STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. BUILDING _____ B. WING _____	C 05/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB	4911 SW 19TH STREET DES MOINES, IA 50315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 6-8-18 The following deficiencies were identified during the investigation of #75163-A and 74750-M completed on May 2-10, 2018. (See Code of Federal Regulations (42CFR), Part 483, Subpart B - C.)	F 000	Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews, the facility failed to prevent an employee from physically and emotionally abusing one out of three (Resident #1) residents which resulted in a fractured leg. The facility reported a census of 83 residents. Findings include: According to the Minimum Data Set (MDS)	F 600	The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it. **<u>This constitutes my credible allegation of compliance as of June 8th, 2018.</u>** **F600** **<u>Correct to the individual:</u>** R # 1 plan of care was reviewed and revised initially on 3/23/18 and 3/30/18.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	NHA	06/17/2018

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

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F 600	Continued From page 1 assessment dated 1/29/18 Resident #1 had diagnoses of anxiety disorder, psychotic disorder, difficulty walking, altered mental status and delusional disorders. The MDS noted the resident dependent on staff for activities of daily living, required extensive assistance of two for transfers. The MDS documented the resident's BIMS (brief interview for mental status) score 6 out of 15 indicating severely impaired cognition. The resident's Care Plan with a Target date of 4/28/18 identified the resident with a self care deficit related to confusion and dementia. The Care Plan directed nursing staff to: a. Provide perl care after each incontinent episode. b. Extensive assistance of one staff to turn and reposition in bed every 2 hours and as necessary. c. Dependent on one staff for dressing. d. Resident does not ambulate at this time. e. Dependent on two staff for toileting. f. Requires assistance of two staff for transferees. g. Requires assistance of one staff for personal hygiene and oral care. h. Allow resident time to process new information. i. Do not rush during cares. j. Provide safe environment. When interviewed on 5/2/18 at 1:15 p.m. Resident #2 (Resident #1's roommate) reported she witnessed the incident between Staff B and Resident #1 which took place in their room on 3/19/18 between 8:30 or 9:00 p.m. Resident #2 said Staff B pulled the privacy curtain about ¼ of the way closed so she still had a full view of the entire room and all the way up to the edge of Resident #1's bed. Resident #2 said she could see everything in a mirror that hung across from Resident #1's bed.	F 600	**Protect residents in similar situation:** Staff B was immediately suspended, pending facility investigation, on 3/22/18 and employment terminated on 3/26/2018. The facility's abuse policy was reviewed with staff from 4/2/18 to 6/8/18. The facility self-reported this incident on 3/22/18.	

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F 600	Continued From page 2 Resident #2 said she became more attentive than normal because of how Staff B spoke to Resident #1. Staff B did not yell at Resident #1, but said "quit sassing me, why are you sassing me? I have not done anything to you; I'm just trying to put you to bed." Resident #2 said nobody else would have witnessed what happened because they were the only 3 people in the room at the time and the door to their room was closed. Resident #2 said Staff B angled Resident #1's wheelchair facing her bed, so she had a good view of Resident #1's right side and back. Resident #2 said Staff B forcefully pulled Resident #1's shirt over her head and arms so he could put her night shirt on her. Resident #1 screamed "stop it, stop it. Don't touch me, get away from me." Staff B got Resident #1's shirt off of her as Resident #1 said "g------n it, I said stop touching me. Get someone else to help. Get away from me." Staff B repeated "Don't sass me, I'm just trying to help get you into bed. You ain't got no reason to sass me." Staff B continued to forcefully pull Resident #1's night shirt on over her arms and head as she continued to object. Resident #2 said Staff B then pulled the curtain completely open again. Resident #2 reported Staff B came in from behind Resident #1 put both of his arms under her armpits, to lift her from the wheelchair, "scooped her up" and used one of his legs to move the wheelchair out of his way and caught Resident #1 under her legs with one arm, like cradling a baby, then he used that momentum and threw Resident #1 onto her bed all in one swift motion. She stated Resident #1 landed on her back and hit so hard she literally bounced up off the mattress and moaned in pain,. Resident #2 said she repeatedly	F 600	**Measure/system prevents re-occurrence:** The facility has a comprehensive abuse prevention policy and procedure in place. All staff is pre-screened and a criminal background check is completed prior to hire through the Department of Human Services. The abuse prevention policy is reviewed with all staff during new hire orientation, annually, and as needed. Though State and Federal law allow for an employee to complete the State required mandatory dependant adult abuse training within their first 6 months of employment, the facility completes the mandatory training on all new hires on the first day of hire. All staff are required to be re-trained on the State required mandatory dependant adult Abuse training every 5 years thereafter. The facility investigates all alleged incidents of abuse, injuries of unknown origin and/or unusual occurrences to ensure the prevention of dependant adult abuse. All facility employees are mandatory reporters and expected to follow the facility's abuse prevention policy.	

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F 600	Continued From page 3 said "Dude stop. She doesn't want you touching her. Go get somebody else." Staff B responded back that nobody else could help him because they were so busy. Staff B then covered Resident #1, took her wheelchair and left the room. Resident #2 said she asked Resident #1 "are you OK ?" after he left and she said "yes, I'm OK". Resident #2 said Resident #1 did not sleep very well after that and had a bad night. When asked how she knew Resident #1 did not sleep very well, Resident #2 said "when Resident #1's is awake, I'm awake". Resident #2 described Staff B as a big guy at least 6 feet tall. During an interview on 5/2/18 at 12:05 p.m. the facility Administrator reported their investigation concluded: Staff B, CNA did an improper transfer. The Administrator believed Staff B scooped the resident up in his arms, probably because of being in a hurry, and dropped her on the bed. The Administrator said the resident's roommate saw the whole thing. The Administrator said Resident #2 (Resident #1's roommate) can be kind of histrionic or dramatic, but they think "there's nuggets of truth in what she is saying." The Administrator said Resident #2's is alert, oriented and has a BIMS of 15 out of 15 (which indicates no cognitive impairment). The Administrator did not think Staff B intentionally harmed Resident #1, but his inappropriate actions caused the resident's injury. The Administrator said critical care had also been withheld because Staff B did not come forward and report what occurred. When interviewed on 5/2/18 at 3:05 p.m. Staff F said she worked with Staff B on the 2nd shift sometimes. She described his personality as "very different." She said she did not think Staff B had much compassion. She reported he "flew off	F 600	**Monitor for permanent solutions:** The Human Resource Director and/or Designee will continue to frequently audit all employee personnel files to ensure abuse prevention training and screening for the potential of abuse are current. All concerns will be immediately addressed. Findings will be reviewed and discussed at the monthly QAPI meeting for resolution.	

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F 600	Continued From page 4 the handle at the drop of a hat." at both Staff and residents. She reported she witnessed Staff B calling nurses "H- and B---chs" if they told him something he did not like, and she heard Staff B talking rudely to another resident. Staff F reported she never told anyone of the following. On 5/3/18 at 12:05 p.m. Staff I, CNA reported she worked with Staff B a lot. According to Staff I, Staff B got along with the residents OK. Staff I remembered a time when Staff B was trying to help fix the hair of a female resident sitting at the nurse's station when she yelled "get out of my face, get out of my face". Staff I said she moved closer to see what was going on. Staff B said "I was only trying to help you." Staff I said Staff B backed away. Staff I said she heard the resident say "he's a man trying to act like a woman, I don't like him". Staff I told Staff B that "she's OK, just leave her alone". Staff I said she has never seen Staff B mistreat any residents or coworkers. She described Staff B as a "fun guy". Staff I said Staff B went back into that resident's room to help her roommate and she heard the resident say "get out of my room, get out of my room, I don't like him". Staff I said that was the first time she ever saw those residents act like that towards Staff B. According to Staff I, that occurred about a week before the alleged incident between Staff B and Resident #1. Abuse Policy The August 25, 2016 revised Abuse Policy Statement noted "Abuse of residents in nursing facilities is prohibited by law and this facility." According to the Policy Statement, all residents have the right to be free from abuse and must not be subjected to it by anyone.	F 600		

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F 600	Continued From page 5 Employee Warning and Discharge Notice signed and dated 2/5/18 reflected disciplinary action that Staff B, CNA received for the violation of a company rule and inappropriate negligent behavior (5 day suspension) - on 1/27/18 Staff B displayed obscene and inappropriate behavior during a verbal altercation with another co-worker; using foul and profane language. The facility expected Staff B to conduct himself professionally and work as a team with others. Issues must be brought to the supervisor and not addressed on his own. Further incidents would lead to termination. Other disciplinary action: 3/26/18 violation of company rule and inappropriate negligent behavior - Staff B performed a resident transfer from the chair to bed in violation of care planned transfer status. He transferred the resident alone instead of having the help of another staff member which may have resulted in harm to the resident and denial of critical care. Staff B was discharged due to the seriousness of the offense on 3/26/18 and refused to sign the document. Personnel File: Staff B's Personnel Record revealed on January 10, 2018, Staff B, signed acknowledgement that he received a copy of the August 25, 2016, Policy and Procedure for Abuse Prevention and Reporting. Staff B signed that the Abuse information had been explained to him and he acknowledged that he understood the information presented to him and that he was responsible for complying with this material.	F 600		

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F 689	Continued From page 6	F 689		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews, the facility failed to ensure 1 of 4 residents were transferred in manner to prevent physical injury. Concerns were identified with Resident #1. The facility reported a census of 83 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 1/29/18 Resident #1 had diagnoses of anxiety disorder, psychotic disorder, difficulty walking, altered mental status and delusional disorders. The MDS noted the resident dependent on staff for activities of daily living, required extensive assistance of two for transfers. The MDS documented the resident's BIMS (brief interview for mental status) score 6 out of 15 indicating severely impaired cognition. The resident's Care Plan with a Target date of 4/28/18 identified the resident with a self care deficit related to confusion and dementia. The Care Plan directed nursing staff: a. Requires assistance of two staff for transfers. b. Provide peri care after each incontinent	F 689	**F689** **Correct to the individual:** R # 1 plan of care was reviewed and revised initially on 3/20/18 and 3/30/18. **Protect residents in similar situation:** Staff B was immediately suspended, pending facility investigation, on 3/22/18 and employment terminated on 3/26/18. Nursing Staff were re-educated to always transfer residents according their plan of care/pocket care plan on 3/28/2018. Transfer audits were initiated with nursing staff, from 3/28/18 to 6/8/18, to ensure compliance.	

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F 689	Continued From page 7 episode. c. Extensive assistance of one staff to turn and reposition in bed every 2 hours and as necessary. d. Dependent on one staff for dressing. e. Resident does not ambulate at this time. f. Dependent on two staff for toileting. g. Requires assistance of one staff for personal hygiene and oral care. h. Allow resident time to process new information. i. Do not rush during cares. j. Provide safe environment. l. Monitor for any signs and/or symptoms of pain. Anticipate the resident's need for pain relief and to respond immediately. A Nurse's Note dated 3/10/18 at 3:00 p.m. noted that staff observed Resident #1 on the floor near the nurse's station after they heard a "thud" at 7:15 a.m. The nurse noted that Resident #1 sustained a hematoma to her left temple which warranted being sent to ER for evaluation and treatment. The nurse also noted there were no other visible injuries at that time. Review of the Nursing Documentation and Fall Assessment Form dated 3/10/18 at 7:15 a.m. revealed Resident #1 sustained a hematoma (collection of blood under the tissue) to her left temple after staff observed her on the floor after they heard a "thump". The Emergency Department (ED) Physician Note dated 3/10/18 at 8:38 a.m. noted Resident #1 presented with a head injury she sustained after she fell just prior to arriving. The report noted the resident did not know why she was there and had no complaints at the time. The assessment documented the resident attempted to stand and ambulate and fell striking the right side of her	F 689	**Measure/system prevents re-occurrence:** The facility makes every effort to ensure the resident's environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. Employees are issued a gait belt at the time of hire, free of charge, and trained by the facility's therapy department on proper transfer techniques and equipment use. The facility also conducts an annual "transfer technique" fair annually. The ADON and/or designee will continue to conduct frequent transfer audits to ensure proper technique and residents plan of care is being followed. Copies of these audits will be kept on file for review. **Monitor for permanent solutions:** The Director of Nursing and/or designee will randomly audit the completed transfer audits, on file, for the next 90 days to ensure compliance. All concerns will be immediately addressed. Findings will be reviewed and discussed at the monthly QAPI meeting for resolution.	

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F 689	Continued From page 8 head. The physician's assessment revealed no tenderness, no swelling and no deformities. The CT scan ruled out any internal brain hemorrhage and the resident discharged back to the facility. The Nurse's Notes dated March 11, 12, 14, 16, 17, 18, 2018 documented the resident denied pain or discomfort. The Nurse's Notes dated 13, 15, documented the resident had normal range of motion and denied pain. The Nurse's Note dated 3/19/18 at 3:50 p.m. noted the resident remained Hospice level of care without any changes. The Nurse's Note dated 3/19/18 at 10:00 p.m. noted the resident remained very agitated and an antianxiety medication Lorazepam had been administered. The Nurse's Note dated 3/20/18 at 1:00 a.m. noted the resident remained very agitated, would not rest, wanted to leave and had delusions. The nurse noted that resident became combative and refused bedtime medication. The nurse tried antianxiety medication again at 1:00 a.m. The Nurse's Note dated 3/21/18 at 4:00 p.m. noted the resident complained of pain to her right leg when moved during transfers. Order obtained for an x-ray. An Incident/Accident Report dated 3/21/18 at 4:00 p.m. noted the resident had increased pain after a 3/10/18 fall. The Nurse's Note dated 3/21/18 at 8:30 p.m. noted the x-ray report revealed mildly displaced oblique (slanted or angled) fractures to the right distal (situated further away from point of attachment) tibial and fibular diaphyses (shaft of leg bones). Fractures right leg (tibula and fibula).	F 689		

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F 689	Continued From page 9 The Nurse's Note dated 3/21/18 at 9:00 p.m. noted an order to: 1. Splint the right leg with an immobilizer for the night. 2. See an orthopedic Dr. tomorrow. The Patient Report date 3/21/18 revealed the right foot x-ray results noted a displaced fracture of the distal tibial and fibular diaphyses. The Major Injury Determination Form signed and dated 3/22/18 at 12:15 p.m. by the resident's physician documented the resident sustained a broken right leg due to an inappropriate transfer and rough landing from her chair to bed on 3/19/18. The Nurse's Note dated 3/22/18 at 3:30 a.m. noted the resident tolerated the application of the immobilizer well. The nurse noted the right lower leg as swollen and slightly pink. The Nurse's Note dated 3/22/18 at 3:00 p.m. noted the ambulance transported the resident to her ortho appointment and noted the resident returned with a hard cast to her right lower extremity and should be rechecked in 3 weeks. When interview on 5/2/18 at 12:05 p.m. the Administrator reported their investigation concluded Staff B, CNA did an improper transfer. The Administrator believed Staff B scooped Resident #1 up in his arms, probably because of being in a hurry, and dropped her on the bed. The Administrator said the resident's roommate saw the whole thing. The Administrator said Resident #2 (Resident #1's roommate) can be kind of histrionic or dramatic, but they think "there's	F 689		

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F 689	Continued From page 10 nuggets of truth" in what Resident #2 reported. The Administrator said Resident #2's is alert, oriented and has a BIMS of 15 out of 15 indicating (no cognitive impairment). The Administrator said Staff B's inappropriate actions caused the resident's injury and critical care had been withheld because Staff B did not come forward and report what occurred. An interview on 5/2/18 at 1:15 p.m. with Resident #2 (roommate of Resident #1) revealed that she witnessed the incident between Staff B and Resident #1 which took place in their room on 3/19/18 between 8:30 or 9:00 p.m. Resident #2, reported Staff B only pulled the privacy curtain about ¼ of the way closed so she still had a full view of what transpired. Resident #2 said she could see the entire room and all the way up to the edge of Resident #1's bed. Resident #2 said she could also see everything in a mirror that hung across from Resident #1's bed. Resident #2 said she became more attentive than she normally would have been because of how Staff B spoke to Resident #1. Resident #2 said Staff B did not yell at Resident #1, but said "quit sassing me, why are you sassing me? I have not done anything to you, I'm just trying to put you to bed." Resident #2 said nobody else would have witnessed what happened because they were the only 3 people in the room at the time and the door to their room was closed. Resident #2 said Staff B placed Resident #1's wheelchair facing her bed, so she had a good view of Resident #1's right side and back. Resident #2 said Staff B forcefully pulled Resident #1's shirt over her head and arms so he could put her night shirt on her. Resident #1 screamed "stop it, stop it. Don't touch me, get	F 689		

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(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 689	Continued From page 11	F 689		

away from me." Staff B got Resident #1's shirt off and Resident #1 said "g---it, stop touching me. Get someone else to help, get away from me." Staff B said "don't sass me, I'm just trying to help get you into bed. You don't have any reason to sass me." Resident #2 said Staff B continued to forcefully pull Resident #1's night shirt on over her arms and head as she continued to object. Resident #2 said Staff B then pulled the curtain completely open again.

According to Resident #2, Staff B came from behind Resident #1 put both of his arms under her armpits to lift her from the wheelchair. He then "scooped her up" and used one of his legs to move the wheelchair out of his way and caught Resident #1 under her legs with one arm, like cradling a baby, then used that momentum and threw Resident #1 onto her bed, all in one swift motion. Resident #1 landed on her back and hit so hard she bounced up off the mattress. Resident #2 said she repeatedly said "dude stop. She doesn't want you touching her. Go get somebody else." Resident #2, described Staff B as a big guy that stood at least 6' tall. Resident #2 said she repeatedly said "dude stop. She doesn't want you touching her. Go get somebody else." According to Resident #2, Staff B said nobody else could help him because they were so busy. Resident #2 said Resident #1 moaned in pain. Resident #2 said Staff B covered Resident #1, took her wheelchair and left the room.

Resident #2 said she asked Resident #1 "are you OK Grandma?" after he left and she said "yes, I'm OK". Resident #2 said Resident #1 did not sleep very well after that and had a bad night. Resident #2 said "when Grandma is awake, I'm awake." Resident #2 said she did not notice

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166273	A. BUILDING _____ B. WING _____	C 05/10/2018

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F 689	Continued From page 12 Resident #1 having any pain the next day, but the day after that she did. Resident #2 said on the morning of 3/21/18 Staff G, CNA came in to dress Resident #1 as she laid in her bed. Resident #2 said she didn't notice Resident #1 had any pain while Staff G dressed her. Staff G went into the hall to find someone to help with the transfer, she re-entered the room and closed the door behind her. Resident #2 said Staff J, CNA entered the room and Staff G transferred Resident #1 from her bed to her wheelchair (alone) while Staff J put on gloves. Resident #2 said that is when Resident #1 complained that her leg hurt. Resident #2 said Resident #1 sat on the side of her bed, and Staff G "bear hugged" her, lifted her, spun her around and sat her in the wheelchair. Resident #2 did not know if Resident #1's feet touched the floor to stand/pivot/transfer or if Staff G literally picked her up. Resident #2 said they took Resident #1 to breakfast and she must have been complaining of pain at breakfast because most of the time Resident #1 sets by the nurses station in her chair but Staff G put her back in bed (alone) about 9:00 a.m. Resident #2 said those were the only times she saw people transfer Resident #1 alone. Resident #2 said Staff G did not bother to get Resident #2 up for lunch. Resident #2 said she asked Staff G if they were going to get her up and she said "no, she's sleeping peacefully so I'm not going to bother her." Resident #2 said that Staff G left at 2:00 p.m. and she did not know if Staff G told anyone. Resident #2 said Staff F CNA came in at 2:00 p.m. and she told her about Resident #1's pain. Resident #2 said Staff F told someone and they got an orders for an x-ray.	F 689		

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F 689	Continued From page 13 When interviewed on 5/9/18 at 3:50 p.m. with Staff G reported Resident #1 complained of leg pain when she got her up the morning of 3/21/18. Staff G said they usually transferred Resident #1 alone by giving her a hug and assisting her to stand/pivot transfer. Staff G said Resident #1 usually was able to stand and bear weight with assist of one. Staff G said she could not remember if she transferred her alone that day. Staff G said Resident #1 could not stand or bear weight that morning. Staff G said Resident #1 kept saying "my leg hurts, be careful" during the transfer. Staff G said Resident #1's roommate was in the room at the time and she could not see any physical signs of injury because the roommate did not want them to turn the lights on. Staff G said she and Staff J took Resident #1 to the shower room and she complained of pain. When they took the resident's blankets off and raised her gown they saw a nasty bruise on her right shin. Staff G described the bruise as purplish in color, kind of long and about 1 to 2 inches wide. She told Staff A about the bruise and said she needed to go look at it. Staff G said she finished getting residents up after telling the nurse about the bruise and Staff J stayed with Resident #1 in the shower. Staff G said she never received report from the overnight shift and no one said anything about a bruise. Staff G continued that she saw Resident #1 at the nurse's station between 9:00 - 10:00 a.m. and put her to bed with the help of another aid. Staff G said Resident #1 did not get out of bed for the remainder of her shift. She checked on her before lunch and she stayed in bed. Staff G said she believed one of the nurses said to leave her in bed because she was resting; but she did not	F 689		

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F 689	Continued From page 14 remember who. Staff G said she checked on Resident #1 about 1:30 p.m. before she left and she was still sleeping. Staff G said she did not know if Staff A followed up on the report of Resident #1's pain and bruised leg. Staff G said she told Staff F about the resident's bruise and pain when she reported off at shift change. Staff G said she never noticed if Resident #1 was having any problems in the days before that. When interviewed on 5/7/18 at 2:05 p.m. Staff J, CNA stated she was not in Resident #1's room nor did she help get her up or put her to bed on the morning of 3/21/18. Staff J said Staff G brought Resident #1 to the shower room and the resident complained of her leg hurting. The resident wouldn't let her assist her in any way, even when she tried to console her. Staff J said she saw a bruise about 6" long and 1" wide on the resident's shin and she immediately reported it to Staff A, LPN as Staff G took Resident #1 to the nurse's station. During an interview on 5/3/18 at 12:05 p.m. Staff I, CNA stated Resident #2 (Resident #1's roommate) knows what she is doing, she kind of supervises or oversees Resident #1's care when staff go in to help her. Resident #2 advocates for Resident #1, she informs staff of her observations of Resident #1, like "she didn't sleep well last night" etc. During an interviewed on 5/9/18 at 9:15 a.m. when asked what happened to her casted leg Resident #1 replied "I ran into someone". When asked if her leg hurt, Resident #1 said "yes, very much."	F 689		