STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165482	A. BUILDING _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED PRESBYTERIAN HOME	1203 EAST WASHINGTON STREET WASHINGTON, IA 52353

(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 Amended February 20, 2017 Correction date 2/23/17 The following deficiencies relate to the facility's annual health survey (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000	Plan of Correction 2/22/17 The preparation and execution of this Plan of Correction does not constitute an agreement by the U.P. Home of the interpretation of the rules and regulations set forth in this statement of deficiencies.	
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications), (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 157	F157 Residents #2 had physician updated 2/06/17; Resident #9 had seen the physician on 1/20/17 and the weight loss was noted by the physician at this time. A copy of this progress note was received by the facility. Resident #10 had seen the physician on 1/2/17 and the weight loss was noted by the physician. A copy of this progress note was received by the facility. Nursing will review a weight summary report weekly. Notifications to the physician for gains/losses of 5% in 30 day and 10% in 180 days will be completed. DON or Designee will audit weekly x 6 weeks that process for weight review and notification is completed. Results of audits will be reviewed through the Quality Analysis Improvement Committee. Compliance date: 2/23/17	

2/28/17 DMD

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 157	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to notify the physician of a change in condition for 3 of 13 residents reviewed (Resident #'s 2, 9, 10) The facility reported a census of 52 residents. Findings include. 1. The Minimum Data Set (MDS) assessment tool, dated 1/11/17, listed diagnoses for Resident #2 which included high blood pressure and atrial fibrillation (an abnormal heart rhythm). The MDS stated the resident required limited assistance of 1 staff for bed mobility and walking and extensive assistance of 1 staff for transfers, dressing, toilet use, personal hygiene, and bathing, and listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition.	F 157		

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F 157	Continued From page 2 The resident's Weights and Vital's Summary displayed the following weights and notations. July 2016 172.5 lbs (pounds) August 2016 176 lbs September 2016 176 lbs October 2016 175 5 lbs November 2016 176.5 lbs December 2016 178.5 lbs January 2017 169.5 lbs(-5.0% change) A 1/12/17 nutrition assessment stated the resident had a significant weight loss in the last 30 days most likely related to influenza A on 12/29/16 and stated the resident received a supplement and extra snacks The facility lacked documentation of physician notification of the resident's 5.0% weight loss between December 2016 and January 2017. A care plan entry, initiated 6/12/15, directed staff to report significant weight loss to the physician. 2. The MDS assessment tool, dated 11/23/16, listed diagnoses for Resident #9 which included non-Alzheimer's dementia and deficiency of other specified B group vitamins. The MDS stated the resident required setup assistance with eating, supervision assistance of 1 staff for bed mobility, transfers, toilet use, and personal hygiene, and extensive assistance of 1 staff for dressing and bathing. The MDS listed the resident's BIMS score as 8 out of 15, indicating moderately impaired cognition The resident's Weights and Vitals Summary listed the following dates and notations:	F 157		

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F 157	Continued From page 3 July 2016 150 lbs August 2016 152 5 lbs September 2016 145 lbs October 2016 150.5 lbs November 2016 144 lbs December 2016 147.5 lbs January 2017 135 lbs (-10.0% change in comparison to 8/8/16 weight of 152.2 lbs) The resident's Nutrition Assessment, dated 11/21/16, stated the resident currently weighed 144 lbs, a loss of 7 lbs or 4.6% in 30 days, 9 lbs or 5 8% in 90 days. The Registered Dietician recommended VHC (Very High Calorie) supplement 60 ml (milliliters) three times per day to provide additional calories and nutrition. The facility lacked documentation of physician notification of the resident's weight loss of 12 5 lbs between December 2016 and January 2017 and lacked documentation of additional dietary interventions other than the 11/21/16 supplement initiation. The resident's care plan, initiated 12/3/15, stated the resident had a potential nutritional problem related to dementia and stated the resident would maintain adequate nutritional status as evidenced by not having significant weight loss. The care plan directed staff to invite the resident to activities that promoted additional intake and to report significant weight gain or loss to the physician The care plan did not address the resident's actual weight loss or include any additional interventions to assist the resident in gaining weight. 3. The MDS assessment tool, dated 11/30/16, listed diagnoses for Resident #10 which included	F 157		

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F 157	Continued From page 4	F 157		

non-Alzheimer's dementia, anxiety, and depression. The MDS stated the resident required supervision assistance of 1 staff for walking, limited assistance of 1 staff for transfers and bed mobility, and extensive assistance of 1 staff for dressing, toilet use, personal hygiene, and bathing The MDS listed the resident's BIMS score as 7 out of 15, indicating severely impaired cognition.

The resident's Weights and Vitals Summary listed the following dates and notations:

May 2016	111 lbs
June 2016	108 lbs
July 2016	116 lbs
August 2016	125.5 lbs
September 2016	122.5 lbs
October 2016	131 lbs
November 2016	133 lbs
December 2016	134.5 lbs
January 2017	127 lbs 5.0% change

The facility lacked documentation of physician notification of the resident's 5.0% weight change between December 2016 and January 2017.

The resident's current care plan, revised 12/11/16, lacked documentation and interventions related to the resident's weight fluctuations in the last 8 months and 5.0% weight loss between December 2016 and January 2017

The facility undated Physician Notification policy stated staff must notify the physician when there was a significant change in the resident's physical status.

During an interview on 2/2/17 at 10:00 a.m , the Director of Nursing stated the facility did not have

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F 157	Continued From page 5 documentation of specific weight loss notifications to the physician but stated the physician recently visited the residents.	F 157		
F 241 SS=D	483 10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, the facility failed to provide privacy for a resident toileted in full view of the resident's roommate (Resident #2) and failed to treat a resident with dignity and respect for another resident (Resident #12) out of a total of 12 residents reviewed in the standard sample. The facility reported a census of 52 residents Findings include: 1. Resident #12's Minimum Data Set (MDS) annual assessment completed 12/14/16 identified the resident with the following diagnoses: Arthritis, Non-Alzheimer's Dementia and Seizure Disorder. It also identified the resident as cognitively aware with a brief interview for mental status (BIMS) score of 15 out of 15 and required extensive staff assistance with transfers, toileting, hygiene and bathing. The care plan with the target date of 3/23/17 identified the resident with the problem of being	F 241	Resident #12 was spoken to about the incident in question, as noted by the surveyors, on February 6, 2017 as well as the C.N.A. involved on the same day. The C.N.A. has been made aware of how she made the resident feel and coached on how to handle the resident per the care plan. C.N.A. and nursing staff education was completed on 2/23/17 on closing room doors or closing of bathroom curtains during toileting for resident privacy. DON or Designee will audit weekly x 6 weeks that staff are closing room doors and curtains when resident are toileted. Audits will be reviewed through the Quality Analysis Improvement Committee. Compliance date: 2/23/17	

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F 241	Continued From page 6 verbally bossy related to poor impulse control and directed the staff to: a. Assess the resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation b. Monitor behaviors each shift and as needed. Document observed behavior and attempted interventions c. Provide positive feedback for good behavior Emphasize the positive aspects of compliance d. Provide verbal reminders to let others make decisions about their own care as they have the right to make their own choices e. When the resident becomes agitated, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation. If response is aggressive toward staff, staff to walk calmly away and approach later. During an interview on 1/31/17 at 11:08 a.m., the resident reported on 1/30/17 during the night, the resident had a urinary tract infection and could not wait for the roommate to finish in the bathroom, became incontinent of urine and removed the incontinent brief as he/she did not like the feeling of having a wet brief against the skin while he/she waited for staff to answer the call light The CNA (Certified Nurse Assistant) entered the room, "yelled at me and asked 'what did you have to do that for?', this made me feel terrible!" In an interview on 2/1/17 at 6:05 a.m., Staff A, CNA, could not recall any incidents on 1/30/17 which involved Resident #12 being upset. She also reported that when residents are toileted, the	F 241		

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F 241	Continued From page 7 privacy curtain to the bathroom should be pulled closed. During an interview on 2/1/17 at 6:11 a.m., Staff B, CNA, could not recall any incidents on 1/30/17 which involved Resident #12 being upset. She also reported that when residents are toileted, staff should close the back of the resident's gown, the privacy curtain to the bathroom should be pulled closed and the door to the resident's room should be closed. In an interview on 2/1/17 at 7:07 a.m., Staff C, Licensed Practical Nurse, could not recall any incidents on 1/30/17 which involved Resident #12 being upset. She also reported that when residents are toileted, staff should ensure the privacy curtain to the bathroom is pulled closed During an interview on 2/1/17 at 10:52 a.m., Staff D, CNA, could not recall any incidents on 1/30/17 which involved Resident #12 being upset She also reported that when residents are toileted, staff should shut the door to the room and shut the curtain to the bathroom and close blinds to the windows. In an interview on 2/1/17 at 1:18 p.m., Staff E, CNA, reported the resident had a history of incontinence waiting for the roommate to finish using the shared toilet. During an interview on 2/1/17 at 1:18 p.m., Staff F, CNA, reported the resident to be a reliable historian and usually did not have problems with incontinence. 2. The MDS assessment tool, dated 1/11/17,	F 241		

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F 241	Continued From page 8 listed diagnoses for Resident #2 which included high blood pressure and atrial fibrillation (an abnormal heart rhythm). The MDS stated the resident required limited assistance of 1 staff for bed mobility and walking and extensive assistance of 1 staff for transfers, dressing, toilet use, personal hygiene, and bathing, and listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition. During an observation on 1/31/17 at 9:31 a.m., Staff F, CNA, cleansed the resident's back while the resident sat on the toilet. The curtain was open between the resident's bathroom and the resident's room. The resident's roommate was standing in the room facing the bathroom and the resident sitting on the toilet while talking to Staff F. The curtain remained open for approximately 1 minute before the Activity Director walked in and pulled the curtain shut. Staff F assisted the resident with additional personal cares and then left the room to get supplies and left the curtain half open. The resident then urinated in the toilet with the curtain half open while the resident's roommate remained in the room facing the bathroom. During an interview on 2/1/17 at 4:20 p.m., the Director of Nursing stated staff should close the curtain in between the bathroom and the resident's room to ensure privacy.	F 241		
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the	F 279	For residents #3, 4, 9, 10, 11 and all similarly situated residents, care plan will be revised as needed to meet identified needs from the Care Area Assessments triggered by the MDS. For new admissions, a preliminary care plan will be completed upon admission. Within 14	

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F 279	Continued From page 9 results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483 10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483 40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483 10(c)(6) (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record (iv)In consultation with the resident and the resident's representative (s)-	F 279	days a admission MDS will be completed. Based on the admission MDS assessment and completion of CAA's care plan interventions will be initiated based on the individual residents needs by day 21 after admission. DON or Designee will audit weekly x 6 weeks all new admissions have a preliminary care plan addressed as part of admission ; admission MDS and CAA's completed and a care plan placed by day 21 that addressed the individuals needs. All audits will be reviewed through the Quality Analysis Improvement Committee. Chapter 50.7 was reviewed by the Administrator, Director of Nursing and Social Services Director in regards to major incident reporting. Compliance date: 2/23/17	

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F 279	Continued From page 10 (A) The resident's goals for admission and desired outcomes (B) The resident's preference and potential for future discharge Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by. Based on observation, record review, and interview, the facility failed to develop comprehensive care plans with individualized interventions for 5 of 13 residents reviewed (Resident #3, #4, #9, #10 and #11). The facility reported a census of 52 residents. Findings 1. The MDS(Minimum Data Set) assessment tool, dated 12/7/17, listed diagnoses for Resident #3 included malignant neoplasm(cancer) of other specified sites and primary generalized osteoarthritis(inflammation of the bone and joint). The MDS stated the resident required supervision assistance of 1 staff for transfers and personal hygiene, supervision assistance for walking in the hall, limited assistance of 1 staff for dressing, and extensive assistance of 1 staff for bathing and listed the resident's BIMS(Brief Interview for Mental Status) score as 15 out of 15, indicating intact cognition.	F 279		

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F 279	Continued From page 11 During an observation on 1/31/17 at 9:59 a.m., Staff J and Staff K placed a gait belt on the resident and assisted the resident to stand from a shower chair, pivot, and sit on the bed A 11/23/16 fall incident report stated the resident reached into the closet and lost his/her balance, went down on the knees, but lifted himself/herself up The resident did not sustain an injury. A 1/19/17 fall incident report stated the resident reported to the nurse he/she fell and bit through the lip The resident stated he/she attempted to stand, had a sharp pain, lost his/her balance, and hit his/her lip on the walker. The report stated the resident's lower lip was swollen, split open, and bleeding. The facility's post-fall intervention listed on the incident report stated staff would remind the resident to call for assistance with transfers and walking. A 1/21/17 fall follow-up report stated the resident ambulated with assistance of 1 staff and a wheeled walker The resident's current care card, provided to the surveyor on 1/31/17 at 2:30 p.m. listed the resident's level of assistance needed as "SBA of 1". A key at the bottom of the form stated "SBA-Stand by assist, requires no gait belt" The resident's care plan, revised 3/10/16 stated the resident walked per self with a walker. The facility lacked documentation of an updated care card or care plan to reflect the resident's recent change in condition and requirement of additional transfer assistance.	F 279		

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F 279	Continued From page 12 During the initial tour on 1/30/17 at 9:30 a.m., the Director of Nursing stated the resident was a transfer assist of 1 staff. During an interview on 1/31/17 at 2:30 p.m., the Director of Nursing gave the surveyor a copy of the current care cards she referred to as "cheat sheets" She stated staff referred to these sheets to determine how a resident transferred. During an interview on 2/1/17 at 4:20 p.m., the Director of Nursing stated she would expect care plans to be up to date She stated Resident #3 had a decline since his/her fall where he/she bit his/her lip and currently required the assistance of 1 staff with a gait belt 2. The MDS(Minimum Data Set) assessment tool, dated 12/20/16, listed diagnoses for Resident #4 included diabetes, neuropathy(a condition causing pain, numbness, and reduced sensation), and non-pressure chronic ulcer of other part of unspecified foot with unspecified severity. The MDS stated the resident required extensive assistance of 1 staff for personal hygiene, extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use, and depended totally on 2 staff for bathing The MDS stated the resident was at risk of developing pressure ulcers and had 1 unstageable pressure ulcer with suspected deep tissue injury. The MDS listed the resident's BIMS(Brief Interview for Mental Status) score as 15 out of 15, indicating intact cognition. The resident's Admission Record listed an admit date of 12/13/16 with admission diagnoses	F 279		

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UNITED PRESBYTERIAN HOME	1203 EAST WASHINGTON STREET WASHINGTON, IA 52353

(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 279	Continued From page 13 included Type 2 diabetes, neuropathy, and non-pressure chronic ulcer of other part of unspecified foot with unspecified severity. The Skin Risk Assessment, dated 12/13/16(the resident's admission date), stated the resident had a chronic ulcer under the right great toe and listed the resident's skin risk as low. The document contained no other information related to additional skin concerns upon admission Skilled charting for 12/14/16 stated the resident had no open skin areas on the left or right foot/toes, protecting area on left outer metatarsal(top middle portion of the foot). a. A Skin Observation Tool, dated 12/20/16, stated staff noted a blood blister on the left heel, blister intact, Tegaderm(a transparent film dressing) applied for protection, heels floated in bed, staff informed to avoid all pressure, including shoes and socks and to float heels at all times. Measurements(in length x width x depth)= 2 cm(centimeters) x 3.4 cm x "unmeas". The stage was listed as "suspected deep tissue injury" defined as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. A Skilled Charting entry, dated 12/20/16, stated the resident's heels were flat on the bed, blood blister noted to left heel 2 cm x 3.4 cm, heels floated at this time. The resident's January MAR(Medication Administration Record) displayed a 12/21/16	F 279		

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F 279	Continued From page 14 order for Tegaderm for protection to blister on left heel, check every shift for placement. A Skin Observation Tool, dated 12/27/16, listed the left heel measurements as 3 3 cm x 4.8 cm x "unmeas". A Skin Observation Tool, dated 1/3/17, listed 2 measurements for the left heel 1 6 cm x 1.6 cm x "unmeas" and 2.8 cm x 3.6 cm x 0.1 cm. The document stated the left heel blister was broken and the top skin came off, no inflammation or drainage, center of blistered area darkened, not black at this time, floating heels and no shoes when in recliner/room. A Skilled Charting entry, dated 1/4/17, stated the dark area on the left heel was larger and the resident had no dressing covering the wound. A Skin Observation Tool, dated 1/4/17, listed measurements for the center of the left heel as 2.6 cm x 1.8 cm x "unmeas" and described the center as "black". The document listed the left heel measurement as 3 cm x 2 cm x 0.1 cm. The document stated the center of the left heel changed since 1/3/17, area black and firm. A 1/4/17 physician's order sheet listed the following orders. a. Strict pressure precautions b Blue boot cushion or similar c. Pad foot of recliner d. Egg crate to bed e. No shoes, daily dressing changes to left foot f. Keep wound clean and dry The MDS assessment tool, dated 1/10/17, stated the resident was was at risk of developing	F 279		

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F 279	Continued From page 15 pressure ulcers and had 2 unstageable pressure ulcers with suspected deep tissue injury. A Skin Observation Tool, dated 1/11/17 listed measurements for the black center of the left heel as 3 cm x 2.5 cm x "unmeas" and listed the left heel measurements as 4 cm x 3 cm x "unmeas". A 1/13/17 physician's order sheet listed an order for Levaquin(an antibiotic) 500 mg(milligrams) x 10 days, monitor left heel for infection. A Skin Observation Tool, dated 1/18/17, listed 1 set of measurements for the left heel described as "black eschar(dead tissue)": 2 2 cm x 3 cm x" unmeas". The document stated the left heel pressure round center was blackened, dry, and firm. A Skin Observation Tool, dated 1/25/17, listed measurements for the left heel as 2.2 cm x 3 cm x "unmeas". During an observation on 1/31/17 at 10:40 a.m., Staff H LPN(Licensed Practical Nurse) measured an area of black eschar on the resident's heel at 3 cm x 2 cm. The surveyor noted an odor coming from the wound The facility lacked any documentation of the odor coming from the wound during the surveyor observation b. A Skin Observation Tool, dated 12/27/16, stated the facility noted a small scratch to the top of the left great toe measuring 0.2 cm x 0 4 cm x 0.1 cm and listed the stage as N/A(Not available)	F 279		

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F 279	Continued From page 16 A Skin Observation Tool, dated 1/3/17, described the area to the top left great toe as a scratch/pressure and categorized the area as a Stage 2 described as partial thickness loss of dermis(skin) presenting as a shallow open ulcer with a red pink wound bed. The document listed the measurements as 0 2 cm x 0.2 cm x 0.1 cm A Skin Observation Tool, dated 1/4/17, listed measurements for the top left great toe as 0 2 cm x 0.2 cm x 0.1 cm. A Skin Observation Tool, dated 1/11/17, listed measurements for the top left great toe as 0.3 cm x 0.3 cm x "unmeas". A Skin Observation Tool, dated 1/18/17, listed measurements for the top left great toe as 0 cm x 0 cm x 0 cm and described the area as a dry open scab with slight indentation. A Skin Observation Tool, dated 1/25/17, stated the pressure area on the left great toe resolved, dry flaky skin present. During an observation on 1/31/17 at 10:40 a.m , Staff H LPN measured a pink/red area on the resident's left great toe at 3 cm x 2 cm. The facility lacked documentation of the wound worsening between the 1/25/17 note stating the wound had resolved and the surveyor observation on 1/31/17 with measurements of 3 cm x 2 cm. The initial resident care plan, dated 12/13/16, directed staff to reposition the resident every 2 hours and provide treatment per physician's orders The care plan lacked documentation of additional specific interventions to prevent the	F 279		

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F 279	Continued From page 17 development of pressure ulcers including floating the heels A care plan entry, dated 12/23/16, stated the resident had actual impairment to skin integrity of the left heel related to suspected deep tissue injury. Care plan entries, dated 1/2/17 stated the resident required the following interventions: a Assistance of staff to turn and reposition in bed every 2 hours and as necessary. b. Skin inspection during bathing and as needed, observe for redness, open areas, scratches, cuts, bruises, report changes to the nurse. Care plan entries, dated 1/3/17, stated the resident required the following interventions: a. A pressure relieving/reducing mattress on the bed to protect the skin while in bed b. Float heels while in bed Care plan entries, dated 1/4/17, stated the resident required the following interventions: a. Provide 1 ounce liquid protein twice per day b. Resident is not to wear shoes at this time c. Pressure reducing boots while in bed A care plan entry, dated 1/31/17, stated the resident required an air flow pressure reduction mattress. The care plan lacked documentation of interventions implemented related to the prevention and treatment of the resident's pressure ulcer prior to 1/3/17 During an interview on 2/1/17 at 10:30 a.m., the Assistant Director of Nursing stated she found the	F 279		

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F 279	Continued From page 18 blister on the resident's heel. She stated when she found the blister the resident had his/her heel dug into the mattress. She said it looked like his heel was floated but he pushed the pillow away. During an interview on 2/1/17 at 4:20 p.m the Director of Nursing stated the resident was "absolutely" at risk for skin breakdown upon admission. She stated staff were to float the resident's heels but is "questioning" whether that was done consistently. She stated she would have expected interventions to be on the care plan prior to 1/3/17 and stated in the future, she would assign the staff members to the same residents for the purpose of consistency of care. 3. The MDS assessment tool, dated 11/23/17, listed diagnoses for Resident #9 included non-Alzheimer's dementia and deficiency of other specified B group vitamins. The MDS stated the resident required setup assistance with eating, supervision assistance of 1 staff for bed mobility, transfers, toilet use, and personal hygiene, and extensive assistance of 1 staff for dressing and bathing The MDS listed the resident's BIMS score as 8 out of 15, indicating moderately impaired cognition The resident's Weights and Vitals Summary listed the following dates and notations July 2016 150 lbs(pounds) August 2016 152.5 lbs September 2016 145 lbs October 2016 150.5 lbs November 2016 144 lbs December 2016 147.5 lbs January 2017 135 lbs (-10.0% change in comparison to 8/8/16 weight of 152.2 lbs)	F 279		

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F 279	Continued From page 19 The resident's Nutrition Assessment dated 11/21/16, stated the resident currently weighed 144 lbs, a loss of 7 lbs or 4.6% in 30 days, 9 lbs or 5.8% in 90 days The Registered Dietician recommended VHC (Very High Calorie) supplement 60 ml (milliliters) three times per day to provide additional calories and nutrition The facility lacked documentation of physician notification of the resident's weight loss of 12.5 lbs between December 2016 and January 2017 and lacked documentation of additional dietary interventions other than the 11/21/16 supplement initiation. The resident's care plan, initiated 12/3/15, stated the resident had a potential nutritional problem related to dementia and stated the resident would maintain adequate nutritional status as evidenced by not having significant weight loss The care plan directed staff to invite the resident to activities that promote additional intake and to report significant weight gain or loss to the physician The care plan did not address the resident's actual weight loss or include any additional interventions to assist the resident in gaining weight 4. The MDS assessment tool, dated 11/30/16, listed diagnoses for Resident #10 which included non-Alzheimer's dementia, anxiety, and depression. The MDS stated the resident required supervision assistance of 1 staff for walking, limited assistance of 1 staff for transfers and bed mobility, and extensive assistance of 1 staff for dressing, toilet use, personal hygiene, and bathing. The MDS listed the resident's BIMS	F 279		

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F 279	Continued From page 20 score as 7 out of 15, indicating severely impaired cognition The resident's Weights and Vitals Summary listed the following dates and notations. May 2016 111 lbs June 2016 108 lbs July 2016 116 lbs August 2016 125 5 lbs September 2016 122.5 lbs October 2016 131 lbs November 2016 133 lbs December 2016 134 5 lbs January 2017 127 lbs 5.0% change The facility lacked documentation of physician notification of the resident's 5.0% weight change between December 2016 and January 2017 The resident's current care plan, revised 12/11/16, lacked documentation and interventions related to the resident's weight fluctuations in the last 8 months and 5.0% weight loss between December 2016 and January 2017. During an interview on 2/1/17 at 4:20 p.m., the Director of Nursing stated she expected care plans to be up to date. Resident #11's MDS assessment completed 1/11/17 identified the resident with the following diagnoses other fracture, Non-Alzheimer's Dementia and Parkinson's Disease. It also identified the resident with severe cognitively impairment and required staff assistance with all activities of daily living. The care plan dated 11/3/16 identified the resident with the problem of activities of daily living self-care deficit and directed staff to:	F 279		

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F 279	Continued From page 21 a. Provide standby assist of one with use of walker for ambulation when he/she is seen up b. Provide standby assist of one for transfers when seen up c Provide extensive assist of one for toileting A review of the nurse's notes and incident report revealed the following 12/31/16 at 6:08 a.m. doctor notified of the resident's fall and obtained an order to send to the emergency room via ambulance and obtain a head CT 12/31/16 at 6:05 p m. late entry - resident's roommate calling out for help. Resident found on the floor. Roommate reported the resident stood up on the bed to hang a picture and fell The resident's daughter had been notified. The resident had been sent to the hospital per ambulance. 12/31/16 at 8:05 p m. Director of nursing notified of the fall 1/4/17 at 2:11 p.m. the resident returned from an admission to the hospital where he/she had been since 12/31/16 after sustaining a fall with loss of consciousness, had right and left cerebral hemorrhages (bleeding in the brain), multiple right sided fractures and right clavicle (collar bone) fracture. Also had a Miami J collar to wear at all times, to receive physical and occupational therapy and transferred from the wheelchair to the toilet with the assist of one. A review of the discharge summary revealed the resident was admitted to the emergency department on 12/31/16, admitted to the local hospital, later transferred to the university hospital and discharged on 1/4/17 with the reason for admission - trauma and principal diagnosis of subarachnoid hemorrhage.	F 279		

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F 279	Continued From page 22 (bleeding in the area between the brain and the tissues that cover the brain). The hospital course included orthopedic and neurosurgery consults. A review of the care plan with the target date of 2/8/17 did not address the fall which occurred on 12/31/16, the need for the need to wear the Miami J (neck) collar or the need for physical and occupational therapy services. A review of an Incident Report (fall/injury monitor) revealed the resident fell again on 1/17/17 at 6:15 p m. which resulted in a 3 centimeter hematoma to the left posterior part of the resident's head.	F 279		
F 314 SS=G	483 25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide appropriate	F 314	United Presbyterian Home will ensure that a resident who enters the facility without a pressure ulcer does not develop a pressure ulcer unless the individuals clinical condition demonstrates that they were unavoidable; and that a resident having a pressure ulcer receives the necessary treatment and services to promote healing, prevent infection, and prevent new pressure ulcers from happening unless the resident clinical condition demonstrates this is unavoidable. Resident #4 has a wound to the Left heel, unstageable that is being assessed weekly by nursing. The wound area to the left great toe was healed on 1/25/16. Pressure reducing measures were documented within the wound care records and nurse's notes. United Presbyterian home will assess all residents upon admission and	

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F 314	Continued From page 23 care and treatment to prevent new sores from developing 1 of 2 residents reviewed with pressure ulcers (Resident #4) The facility reported a census of 52 residents. Findings include. 1. The Minimum Data Set (MDS) assessment tool, dated 12/20/16, listed diagnoses for Resident #4 included diabetes, neuropathy (a condition causing pain, numbness, and reduced sensation), and non-pressure chronic ulcer of other part of unspecified foot with unspecified severity The MDS stated the resident required extensive assistance of 1 staff for personal hygiene, extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use, and depended totally on 2 staff for bathing The MDS stated the resident was at risk of developing pressure ulcers and had 1 unstageable pressure ulcer with suspected deep tissue injury. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition. The resident's Admission Record listed an admit date of 12/13/16 with admission diagnoses included Type 2 diabetes, neuropathy, and non-pressure chronic ulcer of other part of unspecified foot with unspecified severity. The Skin Risk Assessment, dated 12/13/16 (the resident's admission date), revealed the resident had a chronic ulcer under the right great toe and listed the resident's skin risk as low. The document contained no other information related to additional skin concerns upon admission. Skilled charting for 12/14/16 documented the resident had no open skin areas on the left or	F 314	with each MDS for risk of developing a pressure ulcer and employ pressure reducing interventions as appropriate. Care plans will be updated with pressure reducing interventions as needed based on skin risk assessment and resident's status. DON or Designee will monitor that all new admission have a skin risk assessment completed upon admission and with each MDS weekly x 6 weeks. Results of audits will be reviewed through the Quality Analysis Improvement Committee. Compliance date: 2/16/17	

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F 314	Continued From page 24 right foot/toes, protecting area on left outer metatarsal (top middle portion of the foot). a. A Skin Observation Tool, dated 12/20/16, revealed staff noted a blood blister on the left heel, blister intact, Tegaderm(a transparent film dressing) applied for protection, heels floated in bed, staff informed to avoid all pressure, including shoes and socks and to float heels at all times Measurements (in length x width x depth) = 2 cm (centimeters) x 3.4 cm x "unmeas" The stage was listed as "suspected deep tissue injury" defined as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue A Skilled Charting entry, dated 12/20/16, documented the resident's heels were flat on the bed, blood blister noted to left heel 2 cm x 3.4 cm, heels floated at this time. The resident's January MAR (Medication Administration Record) displayed a 12/21/16 order for Tegaderm for protection to blister on left heel, check every shift for placement. A Skin Observation Tool, dated 12/27/16, listed the left heel measurements as 3.3 cm x 4.8 cm x "unease". A Skin Observation Tool, dated 1/3/17, listed 2 measurements for the left heel: 1.6 cm x 1.6 cm x "unmeas" and 2.8 cm x 3.6 cm x 0.1 cm. The document stated the left heel blister was broken and the top skin came off, no inflammation or drainage, center of blistered area darkened, not	F 314		

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F 314	Continued From page 25 black at this time, floating heels and no shoes when in recliner/room A Skilled Charting entry, dated 1/4/17, identified the dark area on the left heel was larger and the resident had no dressing covering the wound. A Skin Observation Tool, dated 1/4/17, listed measurements for the center of the left heel as 2.6 cm x 1.8 cm x "unmeas" and described the center as "black". The document listed the left heel measurement as 3 cm x 2 cm x 0.1 cm The document stated the center of the left heel changed since 1/3/17, area black and firm. A 1/4/17 physician's order sheet listed the following orders: a. Strict pressure precautions b. Blue boot cushion or similar c. Pad foot of recliner d Egg crate to bed e. No shoes, daily dressing changes to left foot f Keep wound clean and dry The MDS assessment tool, dated 1/10/17, revealed the resident was at risk of developing pressure ulcers and had 2 unstageable pressure ulcers with suspected deep tissue injury. A Skin Observation Tool, dated 1/11/17 listed measurements for the black center of the left heel as 3 cm x 2 5 cm x "unmeas" and listed the left heel measurements as 4 cm x 3 cm x "unmeas". A 1/13/17 physician's order sheet listed an order for Levaquin (an antibiotic) 500 mg (milligrams) x 10 days, monitor left heel for infection A Skin Observation Tool, dated 1/18/17, listed 1	F 314		

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F 314	Continued From page 26 set of measurements for the left heel described as "black eschar (dead tissue)": 2.2 cm x 3 cm x" unmeas". The document stated the left heel pressure round center was blackened, dry, and firm. A Skin Observation Tool, dated 1/25/17, listed measurements for the left heel as 2 2 cm x 3 cm x "unmeas". During an observation on 1/31/17 at 10:40 a.m , Staff H, Licensed Practical Nurse (LPN) measured an area of black eschar on the resident's heel at 3 cm x 2 cm. The surveyor noted an odor coming from the wound The facility lacked any documentation of the odor coming from the wound during the surveyor observation b. A Skin Observation Tool, dated 12/27/16, identified the facility noted a small scratch to the top of the left great toe measuring 0.2 cm x 0 4 cm x 0.1 cm and listed the stage as N/A(Not available). A Skin Observation Tool, dated 1/3/17, described the area to the top left great toe as a scratch/pressure and categorized the area as a Stage 2 described as partial thickness loss of dermis (skin) presenting as a shallow open ulcer with a red pink wound bed. The document listed the measurements as 0.2 cm x 0 2 cm x 0.1 cm. A Skin Observation Tool, dated 1/4/17, listed measurements for the top left great toe as 0.2 cm x 0.2 cm x 0 1 cm.	F 314		

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F 314	Continued From page 27 A Skin Observation Tool, dated 1/11/17, listed measurements for the top left great toe as 0 3 cm x 0.3 cm x "unmeas". A Skin Observation Tool, dated 1/18/17, listed measurements for the top left great toe as 0 cm x 0 cm x 0 cm and described the area as a dry open scab with slight indentation. A Skin Observation Tool, dated 1/25/17, stated the pressure area on the left great toe resolved, dry flaky skin present During an observation on 1/31/17 at 10:40 a.m., Staff H LPN measured a pink/red area on the resident's left great toe at 3 cm x 2 cm. The facility lacked documentation of the wound worsening between the 1/25/17 note stating the wound had resolved and the surveyor observation on 1/31/17 with measurements of 3 cm x 2 cm The initial resident care plan, dated 12/13/16, directed staff to reposition the resident every 2 hours and provide treatment per physician's orders. The care plan lacked documentation of additional specific interventions to prevent the development of pressure ulcers including floating the heels A care plan entry, dated 12/23/16, stated the resident had actual impairment to skin integrity of the left heel related to suspected deep tissue injury Care plan entries, dated 1/2/17 stated the resident required the following interventions: a. Assistance of staff to turn and reposition in bed every 2 hours and as necessary	F 314		

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F 314	Continued From page 28 b. Skin inspection during bathing and as needed, observe for redness, open areas, scratches, cuts, bruises, report changes to the nurse. Care plan entries, dated 1/3/17, stated the resident required the following interventions a. A pressure relieving/reducing mattress on the bed to protect the skin while in bed b Float heels while in bed Care plan entries, dated 1/4/17, stated the resident required the following interventions· a. Provide 1 ounce liquid protein twice per day b Resident is not to wear shoes at this time c. Pressure reducing boots while in bed A care plan entry, dated 1/31/17, stated the resident required an air flow pressure reduction mattress. The care plan lacked documentation of interventions implemented related to the prevention and treatment of the resident's pressure ulcer prior to 1/3/17. The care plan did not identify any problems related to the resident's refusing to wear the boot or refusing to float heels. During an interview on 2/1/17 at 10:30 a.m., the Assistant Director of Nursing stated she found the blister on the resident's heel. She stated when she found the blister the resident had his/her heel dug into the mattress. She said it looked like his/her heel was floated but he/she pushed the pillow away. During an interview on 2/1/17 at 4:20 p m. the Director of Nursing stated the resident was "absolutely" at risk for skin breakdown upon	F 314		

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F 314	Continued From page 29 admission. She stated staff were to float the resident's heels but is "questioning" whether that was done consistently She stated she would have expected interventions on the care plan prior to 1/3/17 and stated in the future, she would assign the staff members to the same residents for the purpose of consistency of care.	F 314		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible, and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 323	Resident #11 received physical therapy from 1/6/17 to 2/13/17. She was released by P.T. to be up ad lib in her room, which returned her to her prior level of function. To ensure the safety of all residents, Chapter 50.7 was reviewed by the Administrator, Director of Nursing and Social Services Director in regards to major incident reporting. Major Incident Reporting policy was updated to state that if any resident is admitted to a higher level of care after a fall, the Administrator, Director of Nursing and Social Services Director will investigate the fall, review the reporting form, care plan and most recent MDS to determine independent status per Chapter 50.7. If determined the resident was not independent then the Social Services Director or designee will report the incident online. All residents will continue to have a fall risk assessment completed upon admission and with each MDS. Based on the fall risk assessment, care plan interventions to minimize the risk of falls will be planned. Referrals will be	

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F 323	Continued From page 30 facility failed to provide adequate nursing supervision to protect against hazards from self. others or hazards in the environment for 1 of 3 residents reviewed who experienced falls (Resident #11). The resident sustained injuries which included right and left cerebral hemorrhages, multiple rib fractures, and a right clavicle fracture. The facility reported a census of 52 residents. Findings include: 1 According to the Minimum Data Set (MDS) assessment tool dated 1/11/17, Resident #11 had diagnoses of: non-Aizheimer's dementia. other fracture. and Parkinson's disease. It also identified the resident displayed severe cognitive impairment and required staff assistance with all Activities of Daily Living (ADLs). The resident's care plan initiated on 1/10/16 identified the resident experienced impaired cognitive function and thought processes related to impaired decision making with a goal that indicated the resident would remain oriented to self and spouse The care plan also identified the resident displayed an Activities of Daily Living (ADL) deficit and was at risk for falls. The care plan directed staff· a. Anticipate and meet the resident's needs. b. Resident #11 utilized a walker for ambulation (walking). c. Provide standby assist of one staff with use of walker for ambulation when he/she is seen up.	F 323	made to PT and OT as appropriate. PT and OT will issue therapy alerts to alert staff when assistance levels change. DON or Designee will audit weekly x 6 weeks that all new resident have a fall risk assessment completed upon admission and with each MDS and that staff are appropriately adhering to fall interventions. Audits will be reviewed through the Quality Analysis Improvement Committee. Compliance date: 2/16/17	

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F 323	Continued From page 31 d Provide standby assist of one staff for transfers when seen up. e. Provide extensive assist of one staff for toilet use f. Cue, reorient and supervise as needed. g. Present just one thought, idea, question, or command at a time h. Be sure the call light is in reach and encourage the resident to use it. i. Apply bed alarm at bedtime and throughout the night to alert staff when he/she is up so staff may check on and assist the resident (added 1/22/16) j Falls are expected as Resident #11 is not aware of his/her deficits. The resident is able to get down on the floor and he/she often does this to clean floors, baseboards, organize closets and pick up items from the floor. (revised 2/11/16) A Fall/Injury Monitor- Suspected Head Injury form dated 12/31/16 at 6 05p m. revealed the resident's roommate called for help. Staff entered the room and found the resident on the floor on the roommate's side of the room in front of the roommate's recliner with the left side of his/her face against the floor and the rest of the body in the prone position. The resident's feet pointed toward the head of the bed and the rest of his/her body angled toward the doorway of the room. Staff documented the resident's right lower leg lay over the bottom of the resident's tray table with water from the cup on the tray on the floor. The nurse called the resident's name with no response. Vitals signs as follows: Temperature	F 323		

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F 323	Continued From page 32 97 5, P 63 Respirations 16. Blood Pressure 160/100 and Oxygen Saturation 95% on room air The staff documented the resident began to open their eyes and was able to provide the nurse with their daughter's name. The resident sustained a quarter-sized hematoma to the forehead and when the nurse slid a hand under the resident's head on the left side blood was noted. Another staff member had been directed to notify the physician and the writer of the report stayed with Resident #11 until the ambulance arrived. At that time, the resident's roommate reported the resident stood on the bed to hang a picture and fell and hit his/her head Progress Notes dated 12/31/16 at 6:08a m revealed staff documented they notified the physician of the resident's fall and obtained an order to transfer. Progress Notes dated 1/4/17 at 2:11 p m., revealed the resident returned from an admission to the hospital where he/she had been since 12/31/16 after sustaining a fall with loss of consciousness. The resident sustained right and left cerebral hemorrhages, multiple right sided fractures and a right clavicle fracture. Resident #11 had an order for a Miami J (neck) collar to wear at all times, and physical and occupational therapy. Staff documented the resident transferred from the wheelchair to the toilet with the assist of one staff. A review of the discharge summary revealed the resident was admitted to the emergency department on 12/31/16, admitted to the local hospital, later transferred to the university hospital and discharged on 1/4/17 with the reason for admission - trauma and principal diagnosis of	F 323		

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F 323	Continued From page 33	F 323		

subarachnoid hemorrhage (bleeding in the area between the brain and the tissues that cover the brain) The hospital course included orthopedic and neurosurgery consults.
The care plan with the target date of 2/8/17 failed to contain any information related to the resident's fall which occurred on 12/31/16, the Miami J collar, or the need for physical and occupational therapy services

The Progress Notes contained the following entries.

a On 1/10/17 at 9.30p.m. staff found the resident crawling out of bed. Staff assisted him/her to the wheelchair, took the resident to the dining room and gave him/her a snack.

b On 1/15/17 at 12:25 a m. the Resident #11 stood up from his/her low bed and walked into neighbor's room where staff provided care. The alarm did not sound Staff documented the resident walked with no problems and staff escorted the resident back to his/her own room. Staff then took the resident to the bathroom.

c On 1/15/17 at 2:21 p.m , the CNA found the resident standing in his her room with the chair alarm in the recliner with his/her lunch tray. The staff attempted to remove the lunch tray and the resident grabbed the tray and would not let go. The RN documented the CNA called for help and RN responded and witnessed the resident with one hand on the tray and water pitcher and another on the walker. The resident poured water on the tray and floor and staff assisted him/her to the recliner and cleaned up the water Staff then assisted Resident
#11 to the wheelchair with the chair alarm alarm

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F 323	Continued From page 34 and took him/her to the common area by the nurse's station. d On 1/16/17 at 5:45a.m., Staff found the resident's alarm sounding without the resident in the room. They found the resident under the table in main dining room wiping the floor. Staff brought the resident his/her walker and the resident stood up without help, returned to his/her room and went to sleep. f. On 1/20/17 at 5:17a.m., Staff documented they found the resident under the table in main dining room The resident stood up alone with the walker and staff assisted him/her back to bed. g. On 1/21/17 at 12:15 a m. the resident sat at the nurse's station in the wheelchair eating a snack and reading the paper. The resident stood up and began to walk without his/her walker Staff attempted to assist the resident to their room, but the resident was non-compliant and resisted Staff attempted 3 more times and the resident went back to bed. A review of an incident report (fall/injury monitor) revealed the resident fell again on 1/17/17 at 6:15p.m. which resulted in a 3 centimeter hematoma to the left posterior part of the resident's head. In an interview on 2/1/17 at 3:14p.m., Staff G, CNA reported on 12/31/16 the resident's roommate called out for help and reported the resident had attempted to hang a picture on the wall while standing on the bed and fell on the floor. Prior to the fall, the resident had a bed alarm at night and could be up ad lib in the room,	F 323		

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F 323	Continued From page 35 however, if out in the hallway required standby assistance The resident had been found on the floor, unresponsive, sent to the hospital by ambulance and in the hospital for a few days Staff G reported the resident fell a few more times after returning from the hospital and required the assistance of one person for transfers and ambulation, low bed and now a chair alarm. During an interview on 2/1/17 at 3:26 p m., Staff I, RN reported prior to the fall on 12/31/16 the resident required the assistance of one staff member with walker when the resident had been seen up On 12/31/16, staff found the resident on the floor with a small amount of blood noted to the back of the head and unresponsive. Staff sent the resident to the hospital by ambulance. When the resident returned to the facility he/she received skilled services and continued to do so Staff I stated now the resident is care planned to transfer with assist of one with gait belt and walker and has a bed and a chair alarm. The resident had some falls after he/she returned from the hospital. As a result of one of the falls, Resident #11 sustained a hematoma to the back of the head. Staff G reported the resident now required a lot of one-on-one assistance A review of the undated facility policy titled' fall prevention directed staff to. a. Interview the resident and family upon admission to determine if there is a history of falls. Attempt to identify times, locations and what the resident was attempting to do when they fell	F 323		

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F 323	Continued From page 36 b. Establish interventions based on the RAP information to eliminate or decrease the resident's risk and/or causative factors. Identify these on the resident's plan of care and the CNA care guide. c. After each fall, complete the falls assessment record. Look for trending. Identify the possible reason for the fall and make appropriate changes to the plan of care.	F 323		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise, (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to create and carry out interventions for 2 of 3 residents reviewed with a significant weight loss (Resident #'s 9, 10) The facility reported a census of 52 residents	F 325	Residents #2 had physician updated 2/06/17; Resident #9 had seen the physician on 1/20/17 and the weight loss was noted by the physician at this time. A copy of this progress note was received by the facility. Resident #10 had seen the physician on 1/2/17 and the weight loss was noted by the physician. A copy of this progress note was received by the facility. Nursing will review a weight summary report weekly. Notifications to the physician for gains/losses of 5% in 30 day and 10% in 180 days will be completed. DON or Designee will audit weekly x 6 weeks that process for weight review and notification is completed. Results of audits will be reviewed through the Quality Analysis Improvement Committee. Compliance date: 2/23/17	

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F 325	Continued From page 37 Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 11/23/17, listed diagnoses for Resident #9 which included non-Alzheimer's dementia and deficiency of other specified B group vitamins. The MDS stated the resident required setup assistance with eating, supervision assistance of 1 staff for bed mobility, transfers, toilet use, and personal hygiene, and extensive assistance of 1 staff for dressing and bathing. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 8 out of 15, indicating moderately impaired cognition. The resident's Weights and Vitals Summary listed the following dates and notations. July 2016 150 lbs (pounds) August 2016 152.5 lbs September 2016 145 lbs October 2016 150.5 lbs November 2016 144 lbs December 2016 147.5 lbs January 2017 135 lbs (-10 0% change in comparison to 8/8/16 weight of 152.2 lbs) The resident's Nutrition Assessment, dated 11/21/16, stated the resident currently weighed 144 lbs, a loss of 7 lbs or 4 6% in 30 days, 9 lbs or 5.8% in 90 days. The Registered Dietician recommended VHC (Very High Calorie) supplement 60 ml (milliliters) three times per day to provide additional calories and nutrition The facility lacked documentation of physician notification of the resident's weight loss of 12.5 lbs between December 2016 and January 2017 and lacked documentation of additional dietary	F 325		

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F 325	Continued From page 38 interventions other than the 11/21/16 supplement initiation. The resident's care plan, initiated 12/3/15, stated the resident had a potential nutritional problem related to dementia and stated the resident would maintain adequate nutritional status as evidenced by not having significant weight loss. The care plan directed staff to invite the resident to activities that promoted additional intake and to report significant weight gain or loss to the physician. The care plan did not address the resident's actual weight loss or include any additional interventions to assist the resident in gaining weight. 2 The MDS assessment tool, dated 11/30/16, listed diagnoses for Resident #10 which included non-Alzheimer's dementia, anxiety, and depression. The MDS stated the resident required supervision assistance of 1 staff for walking, limited assistance of 1 staff for transfers and bed mobility, and extensive assistance of 1 staff for dressing, toilet use, personal hygiene, and bathing. The MDS listed the resident's BIMS score as 7 out of 15, indicating severely impaired cognition. The resident's Weights and Vitals Summary listed the following dates and notations: May 2016 111 lbs June 2016 108 lbs July 2016 116 lbs August 2016 125 5 lbs September 2016 122 5 lbs October 2016 131 lbs November 2016 133 lbs December 2016 134.5 lbs January 2017 127 lbs 5.0% change	F 325		

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F 325	Continued From page 39 The facility lacked documentation of physician notification of the resident's 5.0% weight change between December 2016 and January 2017. The resident's current care plan, revised 12/11/16, lacked documentation and interventions related to the resident's weight fluctuations in the last 8 months and 5.0% weight loss between December 2016 and January 2017 During an interview on 2/2/17 at 10:00 a.m., the Director of Nursing stated the facility did not have documentation of specific weight loss notifications to the physician but stated the physician recently visited the residents.	F 325		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483 70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff.	F 353	Call light policy was revised 2/16/17. C.N.A. and nursing staff call light education completed 2/23/17. There has been an identified issue with the call lights not clearing out when staff push to clear. A new service provider for the nurse call system was contacted on 2/19/17 due to lack of response from current provider. Verified this is a known problem with the call light system. Vendor is scheduled to come out 3/9/16 to address this issue with the call light system. A letter had to be issued out to the nurse call vendor by UPH approving a new service provider before work can be done on the system. Letter was sent to new vendor on 2/20/17. DON or Designee will complete call light	

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	165482	A. BUILDING _____ B. WING _____	02/02/2017

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F 353	Continued From page 40 (a)(1) 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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by. Based on resident, family and staff interviews and record review, the facility failed to answer call lights in a timely manner for 11 out of 12 residents reviewed in the standard sample (Residents #1, #2, #3, #4, #5, #6, #7, #8, #10 #11 and #12). The facility reported a census of 52 residents. Findings include: 1 Resident #5's Minimum Data Set (MDS)	F 353	audits weekly per the current policy. Results will be reviewed through the quality Assurance improvement committee.	

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F 353	Continued From page 41 annual assessment completed 11/16/16 had documentation of the following diagnoses: coronary artery disease, diabetes mellitus and chronic obstructive pulmonary disease It also identified the resident with a brief interview for mental status score of 14 out of 15 indicating intact memory and required extensive staff assistance with most activities of daily living. The care plan with the target date of 12/23/17 identified the resident with the following problems Activities of daily living self-care deficit At risk for falls Constipation Urinary tract infection Use of antidepressant medication Potential nutritional problem Pain Potential psychosocial well-being problem Potential impairment to skin integrity Indwelling catheter Occasional shortness of breath During an interview on 1/31/17 at 8:22 a.m., the resident reported having to wait as long as an hour to get the call light answered and happened on all 3 shifts. The resident wore a wristwatch to be able to track the time lapsed. In an interview on 2/1/17 at 1:18 p.m., Staff E, Certified Nurse Aide (CNA), reported Resident #5 to be a reliable historian and had complained that he/she had to wait as long as 30 minutes to get the call light answered. She also reported there were two call light systems, the old system is a call light plugged into the wall. Most of them light up above the door, but some are missing parts where they don't all light up. But all call lights on that system show up on a box at the nurse's	F 353		

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F 353	Continued From page 42	F 353		

station. Staff would have to go to the nurse's station to check to see which resident called. If the resident uses the new system where they use a pendant or a watch To cancel the call light on the new system, staff have to hold the button down for at least 3 seconds. She was unsure if residents might be able to cancel their own lights.

During an interview on 2/1/17 at 1:42 p.m., Staff E, CNA, reported the resident would have to press the new call light button continuously for 7 minutes in order to cancel the light.

A review of the call light records from 1/18/17 through 2/1/17 revealed the call light on greater than 15 minutes a total of 27 times, ranging from 17 minutes to 2 hours and 25 minutes with 13 occurrences during first shift and 14 occurrences during second shift and an average time of 38 minutes.

2. Resident #6's MDS quarterly assessment completed 12/21/16 had documentation of the following diagnoses: hypertension (high blood pressure) and malignant neoplasm (a new and abnormal growth of tissue in some part of the body, especially as a characteristic of cancer)to the ascending colon.

The care plan with the target date of 3/22/17 identified the resident with the following problems
Activities of daily living self-care deficit
Impaired cognitive function
Hypertension (high blood pressure)
Dental care
Receives levothyroxine
At risk for falls
Treated for anemia
Urinary tract infections

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F 353	Continued From page 43 Mood/behavior problems Acute pain related to cancer Potential impairment to skin integrity Hospice care A review of the call light records from 1/18/17 through 2/1/17 revealed the call light had been on greater than 15 minutes a total of 5 times, ranging from 16 minutes to 1 hour and 18 minutes with 3 occurrences during first shift and 2 occurrences during second shift and an average time of 47 minutes. 3. Resident #7's MDS admission assessment completed 12/28/16 had documentation of the following diagnoses: Parkinson's Disease, other fracture and repeated falls. It also identified the resident as cognitively impaired and required extensive staff assistance with most activities of daily living. The care plan with the target date of 4/6/17 identified the resident with the following problems: Activities of daily living self-care deficit Communication problem Impaired cognitive function History of falls Occasional constipation Potential nutritional problem Parkinson's Disease affecting gait/balance Potential impairment to skin integrity Requires assistance with toileting A review of the call light records from 1/18/17 through 2/1/17 revealed the call light on greater than 15 minutes a total of 38 times, ranging from 16 minutes to 1 hour and 48 minutes with 16 occurrences during first shift, 19 occurrences during second shift, 3 occurrences during third	F 353		

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F 353	Continued From page 44 shift and an average time of 39 minutes. 4. Resident #8's MDS quarterly assessment completed 12/7/16 had documentation of the following diagnoses: Non-Alzheimer's Dementia, depression and spinal stenosis (a condition where the spinal canal starts to narrow). It also identified the resident as cognitively impaired and required extensive staff assistance with all activities of daily living. The care plan with the target date of 3/7/17 identified the resident with the following problems: Activities of daily living self-care deficit Behavior problem of calling out to staff Hypertension (high blood pressure) Delirium/impaired cognitive function Denture pain Falls History of urinary tract infections Arthritis Receives Trazadone Potential nutritional problem Chronic pain related to osteoarthritis Potential mood/psychosocial well-being problem Potential impairment to skin integrity Bladder incontinence Impaired visual function related to glaucoma A review of the call light records from 1/18/17 through 2/1/17 revealed the call light on greater than 15 minutes a total of 6 times, ranging from 19 minutes to 48 minutes with 1 occurrence during the first shift and 5 occurrences during the second shift and with an average time of 48 minutes. 5 Resident #11's Minimum Data Set significant	F 353		

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F 353	Continued From page 45 change assessment completed 1/11/17 had documentation of the following diagnoses: other fracture, Non-Alzheimer's Dementia and Parkinson's Disease. It also identified the resident with severe cognitive impairment with a brief interview for mental status score of 2 out of 15 and required staff assistance with all activities of daily living. The care plan with the target date of 2/8/17 identified the resident with the following problems: Activities of daily living self-care deficit High risk for wandering Delirium/impaired cognitive function Falls Receives Seroquel Diuretic therapy Potential nutritional problem Impaired skin integrity Urinary incontinence A review of the call light records from 1/18/17 through 2/1/17 revealed the call light on greater than 15 minutes a total of 9 times, ranging from 19 minutes to 63 minutes with 4 occurrences during the first shift and 5 occurrences during the second shift and with an average time of 32 minutes. 6. Resident #12's MDS annual assessment completed 12/14/16 had documentation of the following diagnoses: arthritis, Non-Alzheimer's Dementia and seizure disorder. It also identified the resident as cognitively intact with a brief interview for mental status score of 15 out of 15 and required extensive staff assistance with transfers, dressing and bathing	F 353		

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F 353	Continued From page 46 The care plan with the target date of 3/23/17 identified the resident with the following problems: Activities of daily living self-care deficit Poor impulse control Delirium/impaired cognitive function Oral health problems related to gingivitis At risk for falls Constipation related to decreased mobility History of urinary tract infections Pain Potential nutritional problem Seizure disorder Potential for impairment to skin integrity Complex bladder incontinence A review of the call light records from 1/18/17 through 2/1/17 revealed the call light on greater than 15 minutes a total of 5 times, ranging from 19 minutes to 44 minutes with 1 occurrence during the first shift, 2 occurrences during the second shift, 1 occurrence during third shift and with an average time of 34 minutes During an interview on 1/31/17 at 11:08 a.m., the resident reported having to wait as long as 30 minutes to get the call light answered, usually happens on 3rd shift and wore a wrist watch to be able to track the time lapsed. In an interview on 2/1/17 at 6:05 a.m., Staff A, CNA, reported call lights should be answered within 10 to 15 minutes. During an interview on 2/1/17 at 6:11 a.m., Staff B, CNA, reported call lights should be answered within 15 minutes. In an interview on 2/1/17 at 7:07 a.m., Staff C, Licensed Practical Nurse (LPN) reported staff	F 353		

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F 353	Continued From page 47 have 15 minutes to answer a call light, that there were 2 different call light systems. There are pull buttons in the resident rooms The Elpas system comes through pagers to both CNAs and nurses. If a resident pushed on a Elpas button too long, it could cancel the call light During an interview on 2/1/17 at 1:18 p.m., Staff F, CNA, reported there is a call light system where the call light up shows up above the door and also shows up and rings at the nurse's station. The watch and pendant system work by showing up on phones which the CNAs carry. The nurses don't carry those phones, however, they can check the computer at the nurse's station to see which resident turned on the call light. In an interview on 2/1/17 at 3:53 p m., the Director of Nursing (DON) reported she expected staff to answer the call lights within 15 minutes. The old system involves having a call light from the wall. Elpas is the pendant system We have QA'd (quality assurance meetings) the call light issues. Right now Elpass system calls go through all the pagers and on the nurses' laptop. If any calls out more than 15 minutes the DON will receive a notification via internal e-mail. She had followed up with those and have found out the staff forgot to reset the pendants The resident can reset and cancel the call by holding it more than a few seconds. She spoke to the vendor who then gave provided phones in addition to the pagers to receive the calls from the residents She had concerns because the old system has the adaptable call light and currently less than 10 residents use the old system. She also reported the vendor for the new system had stopped answering the facility's calls. The facility	F 353		

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F 353	Continued From page 48 had contracted with a new company. There are plans to eliminate the old system once the new company comes in. She also reported she wanted this to be implemented within the next year as a new building should have construction completed in the fall. A review of the facility policy titled. Call Light and last updated 3/18/14 had documentation of the following. Responsibility of all staff. CNAs are to monitor lights outside of the hallway as well as calls on the tablets. The nursing staff are to have EV2 program open on laptops to monitor the Elpas system. The Director of Nursing will receive e-mails regarding all 15 minute escalations with the Elpas system. Procedure: a. Always answer the light promptly. Anyone can and should assist with answering call lights. Do not wait until the nursing assistant for that specific hall or resident is available. Work as a team. b. Respond to the emergency lights immediately c. Turn the call light off or cancel the call on the Elpas pendant so staff are aware that the light has been answered. 7. The MDS assessment tool, dated 11/16/16, listed diagnoses for Resident #1 which included high blood pressure and osteoarthritis (inflammation of the bones and joints). The MDS stated the resident required supervision assistance of 1 staff member for transfers and personal hygiene, extensive assistance of 1 staff for toilet use, dressing, and bathing, and extensive assistance of 2 staff for bed mobility. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition.	F 353		

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F 353	Continued From page 49 The resident's call light log from 1/18/17-2/1/17 listed 27 instances of the call light response time exceeding 15 minutes, with the response time ranging from 16 minutes to 1 hour 32 minutes A care plan entry, initiated 9/13/13 stated staff should encourage the resident to receive assistance with peri-care and cleaning. A 12/13/15 entry directed staff to encourage the resident to utilize the call light to call for assistance 8. The MDS assessment tool, dated 1/11/17, listed diagnoses for Resident #2 which included high blood pressure and atrial fibrillation (an abnormal heart rhythm). The MDS stated the resident required limited assistance of 1 staff for bed mobility and walking and extensive assistance of 1 staff for transfers, dressing, toilet use, personal hygiene, and bathing, and listed the resident's BIMS score as 14 out of 15, indicating intact cognition. The resident's call light log from 1/18/17-2/1/17 listed 12 instances of the call light response times exceeding 15 minutes, with the response time ranging from 16 minutes to 3 hours 21 minutes. A care plan entry, revised 3/8/16, stated there resident required assistance with toileting A care plan entry, initiated 6/12/15, stated the resident was at low risk for falls and staff assisted to lessen falls with major injury. The care plan directed staff to anticipate the resident's needs and place the call light within reach and encourage the resident to utilize it for assistance	F 353		

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F 353	Continued From page 50 9 The MDS assessment tool, dated 12/7/17, listed diagnoses for Resident #3 which included malignant neoplasm (cancer) of other specified sites and primary generalized osteoarthritis(inflammation of the bone and joint). The MDS stated the resident required supervision assistance of 1 staff for transfers and personal hygiene, supervision assistance for walking in the hall, limited assistance of 1 staff for dressing,a and extensive assistance of 1 staff for bathing and listed the resident's BIMS score as 15 out of 15, indicating intact cognition. The resident's call light log from 1/18/17-2/1/17 listed 18 instances of the call light response time exceeding 15 minutes, with the response time ranging from 16 minutes to 55 minutes. A 1/19/17 fall incident report stated the resident reported to the nurse he/she fell and bit through the lip The resident stated he/she attempted to stand, had a sharp pain, lost his/her balance and hit his/her lip on the walker. The report stated the resident's lower lip was swollen, split open, and bleeding The facility's post-fall intervention listed on the incident report stated staff would remind the resident to call for assistance with transfers and walking. A care plan entry, initiated 4/18/14 stated the resident was at moderate risk of falls. A 8/10/16 intervention stated the facility educated the resident to call for assistance with transfers and walking if not feeling well. 10. The MDS assessment tool, dated 12/20/16, listed diagnoses for Resident #4 which included diabetes, neuropathy (a condition causing pain, numbness, and reduced sensation), and	F 353		

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F 353	Continued From page 51 non-pressure chronic ulcer of other part of unspecified foot with unspecified severity The MDS stated the resident required extensive assistance of 1 staff for personal hygiene, extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use, and depended totally on 2 staff for bathing. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition. The resident's call light log from 1/18/17-2/1/17 listed 40 instances of the call light response time exceeding 15 minutes, with the response time ranging from 17 minutes to 1 hour 3 minutes. Care plan interventions, initiated 1/2/17, stated the resident required staff assistance for toilet use and transfers and directed staff to encourage the resident to utilize the call light to call for assistance. 11. The MDS assessment tool, dated 11/30/16, listed diagnoses for Resident #10 included non-Alzheimer's dementia, anxiety, and depression. The MDS stated the resident required supervision assistance of 1 staff for walking, limited assistance of 1 staff for transfers and bed mobility, and extensive assistance of 1 staff for dressing, toilet use, personal hygiene, and bathing. The MDS listed the resident's BIMS score as 7 out of 15, indicating severely impaired cognition. The resident's call light log from 1/18/17-2/1/17 listed 3 instances of the call light response time exceeding 15 minutes, with the response time ranging from 26 minutes to 41 minutes. A care plan entry, initiated 6/13/16, stated the	F 353		

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F 353	Continued From page 52 resident required assistance by 1 staff with personal hygiene and directed staff to encourage the resident to utilize the call light to call for assistance.	F 353	The plan of correction constitutes my credible allegation of compliance. All deficiencies and or materials needed to meet code will be completed as of 3/3/17.	

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 101	50.7(1) 481- 50.7 (10A,135C) Additional notification. 481-50 7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III). 50.7(1) Of any accident causing major injury. a. " Major injury " shall be defined as any injury which: (1) Results in death, or (2) Requires admission to a higher level of care for treatment, other than for observation, or (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a " major injury " based upon the circumstances of the accident, the previous functional ability of the resident, and the resident ' s prognosis. b. The following are not reportable accidents (1) An ambulatory resident, as defined in rules 481-57 1(135C), 481-58 1(135C), and 481-63.1(135C), who falls when neither the facility nor its employees have culpability related to the fall, even if the resident sustains a major injury, or (2) Spontaneous fractures; or (3) Hairline fractures. This Statute is not met as evidenced by: Based on staff interview and record review the facility failed to report a major injury to the Iowa Department of Inspections and Appeals as	N 101	Resident #11 received physical therapy from 1/6/17 to 2/13/17. She was released by P.T. to be up ad lib in her room, which returned her to her prior level of functioning. Care plans will be revised as needed to meet identified needs from the Care Area Assessments triggered by the MDS. Chapter 50.7 was reviewed by the Administrator, Director of Nursing and Social Services Director in regards to major incident reporting. Compliance date: 2/16/17	

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0946	A. BUILDING _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 101	Continued From page 1 required for 1 of 3 residents reviewed who experienced falls. (Resident #11). The facility identified a census of 52 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment tool dated 1/11/17, Resident #11 had diagnoses. other fracture, non-Alzheimer's dementia and Parkinson's disease. It also identified the resident as severely cognitively impaired and revealed the resident required staff assistance with all activities of daily living. The care plan dated 11/3/16 identified the resident with the problem of activities of daily living self-care deficit and directed staff to. a. Provide standby assist of one staff with use of walker for ambulation (walking) when he/she is seen up b Provide standby assist of one staff for transfers when seen up c. Provide extensive assist of one staff for toilet use A review of the nurse's notes revealed the following entries a. On 12/31/16 at 6:08 a.m. staff documented they notified the physician of the resident's fall and obtained an order to send him/her to the emergency room via ambulance and obtain a head CT b. On 12/31/16 at 6:05 p m (late entry), the resident's roommate called for help Staff entered the room and found the resident on the floor. Resident #11's roommate reported the resident stood on the bed to hang a picture and	N 101		

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N 101	Continued From page 2 fell. Staff notified the resident's family member and sent the resident to the hospital by ambulance. c. On 12/31/16 at 8:05 p.m., Staff notified the Director of Nursing (DON) of the fall d. On 1/4/17 at 2:11 p.m., the resident returned from an admission to the hospital where he/she had been since 12/31/16 after sustaining a fall with loss of consciousness. The resident sustained right and left cerebral hemorrhages, multiple right sided fractures and a right clavicle fracture. Resident #11 had an order for a Miami J (neck) collar to wear at all times, and physical and occupational therapy. An interview on 2/1/17 at 2:25 p.m. with the State Agency (SA) revealed the facility last reported a major injury in September of 2016. In an interview on 2/1/17 at 3:26 p.m., Staff I, RN reported she sent the physician the determination of major injury form, but did not follow-up on whether or not the physician had completed and returned the form. She thought the Director of Nursing (DON) was responsible for that. During an interview on 2/1/17 at 3:53 p.m., the DON reported when a resident had a major injury, staff reported it to her and then sent a major determination to the doctor for completion. She stated the staff needed to follow up and call if the physician did not send the form back in a timely manner. The administrative staff discussed whether or not to self-report it to the SA. The DON reported she did not self-report the injury to the SA because she thought the resident had been independent, but felt the injuries the resident sustained had been major injuries. She	N 101		

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N 101	Continued From page 3 stated she had waited to see what the doctor wrote on the determination of major injury form. She also stated she should have followed up on the form A review of the 7/13/12 facility policy titled Major Injury Definition/Reporting directed staff a major injury is to be defined as an injury which: a Results in death, or b. Requires admission to a higher level of care for treatment, other than for observation, or c. Requires consultation with the attending physician, designee of the physician, or physician extender who determines in writing on a form designated by the department, that an injury is a "major injury" based upon the circumstances of the accident, the previous functional ability of the resident, and the resident's prognosis. d. The director or the director's designee shall be notified within 24 hours or the next business day by the most expeditious means available	N 101	The plan of correction constitutes my credible allegation of compliance. All deficiencies and or materials needed to meet code will be completed as of 3/3/17.	