STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	C 07/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and physician interviews, the facility failed to alert the	F 157	F157 1. Corrective action has been accomplished for the alleged deficient practice related to Resident #7. Resident #7's physician was notified on July 12, 2012 of a change in the status of the resident's pressure ulcer by the licensed nurse assigned to the resident. New orders were obtained and implemented for treatment of pressure ulcers on July 12, 2012. The residents care plan was reviewed and updated as necessary by the Interdisciplinary Team (IDT) on July 16, 2012, July 30, 2012 and August 2, 2012. 2. Facility residents with changes in condition of pressure ulcers have the potential to be affected by the alleged deficient practice. On or before August 24, 2012, the Interim Director of Nursing (IDON) Assistant Director of Nursing (ADON), RN Admissions Nurse or other assigned licensed nurse will conduct a medical record audit and review of the 72 hour resident status report to identify changes in condition of pressure ulcers from July 1, 2012 forward to ensure that the physician and/or resident/ responsible party has been notified of the change. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: New or changed physician orders, change in condition documentation, 72 hour " Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	7/12/12 8/24/12 8/24/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/8/12

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

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F 157	Continued From page 1 resident ' s physician after discovering that 1 of 3 residents (Resident #7) with pressure ulcers, condition worsened. The findings include: Resident #7 was admitted to the facility on 6/18/12 with the following cumulative diagnoses: dementia, peripheral vascular disease, irritable bowel syndrome, urinary retention and anemia. On his admission Minimum Data Set (MDS), 6/25/12, he was assessed as having short term memory loss and modified independence with his daily decision making. He showed no resistance to care and needed extensive assistance for transfers and bed mobility. He was continent of bowel and used a catheter. Resident #7 did not have a pressure ulcer at the time of his admission or MDS assessment. The Nursing Admission Assessment to identify pressure sore risks was reviewed. It indicated that on the following dates, 6/18/12, 6/25/12, 7/2/12 and 7/9/12, Resident # 7 received a score of 16 each time, which placed him in the Mild Risk (15-18) category. A review of the care plan dated 6/26/12 revealed Resident # 7 had a potential for pressure ulcers due to decreased activity and impaired mobility, impaired diffuse or localized blood flow. The goal included to ensure that Resident # 7 would have intact skin without signs of skin breakdown through the next review in 90 days. Approaches to be used included: Apply a pressure reduction mattress to the bed, reposition in chair frequently for comfort and pressure reduction, turn and reposition while in bed frequently for comfort and	F 157	resident status report, weekly skin checks will be reviewed by the IDON, ADON, Admissions Nurse, RN Supervisor or other assigned licensed nurse daily Monday thru Friday during the morning meeting. The weekend supervisor will monitor weekend changes in condition and ensure timely notification of the residents' physician, resident/responsible party with documentation of the notification as well as any new orders/instructions. The IDON, ADON, Admissions Nurse, RN Supervisor or other assigned licensed nurse will validate that notification of physician and resident/ responsible party is documented by reconciliation of weekly skin checks, new orders, 72 hour report with the resident's medical record, daily for 30 days, then daily, Monday through Friday, for 1 month, then a minimum of 5 records weekly for 1 month. Negative findings will be addressed and corrected upon discovery. The frequency of the reconciliation will be reviewed at the end of this time to determine future frequency. Mandatory in-service will be conducted by the IDON, ADON, Admissions Nurse or RN Supervisor entitled "Notification of Change" for licensed nurses to include the importance notifying the resident's physician and responsible party of any changes. Training will be conducted on or before August 24, 2012. Nurses not trained by August 24, 2012 will not be allowed to assume their duties until the **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 157	Continued From page 2 pressure reduction, provide incontinence care after each incontinence episode, complete a full body check weekly and document, monitor lab values as ordered and referrals to physical, occupational and speech therapy as well as referral to physician. A review of the "Nursing Daily Skilled Summary" dated 6/30/12 revealed a coccyx was noted to be "excoriated (removal of skin); note new orders." On 7/1/12 at 2:40 pm, a nurse's note (Nurse # 9) on the skilled summary sheet indicated on the coccyx, right inner buttocks noted to be open 2.5cm (centimeters) x 1.5cm wound bed red/purple. Peri wound red/white with small amount of red drainage, no odor noted. The right buttock 1.5cm x 2.0cm, wound bed red/purple. Peri wound red/white with small amount of red drainage. Cleansed coccyx and right buttock with normal saline. Applied excuderm, see new order and continue to monitor. Nurse # 9 indicated in her notes that the responsible party and physician were informed. On 7/5/12, the Weekly Pressure Ulcer Record, completed by the Assistant Director of Nursing, documented that Resident # 7's sacrum measured 2.5cm x 1.5cm, with no depth and no undermining. It had serous exudate (an oozing protein fluid) of a scant amount, with a red wound bed and pink color normal surrounding tissue. She checked that there was pain related to the wound and that there were no new orders for treatment. Under her progress notes, she indicated that she would continue to monitor and use an air mattress as an intervention.	F 157	training has been completed. Training for newly hired licensed nurses regarding physician and resident/family notification will be incorporated in the facility's orientation program. 4. The IDON/ADON or other assigned administrative nurse will review data related to pressure ulcers, new orders, changes in condition, 72 hour report weekly for 4 weeks and then monthly thereafter for patterns/trends and report in QA/PI (Quality Assurance/ Performance Improvement) meeting weekly for 4 weeks and then monthly for 2 months thereafter. The QA/PI Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to ensure continued compliance. " Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	8/24/12

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F 157	Continued From page 3 Nurse # 6 was present during an observation of Resident # 7's wound care on 7/12/12 at 8:45am. At 9:00 am she shared that she last provided care to Resident # 7 a week ago and at that time his wound was red and superficial, with no yellow or black colors. She expressed that the current treatment wasn't doing any good. She stated that now his largest wound was yellow and black and had increased in size. The surrounding tissue was red. The coccyx measured at 1.9cm x 6.2cm x 0.9cm; the right buttock measured at 1.6cm x 1.9cm and the left buttock measured at 3.0cm x 0.5cm. On 7/12/12, the facility requested that Resident # 7's wound be re-examined by the physician. On 7/12/12 at 11:25 am, Nurse #2 was interviewed. He shared that at the time of discovering a skin breakdown, he would report the incident, to start an investigation. He would proceed with notifying the doctor so that recommendations and new orders could be given. If the pressure ulcer had black tissue, he shared that he would let the doctor know that it was not getting any better and would ask the doctor to see the resident on his next rounds. He would order blood work to check the protein levels. He shared that black tissue usually indicated necrosis (dying tissue) and an ulcer at Stage III. This normally called for debrieding it and changing the treatment orders to a more frequent dressing change, perhaps daily. On 7/12/12 at 11:40 am, Nurse # 3 was interviewed. She stated that she handled	F 157		

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F 157	Continued From page 4 concerns relating to the worsening of a pressure ulcer, by contacting the physician so that a referral could be made to the wound clinic. She shared that when she noticed that the tissue has turned black, she would expect a more frequent dressing change; perhaps daily. In an interview with the ADON on 7/12/12 at 6:45 pm, she stated that she felt the sacral wound, previously assessed as a Stage II, should be listed as unstageable. Nurse # 5 was interviewed on 7/12/12 at 7:15 pm. She commented that she changed the dressing on Resident # 7 on 7/11/12 and stated that the area looked okay, as this was the first time that she had observed it and could not make a comparison observation. She stated that was no drainage, odor and that she did not measure the area, since someone else did that. Review of the Nursing Daily Skilled Summary from 7/2/12 to 7/11/12 revealed that the physician was not notified again of the condition of Resident # 7's pressure ulcer until 7/12/12. The physician responded to their request to examine Resident # 7 and visited with him while making rounds on 7/13/12 to re-assess his condition. Review of the MD (medical director's) Communication Board for July, 2012, (who was the assigned physician to Resident # 7), documented that no notes were forwarded to the physician about Resident # 7's skin condition. The last note addressed to the MD occurred on 6/29/12 before the discovery of the pressure ulcer.	F 157		

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F 157	Continued From page 5 On 7/13/12 at 11:00 am, the pressure ulcer was again observed with Nurse # 6 and the physician. The nurse and physician felt that the wounds were at stage II as there was no necrosis present, just debris. The physician indicated that if the wound became larger, he would refer Resident # 7 to the wound clinic. Nurse # 6 indicated at 11:15 am that the physician had changed Resident # 7' s blood pressure medication, but the treatment would remain the same for the skin care regimen.	F 157		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff and physician interviews, the facility failed to put prescribed interventions in place (correct air mattress setting , weekly skin checks and physician consultation) to avoid the development of a pressure ulcers for 1 of 3 (Resident # 7) sampled residents. The findings include: Resident # 7 was admitted to the facility on 6/18/12 with the following cumulative diagnoses:	F 314	F 314 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #7. Resident #7's physician was notified on July 12, 2012 of a change in the status of the resident's pressure ulcer by the licensed nurse assigned to the resident. New orders were obtained and implemented for treatment of pressure ulcer on July 12, 2012. Resident # 7 was referred to a wound care specialist for evaluation and treatment. Beginning on July 16, 2012 the resident was evaluated by the wound care specialist and continues to be evaluated and treated by the wound care specialist weekly in the facility. The Registered Dietician (RD) was consulted via telephone on August 2, 2012 and will review the resident's nutritional status in **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	8/24/12

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F 314	Continued From page 6 dementia, peripheral vascular disease, irritable bowel syndrome, urinary retention and anemia. On his admission Minimum Data Set (MDS), 6/25/12, he was assessed as having short term memory loss and modified independence with his daily decision making. He showed no resistance to care and needed extensive assistance for transfers and bed mobility. He was continent of bowel and used a catheter. Resident #7 did not have a pressure ulcer at the time of his admission or MDS assessment. The Nursing Admission Assessment to identify pressure sore risks was reviewed. It indicated that on the following dates, 6/18/12, 6/25/12, 7/2/12 and 7/9/12, Resident # 7 received a score of 16 each time, which placed him in the Mild Risk (15-18) category. On 6/19/12, orders were placed on the Treatment Administration Record, to provide weekly head to skin assessments, each Tuesday. The Head to Toe Skin Checks form was reviewed. There was one note from Nurse # 9, on 6/19/12 that stated that Resident #7 ' s skin was intact and that there was an absence of bruises, skin tears, abrasions or rashes. All preventative measures were in place. There was no data on the form for the following Tuesdays, (6/26/12, 7/3/12 and 7/10/12) when the weekly assessments were due. The Assistant Director of Nursing was interviewed on 7/12/12 at 3:10 pm. She reviewed the Head to Toe Skin Checks form and acknowledged that it lacked evidence of weekly skin assessments being performed. She stated that she does all the measurements of the pressure ulcers in the facility. She stated that Resident # 7 was last	F 314	person on or before August 24, 2012. Recommendations for additional interventions to aid in wound healing made by the RD will be implemented when received. Resident # 7's air mattress settings, based on manufacturer's recommendations, were adjusted based on the resident's current weight. A low air loss pressure mattress was obtained on August 3, 2012 and implemented to further promote healing and to decrease pressure as much as is possible. Resident #7 was referred to a neurologist based on decreased mobility of the lower extremities for assistance in treatment. On August 2, 2012 the resident attended his appointment and further testing was recommended and was scheduled. Resident # 7 was re-evaluated by the therapy staff for seating and positioning to decrease pressure. Current seating was re-evaluated by the Rehab Program Manager and the Physical Therapy Assistant on August 3, 2012, with no changes made to seating. The residents care plan was reviewed and updated as necessary by the Interdisciplinary Team (IDT) on July 16, 2012. Changes to the resident's plan of care have been communicated to the directed care staff via the nursing assistant assignment sheet. 2. Facility residents currently using air mattresses, pressure ulcers or those at risk for the development of pressure ulcers have the potential to be affected by the same alleged **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	8/24/12

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F 314	Continued From page 7 measured by her on 7/5/12 for inner thigh and sacrum wounds and that she had planned to record new measurements today. A review of the care plan dated 6/26/12 revealed Resident # 7 had a potential for pressure ulcers due to decreased activity and impaired mobility, impaired diffuse or localized blood flow. The goal included to ensure that Resident # 7 would have intact skin without signs of skin breakdown through the next review in 90 days. Approaches to be used included: Apply a pressure reduction mattress to the bed, reposition in chair frequently for comfort and pressure reduction, turn and reposition while in bed frequently for comfort and pressure reduction, provide incontinence care after each incontinence episode, complete a full body check weekly and document, monitor lab values as ordered and referrals to physical, occupational and speech therapy as well as referral to physician. On 8/1/12 at 3:20 pm, in a phone interview with Nurse # 10, she stated that the pressure relieving air mattress for Resident # 7 was initiated on 6/26/12. A review of the "Nursing Daily Skilled Summary" dated 6/30/12 revealed a coccyx was noted to be "excoriated (removal of skin); note new orders." On 7/1/12 at 2:40 pm, a nurse's note (Nurse # 9) on the skilled summary sheet indicated on the coccyx, right inner buttocks noted to be open 2.5cm (centimeters) x 1.5cm wound bed red/purple. Peri wound red/white with small amount of red drainage, no odor noted. The right buttock 1.5cm x 2.0cm, wound bed red/purple.	F 314	deficient practice. Residents currently utilizing air mattresses were identified by the Administrator and DON on July 16, 2012. Residents' current weights were verified and air mattress settings adjusted, if needed, based on manufacturer's recommendations. Care plans and nursing assistant assignment sheets were updated to reflect resident current care needs. Facility administrative staff will conduct rounds on a daily basis to ensure air mattress settings remain as recommended by the manufacturer for 30 days and then on a random basis for at least 2 residents per day, Monday through Friday, for 1 month. The facility's administrative staff will then check air mattress settings during scheduled ambassador rounds on an on-going basis and report findings to the Administrator (NHA). 3. Measures put into place to ensure that the alleged deficient practice does not recur include: Newly admitted residents will be assessed by a licensed nurse during the nursing admission assessment, which includes a head-to –toe assessment and the Braden scale to identify both actual skin breakdown and the potential for breakdown based on risk factors. Physicians will be notified of any abnormal skin findings for orders. Based on the results of the assessment and discussion with the physician the facility Interdisciplinary team (IDT) will develop and implement a plan of **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	8/24/12

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F 314	Continued From page 8 Peri wound red/white with small amount of red drainage. Cleansed coccyx and right buttock with normal saline. Applied excuderm, see new order and continue to monitor. Nurse # 9 indicated in her notes that the responsible party and physician were informed. On 7/5/12, the Weekly Pressure Ulcer Record, completed by the Assistant Director of Nursing, documented that Resident # 7's sacrum measured 2.5cm x 1.5cm, with no depth and no undermining. It had serous exudate (an oozing protein fluid) of a scant amount, with a red wound bed and pink color normal surrounding tissue. She checked that there was pain related to the wound and that there were no new orders for treatment. Under her progress notes, she indicated that she would continue to monitor and use an air mattress as an intervention. On 7/12/12 at 8:45 am, Resident # 7 was observed in bed, lying on his back with eyes closed on a pressure relieving air mattress that was set to 10 (firmest). Nurse # 6 was present and was preparing to do his wound care treatment. A chart review revealed his weight as of 7/9/12 was 167.8 pounds. The manufacturer's guidelines on the air mattress, recommended an air setting of 5-6 for an individual weighing the same amount as Resident # 7. Nurse # 6 was interviewed on 7/12/12 at 9:00 am. She shared that she last provided care to Resident # 7 a week ago and at that time his wound was red and superficial, with no yellow or black colors. She expressed that the current treatment wasn't doing any good. Now his largest wound was yellow and black and had increased	F 314	care with interventions aimed at minimizing the risk of skin breakdown and or to promote wound healing. Interventions, including air mattresses, to minimize risk and to promote healing will be communicated to direct care staff utilizing the nursing assistant assignment sheet. The IDT will review assessment findings on the next business day following the resident's admission to the facility on an on-going basis. On an on-going basis weekly skin assessments/ body audits will be conducted by the assigned licensed nurse and results documented on the Treatment Administration record (TAR) once completed. Beginning August 6, 2012 administrative nursing staff to include the IDON, ADON, Admissions Nurse and/or RN Supervisor will validate the completion of the weekly skin assessment/ body audit at least twice weekly for two months and then monthly thereafter. The facility IDT will conduct weekly meetings to review pressure ulcers, including progress of wound healing, continued appropriateness of current interventions, the need for additional interventions and review and update the resident's plan of care as necessary. Administrative staff will conduct rounds on an on-going basis to ensure interventions aimed at pressure ulcer prevention and wound healing have been implemented. By August 7, 2012 the NHA contacted the State's Quality Improvement Organization (QIO) the CCME **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 314	Continued From page 9 in size. The surrounding tissue was red. The coccyx measured at 1.9cmx 6.2cm x 0.9cm; the right buttock measured at 1.6cm x 1.9cm and the left buttock measured at 3.0cm x 0.5cm. On 7/12/12 at 9:30 am, Resident # 7 was viewed lying in bed, on his back. His pressure relieving mattress was still set at 10. The manufacturer's instruction for using the mattress was located at the end of the bed, above the digital setting for firmness. It read that the setting the mattress at 1, was not firm and 10 was the firmest. The setting 10 should be used for an individual weighing 400 pounds. A piece of tape with the numbers 5-6 was on the resident's footboard, next to the manufacturer's guidelines. Resident # 7 remained out of his room, attending therapy at 11:38 am. Despite his absence, the mattress on his bed remained set at 10. At 1:35pm, Resident # 7 was observed sitting in his wheelchair, on a chair cushion. When asked how his bottom felt, he said, "pain". The mattress to his bed remained set at 10. Interviewed was held with Nurse # 3 on 7/12/12 at 11:40 am. She stated that a pressure relieving mattress can be used for residents with pressure ulcers. The mattress setting to her knowledge can be set by the physician or therapist. Normally she found the recommended setting for the mattress documented on the treatment cart or on the appliance. Nursing staff are also expected to turn and reposition the resident every 1 to 2hrs on the alternate side. An interview was held with Nurse Aide # 7 on 7/12/12 at 11:05 am. She stated that some	F 314	for additional education related to pressure ulcers. Mandatory inservice related to Pressure Ulcer Prevention and promoting wound healing will be conducted for nursing staff by the IDON on August 8 and August 9, 2012. The content of this training will include but is not limited to expectations for completion of admission and weekly skin assessments, documentation of skin abnormalities, identifying risk factors for pressure ulcer development utilizing the Braden scale, air mattress settings, body checks during showers and other times of care, reporting new skin problems immediately, notification of physician, nutritional and therapy interventions to promote healing and minimize risk. A directed inservice will be conducted on or before August 24, 2012 by the Wound Care Specialist Physician from VOHRA Wound Physicians Group for licensed nurses to include Pressure Ulcer Prevention and Treatment. Nurses not trained by August 24, 2012 will not be allowed to assume their duties until the training has been completed. Training for newly hired licensed nurses and other nursing staff regarding pressure ulcer prevention will be incorporated in the facility's orientation program beginning August 24, 2012. 4. The IDON/ ADON or other designated administrative licensed nurse will weekly for 4 weeks and then monthly thereafter review data **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	8/24/12

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F 314	Continued From page 10 residents used pressure relieving mattresses that had adjustable firmness. Ordinarily she adjusted the mattress to the firmest position when she performed incontinence care, then softened the mattress when she was done. She did not know the guidelines to set the firmness, stating that she puts the setting back where she found it which was usually halfway in the middle; however, she never based the setting on the resident's weight. On 7/12/12 at 4:00 pm, an observation of Resident # 7 in bed revealed that his mattress setting had been lowered to 6. On 7/12/12 at 5:00 pm, Resident # 7's wound was observed with the (ADON) Assistant Director of Nursing. The measurements she recorded during the observation were: the sacral wound was measured at 4.5cm x 5.0cm and the right inner buttock was 2.0cm x 2.0cm. The sacral wound was pink on the edges, red near the center and some black in the center. The ADON stated that the wound was a stage II. She also indicated that the air pressure on Resident # 7 ' s bed should be set at 5-6; however she was not certain who was responsible for setting the air mattresses. During a follow up interview with the ADON on 7/12/12 at 6:45 pm, she stated that she felt the sacral wound, previously assessed at Stage II, should be listed as unstageable. Review of the Nursing Daily Skilled Summary from 7/2/12 to 7/11/12 revealed that the physician was not notified again of the condition of Resident # 7's pressure ulcer until 7/12/12. On 7/13/12 at 11:00 am, the pressure ulcer was	F 314	obtained during weekly skin assessments, , air mattress setting monitoring , and Physician Communication, analyzing for patterns/trends and reporting in QA/PI meeting weekly for 4 weeks and then monthly for 2 months thereafter. The QA/PI Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to ensure continued compliance. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 314	Continued From page 11 again observed with Nurse # 6 and the physician. The nurse and physician felt that the wounds were at stage II and recommended keeping the skin care treatment orders the same, as there was no necrosis present, just debris. The physician indicated that if the wound became larger, he would refer Resident # 7 to the wound clinic. The DON was interviewed on 7/13/12 at 2:45 pm. She stated that pressure relieving mattresses have a setting to determine firmness, which is based on the resident's weight. She stated that anyone can assess the setting by viewing the guidelines which is listed on the appliance.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to secure catheters to prevent tugging, for 2 of 3 residents (Residents # 7 and # 8) with catheters. The findings include:	F 315	F315 1. Corrective action has been accomplished for the alleged deficient practice in regards to Residents #7 and #8. Foley catheter anchors were obtained and placed for Resident # 7 and Resident #8 on July 12, 2012 by the Assistant Director of Nursing (ADON) to secure foley catheters in place to minimize tugging. 2. Residents with indwelling catheters have the potential to be affected by the same alleged deficient practice. The Administrative nursing staff including the Director of Nursing (DON), **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/12/12 7/12/12

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F 315	Continued From page 12 The facility's undated guidelines on Indwelling Catheter Care and Removal were reviewed. It read under Implementation, "Remove the leg band, or if adhesive tape was used to secure the catheter, remove the adhesive tape. "In addition, the Nursing Alert, suggested, "Provide enough slack before securing the catheter to prevent tension on the tubing, which could injure the urethral lumen or bladder wall." 1. Resident # 8 was admitted to the facility on 12/9/10, and then re-admitted on 6/11/12. Her diagnoses included fibromyalgia, hypertension, urinary retention and anxiety. On the 6/18/12 admission Minimum Data Set (MDS), she was assessed as having moderate cognitive impairments, yet could make her needs known and being non-ambulatory. She used a catheter as well. The Care Plan for Resident # 8 was developed on 6/21/12 for Indwelling Catheter which was related to her urinary retention. Approaches to be used included, "Anchor catheter to prevent excessive tension." On 7/12/12 at 8:55 am, Resident # 8 was observed in bed. She stated that she has had a catheter for a month due to her immobility and problems with her bladder. She stated that whenever, she left the room, staff placed her catheter in a privacy bag and hooked it to her wheelchair. She said, "I'm supposed to have it strapped to my leg but haven't worn it in awhile. I'm not sure the last time it was secured." On 7/12/12 at 9:04 am, Nurse Aide # 5 (NA # 5)	F 315	Assistant Director of Nursing (ADON) and/or the RN Admissions Nurse conducted a physician order audit on July 12, 2012 to identify residents with foley catheters. The administrative nursing staff will review new physician's orders during morning meeting Monday through Friday to identify residents with new indwelling catheters. Once identified foley catheter anchors will be provided. The nursing assistant assignment sheet will be updated to reflect the intervention to ensure communication with direct care staff of resident care needs. Resident Care Plans will be reviewed by the Interdisciplinary Team (IDT) and updated as needed. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: mandatory inservice for nursing staff regarding indwelling catheters, the importance of minimizing the risk of complications related to indwelling catheter use, ensuring indwelling catheters are anchored to prevent pulling/ injury. The administrative nursing staff will review new physician's orders during morning meeting Monday through Friday to identify residents with new indwelling catheters. Once identified foley catheter anchors will be provided. Resident care plans will be reviewed/updated by the IDT when new catheters are identified. The nursing assistant assignment sheet will be updated to reflect the **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	8/6/12

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F 315	Continued From page 13 was interviewed. She was assigned to Resident # 8 and stated that the facility's general policy was to secure the catheter to the leg with a strap, however, she acknowledged that Resident # 8 was not wearing one today. Resident # 8 gave permission to examine her legs, and the catheter tubing was clipped to the bed linen. NA# 6 stated that the nurse's kept the straps to secure the catheters. Nurse Aide # 3 was interviewed on 7/12/12 at 10:25 am. She stated that her duties when performing catheter care were to empty the bag whenever it became half full, to prevent leakage. She shared that when she worked, she never secured the catheters to the leg, which helped to prevent it from dangling. NA# 7 was interviewed on 7/12/12 at 11:02 am. She stated that she has not been assigned to many residents with catheters however; it was never expected of her to anchor the catheter when she provided care. She stated she would clean the tubing, empty the drainage bag every shift and was told to keep the drainage bag in a privacy sack. On 7/12/12 at 11:25 am, Nurse # 2 was interviewed about catheter care. He stated that the catheter tubing should be clipped to a cloth if a leg strap is not available. Securing the tubing helped to prevent non-movement. On 7/12/12 at 11:40 am, Nurse # 3 was interviewed. She shared that it was not a standard practice to secure catheters with a leg strap. She stated that when she had to secure some of the catheters, she found the leg straps in	F 315	intervention to ensure communication with direct care staff of resident care needs to ensure continued compliance. Administrative nursing staff will conduct on-going rounds on a daily basis for 30 days beginning August 6, 2012, then at least twice weekly for 1 month to ensure implementation of anchors. 4. The IDON/ADON or other assigned administrative nurse will review indwelling catheter data for newly admitted and current residents including rounds, new orders, care plans and assignment sheets analyzing weekly for 4 weeks and then monthly for 2 months for patterns/trends and report in QA/PI (Quality Assurance/ Performance Improvement) meeting weekly for 4 weeks and then monthly for 2 months thereafter. The QA/PI Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to ensure continued compliance. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	8/24/12

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F 315	Continued From page 14 the medication room. On 7/12/12 at 4:19 pm, Nurse # 8 was interviewed. She stated that when she performed catheter care she examined the color of the urine, and ensured that the catheter was cleaned properly around the tubing. She stabilized the catheter by clamping the tubing to the bed linen. In the event that the resident moved frequently in bed, she would monitor. She commented that she didn't use a leg strap to secure the catheter. On 7/13/12 at 2:45 pm, the Director of Nursing was interviewed. She stated that catheters should be secured to prevent tugging. 2. Resident # 7 was admitted to the facility on 6/18/12 with the following cumulative diagnoses: dementia, peripheral vascular disease, irritable bowel syndrome, urinary incontinence and hypertension. On the admission Minimum Data Set, 6/25/12 it was noted that he had short term memory problems as well as modified independence for daily decision making. He used a catheter as well. On 6/26/12 his Care Plan was developed for the Indwelling Catheter related to urinary retention. Approaches to be used included: "Secure catheter to facilitate flow of urine maintaining urinary drainage bag below level of bladder." On 7/12/12 at 8:45 am, Resident # 7 was observed lying in bed; a urinary catheter was draining clear, yellow urine. Upon examination, it was revealed that the catheter was not secured.	F 315		

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F 315	Continued From page 15 Nurse Aide # 3 was interviewed on 7/12/12 at 10:25 am. She stated that her duties when performing catheter care were to empty the bag whenever it became half full, to prevent leakage. She shared that when she worked, she never secured the catheters to the leg, which helped to prevent it from dangling. NA# 7 was interviewed on 7/12/12 at 11:02 am. She stated that she has not been assigned to many residents with catheters however; it was never expected of her to anchor the catheter when she provided care. She stated she would clean the tubing, empty the drainage bag every shift and was told to keep the drainage bag in a privacy sack. On 7/12/12 at 11:25 am, Nurse # 2 was interviewed about catheter care. He stated that the catheter tubing should be clipped to a cloth if a leg strap is not available. Securing the tubing helped to prevent non-movement. On 7/12/12 at 11:40 am, Nurse # 3 was interviewed. She shared that it was not a standard practice to secure catheters with a leg strap. She stated that when she had to secure some of the catheters, she found the leg straps in the medication room On 7/12/12 at 4:19 pm, Nurse # 8 was interviewed. She stated that when she performed catheter care she examined the color of the urine, and ensured that the catheter was cleaned properly around the tubing. She stabilized the catheter by clamping the tubing to the bed linen. In the event that the resident moved frequently in bed, she would monitor. She commented that she	F 315		

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F 315	Continued From page 16 didn't use a leg strap to secure the catheter. On 7/13/12 at 2:45 pm, the Director of Nursing was interviewed. She stated that catheters should be secured to prevent tugging.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide continuous supervision for 1 of 3 residents (Resident # 1) who was determined high risk for falls; once they became aware that the self released alarming seat belt malfunctioned. The findings include: Resident # 1 was admitted to the facility on 4/19/12 and re-admitted on 6/18/12 with the following cumulative diagnoses: Alzheimer's disease, cerebral vascular accident, osteoporosis and general muscle weakness. On 4/16/12 an admission's Minimum Data Set (MDS) was performed. It assessed her as having cognitive impairments, needing extensive assistance for transfers as well as limited assistance for ambulating on the unit. She had a known history	F 323	F 323 1. Corrective action has been accomplished for the alleged deficient practice related to supervision to prevent accidents and a malfunctioning seat belt alarm for Resident # 1. Resident # 1's physician was notified following the incident on June 9, 2012 with new orders received and implemented for transfer to an acute care setting for evaluation and treatment. The resident was admitted to the hospital and returned to the facility on June 18, 2012. Upon readmission to the facility the resident was assessed for fall risk potential and an initial plan of care developed and implemented on June 18, 2012. A self-releasing seat belt and bed alarm were ordered and implemented on June 19, 2012. Resident # 1 was evaluated and treatment initiated as deemed appropriate by Physical and Occupational Therapy. The Interdisciplinary Team (IDT) reviewed interventions in place to minimize the risk of falls for the resident during weekly meeting on June 20, 2012. Resident # 1 was discharged from the facility on June 29, 2012. " Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	6/18/12

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F 323	Continued From page 17 of falls, resulting in no injuries. The medical chart was reviewed and indicated that Resident #1 had sustained two falls on 4/9/12 and 5/7/12; neither resulting in injuries. Interventions to be used to prevent reoccurrence included: using a chair and bed alarm, placing her in a low bed, keeping her call light within reach, placing a fall mat on the floor next to her bed and keeping her in view of staff when she was up in her wheelchair. On the Fall Risk Evaluations, dated 4/9/12, 4/16/12, 4/23/12 and 4/30/12 she scored a 14, this placed her in the high risk category. On 4/19/12, a doctor's order for a trial self release alarming seat belt was obtained due to decreased safety awareness and continual attempts to get stand independently. The June, 2012 Medication Administration Record reflected that an anti-anxiety medication was also used as needed when she showed anxiety and agitation that could not be redirected. An 6/9/12 Incident/Accident Report documented that at 3:30 pm, Resident # 1 was heard by Nurse # 2, screaming after a loud noise was heard at the nurse ' s station. Staff rushed to the scene and found her lying on her left side in the fetal position. Resident #1 had tried to ambulate unassisted before the incident. Her wheelchair contained a non-functioning self-release seat belt. On 7/12/12 at 10:40 am, Nurse Aide #1 (NA# 1) was interviewed. She stated that she was assigned to Resident # 1 on 6/9/12 from 7:00 am to 7:00 pm. She shared, that morning around 8:30-9:00 am, after breakfast, she went to adjust	F 323	2. Facility residents at risk for falls and those who use safety devices have the potential to be affected by the same alleged deficient practice. The Administrator identified residents who currently utilize safety devices on July 20, 2012. A review of falls since June 1, 2012 was conducted by the Interim Director of Nursing (IDON) on August 17, 2012 to identify additional residents. An audit was conducted of residents with falls over the previous 60 days to include review of resident care plan interventions and post fall review documentation by the IDON, Registered Nurse, and other members of the IDT on August 1 and August 2, 2012. Resident-care needs for safety devices and fall risk potential were reviewed and updated to reflect current risk factors on or before August 10, 2012 by the IDON, ADON Admissions nurse, or other assigned licensed nurse. Care plans were reviewed and updated as needed on or before August 10, 2012 by members of the Interdisciplinary Team (IDT). Changes in resident fall risk potential and current safety needs were communicated to direct care staff via the nursing assistant assignment sheets. Safety devices including but not limited to seat belts and alarming devices were/will be inspected on or before August 10, 2012 to identify potential malfunctioning / non-functional equipment by the Maintenance Supervisor and/contracted vendors. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	8/24/12

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F 323	Continued From page 18 Resident # 1's seatbelt and noticed that the alarm wasn't working. She stated that it was typical for Resident # 1 to mess with her alarm a lot. Once she discovered that the alarm wasn't working properly she went to tell Nurse # 1, who advised her to keep an eye on Resident # 1. They also brought their concern to the attention of the weekend nurse supervisor, Nurse # 2. NA# 1 commented that she had 11 residents that day, so she took Resident # 1 to the nurse's station after her family members were finished with her visit. She stated that Nurse # 2 was sitting at the nurse's station when she took her down there. On 7/12/12, at 6:15pm, the Administrator presented a typed statement, dated 6/10/12 from NA#1. It read, "On Saturday, June 9th, Resident #1 fell out of her wheelchair. I had been advised by Nurse #1 to keep her in at the nurse's station in high visible area. The chair alarm she had was not working properly. She stood up and nobody could get to her soon enough before she fell." NA# 2 was interviewed on 7/13/12 at 11:17 am. She stated that she was working on the 300 hall on 6/9/12 when she saw the call light on in Resident # 1's room. She stated that she went in the room, close to lunch time and found Resident #1 in bed, with several family members present. They requested that she assist them with moving Resident # 1 from the bed into her wheelchair, which she did. She noticed that the seatbelt was already unfastened in the wheelchair. When she secured the device to Resident # 1, then re-opened it to make sure it was working, it didn't sound. At the point, she stated that she explained	F 323	Incidents/accidents will be reviewed in morning meeting daily Monday through Friday. Post Fall Review and care plan revisions/ updates will be completed for each fall by the IDT. Resident care rounds to include random observation at least daily of compliance with safety measures/devices will be conducted by administrative staff daily for 30 days beginning August 6, 2012, then at least twice weekly for 1 month and then weekly thereafter. The IDT will review falls weekly during IDT meeting. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: Newly admitted residents will be assessed/evaluated for fall risk potential on admission and weekly for 3 weeks, then quarterly thereafter. Residents with falls will be evaluated by the IDT following the fall and interventions currently in place reviewed and updated as needed. The IDT will review residents with falls weekly for a total of 4 weeks following a fall to ensure interventions are working to decrease falls. Fall risk assessments for current residents will be updated by the IDT on or before August 24, 2012, following a fall and then at least quarterly thereafter. Resident safety devices and other resident use equipment will be inspected for functionality as a part of the facility's preventative maintenance program (PM), with equipment inspected prior to being **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	8/24/12

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
	345362	A. BUILDING _____ B. WING _____	C 07/13/2012

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F 323	Continued From page 19 to the family member that she needed to put Resident # 1 back in bed for safety precautions and took the wheelchair to the nurse's station for Nurse # 1 to examine. Nurse # 1 told her to take the wheelchair to the therapy department. The therapist told her that they didn't have an extra seatbelt alarm so she suggested that NA# 2 keep Resident #1 in bed, where an alarm functioned or if they left her up, she would need to be monitored. She commented that monitoring meant that Resident # 1 shouldn't be left by herself and someone would need to sit with her at the nurse's station, at all times. She recalled that the wheelchair's cushion had a working alarm on it. The therapist told NA# 2 that she would write up an order to have the wheelchair self released seat belt alarm evaluated and replaced. At that point, NA# 2 took the chair back to the nurse and informed her of the therapist's direction. Then she explained that she took the chair to NA# 1 who was assigned to Resident # 1 and informed her about the seatbelt alarm not working. On 7/12/12 at 11:30 am, the Rehabilitation Director was interviewed. She stated that the alarms are checked weekly and she accompanied her technician and the admission nurse to check Resident # 1's self released alarming seatbelt on 6/8/12 and it was functioning properly. On 7/12/12 at 11:57 am, the Certified Occupational Therapy Assistant (COTA) was interviewed. She stated that she was on duty, 6/9/12, when NA # 2 came to the therapy	F 323	placed in service and at regular intervals throughout its use in the facility based on recommendations of the PM program. Mandatory inservice will be conducted on or before August 24, 2012 by the IDON for facility staff regarding the facility's falls management system which includes importance ensuring adequate supervision and devices are provided to residents to minimize the risk of accidents/ incidents including the use of devices, types of devices, functionality of resident equipment. In addition a directed inservice for nursing staff will be provided on or before August 24, 2012 and includes the DVD approved by, and obtained from, the State's Department of Health Service Regulation for citations at 483.25(a) and (h)(1-2) involving transfers, ambulation and accidents or falls involving mobility problems. Nursing staff not trained by August 24, 2012 will not be allowed to assume their duties until the training has been completed. Training for newly hired licensed nurses and other nursing staff regarding fall prevention will be incorporated in the facility's orientation program beginning August 24, 2012. Incidents/accidents will be reviewed in morning meeting daily Monday through Friday. Post Fall Review and care plan revisions/ updates will be completed for each fall by the IDT. The Weekend Supervisor will ensure post fall interventions are implemented with **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 323	Continued From page 20 department with Resident # 1's wheelchair. The chair had a self release alarming seat belt attached to it. The alarm should go off when the Velcro was unstripped from the belt, but hers didn't. She explained that underneath the fabric belt are wires, which had loosened. The wires were fed into an alarm box. The device was actually mounted underneath the chair. She was trained to reinstall the device but was not aware that an old self release alarming seat belt was in storage in her supervisor's office. The COTA stated that on 6/9/12 she told NA# 2 to keep the current self release alarming seat belt on the resident as a deterrent to stand up, but to keep her in a high traffic area for monitoring or she should put Resident #1 back to bed, where there was an alarm in place. On 7/12/12 at 6:15 pm, the Administrator presented a typed statement from Nurse # 1 dated 6/10/12 that read, " Family into visit Resident # 1. Got Resident #1 out of bed. Checked alarm, noted not working. Also told family member when you get ready to leave please bring Resident to nurse's station so we can monitor her. Family brought resident to nurse's station and left. Told therapy she needed new alarm because hers wasn't working and reported it to oncoming nurse." Nurse # 2 was interviewed on 7/12/12 at 11:13 am. He stated that last month, he worked at the facility as the weekend supervisor. On 6/9/12, he functioned in that role, however, had to go on the floor to pass meds at 3:00 pm for a nurse who called out.	F 323	recommendations of the IDT as needed beginning August 6, 2012. Licensed nurses will check the placement and functionality of alarms and safety devices during each shift, documenting in the medical record that the check has occurred. The licensed nurse will immediately replace/repair any device that is not functioning appropriately when checked. Equipment noted to be not functional and not repairable by the licensed nurse will be removed from service and replaced. Resident care rounds to include random observation at least daily of compliance with safety measures/devices will be conducted by administrative staff on an on- going basis and will included inspection of safety devices. The IDT will review residents with a risk for falls weekly during IDT meeting. 4. The Interim Director of Nursing, ADON, Admissions Nurse or other assigned licensed nurse will review data obtained during resident care rounds, incident /accident review in morning meeting, analyzing for patterns / trends and reporting in QA/PI meeting weekly for 4 weeks, then monthly for 2 months thereafter, adjusting the above plan as needed based on evaluation of the QA/PI committee for effectiveness of the plan during aforementioned meetings. The QA/PI Committee will develop additional interventions and ensure implementation of **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	8/24/12

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F 323	Continued From page 21 He shared that Resident # 1 wore an alarmed seatbelt once she was gotten up from bed and was ordinarily brought to the nurse's station so that staff could keep an eye on her. On 6/9/12, he learned from Nurse #1 that the alarm wasn't working on her seatbelt. They thought that it had some wires short, preventing it from working properly. To his knowledge, the device had stopped working mid-day on 6/9/12. He recalled that someone brought Resident # 1 down to the nurse's station, to be supervised because she had a habit of always trying to get out of her chair. He was sitting at the nurse's station, making phone calls to businesses that may be able to come to the facility to repair her alarm. He stated that his stature is tall enough, that he could see her while he sat at the nurse's station. He mentioned that she was positioned between the 200-300 halls. Nurse # 2 stated that he kept popping up from his seat to check on her, when he realized that she had removed her seat belt and took a few steps down the hall and fell. He shared that Resident #1 gait was not good at all. On 7/12/12, at 6:15 pm, the Administrator provided a typed statement from Nurse # 2, dated 6/9/12 that read, "I was down the hall doing med pass when I noticed Resident #1 trying to stand unassisted while she was at the nurse's station to be monitored. I went down to try and assist Resident # 1 but she had already fallen onto her left side. Resident # 1 was assessed for injuries. Due to Resident # 1's reaction to movement from present position, was sent to hospital for possible fracture."	F 323	those interventions for negative trends identified to ensure continued compliance. " Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 323	Continued From page 22 The Administrator was interviewed on 7/12/12 at 4:50 pm. He stated Resident # 1 was a busy individual who stayed confused. She needed interventions from staff, to prevent her from falling. They would keep her in proximity to staff, as well as use a self released seat belt, that sounded when unhooked. On 6/9/12, he was told that family members visiting with Resident # 1 told staff that the alarm was not working on her seatbelt. So staff took her to the nurse's station for monitoring. He stated that staff kept her busy with activities at the station, to keep her occupied. When Nurse # 2 stepped away from the nurse's station, he was told that she stood up and fell. On 7/13/12 at 2:45 pm, the DON was interviewed. Regarding Resident # 1, she felt that staff monitored her the best way they could on 6/9/12 by placing her at the nurse ' s station. She commented that although alarms sound to alert others of a resident ' s intent to stand, supervision was still the best way to prevent an accident and in the case of Resident # 1, she felt the fall was unavoidable, since she was in a high traffic area, yet still managed to get up and fall. The hospital's discharge summary, dated 6/18/12 was reviewed. It revealed that on admission, Resident #1 was found to have a urinary tract infection and left femoral neck fracture (hip) fracture. On 6/12/12, her hip was surgically repaired. On 6/18/12, Resident # 1 was re-admitted to the facility, but then transferred to another skilled nursing facility, closer to relatives on 6/29/12.	F 323		