STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345494	A. BUILDING: ______ B. WING ______	2/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - GASTONIA	**2780 X-RAY DR GASTONIA, NC**

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F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews the facility failed to develop a comprehensive care plan for behaviors related to refusal of medications and resistance of care for 1 of 6 sampled residents. (Resident #25).

The findings included:

Resident #25 was admitted to the facility on 06/09/03 with diagnoses which included thyroid disease, anxiety, depression and Alzheimer's disease.

The most recent quarterly Minimum Data Set (MDS) dated 12/13/12 indicated Resident #25 had short term and long term memory problems and was severely impaired with cognition for daily decision making. The MDS further indicated Resident #25 was totally dependent on staff for activities of daily living (ADL). The MDS also indicated in Section E titled Behavior there were no behavior problems listed.

A review of Medication Administration Records (MARs) dated 12/01/12 through 12/15/12 under a section titled Medication Notes indicated Resident #25 refused medications on 12/03/12 and 12/04/12 during the 3:00 PM - 11:00 PM shift; 12/07/12 during the 3:00 PM - 11:00 PM shift and on 12/15/12 at 6:00 AM.

A review of care plans that were updated on 12/17/12 with problem statements that indicated Resident #25 was at risk for depression, at risk for acute anxiety episodes and had memory and recall problems related to a diagnosis of advanced Alzheimer's disease. There was no care plan with interventions that addressed behaviors related to resistance of care or refusal of medications.

A review of MARs dated 12/17/12 through 12/21/12 under a section titled Medication Notes indicated Resident #25 refused medications on 12/21/12 at 9:00 AM.

A review of a nurse's note dated 12/21/12 at 9:00 AM indicated Resident #25 refused all 9:00 AM

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

The above isolated deficiencies pose no actual harm to the residents

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medications after several attempts.

A review of MARs dated 12/22/12 through 12/25/12 under a section titled Medication Notes indicated Resident #25 refused medications on 12/24/12 and 12/25/12 at 9:00 AM.

A review of a nurse's note dated 12/25/12 at 9:00 AM indicated Resident #25 refused all 9:00 AM medications after several attempts. The notes also indicated Resident #25 was educated on the risks of refusing medications but the resident continued to refuse and the physician was notified.

A review of MARs dated 12/26/12 through 12/31/12 under a section titled Medication Notes indicated Resident #25 refused medications on 12/26/12 and 12/27/12 at 6:00 AM.

A review of MARs dated 01/01/13 through 01/18/13 under a section titled Medications Notes indicated Resident #25 refused medications on 01/01/13 at 6:00 AM and 9:00 AM; 01/08/13 during the 3:00 PM - 11:00 PM shift; 01/10/13 at 6:00 AM; 01/12/13 at 6:00 AM; 01/13/13 at 6:00 AM and 9:00 AM; 01/14/13 at 6:00 AM; 01/15/13 at 6:00 AM and 9:00 AM; 01/17/13 at 9:00 AM and 01/18/13 at 6:00 AM.

A review of a nurse's note dated 01/18/13 at 9:15 AM indicated Resident #25 refused all morning medications after several attempts and the physician was aware.

A review of MARs dated 01/19/13 through 01/30/13 under a section titled Medications Notes indicated Resident #25 refused medications on 01/19/13 at 9:00 AM and 9:00 PM; 01/23/13 at 9:00 AM; 01/24/13 at 9:00 AM; 01/26/13 at 9:00 AM and 9:00 PM; 01/27/13 at 9:00 AM and 9:00 PM and 01/30/13 at 9:00 AM.

A review of a document titled "Point of Care History" dated from 01/19/13 until 02/01/13 indicated Resident #25 was short tempered and was easily annoyed on 1/19/13; 01/22 - 01/26/13; 01/29/13 - 01/31/13; 02/05/13 - 02/06/13; and 02/12/13 - 02/16/13.

A review of a nurse's note dated 02/15/13 at 7:00 AM indicated Resident #25 continued to refuse a medication for thyroid disease after education and persuasion.

A review of a "Resident Care Information Sheet" on 01/18/13 at 11:40 AM revealed the nurse aide care plan for Resident #25 indicated in part that Resident #25 was alert with short term and long term memory problems, was oriented to self but was confused and forgetful. There were no interventions listed for resistance of care.

A review of a notebook titled "Behavior Management" on 02/18/13 at 11:06 AM revealed a sheet of paper with Resident #25's name on it but there was no documentation of any resistance to care or medications.

A review of a 24 hour report notebook on 02/18/13 at 11:08 AM revealed there was no documentation regarding Resident #25's resistance of care or refusal of medications.

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During an interview on 02/07/13 at 5:17 PM with NA #6 she stated she had worked in the facility on weekends and routinely provided care for Resident #25. She explained Resident #25 was one of her more difficult residents because the resident did not want to let staff provide care for her. She further explained Resident #25 did not like to get out of bed, did not like to be bathed and she did not want them to comb her hair because it was very long and it got tangled easily.

During an interview on 02/18/13 at 10:38 AM with NA #1 she stated Resident #25 needed a lot of prompting during care and was often resistant to care. She explained she thought Resident #25 was uncooperative during care because she did not understand what she was expected to do. NA #1 stated Resident #25 was resistant to care during bathing and when they tried to comb her hair. She stated Resident #25 did not like to have her nails trimmed or cleaned so they usually tried to file them but it was a challenge and sometimes very difficult to do. She explained she reported to the nurse when Resident #25 was uncooperative and resistive to care and she documented it in the point of care computer system under ADL care.

During an interview on 02/18/13 at 10:55 AM Nurse #1 stated she was very familiar with Resident #25 and routinely gave medications to her. She explained Resident #25 would not take her medications when the nurse aides (NAs) were in her room because she was distracted by them and at other times she just refused to take her medications. Nurse #1 stated she documented when Resident #25 refused medications on the MAR. She explained Resident #25 had to be prompted when care was provided and sometimes she resisted care and exhibited behaviors. She further explained nursing staff were supposed to document the resident's behaviors in a behavior notebook that was kept at the nurse's station and it should be documented in the resident's chart. She stated the NAs should document in the point of care computer system when the resident exhibited behaviors or was resistive or uncooperative during care.

During an interview on 02/18/13 at 12:23 PM with a MDS nurse she stated she was responsible for the development of care plans. She explained she usually got information from the nurse's notes regarding resident's behaviors and there was a notebook at the nurse's station where behaviors were supposed to be documented. She stated she looked in the nurse's notes for refusals or resistance to care such as refusal of showers and she looked at the MAR to see if the nurse had documented the resident had refused medications. She explained the NAs entered resident care information into a point of care computer system for each resident. She stated she did not look at the point of care information very much because she got information from the nurse's notes. She further explained resident behaviors were supposed to be documented in the Behavior Management notebook and the information was reviewed daily in morning meetings. The MDS nurse verified she attended the morning meetings most of the time unless she was meeting with a family. She explained if nursing staff did not document behaviors in the nurse's notes or in the Behavior Management notebook she would not know about them. The MDS nurse verified she had not seen the refusal of medications on Resident #25's MARs or in the nurse's notes and she had not reviewed the point of care documentation by the NAs. She stated a care plan for behaviors with specific interventions should have been done for Resident #25 but she had not done one for the resident because she was unaware Resident #25 refused medications and was resistant to care.

During an interview on 02/18/13 at 3:26 PM the Director of Nursing (DON) explained any staff member in

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F 279	Continued From Page 3 the facility could document behaviors on the Behavior Management sheets and it was her expectation for the nurse to document interventions. She explained resident information was passed on from shift to shift during report to provide continuity of care. She stated it was her expectation for NAs to document in the point of care computer system and the nurses should document any behaviors that included resistance of care in the nurse's notes but somebody needed to document it in one place or the other. She stated she expected the nurses to document refusal of medications on the MARs and this information should flow to the MDS nurses so it could be used to develop or update the resident's care plans.
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to include the mechanical soft diet on the cumulative physician orders for 1 of 3 residents reviewed for mechanically altered diets. (Resident #47). The findings included: Resident #47 was admitted with failure to thrive, dementia, anxiety, osteoporosis and dysphagia. A physician's telephone order dated 09/07/12 changed her diet to a mechanical soft diet due to Resident #47 having difficulty with chewing tough solids per the speech therapist. Review of the cumulative physician orders for November 2012, December 2012, January 2013 and February 2013 revealed no orders for any type of diet. Resident #47 was observed with a mechanical soft diet on 02/17/13 at 12:51 PM. Interview with the Director of Nursing (DON) revealed that sometimes the cumulative orders included the diet prescribed by the physician and sometimes it did not. She further stated the facility began a new system where the facility generated the physician orders into the computer. Multiple nurses were responsible for the initial input of physician orders. According to the DON, at the end of each month, third shift staff were responsible for reviewing the completeness and accuracy of the orders for the next month. The DON

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F 514	Continued From Page 4 confirmed the diet orders were not included in the past four months.

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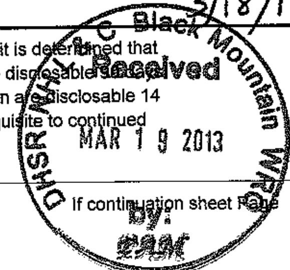
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	F 166	Filing the Plan of Correction does not constitute admission that the deficiencies allged did in fact exist. The Plan of Correction is filed as evidence of the facilities desire to comply with the requirements and to continue to provide quality of care.	
	A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.		Affected Resident	
	This REQUIREMENT is not met as evidenced by: Based on observations, interviews with family and staff, and review of facility grievances, the facility failed to resolve a grievance regarding missing and broken eye glasses for 1 of 3 sampled residents. (Resident #25).		Responsible party for resident #25 requested repair of broken glasses, and only requested replacement of missing glasses if broken glasses could not be repaired.	2/18/2013
			Staff interviews conducted regarding missing eyeglasses.	3/7/2013
	The findings included:		Broken eyeglasses repaired and returned to resident #25.	2/20/2013
	Review of the facility's policy entitled "Filing Grievances/Complaints", revised December 2012, included in part that the administrator has delegated the responsibility of grievances and/or complaint investigation to social services (SS). Upon receipt of a grievance/complaint, SS will investigate the allegations and submit a written report of the findings to the administrator within 5 business days of receiving the grievance/complaint. The administrator will review the findings to determine what corrective action, if any is needed. The person filing the grievance/complaint will be notified of the findings within 5 business days of filing the grievance/complaint.		Responsible party notified of repair of glasses and that they were returned to resident. Responsible party satisfied.	2/20/2013
			Potentially Affected Resident	
			All current residents have the potential to be affected.	
			All residents/resident representatives interviewed regarding outstanding concern/issues.	3/7/2013
			No outstanding concerns identified. Any new concern/grievances were documented and addressed per policy.	
	Resident #25 was admitted to the facility on 06/9/03 with eye glasses.			
	Diagnoses included cataracts, diabetes mellitus			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lydia Kay
TITLE: Administrator
(X6) DATE: 3/18/13



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.

Original Signature Date: 3-8-13

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F 166	Continued From page 1 II, chronic dry eye syndrome and tear film insufficiency. Review of a grievance dated 01/14/13 and filed by the family of Resident #25 revealed the family notified the facility that Resident #25 was missing a pair of eye glasses and the frame of a second pair of eye glasses was broken. The grievance recorded that on 01/14/13, the Resident's room was searched at the family's request, but the eye glasses were not found. The family was notified and told that the facility did not replace glasses. The grievance was signed 02/08/13 by SS staff. Resident #25 was observed on 02/17/13 at 10:43 AM, 11:36 AM, 12:45 PM, 5:30 PM and 5:48 PM and on 02/18/13 at 08:45 AM without wearing her eye glasses. An interview with NA #1 on 02/18/13 at 2:55 PM revealed she cared for Resident #25 for a few months and was accustomed to putting eye glasses on the Resident. NA #1 stated "it has been a while I think her glasses are broken." On 02/18/13 at 2:56 PM NA #1 was observed to go to the Resident's room looked in the top drawer of the Resident's nightstand and removed an eye glass case with a pair of eye glasses. The eye glasses were missing the right temple and tip and the screw located at the hinge. There were two additional empty eye glass cases in the Resident's drawer. NA #1 stated Resident #25 had several pairs of eye glasses which had been missing for over a month, but she had not informed the Resident's nurse. An interview on 02/18/13 at 3:04 PM with Nurse	F 166	Measures/Systemic Changes Administrator in-serviced social worker and social work assistant on concerns/grievances to include: investigation, documentation, follow up with resident/resident representative and logging of concern/grievances. SDC (or designee) in-serviced all staff in all departments i.e. Dietary, Housekeeping, etc. on completing a concern/grievance and submitting it promptly to ensure timely follow up on any concerns, missing items, broken items, etc. In-services initiated 2/19/13. Those staff on leave or on vacation will receive an in-service on completing and submitting any concern/grievances promptly to ensure timely follow up before they begin work again. Social Worker (or designee) to discuss with residents any unresolved concern/grievances during monthly resident council meeting. Any unresolved concern/grievances will be addressed immediately not limited to completion of new concern/grievance form.	2/20/2013 3/18/2013

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F 166	Continued From page 2 #1 who routinely cared for Resident #25 stated she knew the Resident wore eye glasses, but was not sure if the Resident had worn them lately. Nurse #1 located a pair of eye glasses in the top drawer of the Resident's nightstand, looked at them and stated the eye glasses were broken. Nurse #1 stated she had not been informed the Resident's eye glasses were broken; had she known, she would have informed the social worker (SW) so that the Resident could have received assistance with coordinating the repair or replacement of her eye glasses. An interview with the SW on 02/18/13 at 3:18 PM revealed the SS department was responsible for coordinating optometry visits at the facility and provided follow-up to concerns/grievances related to resident's missing/broken items. The SW stated that she was aware that the social worker assistant (SWA) spoke to Resident #25's family regarding a grievance dated 01/14/13 about 2 pairs of eye glasses. The SW stated that the process for the follow-up to the grievance included allowing about 5 days to see if the missing item was located. The SW stated on 02/08/13 she read and signed the grievance form and gave it to the administrator, but could not explain the delay of 28 days before she received the grievance for review and signature. The SW also stated that she discussed the investigation with the SWA and knew that 1 staff person was interviewed about the eye glasses, but in retrospect other staff should have also been interviewed to provide a complete investigation. The SW also stated she was unaware that Resident #25 had a broken pair of eye glasses in her drawer that still needed to be repaired. The SW stated had she known she would have	F 166	Monitoring An audit tool was developed to monitor timely follow up of all concern/grievances. Administrator (or designee) to conduct interviews weekly of 10 residents/resident representatives for 4 weeks and monthly for 2 months. Continued audits will be determined based on the results of the prior 3 months of auditing. Results from audits and resident council minutes wil be reviewed ongoing by the Quality Assurance Committee during the Quarterly Quality Assurance Committee meeting.	3/7/2013

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F 166	Continued From page 3 contacted the family to see if they wanted to have the glasses repaired and informed the family they would be billed for the expense. The SW stated that since this investigation did not include interviews with other staff, it would be difficult to determine what happened to the Resident's glasses now. The SW stated she did not know if the facility's collection of lost resident items had also been searched. An interview with the SWA occurred on 02/18/13 at 3:32 PM and revealed that on 01/14/13, the family of Resident #25 spoke to her regarding 2 pairs of eye glasses. One pair was broken and left in the Resident's nightstand and one pair was missing. The SWA searched the Resident's room for the missing pair of eye glasses. The SWA stated she looked only in the Resident's nightstand, closet, drawers, and under the bed. The SWA also asked the Resident's first shift nurse aide about the eye glasses, and then wrote up the grievance that the eye glasses could not be found. The SWA then stated she did locate the broken pair of eye glasses in the nightstand and placed them back in the drawer. The SWA stated after searching the Resident's room and talking to the nurse aide, she contacted the family back, the same day and informed that the missing pair of eye glasses could not be located and the family could repair the broken pair themselves. She also informed the family that the facility would not pay for the Resident to get new eye glasses. The SWA stated that if she did not record it on the grievance, she did not think additional staff were interviewed as part of the investigation. On 02/18/13 at 4:02 PM, the family of Resident	F 166		

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F 166	Continued From page 4 #25 was interviewed. The family member recalled having a phone conversation with the SWA on 01/14/13. The family stated during the conversation the SWA was told that Resident #25 had a pair of eye glasses in the top drawer of her nightstand which were broken and a pair of eye glasses was also missing. The family granted permission for the Resident's room to be searched, but was told by the SWA that the missing pair of eye glasses was not found. The family stated the Resident's eye glasses were located in the facility's "lost and found" before, but she did not know if this area had also been searched. The family was told to take the broken eye glasses to have them fixed and if needed, the facility could assist the family with getting the Resident a prescription for a new pair of eye glasses. However, the facility would not pay for them. The family stated it was unknown how long the Resident was without her eye glasses and the family would like for the Resident to have her glasses repaired. The family stated they did not live in the area and had not been able to visit the facility recently to pick up the eye glasses for repair. The family stated they did not know they could be billed for the repair. The family stated that when the family visited, the Resident and family read together and looked at family photos, since the Resident had been without her eye glasses, this family activity had not occurred. During an interview with the administrator on 02/18/13 at 4:58 PM, the interview revealed that when the facility received notification of a grievance, the administrator expected the SS department to start the investigation and inform the administrator of the outcome within 5 business days of receipt of the grievance. Once	F 166		

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F 166	Continued From page 5 the administrator was notified, she provided follow-up to the family or resident such that the grievance is resolved in about 5 business days. The administrator stated she received documentation of the grievance regarding missing eye glasses for Resident #25 on last Thursday or Friday (02/14/13 or 02/15/13) and had not yet followed-up. The administrator reviewed the grievance during the interview and stated she had not noticed that the grievance was filed on 01/14/13, over 30 days ago. The administrator stated this grievance was currently unresolved and follow-up had not been provided in a timely manner to the family. The administrator stated that additional staff would be interviewed, the family would be contacted and assistance provided by the facility to facilitate getting Resident #25 a functioning pair of eye glasses.	F 166		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide water with in reach and in a manageable container for 1 of 4 sampled residents. (Resident #47).	F 246	Affected Resident Resident labs prior and after observation reflected no negative outcomes. Water pitcher of resident #47 placed within reach. Manageable container provided to resident #47. Potentially Affected Residents All residents have the potential to be affected. SDC conducted 100% audit of all residents water pitchers. All water pitchers within reach and manageable container available.	2/19/2013 3/7/2013

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	345494	A. BUILDING ______ B. WING ______	C 02/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 246	Continued From page 6 The findings included: Resident #47 was admitted on 11/21/07 and diagnoses included failure to thrive, dementia, and urinary tract infection. The most recent Minimum Data Set (MDS), a quarterly dated 11/28/12, coded her as not finishing the brief interview for mental status. She was also coded as requiring extensive assistance for all activities of daily living except for eating where she was independent after set up. The resident was not listed as interviewable on the list provided by the facility. Resident #47 was observed in bed with her white water pitcher with the lid on top as follows: *02/17/13 at 11:28 AM: The resident was in bed and the water pitcher was on the far side of bedside table over an arm's length away. *02/17/13 at 12:41 PM: The resident was in bed and the water pitcher was on the far side of bedside table over an arm's length away. *02/17/13 at 4:11 PM: The resident was in bed and the water pitcher was on the far side of bedside table over an arm's length away. *02/17/13 at 5:15 PM: The resident was in bed, awake and the water pitcher was on the far side of bedside table over an arm's length away. *02/17/13 at 5:36 PM: The resident was in bed, awake and the water pitcher was on the far side of bedside table over an arm's length away. *02/17/13 at 5:55 PM: The resident drank independently from a small cup of a supplement provided by the nurse. *02/17/13 at 6:01 PM: The resident drank independently the tea served with her meal tray from a small plastic cup with a lid and straw	F 246	Measures/Systemic Changes SDC (or designee) in-serviced nursing staff on items being within reach of residents and reporting needs to appropriate staff regarding residents having manageable containers for hydration. In-services initiated 2/19/13. Any nursing staff on leave or on vacation will receive an in-service on items being within reach of residents and reporting needs to appropriate staff regarding residents having manageable containers for hydration before they begin work again. Lead C.N.A. (or designee) will conduct routine rounds weekly to monitor compliance in this area. Any issues in this area will be discussed by interdisciplinary team during weekly standards meeting and addressed. Monitoring An audit tool was developed to monitor residents water being within reach and in a manageable container. DON (or designee) to conduct weekly audits of 10 residents for 4 weeks and monthly audits for 2 months. Continued audits will be determined based on the results of the prior 3 months of auditing. Results from audits will be reviewed ongoing by the Quality Assurance Committee during the Quarterly Quality Assurance Committee meeting.	3/15/2013 3/7/2013

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F 246	Continued From page 7 without any problems. On 02/17/13 at 6:22 PM, Nurse Aide (NA) #4 stated that she kept the water pitcher over on the bedside table because Resident #47 will spill it if it is within reach. She further stated that if the fluids were in a small cup with a lid and straw, Resident #47 could readily drink independently without spilling it. On 02/18/14 at 2:51 PM, Resident #47 was again in bed, just after receiving care by NA #2. The water pitcher was observed on the bedside table out of her reach. NA #2 was interviewed at this time. NA #2 stated she passed liquids in small cups during the hydration pass. NA #2 stated she did not think Resident #47 could handle the large water pitcher and drink from it. NA #2 stated that if the liquids were provided in small cups and left in front of her, Resident #47 could independently drink from the cup. She further stated that sometimes there were cups in residents' rooms to use. She offered no reason for not ensuring water was in a location and container Resident #47 could access. She stated that she only provided liquids in small cups during hydration pass. Interview with Nurse #2 on 02/18/13 at 3:09 PM revealed it was her expectation that water be left within the reach of each resident. She further stated she was unsure if Resident #47 could access her water from a pitcher, if the pitcher was left within her reach. She stated Resident #47 may need her fluids in small cups and should be left so she could access fluids more often than just at hydration pass.	F 246		

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F 246	Continued From page 8 Interview with the Director of Nursing (DON) on 02/18/13 at 3:44 PM revealed she expected ice and water to be passed every shift via the white pitchers with lids. She further stated that a straw could be placed in the pitcher with the lid in place. The DON further stated that Resident #47's water should be within reach as she can drink independently.	F 246		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to review and revise the care plan relating to falls for 1 of 5 residents	F 280	Affected Residents Resident #196 had no adverse affects related to fall intervention issues. Resident was discharged from facility on 3/1/13. Potentially Affected Residents DON audited all fall investigations for the last 60 days to identify potentially affected residents DON reviewed all fall care plans for interventions. All care plans include appropriate fall interventions. Measures/Systemic Changes SDC (or designee) in-serviced nursing staff on interventions being placed on care plans. In-services initiated 2/19/13. Any nursing staff on leave or on vacation will receive an in-service on interventions being placed on care plans before they begin work again. Interdisciplinary team to review fall care plans during weekly Incident/Accident meeting to monitor that care plans are updated appropriately	3/1/2013 3/7/2013 3/7/2013 3/15/2013

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F 280	Continued From page 9 reviewed for falls. Resident #196's fall care plan did not include all interventions planned including personal alarms and a concave mattress. The findings included: Resident #196 was admitted to the facility on 12/21/12 with diagnoses including pain, bipolar disorder, hypertension and urinary tract infection. The initial Minimum Data Set (MDS) dated 12/28/12 coded her as having moderately impaired cognition, no behaviors, requiring extensive assistance for most activities of daily living skills (ADLS) and having a fall in the previous month. The Care Area Assessments completed on 01/03/13 noted she required reorientation as needed, had recent decline in ADLS, had no falls since admission, was working with therapy, and required extensive assistance with transfers. The immediate care plan developed on 12/21/12 relating to safety included the use of floor mats and therapies as ordered. Review of the nursing notes, incident/accident reports, and interview with the Director of Nursing on 02/18/13 at 1:04 PM revealed the following falls and actions taken: 1. On 01/08/13 at 7:00 PM, Resident #196 was found on the floor after she was heard calling for help. Under actions taken on the incident report was resident education and the use of the bed alarm. The DON stated that the alarm was initially applied at the time of the fall. Per her	F 280	Monitoring An audit tool was developed to monitor fall care plans including interventions. DON (or designee) to conduct weekly audits for 4 weeks and monthly audits for 2 months. Continued audits will be determined based on the results of the prior 3 months of auditing. Results from audits will be reviewed ongoin by the Quality Assurance Committee during the Quarterly Quality Assurance Committee meeting.	3/7/2013

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F 280	Continued From page 10 investigation, the DON stated the resident fell from bed. Once reviewed in morning meeting, the alarm was determined to be appropriate and kept as an intervention. 2. On 01/17/13 at 2:10 AM, Resident #196 was observed sitting on the floor at bedside. The resident told staff she was trying to get into the wheelchair. Neither the incident report nor the nursing notes mentioned if the alarm was on and sounding. Interview with the DON revealed the resident was reminded to call for assistance. The DON further stated that floor mats were added as an intervention at that time as the investigation revealed she fell from bed. The DON stated her investigation did not include if the alarm was in place or sounding. 3. On 01/23/13 at 3:30 AM, Resident #196 was found sitting on the floor. Actions taken revealed a concave mattress. Neither the incident report nor the nursing notes mentioned if the alarm was on and sounding. Per interview with the DON, the resident slid from bed to the floor. She stated her investigation did not indicate if the alarm was on or sounding or the mat was in place. The intervention included the use of a concave mattress. 4. On 02/01/13 at 6:00 PM, Resident #196 was found on the floor beside the bed. The resident stated she was trying to get out of bed and her feet slid. The action noted on the incident report was for resident education. Neither the incident report nor the nursing notes mentioned if the alarm was on and sounding. The DON stated per her investigation the resident landed on the mat per her investigation and was on a concave	F 280		

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F 280	Continued From page 11 mattress. The DON had no information if the alarm was in place. An additional intervention was a therapy referral as the DON stated she wanted them to determine if additional interventions would be appropriate. 5. On 02/06/13 at 5:45 PM, Resident #196 was found sitting on the floor in front of the wheelchair. She stated she had tried to get into bed. Action taken was resident education. Interview with the DON revealed a dycem (a thin nonskid mat) was placed in her wheelchair. During the review of Resident #196's medical record, the only care plan in the medical record relating to falls was the immediate care plan of 12/21/12. The MDS nurse confirmed the immediate care plan was not the current care plan which was still in the computer. She provided the current care plan on 02/18/13 at 12:21 PM after printing it off her computer. Review of the current care plan dated 01/17/13 and last updated on 02/06/13 addressed the problem of Resident #196 being at risk for falling due to increased sway, neuromuscular retardation and decreased sensory input secondary to the aging process. The goal was for the resident injuries to be minimized. Interventions included: *mats at bedside initiated 01/17/13 *provide proper, well-maintained footwear initiated 01/17/13 *keep bed in lowest position with brakes locked initiated 01/17/13. *therapy referral and resident education added 02/01/13 *dycem in wheelchair added 02/06/13	F 280		

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F 280	Continued From page 12 There was no mention of a concave mattress or personal alarms. Observations revealed there were no mats in use or in the room and no concave mattress was on the bed during observations of Resident #196 in bed as follows: *On 02/17/13 at 4:22 PM, at 4:38 PM, at 5:13 PM, at 5:34 PM, and at 6:05 PM. *On 02/18/13 at 8:05 PM, at 8:54 AM, at 9:37 AM, at 10:45 AM, and at 11:43 AM. On 02/18/13 at 11:53 AM, NA #3 stated that she did not recall ever seeing any mats in the room and was unaware they were to be in place. On 02/18/13 at 12:21 PM, the MDS nurse stated that she was responsible for ensuring the care plan for falls for Resident #196 was developed and completed with interventions. She stated she updated the care plan based on morning meeting information, review of the actions taken on the incident accident reports and any changes in physician orders. She could not explain why the care plan interventions did not include the concave mattress or pressure alarms. Interview with the DON on 02/18/13 at 1:04 PM revealed that every morning staff reviewed the falls from the previous day and ensured the action taken was appropriate or that a change should be made. Per the DON, the care planned interventions for Resident #196's fall risk should have included the floor mats and concave air mattress. Observations were made with the DON on 02/18/13 at 1:20 PM. Resident #196 was in bed,	F 280		

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F 280	Continued From page 13 no mats were located in the room and no concave mattress was in place.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to keep 1 resident's nails clean and free of debris from a sample of 4 residents reviewed for activities of daily living skills (ADLS). (Resident #196). The findings included: Resident #196 was admitted to the facility on 12/21/12 with diagnoses including pain, bipolar disorder, hypertension and urinary tract infection. The initial Minimum Data Set (MDS) dated 12/28/12 coded her as having moderately impaired cognition, having no behaviors, being independent with eating after set up, and requiring extensive assistance for dressing and hygiene. The Care Area Assessment dated 01/03/13 indicated no care plan for ADLS would be developed. The undated Resident Care Information Sheet	F 312	Affected Resident Resident #25's nails clipped and cleaned. Resident discharged from facility on 3/1/13. Potentially Affected Residents All residents have the potential to be affected. SDC conducted 100% audit of residents nails. All resident's nails are clean and free of debris. Measures/Systemic Changes SDC (or designee) in-serviced nursing staff on nail care being performed routinely and as needed. In-servicce initiated 2/19/13. Any nursing staff on leave or on vacation will receive an in-service on nail care being performed routinely and as needed before they begin work again. Lead C.N.A. (or designee) will conduct routine rounds weekly to monitor compliance in this area. Any issues in this area will be discussed by interdisciplinary team during weekly standards meeting and addressed.	3/1/2013 3/7/2013 3/15/2013

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F 312	Continued From page 14 used by the nurse aides for individual resident needs revealed Resident #196 had long and short term memory impairments and required total care with dressing and grooming. The care sheet stated she could eat independently with set up only. Resident #196 was observed on 02/17/13 at 6:05 PM feeding herself a sandwich while in her room. She was observed with black debris under each of her nails. She was observed using her fingers to help scoop food from bowls onto her spoon and licking her fingers after soiling them in food. On 02/18/13 at 8:05 AM, Resident #196 was observed in bed and her nails remained with heavy black debris under each nail, around the cuticles on each nail. Her hand was smelled of feces. At 8:54 AM, the medication aide set Resident #196 up on the side of the bed for breakfast. The breakfast consisted of bacon, scramble eggs, toast and oatmeal. Resident #196 proceeded to pick up the bacon and with staff assist, make a sandwich out of the toast and bacon using her hands which still had the black debris under the nails and around the cuticles. Staff was not observed making any attempt to wash the resident's hands prior to serving her breakfast tray. On 02/18/13 at 9:37 AM, Resident #196 was in bed eating a grilled cheese sandwich. Nurse #2 brought in some juice for the resident. The resident's nails remained soiled. Her nails remained soiled at 10:45 AM. Interview with Nurse Aide (NA) #3 on 02/18/13 at 11:20 AM revealed Resident #196 was washed	F 312	Monitoring An audit tool was developed to monitor nails being clean and free of debris. DON (or designee) to conduct weekly audits of 10 residents for 4 weeks and monthly for 2 months. Continued audits will be determined based on the results of the prior 3 months of auditing. Results from audits will be reviewed ongoing by the Quality Assurance Committee during the Quarterly Quality Assurance Committee meeting.	3/7/2013

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F 312	Continued From page 15 up and dressed by third shift this morning. When asked what care NA #3 had provided since coming on duty, she replied she had changed her incontinent brief once. On 02/18/13 at 11:43 AM, NA #3 and nurse #2 transferred Resident #196 to the wheelchair for a shower. NA #3 stated she attempted to soak the resident's nails just before the transfer for the shower but she refused. Follow up interview with NA #3 revealed Resident #196 did not like the orange sticks or scissors during nail care but would let them soak her nails for cleanliness but she was uncooperative today. NA #3 stated Resident #196 often had dirty nails from playing in feces and picking at her lip until it bled. NA #3 stated staff were to inform the nurse of any uncooperative behaviors. On 02/18/13 at 1:20 PM, the resident's nails were observed with the Director of Nursing who confirmed they needed to be cleaned and trimmed. She stated she had heard from yesterday's staff that Resident #196 was resistant to having her nails trimmed. She was unaware of how dirty they were. The nurse aide behavior documentation sheets dated 01/19/13 through 02/18/13 were reviewed with the DON. The documentation revealed she was resistive to care only on 01/19/13 and 02/02/13. The documentation for 02/17/13 noted no behaviors when documented on 3:07 AM, 8:18 AM and 3:26 PM. The documentation for 02/18/13 noted no behaviors when documented oat 1:07 AM and 1:53 PM.	F 312		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION	F 313		

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F 313	Continued From page 16 To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with family and staff, and review of grievance records, the facility failed to assist 1 of 3 sampled residents with vision services. Resident #25's eye glasses were broken and assistance had not been provided for repair or replacement. The findings included: Resident #25 was admitted to the facility on 06/9/03 with eye glasses. Diagnoses included cataracts, diabetes mellitus II, chronic dry eye syndrome and tear film insufficiency. A quarterly Minimum Data Set (MDS) dated 12/13/12 assessed Resident #25 with impaired cognition and adequate vision with corrective lenses. Activities the Resident preferred included reading books, newspapers and magazines. Review of a grievance dated 01/14/13 and filed by the family of Resident #25 revealed the family notified the facility that Resident #25 was missing	F 313	Affected Residents Social Worker offered assistance to responsible party of resident #25 in repairing/replacing the broken/missing glasses. Responsible party for resident #25 requested repair of broken glasses, and only requested replacement of missing glasses if broken glasses could not be repaired. Broken eyeglasses repaired and returned to resident #25 at facility expense. Responsible party notified of repair of glasses and that they were returned to resident. Responsible party satisfied. Potentially Affected Residents All residents who utilize glasses has the potential to be affected. DON, SDC and MDS Nurse audited 100% of Nursing Admission Data Forms to identify residents with glasses. All residents who use glasses were checked to ensure that glasses were present and in good repair. All resident's glasses present and in good repair.	2/18/2013 2/18/2013 2/20/2013 2/20/2013 3/7/2013 3/7/2013

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F 313	Continued From page 17	F 313		

a pair of eye glasses and the frame of a second pair of eye glasses was broken. The grievance recorded that on 01/14/13, the Resident's room was searched at the family's request, but the eye glasses were not found. The family was notified and told that the facility did not replace glasses. The grievance was signed 02/08/13 by SS staff.

Resident #25 was observed as follows without wearing her eye glasses:
- 02/17/13 at 10:43 AM, Resident #25 was observed in bed with her eyes closed and the TV on.

- 02/17/13 at 11:36 AM, Resident #25 was observed with a banana and a cup of water on her over bed table. The Resident fed herself independent of staff assistance. The Resident was observed to reach around the banana, touching the table until she located the banana.

- 02/17/13 at 12:45 PM, Resident #25 was observed in bed with her lunch meal tray on the over-bed table. The tray was set up by staff. The Resident was observed to attempt to pick up items off her meal tray by reaching around the item until it was found. She received staff assistance with the meal.

-On 02/17/13 at 5:30 PM, Resident #25 was observed in the activity room sitting near the television; the television was on, but the Resident was observed looking around the room and looking down at her hands.

- On 02/17/13 at 5:48 PM, Resident #25 was observed in the main dining room with her dinner meal. She received a turkey sandwich and

Measures/Systemic Changes

SDC (or designee) in-serviced all staff in all departments i.e. Dietary, Housekeeping, etc. on completing a concern/grievance and submitting it promptly to ensure timely follow up on any concerns, missing items, broken items, etc. In-services initiated 2/19/13. — 3/18/2013

Those staff on leave or on vacation will receive an in-service on completing and submitting any concern/grievances promptly to ensure timely follow up before they begin work again.

Glasses added to the weekly standards meeting to be updated by the Lead C.N.A. (or designee). Lead C.N.A. (or designee) to conduct routine rounds weekly to monitor presence and good repair of glasses. Any issues will be reported to Social Work Department for follow up. — 3/15/2013

Monitoring
An audit tool was developed to monitor that assistive devices used to maintain vision are present and in good repair. — 3/7/2013

Administrator (or designee) to conduct weekly audits of 5 residents for 4 weeks and monthly for 2 months. Continued audits will be determined based on the results of the prior 3 months of auditing.

Results from audits will be reviewed ongoing by the Quality Assurance Committee during the Quarterly Quality Assurance Committee meeting.

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vegetable sticks. Resident #25 was observed to reach for foods by touching the plate multiple times until the food items were found. She received staff assistance with the meal.

- 02/18/13 at 08:45 AM, Resident #25 was observed sitting up in bed receiving assistance with her breakfast meal. Nurse aide (NA) #1 was observed to place the Resident's cup and spoon in the Resident's hand to assist the Resident with feeding herself.

An interview with NA #1 on 02/18/13 at 2:55 PM revealed she cared for Resident #25 for a few months and was accustomed to putting eye glasses on the Resident. NA #1 stated "it has been a while I think her glasses are broken."

On 02/18/13 at 2:56 PM NA #1 was observed to go to the Resident's room looked in the top drawer of the Resident's nightstand and removed an eye glass case with a pair of eye glasses. The eye glasses were missing the right temple and tip and the screw located at the hinge. There were two additional empty eye glass cases in the Resident's drawer. NA #1 stated Resident #25 had several pairs of eye glasses which had been missing for over a month, but she had not informed the Resident's nurse.

An interview on 02/18/13 at 3:04 PM with Nurse #1 who routinely cared for Resident #25 stated she knew the Resident wore eye glasses, but was not sure if the Resident had worn them lately. Nurse #1 located a pair of eye glasses in the top drawer of the Resident's nightstand, looked at them and stated the eye glasses were broken. Nurse #1 stated she had not been informed the

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F 313	Continued From page 19 Resident's eye glasses were broken; had she known, she would have informed the social worker (SW) so that the Resident could have received assistance with coordinating the repair or replacement of her eye glasses. An interview with the SW on 02/18/13 at 3:18 PM revealed the SS department was responsible for coordinating optometry visits at the facility and provided follow-up to concerns/grievances related to resident's missing/broken items. The SW stated that she was aware that the social worker assistant (SWA) spoke to Resident #25's family regarding a grievance dated 01/14/13 about 2 pairs of eye glasses. The SW stated that the process for the follow-up to the grievance included allowing about 5 days to see if the missing item was located. The SW stated on 02/08/13 she read and signed the grievance form and gave it to the administrator. The SW also stated she was unaware that Resident #25 had a broken pair of eye glasses in her drawer that still needed to be repaired. The SW stated had she known she would have contacted the family and explained the options to see what the family wanted to do. An interview with the SWA occurred on 02/18/13 at 3:32 PM and revealed that on 01/14/13, the family of Resident #25 spoke to her regarding 2 pairs of eye glasses. One pair was broken and left in the Resident's nightstand and one pair was missing. The SWA searched the Resident's room for the missing pair of eye glasses. The SWA stated she looked only in the Resident's nightstand, closet, drawers, and under the bed. The SWA also asked the Resident's first shift nurse aide about the eye glasses, and then wrote	F 313		

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F 313	Continued From page 20 up the grievance that the eye glasses could not be found. The SWA then stated she did locate the broken pair of eye glasses in the nightstand and placed them back in the drawer. The SWA stated after searching the Resident's room and talking to the nurse aide, she contacted the family back, the same day and informed that the missing pair of eye glasses could not be located and the facility would not pay for the Resident to get new eye glasses. The SWA further stated that she told the family that they could take the Resident's broken eye glasses to get them repaired, but was not sure if she offered the facility's assistance with the repair. On 02/18/13 at 4:02 PM, the family of Resident #25 was interviewed. The family member recalled having a phone conversation with the SWA on 01/14/13. The family stated during the conversation the SWA was told that Resident #25 had a pair of eye glasses in the top drawer of her nightstand which were broken and a pair of eye glasses was also missing. The family granted permission for the Resident's room to be searched, but was told by the SWA that the missing pair of eye glasses was not found. The family was told to take the broken eye glasses to have them fixed and if needed, the facility could assist the family with getting the Resident a prescription for a new pair of eye glasses. However, the facility would not pay for them. The family stated it was unknown how long the Resident was without her eye glasses and the family would like for the Resident to have her glasses repaired. The family stated they did not live in the area and had not been able to visit the facility recently to pick up the eye glasses for	F 313		

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F 313	Continued From page 21 repair. The family stated they did not know they could be billed for the repair. The family stated that when the family visited, the Resident and family read together and looked at family photos, since the Resident had been without her eye glasses, this family activity had not occurred. During an interview with the administrator on 02/18/13 at 4:58 PM, the interview revealed that when the facility receives notification of a grievance, the administrator expected the social services department to start the investigation and inform the administrator of the outcome within 5 business days of receipt of the grievance. Once the administrator is notified, she provides follow-up to the family or resident such that the grievance is resolved in about 5 business days. The administrator stated she received documentation of the grievance regarding missing eye glasses for Resident #25 on last Thursday or Friday (02/14/13 or 02/15/13) and had not yet followed-up. The administrator reviewed the grievance during the interview and stated she had not noticed that the grievance was filed on 01/14/13, over 30 days ago. The administrator stated this grievance was currently unresolved and follow-up had not been provided in a timely manner to the family. The administrator stated that since the grievance has remained incomplete for more than 30 days, the facility would take full responsibility for replacing the Resident's eye glasses.	F 313		
F 323 SS=D	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	F 323		

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F 323	Continued From page 22 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to implement the planned fall interventions of a concave mattress and floor mats for 1 of 5 sampled residents with falls. (Resident #196). The findings included: Resident #196 was admitted to the facility on 12/21/12 with diagnoses including pain, bipolar disorder, hypertension and urinary tract infection. Review of physician orders included physical therapy was ordered on 12/22/12 for 5 times per week for 4 weeks and occupational therapy was ordered on 12/23/12 for 5 times per week for 8 weeks. The initial Minimum Data Set (MDS) dated 12/28/12 coded her as having moderately impaired cognition, no behaviors, requiring extensive assistance for most activities of daily living skills (ADLS) and having a fall in the previous month. The Care Area Assessments completed on 01/03/13 noted she required reorientation as needed, had recent decline in ADLS, had no falls since admission, was working with therapy, and required extensive assistance with transfers	F 323	Affected Residents Resident #196 had no adverse affects related to fall intervention issues. Resident was discharged from facility on 3/1/13 Potentially Affected Residents DON audited all fall investigations for the last 60 days to identify potentially affected residents. SDC conducted 100% audit of residents with noted interventions for the past 60 days. All residents interventions in place. Measures/Systemic Changes SDC (or designee) in-serviced nursing staff on interventions being in place at all times as indicated. In-services initiated 2/19/13. Any nursing staff on leave or on vacation will receive an in-service on interventions being in place at all times as indicated before they begin work again. Fall interventions was added to the weekly standards meeting to be updated by the Lead C.N.A. (or designee)	3/1/2013 3/7/2013 3/7/2013 3/15/2013

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F 323	Continued From page 23 A fall risk assessment completed 12/21/12 scored Resident #196 as being at high risk for falls. The immediate care plan developed on 12/21/12 included the use of floor mats and therapies as ordered. The undated Resident Care Information Sheet used by the nurse aides (NA) for providing care to each resident revealed the section for restrains/positioning devices (which addressed fall intervention) was blank for Resident #196. This form indicated Resident #196 had long and short memory impairments. Review of physician therapy orders and therapy notes revealed physical therapy was discontinued 01/08/13 and occupation therapy was discontinued on 01/30/13. Both discharge summaries indicated Resident #196 met her maximum potential. Review of the nursing notes, incident/accident reports, and interview with the Director of Nursing on 02/18/13 at 1:04 PM revealed the following falls and actions taken: 1. On 01/08/13 at 7:00 PM, Resident #196 was found on the floor after she was heard calling for help. There were no injuries and a bed alarm was placed on the bed. Under actions taken on the incident report was resident education and the use of the bed alarm. The DON stated that the alarm was initially applied at the time of the fall. Per her investigation, the DON stated the resident fell from bed. Once reviewed in morning meeting, the alarm was determined to be appropriate and kept as an intervention.	F 323	Monitoring An audit tool was developed to monitor that fall interventions appropriately placed. DON (or designee) to conduct weekly audits of 10 residents for 4 weeks and then monthly for 2 months. Continued audits will be determined based on the results of the prior 3 months of auditing. Results from audits will be reviewed ongoing by the Quality Assurance Committee during the Quarterly Quality Assurance Committee meeting.	3/7/2013

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F 323	Continued From page 24 2. On 01/17/13 at 2:10 AM, Resident #196 was observed sitting on the floor at bedside. The resident told staff she was trying to get into the wheelchair. She was noted with skin tears to her toes on the right foot which were treated. The actions taken included first aide and "other." Neither the incident report nor the nursing notes mentioned if the alarm was on and or sounding. Interview with the DON revealed the "other" action meant reminded the resident to call for assistance. The DON further stated that floor mats were added as an intervention at that time. The DON stated her investigation did not include if the alarm was in place or sounding. 3. On 01/23/13 at 3:30 AM, Resident #196 was found sitting on the floor. There was noted bruising and swelling to her left arm and right knee. Actions taken revealed a concave mattress. Neither the incident report nor the nursing notes mentioned if the alarm was on and sounding. Per interview with the DON, the resident slid from bed to the floor. She stated her investigation did not indicate if the alarm was on and or sounding or if the mat was in place. The intervention included the use of a concave mattress. 4. On 02/01/13 at 6:00 PM, Resident #196 was found on the floor beside the bed. The resident stated she was trying to get out of bed and her feet slid. The action noted on the incident report was for resident education. Neither the incident report nor the nursing notes mentioned if the alarm was on and or sounding. The DON stated per her investigation the resident landed on the mat per her investigation and a concave mattress	F 323		

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was in place. The DON had no information if the alarm was in place and or sounding. An additional intervention was a therapy referral as the DON stated she wanted them to determine if additional interventions were appropriate.

5. On 02/06/13 at 5:45 PM, Resident #196 was found sitting on the floor in front of the wheelchair. She stated she had tried to get into bed. Action taken was resident education. Interview with the DON revealed a dycem was placed in her wheelchair.

Review of the care plan dated 01/17/13 and last updated on 02/06/13 addressed the problem of Resident #196 being at risk for falling due to increased sway, neuromuscular retardation and decreased sensory input secondary to the aging process. The goal was for the resident injuries to be minimized. Interventions included:
*mats at bedside initiated 01/17/13
*provide proper, well-maintained footwear initiated 01/17/13
*keep bed in lowest position with brakes locked initiated 01/17/13.
*therapy referral and resident education added 02/01/13
*dycem in wheelchair added 02/06/13

On 02/11/13 a telephone order was obtained for an occupational therapy evaluation only. The evaluation was dated 02/14/13 which identified the resident had numerous falls out of bed and out of the wheelchair. She was evaluated with requiring minimum assistance with transfers. No recommendations for fall prevention were noted in this evaluation.

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F 323	Continued From page 26 Resident #196 was observed as follows: *On 02/17/13 at 4:22 PM and at 4:38 PM, Resident #196 was lying on top of the bed linens, the bed was positioned at regular height, the pressure pad alarm was in a chair and not under the resident, there were no mats on the floor of either side of her bed and her air mattress was not concave. At 5:13 PM and 5:34 PM the pressure pad was observed under her while she remained on top of the bed linens. No mats were observed in place and the mattress was not concave. *On 02/17/13 at 6:05 PM, Resident #196 was sitting on the side of her bed. No mats were on the floor and no concave mattress was on the bed. Resident #196 stated at 6:16 PM that she had never fallen. She could not follow the conversation with appropriate responses. *On 02/18/13 at 8:05 PM. Resident #196 was in bed, the pressure alarm was in place, no mats were on either side of the floor and she was in a regular air mattress. At 8:54 AM she sat on the edge of the bed eating breakfast with no mats on the floor and no concave mattress. At 9:37 AM, the resident was laying in bed and Nurse #1 brought her a grilled cheese and drink. no mats were on the floor nor was there a concave mattress on the bed. At 10:45 AM Resident #196 remained in bed, wearing regular socks and no mats or concave mattress were in place. *On 02/18/13 at 11:43 PM, Resident #196 was in her room, Nurse #1 and Nurse Aide (NA) #3 had just used the sit to stand lift to transfer into her wheelchair. The alarm was in the bed but no	F 323		

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F 323	Continued From page 27 sound was heard. Both Nurse #2 and NA #3 stated the alarm did not sound when they transferred Resident #196 to the wheelchair. NA #3 stated it had sounded earlier in the day. After examining the alarm, it was determined by Nurse #2 that it was malfunctioning. On 02/18/13 at 11:53 AM, NA #3 stated that the alarms had been in place since she had worked with the resident, about one month. NA #3 did not recall ever seeing any mats in the room and was unaware they were to be in place. On 02/18/13 at 12:21 PM, the MDS nurse stated that she was responsible for ensuring the care plan for falls for Resident #196 was developed and completed with interventions. She stated she updated the care plan based on morning meeting information, review of the actions taken on the incident accident reports and any changes in physician orders. She could not explain why the care plan interventions did not include the concave mattress or pressure alarms. Interview with the DON on 02/18/13 at 1:04 PM revealed that every morning staff review the falls from the previous day and ensured the action taken was appropriate or that a change should be made. Per the DON, the care planned interventions for Resident #196's fall risk should have included a concave mattress, mats on both sides of the floor, and a pressure alarm in the bed and in the wheelchair. She further stated that a referral was made for occupational therapy but she had not followed up with occupational therapy to discover what the evaluation results indicated. Observations were made with the DON on 02/18/13 at 1:20 PM. Resident #196 was in bed,	F 323		

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F 323	Continued From page 28 no mats were located in the room and no concave mattress was in place. The DON stated that the facility had concave air mattresses and one should have been on Resident #196's bed as well as mats on the floor. Review of the wheelchair also revealed no dycem in the wheelchair.	F 323		