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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____ FEB 0 8 2012	C 01/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to screen new employees before offering employment by not verifying licenses for 4of 6 nurses (Nurses #1, #3, #4 & #5) and not conducting criminal background checks for 2 of 5 (NA#5 & NA#6) new employees. The findings include: On 1/5/2012 the facility's Abuse Policy dated December 2001, with a revision date of July, 2009 was reviewed. Under the section Screening and Hiring, it read "The screening of all applicants will involve the following pre-employment screenings, and as outlined in the Human Resources policies: Criminal records check and licensure/certification verification." 1. On 1/7/2012 a record review was conducted to verify licenses of nurses on staff. It revealed that Nurse #1 was hired on 8/22/2011 as a Registered Nurse. Her license was verified on 8/23/2011. On 10/31/2011, Nurse #1's license expired. On 1/7/2012 at 3:00pm, it was noted that there was no evidence of Nurse #1's license renewal, therefore new verification was requested to Administrative Staffs #4 and #5. On 1/7/2012 at 6:05pm, Administrative Staff #5 was able to	F 226	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F 226 - Immediate action taken: 1. All Certified Nursing Assistant and Licensed Nurses licenses where verified as current and criminal background screens where checked to ensure for completion. 2. Employees found to have an inactive license and or missing background screening have been removed from the schedule until verification has been received as completed. Action taken for others with potential to be affected: 1. All employees background screening has been verified as complete. 2. All Licensed and Certified Nursing Assistant licenses have been validated as active. 3. All employees found with an inactive licenses or missing background screening have	2/2/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathryn D Dean — TITLE: Administrator — (X6) DATE: 2/2/2012

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

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F 226	Continued From page 1 produce written documentation that the license renewal was verified on 12/6/2011. On 1/7/2012 at 3:30pm, Administrative Staff #4 was interviewed. She shared that she became concerned last month that the former financial counselor did not perform thorough employment screenings for new hires and developed an Action Plan for him, in order to become compliant with the state and federal regulations. She provided a copy of a Performance Improvement Action Plan, dated 12/29/2011 which stated that the personnel files were not meeting the standard set forth by the Administrator, state regulations or federal regulations. Her goal was to complete a 100% audit of all employee files and make corrections, as necessary. In addition, all 100% of employee files would be accurate according to state and federal guidelines. Approaches to be used included hiring a new financial counselor and ensuring that all 100% of employee files would be completed by 1/13/2012. She shared that she had a new financial counselor in place this week and hoped to quickly address the problem. 2. On 1/7/2012 a record review was conducted to verify licenses of nurses on staff. It revealed that Nurse #3 was hired on 10/10/2011 as a Registered Nurse. Her license was verified on 11/1/2011. On 1/7/2012 at 3:30pm, Administrative Staff #4 was interviewed. She shared that she became concerned last month that the former financial counselor did not perform thorough employment screenings for new hires and developed an Action Plan for him, in order to become compliant	F 226	been removed from the schedule until screening have returned as active. Measures and Systemic Changes 1. All new employee Licenses are validated prior to the first day of work. 2. All new employee background checks are completed prior to first day of work. 3. All new employee reference checks are completed prior to the employees first day of work. 4. The Administrator is required to sign off on all new employee files prior to their first day work to validate the reference checks, license verification and background checks have been completed and received. Monitoring: 1. All audited findings from the ~~nd~~ Administrator audits related to the pre-employment screening process will be reviewed in the monthly Performance Improvement committee meeting for patterns and trends and further interventions developed as necessary to ensure continued compliance	

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F 226	Continued From page 2 with the state and federal regulations. She provided a copy of a Performance Improvement Action Plan, dated 12/29/2011 which stated that the personnel files were not meeting the standard set forth by the Administrator, state regulations or federal regulations. Her goal was to complete a 100% audit of all employee files and make corrections, as necessary. In addition, all 100% of employee files would be accurate according to state and federal guidelines. Approaches to be used included hiring a new financial counselor and ensuring that all 100% of employee files would be completed by 1/13/2012. She shared that she had a new financial counselor in place this week and hoped to quickly address the problem. 3. On 1/7/2012 a record review was conducted to verify licenses of nurses on staff. It revealed that Nurse #4 was hired on 8/15/2011 as a Licensed Practical Nurse. Her license was verified on 8/24/2011. On 1/7/2012 at 3:30pm, Administrative Staff #4 was interviewed. She shared that she became concerned last month that the former financial counselor did not perform thorough employment screenings for new hires and developed an Action Plan for him, in order to become compliant with the state and federal regulations. She provided a copy of a Performance Improvement Action Plan, dated 12/29/2011 which stated that the personnel files were not meeting the standard set forth by the Administrator, state regulations or federal regulations. Her goal was to complete a 100% audit of all employee files and make corrections, as necessary. In addition, all 100% of employee files would be accurate according to	F 226		

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F 226	Continued From page 3 state and federal guidelines. Approaches to be used included hiring a new financial counselor and ensuring that all 100% of employee files would be completed by 1/13/2012. She shared that she had a new financial counselor in place this week and hoped to quickly address the problem. 4. On 1/7/2012 a record review was conducted to verify licenses of nurses on staff. It revealed that Nurse #5 was hired on 10/1/2011 as a Licensed Practical Nurse. Her license was verified on 11/1/2011. On 1/7/2012 at 3:30pm, Administrative Staff #4 was interviewed. She shared that she became concerned last month that the former financial counselor did not perform thorough employment screenings for new hires and developed an Action Plan for him, in order to become compliant with the state and federal regulations. She provided a copy of a Performance Improvement Action Plan, dated 12/29/2011 which stated that the personnel files were not meeting the standard set forth by the Administrator, state regulations or federal regulations. Her goal was to complete a 100% audit of all employee files and make corrections, as necessary. In addition, all 100% of employee files would be accurate according to state and federal guidelines. Approaches to be used included hiring a new financial counselor and ensuring that all 100% of employee files would be completed by 1/13/2012. She shared that she had a new financial counselor in place this week and hoped to quickly address the problem. 5. On 1/6/2012 a record review was conducted to	F 226		

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F 226	Continued From page 4 verify screening practices for all new employees. Nurse Aide #5 was hired on 10/31/2011. A criminal background check was requested for Nurse Aide on 11/3/2011. On 1/7/2012 at 3:30pm, Administrative Staff #4 was interviewed. She shared that she became concerned last month that the former financial counselor did not perform thorough employment screenings for new hires and developed an Action Plan for him, in order to become compliant with the state and federal regulations. She provided a copy of a Performance Improvement Action Plan, dated 12/29/2011 which stated that the personnel files were not meeting the standard set forth by the Administrator, state regulations or federal regulations. Her goal was to complete a 100% audit of all employee files and make corrections, as necessary. In addition, all 100% of employee files would be accurate according to state and federal guidelines. Approaches to be used included hiring a new financial counselor and ensuring that all 100% of employee files would be completed by 1/13/2012. She shared that she had a new financial counselor in place this week and hoped to quickly address the problem. 6. On 1/6/2012 a record review was conducted to verify pre-screening practices for all new employees. Nurse Aide #6 was hired on 11/7/2011. A criminal background record check was requested for Nurse Aide #6 on 11/22/2011. On 1/7/2012 at 3:30pm, Administrative Staff #4 was interviewed. She shared that she became concerned last month that the former financial counselor did not perform thorough employment	F 226		

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F 226	Continued From page 5 screenings for new hires and developed an Action Plan for him, in order to become compliant with the state and federal regulations. She provided a copy of a Performance Improvement Action Plan, dated 12/29/2011 which stated that the personnel files were not meeting the standard set forth by the Administrator, state regulations or federal regulations. Her goal was to complete a 100% audit of all employee files and make corrections, as necessary. In addition, all 100% of employee files would be accurate according to state and federal guidelines. Approaches to be used included hiring a new financial counselor and ensuring that all 100% of employee files would be completed by 1/13/2012. She shared that she had a new financial counselor in place this week and hoped to quickly address the problem.	F 226		
F 279 SS=J	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279	F 279 Immediate action taken for involved resident: Resident #3 was transferred to the hospital and now resides in a sister facility. Action taken for others with potential to	2/7/12

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F 279	Continued From page 6 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop a comprehensive care plan for 1(Resident #3) of 3 cognitively impaired residents with a history of falls and who received antiplatelets drugs (aspirin & Plavix). The findings include: The immediate jeopardy began for Resident #3 on 12/05/2011(the date the comprehensive care plan was due after her admission) and was identified on 1/6/2012 at 7:55pm. Immediate Jeopardy was removed on 1/7/2012 at 9:00pm, after the Credible Allegation was validated through staff interviews, record review and observations. The facility will remain out of compliance at a level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) Resident #3 was admitted to the facility on 11/14/2011 with the following diagnoses: vascular dementia, general muscle weakness, abnormal posture, hypertension, a history of falls and multiple cerebrovascular accidents. She also had 81mg of aspirin and 75mg of Plavix administered to her daily, which are antiplatelet drugs used to prevent blood clots; a contributor of strokes. The Admission Minimum Data Set (MDS) was not completed; however there was a nursing assessment, dated 11/22/2011 which indicated that Resident #3 was confused with short term	F 279	be affected: 1. Care plans have been reviewed by the Director of Nursing, Unit Managers, Wound care nurse and clinical reimbursement director beginning on 1/7/12 and revised accordingly if interventions have not been previously identified. 2. The Certified Nursing Assistant care guides have been reviewed by the Director of Health Services, Unit Managers, Wound Care Nurse and Senior Nurse Consultant beginning on 1/7/12, The residents interventions related to fall prevention has been added to the C.N.A. care guide. 3. The Director of Nursing, Unit Manager, and/or Clinical Care Competency Coordinator began education related to interventions placed on the C.N.A care guide was started on 1/6/12 and will continue until all staff has been educated. The nursing assistant is to check the ADL care guide prior to each shift; the ADL care guides are located at the nurse's station in a specific binder and the ADL care guide is updated by the charge nurses, Clinical reimbursement director, Director of Health Services, and/or Unit Managers with order changes and significant change of condition. All nursing staff will receive education on the ADL	

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F 279	Continued From page 7 memory problems. She was totally dependent on one person to assist her with bed mobility and totally dependent on two persons to assist her with transfers. A review of Resident #3's chart revealed a Fall Risk Assessment completed on 11/14/2011 with a score of 14. The guideline on the assessment stated that when residents score 10 or more, interventions should be promptly put in place. The Interim Care Plan dated for 11/14/2011 indicated that she was at risk for falls. Her goal was to not sustain injury related to falling over the next 30 days. Approaches to be used included a Fall Risk Screen on admission; to keep the environment safe and utilize safety devices such as bed and chair alarms. The nurse's notes were reviewed. It revealed that on 11/15/2011, between 10:00pm and 6:00am, Resident #3 was very confused and attempted to get out of bed several times. She was confused and a bed alarm was put into place. On 11/16/2011, the notes recorded that a new order has been written for physical therapy services for evaluation and treatment. Resident #3 was recommended to receive gait training, wheelchair management secondary to weakness and falls. "Patient still very confused and tries so many times to get out of bed. Patient on total for transfers and activities of daily living (ADL)." On the 11/16/2011 Physical Therapy Plan of Care, Therapist #1 indicated a recent referral to physical therapy due to Resident #3 showing a significant decline in bed mobility, transfer, and gait over several months due to medically	F 279	care guide prior to beginning their next scheduled shift. 4. Education related to the assistance the resident requires for transfers was started on 1/6/12 that included placement of the assistance the resident requires for transfers on the ADL care guide and will continue until all staff has been completed. Nursing Assistants will receive education prior to beginning their next scheduled shift. This education was provided by the Director of Nursing, Unit Manager and/or Clinical Competency Coordinator. 5. The Director Health Services, Unit Managers, Senior Care Partner, Clinical Competency Coordinator, Senior Nurse Consultant are observing certified nursing assistants to validate they are transferring residents according to the care plan and ADL care guide, this is to include the utilization of support or unsupported trunk control and amount of assistant required during transfers. This observation began on 1/7/12 Monitoring and Systemic Changes: 1. Education related to updating care plans, C.N.A care guides related to resident transfers has been added to the general orientation for Licensed Nurses and Certified Nursing Assistance.	

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F 279	Continued From page 8 complex conditions resulting from medical problems. She was listed as a balance precaution, including a falls risk. She had modified independence with bed mobility (rolling side to side); bed mobility (supine-sit) and exhibited a static sitting balance (able to maintain balance without balance loss or upper extremity supports). She needed maximum assistance to transfer from bed to wheelchair. On the 11/17/2011 Plan of Care Assessment by Therapist #2 Resident #3 was mentioned to exhibit sliding her hips forward in a chair and leaning to the side while seated in her wheelchair. It further stated that she demonstrated decreased posture in wheelchair. Yet she was able to complete all functional transfers with maximum assistance. On 11/29/2011, an Occupational Therapy Daily Treatment Note stated that "Patient needs maximum cues for hand placement with poor posture and leaning forward." On the 12/8/2011 Occupational Therapist Progress Report, Therapist #2 indicated that Resident #3 was receiving treatment for muscle weakness and abnormal posture. Her goal was to tolerate upright standing maintaining proper postural alignment and weight distribution for 10 minutes to increase upper body trunk strength, standing tolerance and to increase interaction in her environment. She would also achieve effective postural alignment while seated in wheelchair for over 3 hours utilizing adaptive equipment as needed to affect hips sliding forward in chair and leaning to side. During the survey, Therapist #2 was on vacation and was unavailable for interview.	F 279	2. Care plans will be reviewed and /or revised in the daily morning meetings Monday through Friday by the Director of Nursing, Unit Managers, and/or Case Mix Director of all residents with occurrences and/ or significant change of condition. 3. Case Mix Directors have been educated on developing, initiating and accuracy of the comprehensive care plan by the Clinical Reimbursement Coordinator. Monitoring: 1. The Clinical Reimbursement Consultant will audit the facilities significant change MDS's and care plans for accuracy weekly for four weeks then monthly thereafter. 2. The Senior Nurse Consultant will audit the occurrence logs and review the charts for interventions and implementation of interventions and investigation weekly for four weeks then monthly thereafter. 3. The Director of Nursing / Unit Manager will audit the Fall Risk assessments, Care Plans and ADL care guides for fall prevention interventions daily for seven days, weekly for four weeks then monthly thereafter. 4. The audits conducted by the Director of Health Services, Unit Managers, Clinical Competency Coordinator and/or Senior care	

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F 279	Continued From page 9 An undated Nursing Assistant Care Record revealed that Resident #3 needed the assistance of one for transfers and needed the assistance of one to two persons, for repositioning. Safety devices to be used included a bed and chair alarm, which should be in place throughout the day. Administrative Staff #1 was interviewed on 1/6/2012 at 11:40am. She relayed that Resident #3 should have never been sitting on the side of the bed on 12/30/2011. She stated that Resident #3 had poor trunk control and was known to lean forward. In addition, she added that Nurse Aide #4 could have reviewed her ADL book for information on the resident or come talk to a nurse. On 12/25/2011 at 12:00am, the nurse's notes revealed that Resident #3 was observed on the floor with no apparent injury. She was assisted back to bed and attempted to get out of bed twice. She was brought to the nurse ' s station for monitoring. The fall investigative summary, dated 12/25/2011 relayed that the charge nurse had to reposition Resident #3 after she made two attempts earlier to get out of bed, unassisted. Later that shift, Resident #3 was found on the floor on the side of her bed by the charge nurse. The Interim Care Plan reflected the fall on 12/25/11. An Incident Fall Report, 12/26/2011, documented that Resident #3 was observed at 4:00pm on the floor beside her bed. She stated that she slid from her wheelchair and fell. She had no apparent injury. Under the section equipment in	F 279	partner regarding resident observation to ensure the certified nursing assistants are providing care in accordance with the resident care plan will be conducted daily for seven days then weekly for four weeks then monthly. The results of the observation audits will be monitored monthly by the Performance Improvement committee for compliance. 5. Daily and weekly audits of the documentation of all occurrences and all significant changes, the Clinical Reimbursement Consultant accuracy audits and the Senior Nurse Consultant audit of the occurrence logs for interventions, implementation and investigations will be monitored monthly by the Performance Improvement Committee for compliance. 6. All audited findings from the DHS/Administrators documentation of occurrences and significant changes, CRC accuracy, and SNC review of the charts for interventions and implementation of interventions and investigation, education in general orientation will be reviewed in the monthly Performance Improvement committee meeting for patterns and trends and further interventions developed as necessary to ensure continued	

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F 279	Continued From page 10 use, not applicable was written. On the 12/26/2011 Follow-Up Investigation summary, it confirmed that Resident #3 slid from her wheelchair. It indicated when asked, Resident #3 was unable to recall why she slid out of the chair. The Interim Care Plan reflected the fall on 12/26/11. On 12/30/2011, the nurse's notes revealed that at 7:45am, nurse aide #4 (NA#4) notified Nurse #1 that Resident #3 had fallen on the floor in her room. She told her that she had positioned Resident #3 on the side of her bed. NA#4 told Nurse #1 that she made sure she was stable while repositioning her wheelchair, but Resident #3 fell forward, head first and on to the floor. Bleeding was noted from her upper lip and a hematoma on her the right side of her eye. She noted no loss of consciousness and that the nurse practioner who was in the building was immediately notified and came to the room to assess Resident #3 ' s injuries. A call was made for emergency transport and she was taken to the hospital at 8:15am. The fall investigation report from 12/30/2011 was reviewed. It stated that Administrative Staff #1 spoke with NA #4 and "Advised her that unsecure residents unable to sit on side of bed unsupported could result in resident's harm. Employee instructed to never leave resident unsecure on side of bed or standing if resident unable to support self. Employee further instructed to have all necessary equipment/supplies necessary prior to resident transfer." The hospita s emergency department notes were	F 279	compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE - CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11 reviewed and revealed that Resident #3 was admitted on 12/30/2011 at 8:42am for evaluation and treatment after her fall. The initial physical assessment noted that she had a large hematoma inside her upper lip as well as a large hematoma noted to the right eye. At 11:39am, she received sutures for facial laceration repair. The Inpatient Consult Note, dated 12/31/2011 stated that Aspirin and Plavix would be held for at least one week due to a head bleed. The consult note also stated that "fractures do not appear to be operative." The hospital discharge summary, dated 1/6/2012 reported that Resident #3 was treated in the Intensive Care Unit and had a discharge diagnosis of subdural hematoma. The Radiology reports findings included a CAT scan (computerized axial tomography) of the head which confirmed a small right subdural hematoma with blood in the left lateral ventricle. A CAT scan of the maxillofacial (mid-face) revealed a comminuted fracture through the floor of the right orbit extending into the lamina papyracea (thin orbital plate). It noted that there was blood within the right maxillary sinus. As well as fracture fragments were minimally inferiorly displaced. On 1/6/2012 at 12:21pm, Administrative Staff #2 was interviewed. She acknowledged that some of the assessments (activities and social services) were done for Resident #3 on 11/22/2011 but she did not complete the MDS, including the Care Area Assessment (CAA) until 1/5/2012. She stated that whenever a comprehensive assessment gets completed, she must do a Care Plan. The Interim Care Plan stays on the chart until a comprehensive care plan gets developed. She acknowledged that the comprehensive care plan for Resident #3 was completed on 1/5/2012.	F 279		

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F 279	Continued From page 12 Therapist #3 worked with the resident providing occupational supports. She stated during an interview on 1/6/2012 at 12:41pm, that she did not have concerns about her positioning in her wheelchair, but stated that Resident #3 probably could not sit upright without back support. She commented, "If she didn ' t have that support she will tumble backwards or forward, toward the momentum." Therapists #1 and #4 were interviewed on 1/6/2012 at 1:17pm. Therapist #4 stated that Resident #3 participated in physical therapy about 4x a week. Therapist #1 added that Resident #3's lower extremities were fairly weak and sometimes rigid however, she was not paralyzed. Therapist #4 stated that during their sessions she noted a general decline in Resident #3's abilities and she mentioned to the nurse as well as the nurse practioner that Resident #3 was not improving and seemed to be regressing. Therapist #1 shared that on one occasion; she recalled seeing Resident #3 leaning over in her wheelchair, while she was seated in the hallway, as if she was trying to reach for something, like maybe her shoes. She further stated that Resident #3 did not have trunk control or stability to sit up by herself without back support. She also didn't think she had very much safety awareness. On 1/10/2012 at 10:37am, a telephone interview was conducted with Nurse Aide #4. She stated that she worked with the resident twice; around the time of her admission and on 12/30/2011. She stated that she wasn't that familiar with Resident #3's health conditions but that she knew that she had dementia, couldn't walk but was told	F 279		

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that she could stand with assistance. She stated that she gathers her source of information to care for a resident from the nurse or she could go read the chart. The Nurse Aide Care Guide, she commented were kept in the nourishment room closet and it provided information about the type of assistance the resident needed. Her knowledge of Resident #3 was that she was considered total care, needing one staff to assist her and that she could sit on her own. She stated that Resident #3 did not require a mechanical lift for transfers.

NA #4 continued by saying that although she was only assigned to Resident #3 twice, she had observed her previously, while she sat on the hall or in the television room. She recalled that Resident #3 could sit on her own in her wheelchair, and didn't slouch. She would witness her sitting on the edge of her chair and would have to reposition her and tell her to scoot back in her chair. NA #4 shared that she had seen Resident # lean forward in her wheelchair, with both hands on her armrest as if she wanted to get up. She stated that she honestly didn't know if she was a high fall risk and that she felt that Resident #3 could sit on the side of the bed.

During the interview, Nurse Aide #4 explained that on the morning of 12/30/2011 she was giving Resident #3 a bed bath and getting her dressed. She shared that Resident #3 was alert and they were able to converse. She stated that after she gave her a bath, she sat her up on the side of the bed, then stood in front of her, repositioning her clothes and styling her hair. NA #4 had the wheelchair, placed behind her, as the aide stood. She stated that the bed was placed at standard

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height and that Resident #3 was able to sit with the soles of her feet touching the floor. (The Nursing Assessment dated 11/22/2011 indicated that Resident #3 stood 5'4 " tall.) She continued by stating that she did not have to hold Resident #3 while she provided grooming over a 3 to 5 minutes period, because she was able to maintain good trunk control. However she stated that when she removed her hands from Resident #3's shoulders, in order to turn around and move the wheelchair, Resident #3 had fell forward from her seated position on the bed and hit her face on the floor.

On 1/13/12 at 11:37am, a follow up telephone interview was conducted with NA #1. She stated that aides can become familiar with a resident's needs by viewing the care guide located in each resident's closet or the nurse's will instruct the aide during their shift report. She shared that therapy had informed her that Resident #3 was a "leaner", who could pivot but would need assistance. She continued by saying, "On paper it said that she (Resident #3) was a one person transfer but if you couldn't handle all of the leaning, then you would need someone else to help you."

On 1/17/12 at 12:17pm, a follow up telephone interview was conducted with Administrative Staff #2. She commented that when a fall occurs, the nurse immediately updates the interim care plan with writes down interventions. The Unit Manager reviews the plan and the nurses make Administrative Staff #2 aware of any changes so that she can transfer the incidents and interventions onto the comprehensive care plan. She shared that on 12/25/11, staff intervened

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F 279	Continued From page 15 after Resident #3 fell out of bed, by bringing her to the nurse's station for supervision. After her fall on 12/26/11, staff intervened by placing a chair alarm on her wheelchair. On 1/17/12 at 1:00pm, a follow up telephone interview was conducted with Administrative Staff #1. She shared that all licensed staff are able to update the nurse aide care guides with any information about falls and interventions to be used. She added that the care guides are kept in the resident's closet or in the ADL book. Therapist #2 was interviewed by telephone on 1/18/12 at 12:12pm. He stated that he primarily worked with Resident #3 to strengthen her ability to sit in a wheelchair and to assist her with toilet and grab bar transfers. On 11/21/11 and 11/22/11, he modified her wheelchair by adding a longer seat cushion, which was then lowered closer to the ground, thus allowing her feet to touch the floor, which helped her to self-propel and kept her trunk properly aligned. He shared that when Resident #3 was transferred out of her wheelchair, she could sit for a few seconds, but he stated "I never felt comfortable taking my hand off of her, she was still max assist for transfers " The Administrators were notified of the Immediate Jeopardy on 1/6/2012 at 7:55pm. The facility provided a Credible Allegation of Compliance on 1/7/2012 at 9:00pm. The allegation of compliance indicated: Credible Allegation of Compliance: Others with Potential to be effected:	F 279		

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F 279	Continued From page 16 1. Care plans have been reviewed by the Director of Nursing, Unit Managers, Wound care nurse and clinical reimbursement director on 1/7/12 and revised accordingly if interventions have not been previously identified. 2. The Director of Nursing, Unit Manager, and/or Clinical Care Competency Coordinator began education related to interventions placed on the N.A care guide was started on 1/6/12 and will continue until all staff has been educated. The nursing assistant is to check the ADL care guide prior to each shift; the ADL care guides are located at the nurse ' s station in a specific binder and the ADL care guide is updated by the charge nurses, Clinical reimbursement director, Director of Health Services, and/or Unit Managers with order changes and significant change of condition. All nursing staff will receive education on the ADL care guide prior to beginning their next scheduled shift. 3. Education related to the assistance the resident requires for transfers was started on 1/6/12 that included placement of the assistance the resident requires for transfers on the ADL care guide and will continue until all staff has been completed. Nursing Assistants will receive education prior to beginning their next scheduled shift. This education was provided by the Director of Nursing, Unit Manager and/or Clinical Competency Coordinator. Measures and Systemic Changes 1. Education related to updating care plans, Nurse Aide care guides related to resident transfers has been added to the general orientation for Licensed Nurses and Nursing Assistance. 2. All accidents occurrences will be brought to	F 279		

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F 279	Continued From page 17 the stand up meeting daily Monday through Friday by the unit managers for review of the occurrence documentation for completeness, interventions and summarization. 3. Care plans will be reviewed and /or revised in the daily morning meetings Monday through Friday by the Director of Nursing, Unit Managers, and/or Case Mix Director of all residents with occurrences and/ or significant change of condition. 4. Director of Health Services, Unit Managers, Clinical Competency Coordinator and/or Senior Care Partner will observe 10 residents per day to validate the Nursing Assistants are providing resident care in accordance with the resident care plan. Monitoring 1. The Director of Health Services (DHS) and/or Administrator will audit documentation of occurrences for intervention and implementation of the interventions and investigation completion and significant changes to ensure they have been identified on the ADL care guide and care plan, daily for seven days then weekly for four weeks then monthly thereafter. 2. The Clinical Reimbursement Consultant (CRC) will audit the facilities significant change MDS ' s and care plans for accuracy weekly for four weeks then monthly thereafter. 3. The Senior Nurse Consultant (SNC) will audit the occurrence logs and review the charts for interventions and implementation of interventions and investigation weekly for four weeks then monthly thereafter. 4. The Director of Health Services / Unit Manager will audit the Fall Risk assessments, Care Plans and ADL care guides for fall	F 279		

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F 279	Continued From page 18 prevention interventions daily for seven days, weekly for four weeks then monthly thereafter. 5. The audits conducted by the Director of Health Services, Unit Managers, Clinical Competency Coordinator and/or Senior care partner regarding resident observation to ensure the certified nursing assistants are providing care in accordance with the resident care plan will be conducted daily for seven days then weekly for four weeks then monthly. The results of the observation audits will be monitored monthly by the Performance Improvement committee for compliance. 6. Daily and weekly audits of the documentation of all occurrences and all significant changes, the Clinical Reimbursement Consultant accuracy audits and the Senior Nurse Consultant audit of the occurrence logs for interventions, implementation and investigations will be monitored monthly by the Performance Improvement Committee for compliance. 7. All audited findings from the DHS/Administrators documentation of occurrences and significant changes, CRC accuracy, and SNC review of the charts for interventions and implementation of interventions and investigation, education in general orientation will be reviewed in the monthly Performance Improvement committee meeting for patterns and trends and further interventions developed as necessary to ensure continued compliance. The credible allegation was verified 1/7/2012 at 7:00pm, as evidenced by staff interviews on preventing falls, reviewing Nurse Aide Care Guides, completing fall investigation reports and reviewing Fall Risk assessments.	F 279		

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F 279	Continued From page 19 Review of in-service records for Performing Safe Transfers, Event Reporting (to include how the event occurred), and Developing Care Plans, Updated Fall Risk Assessments, and Updated Care Guides indicated participation by 48% of nursing, housekeeping, dietary and therapy staff. Residents were identified and re-screened by Therapy on 1/7/2012 to determine if they were at risk for falls due to balance while sitting. 69 Residents were identified as high risk and/or with trunk control issues. Their charts were reviewed for updated care guides, care plans, fall risk assessments as well as observation of interventions to be used to prevent falls. A revision dated 1/7/2012 was made to the Incident Fall Report to include an Incident Occurrence Investigation Summary that identifies what the resident was doing prior to the occurrence, statement from the resident of what occurred and statements from staff members with a synopsis of what led to the occurrence.	F 279		
F 287 SS=D	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 287	F 287 Action taken for those residents identified: 1. Resident #3 no longer resides in the facility. Action taken for those with potential to be affected: 1. The Case Mix Directors have been provided education by the Clinical Reimbursement Consultants related to the federal transmittal requirements. 2. The Clinical Reimbursement Consultants audited the residents MDS transmittal records on 1/7/2012 with no further issues noted. 3. MDS Assessments are transmitted as they are completed by the Case Mix Directors. Measures and systemic changes 1. Case Mix Directors are transmitting the MDS when completed. 2. Administrator is reviewing the MDS transmittal logs and comparing to the assessment scheduling to ensure compliance. 3. The Clinical Reimbursement Consultants are monitoring the transmittal logs weekly to ensure compliance with federal and state transmittal guideline.	2/7/12

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F 287	Continued From page 20 (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to transmit an Admission Minimum	F 287	Monitoring 1. Clinical Reimbursement Consultants are reviewing transmittals weekly against the MDS schedule. 2. Administrator is reviewing MDS log and transmittals daily to ensure compliance. 3. All audited findings from the Clinical reimbursement Consultants and Administrator audits will be reviewed in the monthly Performance Improvement committee meeting for patterns and trends and further interventions developed as necessary to ensure continued compliance.	

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F 287	Continued From page 21 Data Set (MDS) for 1 of 4 residents (Resident # 3). The findings include: Resident #3 was admitted to the facility on 11/14/2011 with the following cumulative diagnoses: vascular dementia, depression, hypertension, cerebrovascular accident, history of falls and abnormal posture. Review of her chart revealed that the Admission MDS assessment was omitted. On 1/6/2012 at 12:21pm, the Administrative Staff #2 was interviewed. She shared that a partial MDS admission assessment was done on 11/22/2011 for Resident #3, but the Admission MDS did not get transmitted until 1/5/2012. On 1/7/12 at 8:44pm, Administrative Staff #5 was interviewed and relayed that the facility planned to bring in a clinical team to work on MDS assessment and that part of their plan was to do a 100% chart audit to ensure that everything was current. She shared that there would be weekly visits to the facility to review the previous week's assessments to check for accuracy.	F 287		
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.	F 323	F 323 Immediate Action taken: 1. Resident was transferred to the hospital and currently resides in our sister facility. Action taken for others with potential to be affected: 1. All residents fall risk assessments have been reviewed and revised as required, by the Director of Health Services, Unit Managers, Wound Care Nurse and Senior Nurse Consultant to identify the high fall risk residents on 1/7/12. 63 out of 109 residents have	2/7/12

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F 323	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and the review of medical and hospital records, the facility failed to establish the transfer needs as well as the transfer mode for 1 of 4 residents (Resident #3) reviewed for falls and to ensure that nurse aides used a safe transfer technique to prevent injuries. The immediate jeopardy began on Resident #3 on 12/30/2011 and was identified on 1/6/2012 at 7:55pm. Immediate Jeopardy was removed on 1/7/2012 at 9:00pm, after the Credible Allegation was validated through staff interviews, record review and observations. The facility will remain out of compliance at a level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) The findings include: Resident #3 was admitted to the facility on 11/14/2011 with the following diagnoses: vascular dementia, general muscle weakness, abnormal posture, hypertension, a history of falls and multiple cerebrovascular accidents. She also had 81mg of aspirin and 75mg of Plavix administered to her daily. The Admission Minimum Data Set (MDS) was not completed; however there was a nursing assessment, dated 11/22/2011 which indicated that Resident #3 was confused with short term memory problems. She was totally dependent on one person to assist her with bed mobility and totally dependent on two persons to assist her with transfers.	F 323	been identified as high risk for falls. The Fall Risk assessment includes resident's level of conscious, history of falls, ambulation status, vision status, gait/balance, blood pressure, medications and predisposing disease. 2. Residents identified with a high fall risk have been evaluated for interventions and implementation of the interventions to prevent further occurrences are in place i.e., mat, alarms, positioning devices on 1/7/12. 3. Residents identified as a high fall risk who have not previously been screened for trunk balance will be screened by United Rehab Department for trunk control and balance beginning on 1/7/11 and continuing until all high risk residents have been completed. 4. Care plans have been reviewed by the Director of Nursing, Unit Managers, Wound care nurse and clinical reimbursement director on 1/7/12 and revised accordingly if interventions have not been previously identified. 5. The Certified Nursing Assistant care guides have been reviewed by the Director of Health Services, Unit Managers, Wound Care Nurse and Senior Nurse Consultant on 1/7/12, The residents interventions related to fall prevention has been added	

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F 323	Continued From page 23 A review of Resident #3's chart revealed a Fall Risk Assessment completed on 11/14/2011 with a score of 14. The guideline on the assessment stated that when residents score 10 or more, interventions should be promptly put in place. The Lift Evaluation Form, completed on 11/14/2011, stated that she could bear weight and could follow simple commands and had moderate upper body strength. The Interim Care Plan dated for 11/14/2011 indicated that she was at risk for falls. Her goal was to not sustain injury related to falling over the next 30 days. Approaches to be used included a Fall Risk Screen on admission; keep environment safe and utilize safety devices such as bed and chair alarms. The nurse's notes were reviewed. It revealed that on 11/15/2011, between 10:00pm and 6:00am, Resident #3 was very confused and attempted to get out of bed several times. She was confused and a bed alarm was put into place. On 11/16/2011, the notes recorded that a new order has been written for physical therapy services for evaluation and treatment. Resident #3 was recommended to receive gait training, wheelchair management secondary to weakness and falls. "Patient still very confused and tries so many times to get out of bed. Patient on total for transfers and activities of daily living (ADL)." On the 11/16/2011 Physical Therapy Plan of Care, Therapist #1 indicated a recent referral to physical therapy due to Resident #3 showing a significant decline in bed mobility, transfer, and gait over several months due to medically	F 323	to the C.N.A. care guide. 6. The Director of Nursing, Unit Manager, and/or Clinical Care Competency Coordinator began education related to interventions placed on the C.N.A care guide was started on 1/6/12 and will continue until all staff has been educated. The nursing assistant is to check the ADL care guide prior to each shift; the ADL care guides are located at the nurse's station in a specific binder and the ADL care guide is updated by the charge nurses, Clinical reimbursement director, Director of Health Services, and/or Unit Managers with order changes and significant change of condition. All nursing staff will receive education on the ADL care guide prior to beginning their next scheduled shift. 7. Education related to the assistance the resident requires for transfers was started on 1/6/12 that included placement of the assistance the resident requires for transfers on the ADL care guide and will continue until all staff has been completed. Nursing Assistants will receive education prior to beginning their next scheduled shift. This education was provided by the Director of Nursing, Unit Manager and/or Clinical Competency Coordinator. 8. The Director Health Services,	

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F 323	Continued From page 24 complex conditions resulting from medical problems. She was listed as a balance precaution, including a falls risk. She had modified independence with bed mobility (rolling side to side); bed mobility (supine-sit) and exhibited a static sitting balance (able to maintain balance without balance loss or upper extremity supports). She needed maximum assistance to transfer from bed to wheelchair. On the 11/17/2011 Plan of Care Assessment by Therapist #2 Resident #3 was mentioned to exhibit sliding her hips forward in a chair and leaning to the side while seated in her wheelchair. It further stated that she demonstrated decreased posture in wheelchair. Yet she was able to complete all functional transfers with maximum assistance. On 11/29/2011, an Occupational Therapy Daily Treatment Note stated that "Patient needs maximum cues for hand placement with poor posture and leaning forward." On the 12/8/2011 Occupational Therapist Progress Report, Therapist #2 indicated that Resident #3 was receiving treatment for muscle weakness and abnormal posture. Her goal was to tolerate upright standing maintaining proper postural alignment and weight distribution for 10 minutes to increase upper body trunk strength, standing tolerance and to increase interaction in her environment. She would also achieve effective postural alignment while seated in wheelchair for over 3 hours utilizing adaptive equipment as needed to affect hips sliding forward in chair and leaning to side. During the survey, Therapist #2 was on vacation and was unavailable for interview.	F 323	Unit Managers, Senior Care Partner, Clinical Competency Coordinator, Senior Nurse Consultant are observing certified nursing assistants to validate they are transferring residents according to the care plan and ADL care guide, this is to include the utilization of support or unsupported trunk control and amount of assistant required during transfers. This observation began on 1/7/12 9. Education related to Event reporting to include investigation of how the event occurred was started on 1/6/12 for all Licensed Nurses, certified nursing assistance and other ancillary staff will continue until all staff has been completed. All Licensed and Nursing staff will receive education prior to beginning their next scheduled shift. This education was provided by the Director of Health Services, Unit Managers and/or the Clinical Competency Coordinator. Measures and Systemic Changes: 1. An occurrence investigation form that identifies what the resident was doing prior to the occurrence, statement from resident of what occurred and statements from staff members with a synopsis of what led to the occurrence has been initiated on 1/6/12. This occurrence	

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F 323	Continued From page 25 An undated Nursing Assistant Care Record revealed that Resident #3 needed the assistance of one for transfers and needed the assistance of one to two persons, for repositioning. Safety devices to be used included a bed and chair alarm, which should be in place throughout the day. On 12/15/2011, the chart reflected that a physician's telephone was written for a bed and chair alarm on at all times for safety. On 12/25/2011 at 12:00am, the nurse's notes revealed that Resident #3 was observed on the floor with no apparent injury. She was assisted back to bed and attempted to get out of bed twice. She was brought to the nurse ' s station for monitoring. The fall investigative summary, dated 12/25/2011 relayed that the charge nurse had to reposition Resident #3 after she made two attempts earlier to get out of bed, unassisted. Later that shift, Resident #3 was found on the floor on the side of her bed by the charge nurse. The Interim Care Plan reflected the fall on 12/25/11. An Incident Fall Report, 12/26/2011, documented that Resident #3 was observed at 4:00pm on the floor beside her bed. She stated that she slid from her wheelchair and fell. She had no apparent injury. Under the section equipment in use, not applicable was written. On the 12/26/2011 Follow-Up Investigation summary, it confirmed that Resident #3 slid from her wheelchair. It indicated when asked, Resident #3 was unable to recall why she slid out of the chair. The Interim Care Plan reflected the fall on	F 323	investigation is to be initiated by the Charge Nurse on duty at the time of the occurrence. 2. The Administrator and/or Director of Health Services will review and summarize each occurrence investigation daily Monday through Friday with summarization on the investigation form. 3. Education related to updating care plans, C.N.A care guides related to resident transfers has been added to the general orientation for Licensed Nurses and Certified Nursing Assistance. 4. Education related to Occurrence investigations and Occurrence reporting has been added to general orientation for all staff. 5. All occurrences will be brought to the stand up meeting daily Monday through Friday by the unit managers for review of the occurrence documentation for completeness, interventions and summarization. 6. Care plans will be reviewed and /or revised in the daily morning meetings Monday through Friday by the Director of Nursing, Unit Managers, and/or Case Mix Director of all residents with occurrences and/ or significant change of condition. 7. Director of Health Services, Unit Managers, Clinical Competency Coordinator and/or Senior Care	

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F 323	Continued From page 26 12/26/11. On 12/30/2011, the nurse's notes revealed that at 7:45am, nurse aide #1 (NA#1) notified Nurse #1 that Resident #3 had fallen on the floor in her room. She told her that she had positioned Resident #3 on the side of her bed. NA#1 told Nurse #1 that she made sure she was stable while repositioning her wheelchair, but Resident #3 fell forward, head first and on to the floor. Bleeding was noted from her upper lip and a hematoma on her the right side of her eye. She noted no loss of consciousness and that the nurse practioner who was in the building was immediately notified and came to the room to assess Resident #3's injuries. A call was made for emergency transport and she was taken to the hospital at 8:15am. The fall investigation report from 12/30/2011 was reviewed. It stated that Administrative Staff #1 spoke with NA #4 and "Advised her that unsecure residents unable to sit on side of bed unsupported could result in resident's harm. Employee instructed to never leave resident unsecure on side of bed or standing if resident unable to support self. Employee further instructed to have all necessary equipment/supplies necessary prior to resident transfer." The hospital's emergency department notes were reviewed and revealed that Resident #3 was admitted on 12/30/2011 at 8:42am for evaluation and treatment after her fall. The initial physical assessment noted that she had a large hematoma inside her upper lip as well as a large hematoma noted to the right eye. At 11:39am,	F 323	Partner will observe 10 residents per day to validate the Certified Nursing Assistants are providing resident care in accordance with the resident care plan. 8. The facility DHS, Unit Managers, case mix directors, activities, administrator, Senior Nurse Consultant, United Rehab manager and the Senior Care Partner attended a meeting with the representative from CCME on 1/30/12 for an approximate four hour meeting. Additional education is being provided by the CCME representative for the Nurse managers as a train the trainer opportunity and also education to the front line staff on February 9th for two sessions with front line staff. Monitoring: 1. The Director of Health Services and/or Administrator will audit documentation of occurrences for intervention and implementation of the interventions and investigation completion and significant changes to ensure they have been identified on the ADL care guide and care plan, daily for seven days then weekly for four weeks then monthly thereafter. 2. The Clinical Reimbursement Consultant will audit the facilities significant change MDS's and care plans for accuracy weekly for four weeks then monthly	

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F 323	Continued From page 27 she received sutures for facial laceration repair. The Inpatient Consult Note, dated 12/31/2011 stated that Aspirin and Plavix would be held for at least one week due to a head bleed. The consult note also stated that "fractures do not appear to be operative." The hospital discharge summary, dated 1/6/2012 reported that Resident #3 was treated in the Intensive Care Unit and had a discharge diagnosis of subdural hematoma. The Radiology reports findings included a CAT scan (computerized axial tomography) of the head which confirmed a small right subdural hematoma with blood in the left lateral ventricle. A CAT scan of the maxillofacial (mid-face) revealed a comminuted fracture through the floor of the right orbit extending into the lamina papyracea (thin orbital plate). It noted that there was blood within the right maxillary sinus. As well as fracture fragments were minimally inferiorly displaced. On 1/5/2012 at 1:50pm, Nurse Aide #1 was interviewed. She stated that she used to work with Resident #3 and that when she sat in her wheelchair; she witnessed her leaning forward or to her side. She commented that Resident #3 did not have good balance and had trouble moving her legs. On 1/5/2012 at 2:05pm, Nurse #2 was interviewed. She stated that she worked with Resident #3 who had cognitive impairments. She used a wheelchair, which had an alarm on it because Resident #3 would lean in her chair. On 1/5/2012 at 3:10pm, Nurse Aide #2 was interviewed. She shared that she worked with Resident #3 often and that she often summoned the help of another aide to use a mechanical lift to	F 323	thereafter. 3. The Senior Nurse Consultant will audit the occurrence logs and review the charts for interventions and implementation of interventions and investigation weekly for four weeks then monthly thereafter. 4. The Director of Nursing / Unit Manager will audit the Fall Risk assessments, Care Plans and ADL care guides for fall prevention interventions daily for seven days, weekly for four weeks then monthly thereafter. 5. The audits conducted by the Director of Health Services, Unit Managers, Clinical Competency Coordinator and/or Senior care partner regarding resident observation to ensure the certified nursing assistants are providing care in accordance with the resident care plan will be conducted daily for seven days then weekly for four weeks then monthly. The results of the observation audits will be monitored monthly by the Performance Improvement committee for compliance. 6. Daily and weekly audits of the documentation of all occurrences and all significant changes, the Clinical Reimbursement Consultant accuracy audits and the Senior Nurse Consultant audit of the occurrence logs for interventions, implementation	

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F 323	Continued From page 28 transfer Resident #3. She thought that Resident #3 was paralyzed from the waist down and stated that whenever she placed her in bed, she made sure that she laid vertically on the mattress with pillows behind her back for support. She commented that she took that measure "Because I think she would fall out of bed if I sat her on the side. She doesn't have good tone." Furthermore, she stated that Resident #3 would lean to her left side whenever she sat in her chair and she would see her trying to stand up but she couldn't rise from her seat. On 1/6/2012 at 10:13am, Nurse #1 was interviewed. She shared that she worked with Resident #3 often on first shift weekdays and on weekends. She stated that Resident #3 needed extensive assistance with transfers, yet one person was capable of transferring her. She had observed Resident #3 leaning in her wheelchair. She was also known to scoot forward in her wheelchair, so a chair alarm was always in place. The morning of the accident on 12/30/2011, she was called to the room by NA #1. She found Resident #3 on the floor and saw blood coming from her mouth and a hematoma on her forehead. Resident #3 was not able to respond to her name. She took her vital signs and contacted the nurse practioner, to examine her. She was immediately transported to the hospital for assessment and treatment. Administrative Staff #1 was interviewed on 1/6/2012 at 11:40am. She relayed that Resident #3 should have never been sitting on the side of the bed on 12/30/2011. She stated that Resident #3 had poor trunk control and was known to lean forward. Also said that her equipment	F 323	and investigations will be monitored monthly by the Performance Improvement Committee for compliance. 7. All audited findings from the DHS/Administrators documentation of occurrences and significant changes, CRC accuracy, and SNC review of the charts for interventions and implementation of interventions and investigation, education in general orientation will be reviewed in the monthly Performance Improvement committee meeting for patterns and trends and further interventions developed as necessary to ensure continued compliance.	

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(wheelchair) was not set prior to attempting to transfer her from the bed to the wheelchair. In addition, she added that the aide could have reviewed her ADL book for information on the resident or come talk to a nurse.

On 1/6/2012 at 12:21pm, Administrative Staff #2 was interviewed. She acknowledged that some of the assessments (activities and social services) were done for Resident #3 on 11/22/2011 but she did not complete the MDS until 1/5/2012. She stated that whenever a comprehensive assessment gets completed, she must do a Care Plan. The Interim Care Plan stays on the chart until a comprehensive care plan gets developed. She acknowledged that the comprehensive care plan for Resident #3 was completed on 1/5/2012.

Therapist #3 also worked with the resident providing occupational supports. She stated during an interview on 1/6/2012 at 12:41pm, that she did not have concerns about her positioning in her wheelchair, but stated that Resident #3 probably could not sit upright without back support. She commented, "If she didn't have that support she will tumble backwards or forward, toward the momentum."

Therapists #1 and #4 were interviewed on 1/6/2012 at 1:17pm. Therapist #4 stated that Resident #3 participated in physical therapy about 4x a week. Therapist #1 added that Resident #3's lower extremities were fairly weak and sometimes rigid however, she was not paralyzed. Therapist #4 stated that during their sessions she noted a general decline in Resident #3's abilities and she mentioned to the nurse as well as the nurse practioner that Resident #3 was not improving

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and seemed to be regressing. Therapist #1 added that on one occasion, she recalled seeing Resident #3 leaning over in her wheelchair, while she was seated in the hallway, as if she was trying to reach for something like her shoes. She further stated that Resident #3 did not have trunk control or stability to sit up by herself without back support. She also didn ' t think she had very much safety awareness.

Nurse Aide #3 was interviewed on 1/6/2012 at 2:53pm. He stated that he began to work with Resident #3 in December and worked with her on 2nd and 3rd shifts. He shared that she needed a mechanical lift for transfers and he would sometimes assist NA #2 when she had to move her. He felt that Resident #3 had good positioning in her wheelchair, but he would see her lean forward when she got sleepy.

On 1/10/2012 at 10:37am, a telephone interview was conducted with Nurse Aide #4. She stated that she worked with the resident twice; around the time of her admission and on 12/30/2011. She stated that she wasn't that familiar with Resident #3's health conditions but that she knew that she had dementia, couldn't walk but was told that she could stand with assistance. She stated that she gathers her source of information to care for a resident from the nurse or she could go read the chart. The Nurse Aide Care Guide, she commented were kept in the nourishment room closet and it provided information about the type of assistance the resident needed. Her knowledge of Resident #3 was that she was considered total care, needing one staff to assist her and that she could sit on her own. She stated that Resident #3 did not require a mechanical lift

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F 323	Continued From page 31 for transfers. NA #4 continued by saying that although she was only assigned to Resident #3 twice, she had observed her previously, while she sat on the hall or in the television room. She recalled that Resident #3 could sit on her own in her wheelchair, and didn't slouch. She would witness her sitting on the edge of her chair and would have to reposition her and tell her to scoot back in her chair. NA #4 shared that she had seen Resident # lean forward in her wheelchair, with both hands on her armrest as if she wanted to get up. She stated that she honestly didn't know if she was a high fall risk because she didn't wear a yellow wrist band, which was used as an indicator to alert staff that a resident was identified as a fall risk. She felt that Resident #3 could sit on the side of the bed. During the interview, Nurse Aide #4 explained that on the morning of 12/30/2011 she was giving Resident #3 a bed bath and getting her dressed. She shared that Resident #3 was alert and they were able to converse. She stated that after she gave her a bath, she sat her up on the side of the bed, then stood in front of her, repositioning her clothes and styling her hair. NA #4 had the wheelchair, placed behind her, as the aide stood. She stated that the bed was placed at standard height and that Resident #3 was able to sit with the soles of her feet touching the floor. (The Nursing Assessment dated 11/22/2011 indicated that Resident #3 stood 5'4" tall.) She continued by stating that she did not have to hold Resident #3 while she provided grooming over a 3 to 5 minutes period, because she was able to maintain good trunk control. However she stated	F 323		

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that when she removed her hands from Resident #3's shoulders, in order to turn around and move the wheelchair, Resident #3 had fell forward from her seated position on the bed and hit her face on the floor.

On 1/13/12 at 11:37am, a follow up telephone interview was conducted with NA #1. She stated that aides can become familiar with a resident's needs by viewing the care guide located in each resident's closet or the nurse's will instruct the aide during their shift report. When NA #1 worked with Resident #3, she stated that she wore a yellow wrist band, to help identify her as at risk for falls. She shared that therapy had informed her that Resident #3 was a "leaner", who could pivot but would need assistance. She continued by saying, "On paper it said that she (Resident #3) was a one person transfer but if you couldn't handle all of the leaning, then you would need someone else to help you." She shared that she never had transfer techniques for Resident #3 demonstrated to her, but was informed of her standing deficit.

On 1/17/12 at 12:17pm, a follow up telephone interview was conducted with Administrative Staff #2. She commented that when a fall occurs, the nurse immediately updates the interim care plan with writes down interventions. The Unit Manager reviews the plan and the nurses make Administrative Staff #2 aware of any changes so that she can transfer the incidents and interventions onto the comprehensive care plan. She shared that on 12/25/11, staff intervened after Resident #3 fell out of bed, by bringing her to the nurse's station for supervision. After her fall on 12/26/11, staff intervened by placing a chair

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F 323	Continued From page 33 alarm on her wheelchair. She further commented that wrist bands are not used to identify residents at risk for falls. She stated that they rely on their Falls Risk Assessment, which had scored Resident #3 with a high score of 14 at the time of her admission, which placed her at risk for falls. On 1/17/12 at 1:00pm, a follow up telephone interview was conducted with Administrative Staff #1. She stated that the facility does not use a band system to identify residents at risk for falls. She shared that all licensed staff are able to update the nurse aide care guides with any information about falls and interventions to be used. The care guides are kept in the resident's closet or in the ADL book. She also shared that on 12/26/11; a chair alarm was added as a fall intervention, after Resident #3 fell that day. On a follow up telephone interview conducted on 1/17/12 at 2:56pm and 4:45pm, with Therapist #4, she stated that therapist can make recommendations for mechanical lifts but that the nurse makes the final decision and Resident #3 did not require a lift. She shared that Resident #3 was very inconsistent with her transfer skills, whereas some days she needed max assist of two persons and on other days, she needed less. In her role, Therapist #4 never gave any specific instructions on how to transfer Resident #3 to the nurse aides. She further shared that on 11/22/11, she worked with Therapist #2 to adjust Resident #3's wheelchair to help with self-propelling. On 12/16/11, she stated that she shared her concerns that Resident #3 had a functional decline with the nurse (name unknown) and	F 323		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 34 nurse practioner; she reiterated her concerns to the nurse (name unknown) on 12/18/11. Therapist #1 was interviewed by telephone on 1/18/12 at 12:12pm. He stated that he primarily worked with Resident #3 to strengthen her ability to sit in a wheelchair and to assist her with toilet and grab bar transfers. In his role, he never gave instructions to the nurse aides on the manner used to transfer her from a sitting position to her wheelchair. He added that on 11/21/11 he recognized that Resident #3 needed a smaller wheelchair and replaced hers with an 18 x 18 wheelchair, so that the seat height was closer to the ground and this would aide her in placing her feet firmly on the floor, to allow her to self-propel. On 11/22/11 he made another adjustment, with the assistance of Therapist #4, to lower the seat 1 to 2 inches, to prevent Resident #3 from scooting forward in her wheelchair and to keep her body aligned properly. He shared that when Resident #3 was transferred out of her wheelchair, she could sit for a few seconds, but he stated "I never felt comfortable taking my hand off of her, she was still max assist for transfers." On 1/18/12 at 12:22pm, a follow up telephone interview was conducted with Therapist #3. She stated that Resident #3 did not require a mechanical lift because she had the ability to help transfer, stand and reach but needed guidance and (human) support to transport. She further commented that she never gave instructions to the nurse aides on positioning Resident #3 without back support. On 1/18/12 at 12:26pm, Therapist #1 participated in a follow up telephone interview. She shared	F 323		

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

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F 323	Continued From page 35 that she was the evaluating therapist for Resident #3 whereas Therapist #4 administered the plan of care. She shared that the extremities of Resident #3 were all within functional limits and that she did not have any contractures. However, she did need upper extremity support from something (i.e. wheelchair back) or someone. She added that depending on the day that you worked with Resident #3, she might need the max assist of one or two persons. For this reason, she did not demonstrate any transfer techniques to any of the nurse aides, since Resident #3 was so inconsistent with her transfers. The Administrators were notified of the Immediate Jeopardy on 1/6/2012 at 7:55pm. The facility provided a Credible Allegation of Compliance on 1/7/2012 at 9:00pm. The allegation of compliance indicated: Credible Allegation of Compliance: 1. Resident #3 was evaluated by the Nurse Practioner. 2. An order was written for resident #3 to be transferred to the hospital for evaluation. 3. Resident #3 was transferred to the hospital by ambulance. 4. Resident #3 was admitted to the hospital on 12/30/11. 5. The employee involved in the occurrence was verbally counseled and no longer is employed. 6. The investigation identified that the employee involved turned away from the resident to reposition the wheel chair for transfer and resident fell to the floor. Others with Potential to be effected:	F 323		

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F 323	Continued From page 36 1. All residents fall risk assessments have been reviewed and revised as required, by the Director of Health Services, Unit Managers, Wound Care Nurse and Senior Nurse Consultant to identify the high fall risk residents on 1/7/12. Sixty-three out of One Hundred and Nine residents have been identified as high risk for falls. The Fall Risk assessment includes resident ' s level of consciousness, history of falls, ambulation status, vision status, gait/balance, blood pressure, medications and predisposing disease. 2. Residents identified with a high fall risk have been evaluated for interventions and implementation of the interventions to prevent further occurrences are in place i.e., mat, alarms, positioning devices on 1/7/12. 3. Residents identified as a high fall risk who have not previously been screened for trunk balance will be screened by United Rehab Department for trunk control and balance beginning on 1/7/11 and continuing until all high risk residents have been completed. 4. Care plans have been reviewed by the Director of Nursing, Unit Managers, Wound care nurse and clinical reimbursement director on 1/7/12 and revised accordingly if interventions have not been previously identified. 5. The Nursing Assistant care guides have been reviewed by the Director of Health Services, Unit Managers, Wound Care Nurse and Senior Nurse Consultant on 1/7/12, the residents ' interventions related to fall prevention has been added to the Nurse Aide care guide. 6. The Director of Nursing, Unit Manager, and/or Clinical Care Competency Coordinator began education related to interventions placed on the C.N.A care guide was started on 1/6/12 and will continue until all staff has been educated.	F 323		

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F 323	Continued From page 37 The nursing assistant is to check the ADL care guide prior to each shift; the ADL care guides are located at the nurse ' s station in a specific binder and the ADL care guide is updated by the charge nurses, Clinical reimbursement director, Director of Health Services, and/or Unit Managers with order changes and significant change of condition. All nursing staff will receive education on the ADL care guide prior to beginning their next scheduled shift. 7. Education related to the assistance the resident requires for transfers was started on 1/6/12 that included placement of the assistance the resident requires for transfers on the ADL care guide and will continue until all staff has been completed. Nursing Assistants will receive education prior to beginning their next scheduled shift. This education was provided by the Director of Nursing, Unit Manager and/or Clinical Competency Coordinator. 8. The Director Health Services, Unit Managers, Senior Care Partner, Clinical Competency Coordinator, Senior Nurse Consultant are observing certified nursing assistants to validate they are transferring residents according to the care plan and ADL care guide, this is to include the utilization of support or unsupported trunk control and amount of assistant required during transfers. 9. Education related to Event reporting to include investigation of how the event occurred was started on 1/6/12 for all Licensed Nurses, nursing assistance and other ancillary staff will continue until all staff has been completed. All Licensed and Nursing staff will receive education prior to beginning their next scheduled shift. This education was provided by the Director of Health Services, Unit Managers and/or the Clinical	F 323		

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F 323	Continued From page 38 Competency Coordinator. Measures and Systemic Changes 1. An incident occurrence investigation form that identifies what the resident was doing prior to the occurrence, statement from resident of what occurred and statements from staff members with a synopsis of what led to the occurrence has been initiated on 1/6/12. This incident occurrence investigation is to be initiated by the Charge Nurse on duty at the time of the occurrence. 2. The Administrator and/or Director of Health Services will review and summarize each incident occurrence investigation daily Monday through Friday with summarization on the investigation form. 3. Education related to updating care plans, Nurse Aide care guides related to resident transfers has been added to the general orientation for Licensed Nurses and Nursing Assistance. 4. Education related to incident occurrence investigations and incident occurrence reporting has been added to general orientation for all staff. 5. All incident occurrences will be brought to the stand up meeting daily Monday through Friday by the unit managers for review of the occurrence documentation for completeness, interventions and summarization. 6. Care plans will be reviewed and /or revised in the daily morning meetings Monday through Friday by the Director of Nursing, Unit Managers, and/or Case Mix Director of all residents with occurrences and/ or significant change of condition. 7. Director of Health Services, Unit Managers, Clinical Competency Coordinator and/or Senior Care Partner will observe 10 residents per day to validate the Nursing Assistants are providing	F 323		

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F 323	Continued From page 39 resident care in accordance with the resident care plan. Monitoring 1. The Director of Health Services and/or Administrator will audit documentation of occurrences for intervention and implementation of the interventions and investigation completion and significant changes to ensure they have been identified on the ADL care guide and care plan, daily for seven days then weekly for four weeks then monthly thereafter. 2. The Clinical Reimbursement Consultant (CRC) will audit the facilities significant change MDS ' s and care plans for accuracy weekly for four weeks then monthly thereafter. 3. The Senior Nurse Consultant (SNC) will audit the occurrence logs and review the charts for interventions and implementation of interventions and investigation weekly for four weeks then monthly thereafter. 4. The Director of Nursing / Unit Manager will audit the Fall Risk assessments, Care Plans and ADL care guides for fall prevention interventions daily for seven days, weekly for four weeks then monthly thereafter. 5. The audits conducted by the Director of Health Services, Unit Managers, Clinical Competency Coordinator and/or Senior care partner regarding resident observation to ensure the nursing assistants are providing care in accordance with the resident care plan will be conducted daily for seven days then weekly for four weeks then monthly. The results of the observation audits will be monitored monthly by the Performance Improvement committee for compliance. 6. Daily and weekly audits of the documentation	F 323		

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F 323	Continued From page 40 of all occurrences and all significant changes, the Clinical Reimbursement Consultant accuracy audits and the Senior Nurse Consultant audit of the occurrence logs for interventions, implementation and investigations will be monitored monthly by the Performance Improvement Committee for compliance. 7. All audited findings from the DHS/Administrators documentation of occurrences and significant changes, CRC accuracy, and SNC review of the charts for interventions and implementation of interventions and investigation, education in general orientation will be reviewed in the monthly Performance Improvement committee meeting for patterns and trends and further interventions developed as necessary to ensure continued compliance. The credible allegation was verified 1/7/2012 at 7:00pm, as evidenced by staff interviews on preventing falls, reviewing Certified Nurse Aide Care Guides, completing fall investigation reports and reviewing Fall Risk assessments. Review of in-service records for Performing Safe Transfers, Event Reporting (to include how the event occurred), and Developing Care Plans, Updated Fall Risk Assessments, and Updated Care Guides indicated participation by 48% of nursing, housekeeping, dietary and therapy staff. Residents were identified and re-screened by Therapy on 1/7/2012 to determine if they were at risk for falls due to balance while sitting. 69 Residents were identified as high risk and/or with trunk control issues. Their charts were reviewed for updated care guides, care plans, fall risk assessments as well as observation of interventions to be used to prevent falls.	F 323		

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F 323	Continued From page 41 A revision dated 1/7/2012 was made to the Incident Fall Report to include an Accident Occurrence Investigation Summary that identifies what the resident was doing prior to the occurrence, statement from the resident of what occurred and statements from staff members with a synopsis of what led to the occurrence.	F 323		
F 496 SS=D	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and	F 496	F 496 Immediate action taken: 1. All Certified Nursing Assistants licenses where verified as current 2. Employees found to have an inactive license have been removed from the schedule until verification has been received as completed. Action taken for others with potential to be affected: 1. All Certified Nursing Assistant licenses have been validated as active. 2. All employees found with inactive licenses have been removed from the schedule until screening	2/7/12

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F 496	Continued From page 42 competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that 2 of 4 nurse aides (NA #7 & NA #8) maintained current nurse aide registrations, before working with residents. The findings include: 1. On 1/7/2012, a record review was conducted of the employee personnel files. Nurse Aide #7 (NA #7) was hired on 5/3/2011. Her nurse aide registration expired on 12/31/2011. A copy of the Nurse Aide I Registry Verification of Listings revealed that her registration was last verified on 12/6/11. The daily nursing assignments for 1/6/12, were reviewed and it revealed that NA #7 was on the schedule for 1st shift (6:00am-2:00pm) and had worked her assignment. On 1/7/12 at 4:00pm, the Administrative Staffs # 4 and # 5 were informed that NA #7's registration expired on 12/31/11 and continued to work with residents. They were asked if they had any new documentation that showed that NA #7's registration had been renewed. Administrative Staff #5 shared that she recently took over the responsibilities of verifying licenses and certifications. She added that she was working on developing a system to check for expirations. Administrative Staff #4 added that as soon as they became aware on 1/7/12 that NA #7's	F 496	have returned as active. 3. All certified nursing assistant licenses are verified prior to the first day of employment. Certified nursing assistant with inactive licenses will not be able to start employment until licenses have been activated. Measures and Systemic Changes 1. All new employee Licenses are validated prior to the first day of work. 2 The Administrator is required to sign off on all new employee files prior to their first day work to validate the, license verification have been completed and received. 3 Current Employees Licenses are validated the month prior to their expiration. 4. Certified Nursing Assistants are not placed on the schedule to work if they allow their license to lapse. 5. The Clinical Competency Coordinator is responsible to maintain all certified nursing assistant licenses and monitor expiration dates. Monitoring: 1. All audited findings from the Administrator audits related to the pre-employment screening process will be reviewed in the monthly Performance Improvement committee meeting for patterns and trends and further interventions developed	

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F 496	Continued From page 43 registration was expired, they released her from her duties and sent her home. On 1/7/12 at 6:30pm, Administrative Staff #4 produced a copy of NA #7's time card which documented that she worked on 1/6/12 from 5:59am to 2:02pm and on 1/7/12 from 6:10am to 8:32am. 2. On 1/7/2012, a record review was conducted of the employee personnel files. Nurse Aide #8 (NA #8) was hired on 9/6/2011. His registration expired on 12/31/2011. A copy of the Nurse Aide I Registry Verification of Listings revealed that his registration was last verified on 12/6/11. The daily nursing assignments for 1/6/12, were reviewed and it revealed that NA #8 was on the schedule for 2nd shift (2:00pm-10:00pm) and had worked his assignment. On 1/7/12 at 4:00pm, the Administrative Staffs #4 and #5 were informed that NA #8's registration expired on 12/31/11 and continued to work with residents. They were asked if they had any new documentation that showed that NA #8's registration had been renewed. Administrative Staff #5 shared that she recently took over the responsibilities of verifying licenses and certifications. She added that she was working on developing a system to check for expirations. Administrative Staff #4 added that yesterday, they realized that NA #8's registration was expired, and released him from his duties and sent him home. On 1/7/12 at 6:30pm, Administrative Staff #4 produced a copy of NA #8's time card which	F 496	as necessary to ensure continued compliance. 2. The Clinical Competency Coordinator will audit all certified nursing assistant licensure monthly and report findings to the performance improvement committee for patterns and trends and further interventions developed to ensure continues compliance.	

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F 496	Continued From page 44 documented that he worked on 1/2/12 from 1:54pm to 10:01pm; 1/2/12 from 2:15pm to 8:38pm and 9:16pm to 10:01pm; 1/4/12 from 1:58pm to 10:08pm and on 1/6/12 from 2:03pm to 2:12pm.	F 496		