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F 000	INITIAL COMMENTS This complaint investigation survey was initially conducted on 11/29/2011 to 11/30/2011. The survey team returned to the facility on 12/14/2011 to notify the facility of the immediate jeopardy and to validate the facility's corrective action plan.	F 000		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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 observation, resident and staff interviews and medical record reviews, the facility did not address a resident ' s complaints of bilateral leg pain from 4:00 AM until 8:41 AM. The resident called out " my legs are broke " and required hospitalization and the application of leg casts for bilateral lower leg fractures. This was evident for 1 of 3 sampled residents with complaints of pain (Resident #1). Immediate jeopardy began on 11/10/11 when Resident #1 was not assessed or provided relief of multiple complaints of severe leg pain. The immediate jeopardy was corrected on 11/25/11 when the facility completed their resident audits and staff in services. This was cited as past non-compliance. Findings include: Resident #1 was admitted to the facility on	F 224	Past noncompliance: no plan of correction required.	

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

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07/14/11 with DJD (degenerative joint disease) of the right knee and dementia. According to the quarterly MDS (minimum data set) dated 10/17/11 Resident #1 BIMS ' s (brief interview for mental status) indicated that the resident had severe cognitive impairment. The resident was confused at times, but able to make her needs known. Resident #1 required 1 person for assistance for transfers and mobility.

A review of her medication administration record for November 2011 revealed Resident #1 was receiving Tylenol 325 mg po (by mouth) BID (twice a day) for a history of osteoarthritis pain.

A review of the facility standing orders revealed in part: Pain and/or Fever: Tylenol 650 mg (milligrams) po (by mouth) every 4 hours PRN (when necessary) for minor pain. If pain persists more that 24 hours contact the physician.

A review of the Care Plan updated 10/26/11 revealed Resident #1 required one person constant guidance and physical assistance with transferring and mobility due to lack of strength. She was at risk for falls and the bed was placed in the lowest position. Resident #1 had a personal alarm on her bed and in the wheel chair.

An interview on 11/30/11 at 7:20 AM, with MDS RN #1 revealed Resident #1, was alert, oriented during the day and confused in the evening due to " sun downing " (late evening confusion).

An interview on 11/30/11 at 7:30 a.m. with Restorative Aide #1 revealed she provided restorative nursing 6 times a week, Sunday through Friday. She had normal aches and pains

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and she would stop and restart any activity she was doing with encouragement . Resident #1 never screamed during the day and she was a very happy " go lucky " lady.

During an interview on 11/30/11 at 3:45 PM with the DON (director of nursing), she revealed Resident #1 was able to make her needs known.

During an interview with Resident #1 on 12/14/11 at 10:15 AM, she stated " the NA (Nursing assistant) (she was unsure of the name of the NA) hit her (Resident #1 ' s) legs against the side rails of the bed and broke her legs when putting her in the bed. She continued that " I kept calling out for help, but no one helped me. My legs were painful because they were broke. " Resident #1 was unable to recall the time this occurred.

During an interview with NA #1 on 11/30/11 at 6:51 AM she revealed on 11/10/11 at 4:00 AM, NA #1was attempting to transfer the resident back to bed and her knees buckled, NA #1 held the resident by her hips and guided her into the bed to prevent her from falling. NA # 1 demonstrated how she guided the resident to bed. The resident ' s feet were planted on the floor facing NA#1 and she quickly guided the resident by her hips to the right and placed her in the bed which was in the lowest position. NA #1 continued that Resident #1 called out " my legs are broke " . NA #1 informed Nurse #1 that Resident #1 was complaining of pain. She continued that Resident #1 continued to call out the rest of the shift stating " my legs are broke " . NA #1 revealed she did not tell the nurse that the resident almost fell because she did not think it could have caused her pain. NA #1 checked on

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the resident at 6:50 AM before she left and the resident told her that her legs still hurt. NA #1 indicated Resident #1 did get confused at times and called out that she wanted to go home. NA #1 knew Resident #1 was in pain because she was calling out stating, " My legs are broke they hurt. "

A review of the Nurses ' Notes (NN) on 11/10/11 completed by Nurse #1 revealed: " 4:45 AM: Resident confused, yelling out, " Help me Lord!!, my leg is broke " , medicated w/ (with) Tylenol 650 mg po at 4:45 AM, on MD (doctor) list to see today. "

An interview with Nurse #1 on 11/30/11 at 7:30 AM revealed at about 4:45 AM on 11/10/11 she heard Resident #1 calling out " Help me " . Nurse #1 stated Resident #1 was complaining her legs hurt. Nurse #1 continued to pass her meds and when she arrived at Resident #1 ' s room she was calling out " my legs are broke " . Nurse #1 stated she checked the resident ' s record. She did not have an order for pain medication so she gave her Tylenol 650 mg po (This was a facility standing order) at 4:50 AM and told the resident she would have the doctor see her in the morning. She then wrote a note for the doctor to see Resident #1 for complaints of pain. Resident #1 had a history of arthritis. Nurse #1 stated, " I did not ask (Resident #1) why her legs hurt and I did not do an assessment. I assumed it was her arthritis pain. "

An interview on 11/30/11 at 6:45 a.m. with Medication Technician (Med. Tech.) #1 was held. Med. Tech. #1 indicated she was familiar with Resident #1. The Med. Tech continued that she

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was working on the middle hall and Resident #1 lived on the front hall. Med Tech #1 stated (NA #1) never told (Resident #1) was in pain. She continued that she saw Resident #1 at 6:55 a.m. on 11/10/11. She revealed that the resident wanted to get up but she could not because she said her legs were broken. She stated that Resident #1 was a screamer at night but this was different.

An interview with NA #2 on 11/30/11 at 7:05 AM revealed she went to get Resident #1 up for the day, and the resident told her " do not touch my legs they are broke " . Nurse #2 came and assessed the resident; she removed the " derm savers " (a loose-fitting tube that stays in place to protect fragile skin from pressure, friction and minor traumas that result in tears, bruising and minor abrasions) on her legs and saw there was bruising, blue, red and purple discoloration and swelling on to both her shins. The NP came in to assess the resident and x rays were ordered. The resident was sent to the hospital that day.

A NN dated 11/10/11 at 7:44 AM completed by Nurse #2: " (NA #2) requested help with resident during AM ADL (morning activities of daily living); Resident stated she was in pain in both legs; upon assessment, discoloration and swelling in left and right leg. This was reported to NP (nurse practitioner) and charge nurse. "

During an interview with Nurse #2 on 11/29/11 at 4:45 PM she stated she was called to see the resident at 7:15 AM that morning by NA #2 because the resident was complaining her legs hurt. She noted some discoloration and swelling of the resident ' s shins. She (Nurse #2) had to

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cut of the " derm savers " to remove them and she noted diffused redness and swelling to both shins especially the right. She had the NP come and evaluate the resident. The NP ordered x-rays and Vicodin was given for pain. The resident was sent to the hospital for evaluation later that afternoon. She stated she did not get report that any incident had occurred with Resident #1 from the night nurse.

The NN dated 11/10/11 at 8:41AM revealed the NP ordered x rays to right and left legs and Vicodin 5/500 mg po BID for pain.

On 11/29/11 at 5:00 PM an interview with RN Supervisor #1 revealed she went to the resident's room on 11/10/11 in the morning and found the NP (Nurse Practitioner) had evaluated the resident and ordered x-rays. She continued " I looked at the resident ' s legs and they were both bruised in the shin area. They had started to turn yellow. The x-rays were ordered and they confirmed she had fractures of both legs. " She explained Resident #1 could make her needs known too. She continued when the administrator spoke with NA #1 that day, she was present. She indicated NA #1 stated " as the resident started to transfer her knees buckled and I continued to " guide " her to the bed. Immediately, the resident said, "Oh my legs" " . (NA #1) continued, " The resident said the NA broke my legs. (Nurse #1) gave her Tylenol at 4:00 AM, but the resident was still screaming at 7:00 AM. " The RN Supervisor stated " I was told (Nurse # 2), helped (NA #2) because (Resident #1) was complaining of pain in her legs. "

An interview on 11/30/11 at 7:20 a.m. with MDS

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RN #1 revealed she interviewed several residents who complained of hearing loud screaming from Resident #1 during the night of 11/10/11. The MDS RN #1 was unable to provide the names of the residents that complained of Resident #1 calling out.

A review of the Radiology Report dated 11/10/11 revealed in part; " a right knee fracture with no displacement, acute distal tibia and proximal fibula fractures of the right and left lower legs and acute bilateral ankle fractures with swelling and mild displacement. "

The NN dated 11/10/11 at 2:01 PM revealed the resident was transferred to hospital for evaluation.

A review of the hospital x-rays report dated 11/10/11 of the right ankle revealed a displaced fracture of the tibia obliquely (a diagonal fracture of the bone). The x-rays of the right tibia/fibula revealed a displaced (displaced far from their original position because of the sudden twisting of the bones) proximal fibular fracture, the left tibia/fibula revealed a comminuted (this type of fracture occurs when the bone involved in a fracture breaks into at least three or more pieces. This type of fracture is less common but can be difficult to treat because of the complexity created by the break), minimally displaced fracture of the mid shaft of the left tibia and a non-displaced fractures through the proximal shaft of the left fibula. The x-ray of the right knee revealed an oblique fracture involving the proximal fibula. The x-rays of the left knee revealed prominent osteopenia (density bone loss if it continues, it can lead to osteoporosis) with mild degenerative

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changes.
Resident #1 was returned to the facility the same day after a 23 hour stay at the hospital with bilateral casts on her lower extremities. The resident was placed on bed rest.

Review of the incident report dated 11/16/11 at 3:24 PM revealed on 11/10/11 at 4:00 AM Resident #1 had an assisted fall during transfer by NA #1 from chair to bed. The resident ' s level of pain was indicated as " hurts a whole lot " according to the level of pain scale. Results of the x-rays (obtain in the facility) revealed bilateral fractures of her tibia/ fibula and the resident was sent to the hospital.

Review of the investigation summary provided by the administrator on 11/29/11 revealed in part: Resident#1 had an assisted witnessed fall with NA#1 on 11/10/11 at 4a.m.
NA# 1 did not report to the nurse that the resident had an assisted fall while transferring her back to the bed at 4:00 AM on 11/10/11. (Resident#1 ' s legs " buckled as she was being transferred into bed.) "

Review of NA#1 handwritten statement (undated) regarding the fall event that occurred on 11/10/11 revealed " I (referring to NA#1) got a hold to the resident and pushed her onto the bed. Resident started yelling that her legs were broken. "

Review of a typed statement dated 11/11/11 signed by the DON revealed NA#1 used the wrong word of pushing the resident in bed but that NA#1 guided the resident to bed.

Review of Nurse #1 ' s hand written statement

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F 224	Continued From page 8 dated 11/10/11 regarding the events that occurred during her shift with Resident #1 revealed " (NA #1) told me (Resident #1) was complaining about her legs, I heard her yelling out " help me Lord " she told me her legs were broken. I felt she was in pain. I asked (NA#1) what happened? She (NA#1) told me she (NA#1) took the resident to the bathroom and she started carrying on; ; she told (Med Tech #1 Resident #1 had pain) and then she put the resident back to bed. I gave her Tylenol and told her the doctor would see her in the morning. " An interview on 11/30/11 at 7:20 a.m. with MDS RN #1 revealed she interviewed several residents who complained of hearing loud screaming from Resident #1 during the night of 11/10/11. The MDs RN #1 was unable to provide the names of the residents that complained Resident #1 was calling out. Review of MDS RN #1 ' s hand written statement dated 11/11/11 revealed on 11/10/11 around 10:00 AM " I went into Resident #1 ' s room and she stated her legs were hurting and she was unable to get up to her wheelchair. She told me that girl just threw me in the bed. " The investigative report indicated the facility initiated and completed in-services regarding pain assessment, informing the nurse of falls and change in the resident condition from 11/11/11-11/25/11. A review of the facility corrective action was completed on 12/14/11. Corrective Action for Resident #1: An initial report for possibility of resident abuse	F 224		

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was faxed to the DHFS on 11/10/11.
The Chief of Police was notified that the facility had opened an investigation of a possible allegation of abuse on 11/10/11.
Employees providing care to resident on 11/9/11 and 11/10/11 were contacted by the facility and interviewed by administrative staff for relevant information regarding Resident #1.
Thru the interview process, it was determined that Resident #1 ' s initial complaint of pain corresponded to a transfer from the bed side commode to resident ' s bed at approximately 4:00 AM the morning of 11/10/11 by 3rd shift staff.
5-Day follow up report faxed to DHFS on 11-14-11 outlining facility investigation/findings.
Resident #1 did not have any reports of pain in her legs prior to approximately 4:00 AM on 11/10/11.
Resident was transferred from the bed side commode to her own bed by a certified nursing assistant, NA #1 at the time in question as referenced above. Resident was unsure of the employee ' s name; however, the description she provided matches the employee who was assigned to this resident. The employee in question confirmed she had this resident and that she was the employee who transferred Resident #1 from the bed side commode to the bed on the morning of 11/10/11.
Resident had an assisted fall to bed at the time/date in question and in correspondence with the resident ' s report of the event as well.
Resident ' s legs buckled as she was being transferred into bed and the C.N.A. guided resident back into bed to keep her from falling onto the floor.
Resident sustained fractures to her right and left

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tibia/fibula.
Resident was transferred to hospital on 11/10/11 for evaluation and treatment. Via testing, the hospital diagnosed prominent osteopenia in both legs. Hospital determined that resident was not a surgical candidate due to her osteopenia.
As part of the investigation, the facility suspended Resident #1 ' s primary care givers (the nurse and C.N.A.) from the morning of 11/10/11. Suspensions started the same day as the investigation. The employees in question were interviewed by the nursing home administration, notified of the investigation, given an opportunity to provide written statements. Both employees were drug tested and suspended pending the outcome of the investigation.
100% of cognitive residents in facility were interviewed by administration to determine if they had experienced any problems with the C.N.A. in question. None of these residents had any negative information to report when interviewed.
100% of residents in the facility were assessed by the D.O.N. for verbal reports and/or clinical signs or symptoms of pain. There were reports of pain (headache, new surgical patient, etc), but no pain related to transfers. Any reports of pain were reported to that resident ' s nurse for appropriate follow up.
100% staff in-service initiated for nursing staff members related to this investigation, transferring a resident assessing a resident, pain assessment, assisting a resident fall and reporting of an incident.
Pain management and assessment:
Resident that fell - sent to hospital and did not return.
All residents - 100% audit for pain management completed on 11/23/11. No other residents were

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found to have pain without assessment and management.
To audit for residents that may be affected, in an ongoing process:
The DON reviews the 24 hour reports from all nursing units daily Monday thru Friday for acute episodes that were not addressed, and for notification of MD/RP as indicated. Immediate follow up will be taken by the DON for that resident. This will be ongoing, and will be completed by the QI nurse in the absence of the DON.
The corporate nurse reviews the PCC of each resident on a random basis each month. Any areas which indicate a lack of assessment, follow up by nursing, lack of MD/RP notification will receive immediate intervention. The DON/Administrator is to be called, with email to the RVP and VP of nursing. The PCC use of the " High Risk Progress Notes " are used for this audit. The next audit to be done will be 12/19/11. Monthly audits will be done as an ongoing process.
100% all nursing staff were in serviced regarding pain assessment and reporting to the nurse/supervisor by 11/25/11. The in service included MD/RP notification, assessment of the resident, pain assessment and management, for the licensed nurses. The aides were in serviced as to what constitutes a fall, any incident is to be reported to the nurse immediately for their evaluation of the resident.
The in service will be included in the orientation of all licensed nurses and aides beginning with the date of the next new hires. As of today 12/14/11 there have been no new hires.
The audits for pain assessment will continue to be done 100% of all residents and will be done

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F 224	Continued From page 12 weekly X 4 weeks for 1 month, (ending 12/14/11) then monthly on a random basis for 3 months (ending March 14/12). Thereafter it will be on a quarterly basis on random residents. The results will be discussed at the monthly QI meeting to be held on 12/19/11 and monthly thereafter on the fourth Monday of each month for 3 months. The QI committee (Administrator, DON, QI nurse)will monitor for trends of residents not having pain managed. The DON will be responsible for follow up and interventions. The Executive QI meeting (held quarterly) will review the trends and interventions for any additional follow actions. The next Executive QI meeting is scheduled for 1/12/12. The Administrator will be responsible to ensure any follow up action(s) are completed. 100% all nursing staff were in serviced regarding pain assessment and reporting to the nurse/supervisor by 11/25/11. The in service included MD/RP notification, assessment of the resident, pain assessment and management, for the licensed nurses. The aides were in serviced as to what constitutes a fall, any incident is to be reported to the nurse immediately for their evaluation of the resident. Falls Resident that fell was sent out to hospital and did not return. For other Residents that may be effected: Daily stand up meetings are held Monday thru Friday to discuss any incidents with the Administrator, and nursing administration. Any immediate follow up required is taken by the QI nurse. Any resident who experiences a fall/incident are reviewed weekly using the Master Falls Tracking Log. The fall, device, interventions and comments are discussed weekly at the falls	F 224		

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F 224	Continued From page 13 meeting with the QI nurse and DON. The information is given to t he IDT for updates of interventions for care plans. 100% all nursing staff were in serviced regarding pain assessment and reporting to the nurse/supervisor by 11/25/11. The in service included MD/RP notification, assessment of the resident, pain assessment and management, for the licensed nurses. The aides were in serviced as to what constitutes a fall, any incident is to be reported to the nurse immediately for their evaluation of the resident. The in service will be included in the orientation of all licensed nurses and aides beginning with the date of the next new hires. As of today 12/14/11 there have been no new hires. Audits of the falls are done on a weekly basis by the QI nurse and DON. This is an ongoing process and continues. The results will be discussed at the monthly QI meeting to be held on 12/19/11 and monthly thereafter on the fourth Monday of each month for 3 months. The QI committee (Administrator, DON, QI nurse)will monitor for trends of residents not having pain managed. The DON will be responsible for follow up and interventions. The Executive QI meeting (held quarterly) will review the trends and interventions for any additional follow actions. The next Executive QI meeting is scheduled for 1/12/12. The Administrator will be responsible to ensure any follow up action(s) are completed. Validation of Facility ' s Plan of Correction: Validation of the Plan of Correction was completed on 12/14/11. Interviews were held with nursing and administrative staff which revealed they attended recent in services regarding assessing a resident	F 224		

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F 224	Continued From page 14 in pain, notifying a physician of a change in resident ' s condition, assisting a resident with a witnessed fall and reporting an incident to the administrative staff. Staff was able to express the information provided during the in services. On 12/14/11 completed audits were reviewed.	F 224		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and medical record reviews, the facility failed to assess Resident #1 who repeatedly voiced severe legs pain for 1 of 3 sampled residents with complaints of pain. The resident had fractures in bilateral lower extremities. Immediate jeopardy began on 11/10/11 when Resident #1 was not assessed or provided relief of multiple complaints of severe leg pain. The immediate jeopardy was corrected on 11/25/11 when the facility completed their resident audits and staff in services. This was cited as past non-compliance. Findings include: Resident #1 was admitted to the facility on 07/14/11 with DJD (degenerative joint disease) of the right knee and dementia. According to the	F 309	Past noncompliance: no plan of correction required.	

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quarterly MDS (minimum data set) dated 10/17/11 Resident #1 BIMS ' s (brief interview for mental status) indicated that the resident had severe cognitive impairment. The resident was confused at times, but able to make her needs known. Resident #1 required 1 person for assistance for transfers and mobility.

A review of her medication administration record for November 2011 revealed Resident #1 was receiving Tylenol 325 mg po (by mouth) BID (twice a day) for a history of osteoarthritis pain.

A review of the facility standing orders revealed in part: Pain and/or Fever: Tylenol 650 mg (milligrams) po (by mouth) every 4 hours PRN (when necessary) for minor pain. If pain persists more that 24 hours contact the physician.

A review of the Care Plan updated 10/26/11 revealed Resident #1 required one person constant guidance and physical assistance with transferring and mobility due to lack of strength. She was at risk for falls and the bed was placed in the lowest position. Resident #1 had a personal alarm on her bed and in the wheel chair.

An interview on 11/30/11 at 7:20 AM, with MDS RN #1 revealed Resident #1, was alert, oriented during the day and confused in the evening due to " sun downing " (late evening confusion).

An interview on 11/30/11 at 7:30 a.m. with Restorative Aide #1 revealed she provided restorative nursing 6 times a week, Sunday through Friday. She had normal aches and pains and she would stop and restart any activity she was doing with encouragement . Resident #1

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never screamed during the day and she was a very happy " go lucky " lady.

During an interview on 11/30/11 at 3:45 PM with the DON (director of nursing), she revealed Resident #1 was able to make her needs known.

During an interview with Resident #1 on 12/14/11 at 10:15 AM, she stated " the NA (Nursing assistant) (she was unsure of the name of the NA) hit her (Resident #1 ' s) legs against the side rails of the bed and broke her legs when putting her in the bed. She continued that " I kept calling out for help, but no one helped me. My legs were painful because they were broke. " Resident #1 was unable to recall the time this occurred.

During an interview with NA #1 on 11/30/11 at 6:51 AM she revealed on 11/10/11 at 4:00 AM, NA #1was attempting to transfer the resident back to bed and her knees buckled, NA #1 held the resident by her hips and guided her into the bed to prevent her from falling. NA # 1 demonstrated how she guided the resident to bed. The resident ' s feet were planted on the floor facing NA#1 and she quickly guided the resident by her hips to the right and placed her in the bed which was in the lowest position. NA #1 continued that Resident #1 called out " my legs are broke " . NA #1 informed Nurse #1 that Resident #1 was complaining of pain. She continued that Resident #1 continued to call out the rest of the shift stating " my legs are broke " . NA #1 revealed she did not tell the nurse that the resident almost fell because she did not think it could have caused her pain. NA #1 checked on the resident at 6:50 AM before she left and the resident told her that her legs still hurt. NA #1

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indicated Resident #1 did get confused at times and called out that she wanted to go home. NA #1 knew Resident #1 was in pain because she was calling out stating, " My legs are broke they hurt. "

A review of the Nurses ' Notes (NN) on 11/10/11 completed by Nurse #1 revealed: " 4:45 AM: Resident confused, yelling out, " Help me Lord!!, my leg is broke " , medicated w/ (with) Tylenol 650 mg po at 4:45 AM, on MD (doctor) list to see today. "

An interview with Nurse #1 on 11/30/11 at 7:30 AM revealed at about 4:45 AM on 11/10/11 she heard Resident #1 calling out " Help me " . Nurse #1 stated Resident #1 was complaining her legs hurt. Nurse #1 continued to pass her meds and when she arrived at Resident #1 ' s room she was calling out " my legs are broke " . Nurse #1 stated she checked the resident ' s record. She did not have an order for pain medication so she gave her Tylenol 650 mg po (This was a facility standing order) at 4:50 AM and told the resident she would have the doctor see her in the morning. She then wrote a note for the doctor to see Resident #1 for complaints of pain. Resident #1 had a history of arthritis. Nurse #1 stated, " I did not ask (Resident #1) why her legs hurt and I did not do an assessment. I assumed it was her arthritis pain. "

An interview on 11/30/11 at 6:45 a.m. with Medication Technician (Med. Tech.) #1 was held. Med. Tech. #1 indicated she was familiar with Resident #1. The Med. Tech continued that she was working on the middle hall and Resident #1 lived on the front hall. Med Tech #1 stated (NA

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#1) never told (Resident #1) was in pain. She continued that she saw Resident #1 at 6:55 a.m. on 11/10/11. She revealed that the resident wanted to get up but she could not because she said her legs were broken. She stated that Resident #1 was a screamer at night but this was different.

An interview with NA #2 on 11/30/11 at 7:05 AM revealed she went to get Resident #1 up for the day, and the resident told her " do not touch my legs they are broke " . Nurse #2 came and assessed the resident; she removed the " derm savers " (a loose-fitting tube that stays in place to protect fragile skin from pressure, friction and minor traumas that result in tears, bruising and minor abrasions) on her legs and saw there was bruising, blue, red and purple discoloration and swelling on to both her shins. The NP came in to assess the resident and x rays were ordered. The resident was sent to the hospital that day.

A NN dated 11/10/11 at 7:44 AM completed by Nurse #2: " (NA #2) requested help with resident during AM ADL (morning activities of daily living); Resident stated she was in pain in both legs; upon assessment, discoloration and swelling in left and right leg. This was reported to NP (nurse practitioner) and charge nurse. "

During an interview with Nurse #2 on 11/29/11 at 4:45 PM she stated she was called to see the resident at 7:15 AM that morning by NA #2 because the resident was complaining her legs hurt. She noted some discoloration and swelling of the resident ' s shins. She (Nurse #2) had to cut of the " derm savers " to remove them and she noted diffused redness and swelling to both

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shins especially the right. She had the NP come and evaluate the resident. The NP ordered x-rays and Vicodin was given for pain. The resident was sent to the hospital for evaluation later that afternoon. She stated she did not get report that any incident had occurred with Resident #1 from the night nurse.

The NN dated 11/10/11 at 8:41AM revealed the NP ordered x rays to right and left legs and Vicodin 5/500 mg po BID for pain.

On 11/29/11 at 5:00 PM an interview with RN Supervisor #1 revealed she went to the resident's room on 11/10/11 in the morning and found the NP (Nurse Practitioner) had evaluated the resident and ordered x-rays. She continued " I looked at the resident ' s legs and they were both bruised in the shin area. They had started to turn yellow. The x-rays were ordered and they confirmed she had fractures of both legs. " She explained Resident #1 could make her needs known too. She continued when the administrator spoke with NA #1 that day, she was present. She indicated NA #1 stated " as the resident started to transfer her knees buckled and I continued to " guide " her to the bed. Immediately, the resident said, "Oh my legs" " . (NA #1) continued, " The resident said the NA broke my legs. (Nurse #1) gave her Tylenol at 4:00 AM, but the resident was still screaming at 7:00 AM. " The RN Supervisor stated " I was told (Nurse # 2), helped (NA #2) because (Resident #1) was complaining of pain in her legs. "

An interview on 11/30/11 at 7:20 a.m. with MDS RN #1 revealed she interviewed several residents who complained of hearing loud screaming from

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Resident #1 during the night of 11/10/11. The MDS RN #1 was unable to provide the names of the residents that complained of Resident #1 calling out.

A review of the Radiology Report dated 11/10/11 revealed in part; " a right knee fracture with no displacement, acute distal tibia and proximal fibula fractures of the right and left lower legs and acute bilateral ankle fractures with swelling and mild displacement. "

The NN dated 11/10/11 at 2:01 PM revealed the resident was transferred to hospital for evaluation.

A review of the hospital x-rays report dated 11/10/11 of the right ankle revealed a displaced fracture of the tibia obliquely (a diagonal fracture of the bone). The x-rays of the right tibia/fibula revealed a displaced (displaced far from their original position because of the sudden twisting of the bones) proximal fibular fracture, the left tibia/fibula revealed a comminuted (this type of fracture occurs when the bone involved in a fracture breaks into at least three or more pieces. This type of fracture is less common but can be difficult to treat because of the complexity created by the break), minimally displaced fracture of the mid shaft of the left tibia and a non-displaced fractures through the proximal shaft of the left fibula. The x-ray of the right knee revealed an oblique fracture involving the proximal fibula. The x-rays of the left knee revealed prominent osteopenia (density bone loss if it continues, it can lead to osteoporosis) with mild degenerative changes.
Resident #1 was returned to the facility the same

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day after a 23 hour stay at the hospital with bilateral casts on her lower extremities. The resident was placed on bed rest.

Review of the incident report dated 11/16/11 at 3:24 PM revealed on 11/10/11 at 4:00 AM Resident #1 had an assisted fall during transfer by NA #1 from chair to bed. The resident ' s level of pain was indicated as " hurts a whole lot " according to the level of pain scale. Results of the x-rays (obtain in the facility) revealed bilateral fractures of her tibia/ fibula and the resident was sent to the hospital.

Review of the investigation summary provided by the administrator on 11/29/11 revealed in part:
Resident#1 had an assisted witnessed fall with NA#1 on 11/10/11 at 4a.m.
NA# 1 did not report to the nurse that the resident had an assisted fall while transferring her back to the bed at 4:00 AM on 11/10/11. (Resident#1 ' s legs " buckled as she was being transferred into bed.) "

Review of NA#1 handwritten statement (undated) regarding the fall event that occurred on 11/10/11 revealed " I (referring to NA#1) got a hold to the resident and pushed her onto the bed. Resident started yelling that her legs were broken. "

Review of a typed statement dated 11/11/11 signed by the DON revealed NA#1 used the wrong word of pushing the resident in bed but that NA#1 guided the resident to bed.

Review of Nurse #1 ' s hand written statement dated 11/10/11 regarding the events that occurred during her shift with Resident #1

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revealed " (NA #1) told me (Resident #1) was complaining about her legs, I heard her yelling out " help me Lord " she told me her legs were broken. I felt she was in pain. I asked (NA#1) what happened? She (NA#1) told me she (NA#1) took the resident to the bathroom and she started carrying on; ; she told (Med Tech #1 Resident #1 had pain) and then she put the resident back to bed. I gave her Tylenol and told her the doctor would see her in the morning. "

An interview on 11/30/11 at 7:20 a.m. with MDS RN #1 revealed she interviewed several residents who complained of hearing loud screaming from Resident #1 during the night of 11/10/11. The MDs RN #1 was unable to provide the names of the residents that complained Resident #1 was calling out.

Review of MDS RN #1 ' s hand written statement dated 11/11/11 revealed on 11/10/11 around 10:00 AM " I went into Resident #1 ' s room and she stated her legs were hurting and she was unable to get up to her wheelchair. She told me that girl just threw me in the bed. "

The investigative report indicated the facility initiated and completed in-services regarding pain assessment, informing the nurse of falls and change in the resident condition from 11/11/11-11/25/11.

A review of the facility corrective action was completed on 12/14/11.
Corrective Action for Resident #1:
An initial report for possibility of resident abuse was faxed to the DHFS on 11/10/11.
The Chief of Police was notified that the facility

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had opened an investigation of a possible allegation of abuse on 11/10/11.
Employees providing care to resident on 11/9/11 and 11/10/11 were contacted by the facility and interviewed by administrative staff for relevant information regarding Resident #1.
Thru the interview process, it was determined that Resident #1 ' s initial complaint of pain corresponded to a transfer from the bed side commode to resident ' s bed at approximately 4:00 AM the morning of 11/10/11 by 3rd shift staff.
5-Day follow up report faxed to DHFS on 11-14-11 outlining facility investigation/findings.
Resident #1 did not have any reports of pain in her legs prior to approximately 4:00 AM on 11/10/11.
Resident was transferred from the bed side commode to her own bed by a certified nursing assistant, NA #1 at the time in question as referenced above. Resident was unsure of the employee ' s name; however, the description she provided matches the employee who was assigned to this resident. The employee in question confirmed she had this resident and that she was the employee who transferred Resident #1 from the bed side commode to the bed on the morning of 11/10/11.
Resident had an assisted fall to bed at the time/date in question and in correspondence with the resident ' s report of the event as well.
Resident ' s legs buckled as she was being transferred into bed and the C.N.A. guided resident back into bed to keep her from falling onto the floor.
Resident sustained fractures to her right and left tibia/fibula.
Resident was transferred to hospital on 11/10/11

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F 309	Continued From page 24 for evaluation and treatment. Via testing, the hospital diagnosed prominent osteopenia in both legs. Hospital determined that resident was not a surgical candidate due to her osteopenia. As part of the investigation, the facility suspended Resident #1 ' s primary care givers (the nurse and C.N.A.) from the morning of 11/10/11. Suspensions started the same day as the investigation. The employees in question were interviewed by the nursing home administration, notified of the investigation, given an opportunity to provide written statements. Both employees were drug tested and suspended pending the outcome of the investigation. 100% of cognitive residents in facility were interviewed by administration to determine if they had experienced any problems with the C.N.A. in question. None of these residents had any negative information to report when interviewed. 100% of residents in the facility were assessed by the D.O.N. for verbal reports and/or clinical signs or symptoms of pain. There were reports of pain (headache, new surgical patient, etc), but no pain related to transfers. Any reports of pain were reported to that resident ' s nurse for appropriate follow up. 100% staff in-service initiated for nursing staff members related to this investigation, transferring a resident assessing a resident, pain assessment, assisting a resident fall and reporting of an incident. Pain management and assessment: Resident that fell - sent to hospital and did not return. All residents - 100% audit for pain management completed on 11/23/11. No other residents were found to have pain without assessment and management.	F 309		

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F 309	Continued From page 25 To audit for residents that may be affected, in an ongoing process: The DON reviews the 24 hour reports from all nursing units daily Monday thru Friday for acute episodes that were not addressed, and for notification of MD/RP as indicated. Immediate follow up will be taken by the DON for that resident. This will be ongoing, and will be completed by the QI nurse in the absence of the DON. The corporate nurse reviews the PCC of each resident on a random basis each month. Any areas which indicate a lack of assessment, follow up by nursing, lack of MD/RP notification will receive immediate intervention. The DON/Administrator is to be called, with email to the RVP and VP of nursing. The PCC use of the " High Risk Progress Notes " are used for this audit. The next audit to be done will be 12/19/11. Monthly audits will be done as an ongoing process. 100% all nursing staff were in serviced regarding pain assessment and reporting to the nurse/supervisor by 11/25/11. The in service included MD/RP notification, assessment of the resident, pain assessment and management, for the licensed nurses. The aides were in serviced as to what constitutes a fall, any incident is to be reported to the nurse immediately for their evaluation of the resident. The in service will be included in the orientation of all licensed nurses and aides beginning with the date of the next new hires. As of today 12/14/11 there have been no new hires. The audits for pain assessment will continue to be done 100% of all residents and will be done weekly X 4 weeks for 1 month, (ending 12/14/11) then monthly on a random basis for 3 months	F 309		

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F 309	Continued From page 26 (ending March 14/12). Thereafter it will be on a quarterly basis on random residents. The results will be discussed at the monthly QI meeting to be held on 12/19/11 and monthly thereafter on the fourth Monday of each month for 3 months. The QI committee (Administrator, DON, QI nurse)will monitor for trends of residents not having pain managed. The DON will be responsible for follow up and interventions. The Executive QI meeting (held quarterly) will review the trends and interventions for any additional follow actions. The next Executive QI meeting is scheduled for 1/12/12. The Administrator will be responsible to ensure any follow up action(s) are completed. 100% all nursing staff were in serviced regarding pain assessment and reporting to the nurse/supervisor by 11/25/11. The in service included MD/RP notification, assessment of the resident, pain assessment and management, for the licensed nurses. The aides were in serviced as to what constitutes a fall, any incident is to be reported to the nurse immediately for their evaluation of the resident. Falls Resident that fell was sent out to hospital and did not return. For other Residents that may be effected: Daily stand up meetings are held Monday thru Friday to discuss any incidents with the Administrator, and nursing administration. Any immediate follow up required is taken by the QI nurse. Any resident who experiences a fall/incident are reviewed weekly using the Master Falls Tracking Log. The fall, device, interventions and comments are discussed weekly at the falls meeting with the QI nurse and DON. The information is given to t he IDT for updates of	F 309		

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F 309	Continued From page 27 interventions for care plans. 100% all nursing staff were in serviced regarding pain assessment and reporting to the nurse/supervisor by 11/25/11. The in service included MD/RP notification, assessment of the resident, pain assessment and management, for the licensed nurses. The aides were in serviced as to what constitutes a fall, any incident is to be reported to the nurse immediately for their evaluation of the resident. The in service will be included in the orientation of all licensed nurses and aides beginning with the date of the next new hires. As of today 12/14/11 there have been no new hires. Audits of the falls are done on a weekly basis by the QI nurse and DON. This is an ongoing process and continues. The results will be discussed at the monthly QI meeting to be held on 12/19/11 and monthly thereafter on the fourth Monday of each month for 3 months. The QI committee (Administrator, DON, QI nurse)will monitor for trends of residents not having pain managed. The DON will be responsible for follow up and interventions. The Executive QI meeting (held quarterly) will review the trends and interventions for any additional follow actions. The next Executive QI meeting is scheduled for 1/12/12. The Administrator will be responsible to ensure any follow up action(s) are completed. Validation of Facility ' s Plan of Correction: Validation of the Plan of Correction was completed on 12/14/11. Interviews were held with nursing and administrative staff which revealed they attended recent in services regarding assessing a resident in pain, notifying a physician of a change in resident ' s condition, assisting a resident with a	F 309		

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F 309	Continued From page 28 witnessed fall and reporting an incident to the administrative staff. Staff was able to express the information provided during the in services. On 12/14/11 completed audits were reviewed.	F 309		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Fall Based on observation, resident and staff interviews and medical record reviews, the facility failed to safely transfer Resident #1 from the bedside commode to bed causing the resident to have a witnessed fall that resulted in bilateral leg fractures. This was evident in 1 of 5 sampled residents. Immediate jeopardy began on 11/10/11 when Resident #1 sustained a fall during transfer. The immediate jeopardy was corrected on 11/25/11 when the facility completed their resident audits and staff in services. This was cited as past non-compliance. Findings include: Resident #1 was admitted to the facility on 07/14/11 with DJD (degenerative joint disease) of the right knee and dementia. According to the quarterly MDS (minimum data set) dated	F 323	Past noncompliance: no plan of correction required.	

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10/17/11 Resident #1 BIMS ' s (brief interview for mental status) indicated that the resident had severe cognitive impairment. The resident was confused at times, but able to make her needs known. Resident #1 required 1 person for assistance for transfers and mobility.

A review of the Care Plan updated 10/26/11 revealed Resident #1 required one person constant guidance and physical assistance with transferring and mobility due to lack of strength. She was at risk for falls and the bed was placed in the lowest position. Resident #1 had a personal alarm on her bed and in the wheel chair.

During an interview with Resident #1 on 12/14/11 at 10:15 AM, she stated " the NA (Nursing assistant) (she was unsure of the name of the NA) hit her (Resident #1 ' s) legs against the side rails of the bed and broke her legs when putting her in the bed. She continued that " I kept calling out for help, but no one helped me. My legs were painful because they were broke. " Resident #1 was unable to recall the time this occurred.

During an interview with NA #1 on 11/30/11 at 6:51 AM she revealed on 11/10/11 at 4:00 AM, NA #1 was attempting to transfer the resident back to bed and her knees buckled, NA #1 held the resident by her hips and guided her into the bed to prevent her from falling. NA # 1 demonstrated how she guided the resident to bed. The resident ' s feet were planted on the floor facing NA#1 and she quickly guided the resident by her hips to the right and placed her in the bed which was in the lowest position. NA #1 continued that Resident #1 called out " my legs are broke " . NA #1 informed Nurse #1 that

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Resident #1 was complaining of pain. She continued that Resident #1 continued to call out the rest of the shift stating " my legs are broke " . NA #1 revealed she did not tell the nurse that the resident almost fell because she did not think it could have caused her pain. NA #1 checked on the resident at 6:50 AM before she left and the resident told her that her legs still hurt. NA #1 indicated Resident #1 did get confused at times and called out that she wanted to go home. NA #1 knew Resident #1 was in pain because she was calling out stating, " My legs are broke they hurt. "

A review of the Nurses ' Notes (NN) on 11/10/11 completed by Nurse #1 revealed: " 4:45 AM: Resident confused, yelling out, " Help me Lord!!, my leg is broke " , medicated w/ (with) Tylenol 650 mg po at 4:45 AM, on MD (doctor) list to see today. "

An interview with NA #2 on 11/30/11 at 7:05 AM revealed she went to get Resident #1 up for the day, and the resident told her " do not touch my legs they are broke " . Nurse #2 came and assessed the resident; she removed the " derm savers " (a loose-fitting tube that stays in place to protect fragile skin from pressure, friction and minor traumas that result in tears, bruising and minor abrasions) on her legs and saw there was bruising, blue, red and purple discoloration and swelling on to both her shins. The NP came in to assess the resident and x rays were ordered. The resident was sent to the hospital that day.

A NN dated 11/10/11 at 7:44 AM completed by Nurse #2: " (NA #2) requested help with resident during AM ADL (morning activities of daily living);

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Resident stated she was in pain in both legs; upon assessment, discoloration and swelling in left and right leg. This was reported to NP (nurse practitioner) and charge nurse. "

During an interview with Nurse #2 on 11/29/11 at 4:45 PM she stated she was called to see the resident at 7:15 AM that morning by NA #2 because the resident was complaining her legs hurt. She noted some discoloration and swelling of the resident ' s shins. She (Nurse #2) had to cut of the " derm savers " to remove them and she noted diffused redness and swelling to both shins especially the right. She had the NP come and evaluate the resident. The NP ordered x-rays and Vicodin was given for pain. The resident was sent to the hospital for evaluation later that afternoon. She stated she did not get report that any incident had occurred with Resident #1 from the night nurse.

The NN dated 11/10/11 at 8:41AM revealed the NP ordered x rays to right and left legs and Vicodin 5/500 mg po BID for pain.

On 11/29/11 at 5:00 PM an interview with RN Supervisor #1 revealed she went to the resident's room on 11/10/11 in the morning and found the NP (Nurse Practitioner) had evaluated the resident and ordered x-rays. She continued " I looked at the resident ' s legs and they were both bruised in the shin area. They had started to turn yellow. The x-rays were ordered and they confirmed she had fractures of both legs. " She explained Resident #1 could make her needs known too. She continued when the administrator spoke with NA #1 that day, she was present. She indicated NA #1 stated " as the resident started

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to transfer her knees buckled and I continued to " guide " her to the bed. Immediately, the resident said, "Oh my legs" " . (NA #1) continued, " The resident said the NA broke my legs. (Nurse #1) gave her Tylenol at 4:00 AM, but the resident was still screaming at 7:00 AM. " The RN Supervisor stated " I was told (Nurse # 2), helped (NA #2) because (Resident #1) was complaining of pain in her legs. "

An interview on 11/30/11 at 7:20 a.m. with MDS RN #1 revealed she interviewed several residents who complained of hearing loud screaming from Resident #1 during the night of 11/10/11. The MDS RN #1 was unable to provide the names of the residents that complained of Resident #1 calling out.

A review of the Radiology Report dated 11/10/11 revealed in part; " a right knee fracture with no displacement, acute distal tibia and proximal fibula fractures of the right and left lower legs and acute bilateral ankle fractures with swelling and mild displacement. "

The NN dated 11/10/11 at 2:01 PM revealed the resident was transferred to hospital for evaluation.

A review of the hospital x-rays report dated 11/10/11 of the right ankle revealed a displaced fracture of the tibia obliquely (a diagonal fracture of the bone). The x-rays of the right tibia/fibula revealed a displaced (displaced far from their original position because of the sudden twisting of the bones) proximal fibular fracture, the left tibia/fibula revealed a comminuted (this type of fracture occurs when the bone involved in a

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fracture breaks into at least three or more pieces. This type of fracture is less common but can be difficult to treat because of the complexity created by the break), minimally displaced fracture of the mid shaft of the left tibia and a non-displaced fractures through the proximal shaft of the left fibula. The x-ray of the right knee revealed an oblique fracture involving the proximal fibula. The x-rays of the left knee revealed prominent osteopenia (density bone loss if it continues, it can lead to osteoporosis) with mild degenerative changes.
Resident #1 was returned to the facility the same day after a 23 hour stay at the hospital with bilateral casts on her lower extremities. The resident was placed on bed rest.

Review of the incident report dated 11/16/11 at 3:24 PM revealed on 11/10/11 at 4:00 AM Resident #1 had an assisted fall during transfer by NA #1 from chair to bed. The resident ' s level of pain was indicated as " hurts a whole lot " according to the level of pain scale. Results of the x-rays (obtain in the facility) revealed bilateral fractures of her tibia/ fibula and the resident was sent to the hospital.

Review of the investigation summary provided by the administrator on 11/29/11 revealed in part: Resident#1 had an assisted witnessed fall with NA#1 on 11/10/11 at 4a.m.
NA# 1 did not report to the nurse that the resident had an assisted fall while transferring her back to the bed at 4:00 AM on 11/10/11. (Resident#1 ' s legs " buckled as she was being transferred into bed.) "

Review of NA#1 handwritten statement (undated)

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regarding the fall event that occurred on 11/10/11 revealed " I (referring to NA#1) got a hold to the resident and pushed her onto the bed. Resident started yelling that her legs were broken. "

Review of a typed statement dated 11/11/11 signed by the DON revealed NA#1 used the wrong word of pushing the resident in bed but that NA#1 guided the resident to bed.

Review of Nurse #1 ' s hand written statement dated 11/10/11 regarding the events that occurred during her shift with Resident #1 revealed " (NA #1) told me (Resident #1) was complaining about her legs, I heard her yelling out " help me Lord " she told me her legs were broken. I felt she was in pain. I asked (NA#1) what happened? She (NA#1) told me she (NA#1) took the resident to the bathroom and she started carrying on; ; she told (Med Tech #1 Resident #1 had pain) and then she put the resident back to bed. I gave her Tylenol and told her the doctor would see her in the morning. "

The investigative report indicated the facility initiated and completed in-services regarding pain assessment, informing the nurse of falls and change in the resident condition from 11/11/11-11/25/11.

A review of the facility corrective action was completed on 12/14/11.
Corrective Action for Resident #1:
An initial report for possibility of resident abuse was faxed to the DHFS on 11/10/11.
The Chief of Police was notified that the facility had opened an investigation of a possible allegation of abuse on 11/10/11.

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Employees providing care to resident on 11/9/11 and 11/10/11 were contacted by the facility and interviewed by administrative staff for relevant information regarding Resident #1.
Thru the interview process, it was determined that Resident #1 ' s initial complaint of pain corresponded to a transfer from the bed side commode to resident ' s bed at approximately 4:00 AM the morning of 11/10/11 by 3rd shift staff.
5-Day follow up report faxed to DHFS on 11-14-11 outlining facility investigation/findings.
Resident #1 did not have any reports of pain in her legs prior to approximately 4:00 AM on 11/10/11.
Resident was transferred from the bed side commode to her own bed by a certified nursing assistant, NA #1 at the time in question as referenced above. Resident was unsure of the employee ' s name; however, the description she provided matches the employee who was assigned to this resident. The employee in question confirmed she had this resident and that she was the employee who transferred Resident #1 from the bed side commode to the bed on the morning of 11/10/11.
Resident had an assisted fall to bed at the time/date in question and in correspondence with the resident ' s report of the event as well.
Resident ' s legs buckled as she was being transferred into bed and the C.N.A. guided resident back into bed to keep her from falling onto the floor.
Resident sustained fractures to her right and left tibia/fibula.
Resident was transferred to hospital on 11/10/11 for evaluation and treatment. Via testing, the hospital diagnosed prominent osteopenia in both

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legs. Hospital determined that resident was not a surgical candidate due to her osteopenia.
As part of the investigation, the facility suspended Resident #1 ' s primary care givers (the nurse and C.N.A.) from the morning of 11/10/11. Suspensions started the same day as the investigation. The employees in question were interviewed by the nursing home administration, notified of the investigation, given an opportunity to provide written statements. Both employees were drug tested and suspended pending the outcome of the investigation.
100% of cognitive residents in facility were interviewed by administration to determine if they had experienced any problems with the C.N.A. in question. None of these residents had any negative information to report when interviewed.
100% of residents in the facility were assessed by the D.O.N. for verbal reports and/or clinical signs or symptoms of pain. There were reports of pain (headache, new surgical patient, etc), but no pain related to transfers. Any reports of pain were reported to that resident ' s nurse for appropriate follow up.
100% staff in-service initiated for nursing staff members related to this investigation, transferring a resident assessing a resident, pain assessment, assisting a resident fall and reporting of an incident.
Pain management and assessment:
Resident that fell - sent to hospital and did not return.
All residents - 100% audit for pain management completed on 11/23/11. No other residents were found to have pain without assessment and management.
To audit for residents that may be affected, in an ongoing process:

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	345354	A. BUILDING _____ B. WING _____	C 12/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY GROVE NURSING AND REHABILITATION CENTER	728 PINEY GROVE RD KERNERSVILLE, NC 27284

(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
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The DON reviews the 24 hour reports from all nursing units daily Monday thru Friday for acute episodes that were not addressed, and for notification of MD/RP as indicated. Immediate follow up will be taken by the DON for that resident. This will be ongoing, and will be completed by the QI nurse in the absence of the DON.

The corporate nurse reviews the PCC of each resident on a random basis each month. Any areas which indicate a lack of assessment, follow up by nursing, lack of MD/RP notification will receive immediate intervention. The DON/Administrator is to be called, with email to the RVP and VP of nursing. The PCC use of the " High Risk Progress Notes " are used for this audit. The next audit to be done will be 12/19/11. Monthly audits will be done as an ongoing process.

100% all nursing staff were in serviced regarding pain assessment and reporting to the nurse/supervisor by 11/25/11. The in service included MD/RP notification, assessment of the resident, pain assessment and management, for the licensed nurses. The aides were in serviced as to what constitutes a fall, any incident is to be reported to the nurse immediately for their evaluation of the resident.

The in service will be included in the orientation of all licensed nurses and aides beginning with the date of the next new hires. As of today 12/14/11 there have been no new hires.

The audits for pain assessment will continue to be done 100% of all residents and will be done weekly X 4 weeks for 1 month, (ending 12/14/11) then monthly on a random basis for 3 months (ending March 14/12). Thereafter it will be on a quarterly basis on random residents.

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The results will be discussed at the monthly QI meeting to be held on 12/19/11 and monthly thereafter on the fourth Monday of each month for 3 months. The QI committee (Administrator, DON, QI nurse)will monitor for trends of residents not having pain managed. The DON will be responsible for follow up and interventions.
The Executive QI meeting (held quarterly) will review the trends and interventions for any additional follow actions. The next Executive QI meeting is scheduled for 1/12/12. The Administrator will be responsible to ensure any follow up action(s) are completed.
100% all nursing staff were in serviced regarding pain assessment and reporting to the nurse/supervisor by 11/25/11. The in service included MD/RP notification, assessment of the resident, pain assessment and management, for the licensed nurses. The aides were in serviced as to what constitutes a fall, any incident is to be reported to the nurse immediately for their evaluation of the resident.
Falls
Resident that fell was sent out to hospital and did not return.
For other Residents that may be effected: Daily stand up meetings are held Monday thru Friday to discuss any incidents with the Administrator, and nursing administration. Any immediate follow up required is taken by the QI nurse.
Any resident who experiences a fall/incident are reviewed weekly using the Master Falls Tracking Log. The fall, device, interventions and comments are discussed weekly at the falls meeting with the QI nurse and DON. The information is given to t he IDT for updates of interventions for care plans.
100% all nursing staff were in serviced regarding

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pain assessment and reporting to the nurse/supervisor by 11/25/11. The in service included MD/RP notification, assessment of the resident, pain assessment and management, for the licensed nurses. The aides were in serviced as to what constitutes a fall, any incident is to be reported to the nurse immediately for their evaluation of the resident.
The in service will be included in the orientation of all licensed nurses and aides beginning with the date of the next new hires. As of today 12/14/11 there have been no new hires.
Audits of the falls are done on a weekly basis by the QI nurse and DON. This is an ongoing process and continues. The results will be discussed at the monthly QI meeting to be held on 12/19/11 and monthly thereafter on the fourth Monday of each month for 3 months. The QI committee (Administrator, DON, QI nurse)will monitor for trends of residents not having pain managed. The DON will be responsible for follow up and interventions.
The Executive QI meeting (held quarterly) will review the trends and interventions for any additional follow actions. The next Executive QI meeting is scheduled for 1/12/12. The Administrator will be responsible to ensure any follow up action(s) are completed.
Validation of Facility ' s Plan of Correction:
Validation of the Plan of Correction was completed on 12/14/11.
Interviews were held with nursing and administrative staff which revealed they attended recent in services regarding assessing a resident in pain, notifying a physician of a change in resident ' s condition, assisting a resident with a witnessed fall and reporting an incident to the administrative staff. Staff was able to express the

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F 323	Continued From page 40 information provided during the in services. On 12/14/11 completed audits were reviewed.	F 323		