DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

2/13/17 PG

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165350	A. BUILDING _____ B. WING _____	C 01/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN WEST HEALTH CENTER	1501 OFFICE PARK ROAD WEST DES MOINES, IA 50265

(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 Correction date. 1/25/17 The following deficiencies result from the facility's annual survey and investigations of complaints #64716-C, #64201-C, #64076-C and #64079-C, 64946-C, and self reported incidents #64267-I, #64268-I, #64499-I, #64552-I, #64556-I, #64890-I and #65099-I, completed November 16, 2016 to January 24, 2017. • Self Report 64267-I was substantiated • Complaint 64201-C was substantiated • Complaint 64076-C was substantiated • Complaint 64079-C was substantiated • Complaint 64716-C was substantiated. • Self Report 64268-I was substantiated • Self Report 64499-I was substantiated • Self Report 64552-I was substantiated • Self Report 64556-I was substantiated • Complaint 64946-C was not substantiated • Self Reported 64890-I was substantiated • Self Reported 65099-I was substantiated See Code of Federal Regulations (42CFR) Part	F 000		

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

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 000	Continued From page 1 483, Subpart B-C	F 000		
F 157 SS=D	Amended 2/9/17 by JKM, RN 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		

A facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention, a significant change in the resident's physical, mental, or psychosocial status (i.e , a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications), a need to alter treatment significantly (i e , a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment), or a decision to transfer or discharge the resident from the facility as specified in §483 12(a)

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483 15(e)(2), or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member

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F 157	Continued From page 2 This REQUIREMENT is not met as evidenced by. Based on record review and staff interview the facility failed to immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention, a significant change in the resident's physical, mental, or psychosocial status (i e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications), a need to alter treatment significantly (i e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment), or a decision to transfer or discharge the resident from the facility for 2 of 4 residents reviewed The facility did not notify the responsible party of Resident #2's fall on 9/28/16 and failed to notify the physician and responsible party of an incident on 10/16/16 at 5 40 a m. that resulted in a head injury until 4 hours later After the physician was informed, he directed staff to send the resident to ER (emergency room) for evaluation Resident #1 experienced adverse affects to a medication The facility failed to notify the physician so medication adjustments could be made The facility census was ninety-three (93) residents Findings include. 1 A Minimum Data Set (MDS) with assessment reference date of 9/17/16 assessed Resident #2 with a brief interview for mental status (BIMS) score of "5" (severe cognitive impairment) The resident had the following indicator of delirium	F 157		

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F 157	Continued From page 3 that fluctuated through the day inattention. The resident had no behavior symptoms identified The resident required limited staff assistance with bed mobility, transfers and ambulation and extensive staff assistance with toileting, dressing and personal hygiene. A "balance during transitions and walking" test identified the resident as not steady and only able to stabilize with staff assistance The resident used a walker and wheelchair for mobility The resident was occasionally incontinent of bladder The resident had diagnoses that included. dementia An incident report dated 9/28/16 at 5:40 a m revealed staff found the resident sitting on the floor in front of the recliner in his/her room The resident denied pain and did not hit his/her head. The resident received a small pinpoint open area to the lower left extremity The incident report identified the resident's transfer/ambulation ability as "up with assistance of one with front wheel walker and gait belt " The incident report did not identify an intervention following the incident The incident report and nursing progress notes failed to identify the facility informed the resident's responsible party of the incident On 11/30/16 at 10 a m the resident's responsible party stated she did not recall that the facility notified her of the resident's fall on 9/28/16 On 11/30/16 at 9 09 a m the Director of Nursing stated she could not find evidence the facility notified the resident's responsible party of the 9/28/16 fall An incident report dated 10/16/16 at 5 15 a m revealed the resident stated he/she came out of the bathroom and fell. Staff found the resident	F 157		

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F 157	Continued From page 4 sitting on his/her bottom on the resident's room floor The resident said he/she hit their head on the edge of the bed. Staff applied an ice pack to the head The resident received a hematoma to the right forehead and abrasion to the buttock The incident report did not identify an intervention following the incident. The incident report revealed the facility did not notify the physician of the incident until 9 10 a m The physician directed staff to send the resident to the ER for examination Nursing progress notes dated 10/16/16 at 9 16 a m revealed the resident transported to ER for evaluation. The incident report revealed the facility did not notify the responsible party of the incident until 9.15 a.m On 11/30/16 at 10 a.m the resident's responsible party stated she did not know why they didn't call her sooner After she heard about the incident, she spent the day with the resident She stated when the resident falls with signs of trauma, she wants to be informed right away If the resident is bruised or bleeding she wants to be told right away 2 A MDS with assessment reference date of 10/14/16, assessed Resident #1 with a BIMS score of "9" (moderate cognitive impairment) The resident had no behavior symptoms identified The resident required extensive staff assistance with bed mobility, dressing, toileting and bathing The resident required limited assistance of staff with ambulation and personal hygiene A "balance during transitions and walking" test identified the resident as not steady but able to stabilize without staff assistance in all areas of testing The resident used a walker and wheelchair for mobility The MDS identified the resident admitted to the facility 10/7/16 The resident was	F 157		

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F 157	Continued From page 5 occasionally incontinent of bowel and bladder The resident had diagnoses that included dependence on renal dialysis and altered mental status.	F 157		
F 225 SS=D	Review of the resident's October 2016 Medication Administration Record (MAR) revealed the resident had an order for Metoprolol (for blood pressure) 100 milligrams at bedtime The MAR directed staff to check blood pressure and pulse prior to administration of the drug Review of recorded heart rates revealed the resident with a heart rate of 47 on 10/12/16, 48 on 10/14/16, 48 on 10/20/16, 48 on 10/22/16, 44 on 10/23/16 The heart rate was in the 50's 19 times during the month of October 2016 The record failed to identify that the facility notified the physician of the resident's low heart rate. The website HTTPS://www drugs.com/metoprolol directed staff to call the physician at once if the user experienced very slow heartbeats A hospital Discharge Summary dated 10/27/16 revealed the resident had Brady (slow heart rate) so the physician stopped the Metoprolol. 483 13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a	F 225		

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F 225	Continued From page 6 court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken This REQUIREMENT is not met as evidenced by Based on observation, record review and staff interview, the facility failed to ensure that all injuries of unknown origin were investigated for 1 of 3 injuries of unknown origin Resident #8 had a wound to the toe on 7/29/16 The facility did not investigate to determine how the injury occurred The resident sustained further injury to three toes on 11/24/16 and the facility failed to determine	F 225		

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F 225	Continued From page 7 how these injuries occurred The resident was totally dependent on staff. Facility census was ninety-three (93) residents Findings include.	F 225		
	1 A Minimum Data Set (MDS) with assessment reference date of 10/6/16 assessed Resident #8 with short and long term memory impairments and severely impaired decision making skills. The resident was rarely never understood by others and had highly impaired vision The resident was totally dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene, eating and bathing The resident could not ambulate The resident used a wheelchair for mobility The resident was always incontinent if bowel and bladder The resident had diagnoses that included Alzheimer's disease, peripheral vascular disease (PVD) and hemiplegia The MDS did not identify the resident with skin problems of the feet Nursing progress notes dated 7/29/16 at 9 25 a m revealed a less than 1 centimeter (cm) wound to the second digit of the right foot with unknown etiology Staff cleansed the area and applied a steri strip to the area The record lacked evidence the facility investigated how the injury to the foot occurred Nursing progress notes dated 11/24/16 at 8 01 p m revealed a nurse aide observed blood on the resident's sock when getting the resident ready for bed Staff removed the sock and observed partial thickness wounds (PT) on 3 toes on the left foot The second digit had a round PTW that measured 1 25 cm (centimeter) long and 0 25 cm. deep with a moderate amount of blood			

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F 225	Continued From page 8 present, the third digit had a superficial skin tear, edges approximated measuring 1 5 cm. long and 0 5 cm at the widest area no blood present and the 4 th digit had a superficial skin tear that measured 1 5 cm long and 0 5 cm at the widest point. Staff applied steristrips to the 3rd and 4th digits The resident winced with pain. Staff administered PRN (as needed) pain medication The nurse aide stated she did not know when or how the resident's foot got injured The record lacked evidence the facility investigated the cause of the injuries of unknown origin. On 11/28/16 at 4:05 p m the Director of Nursing stated she could not find investigations into the injuries. There was no incident report since the injuries were less than 2 cm The Incident Report policy dated 11/11/14 revealed an incident report would be filled out when there was an injury of unknown origin Skin tears less than 2 cm would not require an incident report Observation showed, on 11/17/16 at 8 55 a m the resident transferred into bed by Hoyer mechanical lift and 2 staff Staff had to position the resident's arms and legs and turn the resident for positioning in bed	F 225		
F 241 SS=D	483 15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality	F 241		

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F 241	Continued From page 9 This REQUIREMENT is not met as evidenced by Based on observation, staff interview, and group interview, the facility failed to acknowledge and answer residents in a dignified manner for 1 random observation and failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for one of 11 residents interviewed and 3 of 8 residents during the group interview Staff threw a washcloth at Resident #18 and then expected the resident to use it when it fell on the floor The resident reported the incident to the social worker. There was no documentation of the incident and the identity of the staff was unknown The facility census was ninety-three (93) residents Findings include 1 Random observation on 12/20/16 at 1 20 p m revealed a resident called out from room 310 repetitively, nurse, nurse Staff Q, Certified Nurse Aide (CNA), went by the room 3 times and looked in but not acknowledge the resident The resident called out come back here sir Staff Q stated, under his breath to himself, he'd go in there but couldn't Staff O, CNA, also went by the room without acknowledging the resident hollering out At 1:23 p m , Staff R, Licensed Practical Nurse (LPN), went by the room with a medication cart. Staff R stopped to acknowledge the resident and the resident stated he/she was supposed to have been transported straight from lunch to the beauty shop The resident's voice shaky and repetitive Staff R checked the beauty	F 241		

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F 241	Continued From page 10 shop list and confirmed the resident should have gone to the beauty shop Staff R stated the staff should have acknowledged the resident. Staff R requested Staff O transport the resident to the beauty shop 2 During the group interview on 12/20/16 from 3 30 p.m to 4 30 p m , three residents out of seven in attendance stated staff had attempted to take them to the shower room in the shower chair unclothed or they had witnessed other resident's being transported completely uncovered down the hallway to the shower rooms on several occasions 1 A Minimum Data Set (MDS) with assessment reference date of 11/10/16 assessed Resident # 18 with a brief interview for mental status (BIMS) score of "13" (no cognitive impairment) The resident had severely impaired vision The resident required extensive staff assistance with bed mobility transfers dressing, toileting, personal hygiene and bathing On 11/29/16 at 9 18 a m observation showed the resident in a wheelchair in his/her room The resident stated she made a complaint once regarding a staff The resident asked for a warm washcloth and the staff threw it at her and it fell to the ground The staff picked it up and expected the resident to wash with it The resident told the social worker about it On 11/29/16 at 4 30 p m Staff EE, social worker, stated the resident reported the incident to the other social worker All the resident said was the aide dropped the washcloth and when the resident asked for a clean one, the aide wouldn't give it to her Staff EE stated nothing was mentioned about the aide throwing it at the	F 241		

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F 241	Continued From page 11 resident Staff EE stated there was no follow up to the incident. She could not tell who the staff was that was involved in the incident. Nothing was documented anywhere about the incident	F 241		
F 279 SS=D	483 20(d), 483 20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment The care plan must describe 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 §483.25, and any services that would otherwise be required under §483 25 but are not provided due to the resident's exercise of rights under §483 10, including the right to refuse treatment under §483 10(b)(4) This REQUIREMENT is not met as evidenced by Based on clinical record review, observations, and staff interview, the facility failed to develop a comprehensive care plan for 2 of 15 residents who required adaptive equipment (Resident # 22 & #23), and for 1 of 3 residents with a catheter (Resident #24) The facility reported a census of 93 residents	F 279		

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F 279	Continued From page 12 Findings include 1 The Minimum Data Set (MDS) assessment dated 11/10/16 documented Resident #22 had a diagnosis of Alzheimer's disease The MDS documented the resident required extensive assistance of one staff for meals, and required a mechanically altered (pureed textured) diet The Speech Therapy evaluation completed 7/5/16, documented the resident had a diagnosis of dysphagia. The speech therapist documented the resident pocketed food in the mouth and had an increased risk for aspiration On 7/18/16 the speech therapist documented the resident took multiple bites before he/she swallowed and when no staff assistance received In a communication note to the physician on 12/8/16, and a progress note dated 12/8/16 at 11 04 p m , the speech therapist had recommended the resident continue on a pureed diet, and a smaller teaspoon or baby spoon used when food served to encourage the resident to take smaller bites The physician signed the order on 12/12/16 The resident's care plan updated 11/5/15 did not address the resident's need for using a baby spoon or smaller teaspoon, or contain speech therapist recommendations for interventions to decrease the risk of the resident taking too large a bite During observation on 12/20/16 at 8 12 a m , the resident sat in the dining room eating hot cereal	F 279		

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F 279	Continued From page 13 with milk. Staff D, Certified Nursing Assistant (CNA), gave the resident a regular sized spoon for him/her to feed self. At 8.40 a m , the resident used a fork, and fed self scrambled eggs Food particles hung out of the resident's mouth The resident chewed food slowly During that time, no staff at the table or assisted the resident. At 8:52 a m., the resident sat in a wheelchair in the room At 8.57 a m , Staff D entered the resident's room Staff D told the resident he/she had food in his/her mouth, and needed to chew the food Staff D then left the room During an interview on 12/22/16 at 9 05 a m , the dietician, stated the resident had an order for a pureed diet, and needed assistance when eating The dietician reported the resident had difficulty swallowing, and needed a baby spoon or smaller spoon so the resident took smaller bites The dietician reported scrambled eggs should have been a pureed texture, not served whole 2 During the noon meal observation on 12/19/16 from 11 45 a m -12 43 p m., it was noted Resident #23 was listed on the Dietary Adaptive Equipment List as needing a blue plate for meals and listed on the Fountain Dining Room Section List as needing a dark plate for meals The noon meal was served to Resident #23 on a tan plate which is standard for all Residents. During an interview with the Dietary Manager at 12.43 p m on 12/19/16, she stated blue plates are used for residents that have vision problems	F 279		

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F 279	Continued From page 14 so they can more easily see the food on their plates. An MDS completed on 12/8/16 revealed an admission date of 5/22/15 and identified Resident #23 with a diagnosis of low vision in both eyes A care plan with a revision date of 3/26/15 identified a problem of impaired visual function related to history of retinal issues, diabetes and history of stroke No intervention was listed for the use of a blue plate at meals 3. The 12/1/16 MDS recorded Resident #24's cognitive skills for daily decision making as intact. The resident required limited assistance of one staff for bed mobility, transfers, dressing, toilet use and personal hygiene The MDS recorded the resident had a catheter The 1/5/16 care plan recorded Resident #24 required assistance of 1 staff for toileting The care plan lacked documentation the resident had a Foley catheter or any directions to care for a Foley catheter The 12/1/16 through 2/28/17 Physician's Orders form recorded an order for Foley catheter with a start date of 6/28/16 During an interview on 12/22/16 at 11 30 a m Staff B, Registered Nurse (RN), acknowledged she would expect the resident's catheter to be addressed on the care plan	F 279		
F 281 SS=E	483 20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality This REQUIREMENT is not met as evidenced by Based on observation, record review, resident	F 281		

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F 281	Continued From page 15 and staff interview, the facility failed to provide services that met professional standards of quality for 6 residents. Resident #1, #4, #5, #11, #14, and #25 Resident #11 did not receive his/her Fentanyl (narcotic) patch as ordered On 10/25/16 Resident #1 had a clonidine (for blood pressure) patch on the left shoulder dated 10/3/16. The clonidine patch order directed staff to change the patch weekly Staff should remove the old patch before applying the new one Staff did not perform Resident #4's skin treatment as ordered by the physician Resident #5 did not receive a narcotic pain medication as ordered by the physician Resident #14 did not receive an afternoon medication as ordered Nursing staff failed to clarify bilateral hand splint orders for Resident #25 Nursing Staff created an order for the bilateral hand splints without the physician's input or knowledge The facility census was ninety-three (93) residents Findings include 1 The Minimum Data Set (MDS) with assessment reference date of 9/15/16 assessed Resident #11 with a score of "5" which indicated severe cognitive impairment The resident required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing and personal hygiene The resident did not ambulate The resident had functional range of motion (ROM) limitations of the upper and lower extremities The resident used a wheelchair for mobility The resident had diagnoses that included dementia and stroke Review of the resident's October 2016 medication administration record (MAR) and controlled	F 281		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	Continued From page 16	F 281		

substance record revealed the resident had an order for Fentanyl (narcotic) 12 mcg (microgram) patch. The order directed staff to change the patch every 3 days Review of the resident's controlled substance record revealed staff failed to apply a new Fentanyl patch on 10/17/16 and 11/4/16

A care plan with completion date of 10/5/16 revealed the resident with a problem of alteration in comfort related to osteoarthritis as evidenced by routine use of analgesic The care plan directed staff to administer analgesics as ordered.

2. A MDS with assessment reference date of 10/14/16 assessed Resident #1 with a score of "9", indicating moderate cognitive impairment The resident had no behavior symptoms identified The resident required extensive staff assistance with bed mobility, dressing, toileting and bathing The resident required limited assistance of staff with ambulation and personal hygiene A "balance during transitions and walking" test identified the resident as not steady but able to stabilize without staff assistance in all areas of testing The resident used a walker and wheelchair for mobility The MDS identified the resident admitted to the facility 10/7/16 The resident was occasionally incontinent of bowel and bladder. The resident had diagnoses that included dependence on renal dialysis and altered mental status

A Hospital Progress note dated 10/5/16 identified the hospital applied a Clonidine patch (for blood pressure) on 10/3/16 The hospital note revealed the patch should be changed weekly and staff needs to remove the old patch before applying a

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F 281	Continued From page 17 new one Nursing progress notes dated 10/7/16 at 9 14 p m. revealed the resident admitted to the facility at skilled level of care. An October 2016 MAR revealed an order for Clonidine patch to skin once weekly on Monday The MAR identified staff should apply a new patch on 10/10/16 The MAR revealed Staff U, Licensed Practical Nurse (LPN) initialed she applied a new patch 10/10/16, 10/17/16 and 10/24/16 ER notes dated 10/25/16 at 10 57 a m revealed the resident had EKG (electrocardiogram) stickers on his/her chest from a prior admission which was over 10 days ago The resident had a medication patch (Clonidine) on the left shoulder dated 10/3/16 Hospital notes dated 10/25/16 revealed the resident did not have his/her Clonidine patch changed and the resident's blood pressure was elevated on that date They documented the blood pressure as 201/191 and pulse 48 On 12/5/16 at 12 12 p m Staff U, LPN, stated she checked the resident before applying the new patch on 10/10/16 and did not see one dated 10/3/16 She stated she applied a new patch on 10/10/16 to the left shoulder and removed that one when she applied a patch to the right shoulder on the 10/17/16 3 A MDS with assessment reference date of 11/10/16 assessed Resident #4 with a score of "14", indicating no cognitive impairment The resident required total assistance of staff for bed	F 281		

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F 281	Continued From page 18 mobility and transfers, extensive staff assistance with dressing, toileting and bathing The resident used a wheelchair for mobility The MDS identified the resident with peripheral vascular disease (PVD, poor circulation) The MDS identified the resident with 3 arterial ulcers Treatment administration records (TARs) revealed an order to cleanse area to right medial malleolus with soap and water and pat dry Apply Lidocaine and solosite (for wound healing) to area and cover with dressings every 3 days Cleanse left medial malleolus with soap and water, rinse and pat dry Apply skin prep to site and cover with dressing every 3 days. Observation showed on 11/22/16 at 10 35 a m Staff P, LPN, just finished treatments to the resident's lower extremity sores When questioned about what she did with the areas to the right and left ankles before the surveyor arrived, Staff P stated she applied Lidocaine to the areas When asked about solosite, she stated she didn't see the solosite on the TAR and did not use any 4 A MDS with assessment reference date of 3/31/16 assessed Resident #5 with a score of "5", indicating severe cognitive impairment The resident had behavior symptoms of verbal and other behaviors 1 to 3 days out of 7 The resident did not reject care The resident required extensive staff assistance with bed mobility, dressing and eating The resident required total assistance with transfers, toileting, personal hygiene and bathing. The resident did not ambulate The resident had functional range of motion limitations of one lower extremity The resident was frequently incontinent of bowel and	F 281		

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F 281	Continued From page 19 bladder. The MDS identified the resident at risk for pressure sores and the resident had pressure sores The MDS did not identify moisture associated skin damage (MASD) The MDS identified the resident with diagnoses that included peripheral vascular disease (PVD) and fracture of the right femur The resident admitted to the facility on 6/10/11. The MDS identified the resident received scheduled pain medications Review of the July 2016 MAR revealed the resident should receive Norco (narcotic) four times a day at 12 a.m., 6 a m , 12 p m and 6 p m Review of the resident's controlled substance record revealed the resident did not receive his/her scheduled Norco 5/325 milligrams the morning of 7/14/16 The controlled substance record identified the resident received one on 7/14/16 at 12 a m. and the next one was administered at 2 30 p m. (2.5 hours late) on 7/14/16 5 The MDS with assessment reference date of 11/17/16 assessed Resident #14 with a score of "15", indicating no cognitive impairment The resident required extensive staff assistance with bed mobility, transfers and toileting On 11/29/16 at 3 55 p m the resident stated Staff Y LPN, did not give the resident his/her afternoon medications on 10/13/16 The resident stated Staff Y told her she didn't give the medication because the resident was not in his/her room On 12/6/16 at 3 p m , Staff Y, LPN, stated she did	F 281		

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F 281	Continued From page 20 not give the resident his/her Gabapentin (to treat nerve pain) on that date because the resident was at an activity in the facility Review of the resident's October 2016 MAR revealed the resident did not receive the PM dose Gabapentin 100 mg. 6 Resident council minutes for 10/6/16 revealed a comment concerning not getting medications at prescribed times or medications not always 4 hours apart 7 According to the MDS dated 12/9/16 Resident #25 had diagnosis that included Alzheimer's disease, atrial fibrillation, heart failure and kidney failure. The same MDS documented the resident dependent for mobility, dressing and hygiene, had limited functional range of motion in both arms and legs The care plan problem initiated 5/15/14. documented the resident had impaired mobility, the intervention dated 12/12/16 directed staff apply the left hand splint and right hand cone as ordered and to refer to the resident's treatment administration record (TAR) for orders The Functional Maintenance Program sheet completed by the occupational therapist (TO) 11/15/16 directed the following Splint Schedule a Left hand. Resting hand splint (soft) b Right hand Cone (soft) splint To be worn daily and skin checked every shift change Please stretch hands or place warm moist towel wraps to placing hands in splints Can be removed for self feeding and bathing, otherwise to be worn all day and night	F 281		

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F 281	Continued From page 21 A physician's telephone order signed 11/15/16 approved the splint schedule as recommended by the OT. The Treatment sheets dated December, 2016 and January, 2017 directed staff to apply the hand splint and cone as ordered on 11/15/16 (to wear all day and night) as well as another order for the resident to wear splints to both hands for 2 hours in the morning and afternoon, all night with removal at 6:00 AM as well as for meals. Review of the resident's clinical record revealed no physician order for the splints to be worn 2 hours AM and PM and all night with removal at 6 00 AM During interview on 1/18/17 at 2 00 PM, Staff P, LPN acknowledged staff were initialing 2 conflicting orders for the resident's hand splint and cone since 12/19/16. When asked for the physician order for the hand splint and cone to be worn 2 hours in the AM and PM and all night with removal at 6 00 AM, Staff P presented a hospital Patient Discharge & Transfer Form dated 12/19/16 documented Treatments Every two hour turns Right hand grip/splint? Staff P stated that she took the documentation as an order and wrote an order for the resident to wear the splint and cone for 2 hours AM, PM and all night with removal at 6 00 AM herself with no physician or OT clarification or signed order Staff P offered no explanation as to why she falsified the order and did not seek clarification from the physician or the OT	F 281		

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F 281	Continued From page 22 During interview on 1/24/17 at 9:40 AM the administrator stated Staff P resigned on 1-18-17 after the interview concerning the falsified order	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care This REQUIREMENT is not met as evidenced by Based on observation, record review, resident and staff interview, the facility failed to provide services in accordance with each resident's written plan of care for 2 of 5 residents Resident #7 was not repositioned according to the care plan Resident #8 was not repositioned or checked and changed as the care plan directed The facility census was ninety-three (93) residents Findings include 1 The Minimum Data Set (MDS) with assessment reference date of 8/11/16 assessed Resident #7 with a score of "13", indicating intact cognition The MDS did not identify any behavior symptoms The resident required extensive staff assistance with bed mobility, transfers and toileting The resident did not ambulate The resident was frequently incontinent of bowel and bladder The resident used a wheelchair for mobility The resident had diagnoses that included Alzheimer's disease.	F 282		

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F 282	Continued From page 23 A care plan completed 8/15/16 identified the resident with potential skin impairment related to risk factors for skin breakdown and incontinence, edema, impaired mobility and cognition, right hand contracture and noncompliance with right hand splint. The care plan directed staff to encourage and assist the resident to change position frequently, avoid lying or sitting in any one position for extended periods of time. Observation showed on 11/28/16 at 1:48 p.m., the resident in bed on his/her back. The resident remained in a back lying position until 4:42 p.m. (3 hours). Observation showed on 11/29/16 at 8:08 a.m. the resident up in the wheelchair. The resident remained up in the wheelchair until 1:27 p.m. when Staff S, Certified Nursing Assistant (CNA), transferred the resident to bed. Prior to transfer to bed, Staff S checked and changed the resident. The resident had red areas on the upper buttocks. On 11/29/16 at 1:43 p.m. Staff W, CNA, stated she and Staff T, CNA, got the resident up around 7 a.m. to 7:30 a.m. and neither she or Staff T did anything with the resident since they brought the resident back from breakfast and started showers. This indicated the resident sat in the wheelchair approximately 6 hours. On 11/29/16 at 11:12 a.m. the resident stated he/she sat in the wheelchair all morning and he/she didn't want to sit that long. The resident stated no one offered or took him/her to the toilet since he/she got up. Nursing progress notes dated 11/23/16 at 1:04 p.m. revealed staff documented the resident with skin impairment of the coccyx (No size or description documented). Staff applied	F 282		

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F 282	Continued From page 24 Dermagran (for skin impairment) to the area. Nursing progress notes dated 11/30/16 identified a decrease in the size of the open area on the right gluteal 2. The MDS with assessment reference date of 10/6/16, assessed Resident #8 with short and long term memory impairments and severely impaired decision making skills. The resident was rarely/never understood by others and had highly impaired vision. The resident was totally dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene, eating and bathing The resident could not ambulate The resident used a wheelchair for mobility The resident was always incontinent if bowel and bladder. The resident had diagnoses that included Alzheimer's disease, peripheral vascular disease (PVD poor circulation) and hemiplegia (limitation on one side) Observation showed on 11/29/16 at 8 10 a.m staff feeding the resident as he/she sat up in the wheelchair The resident remained up in the wheelchair until 1 03 p m At that time Staff T, CNA, stated she was not sure when they got the resident up that morning Staff T stated they repositioned the resident by leaning the resident back in the chair and checked the resident without laying the resident down When asked how they checked the resident Staff T stated they checked the resident as one would a baby and the resident was dry Staff T then stated they had a lot of baths that morning and had trouble finding briefs and wipes Staff T stated they go with the flow and wing it and as long as everyone gets fed and changed after lunch they are "doing good" Observation showed on 11/29/15 at 1 03 p m , the resident wet with urine and pericare	F 282		

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F 282	Continued From page 25 provided. On 11/29/16 at 1:43 p m Staff W, CNA, stated she and Staff T, CNA, got the resident up around 7 a m. to 7.30 a m This indicated the resident sat in the wheelchair for approximately 6 hours A care plan with target completion dated of 10/21/16 identified the resident at risk for skin breakdown related to debility, incontinence and impaired mobility The care plan directed staff to assist with frequent repositioning Avoid sitting or lying in one position for extended periods of time. The care plan directed staff to check and change the resident as directed. The facility policy for the scheduled toileting program directed staff to check and change the resident every two to three hours Nursing progress notes dated 10/24/16 identified a small partial thickness wound (PTW) 0 8 cm by 1 cm. to the right outer buttock Staff applied a Tegaderm transparent dressing The record lacked follow up to the area Observation showed on 11/17/16 at 9 a m no open areas to the resident's buttocks	F 282		
F 309 SS=G	483 25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care This REQUIREMENT is not met as evidenced by Based on observation, record review and staff	F 309		

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F 309	Continued From page 26 interview, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 7 of 7 residents reviewed: Resident #2, #3, #5, #7 #11, #17, and #21 Resident #5 experienced symptoms of stroke that the facility failed to act on in a timely manner Resident #2, Resident #11 and Resident #3 fell and bruised their faces. The facility failed to assess and document the bruising. Resident #7 had an open area to his/her bottom that the facility failed to measure or document a description of The facility failed to follow up on Resident #5's skin impairment Resident #17 had cancer and pain The resident stated the facility failed to administer pain medications in a timely manner Resident #21 fell and fractured his/her upper arm (humerus) and the facility failed to document an ongoing assessment The facility failed to provide a follow up assessment Facility census was ninety-three (93) residents Findings include 1 A Minimum Date Set (MDS) assessment tool dated 3/31/16 assessed Resident #5 with a BIMS score of "5" (severe cognitive impairment) The resident had behavior symptoms of verbal and other behaviors 1 to 3 days out of 7 and did not reject care The MDS documented the resident required extensive staff assistance with bed mobility, dressing and eating and total assistance with transfers toileting, personal hygiene and bathing The MDS also documented Resident #21 did not ambulate and had functional range of motion limitations of one lower extremity, was	F 309		

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F 309	Continued From page 27 frequently incontinent of bowel and bladder, and at risk for pressure sores and the resident had pressure sores The MDS did not identify moisture associated skin damage (MASD) and revealed the resident had diagnoses that included peripheral vascular disease (PVD) and fracture of the right femur. The resident admitted to the facility on 6/10/11 Stroke Nursing progress notes dated 7/28/16 at 8 31 p m and documented by Staff C RN revealed the resident's granddaughter informed the nurse that the resident had right side facial drooping and could not speak The resident appeared sleepy The resident looked at Staff C when staff spoke to him/her The resident attempted to speak to answer questions but could not say any actual words. The right side of the face had drooping and the right grip was weaker The resident could move extremities Temperature was 98 axillary, pulse 84, respirations 16 and blood pressure 128/72 The next nursing progress note entry dated 7/29/16 at 12 45 a m and documented by Staff AA LPN revealed Staff C informed her of the resident's symptoms at 12 30 a m Staff AA observed the resident lying in bed awake and alert with right side of face drooping The resident could usually swallow a pill whole Staff AA had to crush the resident's 12 a m Norco and the resident could not keep it in his/her mouth Water and parts of the pill ran out of the right side of the resident's mouth The resident could follow the nurse with his/her eyes The resident could not speak. The resident could not grasp with the right hand The resident's pupils reacted to light Staff	F 309		

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F 309	Continued From page 28 AA notified the resident's daughter at 1 a m who gave the OK to notify the physician Staff AA called the physician's answering service at 1 10 a m with no answer. At 1 40 a.m the ARNP called and gave the OK to transport the resident to ER At 2 16 a m. the ambulance arrived and transported the resident to the hospital Hospital ED (emergency department) HPI (history of present illness) comments, dated 7/29/16 at 2 56 a.m revealed the resident presented from the nursing home for evaluation of stroke-like symptoms and was noted to develop an acute onset of expressive aphasia with right sided facial droop and right upper extremity weakness around 8 30 p m. last night The facility did not send the resident to the ED at that time Nursing staff at the facility reportedly noted a persistent expressive aphasia and facial droop around 12 30 a m this morning as the resident had difficulty taking his/her pills at that time Therefore EMS (emergency medical services) was finally called around 2 a m to transfer the resident to the ED for further evaluation ED provider notes dated 7/29/16 at 5 26 a m revealed the resident continued to have apparent neurological deficits including facial droop and aphasia The physician suspected the resident's symptoms were related to an acute stroke though the onset and progression of the symptoms. The resident presented well outside the window for any emergent treatment for an acute stroke as symptoms started around 8 30 p m yesterday evening. The resident admitted to the hospital for care A hospital history and physical identified the resident's principal problem as "acute ischemic	F 309		

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F 309	Continued From page 29 stroke" On 11/22/16 at 2.38 p m Staff C RN stated the resident started having symptoms on the 2 p m to 10 p.m shift. The resident was very tired and exhibited unclear speech. Staff C thought it may have to do with the resident being tired Staff C notified the charge nurse Staff M LPN. The resident's vitals were fine and they continued to monitor the resident Staff C stated it was up to the charge nurse to make the decision to send the resident to the hospital. On 11/23/16 at 9 28 a.m. Staff M LPN stated she worked on the skilled unit that night Staff M confirmed she was the charge nurse that shift Staff M stated a resident readmitted and she helped that resident get to his/her room when she was told Staff C needed her Staff M asked what was wrong and the resident's family stated the resident was not acting right Staff M stated she then let Staff C know if she needed help to let her know and she went back to the resident that just returned to the facility Staff M stated she glanced in the room and Staff C was in there and that's when she told her to let her know if she needed help She didn't give Staff C any directives on what to do for the resident and she never heard anything more from Staff C No one told her any specifics other than the resident wasn't acting right On 12/19/16 at 12:16 p m Staff AA LPN stated she came on duty after midnight and Staff C told her the resident's granddaughter had concerns that the resident had signs and symptoms of stroke since 8 or 9 p m Staff AA immediately went to the resident's room and the resident had mumbled speech with right facial drooping Staff	F 309		

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F 309	Continued From page 30 AA thought the resident had a stroke so she sent the resident to the hospital Staff AA stated from what she saw, the resident should have transferred to the hospital a lot sooner On 12/20/16 at 1 p m during phone exit the Administrator identified Staff AA as a disgruntled employee with credibility issues Skin Impairment Nursing progress notes dated 7/13/16 at 9.48 p m revealed a CNA reported the resident had a moderate amount of red blood in his/her brief that appeared to come from the vagina Assessment of the area revealed a small amount of blood from small nodules and lumps on the labia fold Staff cleansed the area and patted dry The resident voiced discomfort to the area The record lacked follow up of the area Nursing progress notes dated 7/29/16 at 2 16 a.m revealed the resident transported to the hospital with stroke symptoms Hospital records dated 7/29/16 at 2 58 p m revealed hospital staff assessed the resident with Stage 2 wounds on the perineal area The resident had multiple open areas on the outer and inner labia and urethral opening On 11/28/16 at 4 05 p m the Director of Nursing (DON) stated she did not find the facility followed up on the 7/13/16 observation and that the resident did not have a physician encounter that addressed it 2 An MDS dated 9/17/16 assessed Resident #2	F 309		

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F 309	Continued From page 31 with a brief interview for mental status (BIMS) score of "5" (severe cognitive impairment) The resident had the following indicator of delirium that fluctuated through the day. inattention The resident had no behavior symptoms identified The MDS documented the resident required limited staff assistance with bed mobility, transfers and ambulation and extensive staff assistance with toileting, dressing and personal hygiene A "balance during transitions and walking" test identified the resident as not steady and only able to stabilize with staff assistance The resident used a walker and wheelchair for mobility. The resident was occasionally incontinent of bladder The resident had diagnoses that included dementia An incident report dated 10/16/16 at 5 15 a m revealed the resident stated he/she came out of the bathroom and fell Staff found the resident sitting on his/her bottom on the resident's room floor. The resident said he/she hit their head on the edge of the bed Staff applied an ice pack to the head The resident received a hematoma to the right forehead and abrasion to the buttock The incident report did not identify an intervention following the incident Nursing progress notes dated 10/16/16 at 9 16 a m revealed the resident transported to ER for evaluation A physician encounter form dated 10/17/16 at 4 51 p m revealed the resident was sent to ER on 10/16/16 after a fall The resident had bruising above and below bilateral eyes as well as the right forehead ER evaluated the bruising The bruising was described as follows Examination of the head and face revealed hematoma around the bilateral eyes and right forehead and tenderness over the right frontal area. The right	F 309		

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F 309	Continued From page 32 eyelid showed swelling of the upper eyelid and extensive bruising around the bilateral eyes The facility failed to document any bruising on the face. Observation showed 11/16/16 at 11.07 a m the resident in bed. The resident had visible bruising around both eyes. 3. An MDS dated 9/15/16 assessed Resident # 11 with a BIMS score of "5" (severe cognitive impairment) The resident required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, and personal hygiene The resident did not ambulate The resident had functional range of motion (ROM) limitations of the upper and lower extremities The resident used a wheelchair for mobility The resident had diagnoses that included dementia and stroke The resident had two or more falls without injury since the previous assessment An incident report dated 10/17/16 at 7 20 p m revealed staff found the resident laying on the right side in the central hallway The resident had a large bump on the forehead and a bloody nose The resident complained of back pain The alarm sounded when the resident fell On 11/23/16 at 1 55 p m , Staff K LPN stated the resident was in the central hallway and fell out of the wheelchair She stated there was a family visiting another resident in the central hall and they alerted staff to the resident's fall No staff heard the resident's wheelchair alarm and found the resident lay face first on the ground. Staff K called the ambulance and the resident transported to ER for evaluation Staff K stated after the incident the resident had black eyes Nursing progress notes dated 10/18/16 at 12 08	F 309		

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F 309	Continued From page 33 a m. revealed the hospital called and informed the facility the resident had a UTI (urinary tract infection) and the resident would return with an order for Keflex (antibiotic) to treat the UTI The head CT and the chest x-ray were OK Nursing progress notes on the same date at 1 48 a.m revealed the resident returned to the facility and had bruising to the forehead and face. There was no further documentation regarding the bruising. Observation showed on 11/23/16 at 1 10 p m Staff L CNA transferred the resident to the toilet via the EZ stand The alarm sounded when Staff L assisted the resident to stand Staff L stated she took care of the resident on 10/17/16 and the resident fell after she left The next day the resident had 2 black eyes. On 11/28/16 at 4 05 p.m the DON stated she could not find any documentation regarding the resident's facial bruising after readmission from ER 4 An MDS dated 7/21/16 assessed Resident #3 with a BIMS score of 8 (moderate cognitive impairment) The resident required extensive staff assistance with bed mobility dressing, toileting, personal hygiene and bathing. The resident required limited staff assistance with bathing A "balance during transitions and walking" test identified the resident as not steady but able to stabilize with staff assistance and revealed the resident used a walker and wheelchair for mobility The MDS identified the resident received daily anticoagulant medication An IR dated 11/22/16 at 5 30 a m revealed a fall in the resident room Staff found the resident on the floor next to the bathroom The resident could not explain what occurred The IR identified the resident had previously been anxious The resident sustained a bump to the forehead that measured 2 cm by 2 cm The intervention	F 309		

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F 309	Continued From page 34 following the incident was to answer the resident promptly when he/she called (Already in place) and a PT/Occupational therapy (OT) screen A hospital report dated 11/23/16 revealed the resident fell 3 times in the past 3 days. The resident sustained arm lacerations to both arms and a left sided forehead hematoma. The report identified a left wrist skin tear and right bicep skin laceration. Observation Observation showed on 11/28/16 at 11 37 a m the resident wheeled self with feet in the wheelchair Observation showed a large bruised area around the left eye When asked what happened the resident stated "it ' s been like that a long time " The record lacked documentation of a left black eye after 11/22/16 5 A MDS with assessment reference date of 8/11/16 assessed Resident #7 with a BIMS score of "13" (no cognitive impairment) The MDS did not identify any behavior symptoms The MDS documented the resident required extensive staff assistance with bed mobility, transfers and toileting, did not ambulate. was frequently incontinent of bowel and bladder, and used a wheelchair for mobility The MDS identified the resident had diagnoses that included Alzheimer's disease A care plan completed 8/15/16 identified the resident with potential skin impairment related to risk factors for skin breakdown and incontinence, edema, impaired mobility and cognition, right hand contracture and noncompliance with right hand splint The care plan directed staff to encourage and assist the resident to change position frequently, avoid lying or sitting in any	F 309		

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F 309	Continued From page 35 one position for extended periods of time On 11/17/16 at 9:28 a m observation revealed a band aide on the resident's left buttock When staff removed the Band-Aid, there was no open or scabbed area beneath it. On the same date at 11 55 a m , observation also revealed two scarred healed areas to the upper buttocks and an open horizontal slit at the top of the upper right buttock area At that time, Staff T LPN confirmed the area was open and applied dermagran (for skin impairment) to the area. Observation showed on 11/28/16 at 1 48 p.m , the resident in bed on his/her back The resident remained in a back lying position until 4 42 p m (3 hours) Observation revealed on 11/29/16 at 8 08 a.m the resident up in the wheelchair The resident remained up in the wheelchair until 1.27 p m when Staff Q transferred the resident to bed Prior to transfer to bed, Staff Q checked and changed the resident The resident had red areas on the upper buttocks. On 11/29/16 at 1 43 p m Staff R CNA stated she and Staff S CNA got the resident up around 7 a m to 7 30 a m and neither she or Staff S CNA did anything with the resident since they brought the resident back from breakfast and started showers This indicated the resident sat in the wheelchair approximately 6 hours On 11/29/16 at 11 12 a m the resident stated he/she sat in the wheelchair all morning and he/she didn't want to sit that long The resident stated no one offered or took him/her to the toilet since he/she got up Documentation Nursing progress notes dated 11/16/16 at 2 49	F 309		

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F 309	Continued From page 36 p m. revealed the resident had two, small thick scar tissue areas to the upper buttocks The entry identified superficial pinpoint areas on the scar tissue areas The facility notified the physician and received an order for dermagran Nursing progress notes dated 11/23/16 at 1 04 p m revealed staff documented the resident with skin impairment of the coccyx. (No measurement or description documented). Staff applied Dermagran to the area. Nursing progress notes dated 11/30/16 identified a decrease in the size of the open area on the right gluteal (no measurement or description) Nursing progress notes dated 12/5/16 at 11 48 a m identified the area as healed On 12/7/16 at 9 10 a m the Director of Nursing (DON) stated the facility did not have skin sheets for the area because they only do skin sheets for pressure, stasis and arterial sores Staff documents in the nursing progress notes 6 An MDS dated 10/20/16 assessed Resident #17 with a BIMS score of "15" (no cognitive impairment) The resident was independent with all cares other than supervision for bathing The resident had diagnoses that included breast cancer with bone, liver and lung metastasis The MDS identified the resident with frequent pain and pain that made it hard to sleep at night at a pain level of "3" on a scale of 0 to 10 with 10 being the worst imaginable pain A care plan dated 10/27/16 identified the resident with a pain/comfort concern related to cancer diagnosis as evidence by usage of pain medication and complaints of pain The care plan directed staff to encourage the resident to verbalize presence, type and location of pain and administer medications as ordered	F 309		

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F 309	Continued From page 37 On 11/29/16 at 9 08 a m. the resident stated she waited 2 hours for a pain pill the day before yesterday (11/27/16) The resident stated he/she pushed the call light at 7 30 a m to be able to get a pain pill by 8 30 a m The resident stated he/she didn't get the pain pill until 10 15 a m when she got both the long acting and short acting pain pills together The resident stated it was hard to get the pain managed after that The same day the resident pushed the call light at 1 30 p m to get his/her 2 p m medication and he/she didn't get it until 3.15 p m At 2 15 p.m the resident pushed the call light again and a nurse aide answered it and said she would tell the nurse the resident wanted his/her 2 p m. medication The resident stated he/she could handle the medication 1 hour late but not longer The resident got up and went to the big nurse ' s station The resident thought he/she may pass out but the resident made it and got the medication instantly then The November medication administration record (MAR) revealed the resident had an order for morphine sulfate 60 milligrams (mg) SA (sustained release) every 12 hours morning and bedtime The resident had a PRN (as needed) order for Morphine Sulfate IR (immediate release) 30 mg every 4 hours as needed for pain Narcotic controlled substance record identified the nurse signed out the morphine 60 mg SA on 11/27/16 at 9 a m and morphine IR 30 mg on 11/27/16 at 9 45 a m , 2 30 p m. and 6 30 p m 7 According to the MDS dated 11/3/16, Resident #21had diagnoses that included osteoarthritis and chronic pain The same MDS documented a	F 309		

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F 309	Continued From page 38 Brief Interview of Mental status score of "14" (intact cognition) and revealed the resident, required extensive assistance with transfers and ambulation, did not ambulate in his/her room or the hallway during the assessment period, utilized a wheelchair for mobility and had decreased functional range of motion in one upper extremity The resident had no falls since the last assessment completed 92 days or less. The care plan problem revised 11/10/16 identified the resident as at risk for falls related to deconditioning and vision and hearing problems and directed staff to provide assist of 1 for transfers from bed The care plan also directed staff to provide assist of 1 with other transfers upon request place the call light placed within reach and encourage the resident to use it The Incident Report dated 1/8/17 documented staff found the resident found lying on the floor on his/her left side at 5.15 PM The resident stated he/she attempted to go to the bathroom and fell The resident complained of pain to the left upper arm and the nurse assessed the resident had decreased range of motion in this arm The progress notes entry in the resident's clinical record completed by Staff WW, RN dated 1/8/17 at 8 29 PM documented the resident sustained an 8 centimeter (cm) skin tear to the left elbow and complained of pain and had limited range of motion in the left arm The Incident Report documented the resident notified by fax if the incident The progress notes contained no further assessment of the resident until 1/9/17 at 2 42 PM which documented the resident had a bruise	F 309		

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F 309	Continued From page 39 and two abrasions on the left knee, in addition to the left arm skin tear The entry documented the resident's range of motion within normal limits The clinical record contained no further information on the resident until 1/10/17 at 1 54 PM which documented the unit secretary told the nurse the resident did not act right and seemed confused The entry failed to contain any assessment of the resident other than vital signs and blood sugar result. Staff placed a call to the physician's office and called 911 to transport the resident to the hospital The progress notes entry dated 1/10/17 at 8 08 PM documented the resident admitted to the hospital with a fracture of the left humerus (bone of the upper arm). During interview on 1/12/17 at 4 04 PM the director of nursing (DON) stated staff failed to continue to assess the resident post-fall and she has disciplined the nurses involved	F 309		
F 312 SS=E	483 25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene This REQUIREMENT is not met as evidenced by Based on observation, record review and staff interview, the facility failed to ensure that a resident who was unable to carry out activities of	F 312		

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	165350	A BUILDING _____ B WING _____	C 01/24/2017

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F 312	Continued From page 40	F 312		

daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 4 of 4 residents. Resident #2 and Resident #43 did not receive adequate pericare Resident #25 did not receive nail care Resident #1 admitted to the facility 10/7/16 and did not have a bath/shower between then and discharge on 10/28/16 The facility census was ninety-three (93) residents.

Findings include:

1 A Minimum Data Set (MDS) with assessment reference date of 9/17/16, assessed Resident #2 with a brief interview for mental status (BIMS) score of "5" which indicated severe cognitive impairment The resident had the following indicator of delirium that fluctuated through the day inattention The resident had no behavior symptoms identified The resident required limited staff assistance with bed mobility transfers and ambulation and extensive staff assistance with toileting, dressing and personal hygiene A "balance during transitions and walking" test identified the resident as not steady and only able to stabilize with staff assistance The resident used a walker and wheelchair for mobility The resident was occasionally incontinent of bladder The resident had diagnoses that included dementia

Observation showed on 11/22/16 at 5 05 p m Staff V CNA and Staff X CNA toilet the resident They stated they did not toilet the resident since coming in duty at 2 p m Staff V stated the resident was a "routine toilet" Staff wheeled the resident into the bathroom and the resident stood up holding onto the bar in the bathroom Staff V identified the resident as wet and smearing bowel

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F 312	Continued From page 41 movement. After using the toilet, staff washed the resident's buttock only A care plan containing an intervention dated 11/17/16 identified the resident required extensive assistance with toileting The resident required prompted toileting Facility policy, Perineal Care, directed staff to wash the perineal area including the groins, hips, buttocks and lower abdomen with cleansing wipes washing front to back 2 The MDS with assessment reference date of 10/14/16 identified Resident #1 with a score of "9", which indicated moderate cognitive impairment The resident had no behavior symptoms identified The resident required extensive staff assistance with bed mobility, dressing toileting and bathing The resident required limited assistance of staff with ambulation and personal hygiene A "balance during transitions and walking" test identified the resident as not steady but able to stabilize without staff assistance in all areas of testing The resident used a walker and wheelchair for mobility The MDS identified the resident admitted to the facility 10/7/16 The resident was occasionally incontinent of bowel and bladder The resident had diagnoses that included dependence on renal dialysis and altered mental status Emergency Room (ER) notes dated 10/25/16 at 10 57 a m revealed the resident had EKG stickers on his/her chest from a prior admission which was over 10 days ago The resident had a medication patch (Clonidine) on the left shoulder dated 10/3/16	F 312		

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F 312	Continued From page 42 Review of bath records revealed the first bath offered was 10/13/16 (1 week after admission) and staff did not give it due to "not applicable". The next bath documented as offered was 1 week later (10/20/16) and staff documented the resident refused the bath. The next bath offered was 4 days later (10/24/16) and not given because "resident not available" The next bath offered was 10/27/16 and documentation revealed the resident refused it 3. The MDS assessment dated 12/9/16 for Resident #25 identified a Brief Interview for Mental Status (BIMS) score of 8 with signs and symptoms of fluctuating altered level of consciousness A score of 8 indicated moderate cognitive impairment. The MDS documented the resident totally dependent on 1 person physical assistance for personal hygiene The care plan identified a focus area initiated 5/15/14 of a self care deficit related to multiple medical problems The care plan intervention revised 7/24/14 directed staff to clean and trim nails as needed and informed the resident as diabetic The Progress Notes dated 7/21/16 at 2 54 p m documented a skin/wound note The note recorded the resident had very long fingernails that curled under The writer soaked the resident's hands in warm, soapy water for 15 minutes to facilitate nail trimming and nail filing to create smooth edges The entry documented the resident had bilateral (both) contractures of hands, although after soaking, the left hand opened to allow cutting of the fingernails	F 312		

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F 312	Continued From page 43 Observation on 12/22/16 at 9 15 a m. revealed the resident's fingernails long and thumbnail jagged on the left hand. The resident wore splints (adaptive devices to prevent contractures) on both hands Staff O, Certified Nurse Aide (CNA), present in the dining room and stated CNAs were not allowed to trim the resident's nails due to the resident's diagnosis of diabetes In an interview on 12/22/16 at 11 55 a m , Staff P, Nurse Case Manager for Hall 2, stated all paperwork requested for documentation of nail care was provided. Staff P said she was not that familiar with the resident's nail care as she just started in September. The clinical record lacked ongoing documentation of the trimming of the resident's fingernails 4 The MDS dated 11/11/16 documented Resident #43 had diagnoses that included Non-Alzheimer's dementia and psychotic disorder The MDS documented the resident required extensive assistance for completion of toileting and hygiene and frequently incontinent of bladder and total incontinence of bowel The care plan problem revised 3/9/15 identified the resident incontinent of urine and directed staff provide incontinence care The care plan also identified the resident had a history of extended-spectrum beta-lactamase (EBSL) bacteria in his/her urine and directed staff to use standard precautions for body fluid contact at all times Observation with the skilled unit manager observing on 1/12/17 at 9:35 AM, revealed Staff	F 312		

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F 312	Continued From page 44 VV and DD, CNA's, turned the resident side to side and removed a soiled brief. Staff DD cleansed the resident's groins with an up and down motion on both sides without changing the area of the disposable cloth. Staff turned the resident to the left and Staff DD cleansed the resident's rectal area with several disposable wash cloths that became soiled with fecal material Staff DD failed to cleanse the area until clear of BM Staff DD then cleansed the resident's right buttock with an up and down motion using the same area of a disposable and cloth Without changing gloves, staff turned the resident to the left side Staff VV then pulled the clean brief through and fastened it without cleansing the resident's right buttock Wearing the same soiled gloves, Staff VV pulled up the resident's slacks, handled the bedcovers, bedrail and call light cord before removing her gloves and washing her hands	F 312		
F 314 SS=G	483 25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing This REQUIREMENT is not met as evidenced by Based on record review and staff interview, the	F 314		

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F 314	Continued From page 45 facility failed to ensure that a resident who entered the facility without pressure sores did not develop pressure sores unless the individual's clinical condition demonstrated that they were unavoidable, and a resident having pressure sores received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for 1 of 5 residents reviewed. The facility failed to ensure Resident # 5's cast padding was smooth without rolling/bunching on 6/21/16 resulting in a deep tissue injury (DTI) to the right heel. ER (emergency room) notes dated 6/25/16 identified the resident with a new decubitus on the right foot developed secondary to pressure at the cast site due to the leg hanging in the dependent position After the cast was removed on 7/15/16, the facility assessed the pressure sores on the right foot There was no further documentation of assessment of the sores The resident transferred to the hospital 7/29/16 Staff initialed they provided the ordered Betadine treatment to the right foot 8 out of 14 days Facility census was ninety-three (93) residents Findings include 1 A Minimum Data Set (MDS) assessment tool dated 3/31/16, assessed Resident #5 with severe cognitive impairment and documented the resident displayed behavior symptoms of verbal and other behaviors 1 to 3 days out of 7, but did not reject care. The resident required extensive staff assistance with bed mobility, dressing, eating and personal hygiene The resident required total assistance with transfers, toilet use and bathing The resident did not ambulate The resident had functional range of motion limitations of one lower extremity. The resident was	F 314		

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F 314	Continued From page 46 frequently incontinent of bowel and bladder The MDS identified the resident at risk for pressure sores and the resident did not have pressure sores The MDS identified the resident with diagnoses that included, peripheral vascular disease (PVD) and fracture of the right femur The resident admitted to the facility on 6/10/11 An MD/nursing communication form dated 6/15/16 at 10 44 a m revealed staff notified the resident's primary physician that the resident saw the orthopedic (ortho) physician on 6/14/16 and had the right lower extremity (RLE) cast removed and the resident now wore a splint on the RLE The resident continued non-weight bearing status The resident had an order for topical use of hydrocolloid dressing and cast padding to the toes of the right foot due to the use of the cast Staff documented the treatment was no longer needed since ortho removed the cast The skin to the toes was intact The physician signed the order 6/15/16 and agreed to the discontinuation of the hydrocolloid dressings and cast padding An MD/nursing communication form dated 6/21/16 at 10 24 a m. revealed Staff Y LPN (licensed practical nurse) asked Staff Z LPN to assess skin breakdown to the right heel. Staff Y removed the compression wrap used to hold the half cast to do a skin assessment The cast padding was not smooth and was rolled up in places, especially the heel and achilles area Staff Z assessed a DTI measuring 2 cm (centimeter) by 2 cm and a 0.7 cm by 0 6 cm wound with dry yellow exudate just superior to it Assessment showed extensive desquamation of the skin on the right foot and ankle The resident did not complain of pain Staff Z instructed Staff Y to place new cast padding to the half cast and a	F 314		

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F 314	Continued From page 47 dressing to the heel. Staff Z requested the following treatment for the wounds: Cleanse wounds at right heel/achilles area with soap and water, rinse and pat dry Apply skin prep to surrounding skin allow to dry. Cover with foam dressing and change every 4 days and as needed. The ARNP (advanced registered nurse practitioner) agreed to the order On 11/29/16 at 10 24 a m. Staff Y LPN stated on 6/21/16 she discovered the resident had skin breakdown so she got Staff Z to check the areas and that was her only part in that incident On 11/29/16 at 5 p m. Staff Z LPN stated the cast padding was rolled up and that could be the cause of the resident's DTI discovered on 6/21/16 A physician encounter form dated 6/21/16 at 11 55 a m identified the ARNP saw the resident for an acute wound to the right heel The resident had a history of right distal femur fracture with secondary pain The ARNP identified the acute wound on the right heel as a pressure ulcer with a soft padded dressing over it The ARNP identified the heel as difficult to float The resident was referred to the wound clinic for follow up Nursing progress notes dated 6/21/16 at 4 30 p m revealed the facility attempted to schedule an appointment at the wound center The wound center stated the first they could see the resident was in 1 to 2 months Nursing progress notes dated 6/22/16 at 1 11 p m revealed the resident's family expressed they did not feel the facility cared for the resident's leg and heel appropriately and tried to	F 314		

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F 314	Continued From page 48 take the resident to the orthopedic physician via car and could not get the resident in the car due to immobility to bend leg An x-ray report identified an x-ray of the RLE completed on 6/22/16 showed no changes from 3/20/16 x-ray. Nursing progress notes dated 6/23/16 at 8:55 a.m. revealed the facility received a phone call from the orthopedic physician office for the resident to come to the office that afternoon to get the RLE recasted. Nursing progress notes dated 6/24/16 at 2 52 p m revealed the new cast contained a heel cut out due to the DTI and Stage 3 ulcer Edema to the heel caused compression against the cast edges especially at the achilles area The facility notified the physician on 6/24/16 at 3 56 p.m of the edema The physician directed staff to elevate the leg as able An ER (emergency room report) dated 6/25/16 at 9 28 p m revealed the resident came to the ER for a cast problem involving an issue with swelling in the right heel and the cast pressing into it The report identified an ortho tech at the ER opened the cast window more and could visualize a 2 cm by 1 cm area of erythema consistent with a new pressure ulcer ER instructed the family, who arrived with the resident that the resident needed to keep his/her leg elevated The family stated they tried to elevate the leg but the facility left the leg in the dependent position up to 8 hours at a time The ER document identified the decubitus developed secondary to pressure at the cast site due to the leg hanging in the dependent position	F 314		

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F 314	Continued From page 49 On 12/19/16 at 11:40 a m. Staff FF LPN stated she worked with the resident on the first day the resident was at the facility with a cast She stated the resident did not have a leg extender on the wheelchair and the resident's leg hung in the dependent position and no one did anything about it so she got a leg extender and pillow so she could elevate the leg. On 12/20/16 at 1 p m during phone exit the Administrator identified Staff FF as a disgruntled employee with credibility concerns On 11/23/16 at 1 24 p m the orthopedic ARNP stated there was no new injury to the RLE when the RLE was recasted on 6/23/16 The ARNP stated there was nothing the ortho office saw regarding the facility care of RLE that caused concerns. There was a lot of he said/she said The ortho recasted the leg on 6/23/16 at the family request Nursing progress notes dated 6/29/16 at 9 52 a m staff documented the heel ulcers identified on 6/21/16 as improved The small superior wound measured 0 6 cm by 0 3 cm. with fibrin in the wound bed The distal DTI measured 2 cm The entry identified an ill-fitting cast with a large gap between the plantar aspect of the foot and the cast Staff visualized purple skin to the skin at the right lateral malleolus at the cast edge measuring 2 3 cm by 0 6 cm A gray/purple wound at the achilles measured 1 cm by 2 5 cm Nurses notes dated 7/1/16 at 1 45 p m. identified a new full cast in place and pressure wounds covered by the new cast	F 314		

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F 314	Continued From page 50 On 11/28/16 at 4 05 p.m the Director of Nursing (DON) stated they facility was unable to assess the areas after 6/29/16 due to placement of long cast. A wound center note identified the resident went to the center 7/13/16 A 4 cm by 2 cm by 0 1 cm unstageable pressure ulcer was present on the right posterior heel A 2 cm by 1 5 cm by 0 1 cm. stage 2 pressure ulcer was present on the dorsal aspect of the foot. The wound center directed staff to apply Betadine and foam dressing daily after the resident got his/her brace fit Review of the treatment administration record (TAR) identified the facility began the Betadine treatment on 7/17/16. Nursing progress notes dated 7/15/16 at 10 45 a m revealed the resident returned with a brace at that time. On the same date at 2.18 p m staff attempted to measure the resident's skin impairments of the RLE The resident did not cooperate so staff could not measure but just estimated sizes as follows 1 There was a deep purple color to the right medial heel approximately 5 cm by 3 5 cm There was no open skin within the area 2 There was a wound to the plantar aspect of the right heel approximately 4 cm by 2 cm The wound bed had black necrotic tissue The periwound skin was dry with desquamation 3 There was an approximate 3 cm by 3 cm, nonblanching red wound to the anterior foot 4 There was an approximate 2 5 cm by 2 5 cm wound to the medical aspect of the right heel There was no skin impairment to the coccyx	F 314		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 51 The record lacked evidence of any further skin assessments. The resident discharged to the hospital on 7/29/16 The TAR identified the facility signed for the Betadine treatment to the RLE 8 out of 14 days	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible for 2 of 5 residents Resident #7 was on a scheduled toileting plan Observation showed the facility did not toilet the resident Resident #6 was on a prompted toileting plan. Staff did not follow facility policy for prompted toileting The facility failed assess and handle a catheter in a manner to reduce the risk of infection for Resident #26. The facility reported a census of 93 residents Findings include	F 315		

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F 315	Continued From page 52 1 The Minimum Data Set (MDS) with assessment reference date of 8/11/16 assessed Resident #7 with a score of "13" which indicated intact cognition The MDS did not identify behavior symptoms The resident required extensive staff assistance with bed mobility, transfers and toileting The resident did not ambulate. The resident was frequently incontinent of bowel and bladder The resident used a wheelchair for mobility The resident had diagnoses that included Alzheimer's disease A care plan completed 8/15/16 identified the resident required extensive assist of 1 staff for toileting The resident was on a scheduled toileting program and able to use a urinal at bedside with staff assist The facility Toileting Program policy for scheduled toileting dated 1/9/08 directed staff to toilet the resident approximately every 2 to 3 hours during the day Observation showed on 11/17/16 at 8 20 a m staff wheeled the resident down the hall in a wheelchair At 9 28 a m the resident went into the shower room for a shower Observation showed staff transfer the resident into the shower chair by EZ stand mechanical lift Staff did not offer the resident the toilet or urinal At 11 45 a m Staff Z, Certified Nursing Assistant (CNA) got the resident up per EZ stand The resident was incontinent of urine Staff did not offer the toilet or urinal At 1 25 p m observation showed the resident still up in the wheelchair. At 1 46 p m Staff S CNA transferred the resident to bed via EZ stand Staff did not offer the resident the urinal or toilet The resident's brief was wet with bowel movement on the brief Staff S provided pericare and laid the resident in bed Observation showed on 11/29/16 at 8 08 a m the	F 315		

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F 315	Continued From page 53 resident up in the wheelchair. The resident remained up in the wheelchair until 1:27 p m when Staff S transferred the resident to bed. Staff S checked and changed the resident. The resident had red areas on the upper buttocks. At that time, Staff S stated the resident will tell him if he/she "needs to go" On 11/29/16 at 1:43 p.m Staff W, CNA, stated the resident got up around 7 a m. to 7 30 a m. and neither she nor Staff S, CNA, did anything with the resident since they brought the resident back from breakfast and started showers On 11/29/16 at 11 12 a m the resident stated he/she sat in the wheelchair all morning and he/she didn't want to sit that long The resident stated no one offered or took him/her to the toilet since he/she got up 2 The MDS with assessment reference date of 11/18/16 assessed Resident #6 with a score of "6", which indicated severe cognitive impairment The resident had no behavior symptoms including rejection of care The resident required extensive staff assistance with bed mobility, transfers, toileting and personal hygiene The resident was frequently incontinent of bladder and occasionally incontinent of bowel The resident had diagnoses that included Alzheimer's disease A care plan completed on 8/25/16 identified the resident with alteration in urinary elimination related to a diagnosis of functional incontinence The resident was frequently incontinent of urine with use of attends briefs The care plan identified the resident on a prompted toileting program The Toileting Program policy for prompted toileting dated 1/9/2008, directed staff should prompt the resident to use the toilet before and after each meal and at bedtime The steps for prompted toileting were listed as follows ask resident if he/she is wet and check for	F 315		

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incontinence, ask resident if he/she would like to use the toilet. If yes help the resident to the toilet and praise the resident for toileting and continence. If no, do not force the resident to toilet. Assist the resident to change any soiled undergarments per manufacturer recommendations. Return to resident at next toileting time and repeat above steps. Toilet resident every morning upon awakening, every night before bedtime and every 3 to 4 hours during the night.

Observation showed on 11/22/16 at 11:22 a.m. the resident in bed asleep. At 11:44 a.m. Staff Q, CNA, got the resident up in the wheelchair for lunch without checking the resident for incontinence, asking the resident if he/she needed the toilet and without toileting the resident. On the same date at 1:12 p.m., a physical therapy staff member asked the resident if he/she wanted the bathroom. The resident stated "no". The staff member then pivot transferred the resident into bed but did not check the resident for incontinence. Staff attempted some exercises with the resident and left the room at 1:40 p.m.

The resident remained in bed on the left side until 4:45 p.m. when Staff AA, Registered Nurse (RN) and Staff A, CNA, got the resident up and asked the resident about the bathroom. The resident replied "sometime". Staff transferred the resident onto the toilet. The resident was incontinent of bowel and bladder.

3. The MDS assessment dated 10/28/16 for Resident #26 identified the resident required the extensive physical assistance of 1 person for toileting and with severe cognitive impairment. The MDS recorded the presence of an indwelling catheter. The MDS documented diagnoses that included benign prostatic hyperplasia (BPH),

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F 315	Continued From page 55 renal insufficiency, urine retention, and Alzheimer's disease. The care plan identified a focus area revised on 5/11/15 of an alteration in urinary elimination related to diagnosis of BPH, urinary retention due to enlarged prostate, and suprapubic catheter (SPC/catheter from lower belly) placement. The focus area documented a history of UTI (urinary tract infection) with MRSA (Methicillin-Resistant Staphylococcus Aureus) in the urine (a drug resistant bacteria). The care plan directed staff to provide catheter cares per protocol; assist with leg bag and down drain bag changing, and observe/report PRN (as needed) s/sx (signs/symptoms) of UTI that included dysuria (painful urination) The Progress Notes dated 12/18/16 at 5:42 a.m. documented on last rounds the resident's suprapubic catheter (SPC) laid on the ground next to the bed. The entry recorded the resident had moderate distention with tenderness. The entry documented a SPC reinserted with some difficulty, urine drained, and all discomfort resolved after procedure completed The Progress Notes dated 12/18/16 at 6:15 a.m. documented the CNA (Certified Nurse Aide) found the resident's SPC on his/her bathroom floor with the balloon intact. The entry recorded the nurse attempted to replace, however, unable due to too much resistance and the charge nurse informed and attempting to replace Observation on 12/20/16 at 1:30 p.m. revealed Staff S, Certified Medication Aide (CMA), transported the resident back to his/her room. Staff S assisted the resident to transfer to the bed	F 315		

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F 315	Continued From page 56 and had placed the catheter bag on the floor After transferring, Staff S picked the bag off the floor and hung the bag on the bed frame In an interview on 12/20/16 at 1 32 p m , Staff R, Licensed Practical Nurse (LPN), stated she would have expected the catheter bag not to be on the floor Staff R said they have dignity bags and clips to hang the bags with. Staff R commented other reasons included infection control purposes and because a bag could be stepped on Staff R reported the facility had an instance where a catheter bag stepped on and the catheter pulled out Observation on 12/21/16 at 1 00 p m revealed the resident at the nursing station stating s/he needed to urinate and it hurt badly The resident repeated s/he experienced terrible pain and needed to urinate but couldn't because his/her bag so full Staff T, Certified Nurse Aide (CNA), stated she emptied the bag at 6 00 a m. and transported the resident to his/her room Staff T emptied a leg bag that was 3/4th full of urine Staff T failed to wipe the drain spout of the catheter tube before or after emptying the bag The resident stated to hurry to tell the nurse he/she still had pain Staff T informed the resident she would let the nurse know to check the catheter and did report it to Staff R The Progress Notes with a print date and time stamp of 12/22/16 at 9 52 a m contained no other entries past 12/18/16 at 6 15 a m The clinical record lacked documentation of further assessments of the catheter placements, pain, or interventions completed for the resident The Emptying of Urinary Catheter Bags policy	F 315		

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F 315	Continued From page 57 dated 2/2015 included the following directives. Purpose - To empty catheter bags appropriately while maintaining infection control practices Procedure - Point 6. Open the top of the alcohol wipes so wipes can be readily accessed Point 7 Remove the drain tube from protective port and unclamp after place tube in graduate Do not allow the drain tube to touch the side of the graduate or fall out of the graduate. Point 8 Clamp foley Point 9 Cleanse drain tube with alcohol wipe Point 10 Replace drain tube into port The undated Catheter - Straight or Indwelling policy and procedure included the following directives Responsibility - Licensed Nurse Purpose - Point 1 To maintain continuous urine flow Point 2 To relieve bladder distention Guidelines - Long-term use of an indwelling catheter is also a significant source of bacteria and UTI A bacterium develops in most persons within 2 to 4 weeks after catheter insertion Procedure - Point 21 Insert the catheter Point 31 Document in resident's record the procedure, size of cath, size of bulb, amount of urine returned, urine characteristics, and how the resident tolerated the procedure	F 315		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to	F 323		

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F 323	Continued From page 58 prevent accidents This REQUIREMENT is not met as evidenced by. Based on observation, record review and staff interview, the facility failed to provide adequate nursing supervision to prevent accidents 9 of 13 residents reviewed Physical Therapy (PT) identified Resident #1, #2, #9, and #43 required assistance with transfers and ambulation (walking) The residents continued to self-transfer and not always use the call light The facility did not consistently implement interventions to address the residents ' risk of falls resulting in multiple falls and injuries, including hip fractures Resident #1 died as the result of complications of hip fracture Resident #11 fell with head injury when he/she attempted to self-transfer No one heard the resident's alarm. Resident #3 was allowed to self-transfer even though a PT treatment note dated 8/11/16 revealed PT and nursing both collaborated on Resident #3 requiring one person assist with transfers After falls, the facility did not implement new interventions Resident #45's care plan directed the resident required assistance with transfers and ambulation The facility implemented interventions after most falls but two (2) of the interventions relied on the resident's memory although he/she experienced persistent cognitive deficits Resident #7 sustained repeated skin tears to the left elbow from bumping into the wall or doorframe when staff used the EZ stand Resident #22 was placed in an EZ stand and facility staff then left him/her alone for an extended period of time. The findings constitute	F 323		

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F 323	Continued From page 59 an immediate jeopardy to the residents' health and safety. The facility identified a census of ninety-three (93) residents. Findings include 1 A Minimum Data Set (MDS) assessment tool dated 9/17/16 revealed Resident #2 had a diagnosis of dementia and a brief interview for mental status (BIMS) score of "5" (severe cognitive impairment) The resident displayed the following indicator of delirium that fluctuated through the day inattention, and had no behavior symptoms identified The resident required limited staff assistance with bed mobility, transfers and ambulation and extensive staff assistance with toilet use, dressing and personal hygiene A "balance during transitions and walking" test identified the resident as not steady and only able to stabilize with staff assistance The resident used a walker and wheelchair for mobility and was occasionally incontinent of bladder. Falls. An incident report (IR) dated 8/9/16 at 6 40 a m revealed the resident fell in his/her room The resident had walked with a glass of water and spilled the water on the floor He/she then slipped in it, fell on his/her bottom and hit his/her head on the bed frame The resident complained of head and back pain following the incident The IR listed the intervention following the incident encourage reminders and encourage resident not to walk with water in room Have staff assist with carrying water as appropriate Following the incident, a transfer form dated	F 323		

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F 323	Continued From page 60 8/9/16 identified the resident transported to the emergency room (ER) for evaluation. Nursing progress notes dated 8/9/16 at 12.51 p m. revealed the facility received a phone call from the hospital ER stating the resident would return to the facility Labs, spine x-rays and head CT (computerized tomography) were all within normal limits. ER personnel stated they gave the resident 50 mcg (micrograms) of Fentanyl (narcotic) with no further back pain noted The resident returned to the facility at 1 40 p.m The resident complained of continued back pain when he/she moved certain ways and continued to have a slight headache An x-ray report dated 8/14/16 revealed osteoporosis and an age indeterminate compression fracture of T 11 A CT of the abdomen and pelvis dated 8/18/16 revealed a T 10 compression fracture with near complete vertebral body height loss A physical therapy (PT) outpatient discharge form identified the PT end date as 8/24/16 The form identified the resident ambulated with contact guard assistance (CGA) of one staff and a front wheel walker, and transferred with limited to extensive assistance of one staff Nursing progress notes dated 8/29/16 at 3 07 a m revealed the resident apparently walked to their roommate's recliner The resident did not use the call light The entry identified the resident required "assist of one assist with walker " Nursing progress notes dated 9/3/16 at 6 05 p m revealed there were times the resident ambulated	F 323		

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F 323	Continued From page 61 alone and did not use the call light. Staff educated the resident to use the call light to request assistance An MDS dated 9/3/16 identified the resident with a BIMS score of "6" (severe cognitive impairment) Nursing progress notes dated 9/4/16 at 1.27 p.m. revealed staff observed the resident ambulating in his/her room. Staff repeated cues and reeducation regarding the need to call for assistance and safety awareness Nursing progress notes dated 9/14/16 at 5.05 p.m. revealed the resident wanted to go to the bank and walked down the hall by themselves without assistance or a walker. Staff reeducated the resident and assisted the resident back to his/her room. Staff also reminded the resident to use the call light and wait for help Nursing progress notes dated 9/15/16 at 6.23 a.m. revealed the resident was up without the walker. Staff then assisted the resident to the toilet A restorative program form dated 9/15/16 directed staff should ambulate the resident with front wheeled walker and CGA of one staff A physician encounter note dated 9/20/16 at 2.08 p.m. identified the resident experienced debility and required increased assistance with transfers and ambulation An IR dated 9/28/16 at 5.40 a.m. revealed staff found the resident sitting on the floor in front of the recliner in his/her room. The resident denied pain and did not hit his/her head. The resident	F 323		

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F 323	Continued From page 62 sustained a small, pinpoint open area to the lower left extremity The IR identified the resident's transfer/ambulation needs as "up with assistance of one with front wheeled walker and gait belt " The IR did not identify an intervention placed following the incident. Nursing progress notes dated 9/29/16 at 2.40 p m. revealed the resident up and wandering in the hallway a couple times on that shift. Staff talked to the resident about using the call button and need for the walker and staff assistance to prevent falls. The resident voiced understanding but seemed forgetful A care plan intervention dated 9/30/16 revealed the resident required limited to extensive assistance of one staff for transfers and toilet use The resident required contact guard assistance of one staff with a front wheeled walker (According to PT 8/24/16 the resident required one staff assistance and walker) The resident was on a prompted toileting plan on 9/30/16 Nursing progress notes dated 9/30/16 at 10 27 a m documented the resident required CGA assistance with ambulation and transfers Nursing progress notes dated 10/3/16 at 4 53 p m identified the resident standing up by themselves in their room An IR dated 10/14/16 at 3 15 a m revealed staff found the resident sitting on the floor in his/her room with the resident's back against the foot of the bed The resident did not know how he/she ended up on the floor The IR identified the intervention following the incident as "assure needs are met before leaving room." The care	F 323		

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F 323	Continued From page 63 plan intervention box identified this intervention was in place since 4/19/16 An IR dated 10/14/16 at 8:30 p m. revealed staff found the resident seated on the floor The resident fell trying to get clothes out of the closet. The resident hit his/her head on the bathroom door. The IR did not identify an intervention following the incident. An IR dated 10/16/16 at 5 15 a m revealed the resident stated he/she came out of the bathroom and fell Staff found the resident sitting on his/her bottom on the floor in his/her room. The resident said he/she hit their head on the edge of the bed Staff applied an ice pack to the head. The resident received a hematoma to the right forehead and abrasion to the buttock The IR did not identify an intervention following the incident Nursing progress notes dated 10/16/16 at 9 16 a m revealed the resident transferred to the ER for evaluation Nursing progress notes dated 10/18/16 at 1 36 p m revealed the resident had a 1 centimeter (cm) by 4 cm scrape to the right upper buttock with a scant amount of blood noted, a 2 cm by 0 1 cm scrape on lower buttock with a scant amount of blood noted, and a 5 5 cm by 1 cm scabbed area on the right hip Staff documented all above areas were due to the resident's previous fall A physician encounter form dated 10/17/16 at 4 51 p m. revealed the resident transferred to the ER on 10/16/16 after a fall The resident had bruising above and below bilateral (both) eyes as well as to the right forehead The ER evaluated the resident with laboratory tests, left hand X-rays, and a CT of head The left hand X-ray	F 323		

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showed mild osteopenia and mild degenerative arthritis The bruising was described as follows.

Examination of the head and face revealed hematoma around bilateral eyes and right forehead and tenderness over the right frontal area. The right eyelid showed swelling of the upper eyelid and extensive bruising around bilateral eyes. The resident fell 4 times in the past week The resident used a walker with assistance and transferred with assistance The resident used a wheelchair for longer distances. The resident's motor strength revealed the resident displayed weakness in both upper and lower extremities. A CT of the abdomen/pelvis on 8/18/16 revealed a T 10 compression fracture

A Tinetti assessment tool identified the resident with a combined balance and gait score of 11/28 A score of less than 21 identified the resident at high risk for falls

An IR dated 11/1/16 at 8 a.m revealed staff found the resident sitting in the hallway on his/her bottom with the left leg flexed outward with his/her back up against the wheelchair wheel The foot pedals were in the down position The resident yelled with range of motion (ROM) and told staff to take him/her to the hospital

A statement dated 11/1/16 and written by the charge nurse revealed the resident was last seen at 7 30 a m At that time, the resident tried to ambulate by themselves The nurse went to pass medications and left the resident with a CNA (certified nurse aide) At 8 a m , the charge nurse heard someone fall from the end of the hallway When she investigated the noise, she observed the resident on the floor with staff beside the

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F 323	Continued From page 65 resident. A transfer form dated 11/1/16 identified the resident transferred to the hospital following the incident. The transfer form revealed staff found the resident sitting in the hallway on the floor with his/her back against the wheelchair wheel and wheelchair pedals in the down position The form identified that there were no witnesses to the incident Nursing progress notes dated 11/1/16 at 1 24 p m revealed ER phoned and reported Resident #5 had sustained a left femur fracture and would undergo surgery to repair the fracture A PT discharge summary revealed the resident did not progress significantly with 3 PT sessions prior to hospitalization on 11/1/16. The resident continued to exhibit cognitive deficits with poor safety awareness and insight into his/her deficits The resident continued to self-transfer and be noncompliant with waiting for CNA assistance Nursing progress notes dated 11/9/16 at 12 23 a m revealed the resident returned to the facility from the hospital at 4 30 p m on 11/8/16 The resident had some bruises on arms from IV's at the hospital and 25 staples in the left hip incision The resident utilized the EZ stand and 2 staff for transfers Nursing progress notes dated 11/10/16 at 4 20 a.m revealed the resident showed inadequate awareness of self-limitations and staff anticipated most to all of the resident's needs A physician visit encounter form dated 11/10/16 identified the resident sustained a left femoral neck fracture secondary to a mechanical fall The resident attempted to stand up from the	F 323		

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F 323	Continued From page 66 wheelchair and fell. The resident readmitted to the facility following ORIF (open reduction and internal fixation) repair of the left femoral neck fracture A hospital trauma daily progress note dated 11/8/16 identified the resident sustained a spiral oblique fracture of the proximal left femoral diaphysis with associated 9 cm shortening The report also identified the resident exhibited bilateral eye bruising Nursing progress notes dated 11/20/16 at 4 20 a m revealed the resident sat up to go to the bathroom and slid off the bed to the floor Staff found the resident on the floor at the bedside The resident did not use the call light and the resident was barefoot The resident's brief was wet The resident did not sustain injury The intervention on care plan dated 11/21/16 after the incident directed staff to take the resident to the bathroom on second rounds. Nursing progress notes dated 11/26/16 at 1 01 a m revealed staff checked the resident every 30 minutes and found the resident sitting in his/her recliner chair The resident did not use the call light and then self-transferred to the recliner. Staff educated the resident to use the call light for assistance Nursing progress notes dated 11/30/16 at 9 32 p m identified staff saw the resident ambulating in his/her room without assistance Staff encouraged the resident to call for assistance when he/she wanted to stand up and walk around The care plan did not contain any new	F 323		

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F 323	Continued From page 67 interventions following the 11/26/16 and 11/30/16 documentation of self-transfers/ambulation Nursing notes dated 12/1/16 at 3:07 a.m. revealed staff continued to check the resident frequently as the resident was noncompliant with call light use. Staff documented reeducation continued without effectiveness due to cognitive decline Care Plan The care plan identified an intervention dated 9/28/16 that directed staff to place the recliner in a safe sitting position when the resident sat in the recliner. The point click care (PCC) care plan box identified staff created the intervention on 11/2/16 The care plan identified an intervention dated 10/17/16 that directed staff to observe resident for signs and symptoms of restlessness during the night time hours. Offer toilet, snack, or relaxing activities if increased restlessness noted. The PCC care plan box revealed staff created the intervention on 11/2/16 The care plan identified an intervention dated 10/17/16 that directed staff to place a call light reminder sign by the resident's bed. The PCC care plan box revealed staff created the intervention on 11/2/16 An intervention on the care plan "follow facility fall protocol" created on 4/19/16, identified the intervention " follow facility protocol" had been in place since that date Review of the facility fall protocol revealed staff would complete a fall assessment on the first day	F 323		

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F 323	Continued From page 68 of admission. If the fall assessment identified the resident as at risk for falls, the team leader/case manager would instruct the staff to monitor the resident frequently, answer the call light promptly and add any other safety measures to help protect the resident. Staff Interviews On 11/17/16 at 2.34 p m Staff E, LPN unit manager stated she worked when the resident fell on 11/1/16 Staff heard the resident yelling When Staff E saw the resident, he/she was sitting on the floor When Staff E asked the resident if he/she could rotate his/her leg, the resident yelled out in pain. The resident complained of hip pain Staff E stated she thought the resident did get up without help On 11/17/16 at 2 p m Staff F CNA stated she worked when the resident fell on 11/1/16 She came up the 100 hall and heard someone yell "help me" After she finished what she was doing, she went down the 300 hall and saw the resident on the floor She stated she didn't know where the 300 hall staff were She started the resident was about 3 feet from the resident room door The resident complained of knee pain. Staff F called for help and the DON (director of nursing) and ADON (assistant director of nursing) arrived When asked what was being done for the resident to prevent falls, Staff F stated she couldn't think of anything as the facility was going " alarm free " Staff F reported Resident #5 was care planned to get up with staff assistance was not to be up by him/herself and did not wait for help, reeducation did not help and staff offered resident things to occupy him/her Staff F also reported the resident did not use the call light	F 323		

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F 323	Continued From page 69 In Staff F's written statement dated 11/1/16, she wrote she last saw the resident at 6 30 a.m standing in the doorway At that time, Staff F redirected the resident to the recliner and offered the resident the toilet and a drink The resident refused both On 11/17/16 at 3 35 p m., Staff G CNA stated prior to the 11/1/16 fracture, the resident got up all the time Staff G found the resident found Resident #5 transferring or ambulating without assistance in the hallway and in the dining room. On 11/28/16 at 2.58 p m Staff H CNA stated the resident was known to get up without asking for assistance On 12/6/16 at 8 10 a.m the DON stated the created date in the point click care plan box was the date the intervention was created. She stated at the end of August a new unit manager (UM) took over and there was miscommunication regarding inputting the new interventions on the care plan On 12/5/16 at 10 41 a m Staff A, CNA (certified nurse aide) stated the resident tried to stand up constantly - 4 to 5 times a shift The resident also did not like to use the call light and tried walk to his/her closet or the bathroom as the resident wanted to use the bathroom frequently On 11/28/16 at 2 40 p m Staff B, LPN (licensed practical nurse) stated the resident was known to get up and not use the call light Sometimes staff found the resident in the midst of standing up when Staff B walked by the room	F 323		

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F 323	Continued From page 70 On 11/17/16 at 3 12 p m. Staff D, LPN stated the resident was known to get up without waiting or using the call light once in a while On 11/28/16 at 2.58 p m Staff H, CNA stated the resident was known to get up without asking for help. Staff H would ask the resident to sit for a second and 2 minutes later the resident would stand up. When Staff H came back, it would startle the resident. Observation On 11/22/16 at 11 35 a m observation showed Staff I CNA transferred the resident and placed the resident in the wheelchair without a gait belt Staff I confirmed he did not use a gait belt, but stated he did use the walker for the transfer Observation showed the walker by the wall approximately 8 feet from Staff I and the resident The care plan in place 11/22/16 contained an intervention dated 11/21/16 that directed staff to stand pivot transfer the resident with one to two staff, gait belt and front wheeled walker 2 An MDS dated 9/15/16 documented Resident #11 had diagnoses of dementia and stroke with a BIMS score of "5" (severe cognitive impairment) The MDS also documented the resident did not ambulate and required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, and personal hygiene The MDS revealed the resident showed functional range of motion (ROM) limitations of the upper and lower extremities, used a wheelchair for mobility and experienced two or more falls without injury since the previous assessment A care plan with a completion date of 10/5/16	F 323		

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F 323	Continued From page 71 identified Resident #11 as at risk for falls related to balance problems, functional ROM problems, osteoarthritis, osteoporosis, severely impaired cognition, incontinence and medication use The care plan directed staff to encourage the resident to self-propel his/her wheelchair and assist as needed (extensive assist of one staff for locomotion in wheelchair) The care plan also directed staff to assist the resident with transfers to desired destination (bed, recliner, toilet, etc) shortly after meals. The resident used a sensor alarm in the wheelchair An IR dated 10/17/16 at 7:20 p m revealed staff found the resident lying on his/her right side in the central hallway with a large bump on the forehead and a bloody nose The resident reported back pain The alarm sounded when the resident fell The "investigation" portion of the incident report was blank. On 11/23/16 at 1 55 p.m , Staff K LPN stated Resident #11 was in the central hallway and fell out of the wheelchair She stated there was a family visiting another resident in the central hall and they alerted staff to the resident's fall No staff heard the resident's wheelchair alarm Staff found the resident first on the ground Staff K called the ambulance and the resident transferred to ER for evaluation Staff K stated after the incident the resident had black eyes. Nursing progress notes dated 10/18/16 at 12 08 a m. revealed the hospital called and informed the facility the resident had a UTI (urinary tract infection) and the resident would return with an order for Keflex (antibiotic) to treat the UTI The head CT and chest X-ray were unremarkable Nursing progress notes dated 11/27/16 at 8 34 p m revealed staff found the resident sitting on the floor in front of the wheelchair The resident attempted to self-transfer to bed The notes did	F 323		

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F 323	Continued From page 72 not identify if the alarm activated The resident did not sustain injury Review of the current care plan revealed no new intervention(s) added following the incident The incident report dated 11/27/16 at 8 30 p m revealed the alarm failed to sound when the resident attempted to self-transfer The incident report also revealed staff added no new intervention(s) following the incident Observation on 11/23/16 at 1 10 p m revealed Staff L CNA transferred the resident to the toilet via the EZ stand The alarm sounded when Staff L assisted the resident to stand Staff L stated she took care of the resident on 10/17/16, but the resident fell after he/she left The next day the resident had 2 black eyes. 3 An MDS dated 7/21/16 assessed Resident #3 with a BIMS score of 8 (moderate cognitive impairment) The resident required extensive staff assistance with bed mobility, dressing, toilet use, personal hygiene and bathing The resident required limited staff assistance with bathing A "balance during transitions and walking" test identified the resident as not steady but able to stabilize with staff assistance The resident used a walker and wheelchair for mobility The MDS identified the resident received daily anticoagulant medication A physical therapy (PT) treatment note dated 8/11/16 revealed the PT and nursing both collaborated on the resident being one person assist The resident discharged from PT on that date The resident remained at risk for falls and nursing educated and posted signs in room to wait for staff assistance prior to attempting to transfer Care plans with completion dates of 7/20/16 and 10/20/16 identified the resident as independent to limited staff assistance of one with	F 323		

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F 323	Continued From page 73 transfers Falls An IR dated 9/14/16 at 11.30 a m revealed staff found the resident seated on his/her bottom with legs stretched out in front of him/her and the resident's back on the wall by the toilet. The resident stated he/she went down easy and fell getting off the toilet. The resident did not sustain injury The IR identified the intervention after the incident as "assure needs are met before leaving room" The 7/20/16 care plan already had the following intervention in place anticipate and meet the resident's needs as appropriate" dated 3/4/15. An IR dated 9/24/16 at 12 45 a m revealed staff found the resident seated on the floor by the bed The resident did not sustain injury The IR did not identify an intervention following the incident. An IR dated 9/24/16 at 2 45 p m revealed the resident slipped forward out of the wheelchair when a CNA pushed the resident without foot pedals The resident hit his/her right temple on the wall and received a small, tender abrasion Staff assisted the resident back in the wheelchair The intervention following the incident was to have foot pedals available on the back of the wheelchair and educate employees on proper procedure The care plan did not contain the intervention An IR dated 10/9/16 at 7 10 p m revealed staff found the resident lying on his/her side on the floor The resident received a skin tear from the incident. The intervention following the incident was to educate the resident to use the call light According to the 7/20/16 care plan the care plan already contained an intervention that directed staff to ensure the resident's call light was in reach and encourage the resident to use it. Staff needed to answer the call light promptly	F 323		

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F 323	Continued From page 74 An IR dated 10/10/16 at 7.10 p m revealed staff found the resident on the floor seated on his/her bottom in the resident room The resident stated he/she attempted to transfer from the wheelchair to the bed and fell The resident hit his/her head on the night stand resulting in a bump measuring 0 7 cm by 0.7 cm on the back of the head The IR did not have an intervention listed following the incident An IR dated 10/20/16 at 1 20 a m. revealed staff heard the resident yell, "help me" Staff found the resident on the floor in his/her room between the wheelchair and bed The resident's head was up and the resident was in a sitting position in his/her room Staff did not observe injury. The intervention following the incident was "call light reminder sign paced on bedside table and assure bedside table is next to resident when in bed" The resident already had a reminder sign in place on 8/11/16 to wait for staff assistance The care plan completed on 10/20/16 continued to contain the intervention that identified the resident as independent to limited staff assistance of one with transfers An IR dated 11/19/16 at 7 45 p m revealed a fall in the resident room The resident tried to get to bed without shoes on and fell to the floor The resident did not sustain injury The intervention following the incident was to assure the resident wore shoes An IR dated 11/20/16 at 6 30 p m identified a fall in the resident room Staff found the resident on the floor lying on his/her back between the bed and window The wheelchair was at the foot of the bed Staff did not observe injury There was no intervention listed following the incident An IR dated 11/22/16 at 5:30 a m revealed a fall in the resident room Staff found the resident on the floor next to the bathroom The resident could	F 323		

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F 323	Continued From page 75 not explain what occurred The IR identified the resident had previously been anxious The resident sustained a bump to the forehead that measured 2 cm. by 2 cm. The intervention following the incident was to answer the resident promptly when he/she called. (Already in place) and a PT/Occupational therapy (OT) screen Nursing progress notes dated 11/22/16 at 5 31 p m. revealed staff observed a skin tear on the right upper arm with purple discoloration surrounding it. The skin tear measured 0 5 cm. by 6 cm by 0 1 cm. Staff closed the wound with 6 steri strips The resident did not know how the injury occurred There was no incident report for the injury An IR dated 11/22/16 at 7.30 p m revealed a fall in the resident room. Staff attempted to transfer the resident from his/her wheelchair into bed The resident's knees buckled and the resident went to the ground The resident did not have shoes on The resident did not sustain injury A hospital report dated 11/23/16 revealed the resident fell 3 times in the past 3 days The resident sustained arm lacerations to both arms and a left sided forehead hematoma The report identified a left wrist skin tear and right bicep skin laceration. On 11/23/16 at 9 28 a m Staff M LPN unit manager confirmed the resident toileted themselves Observation Observation showed on 11/17/16 at 10:20 a m the resident in the bathroom At that time, Staff L CNA stated the resident would take themselves to the bathroom and when he/she wanted off the toilet, the resident would pull the call light On the same date at 10 35 a m , the resident transferred themselves to bed Staff L stated the resident was in the process of transferring when he/she	F 323		

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F 323	Continued From page 76 entered the room The resident did not use the call light On the same date at 10:55 a.m , the resident transferred themselves from bed to wheelchair On 11/28/16 at 11 37 a.m., the resident wheeled themselves using their feet in the wheelchair. Observation showed a large bruised area around the left eye When asked what happened the resident stated "it ' s been like that a long time" The record lacked documentation of a left black eye The DON supplied documentation on a sheet of legal pad paper, a list of interventions implemented following falls 9/14/16 Staff to offer restroom prior to meals The care plan identified the resident was already on a prompted toileting plan which identified prompted toilet before meals in place since 3/4/15 9/25/16 assure resident with appropriate position in wheelchair for safety (This intervention was not on the resident's care plan and the PCC care plan box identified this intervention was created on 11/17/16) 9/26/16 During sleeping hours observe resident for restlessness and if he/she is awake offer drinks, snacks and toilet The PCC care plan box identified this intervention was created on 11/17/16 (The resident already had an intervention on the care plan to observe for restlessness and provide calming activities dated 6/29/16) 10/10/16 Provide patient education related to safe sitting/standing when appropriate (The MDS identified the resident with a BIMS of 8, moderate cognitive impairment) 10/20/16 Call light reminder sign on bedside table (PT notes identified the resident already had a	F 323		

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F 323	Continued From page 77 sign in place 8/11/16 to wait for help) 11/20/16 Staff to assure the resident's wheelchair placed next to bed The PCC care plan box identified this intervention was created on 11/22/16 11/22/16 Assure call light answered promptly According to care plan review, this intervention was already in place since 3/4/15. 11/22/16 Offer snacks and drinks as needed through the day. The PCC care plan box identified this intervention was created on 11/28/16. 4 An MDS dated 10/14/16 assessed Resident #1 with a BIMS score of "9" (moderate cognitive impairment) The resident had no behavior symptoms identified The resident required extensive staff assistance with bed mobility, dressing, toileting and bathing The resident required limited assistance of staff with ambulation and personal hygiene A "balance during transitions and walking" test identified the resident as not steady but able to stabilize without staff assistance in all areas of testing The resident used a walker and wheelchair for mobility. The MDS identified the resident admitted to the facility 10/7/16 The resident was occasionally incontinent of bowel and bladder The resident had diagnoses that included dependence on renal dialysis and altered mental status The resident had one fall without injury since admission A Tinetti assessment tool identified the resident with a fall risk score of 8/28 A score less than 21/28 revealed a high fall risk The initial care plan dated 10/7/16 identified the resident as at risk for falls and required assistance of 1 staff with bed mobility, transfers and ambulation	F 323		

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F 323	Continued From page 78 A care plan with completion dated of 10/12/16 revealed the resident required assistance of one staff with transfers and assistance with toileting The care plan identified the resident with a risk for falls The interventions to assist with the prevention of falls and all dated 10/18/16 included: anticipate and meet the resident's needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, educate resident/family/caregivers about safety reminders and what to do if fall occurs, follow facility fall protocol and PT evaluate and treat as ordered or PRN (as needed) An addendum dated 10/24/16 revealed a directive for frequent visual checks The care plan also identified the resident experienced bladder incontinence and directed staff to encourage fluids to promote prompted voiding responses Facility fall protocol dated 11/2013 directed staff to complete a fall assessment on the first day of admission If the fall assessment identified the resident as at risk for falls, the team leader/case manager would instruct the staff to monitor the resident frequently, answer the call light promptly and any other safety measures to help protect the resident On 12/6/16 at 1 50 p m. Staff E LPN unit manager identified frequent checks as every 2 hour checks at night On 12/6/16 at 1 52 p.m , Staff N RN (registered nurse) unit manager stated she did not have any residents who required frequent checks on her hall She stated when she did, the checks were every 2 hours at night.	F 323		

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F 323	Continued From page 79 On 12/6/16 at 1 57 p m Staff M LPN unit manager stated frequent checks were looking in when going by the room and every 2 hours or as "often as you can". On 12/6/16 at 2 p m the DON stated she didn't know what frequent checks meant. She stated she guessed it depended on the person A hospital discharge summary dated 10/7/16 revealed the resident had a history of frequent falls. When the resident arrived to ER they noted a left frontal scalp hematoma and facial ecchymosis The discharge summary revealed this injury occurred when the resident's family attempted to lift the resident and bumped the resident's head. A PT flowsheet note included with the resident's hospital discharge information and dated 10/5/16 revealed safety concerns The resident was at risk for falls and required 2 staff for bed mobility and transfers/mobility A MD/nursing communication form dated 10/10/16 at 8 36 p m revealed staff found the resident on the floor between the bed and night stand The resident stated he/she tried to get to bed and lost balance The resident sustained no visible injuries The record failed to identify a new intervention after the incident An incident report dated 10/10/16 at 8 p m revealed the resident fell attempting to self-transfer to bed The intervention listed on the IR following the incident was to educate the resident to use the call light A resident encounter form dated 10/12/16 revealed the resident admitted to the facility following hospitalization for weakness, frequent falls and encephalopathy The resident had ecchymosis to the forehead and scalp A MD/nursing communication form dated 10/23/16 revealed the resident attempted to self-transfer at 5 p m on that date The resident	F 323		

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F 323	Continued From page 80 fell resulting in a moderate size hematoma with surrounding bruising. The form did not identify the location of the resident's injury Staff M LPN unit manager documented the resident admitted to the hospital 10/25/16 and according to the nurses note on 10/23/16 the injury was on the "mid frontal area" An IR dated 10/23/16 at 5 p m revealed staff observed the resident on the floor lying on their right side with their head facing south and feet to the north The call light was not activated. The resident stated he/she needed the bathroom and thought he/she could make it without assistance The resident sustained a moderate sized hematoma with ecchymosis to the mid frontal The intervention following the incident was "frequent checks with question need of BRP (bathroom privileges)" According to the 10/12/16 care plan the resident was on prompted toileting as of 10/18/16 and facility fall protocol in place on 10/18/16 already directed staff to provide frequent checks. A resident encounter form dated 10/24/16 revealed the resident with poor safety awareness and had at least 2 falls since admission due to self-transfer attempts The resident had a large hematoma to the forehead and bruising The resident had debility and weakness with risk of falls Nursing progress notes dated 10/25/16 at 12.14 p.m. revealed the resident was lethargic and weak and unable to sit up unassisted The resident went to ER for evaluation The resident's blood pressure was 110/50, pulse 50, respirations 16 and temperature 99 4 degrees A hospital discharge summary dated 10/27/16 revealed the resident was admitted to the hospital for altered mental status, elevated blood pressure and hyperkalemia. Dialysis helped the	F 323		

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F 323	Continued From page 81 hyperkalemia and blood pressure The resident's mental status improved The resident also had bradycardia (low heart rate) and the medication Metoprolol (for blood pressure) was held due to the bradycardia The resident discharged back to the facility A nurses note late entry dated 10/27/16 at 4.30 p m revealed the resident returned to the facility An IR dated 10/28/16 at 8 10 p m revealed staff found the resident lying supine on the floor in the hallway The resident stated he/she heard his/her niece crying and went to help. The resident complained of right hip pain Staff notified the physician and the resident transported to ER for evaluation On 11/17/16 at 3 12 p m Staff D LPN stated the resident stood up and walked to the hallway and fell The resident complained of right hip pain so he/she was sent to ER and they found out the resident had a fracture Staff D stated the resident would get up without assistance The resident had mental status changes and would get up and fall When asked what staff would do to prevent the resident from falling, Staff D stated they would check on the resident often She didn't know when staff last saw the resident On 11/17/16 at 3 35 p m Staff G CNA stated Resident #1 was in bed so he put 2 residents to bed Then he went to another room for a few minutes and then he stopped to talk to Staff D That is when an agency staff (Staff FF) told him Resident #1 was in the vestibule area between the front door and the nurse ' s station The resident heard kids crying and tried to find them He stated he probably saw the resident 10 or 15 minutes before the incident in bed asleep He stated the resident self-transferred in the past and did not use the call light or wait for help The resident fell another time in the bathroom Staff G	F 323		

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went in to see if the resident wanted to get ready for bed and he found him/her on the bathroom floor with a mark on his/her forehead He stated he didn't remember when he saw the resident last prior to that fall. When asked what might prevent the incident, Staff G stated alarms. He stated he usually checked on the resident every half hour On 12/19/16 at 11:40 a m. Staff FF LPN stated she worked on another hall when she heard the door alarm to the outside sound She answered the alarm and found the resident on the floor in the entryway of the facility The resident was inside the facility

Hospital progress notes dated 10/29/16 revealed the resident admitted to the hospital after a fall and sustaining a right intertrochanteric femur fracture The resident reported pain to the right hip The plan was to discuss the resident's case with Internal Medicine Due to all of the comorbidities and frail state, the physician documented that he felt surgery was too risky for the resident and the rate of mortality would be high

Hospital progress notes dated 10/31/16 revealed hospice was contacted The resident would not undergo surgery due to the severe risk of mortality with any surgical option

A death certificate revealed the resident passed away on 11/9/16 due to complications of right hip fracture The manner of death was "accident "

5 A MDS dated 8/11/16 assessed Resident #7 with a BIMS score of 13 (cognitively intact) The MDS did not identify any behavior symptoms The resident required extensive staff assistance with bed mobility, transfers and toileting The resident did not ambulate The resident had functional limitations in range of motion in the upper extremities The resident used a wheelchair for

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F 323	Continued From page 83 mobility. The resident had diagnoses that included Alzheimer's disease. The MDS did not identify the resident with skin tears. A care plan completed on 5/11/16 revealed the resident transferred with the EZ stand and assistance of one staff for all transfers. The care plan also contained an intervention created on 11/30/15 directed staff to use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. Skin Tears During Transfers Nursing progress notes dated 7/3/16 at 7:57 p.m. revealed a CNA transferred the resident to the bathroom on the EZ stand. The resident scraped the left elbow on the wall resulting in a 1 cm by 2.5 cm partial thickness wound on the left elbow. Staff cleansed the area with normal saline and applied a Tegaderm (transparent) dressing. They notified the physician. The family was present when the incident occurred. Nursing progress notes identified the left elbow healed on 7/12/16 at 4:08 p.m. Nursing progress notes dated 7/16/16 at 6:01 a.m. revealed a CNA noted bleeding to the left elbow after an EZ stand transfer resulting in a 3 cm skin tear. Staff cleansed the area with normal saline, approximated the area with steri-strips and applied a Tegaderm (transparent) dressing. They notified the physician and family. The facility documented the area as healed on 7/26/16 at 9:56 a.m. Nursing progress notes dated 10/31/16 at 6:48 p.m. revealed the resident's left elbow bumped against the doorway to the bathroom resulting in a 1 cm by 0.4 cm partial thickness wound. Staff applied a Tegaderm dressing. The resident's family was present when the incident occurred and staff notified the physician. The facility	F 323		

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F 323	Continued From page 84 documented the left elbow as healed on 11/22/16 at 2 41 p m. The care plan failed to identify any change or additional interventions to assist with the prevention of further injuries to the elbows during transfers. Observation showed on 11/17/16 at 1:46 p.m the resident transfer from the wheelchair to bed with the EZ stand and one staff 6 MDS dated 11/10/16 revealed Resident #22 had diagnoses of Alzheimer's dementia, depression, and osteoarthritis The MDS revealed the resident displayed impaired short and long term memory. The MDS documented the resident required extensive assistance of one staff for transfers and toilet use and experienced unsteady balance when transferred or changed positions The care plan dated 6/24/13, and updated on 11/6/14, documented the resident had a history of falls, and impaired communication and cognition The care plan directed staff to do the following a Place call light in reach b Use EZ stand for transfers c Follow falling star protocol d Position resident in areas of staff supervision at times of increased restlessness e Provide reminders for resident to stay seated and use call light for assistance A review of incident reports and the nurse's progress notes revealed the resident had falls on the following dates a 7/24/16 - found on the floor in room b 12/8/16 - slid out of wheelchair onto the floor	F 323		

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F 323	Continued From page 85 The social service progress notes 8/30/16 at 3.28 p m., revealed the resident spoke little English On 11/17/16 at 9·52 a m., the notes revealed resident cried and wept loudly, and felt depressed	F 323		
	The fall assessment completed on 11/30/16, indicated the resident was at risk for falls. During initial tour 12/19/16 at 9 50 a m , Staff I, Registered Nurse/MDS Coordinator stated Resident #22 had a star symbol taped to the doorframe outside the resident's room Staff I reported the symbol indicated the resident was at risk for falls, and the resident had fallen in the past month During continuous observation on 12/21/16, the following occurred a At 4 30 p m , the resident found sitting on the toilet in the bathroom and crying loudly The resident had an EZ stand sling wrapped around the backside, and under each arm The sling straps were attached to the EZ stand, and the EZ stand device was positioned in front of the resident The resident's arms stretched upward, and the sling remained attached to resident and the EZ stand The resident could not reach the call light cord by the wall in the bathroom A visitor in the room reported 2 Certified Nursing Assistants (CNA) had placed the resident in the bathroom 10 minutes prior to when the surveyor entered the room a At 4 35 p m , the resident continued to cry loudly, but due to a language barrier, not able to comprehend what the resident said b At 4 38 p m , Staff F, CNA, walked down the			

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hall past the resident's room The resident sat on the toilet in the bathroom and cried
c At 4 40 p.m , Staff G, Licensed Practical Nurse (LPN), stood by the medication cart parked four doors down the hall from the resident's room The resident continued crying
d At 4.42 p m., Staff F walked down the hall past the resident's room
e. At 4 46 p m , Staff G entered the resident's room, opened the bathroom door and asked the resident if he/she wanted to get off the toilet Staff G placed the call light on, told the resident she would tell a CNA, and then left the room
f At 4 47 p.m , Staff H, CNA entered the resident's room The resident cried Staff H told the resident she had to get assistance The resident sobbed and asked "Soon?" Staff H acknowledged it would be soon, and left the room
g At 4.48 p m , Staff H and Staff F entered the room and assisted the resident

During an interview on 12/21/16 at 4 50 p m , Staff G, LPN, reported she had gone into Resident #22's room to get something, and found the resident on the toilet in the EZ stand Staff G stated she didn't know the facility's practice for EZ stand use, but thought when staff used the EZ Stand, 2 staff were required.

During an interview on 12/21/16 at 5 15 p m Staff H, CNA, reported she had placed the resident on the toilet, but needed assistance of two, and had to wait for assistance to get the resident off the toilet

During an interview on 12/22/16 at 9 30 a m , Staff D, CNA stated residents should not be left

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F 323	Continued From page 87 in an EZ stand alone because the resident could fall In an interview 12/22/16 at 8.50 a.m., Staff I, MDS Coordinator, stated when staff used an EZ stand, she expected staff not leave the resident in an EZ stand unattended Staff I reported if staff left a resident unattended in an EZ stand, it would be unsafe for the resident. In a policy and procedure for EZ stands, dated 5/2016, directed staff to do the following a. Move the resident to the desired location b Lower the resident until fully lowered to bed, chair, or toilet c Unhook the harness d Move the unit away from the resident 7 The MDS dated 11/18/16 documented diagnoses that included anxiety, depression diabetes and heart failure for Resident #9 The same MDS documented A Brief Interview of Mental Status (BIMS) score of 14 (intact cognition), required limited assistance with transfers and ambulation, utilized a wheelchair for locomotion, did not ambulate in the 7 day assessment period and had 2+ falls without injury since the last MDS completed in the prior 92 days or less The care plan problem initiated 6/17/13 identified the resident with a potential for falls related to impaired mobility, incontinence, medication use, debility, osteoporosis and history of fractures of the right ankle, the left tibia and fibula and C 1 (neck) fracture and directed staff to answer call lights promptly at night The Care Plan also directed staff to provide 1 assist for ambulation	F 323		

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F 323	Continued From page 88 and provide patient education related to safe sitting and standing when appropriate, provide supervision to limited assistance with transfers as needed/requested and revealed the resident also self-transfers. The pocket care guide carried by staff identified the resident required 1 assist with activities of daily living (ADL ' s) transfers and ambulation and directed staff to check on the resident before and after meals as needed on all shifts to offer assistance with transfers, toileting and ADL ' s and identified the resident has poor vision The incident Report dated 11/11/16 at 6 40 AM documented staff found the resident on the floor by the bed The report documented the resident transferred themselves from the bed to the wheelchair, slipped to the floor and landed on his/her buttocks The resident sustained no injury and the facility installed an anti-rollback device on the wheelchair The Incident Report dated 11/13/16 at 2315 (11 15 PM) documented staff found the resident sitting on the floor with his/her back against the bed The resident appeared sleepy and stated s/he did not know what happened The resident had no injury The incident report identified the resident ' s call light was on at the time of the occurrence The care plan intervention added 11/13/16 directed staff to answer the resident ' s call light promptly at night The Occupational Therapy Discharge Summary dated 12/9/16 documented the resident received OT services 11/21-12/9/16 and identified the resident required assistance of 1 at all times for	F 323		

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F 323	Continued From page 89 ADLs, transfers and mobility The Incident report dated 1/2/17 at 22 10 (10 22 PM) documented staff found the resident face down on the floor of his/her room with legs extended The resident tried to self-transfer from the wheelchair to the recliner and sustained a laceration to the right forehead Staff called 911 and the resident transferred to the emergency room The Report identified the new intervention assure all resident needs met before leaving the room, i e assisted to the toilet, offer water or snack for hunger The Progress Notes dated 1/3/17 at 5 00 AM documented the resident returned from the hospital with 6 sutures to the right forehead to close the 4 5 cm laceration The resident was educated to use the call light for assistance and placed within reach Observation on 1/12/17 at 11 10 AM revealed staff could not locate the resident Staff ZZ, pool CNA, located the resident in his/her bathroom The resident had self-transferred to the toilet Staff ZZ stated she had just returned from break Prior to going to break Staff ZZ stated the resident had been sitting in his/her recliner Staff ZZ stated other staff had told her the resident does self-transfer and to check on him/her frequently 8 The MDS dated 11/11/16 documented diagnoses that included breast cancer, psychotic disorder Non-Alzheimer ' s dementia and inflammation/infection of an artificial knee joint for	F 323		

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F 323	Continued From page 90 Resident #43. The same MDS documented a BIMS score of 6 (moderate cognitive impairment) and revealed the resident required extensive assistance for transfers, ambulation, hygiene and toileting, and had limited functional range of motion in one leg. The MDS identified the resident was only able to move from seated to standing position, walk or turn around with staff assistance, utilized a wheelchair for mobility and had 2+ falls without injury since the last MDS completed in 92 or less days ago The care plan problem dated 5/20/14 and revised 2/25/16 identified the resident had impaired cognitive functioning related to vascular dementia with episodes of confusion, poor memory recall and impaired temporal orientation. The care plan directed staff to cue, reorient and supervise the resident as needed The care plan problem initiated 3/28/14 and revised on 8/18/16 identified the resident's self-care deficit related to multiple medical problems and debility and directed the resident uses a wheelchair as primary means of locomotion, prefers to sleep in the recliner and required extensive assistance of 1 for all transfers. The care plan intervention dated 3/28/14 identified the resident as independent with controlling the electric recliner The care plan problem dated 3/28/14 and revised on 3/9/15 identified the resident as at risk for falls related to a history of falls and previous fracture of the right humerus, osteoarthritis and osteopenia and directed staff to assure the resident needs are met before leaving the room, i.e. offer toileting, offer water for thirst and snacks for hunger, be sure the call light is in reach and	F 323		

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F 323	Continued From page 91 encourage the resident to use it and to provide prompt response to all requests for assistance as appropriate The Incident Report dated 11/10/16 at 9:20 PM documented the resident ambulated independently to the bathroom and fell to the floor although a pool CNA present in the room Staff placed a " do not fall " sign on the resident ' s bedside table as an intervention after the incident. The Incident report dated 12/8/16 at 10.30 PM documented staff found the resident on the floor between the recliner and the bed with his/her back against the recliner holding on to the side rail and legs under the bed The resident sated s/he attempted to go from the recliner to bed. The Incident Report listed the intervention to check the resident every 2 hours to see if assistance needed to move or change positions The Incident Report dated 12/23/16 at 3 45 AM documented the resident found lying on his/her back in the bathroom with legs extended. The resident stated s/he want to go to the bathroom independently. The resident sustained a skin tear to the left buttock which measured 0 5 cm x 0 5 cm and a skin tear to the right buttock which measured 1 0 cm x 1 0 cm The intervention after the incident was documented as a sign posted in visible sight which said " DO NOT FALL, CALL FOR ASSIST!! " The Physical Therapy (PT) Discharge Summary dated 12/26/16 documented the resident received treatment 7 days from 12/9-12/26/16 The resident refused Tinetti balance testing and last Summary Since Last Progress Report	F 323		

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F 323	Continued From page 92 documented the resident continued with 1 person assist and continued with fall even with PT intervention The Incident Report dated 12/27/ 16 at 5 20 AM documented staff found the resident lying on the floor in front of the recliner with his/her head towards the recliner and the walker laying on top of the resident. The resident right leg below the knee twisted at a 90 degree angle Staff called 911 and the resident left the facility by ambulance at 5 45 AM During interview on 1/12/16 at 11 54 AM Staff UU, LPN stated she found the resident on the floor on 12/27/16 She stated she had been shocked to see the resident ' s right lower leg in the very abnormal position and immediately called 911 Staff UU stated she did not do an assessment of the resident ' s room at the time of the incident, could not recall if the resident ' s electric recliner had been up or down and could not recall if the resident ' s call light on Staff UU stated the resident was often non-compliant with using the call light and frequently self-transferred She did not know when the resident had last been observed by staff prior to the incident Staff UU stated she knew the most important thing had been to get the resident to the hospital as quickly as possible The Hospital Trauma Services Discharge Summary documented the resident sustained a right tibia and fibula fracture, a fracture of the right ankle which required surgical repair as well as 2 small acute subdural hematomas The resident returned to the facility on 1/3/2017 During an interview on 1/12/17 at 2 40 PM, the	F 323		

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F 323	Continued From page 93 DON stated neither she nor staff completed an investigation into the resident ' s fall on 1/27/16 When she came into work that morning around 8 00 AM she did go down to the resident ' s room and sit in the recliner to check out the surrounding, but did not interview staff on duty at the time of occurrence The DON stated the recliner was in regular position when she went to the room but did not know the position of the recliner at the time of the incident Observation on 1/12/17 at 9 00 AM revealed the resident in bed with half side rails up and a lipped mattress on the bed Resident had a CAM boot on the right lower leg The resident ' s call light lay across the resident ' s recliner well out of resident reach and the bedside table, which contained a sign which said " DO NOT FALL " as well as the resident ' s water pitcher, across the room by the divider curtain The sign on the wall to the resident ' s left side read " DO NOT FALL, CALL FOR ASSIST!! " 9 The MDS dated 11/24/16 documented diagnoses that included Alzheimer ' s disease, seizure disorder and blindness in one eye and low vision in the other for Resident #45 The same MDS documented a BIMS score of 9 (moderate cognitive impairment) and revealed he/she required limited assistance for transfers, ambulation, toileting and hygiene The MDS also documented the resident, utilized a wheelchair and had no falls since the last MDS completed 92 days or less ago and received anticoagulant medications 7 of 7 days of the assessment period The care guide carried by the staff documented	F 323		

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F 323	Continued From page 94 the resident required extensive assistance of 1 staff for pivot transfer and utilized a wheelchair for mobility The guide directed staff to place the call light on the right side as the resident was blind in the left eye, do not leave the resident alone in the bathroom and move the electric recliner remote control out of resident reach when he/she sat in it. The progress notes dated 12/25/16 at 20 43 documented staff saw the resident lying on the floor with his/her head resting on the bottom of the recliner and legs straight out The resident sustained a skin tear on the right elbow and a laceration on the right side of the head The Incident Report dated 12/2516 documented the intervention to place the resident ' s call light on the right side when possible due to blindness in the left eye and staff educated the resident use the call light The Incident Report dated 12/27/16 at 8 50 AM documented staff found the resident lying supine in front of the recliner with the wheelchair located a few feet away The wheelchair brakes were not locked The resident could not state what s/he had been doing prior to the fall because of chronic decreased cognition At 9 40 AM staff noted a red area on the resident ' s scalp just above the right ear The progress notes entry dated 12/27/16 at 13 15 (1 15 PM) documented staff found the resident on the floor in front of the recliner in a supine position The resident ' s wheelchair located not far away and tipped on its side The resident could not relate what happened due to longstanding cognitive issues The progress notes entry at 12 21 (1 21 PM) documented the resident had a reddened area above the right ear,	F 323		

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F 323	Continued From page 95 but unclear whether this it was a new area or one from a previous fall. Review of the care plan revealed no new intervention(s) put into place after this incident. The Incident Report dated 12/31/16 at 1400 (2:00 PM) documented staff found the resident on the floor of their room with their head under the wheelchair and their legs outstretched in front. Resident stated s/he had been " picking up the place " but staff noted no trash or clutter noted on the floor The resident sustained a superficial scrape down the middle of the back The Incident Report documented the intervention to keep the resident ' s room/floor clean and instructed the resident to call for assistance when things are on the floor so staff can pick them up The progress notes entry dated 12/31/16 at 16 28 (4 28 PM) documented the resident ' s spouse expressed concern with the resident ' s fall and altered mental status Staff contacted the resident ' s physician and obtained an order to a urinalysis (UA) and to draw a complete blood count and basic metabolic profile today rather than 1/3/17 The Incident Report dated 1/3/17 at 7 50 AM documented the resident attempted to self-transfer from the wheelchair to the recliner and fell onto their buttocks The resident had no noted injury, but the resident ' s blood pressure (BP) measured 160/86 The Incident Report documented as an intervention to monitor and report potential seizure activity The progress notes entry dated 1/3/17 at 2 41 PM documented staff implemented a nursing order to check the resident ' s BP 2 times a day for 3 days and then fax those results to the physician	F 323		

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F 323	Continued From page 96 The progress notes entry dated 1/3/17 at 6 31 p m. documented staff received an order to administer Macrobid (a urinary tract anti-infective medication) 100 milligram (mg) 2 times a day for 10 days The Incident Report dated 1/8/17 at 9.00 AM documented staff found the resident on the floor in front of the recliner. The resident ' s electric recliner elevated forward slightly and the resident slid out and landed on his/her buttocks The resident sustained no injury The Incident Report documented the facility implemented an intervention to place a non-skid pad in the recliner The Incident Report dated 1/8/17 at 2000 (8 00 PM) documented staff found the resident lying on the floor on their right side next to the bed. Resident stated s/he attempted to go from the recliner to the bed and fell The resident sustained no injury The Incident Report documented the staff implemented an OT evaluation and treatment as an intervention after the fall Observation on 1/18/17 at 1 22 PM revealed the resident sat in his/her recliner with feet up The remote control for the recliner placed out of resident ' s reach The resident ' s call light was fastened on the resident ' s left side near his/her hand The facility ' s Falls Prevention Procedure dated 11/2013 directed the following. A fall committee consisting of the Administrator, DON, and quality assurance (QA) nurse will	F 323		

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F 323	Continued From page 97 review the incident report. The review will include the environment where the fall took place, evaluation of the interventions in place, ideas for other interventions that may be appropriate [and] provide education to staff	F 323		
	During an interview on 1/12/17 at 4 00 PM the DON, she stated the current Incident Report form has a section for investigation of the fall as well as witness statement forms, but staff had failed to complete them. She stated she had assumed the DON position at the end of November, 2016 and had plans to change the falls investigations and analysis but has not implemented them at this time because she had been directed by higher management to make changes a little bit at a time She also stated the facility does not have a fall committee and no formal system to review falls and assess the appropriateness or efficacy of interventions She stated the staff has a list of interventions that can be implemented and are taught to put one into place after each fall Review of the list of falls that occurred in the facility 12/1/16 through 1/10/17 documented 35 residents sustained a total of 69 falls in this time frame The facility abated the IJ on 1/16/17 with the following corrective actions 1 The incident report in use were removed and replaced with a report form that included a section that prompted staff to complete incident investigations 2 Standard and individualized safety interventions were developed to put in place to			

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F 323	Continued From page 98 prevent falls 3 Staff were educated regarding the new policies listed above in items 1 and 2. 4 Fall committee meetings were resumed and the first meeting was held on 1/16/17 at 9 30 a m.	F 323		
	10 Observation on 1/11/17 at 11 00 AM revealed an unlocked treatment cart in the hallway next to Room 409. The cart had 2 drawers and shelves that contained Sani-Cloths, Derma-Klenz, multiple tubes of medicated ointments and topical medications such as metronidazole 0 75% gel, 2 tubes of estrace 0 1% cream, urea 40% urea cream and 2 eight ounce bottles of povidine-iodine scrub All labels on the medications and ointments and scrub directed to keep out of reach of children The cart also contained staple remover kits At 10 05 AM Staff TT licensed practical nurse (LPN), came to the treatment cart She stated that she has been in and out of the cart at this time but acknowledged it should be locked During interview at 10 30 AM the DON stated she would expect the treatment cart to be locked when not in use Observation on 1/18/17 at 11 17 AM revealed the same unlocked treatment cart in the hallway next to room 409 The cart contained the same items as observed on 1/11/17 At 11 24 AM the surveyor requested staff summon a nurse The skilled unit manager came to the cart and stated the cart should be locked and went and got Staff TT to lock it Staff TT again acknowledged the cart should be locked when not in use The facility identified 25 residents with cognitive			

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F 323	Continued From page 99 impairment that are independent with mobility	F 323		
F 353 SS=E	483 30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty This REQUIREMENT is not met as evidenced by Based on clinical record review, observations, group interview, and resident and staff interviews, the facility staff failed to provide supervision while a resident placed in an EZ Stand mechanical lift to ensure resident safety for one of eleven residents reviewed with a history of falls (Resident #22) and failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest	F 353		

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F 353	Continued From page 100 practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care Four of 7 residents at the group interview and 5 of 10 residents interviewed individually identified they did not have their call light answered within the required 15 minutes The facility census was ninety-three (93) residents Findings include 1 The Minimum Data Set (MDS) assessment dated 11/10/16, documented Resident #22 had diagnoses of Alzheimer's dementia and depression The MDS revealed the resident had impaired short and long term memory The MDS documented the resident required extensive assistance of one staff for transfers and toilet use The care plan dated 6/24/13 and updated on 11/6/14, included the resident had a history of falls, required assistance for all activities of daily living, exhibited anxiety, and had behaviors of crying out and weeping loudly The care plan directed staff to place call light in reach and provide reminders for the resident to stay seated and use call light for assistance The pocket care plan directed staff to use an EZ Stand for transfers and provide assistance of one to two for activities of daily living A review of Incident Reports revealed the resident had falls on the following dates a 7/24/16 - found on the floor in room b 12/8/16 - slid out of wheelchair onto the floor During initial tour 12/19/16 at 9 50 a m , Staff I,	F 353		

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F 353	Continued From page 101 Registered Nurse/MDS Coordinator stated Resident #22 had a risk for falls, and the resident had fallen in the past month. During continuous observation on 12/21/16 , the following occurred a At 4:30 p m , the resident sat on the toilet in the bathroom and cried loudly The resident had an EZ Stand sling wrapped around the back and under each arm. The sling straps were attached to the EZ Stand with the EZ Stand positioned in front of the resident The resident's arms stretched upward, and hung from the EZ Stand. The resident could not reach the call light cord by the wall. A visitor in the room reported the resident placed in the bathroom at least 10 minutes prior by 2 Certified Nursing Assistants (CNA) b At 4.35 p m , the resident continued to cry loudly, but due to a language barrier, unable to comprehend what the resident had said The crying audible in the hallway c At 4 38 p m., Staff F, CNA, walked down the hall past the resident's room The resident sat on the toilet in the bathroom and cried d At 4:40 p m , Staff G, Licensed Practical Nurse (LPN), stood by the medication cart parked four doors down the hall from the resident's room The resident continued crying e At 4·42 p m Staff F walked down the hall past the resident's room f At 4.46 p m , Staff G, entered the resident's room, opened the bathroom door, and asked the resident if he/she ready to get off the toilet Staff G placed the call light on, told the resident she would tell a CNA, and then left the room g At 4 47 p m , Staff H, CNA entered the resident's room The resident cried Staff H told the resident she had to get assistance The	F 353		

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F 353	Continued From page 102 resident sobbed and asked "Soon?" Staff H acknowledged it would be soon, and left the room h. At 4.48 p m., Staff H and Staff F entered the room and assisted the resident.	F 353		
	In an interview on 12/21/16 at 5 15 p.m , Staff H, CNA, reported she had placed the resident on the toilet, but needed assistance of two, and had to wait for assistance to get the resident off the toilet In an interview 12/22/16 at 8.50 a m , Staff I, MDS Coordinator, reported the facility had recently changed their staffing structure. Staff I reported the facility had used agency staff to help meet staffing needs 2 During the group interview on 12/20/16 from 3 30 p m to 4 30 p m., 4 out of 7 residents in attendance stated staff members have came into their rooms, turned off the call light, not spoken to them or acknowledged that they had a need for assistance and walked back out of the room 3 The MDS with assessment reference date of 11/18/16 assessed Resident #9 with a brief interview for mental status (BIMS) score of "14", indicating no cognitive impairment. The resident required limited staff assistance with transfers toileting and dressing The resident did not ambulate Observation showed on 11/22/16 at 1 31 p m the resident's call light already on Observation showed the call remained activated at 1 55 p m (24 minutes plus) Upon entering the room to see if the resident needed help the resident stated he/she activated the call light to go to the activity At 1 57 p m Staff BB, LPN, entered the room to answer the call light The resident stated he/she			

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F 353	Continued From page 103 didn't time it with a clock but there were times the resident knew he/she waited an hour. Staff tells the resident they don't have time to answer the call light The resident stated there are times he/she didn't make it to the bathroom The resident stated it didn't make him/her feel good and the resident tries to clean it up The resident stated he/she didn't like it because it was not fun to "poop your pants" The resident also stated if he/she calls too frequently then staff don't come so he/she tries to help self and has slipped and fallen. A care plan with a potential for falls problem revised on 9/23/15 directed staff to answer call lights promptly at night and provide reminders and encourage the use of the call light prior to transfers especially during nonwaking hours 2 A MDS with assessment reference date of 11/3/16 assessed Resident #21 with a BIMS score of "14" which indicated no cognitive impairment The resident required extensive staff assistance with bed mobility, dressing and transfers On 11/29/16 at 8 23 a m. observation showed the resident's call light on The resident identified the call light on for 40 minutes The resident stated he/she timed it with the clock on the wall The resident stated he/she wanted to get up and wanted his/her Tylenol. 3 A MDS with assessment reference date of 10/27/16 assessed Resident #16 with a BIMS score of "15" which indicated no cognitive impairment The resident required extensive staff assistance with bed mobility, transfers and toileting	F 353		

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F 353	Continued From page 104 On 11/29/16 at 9 45 a.m the resident stated it sometimes takes awhile to get the call light answered. One morning a week or two ago the resident put the call light on at 6 a m and it took 1 hour and 15 minutes for staff to answer it The resident looked at the clock on the wall to monitor the time The resident needed the bathroom The resident stated he/she made it to the bathroom but 1 more minute and they would have had a mess. 4 A MDS with assessment reference date of 11/17/16 assessed Resident #14 with a BIMS score of "15" indicating no cognitive impairment The resident required extensive staff assistance with bed mobility, transfers and toileting On 11/29/16 at 3 55 p m the resident stated several weeks ago the resident laid there for 3 hours The resident kept turning the call light on and staff came in 4 to 5 times and turned it off The resident stated he/she had a concern with the BiPap mask (for sleep apnea) because it did not seal correctly The resident monitored the time with the clock and cell phone 5 A MDS with assessment reference date of 11/14/16 assessed Resident #10 with a BIMS score of "15", indicating no cognitive impairment The resident required extensive staff assistance with bed mobility transfers and toileting. On 11/23/16 at 10 57 a m the resident stated last night on the evening shift he/she had the call light on for 30 minutes She stated she was on the toilet and, after 30 minutes, he/she just got up per self or he/she would have been there even longer than that. The resident used a watch to check the	F 353		

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F 353	Continued From page 105 time. A care plan dated 4/13/16 identified the resident at risk for falls due to history of stroke with right sided weakness and EZ stand for transfers The care plan directed staff to keep the call light in reach and encourage the resident to use it when he/she needs any assistance 6 Resident council minutes identified the following. 6/2/16. comment about call light wait times 7/7/16 call light wait times are too long 9/1/16 call lights aren ' t answered while CNAs stand in the hall talking 11/3/16 2 to 4 CNAs on the hall ignore call lights	F 353		
F 354 SS=D	483 30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents This REQUIREMENT is not met as evidenced by Based on record review and staff interview, the	F 354		

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F 354	Continued From page 106 facility failed to use the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. The facility census was ninety-three (93) residents Findings include: 1 Review of July 2016 nursing schedules revealed no RN worked 7/16/16 On 12/7/16 at 1 30 p.m the Director of Nursing stated she could not find evidence that an RN worked on 7/16/16	F 354		
F 367 SS=D	483 35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician This REQUIREMENT is not met as evidenced by Based on observation, staff interview, and record review the facility failed to assure that 1 resident (Resident #27) out of 15 reviewed received the diet prescribed by their doctor The facility reported a census of 93 residents Findings include During a noon meal observation of the dietary service from 12 00 p.m to 1.00 p.m on 12/20/16, it was noted dietary staff asking each resident what they would like for the meal and staff would then go to the steam table and tell Staff L, Cook, the type of diet and what the Resident had chosen to eat from the choices offered Staff K was overheard requesting two regular diets, one for Resident #27 There was no observed list in use by Staff L to verify correct diets were being	F 367		

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F 367	Continued From page 107 served. During an interview with Staff K, Dietary Aide (DA) at 12:05 p.m. on 12/20/16, Staff K stated they used Section Lists to identify each resident's prescribed diet, take the resident's food order and then report what the resident wanted to eat to the person serving the food at the steam table. Staff K explained that all residents were on the Section List and identified by the table they sit at. Staff K stated that he did not have a Section List with him at that time to refer to. A Section List was presented to Staff K which identified Resident #27 was to receive a mechanical soft textured diet. During an interview with the Dietary Manager at 12:07 p.m. on 12/20/16, she stated all staff serving trays were to go by the Section Lists and they were responsible for letting the cook/server know what kind of diet each plate needs to be. A Minimum Data Set (MDS) assessment with the assessment reference date of 11/10/16 identified Resident #27 with diagnoses of diverticulosis (pocket in wall of colon), anorexia (desire to not eat), cachexia (weight loss disorder) and disorders of glycoprotein metabolism (difficulty digesting some foods). A care plan initiated 7/11/15 with a revision date of 11/16/16 identified a problem for alteration in nutrition status related to diagnoses as evidenced by low body weight, leaving 25% of food and weight loss greater than 6% in 180 days. A care plan intervention directed Dietary Aides, Certified Nurse Aides (CNA) and nurses to provide and serve diet as ordered three times daily. A record review of a physician's Telephone Orders form dated 12/7/16, indicated Resident #27 was to receive a mechanical soft diet with thin liquids. A Fountain Dining Room Section List indicated the resident to receive a general diet	F 367		

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F 367	Continued From page 108 with mechanical soft texture. The menu for lunch on 12/20/16 was apple glazed ribs with sauerkraut A dietary menu for the various diet textures indicated mechanical soft diets would receive ground apple glazed ribs and sauerkraut	F 367		
F 371 SS=F	483 35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities, and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by Based on observation and interview the facility failed to assure that kitchen shelving, utensil drawers and the kitchen area floor was clean and free of debris The facility reported a census of 93 residents. Findings include During the initial kitchen tour on 12/19/16 from 9 12 a m to 9 28 a m , observation revealed the multiple drawers used for storage of spatulas, scoops, and various other cooking utensils had crumbs and debris present During an interview on 12/19/16 at 9 28 a m , the Dietary Manager stated there is no assigned person responsible for keeping the utensil drawers clean	F 371		
F 441 SS=D	483 65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 109 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility (2) Decides what procedures, such as isolation, should be applied to an individual resident, and (3) Maintains a record of incidents and corrective actions related to infections (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 110 This REQUIREMENT is not met as evidenced by. Based on observation, record review, staff interviews and policy review the facility failed to provide complete catheter care in a manner to prevent infections for 1 of 3 residents reviewed with catheters (Resident #24). The facility reported a census of 93 residents Findings Included According to the 12/1/16 Minimum Data Set (MDS) Resident #24's had intact cognitive skills for daily decision making The resident required limited assistance of one staff for bed mobility, transfers, dressing, toilet use and personal hygiene The MDS recorded that the resident had a catheter The care plan, last revised 1/5/16, directed staff to provide toileting and incontinence care for Resident #27 with the assistance of 1 staff The 12/1/16 through 2/28/17 Physician's Orders form for Resident #24 contained an order for a Foley catheter (to drain urine) with a start date of 6/28/16 Observation on 12/20/16 at 7 00 a m during catheter care for Resident #24 Staff C, Certified Nursing Assistant (CNA), placed a graduate container on the sink top and emptied the catheter drainage bag into it Staff C then emptied the graduate into the toilet Staff C filled the graduate container with soap and water, swished it around and emptied it into the sink of the shared bathroom During an interview on 12/20/16 at 10 30 a m with Staff B, Registered Nurse, acknowledged Staff C should have placed a barrier under the graduate container and emptied the soap/water into the toilet, not the residents sink The 2/2015 facility policy, "Emptying of Urinary Catheter Bags" directed staff to	F 441		

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F 441	Continued From page 111 a Place graduate (container) on the barrier b Take graduate to bathroom, measure, check for abnormalities of urine, empty contents into toilet, rinse with water dumping into toilet and place on the back of the toilet	F 441		
F 496 SS=D	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State, or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry Facilities must follow up to ensure that such an individual actually becomes registered Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation the individual must complete a new training and competency evaluation program or a new competency evaluation program	F 496		

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F 496	Continued From page 112 This REQUIREMENT is not met as evidenced by: Based on personal and resident record review, staff interview and facility policy review, the facility failed to ensure that before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State, or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry Facilities must follow up to ensure that such an individual actually becomes registered Staff DD worked at the facility through an agency When the registry status was checked, Staff DD had never been on the registry The facility failed to ensure successful completion of Certified Nurse Aide (CNA) registry verification check on a newly hired staff member for 1 of 2 nurse aide employee files reviewed (Staff A) The facility reported a census of 93 residents Findings include 1 On 11/29/16 at 10 45 a m Staff EE, social worker, stated she took a call from the hospital nurse practitioner who informed her that Resident #12 reported she was touched inappropriately at the facility During the investigation, the facility narrowed the date of occurrence down to 11/10/16 or 11/11/16 Staff DD fit the resident's description and worked as a Certified Nurse Aide (CNA) on those dates Staff DD worked as a CNA at the facility through a staffing agency	F 496		

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F 496	Continued From page 113 Review of facility staffing sheets revealed Staff DD worked as a CNA on 11/10/16 and 11/11/16. Review of CNA schedules indicated Staff DD also worked at the facility on 10/29/16 and 11/5/16 On 11/19/16 at 11 24 a m. Staff DD refused to answer when asked if he/she was a certified nurse aide On 11/29/16 at 12:30 p.m a representative from the CNA registry stated Staff DD was not on the registry and never had been since the registry had been in place since 2005 2. Record review of Staff A's personnel file revealed a hire date of 10/19/16 as a CNA The file contained documentation of a Nurse Aide Registry verification completed 10/10/16 that documented Staff A's results as ineligible The Timecards by Employee list documented Staff A worked 10/19/16 thru 12/16/16 for a total of 295 hours The Nurse Aid Roster for the facility dated 11/9/16 documented Staff A's status as a CNA as No Test with a hire date of 10/19/16 In an interview on 12/19/16 at 1 55 p m , the Human Resources (HR) Manager verified Staff A hired on 10/19/16 The HR Manager reported she contacted the representative at DIA (Department of Inspections & Appeals) that handled the Nurse Aid Roster The HR Manager stated the representative confirmed the roster read No Test because Staff A failed the test The HR Manager reported Staff A still worked as a CNA and had been working since October 2016	F 496		

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F 496	Continued From page 114 The HR Manager commented the facility was removing Staff A from the schedule immediately and somehow the facility missed the ineligibility status. The Policy and Procedure: Abuse Prevention, Identification, Investigation and Reporting, revised on 9/9/16, included the following under sub-title Employee Screening Point 5. For those employees with certificates (certified nurses' aides), the facility will conduct a check with the appropriate registry to assure that there is no history of abuse, neglect or mistreating Residents	F 496		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year, address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff, and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired This REQUIREMENT is not met as evidenced by Based on record review, facility staff failed to attend the required 12 hours of in-service per year for five of five staff reviewed. Facility census	F 497		

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F 497	Continued From page 115 was ninety-three (93) residents Findings include. 1 The facility identified Staff CC, CNA (certified nurse aide), as hired as 11/29/11 Review of 2015 inservices revealed Staff CC had 9 hours of inservice for the year 2 The facility identified Staff DD, CNA, as hired 6/30/98 Review of 2015 inservices revealed Staff DD attended 3 hours of inservice for the year 3 The facility identified Staff V, CNA, as hired 11/5/14 Review of 2015 inservices revealed Staff V attended 11 hours of inservice for the year 4 The facility identified Staff GG, CNA, as hired 11/4/13 Review of 2015 inservices revealed Staff GG attended 7 hours of inservice for the year 5 The facility identified Staff S, CNA as hired 5/20/14 Review of 2015 inservices revealed Staff S attended 6 hours of inservice for the year	F 497		
F 516 SS=D	483 75(l)(3), 483 20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so The facility must safeguard clinical record	F 516		

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F 516	Continued From page 116 information against loss, destruction, or unauthorized use This REQUIREMENT is not met as evidenced by Based on observation and interviews, the facility failed to assure resident records are secured against unauthorized use The facility identified a census of 93 residents. Findings include 1 Observation on 1-11-17 at 11 25 AM revealed an open storage room next to administrator's office off the main dining room area The room contained wheelchairs, walkers and racks of chairs as well as (25 plus) banker's boxes of resident records for 2013-2016 as well an unlocked 4 drawer file cabinet with 2016 resident records stored inside The room also contained boxes of pharmacy records Observation revealed the administrator not present in his office and a receptionist present in another office out of view of the storage room During interview at on 1/11/17 at 11 37 AM the maintenance supervisor stated the storage room is usually locked, but workmen are installing a new floor in the dining area and the tile is stored in there and is open so they have access During exit conference on 1/18/17 at 3 45 PM the administrator stated his office is next door to the storage room and he kept an eye on that area so no one would have unauthorized access	F 516		
F 520 SS=E	483 75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		

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F 520	Continued From page 117 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary, and develops and implements appropriate plans of action to correct identified quality deficiencies A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions This REQUIREMENT is not met as evidenced by Based on facility record review and staff interviews, the facility failed to have an effective quality assurance (QA) program in place to assist in the provision of quality care for residents The facility identified a census of 93 residents Findings include Review of facility records revealed repeated deficient practices identified during the facility's	F 520		

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FOUNTAIN WEST HEALTH CENTER	1501 OFFICE PARK ROAD WEST DES MOINES, IA 50265

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F 520	Continued From page 118 annual survey completed 1/14/16, complaint surveys completed 3/2/16, 4/12/16, 9/23/16 and current complaint investigation. During interview on 1/24/17 at 9 45 AM the Administrator acknowledged the facility has had repeat deficiencies since annual survey 1/14/16 The administrator stated the form assistant director nursing (ADON) had been provided extensive training and education in the QA as well as quality assurance and performance improvement (QAPI) but had difficulty with implementation As a result of this the ADON was terminated and the former director of nursing (DON) assumed the responsibility for QA/QAPI but was not effective in implementation either. As a result, monitoring of compliance with plans of correction for the identified deficient practices during survey activities had not been done The administrator stated the QA/QAPI process has been revised and the first meeting will be held 1/27/17 The administrator provided a copy of the revised meeting agenda and topics for review	F 520		

F 157 – NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

Accept this as Fountain West Health Center's credible allegation of compliance.

Staff was educated on 12/28/16 regarding the importance of timely physician and family notification when there is a significant change in condition, an accident which results in injury and has potential for requiring physician intervention, and/or a change in treatment. This was covered again the meeting conducted 2-10-17. Family and physician notification is now part of the nurse orientation process.

Resident #2 and similarly situated residents now have parameters set by the physician as to when he/she wishes to be notified if the pulse is outside the normal range. Physician and family notification will be tracked through the Quality Assurance Committee.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 225 – INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

Accept this as Fountain West Health Center's credible allegation of compliance.

Staff was educated on 12/28/16 regarding the importance of reporting immediately any injuries of unknown origin, and re-educated on 2/10/17. Injuries which are not witnessed will be investigated utilizing the "non-fall" incident report that was developed 1/19/17.

Resident #8 and similarly situated residents will have injuries of unknown origin investigated and reported as required. Injuries/incidents are being tracked through the Quality Assurance Committee.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 241 – DIGNITY AND RESPECT OF INDIVIDUALITY

Accept this as Fountain West Health Center's credible allegation of compliance.

All staff was educated on 12/16/16 on the importance of responding to residents call lights/needs promptly, and re-educated 2/10/17. Staff has been educated on anticipating

residents' needs and intervening appropriately. The facility is in the process of scheduling "bath aides" in an effort to provide consistency and dignity with the bathing process. In the interim, all staff has been educated on maintaining dignity while providing care to residents. Staff has acknowledged receipt of instructions regarding proper transport for showers (dress and undress in the shower room whenever possible, and proper covering when not possible).

Resident #8 and similarly situated residents will have grievances/concerns of mistreatment investigated and acted upon immediately as required. Education was provided at the time of survey regarding immediate reporting of any allegations of mistreatment, and all staff is being re-educated on 2/10/17.

An investigation was conducted regarding the incident with resident #18. The employee who was believed to be involved (based on the resident's description of the accent) is no longer working at the facility.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 279 – DEVELOP COMPREHENSIVE CARE PLANS

Accept this as Fountain West Health Center's credible allegation of compliance.

Dietary and nursing staff was educated on 12/21/2016 and re-educated on 2/10/17 on the importance of following therapy recommendations.

Residents #22, 23, and all similarly situated residents have had their recommendations reviewed and adaptive lists in the kitchen have been updated to reflect the residents' needs.

Resident #24 and similarly situated residents have had their care plans reviewed and updated to reflect residents' current needs/devices. The MDS Manager has been re-educated regarding the importance of updating care-plans as residents' needs change.

The Director of Nursing or designee will audit care plans and monitor compliance on an ongoing basis. The Dietician or designee will audit the adaptive equipment list routinely and provide continuing education to dietary staff as needed.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 281 – SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

Accept this as Fountain West Health Center's credible allegation of compliance.

Nurses were educated on 12/16/17 and re-educated on 2/10/17 regarding the importance of following physician orders for all residents. Proper medication administration protocol has been reviewed with nurses. This is now addressed in the charge nurse orientation process upon hire. MARS/TARS are being routinely audited by the Director of Nursing or designee for accuracy and completeness.

Residents #11, 5, 14 and similarly situated residents are having pain assessments completed quarterly and with changes in condition. Staff P is no longer employed at the facility.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 282 – SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

Accept this as Fountain West Health Center's credible allegation of compliance.

Staff was educated 12/16/17 and was re-educated on 2/10/17 regarding the importance of providing proper care to residents, including but not limited to checking, changing, and repositioning residents. This is incorporated into the CNA orientation.

Repositioning/toileting/incontinency care will be monitored by the Director of Nursing or designee on an ongoing basis. The Quality Assurance Committee will follow progress to monitor compliance. Periodic audits will be conducted on an ongoing basis and reviewed by the Quality Assurance Committee to determine the need for further education.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 309 – PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Accept this as Fountain West Health Center's credible allegation of compliance.

Nurses were educated on 12/28/16 regarding proper documentation of skin, assessments with condition change, bruising/non-pressure areas as well as the importance of timely assessments/notification when a resident experiences a change in condition, and re-education

provided on 2/10/17. Non-decub sheets have been implemented to assist nurses with weekly assessments of non-pressure areas such as bruises, incisions, etc. Documentation guidelines have been introduced to assist nurses with documentation of residents experiencing condition changes. This is incorporated into Charge Nurse orientation upon hire.

The Director of Nursing and/or designee will monitor the pressure/non-pressure sheets weekly for accuracy and completeness and documentation will be monitored periodically as residents experience condition changes.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 312 – ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

Accept this as Fountain West Health Center's credible allegation of compliance.

Staff was educated on 12/16/17 regarding proper peri care, and re-educated on 2/10/17. Peri-care training has been incorporated into the C.N.A. orientation program. Periodic peri-care audits are being conducted by the Nurse Managers, and ongoing education will be provided as necessary.

Bathing assignments/completion are being monitored by nurse managers. Fingernails, grooming and hair care are being monitored by the nurse managers, and follow up will be addressed in Resident Council to monitor progress.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 314 – TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

Accept this as Fountain West Health Center's credible allegation of compliance.

Staff has been educated on 12/28/16 and re-educated on 2/10/17 on the importance of proper interventions to prevent pressure sores, and to heal pressure sores that are present. Staff has also been educated on the importance of following physicans' orders and standards of practice regarding minimizing the risk of developing pressure sores.

Staff #5 no longer resides at the facility. Weekly skin assessments are being conducted and the Director of Nursing or designee are monitoring for completeness. MARS/TARS are being checked daily for completeness by Nurse Managers and/or designee.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 315 – NO CATHETER, PREVENT UTI, RESORE BLADDER

Accept this as Fountain West Health Center's credible allegation of compliance.

Staff was educated on 12/16/16 and again on 2/10/17 regarding the importance of toileting residents. It is the expectation that residents are toileted before and after meals, prn, and at HS. They were also educated on the importance of repositioning (to promote skin integrity as well as comfort). The nurse managers have been instructed to monitor position changes/toileting when they are in the building. When they are not in the building, Charge Nurses will be directing staff.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 323 – FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

Accept this as Fountain West Health Center's credible allegation of compliance.

A list of potential fall interventions was developed to assist staff in determining which interventions may be appropriate to reduce the risk of further falls. New incident reports along with Quality Assurance investigative protocols have been implemented to assist with determining the root causes of residents' falls.

Staff was educated at the time of survey on 1/16/17 regarding new incident reports, investigations, and safety interventions, and was re-educated on 2-10-17 regarding proper supervision, response to residents' needs, and interventions to minimize the risk of resident falls. Falls are being tracked and trended in an effort to assure that all facts are considered when determining potential contributing factors. A fall committee has been formed to evaluate each fall and subsequent interventions. This committee met on 1/16/17 and will continue to meet daily Monday through Friday to review falls/incidents. A fall summary has been implemented to assist with tracking interventions to determine if they are appropriate

and effective. Safety is incorporated into CNA and nurse orientation. The falls committee along with the Quality Assurance committee has made fall reduction a priority. A "2 person assist" protocol has been implemented regarding use of the standing "EZ lift" and nursing staff has signed acknowledgment. Staff has been re-educated on the importance of following transfer/ambulation care needs identified in the care plans, and to report immediately to the Director of Nursing and/or designee if fall interventions are not working. Telligen came to the facility on 1/27/17 and provided education regarding fall reduction. The Director of Nursing and/or designee is monitoring incident reports daily to assure that falls are investigated timely and proper interventions implemented.

The Administrator, DON and/or designee along with the Quality Assurance and Fall Committee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 353 – SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS

Accept this as Fountain West Health Center's credible allegation of compliance.

Staff was educated on 12/16/17 regarding prompt response to call lights, and re-educated on 2/10/17. Call light response time is currently a focus of the Quality Assurance Committee. Staff has been instructed not to leave their assigned hall way unless notifying the nurse that they are going on break. Break times are assigned and staggered. The Director of Nursing and/or designee will follow up with Resident Council to monitor response time. Call light response time is incorporated into CNA orientation.

Resident #22 and similarly situated residents will not be left in transfer devices without staff present. Re-education regarding mechanical lift techniques has been provided to nursing staff and acknowledged.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 354 – WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON

Accept this as Fountain West Health Center's credible allegation of compliance.

The staffing coordinator has been re-educated on 12/16/17 regarding the RN staffing requirements.

The facility currently has R.N. coverage of at least 8 consecutive hours per day.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 367 – THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN

Accept this as Fountain West Health Center's credible allegation of compliance.

The cook verifies Resident #27 and similarly situated residents diet orders before filling plates at the steam table. A tray card system software with resident pictures has been ordered from Point Click Care to help ensure the correct diet order is given to each resident.

Diet orders, adaptive equipment and residents requests will be shown by table. The diet type list will be distributed to each nurse manager for CNA awareness.

The Dietician and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 371 – FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

Accept this as Fountain West Health Center's credible allegation of compliance.

Storage units have been cleaned out and new storage unit purchased. The cook of the day is assigned to keep external storage clean and cleaned daily as needed. A sanitation checklist for each station has been updated to include storage bins.

The Dietician and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 441 – INFECTION CONTROL, PREVENT SPREAD, LINENS

Accept this as Fountain West Health Center's credible allegation of compliance.

Staff was educated on 12/28/17 and all nursing staff was re-educated on 2/10/17 regarding proper catheter care, including proper cleansing of the spigot, proper barrier placement under

the graduate when emptying, and proper emptying into the toilet. This has been incorporated into the CNA orientation checklist.

The Quality Assurance committee addresses infection control issues in its quarterly meetings, including issues noted on rounds in the building.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 496 – NURSE AIDE REGISTRY VERIFICATION, RETRAINING

Accept this as Fountain West Health Center's credible allegation of compliance.

Staff DD was removed from staff schedule and will not be allowed to schedule future shifts with the facility until is listed as eligible on the Iowa Nurse Aide Registry. Staff A was removed from staff schedule and is currently not working for the facility.

Staff responsible for employee registry checks was re-educated on 12/21/2016 regarding the importance of obtaining proper background checks, including Nurse Aide Registry verification, prior to employing Nurse Aides.

All outside staffing agencies were contacted by the Business Operations Manager and confirmed with agency all employees are confirmed to be on the Iowa Nurse Aide Registry prior to assigning shifts at the facility. Employees hired by the facility will have their license reviewed by the Director of Human Resources and/or Department Director prior to employment. Department Director or designee will initial license eligibility is active.

The Administrator and/or designee will review any new staffing agency contracts to ensure contracted employees are listed on the Iowa Nurse Aide Registry prior to assigning shifts at the facility. The Administrator and/or designee will review all new employee files for eligibility on the Iowa Nurse Aide Registry and will report to the Quality Assurance team at least quarterly.

Date of Compliance 01/25/2017.

F 497 – NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE

Accept this as Fountain West Health Center's credible allegation of compliance.

Staff responsible for tracking mandatory CNA education was re-educated on 1/19/17 regarding the importance of monitoring staff education to assure that required hours have been completed. Staff in-services are offered monthly and it is the expectation that staff attend.

The Administrator and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 516 – RELEASE RES INFO. SAFEGUARD CLINICAL RECORDS

Accept this as Fountain West Health Center's credible allegation of compliance.

The medical records were moved to a secure location with access granted to only a select few needing entry.

Access is restricted and will be upheld by the Administrator and/or designee.

The Administrator and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of Compliance 01/25/2017.

F 520 – COMMITTEE0MEMBERS/MEET QUARTERLY/PLANS

Accept this as Fountain West Health Center's credible allegation of compliance.

The Quality Assurance Committee has been revised with a new agenda and minutes. Areas of concern identified at the time of survey, as well as concerns observed by staff and identified in Resident Council are being addressed by the committee.

These issues will continue to be monitored by the committee. Members include the Administrator, Director of Nursing, Department Heads, Dietician, Pharmacy Consultant and Medical Director as well as participation/ input from nurses, C.N.A.s, and other floor staff. The committee will meet monthly to address concerns/problems and to follow up on progress/compliance issues.

The Administrator and/or designee will monitor for compliance and the results will be reviewed by the Quality Assurance team.

Date of Compliance 01/25/2017.