STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 01/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interviews and records review, the facility failed to notify the responsible party (RP)or the next listed emergency contact for a resident	F 157	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	2/8/16

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

Electronically Signed | 01/29/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 1 who sustained a fall for 1 of 3 (Resident #1) residents reviewed for accidents. Findings included: Resident #1 was admitted 4/18/14 with cumulative diagnoses of dementia, stage 4 sacral pressure ulcer, seizure disorder, hypertension and dysphasia. The quarterly Minimum Data Set (MDS) dated 10/5/15 indicated severe cognitive impairment, no behaviors, required extensive assistance with bed mobility by two staff, total staff assistance using a lift for transfers, extensive assistance with hygiene by two staff, impairment on both sides and non-ambulatory. A review of the incident report dated 12/25/15 indicated at 6:50 AM, Nurse #2 was called to the room by the nursing assistant (NA) #1. Resident #1 was observed on the floor next to the bed on her right side. There was discoloration noted to Resident #1 ' s forehead and her nose was bleeding. Emergency medical services (EMS) took Resident #1 to the hospital for an evaluation. A review of the hospital records dated 12/25/15 indicated Resident #1 was dropped from the bed during care. The bed was elevated approximately 4 feet when the fall occurred. A computerized tomography (CT scan) of Resident #1 ' s head and cervical spine indicated no injury. A CT scan combines a series of X-ray images taken from different angles and uses computer processing to create cross-sectional. She was returned to the facility later that same day. In a telephone interview on 1/12/16 at 8:09 AM, the RP stated she was heading to the facility from the western part of the state to visit Resident #1 on Christmas day when she got a call from the second listed emergency contact stating Resident #1 was not at the facility but rather had been sent out the hospital for an evaluation after a fall. The	F 157	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F157 Corrective Action for Affected Residents For resident # 1 the responsible party was notified of the residents fall while in the facility on 12/25/2015 by the 7-3 hall nurse. Corrective Action for Potentially Affected Residents All current residents have the potential to be affected by this alleged deficient practice. Beginning on 01/25/2016 the nurse management team began reviewing all fall reports for the past 3 months for current residents to determine if the responsible party had been notified. This was audited by reviewing the notification section of the incident report for responsible party notification. If notifications had not occurred the nurse manager contacted the responsible party. This was completed on 01/27/2016. Systematic Changes On 01/26/16 the nurse managers began in-servicing all current nurses (RN, LPN, both full time and part time) regarding the notification of falls to the responsible party. This in-service included the following topics: The nurse must contact the responsible party when a fall occurs. If you are unable	

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F 157	Continued From page 2 RP stated if the facility attempted to contact her, there was no missed calls on her cell phone and she did not see a missed call upon her return home from the holiday. The RP further stated, at any time the facility was unable to reach her, it was her understanding, the facility would attempt to contact the second person listed on the face sheet in the event of an emergency. In an interview on 1/12/16 at 8:30 AM, Nurse #2 stated she worked third shift on 12/24/15 and recalled the fall Resident #1 sustained. She stated NA #1 called her to the room where Resident #1 was observed on the floor. She stated she called EMS. Nurse #2 stated she attempted to contact the RP using all the phone numbers listed on the face sheet but she did not attempt to contact the second listed emergency contact listed on the face sheet. Nurse #2 stated she left with the understanding Nurse #1 would contact the family. In an interview on 1/12/16 at 9:30 AM, Nurse #1 stated Nurse #2 informed her she had called all the emergency contacts listed on the face sheet prior to leaving and it was her understanding she had left message for the RP to contact the facility. Nurse #1 recalled on Christmas Day, Resident #1 ' s second emergency contact came to the facility to visit and discovered Resident #1 was sent out the hospital. Nurse #1 stated the family was very upset with the facility for not attempting to contact the next person listed on the face sheet. In an interview on 1/12/16 at 12:30 PM, the administrator stated it was her expectation the staff attempt to contact the RP first but if unable to reach the RP, the staff should contact the other individuals listed as emergency contacts.	F 157	to reach the first emergency contact leave a voice message and then notify the second emergency contact. Continue down the emergency contact list until you reach one. If you reach someone other than the first emergency contact (responsible party), then make them aware that you were unable to reach the first emergency contact (responsible party). All contact efforts must be documented in the nurse's notes. If you are unable to reach any of the emergency contacts, notify the Director of Nursing for further instructions. If the fall occurs at shift change, then the off going nurse will document the attempts to call the responsible party in the nurse's notes and report to the oncoming nurse. The on-coming nurse will continue to attempt to reach the responsible party and document the attempts in the nurse's notes following the guidelines above. The Director of Nursing will ensure that any nurse who has not received this training by 02/08/2016 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Notifications". The monitoring will include reviewing 5 fall reports. This tool will audit for responsible party notification of the fall. This will be completed weekly for 4 weeks	

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F 157	Continued From page 3	F 157	then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES 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. This REQUIREMENT is not met as evidenced by: Based on staff interviews and records review, the facility failed to address a grievance dated 12/16/15 regarding the repositioning of 1 of 3 (Resident #1) sampled residents reviewed for grievances. Findings included: Resident #1 was admitted 4/18/14 with cumulative diagnoses of dementia, stage 4 sacral pressure ulcer, seizure disorder, hypertension and dysphasia. The quarterly Minimum Data Set (MDS) dated 10/5/15 indicated had severe cognitive impairment, no behaviors, required extensive assistance with bed mobility by two staff, total staff assistance using a lift for transfers, extensive assistance with hygiene by	F 166	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F166 Corrective Action for Affected Residents For resident # 1 the responsible party was	2/8/16

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F 166	Continued From page 4 two staff, impairment on both sides and non-ambulatory. A review of a grievance dated 12/16/15 completed by the treatment nurse on behalf of Resident #1 ' s responsible party (RP) indicated on 12/12/15 and 12/13/15 during the RP visits, Resident #1 was not repositioned or rendered care for over 3 hours. The grievance indicated the treatment nurse recommended teaching with the weekend staff regarding the need for repositioning. The grievance did not indicate it was resolved but the administrator had signed off on the grievance on 12/18/15. In a telephone interview on 1/12/16 at 8:09 AM, the Resident #1 ' s RP stated before Christmas she spoke with the treatment nurse about concerns related to the staff not repositioning Resident #1 and she never received any follow up from the facility regarding her concerns. She recalled telling the treatment nurse that she wanted to give the facility every opportunity to correct issues without seeking resolution using a different avenue such as contacting the state. In an interview on 1/12/16 at 10:30 AM, the treatment nurse recalled contacting the Resident #1 ' s RP to update her on the wound healing status after the wound consultant ' s assessment on 12/16/15. It was at this time the RP expressed concerns about the weekend staff not repositioning Resident #1. The treatment nurse stated she told the RP she would complete a grievance report and give it to the director of nursing (DON) for follow up with the weekend staff and someone would in in contact with her after the grievance was addressed. In an interview on 1/12/16 at 11:20 AM, the DON stated she recalled receiving the grievance form but she could not find any evidence she did any teaching or follow with the weekend staff	F 166	contacted by the Social Worker on 12/04/2015 concerning the grievance. The Social Worker and Director of Nursing met with the responsible party on 12/04/2015 to resolve the grievance. Corrective Action for Potentially Affected Residents All current residents have the potential to be affected by this alleged deficient practice. Beginning on 01/20/2016 the Administrator began reviewing all grievance reports for current residents for the past 90 days to determine if the grievant had been notified of the resolution and that the concern had been resolved. This was audited by reviewing the grievance report for date resolved and evidence the grievant was notified. If notifications or resolutions had not been reached, the grievant was contacted and a resolution was put in place. This was completed by the Administrator on 02/08/2016. Systematic Changes On 01/28/16 the administrative team (Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Dietary Manager, Housekeeping Director, Activities Director, and MDS Coordinator, Social Worker, Health Information Manager, and Maintenance Director was in-serviced by the Nurse Consultant on the Grievance Policy and Procedure. The topics included: As soon as possible after the filing of a grievance report, the Resident Rights Officer or designee will interview the grievant, interview appropriate other	

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F 166	Continued From page 5 regarding the RP concerns. In an interview on 1/12/16 at 12:30 PM, the administrator stated it was her expectation that grievances be addressed thoroughly and timely with follow up once concern has been addressed,	F 166	parties, examine relevant records, and take any other action which will enable a full understanding of the issue. The inquiry, disposition and decision will be completed within seven (7) days of receipt of a grievance, unless the administrator authorizes an additional five (5) days for reasonable cause with written notice to the grievant. The Resident Rights Officer may authorize another staff member to conduct an inquiry and attempt to resolve a grievance, but ultimate responsibility for the written reports shall be the Officer's. This training was completed on 01/28/2016. This information has been integrated into the standard orientation training for all administrative team members and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Administrator will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Grievances". The monitoring will include reviewing all grievance reports. This tool will audit grievance reports for follow up to the grievant for notification and resolution of the concern. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development	

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F 166	Continued From page 6	F 166	Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	
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, staff interviews and records review, the facility failed to update the care plan and implement interventions for a resident who sustained a fall for 1 of 3 residents (Resident #1) reviewed for accidents. Findings included:	F 280	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of	2/8/16

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F 280	Continued From page 7 Resident #1 was admitted 4/18/14 with cumulative diagnoses of dementia, stage 4 sacral pressure ulcer, seizure disorder, hypertension and dysphasia. A review of the annual Care Area Assessment dated 4/9/15 read that Resident #1 was totally dependent on staff to perform all transfers and mobility and her diagnoses of epilepsy increased her fall risk. The quarterly Minimum Data Set (MDS) dated 10/5/15 indicated the resident had severe cognitive impairment, no behaviors, required extensive assistance with bed mobility by two staff, total staff assistance using a lift for transfers, extensive assistance with hygiene by two staff, impairment on both sides and non-ambulatory. Resident #1 was coded as having a urinary catheter due to a stage 4 sacral pressure ulcer and always incontinent of bowel. Resident #1 was care planned for falls. The care plan was reviewed 10/20/15, 12/15/15 and again on 12/25/15. The interventions included check incontinence routinely and as needed, assess medication as a contributing factor, assess for proper fitting clothing, record and document all falls with goal of determining causative factors to eliminate or correct them if possible and keep the call light in reach and explain to resident how and why she need to use it. There were no new interventions since the fall on 12/25/15. A review of the incident report dated 12/25/15 indicated at 6:50 AM, Nurse #2 was called to the room by the nursing assistant (NA) #1. Resident #1 was observed on the floor next to the bed on her right side. There was discoloration noted to Resident #1 ' s forehead and her nose was bleeding. Emergency medical services (EMS) was contact to take Resident #1 to the hospital for evaluation. A CT scan of Resident #1 ' s head and cervical spine indicated no injury. She was	F 280	correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 280 Corrective Action for Resident Affected: For Resident #1, the residents care plan was reviewed by the Interdisciplinary Care Plan Team and updated on 01/12/2016 with the intervention for two person assistance for bed mobility and transfers. Corrective Action for Resident Potentially Affected: All current residents have the potential to be affected by this alleged deficient practice. Beginning 01/25/2016 the nurse managers began reviewing all current residents who have had a fall in the last 3 months. To accomplish this, the nurse managers printed a list of patients that had a fall incident report in the last 3 months. The incident report was then reviewed by the nurse managers to identify the interventions that were put in place. Interventions for the falls were then reviewed by the nurse manager to ensure that the interventions were appropriate and care planned. This process will be completed on 02/08/2016. Systemic Changes On 01/28/2016, the Corporate MDS Consultant in-serviced the Care Plan	

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F 280	Continued From page 8 returned to the facility later that same day. In an observation on 1/11/16 at 11:15 AM, Resident #1 was lying in bed on an alternating air mattress. The bed was observed in the low position. Quarter rails were observed in place and engaged. She was nonverbal and appeared unaware of her surroundings or circumstances. She appeared clean, absent of odors and dressed for weather. During the wound care observation and interview 1/11/16 at 11:45 AM, the treatment nurse stated Resident #4 was not able to reposition himself without staff assistance. She recalled the fall on Christmas day and understood it was due to staff error. She stated it was her understanding that Resident #1 required staff assistance of two when providing care. In an interview on 1/11/16 at 2:00 PM, NA #2 stated she never provided any of Resident #1 ' s activities of daily living (ADLs) unassisted. She stated Resident #1 was dead weight and she could not hold onto the side rail to avoid a fall. She stated the kardex in the computer did not indicate how much assistance was needed to provide incontinence care but she was not comfortable performing incontinence care on Resident #1 unassisted. In an interview on 1/11/16 at 2:10 PM, the MDS nurse stated the kardex was where the aides went to find out how much assistance was required in providing activities of daily living (ADL) assistance. She stated if there was no mention of two person assistance for an activity, it was understood that only one person was required. The MDS nurse also stated she would only include two person assistance on a care plan if the resident was coded on the MDS for the consistent need of two person assistance. A review of the kardex did not indicate any areas of	F 280	Team on reviewing and updating care plans. The in-service content included: Care plan updates. Care plans should be updated on an “ongoing” basis in order to reflect the most current condition/needs of the resident. This includes updating the care plan promptly after every falls review. Each discipline is responsible for making necessary updates to care plans as necessary so that it will reflect resident condition and needs. The Care Plan Team consisted of the MDS Coordinator, Social Worker, Activities, Dietary Manager and Nurse Managers. This training was completed on 01/28/2016. This information has been integrated into the standard orientation training for all Care Plan Team Members and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the Survey Quality Assurance Monitor Care Plan Audit for monitoring updating care plans with new fall interventions as identified in QA and physician orders. This will be completed on all residents with falls weekly times 4 weeks then on 10 residents with falls monthly times 2 months or until resolved by QOL/QA committee. See Attachment A. Reports will be given to the weekly QOL/QA committee and corrective action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing, Nurse Managers,	

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F 280	Continued From page 9 ADL assistance that required the assistance of two staff members. In a telephone interview on 1/11/16 at 2:40 PM, NA #1 stated she worked third shift on 12/24/15. She stated she was doing her last round on Resident #1 and had asked for help to provide her incontinence care but all the other staff stated they were too busy. NA #1 stated she did not feel comfortable completing Resident #1 ' s incontinence care unassisted, but on this occasion, she did it anyway. She stated Resident #1 had stool so she raised the bed to the highest positon and pulled Resident #1 close to her and turned her over to wipe her when Resident #1 rolled over onto the floor. She stated the kardex did not indicate that two staff were needed to perform her ADLs. In a review of Resident #1 ' s skin impairment care plan last revised 12/15/15, the MDS nurse had care planned Resident #1 for two person assistance with bed mobility due to her impaired mobility. In an another interview on 1/11/16 at 3:30 PM, the MDS nurse stated she did care plan Resident #1 for two person assistance with bed mobility to avoid shearing but it was not reflected on the kardex. She also stated the kardex did not reflect the two staff required on Resident #1 ' s quarterly assessment dated 10/5/15. She stated she did not update the care plan or kardex after the fall that occurred on 12/25/15. In an interview on 1/12/16 at 12:30 PM, the administrator stated it was her expectation the MDS, care plan and kardex be accurate and updated in order to provide care safely for the residents.	F 280	Social Workers and Dietary Manager.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		2/8/16

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F 323	Continued From page 10 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and records review, the facility failed to prevent two resident falls contributed to staff error (Resident 4 and Resident 1) resulting in injuries for 2 of 3 residents reviewed for accidents. The facility also failed analyze the circumstances surrounding the fall for 1 of 3 (Resident #1) residents reviewed for accidents. Findings included: 1. Resident #4 was admitted 4/24/08 with cumulative diagnoses of prostate cancer, aphasia and dementia with behaviors. The quarterly Minimum Data Set (MDS) dated 9/23/15 indicated Resident #4 had severe cognitive impairment and behaviors directed toward himself. He was coded for extensive assistance of one staff for bed mobility and hygiene and incontinent of bowel and bladder. A review of an incident report dated 10/4/15 at 2:00 AM, the nurse was called to the room to observe Resident #4 lying on the floor face down with the bed in the highest position. The aide stated when she was changing him, he fell off the side of the bed. He sustained a laceration to his outer left forearm and screamed in pain during assessment for range of motion in his legs. Emergency medical services was notified and Resident #4 was sent out for evaluation. The	F 323	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F323 Corrective Action for Affected Residents Resident # 4 was sent to hospital on 10/04/15 for evaluation post fall. The resident returned and on 10/05/15 an x-ray was performed in the facility due to signs of pain. Xray results indicated a left femoral neck fracture. The resident was transported to the hospital on 10/05/15 for admission. The resident has not had a fall since 10/04/15. The residents care plan was reviewed and updated by the Interdisciplinary Care Plan Team on 01/12/2016. New interventions included two person assistance with bed mobility and transfers.	

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F 323	Continued From page 11 original x-ray was negative for any fractures at the hospital and Resident #4 was returned to the facility. A nursing note dated 10/5/15 at 9:41 PM indicated a repeat x-ray was done at 5:30 PM per physician orders due to continued outward signs of pain to include moaning. The x-ray completed at the facility on 10/5/15 indicated Resident #4 had an acute fracture of the left femoral neck and he was sent back out the hospital for surgical intervention. He was readmitted to the facility on 10/12/15. There was a care plan for falls initiated on 10/12/15 upon Resident # 4 ' s readmission from the hospital after sustaining a left femur fracture when he fell from the bed. Interventions included to record and document all falls with the goal of understanding, eliminating and correcting any causative factors if possible. Interventions also included keeping the call light in reach and explain to the resident the need to use the call light. The care plan included praise for complaint behaviors, and reminding him of his limitations, frequent incontinence checks and frequent staff observation. In an observation on 1/11/16 at 11:45 AM, Resident #4 appeared contracted in both upper and lower extremities and lying on his right side in the fetal position. He was yelling out periodically and did not appear aware of his surroundings or circumstance. He was clean and well groomed, absent odors and dressed for weather. His bed was in the low position and his quarter rails were engaged. He was lying on an alternating air mattress. During the wound care observation and interview 1/11/16 at 11:45 AM, the treatment nurse stated Resident #4 was not able to reposition himself without staff assistance. She recalled the fall last	F 323	Resident # 1was sent to the hospital on 12/25/15 for evaluation post fall. The resident was returned to the facility without injury. The residents care plan was reviewed and updated by the Interdisciplinary Care Plan Team on 01/12/2016. New interventions included two person assistance with bed mobility and transfers. Corrective Action for Potentially Affected Residents All current residents have the potential to be affected by this alleged deficient practice. Beginning 01/25/2016 the nurse managers began reviewing all current residents who have had a fall in the last 3 months. To accomplish this, the nurse managers printed a list of patients that had a fall incident report in the last 3 months. The incident report was then reviewed by the nurse managers to identify the reason and/or contributing factors for the fall. This included reviewing falls for any indication that the resident required two assistants with bed mobility. Interventions for the falls were then reviewed by the nurse manager to ensure that the interventions were appropriate. Interventions may include assigning two assistant's for bed mobility, medication evaluations, pharmacy evaluations, therapy evaluations for alternative positioning or strengthening exercises, increased supervision, one on one supervision, and other specifically related to the individual residents need. This process was completed on 01/27/2016	

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F 323	Continued From page 12 October and understood it was due to staff error. In an interview on 1/12/16 at 8:45 AM, the director of nursing (DON) stated it was determined the aide left the resident unattended to get supplies. The aide was terminated. The aide was not available for interview. In a telephone interview on 1/12/16 at 10:40 AM, Nurse #3 stated the aide who left Resident #4 unattended had come in late that night. She stated she had over slept because she had taken a pain pill earlier in the day. Nurse #3 stated she had not had any issues with the aide ' s performance prior to this incident. She recalled the aide stated Resident #4 had stool and she did not have enough supplies. She had raised the bed to the highest position and left him to get more supplies. Nurse #3 stated she obtained the aide ' s statement and there was no other issues with her on that shift. She reported the incident to the DON that morning. Nurse #3 stated Resident #4 was unable to move about in the bed and always stayed in the fetal positon. In an interview on 1/12/16 at 12:30 PM, the administrator stated it was her expectation the staff provide ADL assistance safely and not leave a resident unattended. 2. Resident #1 was admitted 4/18/14 with cumulative diagnoses of dementia, stage 4 sacral pressure ulcer, seizure disorder, hypertension and dysphasia. A review of Resident #1 annual Care Area Assessment dated 4/9/15 read that Resident #1 was totally dependent on staff to perform all transfers and mobility and her diagnoses of epilepsy increased her fall risk. The quarterly Minimum Data Set (MDS) dated 10/5/15 indicated had severe cognitive impairment, no behaviors, required extensive assistance with bed mobility by two staff, total staff assistance using a lift for transfers,	F 323	Systematic Changes On 01/28/2016 the QA Nurse Consultant, in serviced all nurses managers (Director of Nursing, Unit Managers, MDS, and SDC) on falls investigation. Topics included: • Daily during clinical meeting all incident reports will be reviewed by the nurse managers. This review will include a falls investigation that will include at a minimum a review of witness statements, a review of the residents medications, diagnosis, personal interviews of staff as indicated, nursing documentation 48hours prior to the fall, and ask the 5 whys to help determine the root cause of the fall. Upon completion of this review, interventions should be identified. Interventions may include medication evaluations, pharmacy evaluations, therapy evaluations for alternative positioning and strengthening exercises, increased supervision, one on one supervision, and other interventions specifically related to the individual resident. On 01/25/2016 the Staff Development Coordinator began in-servicing all current nursing staff (RN, LPN, Medication Aide, Med Tech, CNA both full time and part time regarding the fall prevention and investigation. What are the most common causes of falls? • Muscle weakness and walking or gait problems are the most common causes of	

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F 323	Continued From page 13 extensive assistance with hygiene by two staff, impairment on both sides and non-ambulatory. Resident #1 was coded as having a urinary catheter due to a stage 4 sacral pressure ulcer but always incontinent of bowel. Resident #1 was care planned for falls. The care plan was reviewed 10/20/15, 12/15/15 and again on 12/25/15. The interventions included to check incontinence routinely and as needed, assess medication as a contributing factor, assess for proper fitting clothing, record and document all falls with goal of determining causative factors to eliminate or correct them if possible and keep the call light in reach and explain to resident how and why she need to use it. A review of the incident report dated 12/25/15 indicated at 6:50 AM, Nurse #2 was called to the room by the nursing assistant (NA) #1. Resident #1 was observed on the floor next to the bed on her right side. There was discoloration noted to Resident #1 ' s forehead and her nose was bleeding. Emergency medical services (EMS) was contact to take Resident #1 to the hospital for evaluation. A review of the hospital records dated 12/25/15 indicated Resident #1 was dropped from the bed during care. The bed was elevated approximately 4 feet when the fall occurred. A CT scan of Resident #1 ' s head and cervical spine indicated no injury. She was returned to the facility later that same day. In an interview on 1/11/16 at 9:30 AM, Nurse #1 stated she was coming in to work first shift on 12/25/15 when NA #1 walked out of the room into the hall and stated Resident #1 rolled out of the bed. Nurse #1 went into the room and observed Resident #1 lying on the floor on her right side. She had bumped her forehead and she was bleeding from her cheek. NA #1 stated she rolled	F 323	falls among nursing home residents. Also, a sense of needing to use the toilet can be a factor in falls. • Environmental hazards in nursing homes can cause falls such as wet floors, poor lighting, incorrect bed height, and improperly fitted or maintained wheelchairs. • Medications can increase the risk of falls and fall-related injuries. Drugs that affect the central nervous system, such as sedatives and anti-anxiety drugs, are of particular concern. • Other causes of falls include difficulty in moving from one place to another (for example, from the bed to a chair), poor foot care, poorly fitting shoes, and improper or incorrect use of walking aids. • Confusion and dementia can contribute to poor safety awareness and increase risk of falls. How can we prevent falls in nursing homes? Fall interventions include but are not limited to: • Safe positioning: Residents should not be left with the bed in high position and/or in an unsafe position. For example, a total care resident left turned on their side without positioning devices with the bed in high position. • When a resident is on their side receiving care, do not turn your back on the resident. Make sure you have all supplies on hand and easily reached prior to giving care. • Use the over bed table to arrange all needed supplies before starting care.	

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F 323	Continued From page 14 Resident #1 over to provide incontinence care when she rolled out of the bed. Nurse #1 stated the quarter side rail were observed up and the bed was in the high position. In an observation on 1/11/16 at 11:15 AM, Resident #1 was lying in bed on an alternating air mattress. The bed was observed in the low position. Quarter rails were observed in place and engaged. She was nonverbal and appeared unaware of her surroundings or circumstances. She appeared clean, absent of odors and dressed for weather. The treatment nurse recalled the fall that occurred on 12/25/15. She stated it was her understanding that the aide rolled Resident #1 over too far resulting in her falling from the bed. During a wound care observation and interview on 1/11/16 at 11:15 AM, the treatment nurse stated when performing wound care she always had assistance because Resident #1 could not assist with holding herself on her side and the altering air mattress caused shifting of body weight periodically. In an interview on 1/11/16 at 2:00 PM, NA #2 stated she never provided any of Resident #1 ' s activities of daily living (ADLs) unassisted. She stated Resident #1 was dead weight and she could not hold onto the side rail to avoid a fall. She stated the kardex in the computer did not indicate how much assistance was needed but she was not comfortable doing Resident #1 unassisted. In a telephone interview on 1/11/16 at 2:40 PM, NA #1 stated she worked third shift on 12/24/15. She stated she was doing her last round on Resident #1 and had asked for help to provide her incontinence care but all the other staff stated they were too busy. NA #1 stated she did not feel comfortable completing Resident #1s	F 323	• If you realize an item is missing. Position the resident to a safe position in bed, lower the bed and place the call bell within reach. • When residents are on air mattresses, make sure the rails are up on the opposite side when giving care. Always return the rails to the up position when leaving the resident. • Always use the number of assistants that the care plan or kardex calls for. • If you feel unsafe transferring or repositioning a resident then notify the nurse for assistance. Never attempt the transfer or reposition alone if you are in doubt. • Nurses: if a CNA reports that they need assistance with transferring a resident or with mobility, assistance should be obtained and provided. Teamwork is vital! • If a resident requires assistance with transfers then they should not be left alone in the bathroom. • Residents with the ability to toilet should be checked at least every 2 hours while awake for the need to toilet, especially before meals. • See the resident's kardex or careplan for interventions to minimize the risk of falls. When in doubt, ask your nurse. • Call lights should be within reach of the resident and answered promptly. • Frequently used items should be kept within reach of the resident. Such items include: remote for TV, water picture, phone, walker, reacher etc. • Keep the walkway of the resident free from clutter.	

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F 323	Continued From page 15 incontinence care alone but on this occasion, she did it anyway. She stated Resident #1 had stool so she raised the bed to the highest positon and pulled Resident #1 close to her and turned her over to wipe her when Resident #1 rolled over onto the floor. NA #1 stated she stepped out of the room and saw Nurse #1 coming up the hall and got her to assess Resident #1. NA #1 stated Resident #1 was lying on her right side and she was bleeding from her cheek. She stated the electronic kardex did not indicate that two staff were needed to perform her ADLs. Since the fall, NA #1 stated she made sure she got help caring for Resident #1. NA #1 stated she was asked to write a statement but she was never asked to come in and discuss the fall or did she receive any phone calls about the incident. NA #1 stated she worked with Resident #1 again on third shift on 12/28/15. On the morning of 12/29/15, the staff development coordinator (SDC) did an in-service for all the aides on safely rolling a resident while in the bed to prevent a fall. In an interview on 1/11/16 at 4:00 PM, NA #3 stated she always sought out assistance with proving incontinence care for Resident #1 because she was a heavy lady who could not keep herself from rolling all the way over. NA #3 stated the mattress on her bed also would inflate and deflate causing Resident #1 to shift in the bed unsafely. In an interview on 1/12/16 at 8:30 AM, Nurse #2 stated she worked third shift on 12/24/15 and recalled the fall Resident #1 sustained. She stated NA #1 called her to the room but Nurse #1 beat her there. Resident #1 was observed on the floor. She stated she called EMS and asked NA #1 what happened. She stated that NA #1 stated she rolled onto the floor while she was proving incontinence care.	F 323	• Make sure the resident has on shoes and report poor fitting shoes to your nurse. • When poorly fitting equipment is suspected such as walkers, w/c's, etc. report this to the nurse. Nurses can make a referral to therapy as needed. • Residents that become restless may require closer monitoring for a time, resident can be offered activity diversions such as cards, puzzles, coloring, etc. They may need to be placed in areas of greater staff presence such as the nurses' station with an activity, etc. • Report any signs of pain such as moaning, facial grimaces, complaints of pain to the nurse immediately. • Nurses, address pain complaints timely. • Frequent position changes may assist some residents with pain control. • Try to keep noise levels down. If alarms are used, respond quickly. Alarms should not be the first step in falls prevention. • Make sure beds are not left in a high position when leaving the room. What do you do when a fall occurs? • All falls will be investigated. Staff who were working with the resident at the time of the fall need to write a statement. The CNA and Nurse who are assigned to the resident at the time of the fall also need to write a statement. All statements should be forwarded to the DON. • Include in the statement: physical surroundings that may have contributed to the fall, any change in the resident before	

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F 323	Continued From page 16 In an interview on 1/12/16, the SDC stated she was asked to in-service all the aides on bed mobility but she was not informed the education was in response to the fall that occurred on 12/25/15. She stated she had not done any observations with NA #1 or any aides to ensure bed mobility was being done safely. In an interview on 1/12/16 at 11:20AM, the director of nursing stated she did not do an investigation into the fall Resident #1 sustained on 12/25/15 because she felt it was an isolated incident. She did direct the SDC to educate all the aides because she felt the fall was the fault of the aide. In an interview on 1/12/16 at 12:30 PM, the administrator stated it was her expectation the staff provide ADL assistance safely and wait for assistance if required before attempting to render care alone	F 323	the fall, the last time you saw the resident and what care was provided at that time, any medication changes and any behavior changes to help determine root cause of the fall. Collect your data and document in the incident report. Nurses education on falls notification • The nurse must contact the responsible party when a fall occurs. If you are unable to reach the first emergency contact leave a voice message and then notify the second emergency contact. Continue down the emergency contact list until you reach one. If you reach someone other than the first emergency contact (responsible party), then make them aware that you were unable to reach the first emergency contact (responsible party). All contact efforts must be documented in the nurse's notes. If you are unable to reach any of the emergency contacts, notify the Director of Nursing for further instructions. The Director of Nursing will ensure that any nurse who has not received this training by 02/08/2016 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the Survey Quality Assurance Monitor for monitoring fall interventions. This audit will review incident reports for the following, investigation documentation, interventions put in place and	

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F 323	Continued From page 17	F 323	interventions care planned. Any newly identified falls interventions will also be reviewed to ensure that they are promptly implemented. This will be completed on all falls weekly times 4 weeks then on 10 falls monthly times 2 months or until resolved by QOL/QA committee. Reports will be given to the weekly QOL/QA committee and corrective action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing, Nurse Managers, Social Workers and Dietary Manager.	