STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345264	A. BUILDING _____ B. WING _____	C 10/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEY TOTAL LIVING CENTER	514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164

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F 000	INITIAL COMMENTS On 10/06/16 the Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section completed a complaint investigation at the facility which identified Past Non Compliance (PNC) for tags F-282 and F-323. Prior to the 2567 report for the 10/06/16 complaint investigation survey being provided to the facility another complaint investigation was completed by DHSR Nursing Home Licensure and Certification Section on 10/19/16 which identified ongoing noncompliance with tag F-282. Based on this current non compliance at tag F-282 it was also determined that PNC could also not be cited at F-323. The exit date for this survey was extended from 10/06/16 to 10/19/16 to capture both of these complaint investigations and the facility's continued non compliance with tags F-282 and F-323. Event ID# JGMM11.	F 000		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, a physician interview and medical record review, the facility failed to follow the plan of care to safely transfer a resident with a gait belt and 2 staff persons, which resulted in a subcutaneous hematoma (a raised bruise due to a ruptured blood vessel under the skin), a wrist fracture and a blood transfusion (Resident #1) and failed to	F 282	Corrective actions taken for those residents affected: Resident #1 was sent to the emergency room for evaluation on 8/13/16 and subsequently admitted for treatment. Following treatment, Resident #1 returned to the facility on 8/14/16 with further orders for treatment. A care plan	11/10/16

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

Electronically Signed | 11/10/2016

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

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F 282	Continued From page 1 implement a bed alarm as a fall intervention, per physician order, (Resident #5) for 2 of 3 sampled residents reviewed for implementation of the plan of care. The findings included: 1. Resident #1 was re-admitted to the facility on 07/16/16. Diagnoses included, in part, diabetes mellitus type 2, Alzheimer's Dementia, age-related osteoporosis, anxiety disorder and a history of falls. Review of an admission Minimum Data Set of 07/23/16, Care Area Assessment and Care Plan both of July 2016 revealed Resident #1 was assessed with intact cognition, understood/understands, clear speech, received Hospice Services and required extensive staff assistance with transfers due to unsteady balance. Care plan interventions included the use of a gait belt with the extensive assistance of 2 staff persons with transfers. Review of a skin audit dated 08/12/16 at 5:54 PM revealed intact skin to Resident #'1 left arm and a skin tear to the right index finger. Review of the facility's Resident Incident Report and a nurse's note (NN) dated 08/12/16 written at 11:30 PM by Nurse #1 recorded that on 08/12/16 at 10:20 PM, Resident #1 presented with a 2.5 inch hematoma on her right forearm. The NN documented that a skin audit completed earlier in the shift (08/12/16 at 5:54 PM) assessed this area as normal for Resident #1. When asked what occurred, the NN documented that Resident #1 stated the hematoma occurred when a nurse aide (NA) put her to bed.	F 282	previously written to require 2-person transfer was continued. Nurse #1 immediately initiated and followed the facility's abuse/neglect policy and procedures upon discovery of the injury on 8/12/16, which included suspension of NA#1. NA#1 remained on suspension until the conclusion of the investigation on 8/22/16 at which point NA#1 was terminated. Local DSS and the NC Health Care Personnel Registry conducted separate investigations regarding the incident with Resident #1 and both agreed with facility findings and outcomes. All safety measures for Resident #5 were reviewed and visually checked by the Administrator on 10/19/16 @ 3:40pm. At that time, Resident #5 was lying in bed with her eyes closed and had on non-skid socks and the bed pad alarm in place/turned on and properly connected. Resident #5 was discharged to home as planned on 10/20/16. Corrective actions taken for those residents with the potential to be affected: An audit of all current Lift/Transfer assessments as well as care plans for transfer requirements was conducted between 11/7/16 – 11/10/16 to verify current requirements for the type of transfer required for each resident. Findings were compared to ensure each was written correctly on the Get To Know Me form for communication with nursing assistants and written correctly on the care plan. Any concerns were	

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F 282	Continued From page 2 A NN dated 08/13/16 written at 12:44 AM noted that Resident #1 was observed with increased swelling to her right arm from the mid bicep to her wrist. The family and physician were notified and a physician's order was obtained to send Resident #1 to the Emergency Department (ED) for further evaluation. Resident #1 was admitted to the hospital. Review of the Hospital Discharge summary dated 08/14/16 recorded that Resident #1 presented to the ED on 08/13/16 with a subcutaneous hematoma to the left forearm. A left arm Xray completed in the ED revealed a nondisplaced scaphoid (wrist) fracture. The hematoma was treated by clot removal and wound closure, the Resident required one multi-donor pack of platelets, one unit of packed red blood cells and the wrist fracture could not be surgically corrected. Resident #1 was re-admitted to the facility on 08/14/16. The facility's investigation included a written statement by NA #1 and a documented interview with Nurse #1 and the Director of Nursing (DON) which revealed NA #1 put Resident #1 to bed after dinner without staff assistance or a gait belt. NA #1 stated Resident #1 wore a long-sleeved shirt at the time of the transfer and the NA did not observe any changes in skin integrity to the Resident's left arm after the Resident was put to bed. The investigation also documented that NA #1 was asked why she put Resident #1 to bed without staff assistance or a gait belt and NA #1 replied that she did so because Resident #1 wanted to be put to bed and NA #1 did not want the Resident to complain of having to wait.	F 282	immediately corrected. A Safety Device audit of all residents was conducted between 10/27/16 – 10/28/16 by the Risk Management Coordinator to verify any alarms currently ordered as well as those with non-skid socks. These orders were then compared to ensure each was actually in place as ordered, written correctly on the Get To Know Me form for communication with nursing assistants, and written correctly on the care plan. Any concerns were immediately corrected. A second Safety Device audit of all residents was conducted between 11/7/16 – 11/10/16 by Nurse Managers to verify any other types of safety measures currently ordered (fall mats, anti-tippers on wheelchairs, perimeter mattresses, etc.) which were then compared to ensure each was actually in place as ordered, written correctly on the Get To Know Me form for communication with nursing assistants, and written correctly on the care plan. Any concerns were immediately corrected. Systemic changes made to ensure deficient practice will not occur: The Mechanical Lift/Transfer policy will be revised to include the requirement of the use of 2 staff members for a transfer as determined by the most recent Lift Assessment form. When any lift assessment is updated which changes the type of lift/transfer required, the nurse completing the assessment will	

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F 282	Continued From page 3 Resident #1 was observed on 10/05/16 at the following times, 10:40 AM, from 12:20 PM to 12:32 PM and at 4:21 PM in her room, in a low bed, covered with a blanket. Staff were observed to encourage and offered to assist Resident #1 with incontinence care, to get out of bed to toilet, sit in her wheelchair and attend activities, but Resident #1 declined each offer and replied "Come back later." On 10/05/16 at 4:53 PM Resident #1 agreed to transfer to her wheelchair. Two nurse aides applied a gait belt, provided extensive assistance to Resident #1 to stand from her bed, pivot and transfer to her wheelchair. The transfer occurred without incident. An interview with the Administrator and DON occurred on 10/05/16 at 1:15 PM and revealed Nurse #1 called the DON on 08/13/16 around 11:00 PM to notify of Resident #1's hematoma that resulted from the 1 person transfer. The DON stated that Nurse #1 continued to monitor Resident #1, around 12:00 AM Nurse #1 noted the Resident's hematoma was larger and Resident #1 complained of pain, the physician was called and an order obtained to send Resident #1 to the hospital for further evaluation. During an interview on 10/05/16 at 3:00 PM, Nurse #1 stated NA #2 reported to him on 08/12/16 after the end of the 3 PM - 11 PM shift, that Resident #1 was found in bed dressed in her day clothes, by NA #2 and NA #3, with a raised bruise to her left arm when they went to check the Resident for incontinence and change her clothes. Nurse #1 stated his NN dated 08/12/16 and 08/13/16 documented a hematoma to the right arm instead of the left arm in error. Nurse #1 stated he assessed Resident #1 with a raised	F 282	immediately write the change directly on the Get To Know Me form (date/time of change). The information changed will also be placed by that same nurse on both the Nurse and CNA 24 hour report forms for communication purposes. Upon receipt/review of the 24 hour report forms, the Risk Management Coordinator will verify that any changes in the type of transfer are written/changed on the Get To Know Me form and will also notify the MDS Coordinator who will ensure that any changes in the type of transfer are written/changed on the care plan. The procedures for the completion of and use of the Get To Know Me forms included in the MDS/Care Plan policy will be revised to indicate that any nurse who processes an order for any type of safety device, intervention, or measure will update the Get To Know Me form (date/time of change), include the information on both the Nurse and CNA 24 hour report forms, and notify the assigned CNA currently responsible for care immediately for the purposes of communication. Upon receipt/review of the 24 hour report forms and the copies of all orders written for the previous day: •the Risk Management Coordinator will verify that any changes in the type of transfer and/or safety measures are written/changed on the Get To Know Me form. •the MDS Coordinator will ensure that any changes in the type of transfer and/or safety measures are written/changed on the care plan.	

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F 282	Continued From page 4 bruise to her left arm the size of his fist. Nurse #1 stated when he interviewed staff, NA #1 stated she put Resident #1 to bed after dinner without a gait belt or staff assistance which required Resident #1 to hold onto the side rail and assist with the transfer. Nurse #1 further stated he determined that must have been when the hematoma occurred because Resident #1 required a gait belt and the extensive assistance of 2 staff persons with transfers and when he completed a skin audit around 5:30 PM on 08/12/16 the hematoma to her left arm was not there. During an interview on 10/05/16 at 3:14 PM, NA #2 stated she worked the 3PM - 11PM shift on 08/12/16 and that she was the assigned NA for Resident #1. NA #2 stated at the end of the shift on 08/12/16, she and NA #3 completed their final rounds, responded to the call light for Resident #1 who requested incontinence care and to be changed into her night clothes. NA #2 stated when she removed the Resident's shirt NA #2 noted a raised bruise to the Resident's left arm. Resident #1 reported to NA #2 that the bruise happened when a NA put her to bed earlier, but that she could not recall who put her to bed or what time. NA #2 stated she immediately reported the bruise to Nurse #1 and while at the nurse's station, NA #1 stated that she put Resident #1 to bed alone, after supper. During a telephone interview on 10/05/16 at 5:41 PM, the Medical Director (MD) stated that Resident #1 was at increased risk for fractures due to her age/comorbidities. The MD stated that the wrist fracture Resident #1 sustained could have occurred as a result of being transferred on 08/12/16 without a gait belt by 1 staff person	F 282	The Report Guidelines (Nurses/CNA's) policy will be revised to include the expectation that walking rounds be conducted between shifts by the nurses and nursing assistants to visually check that all safety measures that are currently ordered and care planned are actually in place and any alarms are working properly/attached/turned on. Each staff member involved in conducting the round will sign the bottom of the 24 hour report form (2 signatures per shift) indicating rounds were complete and all safety measures/devices/interventions are in place as ordered and care planned. The Nursing Assistant Duties policy will be revised to include the expectation of reviewing the care plan information on the kiosk as well as the information on the Get To Know Me forms which include specific details for type of transfer/number of staff required to perform a safe transfer as well as any safety devices/interventions each day for the provision of each residents' needs. This policy will also include the expectation for making walking rounds with the oncoming shift to review the CNA 24 hour report form with any changes noted for transfers/safety measures together and signing the completion of such rounds indicating rounds were complete and all safety measures/devices/interventions are in place as ordered and care planned. The Administrator will conduct in-services for all current nursing staff between	

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F 282	Continued From page 5 instead of 2 staff. The MD stated Resident #1 could stand/pivot during transfers, but that her assistance was minimal, which placed the primary responsibility on the staff during transfers. The MD stated Resident #1 required 2 person extensive assistance to transfer or she would fall. The MD also stated he did not know why NA #1 chose to transfer Resident #1 alone, but that it was a mistake that had a bad outcome. The MD further stated that it was quite possible that the 1 person transfer for Resident #1 that occurred on 08/12/16 resulted in her fractured wrist. He stated to be transferred safely, Resident #1 required the extensive assistance of 2 staff persons. Attempts to interview NA #1 and NA #3 were unsuccessful. During a follow up interview on 10/06/16 at 12:30 PM, the Administrator stated as a result of the facility's investigation NA #1 was terminated for not following the plan of care for Resident #1 which resulted in injury to the Resident. The Administrator stated the facility began corrective measures in response to the 08/12/16 incident that resulted in injury for Resident #1 and monitoring was ongoing. 2. Resident #5 was admitted to the facility on 09/09/16 with diagnoses that included weakness, difficulty in walking, and lack of coordination, Alzheimer's disease, dementia and others. Review of the most recent Minimum Data Set (MDS) dated 09/16/16 revealed that Resident #5 was cognitively impaired and required extensive assistance with activities of daily living (ADLs). The MDS also revealed that Resident #5 had fallen during the month prior to admission and	F 282	11/10/16 – 11/11/16 on the policy revisions for the Mechanical Lift/Transfers, Get To Know Me forms, Report Guidelines (Nurses/CNA's), and Nursing Assistant Duties to ensure awareness of the changes and expectations for resident safety with transfers and the use of safety interventions to prevent falls. Any new nursing staff hired after 11/11/16 will be educated during their initial orientation on the use of the Get To Know Me forms as well as the policies/procedures for Mechanical Lifts/Transfers, Nursing Assistant Duties and Report Guidelines (Nurses/CNA's). How will the facility monitor its performance to make sure solutions are sustained? Each nurse assigned to each unit/hall will observe (2) resident transfers in which either a mechanical lift or 2-person assist was required every shift daily X 2 weeks followed by weekly X 4 weeks, and finally monthly X 3 months to ensure the transfer occurred as care planned. Any concerns will be immediately corrected through the disciplinary process up to and including termination for failure to follow the care plan as written. The Medicare/Restorative Nurse will review 3 Get To Know Me forms from each unit daily X 2 weeks, followed by weekly X 2 weeks, and finally monthly X 3 months to ensure information from the most recent lift assessment as well as any orders for safety devices/interventions are written and/or changed on the form for	

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F 282	Continued From page 6	F 282		

also 2 to 6 months prior to admission. No behaviors or rejection of care were identified.
Review of a facility document entitled "Get to Know Me" dated 09/09/16 indicated the form had been updated on 10/03/16 to reflect the addition of the bed alarm and again on 10/05/16 to reflect the addition of the nonskid socks.
Review of a care plan dated 09/22/16 read, Resident #5 was at risk for falls related to a history of falls prior to admission, impaired mobility and cognition. The goal of stated care plan was Resident #5 would have no avoidable physical harm by the next review. The interventions of stated care plan included bed and chair alarm to alert staff of unsafe movements and nonskid socks when shoes not worn for fall safety.
Review of a physician order dated 10/02/16 read, Bed pad alarm when in bed to alert staff of unsafe movements.
Review of a physician order dated 10/03/16 read, resident to wear nonskid socks when shoes not worn for fall safety.
Observation of Resident #5 on 10/18/16 at 3:10 PM revealed she was resting in bed with eyes closed. Resident #5 was dressed in black pants and a light colored shirt and had on socks that were not nonskid. The pad to the bed alarm was present on the bed but was not connected to the alarm box hanging on the side of the bed.
Observation of Resident #5 on 10/18/16 at 4:43 PM revealed she was resting in bed with eyes open and was alert and verbal. Resident #5 was dressed in black pants and a light color shirt, she had on socks that were not nonskid. The pad to the bed alarm was present on the bed but was not connected to the alarm box that was hanging on the side of the bed.
Interview with Nursing Assistant (NA) #4 on

staff communication. Any concerns will be immediately corrected and reported to the DON for further disciplinary action for failure to follow policy for resident safety.

Each Nursing Supervisor will participate in walking rounds on his/her shift with the nurses and/or CNA's to observe that staff are following the procedures of conducting such rounds by visually checking to ensure that all safety measures currently ordered/care planned are actually in place and any alarms are working properly/attached/turned on. With each round observed, the Nursing Supervisor will sign the bottom of the 24 hour report form with the 2 staff members indicating rounds were complete and all safety measures/devices/interventions are in place as ordered and care planned. This will be done daily X 1 week, followed by weekly X 5 weeks, and finally monthly X 3 months. Any concerns will be immediately corrected and addressed through the disciplinary process up to and including termination for failure to follow the care plan as written.

Findings from the transfer observations conducted by nurses, Get To Know Me forms reviewed by the Medicare/Restorative Nurse, and 24 hour rounds forms signed by the Nursing Supervisors will be reviewed by the Director of Nursing as well as any corrections required upon the completion of each. The Director of Nursing will report findings to the QA&A Committee monthly for any further recommendations

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F 282	Continued From page 7 10/18/16 at 4:48 PM revealed that was taking care of Resident #5 on 2nd shift which started at 3:00 PM. NA #4 stated that when she came on shift Resident #5 was in bed and she checked to make sure her chair alarm was present but did not check her bed alarm. NA #4 did not indicate why she did not check the bed alarm to make sure it was connected and working. NA #4 stated that they were expected to check Resident #5's alarm when they came on shift and every 2 hours. NA #4 observed and confirmed that the bed alarm was not connected to the bed pad on the bed and stated that is should have been connected for her safety. NA #4 explained there was a "Get to Know Me" sheet for every resident and if there was a question about what fall interventions were in place they could refer to it. Interview with Director of Nursing (DON) on 10/19/16 at 3:10 PM revealed that the nonskid socks and bed and chair alarm were put into place as safety interventions for Resident #5 to prevent falls and it was his expectation that they would be in place as ordered. Interview with the Administrator on 10/19/16 at 3:10 PM revealed that she expected fall interventions to be in place as ordered.	F 282	or actions.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		11/10/16

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F 323	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, a physician interview and medical record review, the facility failed to safely transfer a resident, with a gait belt and 2 staff persons, which resulted in a subcutaneous hematoma (a raised bruise due to a ruptured blood vessel under the skin), a wrist fracture and a blood transfusion for 1 of 3 sampled residents reviewed for supervision to prevent accidents (Resident #1). The findings included: Resident #1 was re-admitted to the facility on 07/16/16. Diagnoses included, in part, diabetes mellitus type 2, Alzheimer's Dementia, age-related osteoporosis, congestive heart failure, anxiety disorder and a history of falls and a myocardial infarction (heart attack). Medical record review revealed Resident #1 received 2 antiplatelet medications daily, Aspirin 81 milligrams (mg) and Plavix 75 mg, for heart attack/stroke prevention. Side effects include increased risk for bleeding/bruising. Review of an admission Minimum Data Set of 07/23/16, Care Area Assessment and Care Plan both of July 2016 revealed Resident #1 was assessed with intact cognition, understood/understands, clear speech, received Hospice Services and required extensive staff assistance with transfers due to unsteady balance. Care plan interventions included the use of a gait belt with the extensive assistance of 2 staff persons with transfers. A skin assessment dated 08/12/16 at 5:54 PM recorded by Nurse #1, assessed Resident #1 with a skin tear to her right index finger, right leg and	F 323	Corrective actions taken for those residents affected: Resident #1 was sent to the emergency room for evaluation on 8/13/16 and subsequently admitted for treatment. Following treatment, Resident #1 returned to the facility on 8/14/16 with further orders for treatment. A care plan previously written to require 2-person transfer was continued. Nurse #1 immediately initiated and followed the facility's abuse/neglect policy and procedures upon discovery of the injury on 8/12/16, which included suspension of NA#1. NA#1 remained on suspension until the conclusion of the investigation on 8/22/16 at which point NA#1 was terminated. Local DSS and the NC Health Care Personnel Registry conducted separate investigations regarding the incident with Resident #1 and both agreed with facility findings and outcomes. Corrective actions taken for those residents with the potential to be affected: An audit of all current Lift/Transfer assessments as well as care plans for transfer requirements was conducted between 11/7/16 – 11/9/16 to verify current requirements for the type of transfer required for each resident. Findings were compared to ensure each was written correctly on the Get To Know Me form for communication with nursing assistants and written correctly on the care plan. Any concerns were	

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F 323	Continued From page 9 left leg with no other skin impairment noted. Review of the facility's Resident Incident Report and a nurse's note (NN) dated 08/12/16 written at 11:30 PM by Nurse #1 recorded that on 08/12/16 at 10:20 PM, Resident #1 presented with a 2.5 inch hematoma on her right forearm. The NN documented that a skin assessment completed earlier in the shift (08/12/16 at 5:54 PM) assessed this area as normal for Resident #1. When asked what occurred, the NN documented that Resident #1 stated the hematoma occurred when a nurse aide (NA) was rough when putting her to bed. Nurse #1 notified the Administrator and Director of Nursing (DON) and initiated the facility's Abuse Protocol. A NN dated 08/13/16 written at 12:44 AM noted that Resident #1 was observed with increased swelling to her right arm from the mid bicep to her wrist. The family and physician were notified and a physician's order was obtained to send Resident #1 to the Emergency Department (ED) for further evaluation. Resident #1 was admitted to the hospital. Review of the Hospital Discharge summary dated 08/14/16 recorded that Resident #1 presented to the ED on 08/13/16 with a subcutaneous hematoma to the left forearm. A left arm Xray completed in the ED revealed a nondisplaced scaphoid (wrist) fracture. The hematoma was treated by clot removal and wound closure, the Resident required one multi-donor pack of platelets, one unit of packed red blood cells and the wrist fracture could not be surgically corrected. Resident #1 was re-admitted to the facility on 08/14/16.	F 323	immediately corrected. Systemic changes made to ensure deficient practice will not occur: The Mechanical Lift/Transfer policy will be revised to include the requirement of the use of 2 staff members for a transfer as determined by the most recent Lift Assessment form. When any lift assessment is updated which changes the type of lift/transfer required, the nurse completing the assessment will immediately write the change directly on the Get To Know Me form (date/time of change). The information changed will also be placed by that same nurse on both the Nurse and CNA 24 hour report forms for communication purposes. Upon receipt/review of the 24 hour report forms, the Risk Management Coordinator will verify that any changes in the type of transfer are written/changed on the Get To Know Me form and will also notify the MDS Coordinator who will ensure that any changes in the type of transfer are written/changed on the care plan. The Nursing Assistant Duties policy will be revised to include the expectation of reviewing the care plan information on the kiosk as well as the information on the Get To Know Me forms which include specific details for type of transfer/number of staff required to perform a safe transfer each day for the provision of each residents' needs. The Administrator will conduct in-services for all current nursing staff between	

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F 323	Continued From page 10 The facility's investigation included a written statement by NA #1 and a documented interview with Nurse #1 and the DON which revealed NA #1 put Resident #1 to bed after dinner without staff assistance or a gait belt. NA #1 stated Resident #1 wore a long-sleeved shirt at the time of the transfer and the NA did not observe any changes in skin integrity to the Resident's left arm after the Resident was put to bed. The investigation also documented that NA #1 was asked why she put Resident #1 to bed without staff assistance or a gait belt and NA #1 replied that she did so because Resident #1 wanted to be put to bed and NA #1 did not want the Resident to complain of having to wait. Review of written statements from NA #2 and NA #3 revealed Resident #1 was noted with a raised area to her left arm at the end of the 3PM - 11PM shift on 08/12/16 when they both went to her room to check her for incontinence and change her clothes. Resident #1 was observed on 10/05/16 at the following times, 10:40 AM, from 12:20 PM to 12:32 PM and at 4:21 PM in her room, in a low bed, covered with a blanket. Staff were observed to encourage and offered to assist Resident #1 with incontinence care, to get out of bed to toilet, sit in her wheelchair and attend activities, but Resident #1 declined each offer and replied "Come back later." On 10/05/16 at 4:53 PM Resident #1 agreed to transfer to her wheelchair. Two nurse aides applied a gait belt, provided extensive assistance to Resident #1 to stand from her bed, pivot and transfer to her wheelchair. The transfer occurred without incident. Resident #1 wore a long sleeved shirt and pants, bilateral geri sleeves and non skid socks. Bruising was noted to her left arm. When	F 323	11/10/16 – 11/11/16 on the policy revisions for the Mechanical Lift/Transfers and Nursing Assistant Duties to ensure awareness of the changes and expectations for resident safety with transfers. Any new nursing staff hired after 11/11/16 will be educated during their initial orientation on the use of the Get To Know Me forms as well as the policies/procedures for Mechanical Lifts/Transfers and Nursing Assistant Duties. How will the facility monitor its performance to make sure solutions are sustained: Each nurse assigned to each unit/hall will observe (2) resident transfers in which either a mechanical lift or 2-person assist was required every shift daily X 2 weeks followed by weekly X 4 weeks, and finally monthly X 3 months to ensure the transfer occurred as care planned. Any concerns will be immediately corrected through the disciplinary process up to and including termination for failure to follow the care plan as written. The Medicare/Restorative Nurse will review 3 Get To Know Me forms from each unit daily X 2 weeks, followed by weekly X 2 weeks, and finally monthly X 3 months to ensure information from the most recent lift assessment are written and/or changed on the form for staff communication. Any concerns will be immediately corrected and reported to the DON for further disciplinary action for failure to follow policy for resident safety.	

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F 323	Continued From page 11 asked by the surveyor if she could recall a time she was transferred by 1 staff person instead of 2 or was injured during a transfer and went to the hospital, Resident #1 stated "I don't know." An interview with the Administrator and DON occurred on 10/05/16 at 1:15 PM and revealed Nurse #1 called the DON on 08/13/16 around 11:00 PM to notify of Resident #1's hematoma that resulted from the 1 person transfer and the allegation of physical abuse. The DON stated Nurse #1 immediately assessed Resident #1 and suspended NA #1, NA #2 and NA #3. The DON stated that Nurse #1 continued to monitor Resident #1, around 12:00 AM Nurse #1 noted the Resident's hematoma was larger and Resident #1 complained of pain, the physician was called and an order obtained to send Resident #1 to the hospital for further evaluation. The DON also stated that Resident #1 was transferred to the hospital on 08/13/16 with a hematoma that opened and was lanced during the hospital course. The DON stated upon return to the facility, Resident #1 was assessed with the same capabilities to her left arm as before the injury. The Administrator stated NA #1 was interviewed as part of the investigation and asked why she chose to transfer Resident #1 without assistance. NA #1 stated that Resident #1 asked to be put to bed and NA #1 did not want to upset the Resident, so she just transferred the Resident without help because Resident #1 does not like to wait when she wants to go to bed. The Administrator further stated that once the investigation was completed, NA #1 was terminated. During an interview on 10/05/16 at 3:00 PM, Nurse #1 stated NA #2 reported to him on	F 323	Findings from the transfer observations conducted by nurses and the review of the Get To Know Me forms by the Medicare/Restorative Nurse will be reviewed by the Director of Nursing as well as any corrections required upon the completion of each. The Director of Nursing will report findings to the QA&A Committee monthly for any further recommendations or actions.	

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F 323	Continued From page 12 08/12/16 after the end of the 3 PM - 11 PM shift, that Resident #1 was found in bed dressed in her day clothes, by NA #2 and NA #3, with a raised bruise to her left arm when they went to check the Resident for incontinence and change her clothes. Nurse #1 stated his NN dated 08/12/16 and 08/13/16 documented a hematoma to the right arm instead of the left arm in error. Nurse #1 stated he assessed Resident #1 with a raised bruise to her left arm the size of his fist. Nurse #1 stated Resident #1 denied pain, he applied a dry bandage to keep the area intact and continued to monitor. Nurse #1 stated Resident #1 alleged the hematoma occurred when she was put to bed by a NA, but she could not recall who or the specific time the incident occurred. Nurse #1 stated he immediately implemented the facility's Abuse Protocol. Nurse #1 stated when he interviewed staff, NA #1 stated she put Resident #1 to bed after dinner without a gait belt or staff assistance which required Resident #1 to hold onto the side rail and assist with the transfer. Nurse #1 further stated he determined that must have been when the hematoma occurred because Resident #1 required a gait belt and the extensive assistance of 2 staff persons with transfers and when he completed a skin audit around 5:30 PM on 08/12/16 the hematoma to her left arm was not there. Nurse #1 further stated that when he went back to check on Resident #1 he noted that her left arm had increased swelling, the bruise had spread to her left upper arm and Resident #1 complained of pain. Nurse #1 further stated he contacted the physician and obtained an order to send Resident #1 to the hospital for further evaluation. During an interview on 10/05/16 at 3:14 PM, NA #2 stated she worked the 3PM - 11PM shift on	F 323		

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F 323	Continued From page 13	F 323		

08/12/16 and that she was the assigned NA for Resident #1. NA #2 stated at the end of the shift on 08/12/16, she and NA #3 completed their final rounds, responded to the call light for Resident #1 who requested incontinence care and to be changed into her night clothes. NA #2 stated when she removed the Resident's shirt NA #2 noted a raised bruise to the Resident's left arm. Resident #1 reported to NA #2 that the bruise happened when a NA put her to bed earlier, but that she could not recall who put her to bed or what time. NA #2 stated she immediately reported the bruise to Nurse #1 and while at the nurse's station, NA #1 stated that she put Resident #1 to bed alone, after supper.

During a telephone interview on 10/05/16 at 5:41 PM, the Medical Director (MD) stated that Resident #1 was at increased risk for fractures due to her age/comorbidities. The MD stated that the wrist fracture Resident #1 sustained could have occurred as a result of being transferred on 08/12/16 without a gait belt by 1 staff person instead of 2 staff. The MD stated Resident #1 could stand/pivot during transfers, but that her assistance was minimal, which placed the primary responsibility on the staff during transfers. The MD stated Resident #1 required 2 person extensive assistance to transfer or she would fall. The MD also stated he did not know why NA #1 chose to transfer Resident #1 alone, but that it was a mistake that had a bad outcome. The MD further stated that it was quite possible that the 1 person transfer for Resident #1 that occurred on 08/12/16 resulted in her fractured wrist. He stated to be transferred safely, Resident #1 required the extensive assistance of 2 staff persons.
Attempts to interview NA #1 and NA #3 were

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F 323	Continued From page 14 unsuccessful. During a follow up interview on 10/06/16 at 12:30 PM, the Administrator stated the facility's investigation unsubstantiated the allegation of abuse due to a lack of willful intent, but NA #1 was terminated for not following the plan of care for Resident #1 which resulted in injury to the Resident. The Administrator stated the facility began corrective measures in response to the 08/12/16 incident that resulted in injury for Resident #1 and monitoring was ongoing.	F 323		

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L 039	.2208(E) SAFETY 10A-13D.2208 (e) The facility shall ensure that: (1) the patients' environment remains as free of accident hazards as possible; and (2) each patient receives adequate supervision and assistance to prevent accidents. This Rule is not met as evidenced by: This is a Type B Violation (§ 131E-129. Penalties; remedies). Based on record review, staff, and physician interviews, the facility failed to develop a care plan for falls and supervise a resident to ensure physician ordered fall interventions were in place. This resulted in a resident falling and sustaining a fractured hip for 1 of 3 residents investigated for accidents (Resident #1). Findings included: Resident #1 was admitted to the assisted living facility (ALF) on 01/13/16 with diagnoses that included history of falls, unsteadiness on feet, lack of coordination, dementia, major depressive disorder, anxiety, hypertension, insomnia, and others. Review of a facility document titled New Admission Assessment dated 01/14/16 revealed that Resident #1 was alert and oriented to person and place and was independent with dressing and ambulation with the use of a walker. The New Admission Assessment also indicated that Resident #1 required no safety devices. Review of Resident #1's medical record on the ALF unit revealed no care plan for falls. Review of physician order dated 05/13/16 read	L 039	Corrective actions taken for those residents affected: Resident #1 was sent to the emergency room for evaluation on 9/17/16 @ 3:25pm following results of a mobile x-ray and subsequently admitted for surgery. Resident #1 returned to the facility in skilled level of care on 9/22/16. A tab alarm was ordered and placed on Resident #1 on 9/23/16 to alert staff of unsafe movements. Resident #1 was also placed on caseload for physical therapy on 9/26/16 and occupational therapy on 9/27/16 with the goal of returning to assisted living level of care as able. A care plan for falls was developed and implemented for Resident #1 following her admission MDS assessment on 10/4/16. Corrective actions taken for those residents with the potential to be affected: The Director of Nursing completed an audit of all assisted living residents between 10/24/16 – 10/25/16 on all orders for safety interventions related to falls/fall risk. Findings were then compared to ensure each was written correctly on the	11/10/16

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L 039	Continued From page 1 resident is to wear nonskid sock when shoes are not worn for fall safety. Review of the Medication Administration Record (MAR) dated 09/01/16 through 09/30/16 revealed Tramadol 50 milligrams (mg) by mouth was administered 09/17/16 at 8:20 AM for pain and was effective. Other medications that Resident #1 was prescribed that placed Resident #1 at increased risk of falls included Effexor, Aricpet, Namenda, and Klonopin. Review of a facility document titled "Resident Incident Report" dated 09/17/16 at 2:00 AM revealed that Resident #1 was found on the floor in her room near the air conditioning unit. A form titled "Questions After a Fall" that was attached to the Resident Incident Reported and dated 09/17/16 revealed that Resident #1 was found on the floor near the air conditioning unit on her left side and had on socks that were not nonskid socks. The form also indicated that there were no trip hazards that Resident #1 appeared to have moved everything before she fell and range of motion (ROM) was within normal limits for Resident #1. No other injury was identified. The form also indicated that Resident #1 had no pain. A nurse statement from Nurse #2 on the form indicated that Resident #1 voiced no pain until we got her into bed, Resident #1 then stated that she could not move her left leg. Nurse #1 again performed ROM and no complaints of pain were voiced. Review of a nurse's note dated 09/17/16 at 2:16 AM read in part the Nursing Assistant (NA) entered Resident #1's room and observed Resident #1 laying on the floor on her left side. Resident #1 stated that she had fallen while getting into her wheelchair. Her wheelchair was observed to be locked and on the other side of the room. Resident #1 was wearing pants with both legs in one leg hole. Resident #1 was laying	L 039	Get To Know Me form for communication with nursing assistants and through visual checks to ensure each currently in place as ordered. Any concerns from the audit were immediately addressed and corrected. The Administrator completed an audit of all assisted living residents between 11/7/16 – 11/9/16 which compared all current orders for safety measures/interventions related to falls/fall risk to the most recent Fall Risk Assessment and care plan for all assisted living residents—all care plans were updated to match the Fall Risk Assessment and any orders for safety devices/safety measures as written. Get To Know Me forms were once again audited at that time for comparison to ensure accuracy for CNA communication. Systemic changes made to ensure deficient practice will not occur: The MDS policy will be revised to include assessment and care plan procedures for assisted living residents upon admission, with any significant change, and at least annually to ensure care plans are in place for the care needs of those in assisted living. This policy also includes the procedures for the completion of and use of the Get To Know Me forms which will be revised to indicate that any nurse who processes an order for any type of safety device, intervention, or measure will update the Get To Know Me form (date/time of change), include the information on both the Nurse and CNA 24 hour report forms, and notify the assigned	

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L 039	Continued From page 2 in the middle of floor and appeared to have moved roommate's chair and table away from her prior to falling. Resident #1 stated she had no pain or discomfort and indicated she did not hit her head. ROM was within normal limits for Resident #1. Resident #1 was assisted back to bed and pants and brief were changed and she began complaining of pain in her left knee and hip. Slight redness was noted to the left hip where resident had been laying on it. When ROM performed again resident had no complaints. When Nurse #2 mentioned "there doesn't seem to be any problems", Resident #1 began saying she was in pain and demanded that we call her family multiple times. Nurse #2 called Resident #1's family and they asked that Resident #1 be monitored and if complications arose to send Resident #1 to the hospital. Nurse #2 assured Resident #1's family that she would be monitored. No signs of acute distress were noted. Signed by Nurse #2. Review of a physician order dated 09/17/16 at 12:13 PM read X-ray pelvis, left hip, and left knee. Review of X-ray report dated 09/17/16 read in part there was an acute fracture with proximal retraction of the distal fracture segment and increased angulation deformity. There was also a fracture at the junction of the acetabulum with superior pubic ramus and appears to be a fracture of the ischium that is age indeterminate. Review of a physician order dated 09/17/16 at 3:26 PM read, Send to emergency room (ER) for evaluation and treatment. Review of a nurse's note dated 09/17/16 at 3:43 PM read in part, this am Resident #1 complained of left leg and hip pain and was medicated with as needed tramadol and the medication was effective. Resident #1 was noted to be dragging left leg and unable to hold it up while being	L 039	CNA currently responsible for care immediately for the purposes of communication. Upon receipt/review of the 24 hour report forms and the copies of all orders written for the previous day: •the Risk Management Coordinator will verify that any changes in the type of transfer and/or safety measures are written/changed on the Get To Know Me form. •the MDS Coordinator will ensure that any changes in the type of transfer and/or safety measures are written/changed on the care plan. The Falls Management Program will be revised to include specific monitoring by the nurse on duty following any fall for the first 24 hours to ensure the immediate safety as well as the effectiveness or lack thereof of any safety measures implemented: • every 30 minutes X 2 hours • every hour X 4 hours • every 2 hours X 6 hours • every 4 hours X 12 hours The Falls Management Program will also be revised to include the expectation of the nurse on duty at the time of the fall to: a)implement a new intervention following the fall to ensure continued safety b)note any safety interventions/measures/devices on the Get To Know Me form and the 24 hours report forms for both the nurses and CNA's to ensure communication c)readmission from the hospital following a fall with injury will have safety	

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L 039	Continued From page 3 pushed in the wheelchair. Upon assessment noted swelling and knots to the left knee and left hip. Interview with Nurse #2 on 10/19/16 at 10:03 AM revealed that she routinely worked 3rd shift and routinely took care of Resident #1. Nurse #2 stated that on the ALF unit the NAs rounded and checked on the residents every 2 hours and the ALF residents were able to ring their call bell if they need anything between the 2 hour checks. Nurse #2 recalled the fall on 09/17/16 when Resident #1 fell and stated that one of the NAs answered the call light and Resident #1 was on the floor on her left side. Resident #1 stated she had fallen in front of the air conditioning unit but it appeared everything had been moved prior to the fall. Resident stated to Nurse #2 "I fell on the floor yeah yeah ok and I hit my head on the air condition unit." Nurse #2 stated that ROM for Resident #1 was within normal limits for her and there was no pain or injury noted. Nurse #2 stated she checked her pupils and got her vital signs and got her back into bed and nothing was bothering her. Once in bed Resident #1 stated that she was hurting and needed to go to the hospital but Nurse #2 could not recall where Resident #1 was hurting it may have been her head. Nurse #2 stated that she again performed ROM and Resident #1 had no complaints of pain or discomfort. Nurse #2 stated that the remainder of the shift she performed neurological assessment approximately every 30 minutes and Resident #1 would sleep in between the assessments and had no other complaints during the night. Nurse #2 stated that when Resident #1 fell she had on regular socks and they were not nonskid socks. Nurse #2 stated that she could not recall what fall interventions were in place at the time of the fall and after the fall did not think there was any fall interventions that she should	L 039	interventions/measures/devices immediately implemented and noted on the Get To Know Me form and the 24 hours report forms for both the nurses and CNA's to ensure communication The Incident/Accident policy will be revised to include implementation of a new incident/accident report used following any fall which will also be used immediately by the nurse on duty to conduct a full analysis of the factors/conditions at the time of the fall including: •the lack of or failure of any safety devices ordered/care planned •a post-fall action plan to ensure any safety devices ordered/care planned are reviewed, in place on the Get To Know Me form for communication, and actually put in place following the fall according to orders/care plan as written •review of the possible root cause(s) of the fall •implementation of a new intervention based on the possible root cause(s) immediately The new incident/accident report will then be used to continue the analysis of the fall by the Risk Management Coordinator through a mini QA meeting held daily (Monday – Friday) as well as the Falls Committee which meets weekly for any further discussion related to the root cause(s) and further recommendations for safety interventions. The Report Guidelines (Nurses/CNA's) policy will be revised to include the expectation that walking rounds be conducted between shifts by the nurses	

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L 039	Continued From page 4 have initiated. Nurse #2 could not recall if they placed nonskid socks on Resident #1 after the fall or not. Nurse #2 stated she did not administer any pain medication to Resident #1 during her shift. Interview with NA #4 on 10/19/16 at 10:34 AM revealed that she was responsible for providing care to Resident #1 on 09/17/16 when she fell. NA#4 was also responsible for Resident #1 on the evening shift on 09/16/16 per the facility's assignment sheet. NA #4 stated that on this particular day she had worked a double, 2nd shift on 09/16/16 and 3rd shift going into 09/17/16. NA #4 stated that Resident #1's roommate rang the call light and when I answered the call light Resident #1 was laying on the floor. Resident #1 stated she was trying to get to the bathroom. NA #4 stated that Resident #1 complained of pain but could not recall where she was hurting. NA #4 stated she immediately went and got Nurse #2 who came and assessed Resident #1. After Nurse #2 had assessed Resident #1 we used a gait belt to get Resident #1 back into her bed and Resident #1 had no complaints of pain while transferring back to her bed. NA #4 stated that once Resident #1 was back in bed she did complain of pain down her side but could not recall which side. NA #4 did not recall assisting Resident #1 on the evening shift in getting ready for bed and did not assist her with putting on nonskid socks. NA #4 stated she did not check to see if Resident #1 was wearing nonskid socks at the start of 3rd shift and could not remember if they placed her nonskid socks on Resident #1 after the fall. Interview with Nurse #3 on 10/19/16 at 10:36 AM revealed that she was working with Resident #1 on 1st shift on 09/17/16 after her fall at 2:00 AM. Nurse #3 stated that the NAs had gotten her up to her wheelchair for breakfast like they usually did	L 039	and nursing assistants to visually check that all safety measures that are currently ordered and care planned are actually in place and any alarms are working properly/attached/turned on. Each staff member involved in conducting the round will sign the bottom of the 24 hour report form (2 signatures per shift) indicating rounds were complete and all safety measures/devices/interventions are in place as ordered and care planned. The Nursing Assistant Duties policy will be revised to include the expectation of reviewing the care plan information on the kiosk as well as the information on the Get To Know Me forms which include specific details for type of transfer/number of staff required to perform a safe transfer as well as any safety devices/interventions each day for the provision of each residents' needs. This policy will also include the expectation for making walking rounds with the oncoming shift to review the CNA 24 hour report form with any changes noted for transfers/safety measures together and signing the completion of such rounds indicating rounds were complete and all safety measures/devices/interventions are in place as ordered and care planned. The Administrator will conduct in-services for all current nursing staff between 11/10/16 – 11/11/16 on the changes to the MDS policy regarding the Get To Know Me form as well as the policy/procedures for the Falls Management Program, Incident/Accidents, Report Guidelines (Nurses/CNA's), and Nursing Assistant	

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	NH0386	A. BUILDING: _____ B. WING _____	C 10/19/2016

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L 039	Continued From page 5 and Resident #1 was complaining of pain in her left knee and hip and would not hold her leg up it would just drag and Resident #1 kept wanting to lay back down. Nurse #3 stated that while Resident #1 was in the wheelchair she assessed her left hip and felt a knot and went ahead and placed a call to the physician. Nurse #3 stated that in report Nurse #2 had stated that Resident #1 complained of pain and they had given her something and she was fine. Nurse #3 could not recall if she had given Resident #1 anything for pain that morning or not. Nurse #3 stated she was not aware of any fall interventions that were in place for Resident #1. Nurse #3 stated that she had gone to lunch and while she was at lunch her coworker took the return call from the physician and took the order for X-rays. Nurse #3 stated when she returned from lunch she then processed those orders and ordered the X-rays. Interview with Director of Nursing (DON) on 10/19/16 at 3:10 PM revealed that after a fall occurs the nurse's complete the incident report and the form, Questions After a Fall, and the quality assurance nurse picks those up the following morning or on Monday morning after the weekend. The incidents are then discussed daily during the standup meeting and again at their weekly risk meeting. Both of those meeting are interdisciplinary and the team brainstorms on interventions that could be tired to help prevent the fall. With Resident #1, the DON stated she was very high functioning and would often remove safety interventions. The DON stated that the nonskid socks were put into place as a safety intervention to prevent falls and it was his expectation that they would have been in place. To say that they would have prevented the fall would be speculation and we cannot go back and redo the situation. The DON further stated that he felt like that they did all that they could have	L 039	Duties policies. Nurses will be given a copy of the revised Incident/Accident report & analysis form with overview of the changes and expectations of what the nurse will be responsible for related to any fall upon occurrence. New nursing staff hired after 11/11/16 will be educated during their initial orientation on the use of the Get To Know Me forms as well as the policy/procedures for Falls Management, Incidents/Accidents Report Guidelines (Nurses/CNA's), and Nursing Assistant Duties policies. How will the facility monitor its performance to make sure solutions are sustained: The Medicare/Restorative Nurse will review 3 Get To Know Me forms from each unit daily X 2 weeks, followed by weekly X 2 weeks, and finally monthly X 3 months to ensure information from the most recent lift assessment as well as any orders for safety devices/interventions are written and/or changed on the form for staff communication. Any concerns will be immediately corrected and reported to the DON for further disciplinary action for failure to follow policy for resident safety. Completion of the revised Incident/Accident report including the specific monitoring by the nurse on duty following any fall for the first 24 hours to ensure the immediate safety as well as the effectiveness or lack thereof of any safety measures implemented will be monitored by the Risk Management Coordinator upon review of each individual Incident/Accident report form as it is	

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L 039	Continued From page 6 done to keep Resident #1 safe from falls and injury. Interview with the Administrator on 10/19/16 at 3:10 PM revealed that she expected ordered fall interventions to be in place as ordered. Interview with the Medical Director on 10/19/16 at 3:21 PM revealed that he took care of Resident #1 but could not speak to specifics of Resident #1 because he sees a lot of patients and would need to see the chart. The Medical Director stated that without the nonskid socks in place it certainly places the resident at high risk of falls but could not speak to the specifics of Resident #1 without looking at her chart.	L 039	completed. The Risk Manager will contact nurse on duty at the time of the fall if there are any concerns related to the completion of the form which will be corrected by the within 24 hours—continued concerns with the same nurse for failure to complete the Incident/Accident report thoroughly per policy will result in disciplinary action up to and including termination. Each Nursing Supervisor will participate in walking rounds on his/her shift with the nurses and CNA's to observe that staff are following the procedures of conducting such rounds by visually checking to ensure that all safety measures currently ordered/care planned are actually in place and any alarms are working properly/attached/turned on. With each round observed, the Nursing Supervisor will sign the bottom of the 24 hour report form with the 2 staff members indicating rounds were complete and all safety measures/devices/interventions are in place as ordered and care planned. This will be done daily X 1 week, followed by weekly X 5 weeks, and finally monthly X 3 months. Any concerns will be immediately corrected and addressed through the disciplinary process up to and including termination for failure to follow the care plan as written. Findings from the Get To Know Me forms reviewed by the Medicare/Restorative Nurse, concerns related to the completion of the incident/accident reports, and the 24 hour rounds forms signed by the Nursing Supervisors will be reviewed by the Director of Nursing as well as any	

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L 039	Continued From page 7	L 039	corrections required upon the completion of each. The Director of Nursing will report findings to the QA&A Committee monthly for any further recommendations or actions.	