STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING ______ B. WING ______	C 10/02/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An onsite revisit and Complaint investigation survey was conducted from 10/1/18 through 10/2/18. Tag F600 was corrected as of 9/10/18. A repeat tag was cited. The facility remains out of compliance. On 10/12/18, tag F657 was added to the CMS-2567 per CMS instructions.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		10/17/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/09/2018

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

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F 657	Continued From page 1 assessments. This REQUIREMENT is not met as evidenced by: Based on facility record review, hospital record review and staff interviews the facility failed to update a care plan to reflect how a resident was assessed on the Minimum Data Set (MDS) Assessment for transfers for 1 of 3 residents reviewed for falls (Resident #1). The findings included: Resident #1 was admitted to the facility on 11/14/17 with a diagnosis of Dementia, Severe Osteopenia, Osteoporosis, and Cerebrovascular Accident with left-sided hemiparesis and gait disorder. The Care Area Assessment (CAAs) Summary dated 11/21/17 triggered for falls related to balance problems during transition and surface to surface transfer (transfer between bed and chair) not steady and only able to stabilize with staff assistance of two. She had hemiplegia/hemiparesis. She had Osteoporosis. The CAAs read to proceed to care plan. Review of the updated Care Plan dated 5/9/18 documented a focus area of: Activities of Daily Living (ADL) self-care performance deficit related to a diagnosis of Dementia and left sided hemiparesis. Interventions included staff assistance with transfers (stand pivot). The care plan did not document the number of staff needed for the transfer. Review of the quarterly Minimum Data Set (MDS) Assessment dated 7/26/18 identified Resident #1 as having short and long-term memory problems and severely impaired cognitively for making daily	F 657	Plan to correct specific deficiency and facts that led to the alleged deficient practice. Based on facility record review, hospital record review, and staff interviews the facility failed to update a care plan to reflect how a resident was assessed on the Minimum Data Set (MDS) assessment for transfers for 1 of 3 residents (resident #1) reviewed for falls. Review of the updated care plan dated 5/9/18 documented a focus area of; Activities of Daily living (ADL) self-care performance deficit related to a diagnosis of dementia and left sided hemiparesis. Interventions included staff assistance with transfers (stand pivot). The care plan did not document the number of staff needed for the transfer. The MDS dated 7/26/18 identified resident #1 requiring 2 person assist for bed mobility and transfers. The care plan for resident #1 was updated and revised by the MDS Coordinator on 8/27/18 to reflect the type and amount of assistance required for transfers. The MDS Coordinator assessment based on resident status upon readmission to the facility on 8/27/18. Procedure for implementing a plan of correction for the alleged deficient practice. Director of Nursing conducted a 100% audit of all current resident care plans in order to ensure all current plans are	

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F 657	Continued From page 2 decisions. Resident #1 required extensive two-person assistance for bed mobility and transfers. She had both upper and lower range of motion limitations to the left side of her body. Review of the Incident report dated 8/22/18 documented at approximately 6:00AM Nurse #1 was notified by Medication Aide #1 that Resident #1 had fallen. Upon entering the resident's room, Resident #1 was observed lying supine (on her back) in the floor with the lift pad for the stand to sit lift under the resident's back and a pillow had been placed under her head. NA #1, also in the room, stated that as she attempted to put Resident #1 in the wheelchair, the wheelchair scooted back "(the brake on one side of the w/c was not securely set although NA #1 thought it was)" and Resident #1 started sliding out of the chair. NA #1 stated she assisted Resident #1 to the floor to prevent injury to the resident. Review of the general nursing note dated 8/22/18 by Nurse #1 documented at approximately 6:00 AM revealed Nurse #1 was notified by Medication Aide #1 that resident #1 had fallen. When Nurse #1 entered the resident's room the resident was lying on her back on the floor with the lift pad from the stand to sit lift under her back and a pillow under her head. Nurse #1 documented NA #1 was also in room and stated as she attempted to put Resident #1 in the wheelchair "scooted back (the brake on one side of the wheelchair was not securely set although NA #1 thought it was)." The note further read Resident #1 started sliding out of the chair and NA #1 assisted her to the floor. Review of the statement from Nurse Aide #1 dated 8/23/18 read I (NA #1) was in the process of placing Resident #1 in her wheelchair. As I was	F 657	reflective of current level of assistance required for safe transfers. The audit was completed on 10/16/2018. The results of the audit: 61 skilled residents audited. Any residents found with care plans not specific to the level of assistance required for transferring were corrected immediately (10/16/18) to reflect when 2 or more staff members are required for transferring and bed mobility. The MDS Nurse Consultant educated the MDS Coordinator, Nurse Managers, and Director of Nursing on 10/17/18 regarding the importance of maintaining up to date care plans, that are reflective of the level of assistance required for safe transferring and included in the education was the importance of updating the plan of care as the resident needs change. Monitoring Procedure The Director of Nursing or the Unit Managers in her absence, will monitor all newly admitted residents to ensure the care plan is reflective of the number of staff required for safe transferring; the newly admitted resident care plans will be reviewed within 24 hours of admission. All newly admitted resident monitoring will begin 10/17/18. The Director of Nursing or the Unit Managers in her absence, will review 7 current residents weekly to ensure that the care plan accurately reflects the level of assistance required for safe transfers. 100% of all skilled residents will be reviewed quarterly. The results of the monitoring will be brought to the monthly Quality Assurance Process Improvement meeting to review	

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F 657	Continued From page 3 placing her in her chair the wheelchair rolled back from under her and Resident #1 began to slide to the floor. As she was sliding I immediately placed her gently on the floor. During an interview with NA #1 on 10/1/18 at 4:21 PM she stated she was trying to transfer Resident #1 by pivoting her from the bed to the wheelchair without the use of the lift and the chair slid backwards. She stated the wheelchair was locked. She stated she eased Resident #1 to the floor because she was sliding. During a follow up interview with NA #1 on 10/2/18 at 12:27 PM she stated this was the second time she had worked with the resident and thought she only needed one person to transfer from her bed to the chair. During an interview with Nurse #1 on 10/1/18 at 3:30 PM she stated she was working on the 500 hall when Medication Aide #1 notified her that Resident #1 was on the floor. She stated she entered the room with Medication Aide #1 and Resident #1 was lying on her back on the floor. She stated the resident had the sit to stand lift pad behind her back and a pillow under her head. Her legs were stretched out. She stated Nursing Assistant #1 was staying close to the bed and told her as she was placing Resident #1 in the wheelchair, the brake was not locked, and the chair slid backwards. The resident began sliding and she lowered her to the floor. She stated there were no other witnesses other the NA #1. She stated she did look at the wheelchair and one side was not locked. She stated the sit to stand lift was in the room at the time. Nurse #1 stated that she believed NA #1 had used the sit to stand lift because NA #1 informed Nurse #1 that as she	F 657	results with the interdisciplinary team; adjustments to education and monitoring will be based on those results. The QAPI team will review the results of the monitoring monthly for a minimum of 3 consecutive months and then until no longer deemed necessary. The monitoring tools will be located and maintained in the Director of Nursing office located within the facility.	

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F 657	Continued From page 4	F 657		

lowered the resident the wheelchair moved.

During an interview with Medication Aide (MA) #1 on 10/1/18 at 1:46 PM she stated NA #1 came to her to let her know Resident #1 was on the floor. She stated she notified Nurse #1 that the resident was on the floor. The nurse and MA #1 entered the room at the same. She stated when they entered the room the resident was lying on the floor with a pad under her and a pillow under her head. Resident #1 was on her back. Nurse #1 assessed the resident in her presence.

During an interview with the Director of Nursing on 10/1/18 at 2:37 PM she stated the resident was a stand and pivot transfer without a lift prior to fall and after the fall she required two-person assistance and then was changed to a mechanical lift transfer. She stated the pad was under the resident because the staff were going to get her back up with the lift. She then stated she did not know how the staff got her back up from the floor.

During an interview with the Corporate Minimum Data Set (MDS) nurse on 10/2/18 at 11:25 AM she stated in reviewing the most recent MDS prior to the fall Section G (Functional Status) had two columns and Resident #1 was assessed as an extensive two-person transfer. She further stated whenever we code section G the two persons transfer only had to happen once to be coded as needing two persons. It may not have been truly reflective as to what the resident required daily. She stated on 5/9/18 the resident was a stand and pivot transfer. On 8/27/18 she was changed to requiring staff assistance of two staff members and on 9/3/18 she was changed to a mechanical lift transfer.

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F 657	Continued From page 5 During an interview with the Physician's Assistant on 10/2/18 at 11:03 AM she stated the resident was bedbound and did not get up on her own. She stated Resident #1 had been slow to recover from her Cerebrovascular Accident and had left sided hemiparesis (or weakness). Her Dementia was progressing. She stated Resident #1 did have a diagnosis of Osteoporosis and a gait disorder. She stated staff should be using and should have been using a mechanical lift for all transfers for Resident #1 prior to her fall and after her fall. The wheelchair should always be locked prior to placing a resident in the chair. She stated Resident #1 was a high fall risk and a diagnosis of Osteoporosis placed her more at risk for injury with any fall. She stated she was not in the facility at the time of the fall but there had to be enough force when she landed or was placed on the floor to fracture the hip. She further stated she believed the hip broke when Resident #1 was placed on the floor.	F 657		
F 689 SS=G	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 record review and staff interviews the facility failed to transfer a resident from the bed to the wheel chair with both wheel chair brakes	F 689	Plan to correct specific deficiency and facts that led to the alleged deficient practice	10/2/18

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F 689

Continued From page 6

securely locked, resulting in a left hip fracture which required surgical repair for 1 of 3 sampled residents (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 11/14/17 with a diagnosis of Dementia, Severe Osteopenia, Osteoporosis, and Cerebrovascular Accident with left-sided hemiparesis and gait disorder.

The Care Area Assessment (CAAs) Summary dated 11/21/17 triggered for falls related to balance problems during transition and surface to surface transfer (transfer between bed and chair) not steady and only able to stabilize with staff assistance of two. She had hemiplegia/hemiparesis. She had Osteoporosis. The CAAs read to proceed to care plan.

Review of the updated Care Plan dated 5/9/18 documented a focus area of: Activities of Daily Living (ADL) self-care performance deficit related to a diagnosis of Dementia and left sided hemiparesis. Interventions included staff assistance with transfers (stand pivot). The care plan did not document the number of staff needed for the transfer.

Review of the quarterly Minimum Data Set (MDS) Assessment dated 7/26/18 identified Resident #1 as having short and long-term memory problems and severely impaired cognitively for making daily decisions. Resident #1 required extensive two-person assistance for bed mobility and transfers. She had both upper and lower range of motion limitations to the left side of her body.

F 689

Resident #1 was admitted to the facility on 11/14/17 with a diagnosis of Dementia, Severe Osteopenia, Osteoporosis, and Cerebrovascular accident with left-sided hemiparesis and gait disorder. The Care Assessment Summary (CAA) dated 11/21/17 triggered for falls related to balance problems during transition and surface to surface transfers due to not steady and only able to stabilize with staff assistance of two. Resident #1 with hemiplegia/hemiparesis as a result of the CVA; the CAA proceeded to the plan of care. Review of the care plan dated 5/9/18 documented a focused area Activities of Daily Living self-care performance deficit; with staff intervention of assistance during transfers (stand pivot). The care plan did not specify the number of staff needed for the transfer. Review of the incident report dated 8/22/18 documents at approximately 6:00 AM resident was assisted to the floor by NA #1 during a transfer from bed wheelchair. Through investigation and completing Root Cause Analysis it was determined the NA #1 thought she locked both wheelchair brakes, during the transfer, one side of the wheelchair moved resulting in the patient being lowered to the floor.

Nurse #1 immediately assessed resident #1 at time of incident on 8/22/18. Provider and RP notified on 8/22/18 by Nurse #1 immediately following resident #1 assessment. Resident #1 subsequently transferred to hospital for

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F 689	Continued From page 7 Review of the Incident report dated 8/22/18 documented at approximately 6:00AM Nurse #1 was notified by Medication Aide #1 that Resident #1 had fallen. Upon entering the resident's room, Resident #1 was observed lying supine (on her back) in the floor with the lift pad for the stand to sit lift under the resident's back and a pillow had been placed under her head. NA #1, also in the room, stated that as she attempted to put Resident #1 in the wheelchair, the wheelchair scooted back "(the brake on one side of the w/c was not securely set although NA #1 thought it was)" and Resident #1 started sliding out of the chair. NA #1 stated she assisted Resident #1 to the floor to prevent injury to the resident. Review of the general nursing note dated 8/22/18 by Nurse #1 documented at approximately 6:00 AM revealed Nurse #1 was notified by Medication Aide #1 that resident #1 had fallen. When Nurse #1 entered the resident's room the resident was lying on her back on the floor with the lift pad from the stand to sit lift under her back and a pillow under her head. Nurse #1 documented NA #1 was also in room and stated as she attempted to put Resident #1 in the wheelchair "scooted back (the brake on one side of the wheelchair was not securely set although NA #1 thought it was)." The note further read Resident #1 started sliding out of the chair and NA #1 assisted her to the floor. The note read that Nurse #1 called the after-hour's phone number for the clinic and spoke with the on-call nurse, who stated she would advise the facility of any new orders. The note continued by documenting the day shift Nursing Assistant thought Resident #1's leg appeared swollen, so Nurse #1 re-assessed the leg and found the upper part of the thigh/hip area of the left extremity swollen and slightly bruised.	F 689	evaluation on 8/22/18. Director of Nursing removed resident #1's wheelchair from facility use immediately following recognition of concern on 8/22/18. Maintenance Director assessed resident #1's wheelchair and corrected concern regarding brake locking on 8/22/18. Procedure for implementing a plan of correction for the alleged deficient practice A 100% audit of all wheelchairs and Geri-chairs were inspected on 8/29/2018 by NHA and Maintenance Director. Any wheelchair areas of concern were addressed and corrected on 8/29/2018 by Maintenance Director and Administrator. Nursing staff in-serviced on 8/29/18 by Regional Staff Development Coordinator. Topics included: Wheelchair functioning, including locking of brakes and to notify Maintenance Director via the electronic TELs system (maintenance director's electronic system for documentation) of any concerns related to wheelchair functioning or repair concerns. Education was completed for all nursing staff on or before 9/5/2018 by the Regional Staff Development Coordinator and/or the Director of Nursing. All newly hired associates will receive the same education regarding wheelchair functioning and ensuring locking of brake systems during the orientation process beginning 8/29/2018; the education will be completed by the Regional Staff Development Coordinator and/or the	

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F 689	Continued From page 8 Nurse #1 telephoned the clinic again to update the physician. Nurse #1 called the responsible party to inform her of the fall and passed all pertinent information on to Nurse #2. Review of the general nursing note dated 8/22/18 by Nurse #2 documented she received information related to a fall on the 11pm-7am shift with Resident #1. The note read that authorization for an x-ray would have to wait until the clinic opened at 8AM. Nurse #2 assessed Resident #1's leg at 8:00AM and noted the area to be swollen and sore to touch. Writer called clinic several times after, unable to reach provider and left a voicemail message. She called again to the clinic and expressed to receptionist that it was urgent that she speak to the provider. The provider returned the call and gave an order to send Resident #1 to the hospital for evaluation. The responsible party was made aware. The resident left the facility without any signs of distress. Review of the hospital admission and physical dated 8/22/18 documented Resident #1 was seen in the emergency room on 8/22/18 with left hip pain. The note documented Resident #1 was being moved at the facility when she was noted to have pain and swelling to the left upper thigh. The x-ray showed left hip comminuted and mildly displaced intertrochanteric hip fracture with associated Osteoporosis and severe Osteopenia. She had some pain to the left leg with any movement. The hospital notes stated that at baseline, the resident was not ambulatory. Surgical stabilization was performed on 8/23/18 and the resident was discharged back to the facility on 8/27/18.	F 689	Director of Nursing in his absence. All associates will be educated prior to working independently in direct patient care. The Director of Nursing has ownership to ensure compliance to ensure education is provided prior to direct patient care. Monitoring Procedure The Maintenance Director performed weekly wheelchair inspections X 4 weeks beginning 8/31/18 through 10/1/18. The Maintenance Director maintains the weekly documentation of the 100% wheelchair monitoring in the 'TELS' systems (the electronic maintenance documentation center). The Nursing Home Administrator has ownership to ensure audits/monitoring of wheelchairs remains compliant with up to date documentation. Beginning October 1, 2018 wheelchairs located and in use on 200 and 300 halls in skilled nursing beds will be audited/monitored to ensure proper function with assessment of brakes by the Maintenance Director on or before the 15th day of each month. Wheelchairs located and in use on the 400 and 500 hall skilled nursing beds will be audited/monitored to ensure proper function with assessment of the brakes by the Maintenance Director on or before the last day of each month. The wheelchairs will continue with monthly audits for as long as the facility has wheelchairs in use. The Nursing Home Administrator has ownership to ensure the monthly audits/inspections are completed as	

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F 689	Continued From page 9 Review of the statement from Nurse Aide #1 dated 8/23/18 read I (NA #1) was in the process of placing Resident #1 in her wheelchair. As I was placing her in her chair the wheelchair rolled back from under her and Resident #1 began to slide to the floor. As she was sliding I immediately placed her gently on the floor. After that I informed the nurse and nurse came immediately and checked Resident #1 out by doing an observation, vitals and skin assessment. During an interview with NA #1 on 10/1/18 at 4:21 PM she stated she was trying to transfer Resident #1 by pivoting her from the bed to the wheelchair without the use of the lift and the chair slid backwards. She stated the wheelchair was locked. She stated she eased Resident #1 to the floor because she was sliding. She then went to get one of the nurses. She did place a pillow under the resident's head. She stated the nurse came in and assessed the resident and the nurse, another staff person and herself placed the resident back in bed. She stated she was not using the lift and was not sure why there would have been a pad behind the resident. During a follow up interview with NA #1 on 10/2/18 at 12:27 PM she stated when she locked the wheelchair she pushed both levers down to put on the brakes. She stated the wheelchair did not look any different to her than any other wheelchair. She stated this was the second time she had worked with the resident and thought she only needed one person to transfer from her bed to the chair. Review of the updated Care Plan dated 8/27/18 documented staff assistance of two persons for transferring.	F 689	deemed by the Quality assurance committee. Results of the wheelchair audits will be reported to the Quality Assurance Committee during the monthly meetings; any trends will be noted and immediate correction implemented to ensure compliance. The Administrator is responsible for implementing the acceptable plan of correction. The results of the monitoring will be maintained in a binder clearly labeled within the Administrator's office. The Director of Nursing will ensure compliance in the absence of the Nursing Home Administrator. The Nursing Home Administrator will have ownership to ensure audits stay up to date and compliance.	

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	345481	A. BUILDING ______ B. WING ______	C 10/02/2018

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F 689	Continued From page 10 During an interview on 10/1/18 at 12:44 PM the Director of Nursing (DON) stated prior to the fall Resident #1 was a stand and pivot for transfers. The DON did not emphasize if a lift was needed, but that the resident was a stand and pivot transfer. She also did not state if the resident was a one person or two-person transfer. During an interview with Nurse #1 on 10/1/18 at 3:30 PM she stated she was working on the 500 hall when Medication Aide #1 notified her that Resident #1 was on the floor. She stated she entered the room with Medication Aide #1 and Resident #1 was lying on her back on the floor. She stated the resident had the sit to stand lift pad behind her back and a pillow under her head. Her legs were stretched out. She stated Nursing Assistant #1 was staying close to the bed and told her as she was placing Resident #1 in the wheelchair, the brake was not locked, and the chair slid backwards. The resident began sliding and she lowered her to the floor. She stated there were no other witnesses other the NA #1. She stated she did look at the wheelchair and one side was not locked. She stated the sit to stand lift was in the room at the time. Nurse #1 stated that she believed NA #1 had used the sit to stand lift because NA #1 informed Nurse #1 that as she lowered the resident the wheelchair moved. She stated NA #1, Medication Aide #1 and herself lifted Resident #1 and placed her into the wheelchair. The resident complained that one leg was tender. She oftentimes hollers out when receiving care, so this was not new. She stated there was no bruising or bleeding, just tenderness. She further stated that within an hour or two the leg began swelling. During an interview with Medication Aide (MA) #1	F 689		

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F 689	Continued From page 11 on 10/1/18 at 1:46 PM she stated NA #1 came to her to let her know Resident #1 was on the floor. She stated she notified Nurse #1 that the resident was on the floor. The nurse and MA #1 entered the room at the same. She stated when they entered the room the resident was lying on the floor with a pad under her and a pillow under her head. Resident #1 was on her back. Nurse #1 assessed the resident in her presence. MA #1 stated she did not know why the lift pad was under the resident as she thought the resident was a stand and pivot transfer without a lift. She stated during the assessment Resident #1 stated she hurt. She stated at the time of the assessment the wheelchair was out to the side of the resident and the Resident was on the floor. She stated following the assessment the nurse, nursing assistant and she lifted Resident #1 and placed her in the wheelchair. At this time the resident tried to stretch her legs and stated her left leg hurt. During an interview with Nurse #2 on 10/1/18 at 2:00 PM she stated she was the oncoming day shift nurse on 8/22/18 and she was told the resident fell at her bedside and was lowered to the floor. She stated she called clinic of a sister facility since Resident #1 was their resident but housed in this facility about sending the resident to the hospital but was informed the physician had to be notified first. She stated when she re-assessed Resident #1's left leg, the leg was swollen and painful to touch only and there was some bruising beginning. She stated that was when she called the clinic again and the Physician's Assistant gave an order to send her to the hospital. During a follow up interview with the Director of	F 689		

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F 689	Continued From page 12	F 689		

Nursing on 10/1/18 at 2:37 PM she stated the resident was a stand and pivot transfer without a lift prior to fall and after the fall she required two-person assistance and then was changed to a mechanical lift transfer. She stated the pad was under the resident because the staff were going to get her back up with the lift. She then stated she did not know how the staff got her back up from the floor.

During an interview with the RN Nurse Consultant on 10/1/18 at 3:45 PM she stated the facility identified the root cause as the wheelchair brake not being locked and did an audit of all wheelchairs on 8/29/18. Staff were in-serviced on the correct application of wheelchair brakes on 8 /30/18. She stated staff should always lock the wheelchair prior to placing a resident in the chair.

During a follow up interview with RN Nurse Consultant on 10/2/18 at 11:50am she stated the wheelchair was locked but the hand brakes went in different directions as one pulled upward to lock, and one side pushed downward. She stated the wheelchair was locked but did scoot when the resident was lowered close to the chair. She stated the wheelchair was no longer in use because the Maintenance Director changed the hand brakes to be identical when locked.

During the investigation the Maintenance Director was unavailable for interview.

During an interview with the Corporate Minimum Data Set (MDS) nurse on 10/2/18 at 11:25 AM she stated in reviewing the most recent MDS prior to the fall Section G (Functional Status) had two columns and Resident #1 was assessed as an extensive two-person transfer. She further

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F 689	Continued From page 13	F 689		

stated whenever we code section G the two persons transfer only had to happen once to be coded as needing two persons. It may not have been truly reflective as to what the resident required daily. She stated on 5/9/18 the resident was a stand and pivot transfer. On 8/27/18 she was changed to requiring staff assistance of two staff members and on 9/3/18 she was changed to a mechanical lift transfer.

During an interview with the Physician's Assistant on 10/2/18 at 11:03 AM she stated the resident was bedbound and did not get up on her own. She stated Resident #1 had been slow to recover from her Cerebrovascular Accident and had left sided hemiparesis (or weakness). Her Dementia was progressing. She stated Resident #1 did have a diagnosis of Osteoporosis and a gait disorder. She stated staff should be using and should have been using a mechanical lift for all transfers for Resident #1 prior to her fall and after her fall. The wheelchair should always be locked prior to placing a resident in the chair. She stated Resident #1 was a high fall risk and a diagnosis of Osteoporosis placed her more at risk for injury with any fall. She stated she was not in the facility at the time of the fall but there had to be enough force when she landed or was placed on the floor to fracture the hip. She further stated she believed the hip broke when Resident #1 was placed on the floor.

During an interview with the prior Administrator on 10/2/18 at 11:59 AM he stated he was the interim Administrator at the time of the fall and did assist the maintenance director in doing a 100% audit of all the wheelchairs in the facility. He stated if he remembered correctly after discussing the wheelchair with the Maintenance director both

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F 689	Continued From page 14 sides of the wheelchair brakes were different. They had either been installed incorrectly or were not acting right. The brake did not go up against the tire correctly and therefore did not lock tightly. He stated he did not write up a plan of correction but possibly the consultants did. During an interview with the Director of Nursing (DON) on 10/2/18 at 12:29 PM she stated the facility did an audit of the wheelchairs in the building and educated the staff regarding wheelchair brakes and how they should look and work. She stated part of the education process was if staff saw a wheelchair that wasn't working properly they were to notify Maintenance. She stated the Maintenance director did weekly monitoring on wheelchairs. She stated on Resident #1's wheelchair one side of the wheelchair had a brake that went up to lock and one side went down to lock. We did an investigation and the root cause analysis led us to believe it was the locking system, we did a 100% audit of the wheelchairs and we did education of staff, there was never one person in charge of monitoring because the Nursing Assistants (NAs) were responsible to report if there was a problem. The DON stated when she checked the wheelchair, the wheels locked, and the tires did not move but the chair slid backwards like the tires were bald. During an interview with the Administrator on 10/2/18 at 1:20 PM she stated it was expected that the staff would check to make sure the wheelchairs were functioning properly prior to placing a resident in the wheelchair. She further stated that the previous Administrator may have done a plan of correction. She stated that the facility had components of a plan of correction,	F 689		

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F 689	Continued From page 15 such as wheel chair audits, education and the maintenance director's weekly wheel chair checks from 9/1/18 - 9/29/18 but no written plan of correction.	F 689		