ulcer was not mentioned in relationship to nutritional needs. The decision not to care plan nutritional status in relationship to stage IV pressure ulcer including complications and risk factors was not analyzed. b. Pressure Ulcer CAA: under nature of problem/condition was stage IV; under complications and risk factors the MDS information was listed; and under factors to consider were care plan interventions. There was no analysis of the information to determine the reason for pressure ulcer development and/or prevention.	F 272		

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Interview with the MDS Coordinator on 02/23/15 at 10:17 AM revealed she did not write a narrative on the CAA. She stated the checks on the CAA came from the MDS. She shared that as long as she had been doing MDS, she had not wrapped her head around what was expected related to the CAAs. The MDS Coordinated stated there should be a summary if there is a CAA and further shared that needed a lot of work with this.

Interview with the MDS nurse on 02/23/15 at 10:17 AM revealed he learned how to analyze a CAA about a month ago from the new quality assurance nurse. The MDS nurse shared he thought the CAA was just a worksheet to get to the care plan.

9. Resident #5 was admitted to the facility on 04/19/05 with diagnoses including anemia, anxiety disorder, depression, manic depression (bipolar disease), and schizophrenia.

The significant change Minimum Data Set dated 01/19/15 coded Resident #5 as cognitively intact with no behaviors. Resident #5 required limited assistance for transfers, walking in room, dressing, toileting, and personal hygiene.

Review of the Care Area Assessment (CAA) dated 01/19/15 revealed the following area was not analyzed with the MDS information to determine the resident's strengths, weaknesses and how her condition affected this area as follows:
a. Psychotropic Drug Use CAA: under nature of problem/condition was written antipsychotics for schizophrenia, antidepressant sertraline for depression and divalproex for anxiety; under

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complications and risk factors was the potential for adverse side effects related to the use of psychotropic medications; and under factors to consider were the care plan interventions. There was no analysis to identify nature of condition for use of psychotropic medications and the effects the medication had on Resident #5's quality of life.

Interview with the MDS Coordinator on 02/23/15 at 10:17 AM revealed she did not write a narrative on the CAA. She stated the checks on the CAA came from the MDS. She shared that as long as she had been doing MDS, she had not wrapped her head around what was expected related to the CAAs. The MDS Coordinated stated there should be a summary if there is a CAA and further shared that needed a lot of work with this.

Interview with the MDS nurse on 02/23/15 at 10:17 AM revealed he learned how to analyze a CAA about a month ago from the new quality assurance nurse. The MDS nurse shared he thought the CAA was just a worksheet to get to the care plan.

10. Resident #29 was admitted to the facility on 12/26/12 with diagnoses which included high blood pressure, difficulty speaking, difficulty swallowing, anxiety, generalized muscle weakness, heart disease, right sided paralysis and a stroke.

A review of the annual Minimum Data Set (MDS) dated 10/23/14 indicated short term and long term memory problems and severe impairment in cognition for daily decision making. The MDS also indicated Resident #29 required extensive assistance by staff for activities of daily living.

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A review of the Care Area Assessments (CAA) dated 02/01/15 revealed a checklist but no analysis of the checked items or any analysis of how the checked items affected the resident ' s function or what direction the care plan would take. Examples as follows:
a. Activities indicated this was an actual problem but the section labeled nature of the problem/condition was left blank. Items were checked which indicated depression or anxiety, functional/mobility or balance problems, cognitive deficits and chronic health conditions but there was no analysis of any of the areas to describe how activities were planned or provided. Under care plan consideration was the comment to maintain current level of functioning. This was completed by Activities Director.
b. Falls indicated this was an actual problem and only checked items such as difficulty maintaining sitting balance, impaired balance during transitions, use of antidepressants and antianxiety medications but there was no analysis of any of the areas to prevent falls. Under care plan consideration was the comment to slow or minimize decline, maintain current level of functioning and minimize risks. This was completed by MDS nurse.
c. Communication indicated this was an actual problem and only checked items such as aphasia and mental health problems, received antianxiety and antidepressant medications, had expressive communication, oral motor function problems and mood problems but there was no analysis of any of the areas to describe how this affected her ability to communicate or be understood. Under care plan consideration there was no information documented. This was completed by MDS nurse.
D. Psychosocial Well-Being indicated this was an

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actual problem and a section labeled nature of the problem/condition was left blank. Items were checked such as delirium, aphasia, depression, mood, health problems and change in communication but there was no analysis of any of the areas to describe how this affected her psychosocial well-being. Under care plan consideration was the comment to maintain current level of functioning. This was completed by Activities Director.

During an interview on 02/23/15 at 10:14 AM the MDS coordinator, MDS nurse and Social Worker (SW) #2 revealed the MDS nurse started completing MDSs in September 2014 and SW #2 started the end of July 2014. MDS nurse stated that he just received a quick overview this month on how to complete a CAA. The MDS nurse further stated if he knew he was going to develop a care plan he just used the information from the checklist and was unaware he had to explain his analysis on the CAA. SW #2 stated she had never been trained on how to complete the CAA and generally just put in the information from the brief interview for mental status. She further stated the new quality assurance (QA) nurse told her that training was coming in the future. The MDS Coordinator stated she always had trouble understanding the CAAs and had been overwhelmed with the new responsibilities she had taken on since becoming the coordinator.

During an interview on 02/23/15 at 11:01 AM the Activity Director explained a former MDS nurse and Director of nursing had gone over the CAA with her. She stated she had not been told and was unaware that she was supposed to do notes or a summary for the activities or psychosocial well-being CAAs.

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F 272	Continued From page 38 On 02/27/15 at 9:50 AM, the Administrator stated she had identified that CAAs were not being completed correctly so she brought in the QA nurse to assist with training the MDS staff.	F 272		
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 reviews and staff, resident and physician interviews the facility failed to do an assessment for 1 resident after she was lowered to the floor by staff while being transferred and failed to assess the resident before she was lifted from the floor into a shower chair for 1 of 12 sampled residents for falls. (Resident #24). Immediate Jeopardy began on 11/15/14 when staff failed to assess Resident #24 after she was lowered to the floor by staff during a transfer. Immediate jeopardy was removed on 02/27/15 at 11:35 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of	F 309		

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systems put into place are effective.

The findings included:

A review of a facility document titled "Falls Policy" that was not dated, indicated in part, the following procedure is to be followed for any resident that sustains a fall: a full body assessment will be conducted to determine if any injury has occurred and monitored for 24 hours after the fall.

Resident #24 was admitted to the facility on 02/17/14 with diagnoses which included diabetes, high blood pressure, difficulty speaking and swallowing, arthritis, depression, right sided paralysis and stroke.

A review of a Nursing Admission Information sheet dated 02/17/14 indicated Resident #24 was alert and aware, non-verbal but was able to understand others and answered yes and no to questions. The notes also indicated she was dependent for transfers and bed mobility.

A review of Resident #24's Fall Risk Assessment on 02/17/14 revealed a score of 14 which indicated a total score of 10 or above represented high risk for falls.

A review of a physician's order for Resident #24, dated 02/18/14, indicated she was to be transferred by a mechanical lift.

A review of the admission Minimum Data Set (MDS) dated 03/03/14 revealed Resident #24 had severe impairment in cognition for daily decision making. The MDS also indicated Resident #24 was totally dependent on staff for bed mobility and transfers and Resident #24 did not speak but

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was sometimes understood and usually understood others. The MDS indicated Resident #24 had a fall history with a fall in the last month prior to admission to the facility.

A review of a Fall Risk Assessment on 05/24/14 for Resident #24 indicated she was high risk for falls.

A review of a care plan with a problem statement for accidents/fall risk with an updated date of 10/25/14 indicated approaches to determine possible causes/patterns associated with falls or accidents and lift for transfers.

A review of a care plan with a problem statement for total dependence with an updated date of 10/25/14 indicated Hoyer lift to chair every day.

A review of a care plan with a problem statement for activities of daily living with updated date of 10/25/14 indicated lift for transfers and out of bed to chair with lift.

A review of the monthly physician's orders for November 2014 indicated activity level of a mechanical lift.

A review of Medication Administration Records (MARs) for November 2014 indicated activity level for a mechanical lift.

A review of nurse's notes dated 11/15/14 revealed there were no nurse's notes during the 7:00 AM - 7:00 PM shift.

A review of a nurse's note dated 11/15/14 at 8:30 PM indicated Resident #24 was lying in bed grunting when Nurse #2 went to resident's room

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to administer bedtime medications. The notes further indicated when the head of the bed was raised Resident #24 began yelling out. The notes revealed Resident #24 was nonverbal due to history of a stroke but could answer questions appropriately by nodding her head for yes and no. The notes further revealed when asked where she was hurting Resident #24 pointed to her right leg. The notes indicated an assessment showed no visual injuries or redness but when an attempt was made to roll Resident #24 over she began screaming loudly and Resident #24's responsible party was notified and hospital was notified for transport to the emergency room.

A review of a nurse's note dated 11/15/14 at 9:02 PM revealed emergency medical services (EMS) was in the facility to transport Resident #24 to the hospital emergency room for evaluation.

A review of an EMS report dated 11/15/14 indicated EMS was at Resident #24's bedside at 9:03 PM. A section labeled narrative indicated Resident #24 initially stated on scene that she did not fall however upon talking to emergency room staff it was found out that she did indeed have a fall earlier today.

A review of a nurse's note dated 11/15/14 at 9:25 PM indicated Nurse #2 had a conference with Nurse Aides (NAs) assigned to care for Resident #24 during the 7:00 PM to 7:00 AM shift and there were no reports of injury received from the previous shift to Nurse #2 or to NAs.

A review of a nurse's note dated 11/16/14 at 12:30 AM indicated Nurse #2 called the hospital and was informed Resident #24 was admitted to the hospital with a right hip fracture. The notes

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further indicated Nurse #2 notified Administrative nurse (Assistant Director of Nursing (ADON)) #1 on call and contacted Resident #24's family to give an update.

A review of a nurse's note dated 11/16/14 at 12:42 AM indicated staff from the hospital called the facility and reported when Resident #24 was questioned she indicated she had been dropped onto the floor earlier in the day. The notes further indicated Administrative nurse (ADON #1) was notified.

A review of a Physician's Report of Consultation dated 11/16/14 indicated a consulting diagnosis of intertrochanteric (upper part of the thigh bone) fracture of right hip for Resident #24 who had a history of stroke with right hemiparesis (paralysis) and aphasia (difficulty speaking). The notes revealed Resident #24 was found by the nursing staff lying in bed complaining of hip pain and apparently had a history of falling earlier in the day where she may have injured that hip. The notes further indicated Resident #24 was brought to the hospital emergency room and x-rays revealed a displaced intertrochanteric/subtrochanteric (upper quarter of the thigh bone) fracture of the right hip.

A review of an Operative report dated 11/17/14 indicated intertrochanteric/subtrochanteric fracture of the right hip. The notes further indicated surgery was completed with open reduction (to realign bone fracture into normal position) and internal fixation (hardware used to keep bone fracture stable to heal and prevent infection) with a short gamma nail.

A review of a facility document titled Investigation

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of Resident #24's fracture which was not dated but signed by the Director of Nursing (DON) indicated the following summary in part: On the morning of 11/15/14 NA #1 went in to get resident up and ready for shower. NA #1 asked NA #2 to assist with transferring Resident #24 from bed to chair. The 2 NAs attempted to transfer Resident #24 with an arm and arm method. They stood resident without difficulty but when the NAs started to pivot resident to place her in a shower chair the resident "went limp" and was unable to continue to assist the NAs with the transfer. NAs attempted to place Resident #24 in shower chair but due to her weight was unable to get her safely into the chair. Both NAs report they together slowly lowered resident to the floor. NA #2 went immediately to alert the nurse of the incident and get NA #3 to assist them in putting Resident #24 in the shower chair. Nurse #1 reported she could not confirm or deny she was immediately notified of the incident. NA #3 assisted NA #1 and NA #2 in transferring Resident #24 from floor to shower chair. NAs report Resident #24 did not complain of pain or show signs or symptoms of pain during this transfer. After lunch NA #1 and NA #3 transferred Resident #24 from wheelchair to bed. The resident participated with the transfer and did not complain of pain or show signs or symptoms of pain. At approximately 2:00 PM NA #1 and NA #4 was changing Resident #24 and she started yelling out and grabbing at her leg. NA (not named) asked the resident if she was in pain and she nodded her head yes. NA #4 went to get Nurse #1 and she went to check the resident and reported that both legs looked symmetrical and she "didn't see anything out of the ordinary." Nurse #1 noticed Resident #24 was scratching at her groin area and she had just recently administered scheduled Tylenol to Resident #24.

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Nurse #1 instructed the NAs to clean resident and apply protective ointment. At 4:00 PM Nurse #1 asked Resident #24 if her leg was still hurting and the resident shook her head no. When night shift came in Resident #24 appeared to be in severe pain and Nurse #2 sent resident to the ER and her diagnosis was intertrochanteric fracture of right hip.

During an interview on 02/19/15 at 11:08 AM with Resident #24 she smiled and nodded her head up and down as a response for yes and made repetitive sounds but was unable to form words when spoken to. She nodded her head up and down yes when questioned if she had a hip injury last November. When asked if she had a fall her facial expression changed and she became tearful and attempted to say something but was unable to form the words and then nodded her head vigorously up and down yes. When questioned if her hip was better she shook her head from side to side as a response for no and moved her left hand toward her right hip in a rubbing motion.

During an interview on 02/23/15 at 11:48 AM the Assistant Director of Nursing (ADON) #1 stated after review of Resident #24's nurse's notes for 11/15/14 she did not remember being called on 11/15/14 when the resident was sent to the hospital but if the nurses documented they called her then they probably did. She further stated she did not remember going to the facility on 11/15/14 or 11/16/14. She explained the only thing she remembered was she heard during morning meeting the following week Resident #24 had complained of severe pain in her hip and was sent to the hospital and she had a hip fracture.

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During an interview on 02/23/15 at 12:14 PM the Director of Nursing (DON) upon review of the nurses notes for Resident #24 on 11/15/14 confirmed there were no nurse's notes or nursing assessment during the 7:00 AM to 7:00 PM shift.

During a telephone interview on 02/23/15 at 6:44 PM NA #1 explained she and NA #2 were trying to get Resident #24 out of bed into a shower chair on 11/15/14. She stated therapy staff had been working with Resident #24 to stand and transfer her with 2 staff assist and NA #1 stated she had previously stood Resident #24 next to her bed to transfer her and the resident had done fine and that was the way she usually transferred her. She explained during the transfer on 11/15/14 she had her arm under one of Resident #24's armpits and NA #2 had her arm under the other armpit and they stood her up at the bedside but when they turned her to pivot her she went limp. NA #1 stated when Resident #24 started to slide to the floor they tried to lift her up but they couldn't because she was too heavy. She explained when they realized they could not lift her up they lowered her to the floor and she told NA #2 to go get a nurse. NA #1 further explained she held onto Resident #24's shoulders while she sat in the floor and thought her legs were out in front of her. NA #1 stated NA #2 came back with NA #3 and they picked Resident #24 up off the floor and she took her to the shower room and gave her a shower. She stated she did not notice any obvious redness or bruising when she gave Resident her shower and after the shower NA #2 assisted her to stand Resident #24 up from the shower chair and into a wheelchair. NA #1 further stated after lunch she got NA #2 and NA #3 again to transfer Resident #24 and they stood Resident #24 up from her wheelchair and

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transferred her to bed. She explained about 3 hours after Resident #24 was lowered to the floor she was moaning and holding her right leg and was rubbing it and she reported it to Nurse #1.

During a phone interview on 02/26/15 at 5:48 PM received from NA #1 she stated she had remembered when she sent NA #2 to get Nurse #1 the nurse did not come to the resident's room and Resident #24 was not assessed while she was in the floor or when she was lifted into the shower chair or when she was transferred back to bed after lunch. She further stated when NA #3 came back to the room and stated Nurse #1 said to put Resident #24 in the shower chair they lifted her up off the floor and into the chair.

During a telephone interview on 02/23/15 at 7:04 PM with NA #2 she stated she went to help NA #1 transfer Resident #24 on 11/15/14 for a shower. She explained they sat Resident #24 up on the side of the bed for a few seconds, then stood her up and turned her towards the left and she started to buckle. She stated Resident #24's right leg did not turn as her upper body turned and she slid down to the floor. She further stated when Resident #24 was in the floor her left leg was straight out but her right leg was crisscrossed under her left leg and was bent at a 90 degree angle at her knee. NA #2 stated she went to get Nurse #1 and the nurse asked if the resident had fallen or slid to the floor and when she told the nurse the resident had slid to the floor the nurse said ok and to go ahead and get Resident #24 up in the shower chair and give her a shower. NA #2 stated she went back to Resident #24's room and she and NA #1 placed their arms under each of Resident #24's armpits and lifted her from the floor and into the shower chair. She stated

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Resident #24 complained of her right leg hurting a little bit when she was placed in the shower chair but she thought it was caused by pressure on her legs from the shower chair. She stated she did not assist NA #1 during Resident #24's shower and also verified Nurse #1 did not come to Resident #24's room while the resident was in the floor or after they got her into the shower chair.

During an interview on 02/24/15 at 1:54 PM with NA #3 she stated NA #1 or NA #2 came and got her to assist with getting Resident #24 off the floor on 11/15/14 because she had slid to the floor. She stated when she went into Resident #24's room the resident was sitting on the floor and she remembered Resident #24's legs were not straight out in front of her because she couldn't straighten her legs out fully due to a previous stroke with paralysis on her right side. She explained she placed her arm under one of Resident #24's armpits and NA #1 placed her arm under Resident #24's other armpit and they lifted her up off the floor while NA #2 held the shower chair. She confirmed Nurse #1 did not come in the room while she was in Resident #24's room and after they placed Resident #24 in the shower chair she left the room to resume her assignment on a different hall.

During an interview on 02/23/14 at 8:13 PM with Nurse #1 she confirmed she did not go to Resident #24's room to assess her on 11/15/14 when NA #2 reported the resident had slid to the floor. She stated she was having a very bad day that day and she took full responsibility for not doing what she was supposed to do. She confirmed the only assessment she did was later in the day when Resident #24 was crying out in

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pain and was reaching toward her peri area and the area was red. She stated she couldn't remember exactly what she saw but remembered she gave Resident #24 some routine Tylenol for pain but did not report it or document it because she did not think anything had happened or that anything needed to be reported or documented.

During a telephone interview on 02/23/15 at 7:56 PM with Nurse #2 she stated she worked on the 7:00 PM to 7:00 AM shift on 11/15/14 and that evening the NAs came and got her because they had taken Resident #24 her bedtime snack and she was screaming in pain. She explained she couldn't assess her or touch her because she was in such pain. She further explained Resident #24 had an incontinent episode but they couldn't clean her or turn her because of the pain. She verified she had not received a report from Nurse #1 during shift change that Resident #24 had slid to the floor earlier that day. She stated she sent the resident to the hospital emergency room for evaluation and treatment because Resident #24 did not usually complain of pain and she couldn't figure out why she was having such severe pain. She explained she called the Administrative nurse on call and verified that was ADON #1. She further explained ADON #1 did not come to the facility that night and told her to be sure and document everything so she wrote all she knew in her nurses notes. She stated later that night a nurse from the hospital called and asked about a fall that Resident #24 had earlier that day. She further stated that was the first time she had been told Resident #24 had a fall.

During an interview on 02/24/15 at 3:01 PM with Licensed Physical Therapist #1 he explained therapy staff had been working with Resident #24

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on standing and transfers with 2 staff assist prior to her fall on 11/15/14. He stated Resident #24's participation varied and some days she would stand but then she would spontaneously sit down. He stated it was his understanding that nursing staff had been transferring Resident #24 with a mechanical lift and the plan of care would have been to use a mechanical lift for transfers until Resident #24 was cleared by therapy to transfer with a maximum assist of 2 staff.

During a phone interview on 02/25/15 at 2:00 PM the physician who was also the facility Medical Director stated he was made aware of Resident #24's fall after she had gone to the hospital. He stated the information he had been told about her sliding to the floor did not explain how the fracture happened but he wondered if she had a previous incident or something that had happened which put her at higher risk for a fracture. He stated it was his expectation for nurses to assess and evaluate residents immediately after a fall or when they were lowered to the floor. He further stated he expected the nurses to call the physician to report what had happened, what the resident's level of comfort was, their level of pain and their level of consciousness. He stated residents should be assessed right away then and there and all falls should be considered to be high risk and staff should do what they could to prevent falls.

During an interview on 02/27/15 at 9:36 AM with the Rehabilitation Director she stated it was not therapy's intent for nursing staff to mirror what they were doing with residents during therapy sessions and did not instruct nursing staff to do something different with transfers than what was on the care plan. She explained when nursing

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staff came to her for questions about how to transfer a resident she instructed them to go to the nurse for clarification. She further stated nursing staff should know what each resident required for transfers.

During a follow up interview on 02/27/15 at 11:34 AM the DON stated it was her expectations that the nurse should assess for falls whether they were witnessed or un-witnessed and should follow up to make sure the resident was ok. She explained if the resident was injured the nurse should provide first aid or send the resident to the hospital. She explained the care plan should guide staff with care and the transfer technique should match the care plan. She further explained the closet care plan which guided care provided by NAs that was located in the resident's closet should match the care plan. She stated the closet care plan that was in place prior to Resident #24's fall was discarded when she went to the hospital but she would expect it indicated Hoyer lift for transfers since that was what was documented on the care plans. She further stated they would not change the care plan related to transfers unless therapy had released the resident 100 percent for a change in transfer technique. She stated when staff was notified of Resident #24's fracture she should have also been notified. She further stated she was not aware and was shocked to see there were no nurse's notes for Resident #24 on 11/15/14 for the 7:00 AM to 7:00 PM shift until she was questioned about it during the survey. She also indicated she documented the Investigation of Resident #24's fracture after she talked to staff on Monday 11/17/14 and at that time she did not realize Nurse #1 had not gone to Resident 24's room after she slid to the floor and did not assess

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her.

The facility's Administrator and Director of Nursing were notified of Immediate Jeopardy on 02/24/15 at 3:31 PM for Resident #24. The facility provided a credible allegation of compliance on 02/27/15 at 11:35 AM. The following interventions were put into place by the facility to remove the Immediate Jeopardy.

Credible Allegation of Compliance:
Resident #24 was sent to the hospital emergency room on November 15, 2014 with right hip pain resulting in surgical repair.

Two nurse aides involved with resident #24's care on 11/15/14 were verbally instructed on 11/16/14, their next scheduled work day, regarding not moving a resident after a fall before a nurse assessed the resident. On 11/17/14 all 3 CNAs involved received verbal education regarding utilization of gait belt for transfers and assessment required to be completed by a licensed nurse prior to moving any resident after a fall.

Nurse #1 received a written coaching on 11/17/2014 regarding completing incident reports and completing resident assessments, including assessing a resident after a fall before the resident is moved. She was also educated regarding fall investigation and assessment after falls on 11/21/2014.

All documented falls that occurred in November prior to the identified deficient practice were audited to assess compliance with standards of practice on 11/14/14 -11/16/14 and was utilized to determine if there were other falls that occurred

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with other resident's and/or problems with transfer techniques. There were no other residents identified. Implemented fall clinical meeting daily Monday through Friday on 11/18/14. This is a subcommittee that specifically looks at falls. Fall audit tool initiated 11/18/14 to ensure timely assessment, appropriate documentation, and updated care plan.

On February 24, 2015 at 11 pm nurses and nurse aides present was in serviced on:
New falls and fall risk policy and procedure implemented on February 24, 2015.
Assessment and first aid
Record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities
If evidence of significant injury, nursing staff will provide first aid
Once an assessment rules out significant injury, nursing staff will help resident to a comfortable sitting, lying, or standing position. Resident will not be moved until nursing assessment is completed.
Initial documentation regarding fall and notification of physician and family
Defining details of fall
Identifying causes of fall or fall risk
All off the above items will be documented on Fall: Initial Documentation Note/Progress Notes-5 day
This new form implemented on February 22, 2015 will be placed in the MAR and placed in the nurse's notes after completion of 5 day post fall documentation.
Performing a post-fall evaluation
Within 24 hours after a first fall, the nurse on duty should watch the resident rise from the chair, ambulate several steps if able, and return to sitting. If the resident has no difficulty or

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F 309	Continued From page 53 unsteadiness, further evaluation may not be needed. If the resident has difficulty therapy referral is initiated. This should be documented on Fall: Initial Documentation Note/Progress Notes-5 day The nurse should assess the resident and determine if there are any changes or complications as a result of a fall every shift for 5 days and document on Fall: Initial Documentation/Progress Note-5 day Identifying complications of falls requirement for immediate assessment of residents who have fallen and documentation in resident's clinical record the condition the resident was found assessment data including vital signs, and any obvious injuries Interventions, first aid, or treatment administered Notification of physician and family All of the above to be documented on Fall: Initial Documentation Note/Progress Notes-5 day within Completion of fall risk assessment Appropriate interventions taken to prevent further falls Signature and title of person recording data Report fall to DON, ADON, or RN Supervisor An in service on falls and fall risk policy & procedure and transfers and mechanical lift will be completed for all nursing department staff by 8 pm on February 25, 2015. Any nursing department employee that has not attended above in service or participated in phone in service by February 25, 2015 at 8 pm will not be allowed to work until the in service is completed by DON, ADON, or RN Supervisor. At 8 pm on February 25, 2015 a list of nursing department	F 309		

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employees that did not receive the above in service will be given to the DON. The DON will monitor the daily schedule to ensure that anyone that has not had the above training will not be scheduled to work until the in service is completed. All new nursing department employees will be in serviced during orientation.

Immediate jeopardy was removed on 02/27/15 at 11:35 AM with interviews of direct care and licensed nursing staff who confirmed they received in-service training on new falls and fall risk policy and procedure and use of mechanical lifts prior to reporting for duty.

A review of in-service sign in sheets contained documentation of staff who had attended the in-services. The DON had a list of all staff who had not attended in-services and these names were cross referenced with staff schedules and there were no staff who had not been trained listed on the schedules for work.

Interviews with NAs revealed they had attended in-service training and were knowledgeable to notify a nurse immediately after a fall which included lowering a resident to the floor. Interviews with nurses revealed they had attended in-service training and were knowledgeable to respond and assess residents immediately after a fall or if they were lowered to the floor. They described the expectations for providing first aid, documentation of the incident, notification of physician, responsible party and administrative nursing staff and completion of the fall risk assessment, post fall evaluation and incident report.

Record reviews revealed the Fall: Initial

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F 309	Continued From page 55 Documentation Note/Progress Notes-5 day form was implemented on 02/22/15 and a new fall risk policy and procedure was implemented on 02/24/15.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to allow 1 of 7 sampled residents to feed themselves. Resident #56 was fed two meals and not given the opportunity to feed herself using cues for assistance as needed. The findings included: 1. Resident #56 was admitted to the facility on 10/01/14. Her diagnoses included severe acute ischemic cardiovascular accident. Upon admission, the physician orders revealed she was fed only by nasogastric tube (NG) and took nothing by mouth. Review of speech therapy notes revealed Resident #56 began speech therapy on 10/02/14 which included swallow techniques. Resident #56's NG tube was removed on 10/10/14. The physician ordered a puree diet on 10/13/14.	F 311		

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A restorative care plan was created on 10/15/14 for the problem of impaired ability to safely and adequately consume current diet related to swallow dysfunction. Goals included to chew/swallow without aspiration and included that she alternate liquids and solids, take small bites and sips with minimal assistance of one. The care plan also noted she needed verbal cues to follow safe swallow techniques.

Her quarterly Minimum Data set dated 01/09/15 coded her as having long and short term memory impairment and severely impaired decision making skills. She was coded as requiring total assistance with eating.

On 02/16/15 at 11:25 AM, Nursing Assistant (NA) #3 was observed feeding Resident #56. She continued feeding Resident #56 at 12:26 PM. On 02/24/15 at 9:34 AM, NA #3 was interviewed. She stated that Resident #56 went to restorative dining for some meals but she always just fed her when she was in her room. She further stated she gave Resident #56 no opportunity to feed herself. NA #3 stated she was never instructed on allowing Resident #56 to feed herself.

On 02/18/15 at 11:29 AM, the restorative nurse aide (NA) #11 stated that Resident #56 ate in restorative dining for breakfast and lunch, as there was no restorative dining in the evening.

On 02/19/15 at 11:13 AM Resident #56 was observed feeding herself in restorative dining. NA #11 just assisted by positioning the food in front of her.

On 02/19/15 at 5:24 PM Resident #56 was observed sitting in bed which was lowered to the

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floor. NA #9 was observed sitting in a chair by the bed, the tray in front of the NA. NA #9 did not encourage or assist Resident #56 to feed herself during the meal. NA #9 would hand her a cup and allowed the resident to drink independently from the cup.

NA #9 was interviewed on 02/19/15 at 5:41 PM. She related that this was the first time she had fed Resident #56. She further stated the tray card stated the type of feeding assistance a resident needed but Resident #56's tray card gave no indication of the type of assistance she needed and the other nurse aides told NA #9 Resident #56 needed help feeding so NA #9 just fed Resident #56.

On 02/23/15 at 11:52 PM restorative NA #11 was interviewed again. NA #11 stated Resident #56 was doing exceptionally well feeding herself. She stated that staff needed to thicken the liquids, make sure she ate slowly, alternated bites and liquids, and staff presented one bowl at a time so Resident #56 did not get overwhelmed with the choices in front of her.

On 02/23/15 at 12:12 PM the Rehab Manager/Speech Therapist (ST) was interviewed. She stated Resident #56 had a devastating stroke and was tube fed originally. ST stated restorative had been working with Resident #56 and watched her so she does not take too big of bites. ST stated the family and staff had been trained on supervising Resident #56 during meals. Follow up interview with Rehab Manager/ST on 02/23/15 at 5:19 PM revealed that her self feeding has drastically improved and staff needed to mostly remind her to take smaller bites and slow down. She further stated Resident

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F 311	Continued From page 58 #56 had been on the rehabilitation unit and moved to her current room after the first few months. Rehab Manager/ST stated she was unsure if the staff on the hall where the resident currently resided had been instructed on the supervision required for Resident #56. On 02/24/15 at 2:22 PM, the Director of Nursing and Assistant Director of Nursing #2 revealed during interview that they expected staff to be providing cuing so Resident #56 could feed herself safely. They further stated they were in the process of inservicing and updating tray cards to include the type of supervision required for each resident.	F 311		
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 by: Based on record reviews and staff, resident and physician interviews the facility failed to utilize a mechanical (full body) lift during transfers for 1 of 12 sampled residents for falls (Resident #24). The facility also failed to secure a loose side rail for 1 Resident on 1 of 4 hallways (Resident #33). Immediate Jeopardy began on 11/15/14 when staff transferred Resident #24 three times without	F 323		

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using a mechanical lift. Immediate jeopardy was removed on 02/27/15 at 11:35 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example 2 is at a scope and severity of D.

The findings included:

A review of a facility document titled "Falls Checklist" that was not dated, indicated in part, to complete the falls investigation and witness statements; Notify Director of Nursing (DON) and Administrator if injury sustained and resident sent to emergency room; complete falls investigation to make sure date and time are correct, include what the resident said, include what you observed, what assessments and results for skin, mental, range of motion, vital signs and level of consciousness and plan to prevent further incidents from occurring; complete progress note and it should include in detail all of the above information.

1. Resident #24 was admitted to the facility on 02/17/14 with diagnoses which included diabetes, high blood pressure, difficulty speaking and swallowing, arthritis, depression, right sided paralysis and stroke.

A review of a Nursing Admission Information sheet dated 02/17/14 indicated Resident #24 was alert and aware, non-verbal but was able to understand others and answered yes and no to questions. The notes also indicated she was

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dependent for transfers and bed mobility.

A review of a Fall Risk Assessment for Resident #24 on 02/17/14 revealed a score of 14 which indicated a total score of 10 or above represented high risk for falls.

A review of a physician's order dated 02/18/14 indicated Resident #24 was to be transferred with a mechanical lift.

A review of the admission Minimum Data Set (MDS) dated 03/03/14 revealed Resident #24 had severe impairment in cognition for daily decision making. The MDS also indicated Resident #24 was totally dependent on staff for bed mobility and transfers and Resident #24 did not speak but was sometimes understood and usually understood others.

A review of a Fall Risk Assessment for Resident #24 on 05/24/14 revealed a score of 11 which indicated high risk for falls.

A review of a care plan with a problem statement for accidents/fall risk with an updated date of 10/25/14 indicated approaches to determine possible causes/patterns associated with falls or accidents and lift for transfers.

A review of a care plan with a problem statement for total dependence with an updated date of 10/25/14 indicated mechanical lift to chair every day.

A review of a care plan with a problem statement for activities of daily living with updated date of 10/25/14 indicated lift for transfers and out of bed to chair with lift.

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A review of the monthly physician's orders for November 2014 indicated activity level for a mechanical lift.

A review of Medication Administration Records (MARs) for November 2014 indicated activity level for a mechanical lift.

A review of nurse's notes dated 11/15/14 revealed there were no nurse's notes during the 7:00 AM - 7:00 PM shift.

A review of a nurse's note dated 11/15/14 at 8:30 PM indicated Resident #24 was lying in bed grunting when Nurse #2 went to resident's room to administer bedtime medications. The notes further indicated when the head of the bed was raised Resident #24 began yelling out. The notes revealed Resident #24 was nonverbal due to history of a stroke but could answer questions appropriately by nodding her head for yes and no. The notes further revealed when asked where she was hurting Resident #24 pointed to her right leg. The notes indicated an assessment showed no visual injuries or redness but when an attempt was made to roll Resident #24 over she began screaming loudly and Resident #24's responsible party was notified and hospital was notified for transport to the emergency room.

A review of a nurse's note dated 11/15/14 at 9:02 PM revealed emergency medical services (EMS) was in the facility to transport Resident #24 to the hospital emergency room for evaluation.

A review of an EMS report dated 11/15/14 indicated EMS was at Resident #24's bedside at 9:03 PM. A section labeled narrative indicated

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Resident #24 initially stated on scene that she did not fall however upon talking to emergency room staff it was found out that she did indeed have a fall earlier today.

A review of a nurse's note dated 11/15/14 at 9:25 PM indicated Nurse #2 had a conference with Nurse Aides (NA's) assigned to care for Resident #24 on the 7:00 PM to 7:00 AM shift and there were no reports of injury received from the previous shift to Nurse #2 or to NAs.

A review of a nurse's note dated 11/16/14 at 12:30 AM indicated Nurse #2 called the hospital and was informed Resident #24 was admitted to the hospital with a right hip fracture. The notes further indicated Nurse #2 notified Administrative nurse (Assistant Director of Nursing (ADON)) #1 on call and contacted Resident #24's family to give an update.

A review of a nurse's note dated 11/16/14 at 12:42 AM indicated staff from the hospital called the facility with questions and reported when Resident #24 was questioned she indicated she had been dropped onto the floor earlier in the day. The notes further indicated Administrative nurse (ADON #1) was notified.

A review of a Physician's Report of Consultation dated 11/16/14 indicated a consulting diagnosis of intertrochanteric (upper part of the thigh bone) fracture of right hip for Resident #24 who had a history of stroke with right hemiparesis (paralysis) and aphasia (difficulty speaking). The notes revealed Resident #24 was found by the nursing staff lying in bed complaining of hip pain and apparently had a history of falling earlier in the day where she may have injured that hip. The

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notes further indicated Resident #24 was brought to the hospital emergency room and x-rays revealed a displaced intertrochanteric/subtrochanteric (upper quarter of the thigh bone) fracture of the right hip.

A review of an Operative report dated 11/17/14 indicated intertrochanteric/subtrochanteric fracture of the right hip. The notes further indicated surgery was completed with open reduction (to realign bone fracture into normal position) and internal fixation (hardware used to keep bone fracture stable to heal and prevent infection) with a short gamma nail.

A review of a facility document titled Investigation of Resident #24's fracture which was not dated but signed by the Director of Nursing (DON) indicated the following summary in part: On the morning of 11/15/14 NA #1 went in to get resident up and ready for shower. NA #1 asked NA #2 to assist with transferring Resident #24 from bed to chair. The 2 NAs attempted to transfer Resident #24 with an arm and arm method. They stood resident without difficulty but when the NAs started to pivot resident to place her in a shower chair the resident "went limp" and was unable to continue to assist the NAs with the transfer. NAs attempted to place Resident #24 in shower chair but due to her weight was unable to get her safely into the chair. Both NAs report they together slowly lowered resident to the floor. NA #2 went immediately to alert the nurse of the incident and get NA #3 to assist them in putting Resident #24 in the shower chair. Nurse #1 reported she could not confirm or deny she was immediately notified of the incident. NA #3 assisted NA #1 and NA #2 in transferring Resident #24 from floor to shower chair. NAs report Resident #24 did not complain

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of pain or show signs or symptoms of pain during this transfer. After lunch NA #1 and NA #3 transferred Resident #24 from wheelchair to bed. The resident participated with the transfer and did not complain of pain or show signs or symptoms of pain. At approximately 2:00 PM NA #1 and NA #4 was changing Resident #24 and she started yelling out and grabbing at her leg. NA (not named) asked the resident if she was in pain and she nodded her head yes. NA #4 went to get Nurse #1 and she went to check the resident and reported that both legs looked symmetrical and she "didn't see anything out of the ordinary." Nurse #1 noticed Resident #24 was scratching at her groin area and she had just recently administered scheduled Tylenol to Resident #24. Nurse #1 instructed the NAs to clean resident and apply protective ointment. At 4:00 PM Nurse #1 asked Resident #24 if her leg was still hurting and the resident shook her head no. When night shift came in Resident #24 appeared to be in severe pain and Nurse #2 sent resident to the ER and her diagnosis was intertrochanteric fracture of right hip.

During an interview on 02/19/15 at 11:08 AM with Resident #24 she smiled and nodded her head up and down as a response for yes and made repetitive sounds but was unable to form words when spoken to. She nodded her head up and down yes when questioned if she had a hip injury last November. When asked if she had a fall her facial expression changed and she became tearful and attempted to say something but was unable to form the words and then nodded her head vigorously up and down yes. When questioned if her hip was better she shook her head from side to side as a response for no and moved her left hand toward her right hip in a

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rubbing motion.

During an interview on 02/23/15 at 11:48 AM the Assistant Director of Nursing (ADON) #1 stated after review of Resident #24's nurse's notes for 11/15/14 she did not remember being called on 11/15/14 when the resident was sent to the hospital but if the nurses documented they called her then they probably did. She further stated she did not remember going to the facility on 11/15/14 or 11/16/14. She stated the only thing she remembered was she heard during morning meeting the following week Resident #24 had complained of severe pain in her hip and was sent to the hospital and she had a hip fracture. She further stated she did not remember being involved in an investigation regarding Resident #24's fall.

During an interview on 02/23/15 at 12:14 PM the Director of Nursing (DON) upon review of the nurses notes for Resident #24 on 11/15/14 confirmed there were no nurse's notes or nursing assessment during the 7:00 AM to 7:00 PM shift.

During a follow up interview on 02/23/15 at 12:14 PM the DON explained nursing staff was supposed to call the administrative nurse on call when a resident had a fall or injury and the nurse on call should go to the facility to investigate or call the DON and she would go to the facility to investigate. She confirmed she was not called and did not go to the facility on 11/15/14 or 11/16/14 to investigate Resident #24's fall.

During a telephone interview on 02/23/15 at 6:44 PM NA #1 explained she and NA #2 were trying to get Resident #24 out of bed into a shower chair on 11/15/14. She stated therapy staff had been

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working with Resident #24 to stand and transfer her with 2 staff assist and NA #1 stated she had previously stood Resident #24 next to her bed to transfer her and the resident had done fine and that was the way she usually transferred her. She explained during the transfer on 11/15/14 she had her arm under one of Resident #24's armpits and NA #2 had her arm under the other armpit and they stood her up at the bedside but when they turned her to pivot her she went limp. NA #1 stated when Resident #24 started to slide to the floor they tried to lift her up but they couldn't because she was too heavy. She explained when they realized they could not lift her up they lowered her to the floor and she told NA #2 to go get a nurse. NA #1 stated she held on to Resident #24's shoulders while she sat in the floor and thought her legs were out in front of her. NA #1 further stated NA #2 came back with NA #3 and they picked Resident #24 up off the floor and she took her to the shower room and gave her a shower. She explained she did not notice any obvious redness or bruising when she gave Resident her shower and after the shower NA #2 assisted her to stand Resident #24 up from the shower chair and into a wheelchair. NA #1 stated after lunch she got NA #2 and NA #3 again to transfer Resident #24 and they stood Resident #24 up from her wheelchair and transferred her to bed. She explained about 3 hours after Resident #24 was lowered to the floor she was moaning and holding her right leg and was rubbing it and she reported it to Nurse #1.

During a telephone interview on 02/23/15 at 7:04 PM with NA #2 she stated she went to help NA #1 transfer Resident #24 on 11/15/14 for a shower. She explained they sat Resident #24 up on the side of the bed for a few seconds, then stood her

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up and turned her towards the left and she started to buckle. She stated Resident #24's right leg did not turn as her upper body turned and she slid down to the floor. She further stated when Resident #24 was in the floor her left leg was straight out but her right leg was crisscrossed under her left leg and was bent at a 90 degree angle at her knee. NA #2 stated she went to get Nurse #1 and the nurse asked if the resident had fallen or slid to the floor and when she told the nurse the resident had slid to the floor the nurse said ok and to go ahead and get Resident #24 up in the shower chair and give her a shower. NA #2 stated she went back to Resident #24's room and she and NA #1 placed their arms under each of Resident #24's armpits and lifted her from the floor and into the shower chair. She stated Resident #24 complained of her right leg hurting a little bit when she was placed in the shower chair but she thought it was caused by pressure on her legs from the shower chair. She stated she did not assist NA #1 during Resident #24's shower and also verified Nurse #1 did not come to Resident #24's room while the resident was in the floor or after they got her into the shower chair. She explained the DON talked to her on Monday 11/17/14 to ask what had happened during the transfer of Resident #24 on 11/15/14 and sometime after that staff had an in-service about use of gait belts and gait belts were issued to everybody but that was all that changed.

During an interview on 02/24/15 at 1:54 PM with NA #3 she stated NA #1 or NA #2 came and got her to assist with getting Resident #24 off the floor on 11/15/14 because she had slid to the floor. She stated when she went into Resident #24's room the resident was sitting in the floor and she did not think Resident #24's legs were

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straight out in front because she couldn't straighten her legs out fully due to a previous stroke with paralysis on her right side. She demonstrated she placed her arm under one of Resident #24's armpits and NA #1 placed her arm under Resident #24's other armpit and they lifted her up off the floor while NA #2 held the shower chair. She confirmed Nurse #1 did not come in the room while she was in Resident #24's room and after they placed Resident #24 in the shower chair she left the room to resume her assignment on a different hall. She stated she did not remember anyone asked her about what had happened or what she saw when she went to Resident #24's room.

During an interview on 02/23/14 at 8:13 PM with Nurse #1 she confirmed she did not go to Resident #24's room to assess her on 11/15/14 when NA #2 reported the resident had slid to the floor. She stated she was having a very bad day and took full responsibility for not doing what she was supposed to do. She confirmed the only assessment she did was later in the day when Resident #24 was crying out in pain and was reaching toward her peri area and the area was red. She stated she couldn't remember exactly what she saw but remembered she gave Resident #24 some routine Tylenol for pain but did not report it or document it because she did not think anything had happened or that anything needed to be reported or documented.

During a telephone interview on 02/23/15 at 7:56 PM with Nurse #2 she stated she worked on the 7:00 PM to 7:00 AM shift on 11/15/14 and that evening the NAs came and got her because they had taken Resident #24 her bedtime snack and she was screaming in pain. She explained she

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couldn't assess her or touch her because she was in such pain. She further explained Resident #24 had an incontinent episode but they couldn't clean her or turn her because of the pain. She verified she had not received a report from Nurse #1 during shift change that Resident #24 had slid to the floor earlier that day. She stated she sent the resident to the hospital emergency room for evaluation and treatment because Resident #24 did not usually complain of pain and she couldn't figure out why she was having such severe pain. She explained later that night a nurse from the hospital called her and asked about a fall that Resident #24 had earlier that day. She stated that was the first time she had been told Resident #24 had a fall. She explained she called ADON #1 who was the nurse on call and told her what the hospital had reported. She stated ADON #1 told her to make sure she had everything documented. She stated nobody on her shift knew anything about Resident #24's fall earlier that day because nothing had been reported to them during shift report. She explained she expected to see nursing documentation when a resident had a fall or was lowered to the floor and she thought there should have been some investigation to determine why Resident #24 had a hip fracture since she had been lowered to the floor during transfer earlier that day.

During an interview on 02/24/15 at 3:01 PM with Licensed Physical Therapist #1 he explained therapy staff had been working with Resident #24 on standing and transfers with 2 staff assist prior to her fall on 11/15/14. He stated Resident #24's participation varied and some days she would stand but then she would spontaneously sit down. He stated it was his understanding that nursing staff had transferred Resident #24 with a

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mechanical lift and the plan of care would have been to use a mechanical lift for transfers until Resident #24 was cleared by therapy to transfer with a maximum assist of 2 staff.

During a follow up interview on 02/24/15 at 3:24 PM the DON verified she wrote the summary titled Investigation of Resident #24's fracture after she talked to staff who had been assigned to care for Resident #24 on Monday 11/17/14 and it was a summarization of what staff had told her. She stated she could not find an incident report related to Resident #24's fall and there was no incident recorded on the incident logs for Resident on 11/15/14.

During a phone interview on 02/25/15 at 2:00 PM the physician who was also the facility Medical Director stated he was made aware of Resident #24's fall after she had gone to the hospital. He stated the information he had been told about her sliding to the floor did not explain how the fracture happened but he wondered if she had a previous incident or something that had happened that put her at higher risk for a fracture. He stated it was his expectation for nurses to assess and evaluate residents immediately after a fall or when they were lowered to the floor. He further stated he expected the nurses to call the physician to report what had happened, what the resident's level of comfort was, their level of pain and their level of consciousness. He stated residents should be assessed right away then and there and all falls should be considered to be high risk and staff should do what they could to prevent falls.

During an interview on 02/27/15 at 9:36 AM with the Rehabilitation Director she stated it was not therapy's intent for nursing staff to mirror what

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they were doing during therapy sessions and they did not instruct nursing staff to do something different than what was on the care plan. She explained when nursing staff came to her for questions about how to transfer a resident she instructed them to go to the nurse for clarification. She further stated nursing staff should know what each resident required for transfers.

During another follow up interview on 02/27/15 at 11:34 AM the DON stated it was her expectations that the nurse should assess for falls whether they were witnessed or un-witnessed and should follow up to make sure the resident was ok. She explained if the resident was injured the nurse should provide first aid or send the resident to the hospital. She explained the care plan should guide staff with care and the transfer technique should match the care plan. She further explained the closet care plan which guided care provided by NAs that was located in the resident's closet should match the care plan. She stated the closet care plan that was in place prior to Resident #24's fall was discarded when she went to the hospital but she would expect it indicated mechanical lift for transfers since that was what was documented on the care plans. She further stated they would not change the care plan related to transfers unless therapy had released the resident 100 percent for a change in transfer technique. She stated when the nurse on call was notified of Resident #24's fracture she should have also been notified and an investigation should have been done. She emphasized it was her expectation if a resident had an incident with injury she should be notified immediately. She further stated she was unaware there were no nurse's notes for Resident #24 on 11/15/14 for the 7:00 AM to 7:00 PM shift until she was

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questioned about it during the survey. She stated Nurse #1 had told her she assessed Resident #24 but she did not realize at that time Nurse #1 had not assessed the resident after she was lowered to the floor or before she was moved from the floor to the shower chair.

During an interview on 02/27/15 at 12:20 PM the Administrator explained she had just started to work in the facility on 11/11/14 and identified the facility was lacking processes to address a number of issues which included falls. She explained a lot of work had begun to implement new processes and changes but there was still a lot of work that needed to be done.

The facility's Administrator and Director of Nursing were notified of Immediate Jeopardy on 02/24/15 at 3:31 PM for Resident #24. The facility provided a credible allegation of compliance on 02/27/15 at 11:35 AM. The following interventions were put into place by the facility to remove the Immediate Jeopardy.

Credible Allegation of Compliance

Resident #24 was sent to the hospital emergency room on November 15, 2014 with right hip pain resulting in surgical repair.

Upon readmission on 11/20/14, resident #24 was assessed by ADON, PT, and nurse with regards to impaired cognition, pain, hemiplegia, body habitus, and recent history of a fall with fracture and it was determined that the safest transfer method was mechanical lift by 2 person assist. On 11/17/14 Resident care information sheets were checked for accuracy. Updates made to assure safest transfer method was being used for

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resident resident #24. Resident care information is located in resident's closets for direct care to refer to for care including transfers for residents.

Two nurse aides involved with resident #24's care on 11/15/14 were verbally instructed on 11/16/14, their next scheduled work day, regarding not moving a resident after a fall before a nurse assessed the resident. On 11/17/14 all 3 CNAs involved received verbal education regarding utilization of gait belt for transfers and assessment required to be completed by a licensed nurse prior to moving any resident after a fall.

Nurse #1 received a written coaching on 11/17/2014 regarding completing incident reports and completing resident assessments, including assessing a resident after a fall before the resident is moved. She was also educated regarding fall investigation and assessment after falls on 11/21/2014.

All documented falls that occurred in November prior to the identified deficient practice were audited to assess compliance with standards of practice on 11/14/14-11/16/14 and was utilized to determine that there were no other falls that occurred with other resident ' s and/or problems with transfer techniques. Implemented fall clinical meeting daily Monday through Friday on 11/18/14. This is a subcommittee that specifically looks at falls. Fall audit tool initiated 11/18/14 to ensure timely assessment, appropriate documentation, and updated care plan.

On February 24, 2015 Fall Risk Evaluation was completed on all residents. Care plans will be reviewed and updated with 100% completion on

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F 323	Continued From page 74 February 25, 2015. On February 24, 2015 at 11 pm nurses and nurse aides present was in serviced on: New falls and fall risk policy and procedure implemented on February 24, 2015 Assessment and first aid Record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities If evidence of significant injury, nursing staff will provide first aid Once an assessment rules out significant injury, nursing staff will help resident to a comfortable sitting, lying, or standing position. Resident will not be moved until nursing assessment is completed. Initial documentation regarding fall and notification of physician and family Defining details of fall Identifying causes of fall or fall risk All off the above items will be documented on Fall: Initial Documentation Note/Progress Notes-5 day This new form implemented on February 22, 2015 will be placed in the MAR and placed in the nurse ' s notes after completion of 5 day post fall documentation. Performing a post-fall evaluation Within 24 hours after a first fall, the nurse on duty should watch the resident rise from the chair, ambulate several steps if able, and return to sitting. If the resident has no difficulty or unsteadiness, further evaluation may not be needed. If the resident has difficulty therapy referral is initiated. This should be documented on Fall: Initial Documentation Note/Progress Notes-5 day The nurse should assess the resident and determine if there are any changes or	F 323		

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F 323	Continued From page 75 complications as a result of a fall every shift for 5 days and document on Fall: Initial Documentation/Progress Note-5 day Identifying complications of falls requirement for immediate assessment of residents who have fallen and documentation in resident's clinical record the condition the resident was found assessment data including vital signs, and any obvious injuries Interventions, first aid, or treatment administered Notification of physician and family Completion of fall risk assessment Appropriate interventions taken to prevent further falls Signature and title of person recording data Report fall to DON, ADON, or RN Supervisor All of the above should be documented on the Fall: Initial documentation/Progress Notes-5 day, to be completed by the end of shift An in service on falls and fall risk policy & procedure and transfers and mechanical lift will be completed for all nursing department staff by 8 pm on February 25, 2015. Any nursing department employee that has not attended above in service or participated in phone in service by February 25, 2015 at 8 pm will not be allowed to work until the in service is completed by DON, ADON, or RN Supervisor. At 8 pm on February 25, 2015 a list of nursing department employees that did not receive the above in service will be given to the DON. The DON will monitor the daily schedule to ensure that anyone that has not had the above training will not be scheduled to work until the in service is completed. All new nursing department employees will be in serviced during orientation	F 323		

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All residents were assessed for transfers by DON, ADONs, nurse, and therapy. All affected residents who were identified as two person assistant with transfers were referred to therapy on 2.25.15 for screen to verify safest transfer technique.

Every resident fall will be reviewed Monday through Friday each morning at the Clinical Meeting and will ensure initial documentation has been completed. A revised falls audit tool has been implemented on 02/25/2015 and will include documentation and confirmation that all fall strategies are implemented and action taken when a fall occurs.

Immediate jeopardy was removed on 02/27/15 at 11:35 AM with interviews of direct care and licensed nursing staff who confirmed they received in-service training on new falls and fall risk policy and procedure and use of mechanical lifts prior to reporting for duty.

A review of in-service sign in sheets contained documentation of staff who had attended the in-services. The DON had a list of all staff who had not attended in-services and these names were cross referenced with schedules and no staff that had not been trained was listed on the schedules.

Interviews with NAs revealed they had attended in-service training and were knowledgeable to notify a nurse immediately after a fall which included lowering a resident to the floor. Interviews with nurses revealed they had attended in-service training and were knowledgeable to respond and assess residents immediately after a fall or if they were lowered to

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the floor. They described the expectations for providing first aid, documentation of the incident, notification of physician, responsible party and administrative nursing staff and completion of the fall risk assessment, post fall evaluation and incident report.

Record reviews revealed the fall: Initial Documentation Note/Progress Notes-5 day form was implemented on 02/22/15 and a new fall risk policy and procedure was implemented on 02/24/15.

2. Review of the medical record revealed Resident #33 was admitted on 10/05/06 with diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and generalized muscle weakness.

Review of a care plan last reviewed 11/24/14, stated Resident #33 was at risk for falls and accidents due to impaired mobility, cognition, vision, hearing and/or decision making skills associated with dementia, COPD, anxiety, history of pelvis fracture, and medications. Included in the goals was an environment as free as possible of accident or fall hazards for the next 90 days. Interventions included notifying the maintenance department of any defective equipment such as bed side rails, hand rails, chairs, and beds.

Review of the most recent side rail assessment dated 10/24/14 revealed Resident #33 required bed rails for turning and repositioning, had cognitive impairment, and could identify bed boundaries.

Review of a quarterly Minimum Data Set (MDS) dated 11/15/14 revealed Resident #33 had severely impaired cognition and required

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F 323	Continued From page 78 extensive assistance of one person for bed mobility and transfers. Review of the log used to notify maintenance staff of repairs for Resident #33's side of the facility revealed there were 7 side rail related problems documented from 01/01/15 through 02/24/15. Resident #33's bed side rails were not listed on the maintenance clip board. Observations of Resident # 33's bilateral ¼ bed side rails were as follows: - On 02/16/15 at 2:22 PM the right side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 2 inches. The left side rail was not loose and fit properly. - On 02/18/15 at 1:00 PM the right side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 2 inches. The left side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 1 inch. - On 02/19/15 at 1:00 PM the right side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 2 inches. The left side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 1 inch. - On 02/23/2015 at 12:50 PM the right side was loose and leaned away from the edge of the mattress approximately 4 inches. The left side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 1 inch. - On 02/24/2015 at 10:45 AM the right side was	F 323		

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loose and leaned away from the edge of the mattress approximately 4 inches. The left side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 1 inch.

An interview with Nurse Aide (NA) #5 on 02/24/15 at 10:49 AM revealed she checked the bed side rails while providing care to her residents and when she noticed a loose side rail she reported this to the maintenance department directly or paged them overhead. NA #5 confirmed she had assisted Resident #33 out of bed on 02/24/15 and also stated Resident #33 used the side rails to turn in bed and when able used the right side rail for transferring out of bed. The interview further revealed NA #5 was not aware of any loose side rails on her room assignment which included Resident #33's room.

During an interview on 02/25/15 at 10:16 AM the Maintenance Director stated staff notified him of maintenance issues and needed repairs by overhead paging him when he was in the facility or documenting the issue on the maintenance log. The Maintenance Director stated he checked the maintenance log on both sides of the facility daily and he and his assistant had just completed an audit of all bed side rails on 02/20/15 and 02/23/15. The interview further revealed the Maintenance Director audited the 100 and 200 hall bed side rails and his assistant was assigned to audit the 300 and 400 hall bed side rails. At 02/25/15 at 10:21 AM the Maintenance Director was accompanied to Resident #33's room and examined the bed side rails. The Maintenance Director stated the two screws that secured the right side rail were "loosened out" and also noted this particular type

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F 323	Continued From page 80 of side rail loosened up quickly. The Maintenance Director confirmed the screws for both side rails would need to be tightened up to make the bed side rails fit properly. The Maintenance Director then lifted the mattress and noted one of the clips on the rod that secured the right side rail to the bed frame was missing and stated it would need to be replaced. A follow up interview was conducted with the Maintenance Director on 02/25/15 at 3:23 PM. The Maintenance Director stated the 300 hall bed side rails had not been audited on 02/20/15 or 02/23/15 because his assistant was off one of the days of the audit. The interview further revealed bed side rails were typically audited every two weeks but no documentation was maintained. The Maintenance Director further stated the screws worked their way out of the bed side rails if residents leaned on the bed side rail.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329		

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F 329	Continued From page 81 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and pharmacist and physician interviews the facility failed to stop a discontinued medication for 1 of 5 residents sampled for maintaining a drug regimen free of unnecessary medications (Resident #135). The findings included: Resident #135 was admitted to the facility on 11/29/12 with diagnoses that included but was not limited to diabetes, heart disease, Parkinson's disease, and kidney disease. Review of the most recent quarterly Minimum Data Set (MDS) dated 01/02/15 indicated resident #135 was cognitively intact. Further review of the MDS revealed Resident #135 required extensive assistance to being totally dependent for most activities of daily living (ADL's). The MDS also indicated Resident #135 received antibiotic medication 7 days a week. Review of the medical record revealed Resident #135 was admitted to the hospital on 07/28/2014 with a diagnosis of an acute episode of blood in his urine among other issues. After he received	F 329		

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treatment, he was released back to the facility on 7/29/14. Physician's orders reviewed on his discharge summary indicated he was to receive an antibiotic, Ceftin 250 milligrams (mgs.) two times daily for 5 days for urinary tract infection.

Review of the Medication Administration Records (MAR's) from July of 2014 to February of 2015 revealed the order was transcribed for Resident #135 to be started on Ceftin 250 milligrams (mgs.) two times daily on 07/29/14. Further review of the MAR indicated the medication was documented to have been given two times daily since 07/29/14 with no date for the medication to be stopped.

On 02/18/15 at 11:40 AM an interview was conducted with the Assistant Director of Nursing (ADON #1). She was unable to locate the order for the Ceftin, or determine when the medication was to be stopped. ADON #1 called the hospital and retrieved Resident #135's discharge summary from the 07/29/14 hospitalization. She stated the orders indicated the Ceftin should have been stopped or the orders should have been clarified by someone when monthly MAR reviews were conducted. ADON #1 stated she did not know why the medication was not stopped after 5 days or the physician notified. She stated it was her expectation that staff would have discovered the medication error during the monthly medication reviews. The ADON stated she would make the correction immediately and notify the physician.

On 02/18/15 at 12:20 PM an interview was conducted with the Director of Nursing (DON). She stated the facility had a system in place to review medication orders which included the

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nurse who admitted the resident, transcribed the orders and checked all medication orders for stop dates. The DON further acknowledged that during monthly review of medications, the order should have been clarified with the physician and a stop date indicated on the order. She stated it was her expectation for the process to be followed each month, and it was not done in this case.

On 02/18/15 at 3:40 PM another interview was conducted with the DON. She indicated a telephone conference was held with the Medical Director (MD). She stated he acknowledged the medication should have been discontinued after 5 days from the start date of 07/29/14. The DON revealed the MD ordered for the medication to be discontinued and a urology consult was to be obtained for Resident #135 to determine if he needed a long-term antibiotic.

On 02/19 15 at 12:00 Noon an interview was conducted with the facility pharmacist. She indicated she had been doing monthly reviews on the resident's medication treatment regimen since August or September of 2014. The pharmacist stated the monthly process of reviewing resident medications involved checking all medications for current diagnoses as well as making sure all medications had a stop date on the MAR. If medications did not include a stop date, she would request a stop date from the physician. She stated the stop date for the Ceftin ordered for Resident #135 should have been discovered during pharmacy reviews and a stop date secured from the physician.

On 02/25/15 at 2:00 PM an interview was conducted with the MD. He acknowledged he

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F 329	Continued From page 84 was aware of the medication error. The MD stated the error should never have occurred and was missed by a number of people responsible for medication reviews. He stated no antibiotic should be provided without a stop date, and medications without stop dates should be clarified with the physician.	F 329		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and pharmacist and physician interviews the facility failed to prevent a significant medication error by administering a discontinued medication for 1 out of 5 residents reviewed for medication administration (Resident #135). The findings included: Resident #135 was admitted to the facility on 11/29/12 with diagnoses that included but was not limited to diabetes, heart disease, Parkinson's disease, and kidney disease. Review of the most recent quarterly Minimum Data Set (MDS) dated 01/02/15 indicated resident #135 was cognitively intact. Further review of the MDS revealed Resident #135 required extensive assistance to being totally dependent for most activities of daily living (ADL's). The MDS also indicated Resident #135 received antibiotic medication 7 days a week.	F 333		

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Review of the medical record revealed Resident #135 was admitted to the hospital on 07/28/2014 with a diagnosis of an acute episode of blood in his urine among other issues. After he received treatment, he was released back to the facility on 7/29/14. Physician's orders reviewed on his discharge summary indicated he was to receive an antibiotic, Ceftin 250 milligrams (mgs.) two times daily for 5 days for urinary tract infection.

Review of the Medication Administration Records (MAR's) from July of 2014 to February of 2015 revealed the order was transcribed for Resident #135 to be started on Ceftin 250 milligrams (mgs.) two times daily on 07/29/14. Further review of the MAR indicated the medication had continued to be given two times daily since 07/29/14 with no date for the medication to be stopped.

On 02/18/15 at 11:40 AM an interview was conducted with the Assistant Director of Nursing (ADON #1). She was unable to locate the order for the Ceftin, or determine when the medication was to be stopped. ADON #1 called the hospital and retrieved Resident #135's discharge summary from the 07/29/14 hospitalization. She stated the orders indicated the Ceftin should have been stopped or the orders should have been clarified by someone when monthly MAR reviews were conducted. ADON #1 stated she did not know why the medication was not stopped after 5 days or the physician notified. She stated it was her expectation that staff would have discovered the medication error during the review process of the monthly medications. The ADON stated she would make the correction immediately and notify the physician.

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On 02/18/15 at 12:20 PM an interview was conducted with the Director of Nursing (DON). She stated the facility had a system in place to review medication orders which included the nurse who admitted the resident, transcribed the orders and checked all medication orders for stop dates. The DON further acknowledged that during monthly review of medications, the order should have been clarified with the physician and a stop date indicated on the order. She stated it was her expectation for the process to be followed each month, and it was not done in this case.

On 02/18/15 at 3:40 PM another interview was conducted with the DON. She indicated a telephone conference was held with the Medical Director (MD). She stated he acknowledged the medication should have been discontinued after 5 days from the start date of 07/29/14. The DON revealed the MD ordered for the medication to be discontinued and a urology consult was to be obtained for Resident #135 to determine if he needed a long-term antibiotic.

On 02/19 15 at 12:00 Noon an interview was conducted with the facility pharmacist. She indicated she had been doing monthly reviews on the resident's medication treatment regimen since August or September of 2014. The pharmacist stated the monthly process of reviewing resident medications involved checking all medications for current diagnoses as well as making sure all medications had a stop date on the MAR. If medications did not include a stop date, she would request a stop date from the physician. She stated the stop date for the Ceftin ordered for Resident #135 should have been discovered during pharmacy reviews and a stop

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F 333	Continued From page 87 date secured from the physician. The pharmacist also indicated that long-term adverse effects of Ceftin use could include diarrhea, nausea, vomiting, and loss of intestinal bacteria. She stated an intestinal enzyme could be provided for long-term antibiotic usage to replace depleted bacteria in the intestine. Resident #135 was not receiving an intestinal enzyme. On 02/25/15 at 2:00 PM an interview was conducted with the MD. He acknowledged he was aware of the medication error. He revealed the biggest concern for Resident #135 related to taking Ceftin for such a long period of time would be diarrhea and development of a drug sensitivity or drug reaction. The MD stated the error should never have occurred and was missed by a number of people who should have reviewed the medication regimen. He stated no antibiotic should be provided without a stop date, and medications without stop dates should be clarified with the physician.	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews the facility failed to maintain the cleanliness of the exterior door panels of the reach-in refrigerator, knife rack, coffee machine, and microwave.

The findings included:

1. Observations of the reach-in refrigerator on 02/16/15 at 9:48 AM revealed a dime-sized piece of dried orange matter on the left exterior door, white dried spills on the exterior of both doors, and brown dried matter on the top half of both doors.

Observations of the reach-in refrigerator on 02/18/15 at 12:39 PM revealed a dime-sized piece of dried orange matter on the left exterior door, white dried spills on the exterior of both doors, and brown dried matter on the top half of both doors.

Observations of the reach-in refrigerator on 02/19/15 at 4:07 PM revealed a dime-sized piece of dried orange matter on the left exterior door, white dried spills on the exterior of both doors, and brown dried matter on the top half of both doors.

An interview was conducted with the Dietary Manager (DM) on 02/19/15 at 4:10 PM. The DM stated she posted a cleaning schedule weekly and the dietary aide responsible was listed in the column next to the list of areas to be cleaned. The DM indicated the staff had until 02/22/15 to complete their cleaning assignments. The weekly cleaning schedule for 02/16/15 through 02/22/15 was reviewed during the interview and none of

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the assigned areas to be cleaned were initialed as completed. The reach-in refrigerator was listed on the weekly cleaning schedule.

Observations of the reach-in refrigerator on 02/23/15 at 1:08 PM revealed a dime-sized piece of dried orange matter on the left exterior door, white dried spills on the exterior of both doors, and brown dried matter on the top half of both doors.

During a follow up interview on 02/23/15 at 1:16 PM the DM observed the exterior door panels of the reach-in refrigerator and agreed they were not clean. The cleaning schedule for the week of 02/16/15 through 02/22/15 was reviewed and the reach-in refrigerator was initialed by a dietary aide and also the DM. The DM stated she initialed the weekly cleaning schedule for each of the assigned areas after she confirmed the task had been completed. The DM further stated she did not notice the dried food matter or dried spills on the exterior door panels of the reach-in refrigerator when she completed her observations of the reach-in and initialed the cleaning schedule.

2. Observations of the knife rack on 02/16/15 at 9:48 AM revealed the front of the knife rack had dried brown spills over the entire surface and the top of the rack where the knife blades were inserted had a thick covering of white dust.

Observations of the knife rack on 02/18/15 at 12:39 PM revealed the front of the knife rack had dried brown spills over the entire surface and the top of the rack where the knife blades were inserted had a thick covering of white dust.

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Observations of the knife rack on 02/19/15 at 4:07 PM revealed the front of the knife rack had dried brown spills over the entire surface and the top of the rack where the knife blades were inserted had a thick covering of white dust.

An interview was conducted with the Dietary Manager (DM) on 02/19/15 at 4:10 PM. The DM stated she posted a cleaning schedule weekly and the dietary aide responsible was listed in the column next to the list of areas to be cleaned. The DM indicated the staff had until 02/22/15 to complete their cleaning assignments. The weekly cleaning schedule for 02/16/15 through 02/22/15 was reviewed during the interview and none of the assigned areas to be cleaned were initialed as completed. The knife rack was not listed on the weekly cleaning schedule.

Observations of the knife rack on 02/23/15 at 1:11 PM revealed the front of the knife rack had dried brown spills over the entire surface and the top of the rack where the knife blades were inserted had a thick covering of white dust.

During a follow up interview on 02/23/15 at 1:16 PM the DM observed the knife rack and agreed the knife rack needed to be cleaned and stated she did not think the knife rack was listed on the weekly cleaning schedule and she would need to add it.

3. Observations of the coffee machine on 02/19/15 at 4:07 PM revealed a thick covering of dust on the entire top surface and dried spills and dried green particles on the right side panel.

An interview was conducted with the Dietary Manager (DM) on 02/19/15 at 4:10 PM. The DM

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stated she posted a cleaning schedule weekly and the dietary aide responsible was listed in the column next to the list of areas to be cleaned. The DM indicated the staff had until 02/22/15 to complete their cleaning assignments. The weekly cleaning schedule for 02/16/15 through 02/22/15 was reviewed during the interview and none of the assigned areas to be cleaned were initialed as completed. The coffee machine was listed on the weekly cleaning schedule.

Observations of the coffee machine on 02/23/15 at 1:11 PM revealed a thick covering of dust on the entire top surface and dried spills and dried green particles on the right side panel.

During a follow up interview on 02/23/15 at 1:16 PM the DM observed the coffee machine and agreed it was not clean. The cleaning schedule for the week of 02/16/15 through 02/22/15 was reviewed and the coffee machine was initialed by a dietary aide and also the DM. The DM stated she initialed the weekly cleaning schedule for each of the assigned areas after she confirmed the task had been completed. The DM further stated she did not notice the dust, dried food matter, or dried spills on the coffee machine when she completed her observations and initialed the cleaning schedule.

4. Observations of the microwave on 02/19/15 at 4:07 PM revealed dried food matter on all the surfaces of the inside of the microwave and white dried spills on the exterior of the door. The door handle was sticky to the touch.

An interview was conducted with the Dietary Manager (DM) on 02/19/15 at 4:10 PM. The DM stated she posted a cleaning schedule weekly

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F 371	Continued From page 92 and the dietary aide responsible was listed in the column next to the list of areas to be cleaned. The DM indicated the staff had until 02/22/15 to complete their cleaning assignments. The weekly cleaning schedule for 02/16/15 through 02/22/15 was reviewed during the interview and none of the assigned areas to be cleaned were initialed as completed. The microwave was not listed on the weekly cleaning schedule. Observations of the microwave on 02/19/15 at 1:16 PM revealed dried food matter on all the surfaces of the inside of the microwave and white dried spills on the exterior of the door. The door handle was sticky to the touch. During a follow up interview on 02/23/15 at 1:23 PM the DM observed the microwave and agreed it was not clean and stated the microwave was not listed on the weekly cleaning schedule and she would need to add it. The DM further stated had looked in the microwave this week but had not noticed the spills on the exterior of the door or the condition of the door handle.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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F 441	Continued From page 93 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to follow contact precautions for 1 of 1 resident reviewed for contact precautions (Resident #192). The findings included: Review of the facility Contact Isolation Policy dated November 2003 revealed contact precautions would be implemented for specific residents known or suspected to be infected or	F 441		

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colonized with microorganisms that could be transmitted by direct contact with the resident such as hand or skin contact that occurred from performing resident care that required touching the residents dry skin and by indirect contact such as touching environmental surfaces or resident care items in their room. The policy further revealed gloves should be worn when entering the resident's room on Contact Isolation and removed before leaving the residents room with immediate hand washing. After hand washing and glove removal ensure hands did not touch potentially contaminated environmental surfaces or items in the resident's room to avoid transfer to other residents or environments.

Review of the physician orders dated 02/13/15 revealed Resident #192 was to be placed on contact isolation for methicillin resistant staphylococcus aureus (MRSA), a multiple drug resistant organism in a stage III sacral pressure wound.

An observation was made on 02/16/15 at 11:00 AM of Resident #192's room with a contact precaution sign on the wall beside the door and an over bed table with gloves located outside the room.

An observation made on 02/16/15 at 11:35 AM revealed hospitality aide (HA) #1 entered Resident #192's room without gloves on and opened Resident #192's privacy curtain and moved his over bed table. HA #1 left Resident #192's room without washing her hands or using hand sanitizer and entered Resident #92's room without washing her hands and began to set up the lunch tray on the over bed table for Resident #92.

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F 441	Continued From page 95 An observation made on 02/16/15 at 11:52 AM revealed HA #1 entered Resident #192's room without washing her hands or wearing gloves. HA #1 straightened Resident #192's bed linens, closed his privacy curtain and brought his lunch tray out of his room and placed it on the tray cart. HA #1 did not wash her hands or use hand sanitizer after leaving Resident #192's room. An interview was conducted on 02/16/15 at 1:30 PM with HA #1. She stated she did not wash her hands or wear gloves in Resident #192's room because she did not know he was on contact precautions. She stated she did not see the contact precaution sign or notice the table with gloves outside his room. HA #1 stated she should have washed her hands and worn gloves while she was in his room and discarded the gloves and washed her hands before leaving his room. An interview was conducted on 02/27/15 at 10:50 AM with the Director of Nursing (DON). She stated it was her expectation for staff to follow the contact precaution signs posted on Resident #192's door and wear gloves and wash their hands when entering and leaving the room if they had any contact with the resident or resident items in the room. She stated she was unaware staff had not been following contact precautions for Resident #192.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514		

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accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews the facility failed to document nurse's notes regarding a resident who was lowered to the floor during a transfer and failed to document neurological (neuro) checks or assessments of a skin tear for 4 of 12 residents sampled for falls (Resident #24, #198, #56 and #55). The facility also failed to document assessments of a fistula site or vital signs weekly for 1 of 1 resident sampled for dialysis. (Resident #132).

The findings included:

A review of a facility document titled Falls Checklist that was not dated indicated in part to complete a progress note and it should include in detail and include what the resident said, include what you observed, what assessments and results for skin, mental, range of motion, vital signs and level of consciousness and plan to prevent further incidents from occurring;

1. Resident #24 was admitted to the facility on 02/17/14 with diagnoses which included difficulty speaking or swallowing, arthritis, and right sided paralysis and stroke.

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A review of the admission Minimum Data Set (MDS) dated 03/03/14 revealed Resident #24 had severe impairment in cognition for daily decision making. The MDS also indicated Resident #24 did not speak but was sometimes understood and usually understood others.

A review of nurse's notes dated 11/15/14 revealed there were no nurse's notes or nursing assessment during the 7:00 AM - 7:00 PM shift. A review of Resident #24's medical record revealed there was no documentation of a fall on 11/15/14.

During an interview on 02/23/15 at 12:14 PM the Director of Nursing (DON) upon review of the nurses notes for Resident #24 on 11/15/14 confirmed there was no documentation in the nurse's notes or nursing assessment notes for the 7:00 AM to 7:00 PM shift of 11/15/14. She also confirmed there was no documentation in the medical record for the 7:00 AM to 7:00 PM shift.

A review of a nurse's note dated 11/15/14 at 8:30 PM indicated Resident #24 was lying in bed grunting when Nurse #2 went to the resident's room to administer bedtime medications. The notes further indicated when the head of the bed was raised Resident #24 began yelling out. The notes revealed Resident #24 was nonverbal due to history of a stroke but could answer questions appropriately by nodding her head for yes and no. The notes further revealed when asked where she was hurting Resident #24 pointed to her right leg. The notes indicated an assessment showed no visual injuries or redness but when an attempt was made to roll Resident #24 over she began screaming loudly and Resident #24's responsible

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party was notified and hospital was notified for transport to the emergency room.

A review of a hospital Physician's Report of Consultation dated 11/16/14 indicated a consulting diagnosis of intertrochanteric (upper part of the thigh bone) fracture of right hip for Resident #24. The notes revealed Resident #24 was found by the nursing staff lying in bed complaining of hip pain and apparently had a history of falling earlier in the day where she may have injured that hip.

During a telephone interview on 02/23/15 at 6:44 PM NA #1 explained she and NA #2 were trying to get Resident #24 out of bed into a shower chair on 11/15/14. She explained during the transfer on 11/15/14 she had her arm under one of Resident #24's armpits and NA #2 had her arm under the other armpit and they stood her up at the bedside but when they turned her to pivot her she went limp. NA #1 stated when Resident #24 started to slide to the floor they tried to lift her up but they couldn't because she was too heavy. She explained when they realized they could not lift her up they lowered her to the floor and she told NA #2 to go get a nurse. NA #1 stated she held on to Resident #24's shoulders while she sat in the floor and thought her legs were out in front of her. NA #1 further stated NA #2 came back with NA #3 and they picked Resident #24 up off the floor and she took her to the shower room and gave her a shower. She explained she did not notice any obvious redness or bruising when she gave Resident her shower and after the shower NA #2 assisted her to stand Resident #24 up from the shower chair and into a wheelchair. NA #1 stated after lunch she got NA #2 and NA #3 again to transfer Resident #24 and they stood

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Resident #24 up from her wheelchair and transferred her to bed. She explained about 3 hours after Resident #24 was lowered to the floor she was moaning and holding her right leg and was rubbing it and she (NA #1) reported it to Nurse #1.

During a phone interview on 02/26/15 at 5:48 PM received from NA #1 she stated she had remembered she sent NA #2 to get a nurse but the nurse did not come to the resident's room. She further stated Resident #24 was not assessed while she was in the floor or when she was lifted into the shower chair or when she was transferred back to bed after lunch. She explained NA #3 came back to the room and said the nurse said to put Resident #24 in the shower chair so the NAs lifted her up off the floor and put her in the chair.

During an interview on 02/23/14 at 8:13 PM with Nurse #1 (who was responsible for the care of Resident #24 on the 7:00 AM-7:00 PM shift on 11/15/14) she confirmed she did not go to Resident #24's room to assess her on 11/15/14 when NA #2 reported the resident had slid to the floor. She confirmed the only assessment she did was later in the day when Resident # 24 was crying out in pain and was reaching toward her peri area and the area was red. She stated she couldn't remember exactly what she saw but remembered she gave Resident #24 some routine Tylenol for pain but did not report it or document it because she did not think anything had happened or that anything needed to be reported or documented.

During a telephone interview on 02/23/15 at 7:56 PM with Nurse #2 she stated she worked on the

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7:00 PM to 7:00 AM shift on 11/15/14 and that evening the NAs came and got her because they had taken Resident #24 her bedtime snack and she was screaming in pain. She explained she couldn't assess her or touch her because she was in such pain. She verified she had not received a report from Nurse #1 during shift change that Resident #24 had slid to the floor earlier that day. She stated she sent the resident to the hospital emergency room for evaluation and treatment because Resident #24 did not usually complain of pain and she couldn't figure out why she was having such severe pain. She explained she expected to see nursing documentation when a resident had a fall or was lowered to the floor.

During an interview on 02/23/14 at 8:13 PM with Nurse #1 who was assigned to the care of Resident #24 on the 7:00 AM - 7:00 PM shift on 11/15/14 she confirmed she did not go to Resident #24's room to assess her on 11/15/14 when NA #2 reported the resident had slid to the floor. She stated she was having a very bad day and took full responsibility for not doing what she was supposed to do. She confirmed the only assessment she did was later in the day when Resident #24 was crying out in pain and was reaching toward her peri area and the area was red. She stated she couldn't remember exactly what she saw but remembered she gave Resident #24 some routine Tylenol for pain but did not report it or document it because she did not think anything had happened or that anything needed to be reported or documented. Nurse #1 further confirmed she did not document an assessment immediately after Resident #24 slid to the floor because she did not go to the resident's room until later in the afternoon when

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NAs told her Resident #24 was complaining of pain in her right leg.

During a follow up interview on 02/27/15 at 11:34 AM the DON stated she was unaware there were no nurse's notes for Resident #24 on 11/15/14 for the 7:00 AM to 7:00 PM shift until she was questioned about it during the survey. She stated Nurse #1 had told her she assessed Resident #24 but she did not realize that Nurse #1 had not assessed the resident after she was lowered to the floor or before she was moved from the floor to the shower chair.

2. Resident #198 was admitted to the facility on 06/13/14 with diagnoses including multiple myeloma, uncontrolled hypertension, and muscle weakness.

Review of nursing notes revealed that on 06/14/14 at 1:10 AM, Resident #198 attempted to ambulate to the bathroom without calling for assistance and fell onto the floor from a standing position. The nursing note indicated she received a 1 centimeter (cm) superficial laceration to her head and was sent to the emergency room for an evaluation. Nursing notes revealed that Resident #198 returned from the hospital on 06/14/14 at 4:00 AM. In addition to the laceration on her head, Resident #198 also returned with a small half cm skin tear on her left elbow that had a dressing in place.

The medical record lacked documentation as follows:

a. Review of the medical record revealed no documentation that nurses completed neurochecks upon her return from the hospital.

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A phone interview with Nurse #5 who wrote the nursing notes on 06/14/14 at 1:10 AM and 4 AM was conducted on 02/19/15 at 6:02 PM. Nurse #5 stated he barely recalled the incident and sending Resident #198 to the hospital. He stated upon her return he should have started neurochecks per the facility policy which would have lasted at least 72 hours. He further stated this would have been documented on a specific sheet for neurochecks. He could not recall if he started documentation on the neurocheck sheet or not.

The Treatment Nurse stated on 01/19/15 at 4:24 PM, neurochecks should have been started for Resident #198 and she could not find any documentation in the medical record.

On 02/23/15 at 4:17 PM, the Assistants Director of Nursing #1 and #2 were interviewed together and stated neurochecks were to be documented following any fall with a head injury on a specific sheet or in the nursing notes every 15 minutes x 4, then every 30 minutes x 4 and ten every hour x 4 and then very shift x 4. If a resident was sent to the hospital then nursing staff were expected to pick up neurochecks as if the resident never left the building.

b. Review of the medical record revealed nothing was documented about the skin tear on her elbow or any treatments administered after her return from the hospital.

Interview with the Treatment Nurse on 02/19/15 at 10:18 AM revealed she was responsible for documentation and treatment of all wounds including skin tears. She stated nursing was responsible for letting her know about any

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wounds or skin tears noted at the hospital and she would then follow the standing orders and begin documentation on the treatment sheets.

Follow up interview with the Treatment Nurse on 02/19/15 at 4:50 PM revealed she could locate no documentation about the skin tear or treatments other than the nursing note on 06/14/14 when she returned from the hospital with a dressing. She stated that she recalled family expressing concern about the skin tear possibly being infected and when she looked the skin tear was not infected but scabbed. She confirmed that there should have been documentation on the treatment record about the skin tear and any treatments administered.

Interview with the Director of Nursing and Assistant Director of Nursing #1 (both employed at the time of this resident's stay) was held on 02/24/14 at 1:58 PM. Neither could recall or provide any documentation relative to the skin tear on her elbow which was treated at the hospital.

3. Resident #56 was admitted to the facility on 10/01/14. Her diagnoses included severe acute ischemic cardiovascular accident. Upon admission, the physician orders revealed she was fed only by nasogastric tube (NG) and took nothing by mouth.

Physician Orders dated 10/01/14 noted Resident #56 was to received Perative (tube feeding) via NG tube until Osmolite 1.5 became available. The Perative was to be increased on 10/01/14 to 35 cc an hour at 7:00 PM and then increased to 40 cc an hour at 3 AM on 10/02/14.

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Review of the Medication Administration Record (MAR) for October 2014 revealed that all tube feedings were discontinued on 10/02/14. Osmolite was never entered on the MAR as being started. Per the MAR, Resident #56 received no nutrition from 10/03/14 until an intravenous (IV) was started on 10/10/14 at 4:00 AM. A diet for trial puree was not ordered by the physician until 10/13/14.

On 02/25/15 at 2:00 PM Assistant Director of Nursing (ADON) #2 was interviewed. ADON #2 stated that the Osmolite must have come in and was not put on the MAR in place of the Perative. She further stated this was an inaccurate medical record.

4. Review of an undated facility falls policy stated in part: "The following procedure is to be followed for any resident that sustains a fall. #2. Neuro (neurological) checks will be done as appropriate."

Review of an undated facility falls checklist stated in part: "Initiate neuro checks if fall is unwitnessed or staff witness trauma to the head."

Resident #55 was admitted on 02/25/11 with diagnoses including dementia, history of cerebrovascular accident (CVA), and a history of falls.

A significant change Minimum Data Set (MDS) dated 09/10/14 revealed Resident #55 had short and long-term memory problems and severely impaired cognitive skills for daily decision making. The significant change MDS also stated Resident #55 required extensive assistance with transfers, had unclear speech, and was sometimes understood.

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Review of Resident #55's care plan for falls last reviewed on 01/16/15 stated she was at risk for falls due to impaired mobility, cognition, dementia, and agitation. Interventions included: toilet frequently, chair and bed alarms, bed against the wall, fall mats when in bed, low bed, and non-skid footwear.

Review of nurse's notes revealed on 06/24/14 at 6:00 AM the nurse was called to Resident #55's room by a nurse aide (NA) and observed Resident #55 sitting on the floor holding the right side of her face. A less than one inch laceration was noted over her right eye with bruising and minimal bleeding. Resident #55 was unable to state what happened. The nurse also noted Resident #55 was observed sitting in her wheelchair in her room a few minutes before the fall. Neuro checks were not mentioned in the nurse's note.

Review of a nurse's note dated 12/04/14 at 11:40 AM revealed the nurse heard Resident #55's personal alarm sound and observed Resident #55 fall from her wheelchair hitting her forehead on the floor. The nurse noted Resident #55 was attempting to pick a piece of tissue off the floor at the time of the fall.

Review of a falls investigation worksheet dated 12/04/14 revealed Resident #55 had a witnessed fall from her wheel chair at 11:40 AM. In an attached written statement dated 12/08/14 the nurse stated she heard Resident #55's personal alarm sound on 12/04/14 at 11:40 AM and observed Resident #55 leaning over in her wheelchair touching the floor. The nurse further stated she was not able reach Resident #55 in

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time to prevent the fall and Resident #55 fell forward out of her wheelchair. The nurse documented Resident #55's vital signs were stable, she moved all four extremities, and her pupils were equal and reactive to light (PERLA). There was no further documentation of any part of a neuro check.

Review of Resident #55's medical record revealed no documented neuro checks for the unwitnessed fall on 06/24/14 or the observed fall with head trauma on 12/04/14.

An interview was conducted with Assistant Director of Nursing (ADON) #1 on 02/23/15 at 4:17 PM. During the interview ADON #1 stated nursing staff were expected to complete neuro checks for any unwitnessed fall or if staff witnessed a resident hitting their head.

A follow up interview was conducted with ADON #1 on 02/24/15 at 3:50 PM during which Resident #55's fall were reviewed. At the time of the interview neuro checks for the falls that occurred on 12/04/14 and 06/24/14 were not located and ADON #1 stated she would review Resident #55's current and thinned medical record for the neuro checks.

During an interview on 02/26/15 at 12:05 PM ADON #2 stated she had reviewed Resident #55's medical record and did not locate any documented neuro checks for the falls that occurred on 12/04/14 and 06/24/14.

3. Resident #132 was admitted to the facility on

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04/08/14 with diagnoses that included but were not limited to diabetes, end stage renal disease, heart failure, and high blood pressure. Review of the latest quarterly Minimum Data Set (MDS) dated 01/01/15 indicated he was cognitively intact, and was on dialysis.
Review of Resident #132's medical record revealed he had a physician order for checking his dialysis fistula site and listening for the thrill and bruit at the site every shift. The order was dated 04/28/14, and no stop date was ordered.
Also ordered on 04/08/14 was for Resident #132 to receive weekly checks of vital signs every Thursday to include blood pressure, pulse, respirations, temperature, and blood oxygen levels. Documentation of Resident 132's fistula site and vital signs was to be indicated on the Medication Administration Record (MAR).
Further review of the medical record, which included analysis of Resident #132's dialysis documentation for the months of November and December of 2014, and January of 2015 was initiated. The review revealed multiple shifts on multiple days where assessment documentation on the MAR or in the nurses' notes was omitted. Included in the missed documentation was review of the fistula site every shift and checking of the thrill and bruit at the fistula site. Missed documentation also included multiple weeks of missed vital signs and blood oxygen levels, which included documentation shown only the first week of December 2014 with the remainder of the month left omitted.
On 02/19/15 at 3:55 PM an interview was conducted with Nurse #4, who was a charge nurse. She stated nurses are to check on Resident #132 after each dialysis visit, and which included fistula checks and checked vital signs. Nurse #4 indicated these assessments of the

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fistula and vital signs should be documented on the MAR. She acknowledged she did not know why there were areas of documentation omitted on the MAR. Nurse #4 indicated she would expect nurses' to document their findings each time dialysis checks and vital signs were completed. Nurse #4 stated she was not aware of another place in the medical record where documentation of the dialysis checks were located.

On 02/19/15 at 4:15 PM an interview was conducted with the Director of Nursing (DON). She acknowledged it was her expectation that the nurses document in the appropriate places when an assessment was performed. The DON revealed spot checks were being done on the MAR's to check for completed documentation, but these issues were not addressed. She indicated the facility was trying to do a better job of documenting in the medical record.

On 02/24/15 at 9:45 AM an interview was conducted with Nurse #3. She stated it was the nurse's responsibility to assess Resident #132 each time he returned from dialysis. Nurse #3 revealed she knew an assessment should be recorded on the MAR each time it is performed, but acknowledged she did not always document when she completed the assessment checks.

On 02/27/15 at 9:40 AM an interview was conducted with the Administrator. She stated it was her expectation that all nursing assessments be documented in appropriate places following a resident evaluation.