STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 03/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON SALEM NURSING & REHABILITATION CENTER	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(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 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on resident, staff interviews and records review, the facility failed to offer showers as scheduled for 3 of 40 sampled residents. (Resident # 5, Resident # 10 and Resident # 11). The findings included: 1. Resident #5 was admitted to the facility on 11/5/2014 with the diagnoses of Dementia, muscle weakness and hyperlipidemia. The quarterly Minimum Data Set (MDS) dated 3/14/2016 indicated Resident #5 had no cognitive impairments and no behavioral problems. Resident # 5 was coded as totally dependent with 1 person for her hygiene and bathing. The resident's care plan updated 3/14/2016 indicated the resident's shower days as Mondays, Wednesdays and Fridays A review of the 400 hall Shower List dated	F 242	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Winston-Salem Nursing & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. 1. Corrective action for resident affected, Resident #5, #10, #11 were interviewed by social services director to determine shower preferences.this information will be up dated on residents care guide by	4/21/17

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

Electronically Signed | 04/20/2017

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F 242	Continued From page 1 3/27/2017 indicated Resident # 5 shower days were Mondays, Wednesdays and Fridays. A review of the Task: ADL(Activity of Daily Living) - Bathing (Prefers Shower) Sheet (this is the printed sheet from the Nursing Assistants electronic kiosk data entry) for Resident #5 indicated no refusals and no showers done on Mondays, Wednesdays and Fridays or any other days of the week for the months of January 2017, February 2017 and March 2017. A review of the nursing progress notes from 1/1/2017 to present made no mention of Resident #5 refusing her showers. In an interview on 03/28/2017 at 9:25 AM, Resident # 5 stated she was not given showers on her scheduled shower days of Mondays, Wednesdays and Fridays. The resident stated she only got bed baths every day and no showers. She also said the staff only gave her baths and had not offered to give her showers for the last 3 months since the facility did away with the shower team. In an interview on 03/28/2017 at 3:36 PM, Nursing Assistant (NA) #1 who was assigned to the resident stated showers were not given due to not having enough staff at the facility most of the time. NA #1 reported any refusals were to be reported to the nurse and documented on her kiosk. She did not recall Resident # 5 as refusing her showers. In an interview on 03/28/2017 at 4:00 PM, the Administrator stated it was her expectation that the residents receive their showers as scheduled and if they refused, the staff was to attempt again	F 242	social work, unit managers and charge nurses to ensure residents are receiving showers as scheduled. 2. Corrective action will be accomplished for those residents having potential to be affected, resident population will be interviewed by Social Services, unit managers and charge nurses on admission, quarterly assessments and per resident preferences. The shower preferences will be updated on Care guides. 3. Measures/Systemic changes to ensure deficient practice will not occur: The Director of Nurses and Unit Managers and Staff Development Coordinator will re-educate nursing staff regarding the Residents Right to make choices with emphasis on showers.Education will be incorporated into new employee orientation program for nursing staff. 4.Monitoring Process ,The Director of Nurses, Unit Managers, and charge nurses will audit 40 residents shower schedules 2 times weekly, times 4 weeks, weekly times 4 and then monthly times 3 to ensure ongoing compliance. Data collection to be analyzed and reviewed at monthly Quality Assurance meeting for 3 months with subsequent POC as needed.	

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later and should report it to the Charge Nurse on shift.

2. Resident # 10 was admitted to the facility on 11/3/2010 with the diagnoses of muscle weakness, major depressive disorder and hemiplegia. The quarterly Minimum Data Set (MDS) dated 1/25/2017 indicated Resident #10 had no cognitive problems and no behavioral problems. Resident #10 was coded as totally dependent with 2 person for her hygiene and bathing. The resident's care plan updated 1/25/2017 indicated the resident's shower days as Tuesdays, Thursdays and Saturdays.

A review of the 400 hall Shower List dated 3/27/2017 indicated Resident # 10 shower days were Tuesdays, Thursdays and Saturdays.

A review of the Task: ADL(Activity of Daily Living) - Bathing (Prefers Shower) Sheet (this is the printed sheet from the Nursing Assistants electronic kiosk data entry) for Resident #10 indicated no refusals and no showers done on Tuesdays, Thursdays and Saturdays or on any other dates for the months of January 2017, February 2017 and March 2017.

A review of the nursing progress notes from 1/1/2017 to present made no mention of Resident #10 refusing her showers or baths.

In an interview on 03/28/2017 at 9:40 AM, Resident # 10 stated she was not given showers on her scheduled shower days of Tuesdays, Thursdays and Saturdays. She reported she did not get showers at the facility on any day of the weekend and received only bed baths. She

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added it had been a while since she got a shower. She also indicated she would like to have showers on her scheduled shower days or any other day of the week.

In an interview on 03/28/2017 at 3:36 PM, Nursing Assistant (NA) #1 stated showers were not given due to not having enough staff at the facility most of the time. NA #1 reported any refusals was to be reported to the nurse and documented on her kiosk. She did not recall Resident # 10 as refusing her showers.

In an interview on 03/28/2017 at 4:00 PM, the Administrator stated it was her expectation that the residents receive their showers as scheduled and if they refused, the staff was to attempt again later and should report it to the Charge Nurse on shift.

3. Resident # 11 was admitted to the facility on 9/11/2015 with the diagnoses of hemiplegia, muscle weakness and contracture. The quarterly Minimum Data Set (MDS) dated 12/26/2016 indicated Resident #11 had no cognitive impairments and no behavioral problems. Resident #11 was coded as totally dependent with 2 person for her hygiene and bathing. The resident's care plan updated 12/26/2016 indicated the resident's shower days as Mondays, Wednesdays and Fridays

A review of the 400 hall Shower List dated 3/27/2017 indicated Resident # 10 shower days were Mondays, Wednesdays and Fridays.

A review of the Task: ADL(Activity of Daily Living) - Bathing (Prefers Shower) Sheet (this is the

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F 242	Continued From page 4 printed sheet from the Nursing Assistants electronic kiosk data entry) for Resident #11 indicated no refusals and no showers done on Mondays, Wednesdays and Fridays or any other day of the week for the months of January 2017, February 2017 and March 2017. A review of the nursing progress notes from 1/1/2017 to present made no mention of Resident #11 refusing her showers or baths. In an interview on 03/28/2017 at 9:29 AM, Resident # 11 stated she was not given showers on her scheduled shower days of Mondays, Wednesdays and Fridays. The resident stated it had been a while since she got a shower any day of the week. She added she had asked for showers but she did not know why she had not been given the showers yet. In an interview on 03/28/2017 at 3:36 PM, Nursing Assistant (NA) #1 who was assigned to the resident stated showers were not given due to not having enough staff at the facility most of the time. NA #1 reported any refusals was to be reported to the nurse and documented on her kiosk. She did not recall Resident # 11 as refusing her showers. In an interview on 03/28/2017 at 4:00 PM, the Administrator stated it was her expectation that the residents receive their showers as scheduled and if they refused, the staff was to attempt again later and should report it to the Charge Nurse on shift.	F 242		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		4/21/17

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F 309	Continued From page 5 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assess 1 of 2 sampled residents who had a fall resulting to a right femur fracture	F 309	1. Corrective action for resident #6: Resident #6 was assessed by the RN and sent to the hospital for treatment.	

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F 309	Continued From page 6 and right humerus fracture (Resident # 6). Findings included: Resident # 6 was admitted to the facility on 10/7/2014 with diagnoses of Hypertension, Renal Failure and Osteoarthritis. The most current Minimum Data Set (MDS) dated 1/16/2017 revealed the resident had no short or long term memory problems; she needed extensive assistance with 1 person for bed mobility and extensive assistance with 1 person for transfer. Resident #6's Care Area Assessment (CAA) worksheet dated 7/6/2016 documented "Resident requires limited to extensive one person assistance with Activities of daily Living (ADL)'s except set-up for eating. Staff intervention is necessary to identify risk factors and solutions to help prevent decline in ADL's and complications. She is alert and able to make her needs known to staff. She wheels self in wheelchair around unit. She has had one fall since last assessment with no injury. This places her at increased risk for further falls, skin breakdown, dignity issues and weight loss. Further falls may cause fractures, increased pain and decline in overall function. Staff intervention is necessary at this point to identify and address risk factors to prevent further falls from occurring." Resident # 6's care plan dated 1/21/2017 documented "the resident is at risk for falls due to decreased mobility." The care plan documented the following interventions: "Keep environment free of hazards, Do not leave resident unattended without safety device, Eliminate potential hazards, Give resident verbal reminders not to try to ambulate or transfer without assistance."	F 309	Resident #6 was transferred to the hospital emergency department on 3-12-2017 for further evaluation. Resident #6 was returned to the facility on 3-13-2017.Rn will be re- educated by Director of nursing services regarding procedures to assess a resident after a fall.NA#1 was suspended and terminated for failure to report a fall. 2.Corrective action for residents that have the potential to be affected by the alleged deficient practice will include: An audit was conducted on residents that had a fall in the last 30 days to ensure assessment was completed.Residents will be assessed by the licensed nurse to determine any immediate injury. Residents that have had a fall will be re-assessed with in 24 hours by unit manager/charge nurse. 3.Measures/Systemic changes to ensure deficient practice will not occur: Licensed nurses will be educated by the Director of Nursing regarding the procedure of assessing a resident after a Fall, education included in new employee education orientation program. 4.Monitoring Practice: Falls will be reviewed during morning clinical meeting by Nursing Administration team to assure appropriate assessment and intervention. Nursing Supervisor to review on weekends. Falls/Assessment data to be reviewed at weekly Risk Meeting and will be reviewed and analyzed at monthly Quality Assurance meeting for 3 months	

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F 309	Continued From page 7 On 3/12/2017 a nurse's note at 3:21 PM documented "Resident with right arm and right leg pain this morning at 8:00 PM. Resident # 6 stated she was not sure why it's hurting so bad but wants the doctor to look at it. Resident # 6 has refused going to the hospital at that time. At current time, resident's right arm is very swollen. Resident is requesting to go to the hospital for evaluation." Review of the resident's incident report dated 3/12/2017 revealed under description "Resident with pain in right arm after staff assistance with transfer from bed to wheelchair." The incident report under description of resident's injury subheading documented "completed interview with the resident, who is usually alert and oriented seems hesitant to clarify what happened. The resident further stated she was hollering for help and she went and got help after NA#1 helped her up after she fell." The report indicated the resident had a fracture of a right femur and a right humerus. Review of the facility's investigation summary note date 3/13/2017 documented " Per resident, NA #1 came in; resident showed NA#1 the clothes she wanted to put on and resident reports she was sitting on side of bed. NA #1 assisted with putting clothes on, and then resident requested to have wheelchair placed by the bed. Resident # 6 asked was the wheelchair locked; NA#1 replied yes. Resident # 6 states she attempted to transfer self from bed to wheelchair, and the wheelchair slipped; she fell on the floor and wheelchair was on top of the resident. Resident states that NA #1 assisted her back to chair, she then complained of right arm pain, and the NA#1 apologized." Summary note also	F 309	with subsequent plan of correction as needed.	

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documented "per NA#1 interview, she assisted resident out of bed to wheelchair with the assistance of another Nurse assistant. NA#1 states that resident started complaining of right arm pain after transferring to wheelchair from bed."

Review of the discharge summary dated 3/12/2017 revealed the resident was discharged back to the facility with the diagnoses of fracture of right humerus and fracture to right femur.

Observation of Resident # 6 at 7:35 PM on 3/26/17 revealed the resident as alert and talkative. It was noted the resident's right arm as swollen with pitting edema. Right arm was up on pillows.

During the interview with Nurse Assistant (NA) # 2 on 3/28/2017 at 10:13 AM, she reported she was not assigned to take care of the resident on 3/12/2017 but she assisted NA#1 to transfer Resident # 6 from the bed to the wheelchair. She reported she was assigned opposite hall from Resident #6's hall. NA# 1 ask her to help transfer resident # 6 to the wheelchair. She went in the room and she saw Resident # 6 was on the bed moaning a little. She stated they put the resident in the wheelchair and after that the resident was complaining about her right arm hurting.

During the interview with Med Aide # 1 on 3/28/2017 at 1:30 AM, she reported she was assigned to Resident # 1 on 3/12/2017. She stated it was in the morning when it was reported to her by NA #1 that the resident's arm was swollen. She reported she notified the supervisor who came and did an assessment on the resident. The resident did not want to go to the

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F 309	Continued From page 9 hospital so she gave her pain medication since her vital signs were stable. During the interview with the Administrator on 3/28/2017 at 4:00 PM, she reported that on 3/12/2017 she received a call from the weekend supervisor who was letting her know about a possible fall with Resident # 6 that had happened some time on 7-3 shift. She was informed that the fall resulted in a fracture. She added she went in on Monday morning around 8am and spoke with Resident # 6, she told her that they dropped her, and she asked her how it happened, she then told her she fell when sitting in her wheelchair because the wheels were not locked, and then she said the chair turned over on her. The Administrator said she immediately started looking at staff that had worked with the resident before she had injury. She added NA # 1 was on duty on 3/12/2017 in 7-3 shift, the injury occurred when she was trying to transfer Resident #6 . The administrator felt that NA # 1 lifted Resident # 6 from the floor and sat her on the edge of the bed, went and got NA # 2 to assist her before getting a nurse to assess the resident. She added her expectation was for staff to lock the wheelchair and assist the residents with transfers to prevent accidents.	F 309		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision	F 323		4/21/17

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F 323	Continued From page 10 and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews, the facility failed to provide a safe transfer for 1 of 2 sampled residents, resulting right femur fracture and right humerus fracture. (Resident # 6). Findings included: Resident # 6 was admitted to the facility on 10/7/2014 with diagnoses of Hypertension, Renal Failure and Osteoarthritis. The most current Minimum Data Set (MDS) dated 1/16/2017 revealed the resident had no short or long term memory problems; she needed extensive assistance with 1 person for bed mobility and extensive assistance with 1 person for transfer. Resident # 6's Care Area Assessment (CAA) worksheet dated 7/6/2016 documented "Resident requires limited to extensive one person assistance with Activities of daily Living (ADL)'s	F 323	1.Corrective Action for resident affected: Resident #6 was transferred to the hospital emergency department on 3-12-2017 for further evaluation. Resident #6 was returned to the facility on 3-13-2017.Resident #6 was transferred to the hospital for appropriate treatment.Rn will be re- educated by Director of nursing services regarding procedures to assess a resident after a fall.NA #1 was suspended and terminated for failure to report a fall. 2.Corrective action for those residents with the potential to be affected: Current resident populations care guides were reviewed and updated to reflect method of resident transfer. Method of transfer will	

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F 323	Continued From page 11 except set-up for eating. Staff intervention is necessary to identify risk factors and solutions to help prevent decline in ADL's and complications. She is alert and able to make her needs known to staff. She wheels self in wheelchair around unit. She has had one fall since last assessment with no injury. This places her at increased risk for further falls, skin breakdown, dignity issues and weight loss. Further falls may cause fractures, increased pain and decline in overall function. Staff intervention is necessary at this point to identify and address risk factors to prevent further falls from occurring." Resident # 6's care plan dated 1/21/2017 documented "the resident is at risk for falls due to decreased mobility." The care plan documented the following interventions: "Keep environment free of hazards, Do not leave resident unattended without safety device, Eliminate potential hazards, Give resident verbal reminders not to try to ambulate or transfer without assistance." On 3/12/2017 a nurse's note at 3:21 PM documented "Resident with right arm and right leg pain this morning at 8:00 am. Resident # 6 stated she was not sure why it's hurting so bad but wants the doctor to look at it. Resident # 6 has refused going to the hospital at that time. At current time, resident's right arm is very swollen. Resident is requesting to go to the hospital for evaluation." Review of the resident's incident report dated 3/12/2017 revealed under description "Resident with pain in right arm after staff assistance with transfer from bed to wheelchair." The incident report under description of resident's injury subheading documented "completed interview	F 323	be determined by nursing on admission, quarterly and with any change of condition with emphasis placed on locking wheel chair before resident transfers. 3.Measures /systemic changes to ensure deficient practice will not occur: Nursing staff to be in-serviced on appropriate resident transfers.Method of transfer will be determined by nursing on admission, quarterly and with any change of condition with emphasis placed on locking wheel chair before resident transfers,this information will be included in the new hire orientation education program. 4.Monitoring Process- Director of Nurses, Unit Managers, SDC will observe 20 resident transfers 2 times weekly for 4 weeks and then weekly times four and monthly times 3 to ensure compliance with transfers. Data results analyzed and reviewed at monthly Quality Assurance meeting for 3 months with a subsequent plan of correction as needed.	

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with the resident, who is usually alert and oriented seems hesitant to clarify what happened. The resident stated she had asked NA (Nurse Assistant) # 1 if her wheelchair was locked when she fell and hit her arm on wheelchair and was under wheelchair when it rolled back. The resident stated NA#1 told her she knew what she was doing. The resident further stated she was hollering for help and she went and got help after NA#1 helped her up after she fell." The report indicated the resident had a fracture of a right femur.

Review of the facility's investigation summary note date 3/13/2017 documented " Per resident, NA #1 came in; resident showed NA#1 the clothes she wanted to put on and resident reports she was sitting on side of bed. NA #1 assisted with putting clothes on, and then resident requested to have wheelchair placed by the bed. Resident # 6 asked was the wheelchair locked; NA#1 replied yes. Resident # 6 states she attempted to transfer self from bed to wheelchair, and the wheelchair slipped; she fell on the floor and wheelchair was on top of the resident. Resident states that NA #1 assisted her back to chair, she then complained of right arm pain, and the NA#1 apologized." Summary note also documented "per NA#1 interview, she assisted resident out of bed to wheelchair with the assistance of another Nurse assistant. NA#1 states that resident started complaining of right arm pain after transferring to wheelchair from bed."

Review of the discharge summary dated 3/12/2017 revealed the resident was discharged back to the facility with the diagnoses of fracture to right femur and a fracture to right humerus.

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On 3/13/2017 a nurse's note at 5:19 PM documented "Writer received call from the doctor from the hospital. The doctor reports that CT (computerized tomography) scan results is a fracture to right femur. Resident is non weight bearing status to right leg per doctor and states that orthopedics will set up appointment for tomorrow."

On 3/15/2017 a nurse's note at 2:45 AM documented "ace wrap/splint remains in place to right arm/ shoulder, fingers slightly edematous."

Review of the orthopedic consultation report dated 3/20/2017 revealed the following treatment plan to the fractured femur "Brace to knee PRN (as needed) for comfort, ROM (range of motion) as required. Maintain splints."

Observation of Resident # 6 at 7:35 PM on 3/26/17 revealed the resident as alert and talkative. It was noted the resident's right arm as swollen with pitting edema. Right arm was up on pillows. The resident started to talk about an accident but stopped. The resident talked about her arm in a soft cast unlike the old days. She stopped talking after mentioning she had a fall from a wheelchair then she said she went to the hospital.

During the interview with Nurse Assistant (NA) # 2 on 3/28/2017 at 10:13 AM, she reported she was not assigned to take care of the resident on 3/12/2017 but she assisted NA#1 to transfer Resident # 6 from the bed to the wheelchair. She reported she was assigned opposite hall from Resident #6's hall. NA# 1 ask her to help transfer

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resident # 6 to the wheelchair. She went in the room and she saw Resident # 6 was on the bed moaning a little. She stated they put the resident in the wheelchair and after that the resident was complaining about her right arm hurting.

During the interview with Med Aide # 1 on 3/28/2017 at 1:30 AM, she reported she was assigned to Resident # 1 on 3/12/2017. She stated it was in the morning when it was reported to her by NA #1 that the resident's arm was swollen. She reported she notified the supervisor who came and did an assessment on the resident. The resident did not want to go to the hospital so she gave her pain medication since her vital signs were stable. She further added the resident went to sleep and woke up around 2:00 pm and both the arm and her leg were swollen. She also reported the ambulance was called and the resident was transferred to the hospital. She added the resident told the EMS (Emergency services) person that the aide dropped her during the transfer to the wheelchair.

During the interview with NA # 3 on 3/28/2017 at 2:33 PM, She reported that she on 3/12/2017, was standing at the nurses station writing down her assignment and she heard a loud scream and she found out it was coming from Resident # 6 's room. She went to see what was wrong with the resident. On her way to the resident's room, she ran into NA # 1 coming around the corner wheeling Resident # 6 in the wheelchair. The resident looked up at her and said to her "please help me I have pain coming from my arm." She stated she reported the resident's concern to Med Aide # 1.

During the interview with the weekend supervisor

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on 3/28/2017 at 3:00 PM, she reported the resident was in pain after it was reported to her by the Med Aide # 1 that the resident hand and leg were swollen. She stated she suspected the resident had a fall so she called the ambulance and the resident was sent out to the hospital for an evaluation.

During the interview with the Administrator on 3/28/2017 at 4:00 PM, she reported that on 3/12/2017 she received a call from the weekend supervisor who was letting her know about a possible fall with Resident # 6 that had happened some time on 7-3 shift. She was informed that the fall resulted in a fracture. She added she went in on Monday morning around 8am and spoke with Resident # 6, she told her that they dropped her, and she asked her how it happened, she then told her she fell when sitting in her wheelchair because the wheels were not locked, and then she said the chair turned over on her. The Administrator said she immediately started looking at staff that had worked with the resident before she had injury. She added NA # 1 was on duty on 3/12/2017 in 7-3 shift, the injury occurred when she was trying to transfer Resident #6 and did not lock the wheelchair. The administrator felt that NA # 1 lifted Resident # 6 from the floor and sat her on the edge of the bed, went and got NA # 2 to assist her and before getting a nurse to assess the resident. She added her expectation was for staff to lock the wheelchair and assist the residents with transfers to prevent accidents.

NA# 1 who was accused of not locking the wheelchair before transferring Resident # 6 was unavailable for interview. She (NA # 1) was terminated from employment on 3/16/2017.

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F 520	Continued From page 16	F 520		
F 520 SS=G	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		4/21/17

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F 520	Continued From page 17 (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in January 2017. This was for one recited deficiency that was originally cited in January 2017 on a complaint investigation survey and subsequently recited in March 2017 on a complaint investigation. The deficiency was in the area of Quality of Care. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The Findings included: This tag is cross referenced to: F309 Quality of care: Based on record review and staff interviews, the facility failed to assess 1 of 2 sampled residents who had a fall resulting to a right femur fracture and right humerus fracture (Resident # 6). During the complaint investigation of 3/28/2017 the facility was cited for failure to assess 1 of 2 sampled residents who had a fall resulting to a right femur fracture and right humerus fracture (Resident # 6). During an interview with the Administrator on 3/28/17 at 3:00 p.m., the Administrator stated after any survey or an accident at the facility	F 520	The facility has a quality assurance and assessment committee that meets monthly that include Medical Director,Administrator,Director of nursing, Nurse Managers, Therapy ,Dietary,buisness office and Maintenance Director. The facility meets to identify issues with respect to which quality assessment and assurance activities that are necessary and develop and implement appropriate plans of action to identify quality deficiencies. 1.Corrective action for resident #6: Resident #6 was assessed by the RN and sent to the hospital for treatment. Resident #6 was transferred to the hospital emergency department on 3-12-2017 for further evaluation. Resident #6 was returned to the facility on 3-13-2017.Rn will be re- educated by Director of nursing services regarding procedures to assess a resident after a fall. NA #1 was suspended and terminated for failure to report a fall. 2.Corrective action for residents that have the potential to be affected by the alleged deficient practice will include: An audit was conducted on residents that had a fall in the last 30 days to ensure assessment	

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F 520	Continued From page 18 related to taking care of the residents, sufficient training was completed. The Administrator stated the current issue was a "per instance one-time event". The Administrator stated Nursing Assistant (NA) #1 had received sufficient training related to safe transfer of residents during the orientation and had been aware of the proper protocols of the facility.	F 520	was completed. Residents will be assessed by the licensed nurse to determine any immediate injury. Residents that have had a fall will be re-assessed with in 24 hours by unit manager/charge nurse. The Method of transfer for each resident will be determined by nursing on admission, quarterly and with any change of condition with emphasis placed on locking wheel chair before resident transfers. 3.Measures/Systemic changes to ensure deficient practice will not occur: Licensed nurses will be educated by the Director of Nursing regarding the procedure of assessing a resident after a Fall, Method of transfer will be determined by nursing on admission, quarterly and with any change of condition with emphasis placed on locking wheel chair before resident transfers, this information will be included in the new hire orientation education program. 4.Monitoring Practice: Falls will be reviewed during morning clinical meeting by Nursing Administration team to assure appropriate assessment and intervention. Nursing Supervisor to review on weekends. Falls/Assessment data to be reviewed at weekly Risk Meeting and will be reviewed and analyzed at monthly Quality Assurance meeting for 3 months with subsequent plan of correction as needed. The RDO and the RDCO will observe QA weekly x 4 weeks, then monthly times three, then quarterly x 2.	

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F 520	Continued From page 19	F 520	The Regional Director of Operations as well as Regional Director of Clinical Operations re-educated Administrator regarding effective Quality Assurance with emphasis on consistent monitoring of implemented procedures on 4/19/17. The Regional Director of Operations and /or Regional Director of Clinical Services will validate areas taken to QA are being monitored as indicated with monthly communication via Administrator to ensure ongoing compliance.	