STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING _____ B. WING _____	C 06/07/2018

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AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 000	INITIAL COMMENTS The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section conducted an onsite revisit and complaint investigation survey on 5/21/18-5/23/18. The State Agency decided to continue with further investigation to obtain additional information onsite from 6/6/18-6/7/18. During the survey, it was determined that the facility provided substandard quality of care at the immediate jeopardy level at F689. The immediate jeopardy began on 5/1/18 and was removed as of 5/23/18. The deficiencies from the recertification/complaint survey on 4/5/18 (F578, F658, F755, F760, F773, F812, and F842) were corrected effective 6/7/18. However, the facility remained out of compliance with new deficiencies cited for the complaint investigation (Event ID # SV9I11).	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580		6/21/18

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

Electronically Signed | 06/21/2018

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F 580	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on facility staff and Medical Director interviews and record reviews, the facility failed to notify the physician immediately after a resident on an anticoagulant medication had an assisted fall. This occurred for one of three sample residents reviewed for accidents (Resident #189).	F 580	The process that lead to the deficiency: Facility failed to notify the physician timely of incident. The plan for correcting the specific deficiency:	

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F 580	Continued From page 2 The findings included: Resident #189 was admitted to the facility on 4/5/18 from a hospital with a cumulative diagnoses which included a history of deep vein thrombosis (DVT), pulmonary edema (PE), cancer, and recent history of a right below knee amputation (BKA) on 3/24/18. A review of the resident ' s medical record revealed her admission medication orders dated 4/5/18 included 80 milligram (mg) / 0.8 milliliter (ml) Lovenox solution (an injectable anticoagulant medication) to be administered as 0.7 ml subcutaneously two times a day. Resident #189 ' s admission Minimum Data Set (MDS) dated 4/12/18 indicated the resident had intact cognitive skills for daily decision making. Section N of the MDS indicated Resident #189 received an anticoagulant medication on 7 out of 7 days during the look back period. Resident #189 ' s Care Plan (last revised 4/18/18) included the following areas of focus, in part: --The resident is on anticoagulant therapy related to pulmonary embolism and DVT of right lower extremity (initiated on 4/5/18). Review of an Incident/Accident report written by Nurse #1 and dated 5/1/18 at 6:33 PM revealed Resident #189 had a witnessed fall. A description of the fall reported the resident ' s nursing assistant (NA #1) informed the nurse that Resident #189 slid off of the sliding board during a transfer. When the nurse entered the room, the resident was in a sitting position parallel to the bed with her legs extended. The resident was	F 580	Affected resident was discharged. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: 1. An audit was completed on 5-25-18 by the Medical Records Director for current residents that had falls since 4-25-18 to ensure the physician was notified. 2. Education for 100% of licensed nurses completed on 5-23-18 by the Staff Development Nurse for completing an S-Bar and notifying the physician timely via phone or face-to-face for any resident accidents, incidents, or change in status; and, also that there will no longer be a physician notification/communication book. The monitoring procedure to ensure the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: 1. The 24 hour report and S-Bars will be reviewed by the interdisciplinary team to identify changes in condition 5 times a week in clinical meeting to ensure ongoing compliance with physician notification for 30 days. 2. An audit of changes in condition will be completed by the Administrator in clinical meeting to ensure ongoing compliance with physician notification for 30 days. 3. Audit results will be reviewed by the	

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F 580	Continued From page 3 reported to be, "moaning in pain and holding amputated site." The nurse assessed the resident and assisted the NA with transferring her onto the bed with a total mechanical lift. The nurse reported reassessing the surgical site further and found the staples were intact with no bleeding or open areas (bruising was not specifically addressed in the report). The nurse redressed the surgical site and gave Resident #189 her prescribed pain medication. The Incident/Accident report indicated the nurse made a note to the provider (placed in the provider ' s binder to address the next day) and notified the resident ' s family. Further review of the resident ' s medical record included a Nursing Note written by Nurse #1 and dated 5/1/18 at 6:33 PM. The Nursing Note further described the incident by reporting an NA lowered the resident to the floor when the "resident failed to transfer from w/c (wheelchair) to bed correctly." The resident was described as tearful and moaning. The resident ' s perceived level of pain was a "10" (based on a scale ranging from 0 to 10, with 10 being the highest level of pain). A review of the facility ' s Registered Nurse (RN) Supervisor Communication Sheet to the physician included a notation dated/timed on 5/1/18 at 6:50 PM. The documentation reported Resident #189 had a "witnessed fall no injury." A review of Resident #189 ' s medical record revealed the resident was seen on 5/2/18 at 10:04 AM by the Nurse Practitioner (NP) who helped care for her. The NP ' s Progress Note acknowledged Resident #189 had a fall the previous night when she slipped from the sliding	F 580	QAPI committee weekly for 4 weeks. Title of person responsible for implementing the acceptable Plan of Correction: Implementation of the plan will be overseen by the Administrator of the facility with assistance from the Director of Nursing. Completion Date: 6-21-18	

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F 580	Continued From page 4	F 580		

board to the floor. She noted there were no injuries. The resident was assessed to be alert and oriented x 3. The resident ' s right BKA was reported to be dressed with the dressing noted as clean, dry and intact.

Resident #189 was discharged from the facility as planned on the morning of 5/2/18.

An interview was conducted on 6/6/18 at 11:03 AM with Nurse #1. Nurse #1 was identified as the hall nurse who was working at the time Resident #189 had a fall on 5/1/18. During the interview, Nurse #1 stated, "I don ' t know what happened or why she wasn ' t transferred successfully." When the nurse got to the room, the resident was sitting on her bottom with her legs extended and parallel to the bed. When asked what the resident said, the nurse reported, "Not much of anything. She said she was hurting and she was upset. I assessed her stump bandage on the floor and it was clean. There were no other bumps or cuts on body." The nurse reported she had the NA get the lift and the two of them put her on the bed. Once on the bed, the nurse took the bandage off of the resident ' s stump. Nurse #1 reported that she, "looked at it real good, staples were in place and there were no open areas or bleeding. I cannot say if it was hit or not because I wasn ' t there." The nurse reported Resident #189 said, "My leg hurt." The nurse stated she redressed the incision and gave the resident a pain pill. She stated the resident told her she "slid off of the board." When asked if the resident reported striking her stump, the nurse stated she did not recall. However, Nurse #1 reported the resident was holding her stump and other leg saying, "It hurts."

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F 580	Continued From page 5	F 580		

During the interview conducted on 6/6/18 at 11:03 AM with Nurse #1, the nurse stated she was aware Resident #189 was on an anticoagulant at the time of her fall. When asked if she would do anything differently about notifying the physician about a fall for a resident on an anticoagulant, the nurse indicated she would. She stated, "It didn ' t dawn on me the Lovenox may have been an issue with bruising or bleeding. I should have called (the physician)."

A telephone interview was conducted on 5/23/18 at 1:00 PM with the facility ' s Medical Director. During the interview, the Medical Director was asked when she thought a physician should be notified of an assisted fall or fall for a resident receiving an anticoagulant medication. The Medical Director stated, "The tricky issue is the Lovenox." Based on Resident #189 ' s medical history, she reported this resident obviously needed the Lovenox. However, she reported "I ' m worried about the fall in combination with the Lovenox ...If I would have been the nurse, I would have called the physician ...I think they (the nurse) took too much responsibility on themselves." A follow-up telephone interview was conducted on 6/6/18 at 2:13 PM with the Medical Director. During the interview, the Medical Director reported the physician should be telephoned if a resident on an anticoagulant had a fall or an assisted fall.

An interview was conducted on 5/22/18 at 12:11 PM with the facility ' s Director of Nursing (DON). Upon inquiry as to how a physician should have been notified of a fall (or assisted fall) for a resident on an anticoagulant medication, the DON stated, "I would have expected the nurse to have called the physician." A follow-up interview

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F 580	Continued From page 6 was conducted on 5/23/18 at 2:55 PM with the DON. During this interview, the DON stated, "We didn ' t note the Lovenox. If they had noted the Lovenox, we should have notified the physician."	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		6/21/18

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F 656	Continued From page 7 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan that addressed the requirements for an assistive device and the assistance of two staff members to safely perform transfers for 1 of 3 sampled residents reviewed for accidents (Resident #189). The findings included: Resident #189 was admitted to the facility on 4/5/18 from a hospital with a cumulative diagnoses which included a history of deep vein thrombosis (DVT), pulmonary edema (PE), cancer, and recent history of a right below knee amputation (BKA) on 3/24/18. A review of Resident #189 ' s Physical Therapy (PT) Evaluation and Plan of Treatment dated 4/5/18 was completed. The resident was evaluated as requiring maximum assistance of two persons for transfers out of bed using a slide board. Resident #189 ' s admission Minimum Data Set (MDS) dated 4/12/18 indicated the resident had intact cognitive skills for daily decision making. Section G of the MDS assessment revealed the resident required extensive assistance of "two +	F 656	The process that lead to the deficiency: Facility failed to have a process in place to have accurate Care Plan related to resident transfer status. The plan for correcting the specific deficiency: Process implemented by the Administrator on 6-11-18 to keep care plans accurate related to transfer status: Minimum Data Set (MDS) Director or designee will review orders daily (Monday through Friday) in the Interdisciplinary Morning Meeting and update care plans as needed to reflect current transfer status. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: 1. 100% audit of care plans were audited and updated to reflect resident transfer status. This audit was completed on 6-6-18 by the Director of nursing and a designee. 2. Nursing management (Director of Nursing, Assistant Director of Nursing, 7am-3pm Nursing Supervisor, Minimum	

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F 656	Continued From page 8 (plus) persons" for bed mobility, transfers, locomotion on/off the unit, and toileting. The MDS also addressed Resident #189 ' s balance during transitions. It indicated she was not steady and only able to stabilize with staff assistance for surface-to-surface transfers (transfer between bed and chair or wheelchair). A review of the resident ' s Care Area Assessment (CAA) Worksheets for ADL/Functional/Rehabilitation Potential and Falls (dated 4/12/18) included an analysis of findings. These findings read, in part: " ...She is extensive assist of two with most adls (ADLs), set up for eating. She is presently on therapy services ..." Resident #189 ' s Care Plan (last revised 4/18/18) included the following areas of focus, in part: --Resident is at risk for falls. The planned interventions did not indicate an assistive device (slide board) and staff assistance of two were required to safely transfer the resident from one surface to another. --Resident has self-care deficit. The planned interventions did not indicate an assistive device (slide board) and staff assistance of two were required to safely transfer the resident from one surface to another. A review of Resident #189 ' s undated Kardex (a printed summary of individual patient needs) included a section on ADL Self Performance and Support. This section indicated the resident required extensive assistance with "two + persons physical assist." It also reported the resident was not steady during transitions/walking when moving from seated to standing; moving on and off the toilet; and for surface-to-surface transfers. The Kardex did not indicate use of a	F 656	Data Set Nurse, Staff Development Nurse) will be educated by the Staff Development Director in person by 6-15-18 on the process, roles and responsibilities on having care plans reflect resident specific transfer status. The monitoring procedure to ensure the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Administrator, with assistance from the Minimum Data Set (MDS) Director or designee, will audit 5 random residents a week for 4 weeks and then monthly x 2 to ensure care plans reflect resident specific transfer status beginning on 6-15-18. Results of these audits will be reviewed by the QAPI Committee weekly for 4 weeks beginning 6-15-18. Title of person responsible for implementing the acceptable Plan of Correction: Implementation of the plan will be overseen by the Administrator of the facility with assistance from the Director of Nursing. Completion date: 6-21-18	

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F 656	Continued From page 9	F 656		

slide board was required to transfer the resident safely.

An interview was conducted on 5/22/18 at 9:25 AM with the facility ' s MDS Coordinator #1. During the interview,
MDS Coordinator #1 reported the information on the Kardex Report "should be" current and accurate. The MDS Coordinator reported the information on the ADL section of the Kardex was based on therapy and nursing staff assessments, not on the MDS assessment information. A follow-up interview was conducted on 6/6/18 at 11:35 AM with MDS Coordinator #1. During the interview, Resident #189 ' s care plan was reviewed. MDS Nurse #1 reported that she had completed Resident #189 ' s CAA Worksheets and initial Care Plan. The MDS nurse was asked whether the type of ADL assistance required for safe transfers should have been included on the resident ' s care plan. The MDS nurse stated she was hesitant to include the ADL assistance needed on the care plan for rehab residents because it would need to be kept up to date, and this may be difficult due to the resident ' s rehab potential to either increase or decrease. MDS Nurse #1 was also asked what her thoughts were in regards to including assistive devices for transfers on the resident ' s care plan. The nurse stated, "If rehab knows for sure that a device (such as slide board) should be used for transfer, then it should probably be included in the care plan, assuming this is communicated."

An interview was conducted with the facility ' s Director of Nursing (DON) on 5/22/18 at 12:11 PM. During the interview, the DON was asked how staff were informed as to the number of persons required to safely transfer a resident.

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F 656	Continued From page 10 The DON reported this information was typically found on the resident ' s care plan and in the electronic Kardex. A follow-up interview was conducted on 6/7/18 at 11:53 AM with the DON. During this interview, the DON reported she would expect information on how to care for a resident and provide ADL assistance to be on the resident ' s care plan.	F 656		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on facility staff, Nurse Practitioner, Home Health staff, and surgeon interviews and facility, surgeon, and hospital record reviews, the facility failed to use two staff members as required to safely transfer a resident resulting in an assisted fall. The resident incurred an injury to the incision site of a recent amputation that required further surgical intervention. This occurred for one of three sample residents reviewed for accidents (Resident #189). Immediate Jeopardy began on 5/1/18 when Nursing Assistant (NA) #1 attempted to transfer Resident #189 from her wheelchair to the bed using a slide board and assist of one. The resident sustained a fall, resulting in an injury to the incision site of a recent below knee	F 689	The process that lead to the deficiency This deficiency occurred because a nursing assistant transferred the resident by herself using a slide board instead of having 2 people present when using a slide board for transfers on 5/1/2018 around 6:30pm. This resulted in an assisted fall/ lower to the floor for this resident. Resident was identified on the MDS as requiring 2 people to assist with transfers. The resident affected was discharged to home as pre planned on 5/2/18 around 9:30am. The plan for correcting the specific deficiency The Director of Nursing corrected this	6/21/18

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F 689	Continued From page 11 amputation (BKA). Resident #189 was evaluated by her surgeon three days after the fall. Due to extensive tissue damage, the surgeon determined the probability of salvaging her BKA was low at that time. The resident underwent an above knee amputation (AKA) on 5/9/18. Immediate Jeopardy was removed as of 5/23/18 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level "D" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to continue staff education and ensure monitoring systems put into place are effective. The findings included: Resident #189 was admitted to the facility on 4/5/18 from a hospital with a cumulative diagnoses which included a history of deep vein thrombosis (DVT), pulmonary edema (PE), cancer, and recent history of a right below knee amputation (BKA) on 3/24/18. A review of Resident #189 ' s Physical Therapy (PT) Evaluation and Plan of Treatment dated 4/5/18 was completed. The resident was evaluated as requiring maximum assistance of two persons for transfers out of bed using a slide board. Resident #189 ' s admission Minimum Data Set (MDS) dated 4/12/18 indicated the resident had intact cognitive skills for daily decision making. Section G of the MDS assessment revealed the resident required extensive assistance of "two + (plus) persons" for bed mobility, transfers, locomotion on/off the unit, and toileting. The	F 689	issue with immediate education related to proper use of a sliding board, including a return demonstration of how to use. (This included using 2 people when using a slide board). This education was provided to the staff member on 5/2/18, before she was allowed to return to work. Additional education to this employee was provided that included the use of a Hoyer lift, stand to sit lift, stand to pivot, and using 2 staff members to transfer if required and Review of Resident Safe handling Video. Audits and education were completed by the facility to ensure resident care guides reflected accurate resident transfer status. Nursing staff educated to use care guide for transfer status on 5/22/18 by the Staff Development Nurse. Additional education to the nursing staff was provided on 5/16/2018 by the Director of Nursing: The education was titled, “Lift Program,” and included education on the proper use of a sliding board, use of a hoyer lift, stand to sit lift, stand to pivot, and using 2 staff members to transfer if required and Review of Resident Safe handling Video. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The nursing department completed an audit for all residents on 5/22/2018 using the “Resident mobility/transfer profile” to determine and ensure that the transfer status of each resident was correctly assessed and properly identified on the resident care guide. A 100% audit of Resident Care Guides for	

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F 689	Continued From page 12 MDS also addressed Resident #189 ' s balance during transitions. It indicated she was not steady and only able to stabilize with staff assistance for surface-to-surface transfers (transfer between bed and chair or wheelchair). A review of the resident ' s Care Area Assessment (CAA) Worksheets for ADL/Functional/Rehabilitation Potential and Falls (dated 4/12/18) included an analysis of findings. These findings read, in part: " ...She is extensive assist of two with most adls (ADLs), set up for eating. She is presently on therapy services ..." Resident #189 ' s Care Plan (last revised 4/18/18) included the following areas of focus, in part: --Resident is at risk for falls. The planned interventions did not specifically address transfers of the resident from one surface to another. --Resident has self-care deficit. The interventions did not specifically address transfers of the resident from one surface to another. A review of Resident #189 ' s undated Kardex (a printed summary of individual patient needs) included a section on ADL Self Performance and Support. This section indicated the resident required extensive assistance with "two + persons physical assist." It also reported the resident was not steady during transitions/walking when moving from seated to standing; moving on and off the toilet; and for surface-to-surface transfers. A review of Resident #189 ' s medical record from her surgeon ' s office indicated the resident was seen for a follow-up visit with the surgeon on 4/17/18. The surgeon ' s progress note reported the patient had some open wounds on the medial	F 689	accurate transfer status was completed by the Director of Nursing on 5-22-18. (The resident care guide is an internal document that provides information about the resident such as transfer status for the caregivers to use). The nursing staff were educated by the Director of Staff development on the resident care guide which included resident transfer status on 5/23/18. The nursing staff were educated on this because prior education provided on 5-16-18 didn't cover where to locate resident transfer status. New employees will receive education upon hire on: Resident Care Guide, which includes Resident Care Guide content such as resident transfer status and delivering care. New employees will be educated on the Lift Program including education on the proper use of a sliding board, use of a hoyer lift, stand to sit lift, stand to pivot, and using 2 staff members to transfer if required and Review of Resident Safe handling Video. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The facility will interview 3 nursing staff weekly x4, then monthly x2 to ensure staff are aware of how to locate resident transfer status and delivering care such as transfers using the Resident Care Guide. Immediate education will be provided as needed. The facility will observe 3 transfers	

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F 689	Continued From page 13 (inside portion of the knee) and lateral side (outside portion) of the right BKA that had Xeroform in place. Xeroform is a fine mesh gauze used as an occlusive wound dressing that prevents air from reaching the wound. The surgeon ' s note also reported the incision ' s staples were in place and approximated (meaning the wound edges were close together, closed, and in relative alignment) with no drainage noted. A review of the facility ' s medical record for Resident #189 included a Nursing Note dated 5/1/18 at 9:02 AM. The Nursing note was written as a weekly wound care note by the facility ' s Wound Care Nurse. The nurse reported the resident ' s right BKA surgical site continued to have staples in place and noted the lateral sides of the incision were starting to heal. Review of an Incident/Accident report written by Nurse #1 and dated 5/1/18 at 6:33 PM revealed Resident #189 had a witnessed fall. A description of the fall reported the resident ' s nursing assistant (NA #1) informed the nurse that Resident #189 slid off of the sliding board during a transfer. When the nurse entered the room, the resident was in a sitting position parallel to the bed with her legs extended. The resident was reported to be, "moaning in pain and holding amputated site." The nurse assessed the resident and assisted the NA with transferring her onto the bed with a total mechanical lift. The nurse reported reassessing the surgical site further and found the staples were intact with no bleeding or open areas (bruising was not specifically addressed in the report). The nurse redressed the surgical site and gave Resident #189 her prescribed pain medication.	F 689	(requiring 2 person assist, i.e. slide board) weekly x4, then monthly x2 to ensure residents are being transferred per the resident care guide. Immediate education will be provided as needed. The results of the audits will be forwarded to the facility QAPI committee, weekly for 4 weeks and then monthly x 2, for further review and recommendations. The facility held an Ad hoc QAPI meeting on 5/22/18 to address the deficient practice and put a plan of correction in place. Title of person responsible for implementing the acceptable Plan of Correction Implementation of the plan will be overseen by the Administrator of the facility with assistance from the Director of Nursing. Completion Date: 5/23/18	

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Further review of the resident ' s medical record included a Nursing Note written by Nurse #1 and dated 5/1/18 at 6:33 PM. The Nursing Note further described the incident by reporting an NA lowered the resident to the floor when the "resident failed to transfer from w/c (wheelchair) to bed correctly." The resident was described as tearful and moaning. The resident ' s perceived level of pain was a "10" (based on a scale ranging from 0 to 10, with 10 being the highest level of pain).

A Nursing Note written by Nurse #1 (dated 5/2/18 at 10:33 AM) indicated a "Head to Toe Evaluation" was completed as follow up to Resident #189 ' s fall. The resident was reported to have a surgical incision that was intact and well approximated. The dressings were dry and intact. No injury or pain was reported from the fall and the staples were reported as intact. The Nursing Note indicated the resident required two + persons physical assist with transfers. The resident was described as alert and oriented x 3. Bruising was not specifically addressed in the Nursing Note. The Nursing Note did not indicate the resident ' s dressing was removed or that the incision assessed on 5/2/18.

Resident #189 was discharged from the facility as planned on the morning of 5/2/18.

A review of the facility ' s Grievance and Complaint Log revealed a concern was reported on 5/3/18 by Resident #189 ' s family in regards to her 5/1/18 fall. The concern reported the resident ' s amputation site was "discolored black." Follow-up was conducted by the facility and noted no bruising was reported after the incident. "Safe handling" re-education was

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completed with the employee (NA #1) prior to her returning to work. The family member was notified of the concern resolution on 5/7/18, but documentation on the report indicated the family member was not satisfied with the facility ' s resolution.

Further review of Resident #189 ' s medical record from the surgeon ' s office was conducted. These records indicated the resident was seen for another follow-up visit with the surgeon on 5/4/18. The surgeon ' s progress note included an impression which read: "Hx (history) of right BKA. She had been well but recently fell on the wound with significant compromise." The patient ' s plan read as follows: "I am concerned about the ability to salvage the BKA. Plan on surgical debridement (the removal of damaged tissue from a wound) and possible conversion to AKA (above knee amputation)."

Resident #189 was admitted to the hospital on 5/9/18. A review of the resident ' s hospital records revealed she underwent surgery on 5/9/18 for an above knee amputation.

An interview was conducted on 5/21/18 at 4:10 PM with the Physical Therapist (PT) #1 who completed Resident #189 ' s initial PT evaluation and discharge summary. PT #1 reported she was the primary PT who worked with this resident and her family to prepare for her upcoming discharge home. When asked how the resident was supposed to be transferred while she resided in the facility, the PT stated she had verbally communicated with the nursing staff the resident should be transferred with the assistance of two staff members. Upon inquiry, the PT stated she did not recall recommending the transfers be

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done with only one staff member. The PT stated, "It should have been two."

An interview was conducted on 5/22/18 at 12:23 PM with the Physical Therapy Assistant (PTA) who had frequently worked with Resident #189. The PTA was accompanied by PT #1. During the interview, the PTA was asked how the resident was transferred during her stay at the facility. The PTA stated, "We used a sliding board with her ...when I went in it was usually myself and OT. Sometimes she didn ' t require both of us, but I liked to have them in there." When asked if the assistance provided by therapy staff in transferring a resident was sometimes different from how nursing staff was instructed to safely transfer that same resident, PT #1 stated, "Yes."

An interview was conducted on 5/23/18 at 2:20 PM with the facility ' s Wound Care Nurse. During the interview, the Wound Care Nurse reported wound care was provided once daily for Resident #189 ' s BKA surgical incision. She reported that from the time the resident was admitted to the facility and up until the last day she saw the incision on 5/1/18 (prior to her fall), the wound was healing. She reported there was no swelling or bruising noted. The wound care nurse reported she did not see the incision site after Resident #189 ' s fall because the resident was discharged on 5/2/18 before she got to her hall to do the treatments that day.

Interviews were conducted on 5/21/18 at 3:03 PM and 6/6/18 at 2:30 PM with NA #1. NA #1 was the nursing assistant who attempted to transfer Resident #189 on 5/1/18 at the time the resident fell. The NA reported on the evening of 5/1/18, Resident #189 had eaten her evening meal on a

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tray while she was sitting in her wheelchair. The resident asked the NA to put her to bed. The NA stated she would, but she needed to finish passing the hall meal trays first. When the NA came back to transfer Resident #189 from the wheelchair to the bed, she reported the resident was already upset. The NA was not sure why she was upset because the resident did not say. In describing the transfer, the NA stated she had a sliding board under the resident and was trying to assist her with the transfer from the wheelchair to her bed. NA #1 reported, "She did not hold onto the board to help scoot her." The NA stated the resident was supposed to have her hand flat on the sliding board, but she didn ' t do that. The NA showed the resident where to put her hand but she didn ' t. NA #1 stated Resident #189 became "hysterical" and fell forward. The NA stated she had a hold of the resident ' s gait belt but could not hold her because of the weight. The NA reported she had to think fast so she released the break on the wheelchair and moved it over. The resident was still on the sliding board so the NA pulled the sliding board from the wheelchair and used it to slide the resident onto the floor. She stated the resident landed on her bottom (no longer on the board) and was sitting up with her back to the bed and her legs perpendicular to the bed when she landed on the floor. NA#1 reported, "She basically was eased to the floor." The NA stated she hollered for the hall nurse (Nurse #1). After the nurse came, they got her into the bed and checked her vital signs. The nurse removed the dressing from her stump while the NA was in the room. The NA stated she saw there was no bleeding. During the interview, the NA was asked if there was any impact on the resident ' s stump during the fall. The NA replied, "It didn ' t hit." When asked what Resident #189

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said after the fall, the NA reported the resident asked Nurse #1 to check her stump. NA #1 stated she thought the resident said her stump hurt, but also reported it was not unusual for her to say her stump hurt.

During the interview conducted on 5/21/18 at 3:03 PM with NA #1, the NA was asked how many people were required to transfer the resident safely. She responded by stating, "At the end, just one." NA #1 was asked how she would have been notified if it was be safe to transfer a resident with one person assistance versus two person assist. The NA stated that most of the time, therapy staff would come and show the NAs how to transfer a resident or tell them if a resident ' s transfer status had changed. NA #1 stated, "I think one day I just happened to be there when she (an unidentified therapy staff member) was assisting the resident to the bed" with only the assistance of one. During the follow-up interview conducted on 6/6/18 at 2:30 PM, the NA reiterated that she had been in the room when she observed a therapy person (unidentified) transfer the resident by herself, so thought she could do so as well. The NA reported that at no time was she told Resident #189 could be transferred with the assistance of only one person (versus two).

A telephone interview was conducted on 5/21/18 at 5:45 PM with Nurse #1. Nurse #1 was identified as the hall nurse who was working at the time Resident #189 had a fall on 5/1/18. Upon inquiry, the nurse recalled the incident but stated she could not provide details about the incident because she was not in the room at the time of the fall. During a follow-up interview conducted on 6/6/18 at 11:03 AM, Nurse #1

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stated the resident ' s nursing assistant (NA #1) came and got her after the fall. She reported when NA #1 came and got her, the NA told her in the hallway on the way to the room that she had lowered the resident to the floor. "I don ' t know what happened or why she wasn ' t transferred successfully." When the nurse got to the room, the resident was sitting on her bottom with her legs extended and parallel to the bed. When asked what the resident said, the nurse reported, "Not much of anything. She said she was hurting and she was upset. I assessed her stump bandage on the floor and it was clean. There were no other bumps or cuts on body." The nurse reported she had the NA get the lift and the two of them put her on the bed. Once on the bed, the nurse took the bandage off of the resident ' s stump. Nurse #1 reported that she, "looked at it real good, staples were in place and there were no open areas or bleeding. I cannot say if it was hit or not because I wasn ' t there." The nurse reported Resident #189 said, "My leg hurt." The nurse stated she redressed the incision and gave the resident a pain pill. When asked how the resident landed on the floor, the nurse reported she did not know. She stated the resident told her she "slid off of the board." When asked if the resident reported striking her stump, the nurse stated she did not recall. However, Nurse #1 reported the resident was holding her stump and other leg saying, "It hurts." When asked if the nurse considered this an assisted fall, she reported the NA had told her, "She didn ' t fall, I lowered her."

During the interview conducted on 6/6/18 11:03 AM with Nurse #1, Resident #189 ' s Incident Report dated 5/1/18 and completed by Nurse #1 was discussed. The Incident Report described

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this incident as a witnessed fall. When asked why the incident was not described as an assisted fall, the nurse reported the only options to describe the fall on this electronic report were either as "witnessed" or "unwitnessed." Nurse #1 was then asked what she meant in her Nursing Note dated 5/1/18 at 6:33 PM when she wrote, "resident failed to transfer from w/c (wheelchair) to bed correctly." The nurse stated, "It would have been better if there was two (persons for the transfer)."

Another follow-up interview was conducted on 5/23/18 at 2:25 PM with Nurse #1. When asked, the nurse confirmed she worked with Resident #189 on the morning of 5/2/18 when she was discharged. Nurse #1 stated she did not do a dressing change for the resident that morning, so she did not look at the incision site prior to her discharge.

An interview was conducted on 5/22/18 at 9:53 AM with the facility ' s Nurse Practitioner (NP). Upon inquiry, the NP confirmed she saw Resident #189 the morning of 5/2/18 prior to her discharge. The NP stated the resident told her she had a fall the night before. When asked if she removed the resident ' s wound dressing to look at the incision that morning, the NP stated, "No."

An interview was conducted on 6/7/18 at 9:38 AM with the Home Care Nurse who worked with Resident #189 upon her discharge from the facility. Upon review of the resident ' s records, the nurse confirmed she went to see Resident #189 for an initial home care visit on 5/3/18. The nurse reported when she arrived at the home, the resident was up in her wheelchair with her stump elevated on the leg rest. The nurse reported a

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family member was observed as he appropriately transferred the resident to a hospital bed so she could be assessed. The nurse recalled Resident #189 was in a lot of discomfort. After the dressing was removed from the resident ' s stump, the nurse noted the distal aspect of the stump had bruising with eschar (dead tissue that falls off or sheds from healthy skin) along the incision line and lateral aspect. She reported the resident and her family were very concerned because the stump looked quite different from the last time they had seen it. At that time, Resident #189 told the nurse she had fallen directly on her stump the night before she was discharged home from the facility. The nurse reported she contacted both the surgeon ' s office and the resident ' s primary care physician about the changes seen in her stump. The Home Care Nurse reported another nurse visited the resident on 5/5/18. On 5/8/18, she herself went back out to see Resident #189. When asked how her stump looked on 5/8/18, the nurse reported, "It looked darker with eschar more apparent." She reported the resident was scheduled for debridement on 5/9/18 with the possibility of undergoing an above knee amputation.

A telephone interview was conducted on 5/25/18 at 10:20 AM with Resident #189 ' s surgeon. During the interview, the surgeon was asked how the BKA incision looked on 4/17/18 when the resident was seen for a follow-up visit. The surgeon stated, "It looked wonderful ...I was surprised and had a lot of concerns about it, but it actually looked very good." He reported the wound edges were clean and healthy at the 4/17/18 follow-up visit. When asked how the incision site had changed when the resident was seen on 5/4/18, the surgeon reported she had a

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disruption of skin and subcutaneous tissue and necrosis on the lateral aspect of the BKA. He stated there was obvious extensive tissue damage noted at that time and he told the resident the probability of salvaging the BKA was low. The surgeon reported he needed to operate and make the decision from there. The operation took place on 5/9/18 and Resident #189 underwent an AKA. The surgeon was asked for his medical opinion on whether the changes seen in the resident ' s incision site on 5/4/18 were directly caused by an injury or another possible complication unrelated to the reported fall. He responded, "I suspect more of a traumatic injury ...there was significant ecchymosis and bruising along the stump site." He reported if this would have been solely a vascular issue, he thought concerns would likely have been seen earlier on. The surgeon was also asked if the incision site observed on 5/4/18 was consistent with an injury which would have been incurred 2-3 days prior to the follow-up visit. The surgeon stated, "Yes, but it seems more extensive then I would have expected, but there is the combination of the injury with her existing vascular issues."

An interview was conducted with the facility ' s Director of Nursing (DON) on 5/22/18 at 12:11 PM. During the interview, the DON was asked how staff were informed as to the number of persons required to safely transfer a resident. The DON reported this information was typically found on the resident ' s care plan and in the electronic Kardex. During an interview conducted on 5/23/18 at 8:30 AM with the DON, the DON confirmed Nurse #1 ' s immediate assessment after Resident #189 ' s fall on 5/1/18 was the last time the resident ' s surgical incision was assessed prior to her discharge on 5/2/18. A

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follow-up interview was conducted on 5/23/18 at 2:55 PM with the DON. At that time, the DON was asked what her expectation was in regards to Resident #189 ' s transfer and fall on 5/1/18. The DON stated, "I would expect that she (the NA) would transfer with two people." Another follow-up interview was conducted on 6/6/18 at 3:35 PM with the DON. During this interview, the DON reported she looked at falls each day and when she saw a pattern emerge, she did conduct in-service education in mid-May which included resident transfers. However, the "missing piece" not included in the education was where information could be found on the assistive devices needed and the number of persons required for the safe transfer of a resident.

The facility ' s Administrator was notified of Immediate Jeopardy on 6/6/18 at 5:10 PM. On 6/7/18 at 11:00 AM, the facility provided the following credible allegation of Immediate Jeopardy removal.

The process that lead to the deficiency
This deficiency occurred because a nursing assistant transferred the resident by herself using a slide board instead of having 2 people present when using a slide board for transfers on 5/1/2018 around 6:30pm. This resulted in an assisted fall/ lower to the floor for this resident. Resident was identified on the MDS as requiring 2 people to assist with transfers. The resident affected was discharged to home as pre planned on 5/2/18 around 9:30am.

The plan for correcting the specific deficiency
The Director of Nursing corrected this issue with immediate education related to proper use of a sliding board, including a return demonstration of

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how to use. (This included using 2 people when using a slide board). This education was provided to the staff member on 5/2/18, before she was allowed to return to work. Additional education to this employee was provided that included the use of a Hoyer lift, stand to sit lift, stand to pivot, and using 2 staff members to transfer if required and Review of Resident Safe handling Video. Audits and education were completed by the facility to ensure resident care guides reflected accurate resident transfer status. Nursing staff educated to use care guide for transfer status on 5/22/18 by the Staff Development Nurse.

Additional education to the nursing staff was provided on 5/16/2018 by the Director of Nursing: The education was titled, "Lift Program," and included education on the proper use of a sliding board, use of a hoyer lift, stand to sit lift, stand to pivot, and using 2 staff members to transfer if required and Review of Resident Safe handling Video.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The nursing department completed an audit for all residents on 5/22/2018 using the "Resident mobility/transfer profile" to determine and ensure that the transfer status of each resident was correctly assessed and properly identified on the resident care guide.

A 100% audit of Resident Care Guides for accurate transfer status was completed by the Director of Nursing on 5-22-18. (The resident care guide is an internal document that provides information about the resident such as transfer status for the caregivers to use).

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The nursing staff were educated by the Director of Staff development on the resident care guide which included resident transfer status on 5/23/18. The nursing staff were educated on this because prior education provided on 5-16-18 didn ' t cover where to locate resident transfer status.

New employees will receive education upon hire on: Resident Care Guide, which includes Resident Care Guide content such as resident transfer status and delivering care. New employees will be educated on the Lift Program including education on the proper use of a sliding board, use of a hoyer lift, stand to sit lift, stand to pivot, and using 2 staff members to transfer if required and Review of Resident Safe handling Video.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
The facility will interview 3 nursing staff weekly x4, then monthly x2 to ensure staff are aware of how to locate resident transfer status and delivering care such as transfers using the Resident Care Guide. Immediate education will be provided as needed.

The facility will observe 3 transfers (requiring 2 person assist, i.e. slide board) weekly x4, then monthly x2 to ensure residents are being transferred per the resident care guide. Immediate education will be provided as needed.
The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.
The facility held an Ad hoc QAPI meeting on 5/22/18 to address the deficient practice and put

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F 689	Continued From page 26 a plan of correction in place. Title of person responsible for implementing the acceptable Plan of Correction Implementation of the plan will be overseen by the Administrator of the facility with assistance from the Director of Nursing. Completion Date: 5/23/18 The credible allegation was verified on 6/7/18 at 4:50 PM as evidenced by licensed and non-licensed staff interviews on where to locate information regarding the assistive devices needed and the number of persons required for the safe transfer of a resident. Review of on-going in-service records revealed licensed and unlicensed staff were in-serviced prior to working on the floor. Based on the staff interviews and a review of the facility ' s in-service records, the facility ' s credible allegation of compliance was verified as having been implemented as of 5/23/18 (the date of the initial survey exit).	F 689		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 732		6/21/18

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F 732	Continued From page 27 (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to retain nursing staff postings for 8 of the past 90 days reviewed (3/24/18, 3/25/18, 3/31/18, 4/1/18, 4/6/18, 4/7/18, 4/8/18 and 5/20/18). The findings included: A review of the facility ' s nursing staff postings was conducted on 6/7/18. The review included nursing staff postings from 3/6/18 to 6/6/18 and revealed the daily postings had not been retained for each of the following dates: Saturday, 3/24/18; Sunday, 3/25/18; Saturday, 3/31/18;	F 732	The process that lead to the deficiency: Facility didn't have specifically assigned staff member to manage staffing posting and retention 7 days a week. The plan for correcting the specific deficiency: Unit Manager for 7am-3pm assigned primarily to South Nurses' Station will ensure that required staffing is posted daily and the Director of Nursing is the backup for this process effective 6-8-18. Medical Records Director will collect the required staffing posting Monday through	

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F 732	Continued From page 28 Sunday, 4/1/18; Friday, 4/6/18; Saturday, 4/7/18; Sunday, 4/8/18; and Sunday, 5/20/18. . An interview was conducted on 6/7/18 at 11:45 AM with the facility ' s Director of Nursing (DON). During the interview, the missing nursing staff postings from the past 90 days was discussed. Upon review of the findings and identifying several of the dates as weekend days, the DON stated, "Yes, they are probably missing then." The DON reported the administrative nursing staff was responsible for posting the nurse staffing information on the weekends. The records were are kept in a book in the nursing supervisor ' s office. When asked what her expectation was in regards to the nursing staff postings, the DON reported the staffing sheets needed to be completed and posted daily, as well as retained.	F 732	Friday (on Monday the Medical Records Director will collect the posting for the prior weekend) and retain starting 6-8-18. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Staff Development Manager will educate the Unit Manager, Medical Records Director and Director of Nursing on this process in person by 6-15-18. The monitoring procedure to ensure the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: 100% audit of staffing posting records to be completed by the Medical Records Director for the period of June 2016 to June 8, 2018 by 6-14-18. Medical Records Director or designee will audit the retention of staffing posting records weekly for 4 weeks beginning 6-14-18. The administrator will also review the audits. Results of the weekly audits will be reviewed by the QAPI Committee weekly for 4 weeks beginning 6-14-18. Title of person responsible for implementing the acceptable Plan of Correction: Implementation of the plan will be overseen by the Administrator of the facility with assistance from the Director of Nursing. Completion Date: 6-21-18	