STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	C 07/26/2017

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F 000	INITIAL COMMENTS Correction date 8/17/17 V KK 8/17/17 The following deficiencies were identified during investigation of incident #68703 & #69354 and complaint #68613 & #69250. (See Code of Federal Regulations (42CFR0, Part 483, Subpart B - C).	F 000		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/17/2017

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 309	Continued From page 1 (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and resident, staff, family, physician and ombudsman interviews, the facility failed to contact the attending physician immediately after one resident out of three sustained a head injury after a fall (Resident #6). The facility reported a census of 46 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 6/5/17 documented diagnoses that included dementia, anxiety, depression, schizophrenia, atrial fibrillation, unsteadiness on their feet, a history of falling, difficulty walking and other lack of coordination. The assessment documented Resident #6 had long and short term memory problems and severely impaired cognitive skills for daily decision making. The resident experienced signs and symptoms of delirium, including inattention and disorganized thinking. According to the MDS, Resident #6 experienced delusions and s/he wandered daily. The MDS documented Resident #6 received daily antipsychotic, antianxiety, antidepressant, anticoagulation and diuretic medications. Resident #6 fell twice with injury and once without injury since the previous assessment. The facility form #527 Fall dated 7/9/17 at 4:50	F 309		

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F 309	Continued From page 2 p.m. documented staff found Resident #6 on the floor by the Service Aid at 2:45 p.m. According to the document, Resident #6 sustained a 3 cm (centimeter) x 0.5 cm laceration to the back of the head with minimal blood loss. Staff A, RN (Registered Nurse) documented he notified the doctor at 4:51 p.m. A fax Correspondence between Staff A and Resident #6's physician dated 7/9/17 noted receipt of an order at 6:31 p.m. to send Resident #6 to the emergency room (ER) for possible stitches and X-ray or CT (computerized tomography) of the resident's head. A Nurses Noted dated 7/9/17 at 6:33 p.m. and authored by Staff A documented that he called the doctor to notify him of the head laceration Resident #6 sustained during a fall. According to Staff A, orders had been obtained to send the resident to ER for possible stitches and or CT of the head. A Nurses Note dated 7/9/17 at 7:05 p.m. noted Resident #6 transported to the ER by a family member. A Nurses Note dated 7/10/17 at 3:24 a.m. recorded Resident #6 had 3 staples in the back of his/her head to approximate (close) the skin. A Nurses Note dated 7/11/17 at 4:10 p.m. and authored by the DON (Director of Nursing) indicated she spoke with Resident #6's family about concerns they had about the way staff handled Resident #6 after the 7/9/17 fall and head injury. The DON noted she obtained information from her staff that indicated Resident #6's physician had not been readily available due	F 309		

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F 309	Continued From page 3 to being at a funeral visitation. An interview on 7/18/17 at 8:20 a.m. with the Ombudsman revealed that she had been contacted by Resident #6's family. According to the Ombudsman, the family had multiple complaints. As a resident advocate, the Ombudsman said she contacted Resident #6's physician and relayed the family's concerns. She said the doctor agreed, there should not have been a delay in transporting the resident to the ER. The Ombudsman said she did not know if the doctor specified how Resident #6 should have been transported. An interview on 7/18/17 at 10:50 a.m. with the DON revealed Staff A related what happened following the 7/9/17 fall that caused Resident #6 to sustain a head injury. According to the DON, Staff A called the doctor and had to leave a message because he was at a funeral visitation in Des Moines. During interview on 7/18/17 at 3:30 p.m. with Staff A stated he had been processing the paper work from two previous falls when the Service Aid informed him he found Resident #6 bleeding while lying on the floor of his/her room. Staff A said he went to the resident's room to complete an assessment. According to the RN, a CNA (certified nursing assistant) applied pressure to the laceration on the back of the resident's head using some wash cloths. Staff A stated he initiated neurological checks and vital signs and these checked out fine. Staff A stated the resident's wound measured about 3 cm long and Resident #6 tried to get up, so he realized the resident had full range of motion (ROM). Staff A stated he left Resident #6 with the CNAs while he	F 309		

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F 309	Continued From page 4 went to do paperwork for the third incident. Staff A said he left a message for the DON and the Assistant ADON. Staff A stated he called and spoke to Resident #6's physician right after the third fall. He said he obtained telephone orders to send Resident #6 to the ER by ambulance for a CT (medical imaging) or X-ray of the head and sutures as needed. On 7/19/17 at 9:00 a.m. Resident #6's physician stated his expectations are for staff to follow his order to send a resident to ER. According to the physician, he remembered getting a call from the facility on 7/9/17, but could not recall the time. The doctor said they reported Resident #6 sustained a head injury from a fall and h/she remained stable. The physician said he told them to send the resident to ER right away, but did not specify the mode of transportation. When asked, the doctor said when he said right away, he meant in a reasonable amount of time. The physician said once the paper work and all the particulars that needed to accompany the resident had been generated, he expected the resident to be out the door within 15 to 30 minutes. An interview on 7/19/17 at 9:20 a.m. with Staff F, LPN revealed she reported for her shift at about 6:00 p.m. on 7/9/17. Staff F stated Staff A reported Resident #6 fell and gashed his/her head. Staff F stated Staff A told her he notified the doctor of the resident's fall by fax (facsimile). Staff F stated that since the bleeding started again, she told Staff A to call the doctor for orders. Staff F said Staff A then called the doctor immediately and obtained an order to have Resident #6 sent to ER for a CT (medical imaging) and evaluation for treatment. Staff F	F 309		

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F 309	Continued From page 5 said Resident #6 returned to the facility with 3 staples in the back of his/her head. Staff F stated they are supposed to get ahold of the doctor right away any time a resident gets injured, no matter how minor. Staff F felt upset when she walked into work and realized Staff A had only faxed the doctor and not called him. Staff F said a fax would only be appropriate if a fall did not result in an injury. An interview on 7/19/17 at 12:45 p.m. with DON revealed a fax to the doctor is sufficient if the fall did not result in an injury. The DON said if an injury is sustained, no matter how small, even if an injury is suspected, the doctor needs to be notified. According to the DON, she considered Resident #6's head laceration an injury when the doctor should have been contacted right away. An interview on 7/26/17 at 4:10 p.m. with the Corporate Nurse revealed the doctor should be contacted as soon as possible after a fall with a head injury.	F 309		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision 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	F 323		

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F 323	Continued From page 6 must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide adequate supervision to one out of three residents (Resident #6); and failed to ensure safe transfers for 2 of 3 residents (Resident #5 and Resident #4). Record review revealed Resident #6 had a history of falls and on 7/9/16 the resident fell 3 times. The resident demonstrated signs of an unsteady gait and fell at 2:50 p.m., and 3:15 p.m., and again at 4:45 p.m., requiring sutures for a head laceration. The facility failed to use an appropriate sized gait belt for safe transfers for (Resident #5); and failed to pull up a disposable brief from around Resident #4's knees while assisting the resident with walking from their bedside to the bathroom. The facility reported a census of 46 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 6/5/17 documented Resident #6 had	F 323		

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F 323	Continued From page 7 diagnoses of dementia, anxiety, depression, schizophrenia, atrial fibrillation, unsteadiness on feet, history of falling, difficulty walking and lack of coordination. The MDS also noted Resident #6 had long and short term memory problems and a severely impaired cognitive status with inattention and disorganized thinking. According to the MDS, Resident #6 had delusions and wandered on a daily basis. The MDS documented Resident #6 received antipsychotic, antianxiety, antidepressant, anticoagulation and diuretic medications and had two or more falls with injuries since being admitted to the facility. The care plan noted Resident #6 exhibited signs of confusion, depression and being confused to person, place and time of day, which contributed to anxiety. According to the Care Plan, staff should allow Resident #6 to ambulate around the facility, check on him/her frequently and intervene as needed for safety. According to the revision dated 1/13/14, Resident #6 has a history of urinary tract infections (UTI). The Care Plan indicated that changes in usual routines and diminished functional abilities should be observed and reported. Resident #6 ambulates independently throughout the facility. The 1/30/17 revision instructed staff to intervene and attempt to lower Resident #6 to the floor if they observed a fall in progress. According to the 2/26/17 revision, when Resident #6 appeared to be tired, staff should sit with the resident in his/her room in hopes h/she falls asleep. On 7/9/17 staff received education about not following Resident #6 too closely while they are supervising him/her. According to the 3/18/17 Care Plan, Resident #6 receives diuretic medication, which may cause dizziness, fatigue and an increased risk for falls.	F 323		

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F 323	Continued From page 8 Record review revealed eleven falls were documented on the resident's Care Plan between 2/26/17 and 7/23/17. A document titled #482 Fall and dated 4/14/17 at 12:32 a.m. noted the nurse saw Resident #6 walk/running down the hall. According to the documentation, as the nurse prepared to tell him/her to slow down, she saw Resident #6 trip and fall to the floor. A document titled #491 Fall and dated 5/14/17 at 11:00 a.m. noted that Resident #6 had a "ground level" fall and sustained a 2.5 centimeter (cm) laceration to the back of the head. A document titled #517 Fall and dated 6/27/17 at 11:57 a.m. noted that as a CNA assisted Resident #6 with cares, h/she made movements ("stutter stepping") that indicated h/she might fall. According to the document, the CNA prevented the fall by guiding the resident to the floor. A Nurses Note dated 6/28/17 at 11:00 a.m. noted Resident had increased wandering. A document titled #525 Fall and dated 7/9/17 at 3:03 p.m. noted that Resident #6 had been walking in the hall when staff witnessed him/her stop for a brief moment and then went to his/her knees. A document titled #526 Fall and dated 7/9/17 at 3:16 p.m. noted that staff witnessed Resident #6 fall again at 3:10 p.m. A document titled #527 Fall and dated 7/9/17 at 4:50 p.m. noted that Resident #6 had been found on the floor by the Service Aid.	F 323		

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F 323	Continued From page 9 According to the document, Resident #6 sustained a 3 cm x 0.5 cm laceration to the back of the head. A Nurses Note dated 7/9/17 at 6:33 p.m. revealed staff contacted the physician due to Resident #6's falls and laceration to back of head, the physician gave orders for possible stiches and head CT (computed tomography). At 7:05 p.m. noted Resident #6 had been transported to the ER by a family member. At 7/9/17 at 10:22 p.m. Resident #6 returned to the facility. A Nurses Note dated 7/10/17 at 3:24 a.m. noted Resident #6 had 3 staples in the back of his/her head to approximate (close) the skin. A Nurses Note dated 7/11/17 at 3:49 a.m. noted Resident #6 had been up ambulating independently earlier in the shift. A Nurses Note dated 7/12/17 at 2:01 a.m. noted Resident #6 had gotten out of bed and started walking around. A document titled #535 Fall and dated 7/19/17 at 2:47 a.m. noted that the nurse heard a loud thump in the living area. According to the document, the Aide said "come into the living area". The nurse documented she found Resident #6 on the floor in a fetal position crying. According to the author, once vital signs had been obtained, Resident #6 immediately started to walk off. A Nurses Note dated 7/21/17 at 12:49 a.m. noted Resident #6 had been up walking in facility by him/herself.	F 323		

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F 323	Continued From page 10 A Nurses Note dated 7/22/17 at 1:19 a.m. noted Resident #6 continued on 15 minute checks and had been walking up and down the halls. A Nurses Note dated 7/23/17 at 2:17 a.m. noted Resident #6 had been up walking most of the shift and continued to be on 15 minute checks to prevent falls. A document titled #538 Fall and dated 7/23/17 at 5:36 p.m. noted that Resident #6 had been on 15 minute checks. According to the document, a CNA heard a loud thump and the resident crying. The nurse documented the CNA found the resident on the floor bleeding from his/her nose, forehead and possibly mouth. Resident #6 cried immediately after the fall and staff called 911. The nurse was unable to obtain a good pupil reaction due to the resident kept his/her eyes closed. The emergency department report dated 7/23/17 documented Resident #6 sustained a laceration on his/her forehead, closed fracture of nasal bone and head injury. A Nurses Note dated 7/24/17 at 3:34 p.m. noted that Resident #6 walked throughout the facility and continued on 15 minute checks. Documents titled "Resident #6 15 Minute Check" and dated 7/21/17 through 7/26/17 had been submitted to verify checks had been done. When asked for a policy on safe transfers, the DON provided the agenda she used to evaluate staff's clinical skills on 1/27/17. Transfer with gait belts had been included on the agenda.	F 323		

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F 323	Continued From page 11 An observation on 7/19/17 at 1:25 p.m. revealed the following. As this surveyor worked in room #206, the door handle turned and Resident #6 entered the room unsupervised. The resident appeared very confused. After about 30 seconds, a CNA walked past the room. The CNA seemed to be preoccupied and did not notice Resident #6 standing in the doorway of another room (206). Without disturbing Resident #6, this surveyor alerted the CNA and intervened at this surveyor's prompt. Resident #6 had been redirected out of room #206. An interview on 7/18/17 at 1:00 p.m. with Staff G, CNA, revealed her description of a movement Resident #6 typically made that sometimes preceded a fall and indicated the resident should be monitored for unsteadiness. Staff G said she worked 7/9/17 when Resident #6 fell three times. The CNA said h/she did this "jerking thing" that caused him/her to become unsteady. The CNA said it reminded her of someone seizing up and thought it might be possible to prevent at least some of his/her falls if someone had been monitoring the resident closely enough. According to the CNA, Resident #6 had been exhibiting those signs more than usual that day. Staff G said Resident #6 had days h/she did not do it at all and other days when h/she does it once in a while. The CNA said Resident #6 had been doing it about every 5 minutes all day long while h/she was awake on 7/9/17. According to the CNA, Resident #6's first two falls on 7/9/17 happened as a result of his/her "jerking". Staff G said "I know because I was standing right there." The CNA said that although her back had been turned, the housekeeper witnessed one of them and said the "jerking thing" caused the fall.	F 323		

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F 323	Continued From page 12 According to Staff G, the housekeeper could not intervene, so the fall could not be prevented. Staff G said they do not have enough staff to assign someone to walk with Resident #6 all the time. Staff G said they were able to prevent other falls that day because they were able to steady Resident #6 six or seven other times h/she exhibited the same signs between the first fall and the third fall. According to Staff G, there were only 3 CNAs and 2 nurses in the facility that day. Staff G said Staff A told them "I hate to do it to you guys, but I have to pull one of you to watch Resident #6." The CNA said Staff A asked another CNA to stay with Resident #6 in his/her room until h/she fell asleep after the 2nd fall. According to Staff G, once the resident fell asleep the other CNA left the resident's room. Staff G said after the other CNA left Resident #6's room, the Service Aid reported to the nurse at about 4:45 p.m. that he found Resident #6 on the floor of his/her room bleeding from his/her head. The CNA said once Staff A assessed Resident #6 and got him/her cleaned up, they laid the resident back down. Staff G said another CNA stayed with the resident until after 6:00 p.m. at which time the Service Aid provided one to one supervision. According to Staff G, she believed the falls might have been prevented if someone had been with Resident #6 the whole time. The CNA said they are not staffed well enough to do that. Staff G said that included the bath aid and RA, which only left three CNAs on the floor about 90% of the time. According to Staff G, there were only two CNAs on the floor from 2:00 p.m. to 6:00 pm about 35% of the time because of high school kids and people calling in. Staff G said there are also times when only two people are scheduled from 2:00 p.m. to 6:00 p.m. because they cannot get anyone to work. The CNA spoke of Mulberry	F 323		

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F 323	Continued From page 13 Hall having six people that needed to be transferred by Hoyer lifts. According to the CNA, if someone supervised Resident #6 all the time, there would only be two CNAs left on the floor. The CNA continued by saying if someone that required a Hoyer needed help, nobody except the nurses and CMAs would be left, and some of them are not as good about helping as others. Staff G said she thought the facility would retaliate against her for saying so, but she would rather protect Resident #6 than herself. An interview on 7/18/17 at 3:30 p.m. with Staff A revealed his observations of Resident #6 after h/she awakened on 7/9/17. According to the RN, he could immediately tell the resident would probably have a bad day because h/she demonstrated "jerky motions" h/she sometimes makes that causes him/her to be unsteady. Staff A said "it wasn't a matter of if h/she would fall, but a matter of when h/she would fall." The RN said because he anticipated it happening he told the CNA's he needed to get his charting and treatments done in preparation for when Resident #6 fell. According to Staff A, shortly after saying that, the housekeeper informed him that she attempted to lower Resident #6 to the floor as h/she fell. Staff A said he and the CNA's went to check his/her vital signs. The RN said Resident #6 seemed as cognizant as h/she normally would be and his/her vital signs were within normal limits (WNL). Staff A said they got the resident back up on his/her feet and put him/her into a wheelchair. The RN stated that did not last long because Resident #6 got up and tried pushing the wheelchair. He said he intervened by taking the wheelchair away to prevent another fall. Staff A said from that point on Resident #6 strolled around the facility like h/she normally did.	F 323		

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F 323	Continued From page 14 According to the RN, while he processed the paperwork and notified the doctor. and family at the nurses' station, he heard another "holler" from a CNA in the lounge requesting a nurse's help because Resident #6 had fallen again. Staff A said he went to where the resident had fallen the second time and everything checked out alright. The RN said they stood the resident back on his/her feet and h/she started wandering around the facility again like usual. According to the RN, he proceeded to process the paperwork and make the appropriate notifications for the 2nd fall when the Service Aid informed him he found Resident #6 bleeding while lying on the floor of his/her room. Staff A said he went to the resident's room to complete an assessment. According to the RN, a CNA applied pressure to the laceration on the back of his/her head using some wash cloths. Staff A said neurological checks and vital signs were initiated and checked out fine. Staff A said at that point he told a CNA "I know we don't have enough staff, but you're going to have to sit with Resident #6." The RN said he checked the resident's wound. He said the wound measured about 3 cm long. He also said it remained approximated which made it hard to tell where h/she was actually bleeding from. The RN said Resident #6 had been trying to get up, so he realized h/she had full range of motion (ROM). According to the RN, he left Resident #6 with the CNA's while he went to do paperwork for the third incident. Staff A said he left a message for the DON and the Assistant Director of Nursing (ADON). According to the RN, he called and spoke to Resident #6's physician right after the third fall. He said he obtained telephone orders to send Resident #6 to the ER by ambulance for a CT or X-ray of the head and sutures as needed. The RN said he suspected	F 323		

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F 323	Continued From page 15 Resident #6 was going to fall from the minute he/she got up based on his observations of his/her disposition and unsteadiness. The RN said the resident has what he described as "ticks"; movements that cause the resident's knees to give out. He said some days his/her ticks are worse than other days, and based on the number of ticks h/she had that day, he considered it a bad day. According to Staff A, he would have assigned someone for one to one supervision of Resident #6 that day, but they were not staffed well enough to do that. According to Staff A, he did not think they are adequately staffed, however the problem is compounded by people calling in frequently. He said that once those issues are factored into the equation, they were almost always short staffed. The RN said he thought someone called in almost daily, or about 90% of the time. Staff A expressed his frustration over nothing being done about it and the problem just continued to happen. According to the RN, having someone walking side by side or trailing Resident #6 caused him/her to become anxious or nervous. Staff A spoke of the importance of being close enough to make observations of potential falls, but not so close to contribute to them. Staff A said Resident #6 seemed more receptive to some people than others. He also described it as a balance between safety and causing the resident to be agitated. According to the RN, Administration would have to make more staff available to them in order to monitor the resident well enough to prevent the "preventable falls." Staff A said he believed some of his/her falls could be could be attributed to being short staffed. An interview on 7/19/17 at 9:20 a.m. with Staff F,	F 323		

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F 323	Continued From page 16 LPN revealed she reported for her shift at about 6:00 p.m. on 7/9/17. According to Staff F, Staff A reported Resident #6 had fallen three times and gashed his/her head on the third fall. Staff F said the off-going nurse told her he had assigned someone to Resident #6 for one on one supervision. Staff F thought Resident #6 had been in her room at the time she reported for work, but h/she got up soon after which caused the wound to slightly bleed again. Another nurse on duty addressed the bleeding. According to the LPN, Staff A told her he had notified the doctor of all 3 falls via fax. The LPN said since the bleeding started again, she told Staff A to call the doctor for orders. Staff F said Staff A called the doctor immediately and obtained an order to have Resident #6 sent to ER for CT and evaluation for treatment. Staff F said Resident #6 returned to the facility with three staples in the back of his/her head. According to Staff F, they are supposed to get ahold of the doctor anytime a resident gets injured, no matter how minor. The LPN said she got upset when she walked into work and realized Staff A had only faxed the doctor and not called him. Staff F said a fax would only be appropriate if a fall did not result in an injury. An interview on 7/19/17 at 12:45 p.m. with the Director of Nursing (DON) revealed that although she had mixed feelings about assigning staff one to one with Resident #6, she agreed that it would be necessary in order to determine if any of the resident's falls were preventable. The DON concurred that if nobody was present to witness the falls, they would not know if they could have been prevented. An interview on 7/19/17 at 3:30 p.m. with Staff D, Service Aid, revealed his account of the fall that	F 323		

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F 323	Continued From page 17 caused a head laceration to Resident #6 on 7/9/17 at about 4:15 p.m. According to Staff D, Resident #6 either spent his/her time walking around the facility or taking naps. He said h/she "did a kind of lurching/stumbling" thing as if his/her foot caught the floor. He said it resembled falling forward. The Aid said they told him he should shadow Resident #6 when he came to work at 4:00 p.m. because of Resident #6's tendency of wandering into other residents' room, not because of being at risk for falling. The Service Aid said he could not actually help the resident walk, but if h/she stumbled he could intervene and help steady him/her. According to the Aid, he usually walked a little bit behind and to the side of the resident. Staff D said the resident randomly talked to him and smiled, but never became agitated or anxious as he shadowed him/her. The Aid said Resident #6 almost seemed amused with him sometimes. Staff D said he could not locate the resident for a little while. He described his primary responsibility as passing ice water and snacks, but had had been instructed to walk with Resident #6 too. The Aid said he usually passed ice water and/or snacks to a couple of rooms and then checked on Resident #6 to keep a close eye on him/her. Staff D said he checked in Resident #6's room about 4:15 p.m. and found him/her alone lying on the floor [on 7/9/17]. The Service Aid said he noted a little bit of blood on the floor, and on his/her hand and face. The Aid said he went to get Staff A. According to Staff D, nobody told him Resident #6 had fallen two other times that day. A subsequent interview on 7/24/17 at 9:50 a.m. with Staff A revealed his account of Resident #6's most recent fall on 7/23/17. According to the RN,	F 323		

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F 323	Continued From page 18 Resident #6 had been strolling around all day. He said h/she seemed pretty steady and stable, but his/her pace seemed faster than he would have liked to seen him/her walk. Staff A said Resident #6 had been assigned to another nurse that day. The RN said he and the resident's nurse anticipated that Resident #6 may fall based on the pace he/she had been walking. Staff A said he did not think anyone witnessed the fall. He said an aide told him Resident #6 had fallen down by the Sunshine room at 4:30 p.m. According to Staff A, a couple CNA's were there assisting Resident #6 when he arrived. The RN said there were already bloody rags there when he got there, but he did not know who applied the pressure. He said the other nurse approached the site to do vital signs and an assessment right after he got there. Staff A said once the other nurse completed the assessment, they left Resident #6 with the CNA's while they went to the nurses' station where the other nurse called 911. According to Staff A, Resident #6 had blood on his/her forehead and in his/her mouth. Staff A said nobody had been walking with the resident, but there had been "a lot of eyes on him/her." Staff A said they had been keeping a closer eye on the resident because it bothered him that h/she had been walking so fast. The RN mentioned that a helmet might be an appropriate intervention in light of the fact that Resident #6 sustained head injuries on multiple occasions. A subsequent interview on 7/24/17 at 12:40 p.m. with the DON revealed they had been doing hourly checks on Resident#6. According to the DON, she did not consider that as adequate so fifteen minute checks were implemented last Friday morning. According to the DON, they also had to record what Resident #6's activities were	F 323		

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F 323	Continued From page 19 at the time of the check. She said Corporate recently agreed to provide one on one supervision for Resident #6 24 hours a day, seven days a week. The DON said Resident #6's daughter threw a fit about one to one supervision. According to the DON, whether or not Resident #6 got agitated by being so closely supervised depended on the person following him/her. When asked about staff to resident ratio, the DON said bath aids and restorative aids are counted amongst the numbers scheduled as direct care givers. According to the DON, RAs do not provide restorative therapy during meals so they were able to help feed and answer call lights. The DON said otherwise she scheduled one CNA to each of the three halls and one nurse or one certified medication assistant (CMA) to each hall. The DON agreed, some nurses and CMAs help CNAs more than others. The DON said there were ten to twelve residents that required the assistance of two staff members to transfer them with a Hoyer (mechanical lift) and one staff member to transfer 3 residents with EZ stands (mechanical lift). The DON said the CNAs have scheduled lunch breaks, and they are also supposed to take 15 minute breaks. The DON said nurses and CMAs cover their breaks and she insisted that they take them. A subsequent interview on 7/24/17 at 3:15 p.m. with Staff G said she worked on 7/23/17 when Resident #6 fell again and cut his/her head. According to Staff G, nobody witnessed the fall. She said the resident had been walking at a very fast pace and they kept encouraging him/her to slow down. Staff G said she was nearby and heard the "thump" and crying after Resident #6 fell. Staff G said they had been "on top" of the resident's fifteen minute checks, but it still	F 323		

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happened. According to Staff G, it would absolutely take someone being with Resident #6 at all times to prevent any falls that might be preventable.

An interview on 7/25/17 at 11:55 a.m. with Staff E, LPN, revealed what she knew of Resident #6's most recent fall on 7/23/17. According to Staff E, Resident #6 walked the halls quite a bit and had been down by the activity room when h/she fell. The LPN said a CNA reported the fall to her. Staff E said when she arrived, a CNA sat next to Resident #6 as h/she laid on the floor. According to Staff E, they had already placed a rag on the resident's forehead to stop the bleeding. Staff E said Resident #6's forehead appeared to have an indentation at the site of the laceration and his/her nose bled with swelling on the bridge of his/her nose. Staff E said Resident #6 had been crying. The LPN said she called 911 and then called the doctor who told her to call 911. The LPN relayed the information to a family member; telling them the injury seemed bad and the doctor also ordered a CT. According to Staff E, the fall occurred at about 4:30p.m. When asked about the resident's disposition prior to the fall, Staff E said h/she had been quiet, walking the halls and carrying his/her baby like usual. The LPN said she thought Resident #6 needed a dementia unit to address his/her needs.

An interview on 7/26/17 at 9:50 a.m. with Staff H, Housekeeper revealed she worked 7/9/17 from 1:00 a.m. to 5:00 p.m. in activities. According to Staff H, she happened to be near Resident #6 as h/she stumbled and fell. The Housekeeper said she managed to soften the fall and prevented Resident #6 from hitting his/her head. Staff H said she did not notice any injuries, but immediately

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F 323	Continued From page 21 called for other staff to assist. According to Staff H, Resident #6 had been stumbling a lot that day, which caused him/her to be unsteady on his/her feet. The Housekeeper also said that Resident #6 "goes when h/she wants to go, whether h/she is stumbling or not. There's no stopping him/her". Staff H said the resident needs placement in a dementia unit because h/she "isn't safe here." 2. The MDS assessment dated 6/16/17 noted dementia, respiratory failure, atrial fibrillation (irregular heart rhythm), muscle weakness and unsteadiness on feet as diagnoses of Resident #4. The MDS also noted Resident #4 had been unsteady, could only stabilize with staff assistance and required limited assistance of one staff to transfer and toilet. The MDS documented Resident #4 had two or more falls since being admitted to the facility. The Care Plan noted on 2/3/17 Resident #4 began receiving diuretic (medication to induce urination) therapy, which may cause dizziness, fatigue and an increased risk of falling. The Care Plan also documented that Resident #4 required one staff to assist with toileting, transfers and ambulation, and had nine falls between 3/8/17 and 7/19/17 related to deconditioning. An observation on 7/6/17 at 8:00 a.m. revealed Staff B, Certified Nurses' Assistant (CNA) and Staff C, CNA as they assisted Resident #4 to stand from the bed and walk to the bathroom. As the resident sat on the side of the bed, Staff B put a new disposable brief on the resident and pulled it up to his/her knees, although Resident #4 was already wearing a brief. Staff B applied a gait belt and assisted Resident #4 to stand. Without	F 323		

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F 323	Continued From page 22 pulling the new brief up any farther, Staff B assisted the resident to walk with a walker from the bed to the toilet (approximately 6 to 8 feet). After a few steps, Staff B realized the brief hindered Resident #4's ability to walk, so she pulled one side up just above the knee. As the resident shuffled towards the bathroom, the brief fell back down around his/her knee. It remained there until h/she completed the walk to the bathroom, at which time the resident's other brief was removed so he/she could sit down on the toilet. 3. The MDS assessment dated 6/21/17 noted anemia (deficiency of red blood cells or hemoglobin), schizophrenia, anxiety, depression, atrial fibrillation, weakness, lack of coordination, and the need for assistance with personal care as diagnoses of Resident #5. The MDS also noted Resident #5 had been unsteady, could only stabilize with staff assistance and required limited assistance of one staff to transfer and extensive assistance of one staff to toilet. The 7/22/14 Care Plan noted that Resident #5 had anemia and should be monitored for fatigue, dizziness and weakness. The Care Plan also noted that Resident #5 required assistance of one staff, a gait belt and walker to transfer. An observation on 7/6/17 at 8:15 a.m. of Staff A, RN assisting Resident #5 revealed the following. The RN borrowed a gait belt from a CNA in the room. As Resident #5 sat on the side of the bed, Staff A attempted to apply the gait belt to the resident. Staff A said to the CNA, "your gait belt doesn't fit" the resident. The gait belt would not buckle because of being too short to fit around	F 323		

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the resident. Staff A grabbed Resident #5's shirt with the same hand that he held the two ends of the gait belt together with and used his other hand under Resident #5's arm to help the resident stand from the bed and transfer to the wheelchair.
During the transfer, Resident #5 seemed very weak and struggled to stand even with assistance. When asked, the RN said he did not take the time to get a gait belt that fit.

An interview on 7/26/17 at 11:10 a.m. with the DON revealed that though their corporation agreed to provide one to one supervision for Resident #6, they need to hire more staff in order to accomplish that. This surveyor observed Resident #6 walking around the facility alone on 7/26/17 at 9:45 a.m., which prompted the surveyor to ask the DON about her previous statement that one to one supervision would be provided.
The DON said she would have to "steal" people from the floor to provide that kind of supervision, and they just do not have the manpower yet.
When asked, the DON said she would have expected Staff A to use an appropriately sized gait belt to ensure Resident #5's safety when transferring him/her. The DON also said she would have expected Staff A to call the doctor immediately after a fall with injury per protocol instead of just faxing the SBAR. The DON said she would have expected Staff B to pull Resident #4's brief all the way up so as not to jeopardize his/her safety.

On 7/26/17 at 11:45 a.m., the Corporate Nurse had been overheard saying "the skills checklist provides guidance to staff, but a formal document titled Transfer Safety Policy does not exist" in

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F 323	Continued From page 24 response to this surveyor asking the DON for a policy.	F 323		

Oakland Manor

Plan of Correction for Self-report/Complaint Survey 7/5/17-7/26/17

Submission of the response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Executive Director, or other associates, agents, or other individuals who draft or may be discussed in this response and plan of correction. Preparation and submission of this plan of correction does · not constitute an admission or agreement of any kind by the facility of the truth of any fact alleged or the correctness of any conclusion set forth in these allegations by the survey agency.
Date of compliance with this plan of correction: 8/17/2017.

F323 – Supervision and safe transfer

Resident #4

- CNA was reeducated on proper transfer and ambulation with residents immediately following the time incident occurred.
- Transfer audit completed and employee education form completed.

Resident #5

- Nurse observed doing the transfer educated on proper size and fit of gait belt and on safe practice with transfers immediately.
- Transfer audit completed with this nurse and education form completed immediately.

Resident #6

15 minute checks indefinitely and care planned if displays jerking motion noted to be precursor to falls that resident will be placed on one on one supervision until no further symptoms observed. Order obtained on 7/26/17 for padded helmet to be worn at all times. Care plan updated with other preventative interventions.

For all other residents, care plans were audited for proper transfer status and fall interventions.

In-service with nursing staff on proper transfers, gait belt use, and body mechanics given by physical therapy on 8/3/17. Nurse managers educated on implementation of fall interventions.

Random audits will be completed by DON/designee for fall interventions and transfers per care plan. Any concerns noted brought to QAPI committee for review and further action needed.

F309 – Notification of the physician

Resident #6

- Education immediately provided to nurse identified in the initial complaint.

For all other residents in similar situations:

- Record reviews revealed no other like instances have occurred.

All nursing staff have read and signed after a full review of policy and procedure for falls and change of condition notifications of physician with instances of injury.

Random audits will be completed on all incident and change of condition occurrences to ensure proper notification of physician by DON/designee . Any variances will be referred to the QAPI committee for review and further action.