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
	165149	A. BUILDING _____ B. WING _____	C 01/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWLEY MEMORIAL MASONIC HOME	3000 EAST WILLIS AVENUE PERRY, IA 50220

(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 2/7/18 Complaint # 72220-C was substantiated. Investigation of facility-reported incident # 73068-I resulted in facility deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan for 1 of 10 residents reviewed (Resident #1). The resident had occasional incontinence of urine and frequent incontinence of bowel. Staff documented they observed moisture associated skin damage breakdown on both buttocks on 12/31/17. Observation showed staff asked the resident if she needed to use the toilet and the resident said no. Staff did not check the resident for incontinence. The facility also failed to	F 684	Without waiving the foregoing statement, the facility states that with respect to resident #1, and all similarly situated residents, the facility has reviewed and revised where appropriate facility practices and policies related to the development and implementation of comprehensive resident-centered care plans, admission assessments, incontinence care, bowel assessments and management, cognitive status, skin and wound assessment and treatment and documentation of treatments.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/31/2018

POC accepted 2/12/18 KKummer

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F 684	Continued From page 1 manage the resident's bowel status adequately. The facility identified a census of 51 current residents. Findings include: The Minimum Data Set (MDS) assessment dated 12/27/17 assessed Resident #1 with a brief interview for mental status score of 7, indicating severe cognitive impairment. The resident required the assistance of 2 staff for bed mobility, transfers, toilet use, dressing and personal hygiene. The resident did not walk. The resident was occasionally incontinent of bladder and frequently incontinent of bowel. The MDS documented she had one unhealed pressure sore Stage 1 or higher and moisture associated skin damage. An admission assessment dated 11/20/17 did not identify skin breakdown on admission. A care plan problem dated 11/29/17 identified a problem of ADL (activities of daily living) and elimination deficits. The problem revealed that, since the fall and fracture of sacrum and then new fracture of pelvis, the resident required more assistance with ADLs. The resident was incontinent of bowel and bladder. An intervention identified the resident wore blue pads and snap pants and depends PRN. Under the area of "toileting" , the care plan directed staff to use a commode with assistance of 2. The care plan did not identify frequency of toileting or to check the resident for incontinence. On 1/10/18 at 11:26 a.m. the care plan nurse stated she expected staff to toilet the resident every 2 hours based on standard nursing practice. She stated if the resident said no to the toileting she expected staff	F 684	The Director of Nursing and Assistant Director of Nursing have re-educated nurses, and the MDS RN on the requirement to the develop and implement comprehensive resident-centered care plans, policies and procedures related to admission assessments, incontinence care, bowel assessments and management, cognitive status changes, skin and wound assessment and treatment and documentation of treatments. Completed: February 7, 2018 All nurses and direct care staff have been re-educated on the capabilities of residents to appropriately answer questions based on resident's cognitive status. Appropriate interventions provided to staff to encourage residents with impaired cognition to participate in activities of daily living. Completed: January 31, 2018 All nurses and direct care staff have been re-educated on following comprehensive resident-centered care plans. New Stop and Watch forms have been introduced to aid in communication and identification between staff of observed changes in resident. Completed: February 7, 2018	

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F 684	Continued From page 2 to check the resident for incontinence. 1. Progress notes dated 12/31/17 at 9:59 p.m. identified bleeding areas to the buttocks. Staff noted a 2.3 centimeter (cm.) by 1.2 cm. open area to the left buttock and a 1.8 by 1 cm. open area to the right buttock. Staff applied Calmoseptine (barrier) cream and educated the resident to lay on her side. Progress notes dated 1/1/18 at 3:11 p.m. identified communication with the physician. Staff informed the physician of new moisture associated skin damage to both the right and left buttocks. Staff noticed the resident with increased incontinence of bowel and bladder since the resident's pelvic fracture (on 12/14/17). Staff described the buttocks as red with distinct open areas to both buttocks. The buttock areas were deep red with flaking skin around the edges. Staff requested an order for Calmoseptine/Vitamin A & D mixture to the buttocks/coccyx with each incontinence episode until healed. Progress notes dated 1/2/18 at 8:57 a.m. revealed the facility received physician orders for the areas. The physician ordered Calmoseptine and Vitamin A & D ointment to the resident's buttocks after each incontinence episode. During observation on 1/8/18 at 1:20 p.m., two staff laid the resident in bed. Staff did not check the resident for incontinence or assist her to use the toilet. After the resident was in bed, Staff F CMA (certified medication aide) stated she asked the resident if she needed the toilet and the resident said no. Staff F stated the resident knew if she needed to use the bathroom.	F 684	The Director of Nursing and/or their designee will monitor to ensure comprehensive resident-centered care plans are being developed and implemented appropriately, policies and procedures related to admission assessments, incontinence care, bowel assessments and management, cognitive status changes, skin and wound assessment and treatment and documentation of treatments are being followed. ONGOING The Director of Nursing and/or their designee will conduct random observational audits to monitor compliance with policies, revisions, and protocols. ONGOING	

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F 684	Continued From page 3 On 1/9/18 at 12:12 p.m. staff got the resident up from bed. At that time they asked the resident if she needed the bathroom and the resident said no. Staff did not check for incontinence. On the same date at 1:25 p.m. staff asked the resident if she needed the bathroom. The resident said no. Staff transferred the resident back to bed. At that time, staff removed the resident's pants and brief for the skin nurse to assess the areas. Staff identified the resident's pad as wet. Review of the January 2018 treatment administration record (TAR) did not identify that staff applied the Calmoseptine/A & D ointment that month. Progress notes dated 1/2/18 at 8:20 p.m. revealed the resident continued with a skin treatment to the buttocks. Progress notes dated 1/4/18 at 12:16 a.m. and 9:15 p.m. revealed she continued with Calmo (Calmoseptine) to open areas on her buttocks. Progress notes dated 1/5/18 at 10:40 p.m. revealed the treatment continued to the open areas on the buttocks. Progress notes dated 1/6/18 at 12:37 p.m. revealed the skin care treatment continued to the buttocks. Progress notes dated 1/7/18 at 9:15 p.m. revealed continued on Calmo and A&D to open areas on buttocks. Progress notes dated 1/8/18 at 6:43 a.m. revealed staff applied Calmo/A&D to the open areas as ordered. Progress notes dated 1/9/18 at 10:06 a.m. recorded staff continued to apply Calmo/A&D ointment. The resident's Skin and Wound Assessment form documented that on 1/4/18 the right buttock wound measured: length-2.1 cm., width 1.6 cm. with no depth measurement. The right buttock	F 684		

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F 684	Continued From page 4 had light bloody drainage with superficial loss of tissue. On 1/4/18 the left buttock, measured 2. cm in length and 1.1 cm. wide with light bloody drainage with superficial loss of tissue. Both measurements were larger than the initial 12/31/17 measurements. Updated measurements dated 1/11/18 at 3:43 p.m. revealed the left buttock wound measured: length-2.3 cm., width 1.1 cm. and depth 0.1 cm. The right buttock measured a length of 1.8 cm., width 1.2 cm. and 0.1 cm. depth. 2. Bowels: Progress notes dated 11/20/17 revealed the resident entered the facility. Progress notes dated 11/21/17 revealed the resident reported she had no bowel movement for a few days. A November 2017 medication administration record (MAR) revealed the resident received Miralax (laxative) daily as a routine order. The resident had as needed (PRN) Milk of Magnesia (MOM) available and Dulcolax Suppository PRN available for constipation. A December 2017 MAR revealed an order for Citrucel (laxative) 12/15/17 for daily administration in addition to Miralax and PRN orders. Bowel records did not identify a bowel movement (BM) until 11/26/17. Review of the November 2017 MAR did not identify an additional laxatives administered during that time. The bowel record did not identify a BM from 11/26/17 to 12/2/17. Progress notes dated 11/30/17 at 11:51 a.m. revealed the resident requested and received MOM. The bowel record did not identify a BM then from 12/3/17 until 12/9/17. The resident had	F 684		

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F 684	Continued From page 5	F 684		

a small BM on 12/5/17, 12/6/17 and 12/8/17. The bowel record did not identify a BM from 12/14/17 until 12/20/17 other than a small BM on 12/15/17, 12/17/17 and 12/19/17. The bowel record did not identify a BM from 12/21/17 until 12/29/17 other than small BMs on 12/23/17, 12/24/17 and 12/25/17.

The MAR identified one dose of MOM given on 12/1/17 and one Dulcolax Suppository administered on 12/2/17 the entire month.

On 1/10/18 at 12 p.m. the ADON (assistant director of nursing) stated the facility did not count small BMs unless there was 2 small BMs in one day. Also at that time, the ADON checked admission paperwork and stated she could not find when the resident had a BM prior to 11/20/17 admission to the facility.

Progress notes dated 12/18/17 at 11:20 a.m. revealed the resident's Citrucel for daily administration was not in the resident's medication supply. The MAR identified staff did not administer the Citrucel until 12/19/17.

On 1/7/18 at 12:42 p.m. Staff B CMA (certified medication aide) stated she offered the resident Citrucel on 12/15/17 and the resident said she didn't want it. If the resident would have said yes then she would have borrowed from someone.

On 1/17/18 at 11:38 a.m. Staff I CMA stated she gave the resident Citrucel on 12/16/17. The resident did not have her own supply so she borrowed from someone.

The facility's Policy and Procedure for Bowel Assessments, dated 12/3/14, instructed if the

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F 684	Continued From page 6 resident did not have a BM in 2 days, staff would administer a PRN laxative, If no BM in 3 days, staff would administer a suppository.	F 684		
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 observation, record review and staff interview, the facility failed to ensure that the resident environment remained as free of accident hazards as possible; and each resident received adequate supervision and assistance devices to prevent accidents for 3 of 10 residents reviewed. Resident #1 fell and sustained a pelvic fracture on 12/14/17. Interviews with staff revealed prior to the fall, staff observed the resident self-transferring and toileting self; and Resident #1 did not reliably use the call light. The facility failed to revise the resident's plan of care based on Resident #1's needs. Resident #3 had 8 falls in 6 months, hitting their head during 4 of the falls. The facility failed to fully investigate the falls to identify if interventions were in place or revise interventions to increase supervision of the resident. Resident #2 fell during self-transfers to the toilet or from bed. The facility failed to increase supervision of the resident. Facility census was fifty-one (51) residents.	F 689	F689 Without waiving the foregoing statement, the facility states that with respect to resident #1, #2 and #3, and all similarly situated residents, the facility has reviewed and revised where appropriate facility practices and policies related to the residents' environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Additionally, the facility has reviewed and revised where appropriate facility practices and policies related to admission fall risk assessment, falls investigation protocol, resident nurse assessment post fall, appropriate interventions for residents at risk for falls and post falls, develop and implement comprehensive resident-centered care plans.	

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F 689	Continued From page 7 Findings include: 1. A Minimum Data Set (MDS) with assessment reference date of 11/27/17 assessed Resident #1 with a Brief Interview for Mental Status (BIMS) score of "12" (moderate cognitive impairment). The resident required extensive staff assistance of one staff with bed mobility, transfers, and toileting. The resident required limited staff assistance with ambulation in room, dressing and personal hygiene. The resident was occasionally incontinent of bladder and frequently incontinent of bowel. A "balance during transitions and walking" test revealed the resident was not steady and only able to stabilize with staff assistance in all areas of testing. The MDS identified the resident with almost constant pain with intensity of "7" that interfered with sleep and daily activity. A facility admission record dated 12/15/17 revealed the resident admitted to the facility 11/20/17 with a primary diagnosis of fractured sacrum. A fall risk assessment dated 11/20/17 identified the resident as a moderate fall risk. In response to the question "has the resident ever fallen before". The facility wrote "no" [inaccurate]. Review of physical therapy (PT) notes dated 12/6/17 revealed the resident was a continued fall risk and recommendations continued for the resident to have one person close by for supervision (ambulation) with recommendations for CGA (contact guard assistance) of one [staff] for gait with front wheeled walker. The resident required 2-3 attempts to stand at times and required verbal cues for proper hand placement and safety.	F 689	The Director of Nursing and Assistant Director of Nursing have re-educated nurses, and the MDS RN on the requirement that the residents' environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Additionally, all nurses have been re-educated on facility practices and policies related to admission fall risk assessment, falls investigation protocol, resident nurse assessment post fall, appropriate interventions for residents at risk for falls and post falls, develop and implement comprehensive resident-centered care plans. Completed: January 31, 2018 All nurses and direct care staff have been re-educated on the capabilities of residents to appropriately utilize the call system to request staff assistance based on resident's cognitive status. All direct care staff re-educated on following residents' care plans and the monitoring of residents who are high risk for falls. Completed: January 31, 2018 All staff re-educated on the requirement that the residents' environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Completed: January 31, 2018 The Director of Nursing and/or their designee will review all falls investigations, assessments, care plans and interventions promptly. Interdisciplinary team will be utilized to discuss and determine if interventions are appropriate. ONGOING The Director of Nursing and/or their designee will conduct observational audits of nurses and direct care for following residents' plan of care, residents' interventions are appropriately in place per care plan, nurse assessment skills audits, and review electronic medical records for proper documentation and/or care plan interventions. ONGOING	

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F 689	Continued From page 8 An incident report dated 12/14/17 at 9:10 a.m. and documented by Staff A RN (registered nurse) revealed staff heard a noise in the resident's bathroom and found the resident on the floor on her back parallel to the sink with her head near the toilet. The resident stated she was "going to the bathroom". Staff observed an abrasion to the left elbow. A progress note dated 12/14/17 at 9:52 a.m. revealed the resident complained of pain at level "5" on a scale of 0 to 10 with 0 being no pain and 10 being the worst pain. There was no shortening or external rotation noted. The resident denied increased pain related to the fall. The resident was able to bear weight. The resident informed staff she thought she should see a doctor. A progress note dated 12/14/17 at 10:20 a.m. revealed staff called the physician who had no clinic openings and directed staff to send the resident to the ER (emergency room). Staff called the resident's family to see if they could transport the resident to the ER. Staff attempted to sit the resident on the side of the bed and the resident was unable to tolerate sitting up due to pain. Staff then decided to call for an ambulance. A progress note dated 12/14/17 at 11:04 a.m. identified the resident heard a "pop" sound when she moved the left leg and then staff transferred her to ER. A progress note dated 12/14/17 at 1 p.m. revealed the resident returned to the facility with diagnosis of left superior and inferior pubic rami fracture. The physician increased the resident's hydrocodone to 1 every 4 hours as needed for	F 689	The Director of Nursing and/or their designee will conduct observational audits of nurses and direct care for following residents' plan of care, residents' interventions are appropriately in place per care plan, nurse assessment skills audits, and review electronic medical records for proper documentation and/or care plan interventions. ONGOING	

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F 689	Continued From page 9	F 689		

pain and orders for PT to evaluate and treat the new fracture.

A hospital emergency room (ER) history and physical dated 12/14/17 revealed the resident admitted to the nursing home to recuperate from a sacral fracture received from a fall prior to Thanksgiving.
The ER history and physical dated 12/14/17 revealed the resident arrived to ER with moderate pain in the left hip and groin. The onset was just prior to arrival at the ER and the result of a fall. The resident fell and landed on her left side. Staff got her up and into bed. The resident complained of discomfort to the left hip so she came to the ER. The resident had a history of sacral fracture from a previous fall and was at the nursing home getting therapy for it. The resident stated the pain was doing pretty well until this fall and now she has increased discomfort. The ER musculoskeletal exam showed limited range of motion and tenderness in the left anterior and posterior hip. There was moderate pelvic tenderness.

A radiology report dated 12/14/17 of the left hip identified moderately displaced and comminuted fractures of the inferior and superior pubic rami on the left.

The physician discharge information dated 12/14/17 at 12:28 p.m. revealed the treatment for the injuries would be pain control with initial rest and then slowly start physical therapy to allow for healing of the pelvic fractures. The resident had pain when sitting up beyond approximately 45 degrees and therefore needed to transfer back to the facility per ambulance. The physician identified this would be a long recovery and they

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F 689	Continued From page 10 would take it one day at a time. Pain Control Prior to the 12/14/17 fall with fracture, the resident received the following for pain control: Fentanyl (narcotic) Patch 50 microgram (mcg.) per hour change every 3 days. Ordered 11/30/17. Hydrocodone/APAP (narcotic) 5/325 milligrams (mg.) one every 6 hours PRN (as needed) After the 12/14/17 fall: Fentanyl Patch same as before Hydrocodone/APAP 5/325 mg. one every 4 hours PRN (ordered 12/14/17) Changed to Oxycodone 5 mg every 4 hours PRN on 12/20/17 Changed to Oxycodone 5 mg. 2 tablets every 4 hours PRN on 12/23/17. After the fall, the 12/27/17 MDS identified a decline in status with BIMS of "7" (severe cognitive impairment) and extensive staff assistance needed with transfers, dressing, toileting and personal hygiene. The resident did not ambulate. The resident reported occasional pain with pain intensity of "7" that limited day to day activities and interfered with sleep. The MDS also identified the resident developed a pressure sore. Care Plan A care plan dated 11/29/17 identified the resident with a problem of ADL (activity of daily living) deficit related to rehab and urinary incontinence. The care plan identified the resident transferred	F 689		

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F 689	Continued From page 11 with the assistance of one staff. The resident used wheelchair for distance and a walker and one staff assistance in the room. Staff should start walking the resident to the restroom using a front wheeled walker and assistance of 1 as pain allowed. Staff Interviews: On 1/8/18 at 1:27 p.m. Staff A RN stated she was assisting Resident #1's roommate when she heard a walker rattling and then saw the resident on the bathroom floor. Staff A pushed the resident's wrist button to summon help. Staff A stated the resident was reliable about using the call light and Staff A peeked in on the resident earlier in the shift and the resident's eyes appeared closed and she rested comfortably. Staff A stated it appeared the resident took 2 steps into the bathroom and went down. Staff A assessed the resident's range of motion and asked the resident to move her legs. The resident complained of pain in the left gluteal region and rated the pain as 5 on a 0 to 10 scale. Staff A palpated the resident's hips with no complaints of pain. Staff A pressed on the pubic bone and there was no increased pain (same level). They put a gait belt on the resident and assisted her to stand with no increased pain. The resident started walking and walked fine from the bathroom back to bed. The resident's daughter came and they discussed whether to send the resident to the ER for examination. The daughter preferred to wait. Shortly after, the daughter informed Staff A that the resident lifted her left leg and heard a pop. The pain then increased so they decided to send the resident to the ER. Staff A was asked why she moved the resident if she had pain and responded, she got the resident up after the fall	F 689		

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because there was no increased pain and everything else checked out fine. Staff A stated the resident wanted to see the doctor because the resident thought something was wrong, however nothing seemed to be wrong when Staff A assessed the resident.

On 1/9/18 at 10:20 a.m. Staff B, CNA (certified nurse aide) stated a call light came on and when she answered it, the resident and Staff A were in the bathroom and the resident was on the floor. Staff B stated she thought the resident went to the toilet about 1 and ½ hours before the incident. Staff A assessed the resident and the resident denied pain or injury. They got the resident up and there was no indication there was anything wrong. A couple hours later the resident said she was hurting and she went to ER. Staff B stated the resident did try to self-transfer/ambulate without assistance more than once prior to the incident. Staff B caught the resident a couple times when the resident was up per self. Staff B informed more than one nurse about it. Staff B stated there was no protocol on checking the resident. Staff B stated they knew this could happen because the resident felt better.

On 1/8/18 at 3:20 p.m. Staff C, CNA stated she caught the resident up on her own before the fall. Staff C saw the resident at least 2 times on the toilet after walking there per self. When Staff C told the resident she should not transfer/ambulate per self, the resident apologized. She stated she told nurses when the resident got up per self.

On 1/8/18 at 3:20 p.m. Staff D CNA stated she caught the resident up on her own and on the toilet 2 or 3 times before the resident fell. Staff D said she reminded the resident to use the call

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light and the resident would just smile. Staff D stated the resident didn't always remember she wasn't supposed to ambulate without assistance. Staff D told nurses when the resident self-transferred.

On 1/10/18 at 7:25 p.m. Staff E RN stated she caught the resident up unassisted before the 12/14/17 fall and then assisted the resident the rest of the way. She stated she had caught the resident less than 5 times. She stated she rarely saw the resident's call light on. Staff E stated she did not think the resident had the cognition to use the call light.

Observation

On 1/8/18 at 9:10 a.m. observation showed the resident on her back in bed. The resident stated she fell when she used a 2 step foot stool and hurt her tailbone. The resident denied falling at the facility. The resident said she got up a little bit but it was painful.

Review of the resident's medication orders revealed the resident had pain medication changes on 12/23/17 to Oxycodone 5 milligrams 2 tablets every 4 hours as needed moderate pain. The 12/27/17 MDS (after the 12/14/17 fall) identified the resident with occasional pain that limited activity and made it hard to sleep.

On 1/9/18 at 10:55 a.m. the care plan nurse stated no care plan revisions were made based on staff knowing the resident self-transferred and tried to toilet self. She was not aware the resident self-transferred until the day of the fall (12/14/18). Following that fall, the new intervention was to keep a commode by the bed. She also stated the

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F 689	Continued From page 14 care plan did not contain any revision based on the resident not being reliable with call light use. 2. A MDS with assessment reference date of 11/10/17 assessed Resident #3 with a BIMS score of "5" (severe cognitive impairment). The resident required extensive staff assistance e with transfers and bed mobility. The resident required limited staff assistance with toileting and personal hygiene. A "balance during transitions and walking" test identified the resident as not steady and only able to stabilize with staff assistance while toileting. The resident was identified as not steady and able to stabilize self in all there areas of testing. A physical therapy (PT) recommendation at end of therapy dated 3/31/17 identified the resident should use a front wheeled walker and shoes with all mobility. An incident report dated 8/3/17 at 11:58 a.m. identified an unwitnessed fall in the resident's bathroom. Staff found the resident on her back in the bathroom. The intervention following the incident was to move the plastic organizer into the shower room to free up space. The fall investigation did not identify what the resident had on her feet when the fall occurred. An incident report dated 8/3/17 at 2:15 p.m. identified an unwitnessed fall in the resident's room. Staff found the resident on the floor between the bed and wall with right foot under the left leg. Bleeding was noted by the resident's right eye. The incident report identified a 2.5 cm. cut in the eyelid with swelling and purple discoloration. The resident transported to the emergency room (ER). The incident report revealed the resident's	F 689		

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left shoelace was untied. The intervention was for the resident's family to come and free up space in the room.

ER records dated 8/3/17 revealed a CT (computerized tomography) and scan was done which with negative results. The physician performed 0.5 cm. repair to the right upper eyelid full thickness laceration. The skin was closed with adhesive. The ER report also identified a contusion to the right eye.

An incident report dated 10/1/17 at 5 a.m. identified an unwitnessed fall in the resident's room. Staff observed the resident sitting on the floor next to the bed. The resident did not sustain injury. The resident stated she fell out of bed. The report did not identify what the resident wore for footwear or if the walker was available. The intervention was "med review". A resident status sheet submitted to the physician for medication review, dated 10/3/17 revealed the physician stated he would discontinue the rivastigmine (for dementia) patch. A progress note dated 10/3/17 at 3:54 p.m. revealed the resident's family declined the discontinuation of the medication.

An incident report dated 10/4/17 at 7:05 p.m. revealed an unwitnessed fall in the resident's room. Staff observed the resident on the floor with back against chair. The resident hit her head. The resident could not identify why she fell. The report did not identify what the resident was trying to do. The resident had a 2 cm. by 2 cm. red area to the back of the head. The resident had socks on only. Staff instructed the resident to wear shoes. The resident was not using a walker. The intervention following the incident was to check orthostatic blood pressures each shift for 3 days.

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F 689	Continued From page 16 An incident report dated 11/1/17 at 4:30 p.m. revealed an unwitnessed fall in the resident's room. Staff found the resident laying on the floor across from the bed. The resident laid on her back and it appeared the resident hit her head on the bottom drawer. The resident said she fell out of bed. Staff assessed a soft tender area to the left side of the back of the head. The report did not identify what the resident wore for footwear or if the walker was available. The intervention following the incident was to remove wheels from bed. An incident report dated 12/18/17 at 6:05 a.m. revealed an unwitnessed fall in the resident's room. The resident was on the floor between the bed and closet. The resident stated she slipped off the side of the bed. The walker was next to the bed. The resident wore improper footwear. The intervention was staff placed gripper socks on the resident's feet and assisted the resident into bed. Staff informed the family of the resident having difficulty getting in and out of bed due to the height of the bed. Resident had her own personal bed and required assistance to get in and out of bed. On 1/10/18 at 2:20 p.m. the DON stated the care plan nurse thought the family placed a new box spring on 12/21/17. An incident report dated 12/31/17 at 2:30 p.m. revealed an unwitnessed fall in the resident room. Staff found the resident on the floor leaning against the foot of the bed on the right side across from the dresser. The resident said she slid off the bed. Staff assessed slight redness measuring 4 inches by 3 inches on the mid back	F 689		

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area. The report did not identify what the resident had on her feet and if she used the walker. The intervention following the incident was to put walker in reach and resident told to notify nurse aides when wanting to transfer. Staff would also obtain an order for PT and OT (occupational therapy) to evaluate.

An incident report dated 1/15/18 at 3:29 p.m. revealed an unwitnessed fall in the resident's bathroom. The resident reported standing next to spouse and waited for him to finish using the toilet. The resident got tired of waiting and sat down. The resident did not sustain injury. The report identified the resident had shoes on and used a walker. The intervention after the incident was to instruct resident to use the call light and hourly checks for toileting and safety for 24 hours.

A care plan dated 3/17/16 identified the resident with a problem of falls. The care plan directed staff to ensure the resident wore proper footwear when ambulating and on 12/18/17 the care plan directed staff to apply gripper socks to the resident in bed. The care plan also directed staff to make comfort rounds. Make every 2 to 3 hour comfort and toileting rounds. The comfort round interventions were dated 3/17/16. On 1/19/18 at 10 a.m. the care plan nurse identified "comfort rounds" as every 2 hours. Staff checks on the resident, changes them, offers water, reposition them and ensures the call light is available.

3. A MDS with assessment reference date of 11/17/17 assessed Resident #2 with a BIMS score of "11" (moderate cognitive impairment). The resident required extensive staff assistance with bed mobility, transfers, dressing, personal hygiene and bathing. The resident had functional

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limitations in range of motion on one side of the upper and lower extremities. The resident was frequently incontinent of bladder and occasionally incontinent of bowel. The resident did not ambulate. A "balance during transitions and walking" test, revealed the resident as not steady and only able to stabilize with staff assistance when moving on and off the toilet and surface to surface transfers. The resident was unable to complete any other areas of the balance test. The resident had a diagnosis of stroke with left side weakness.

A physical therapy (PT) discharge instruction sheet directed staff to assist the resident with 2 staff and use a wheelchair for mobility.

An incident report dated 9/25/17 at 9 a.m. revealed the resident fell when he attempted to self-transfer to the toilet. The resident's wife stated she could not get there in time to stop the resident. The resident did not sustain injury. Staff educated the resident and the resident's wife to request assistance from nursing staff for all transfers. (Bathroom related) The fall investigation did not identify when staff last saw or toileted the resident.

An incident report dated 10/7/17 at 6:15 p.m. revealed the resident pulled on the door to the bathroom and fell to the floor with the wheelchair sliding away. The resident hit his head on the foot board. Staff assessed a 2 inch abrasion to the forehead. (Bathroom related). The intervention was to not place the resident in front of the bathroom door as the resident thinks he can use it for a transfer bar. The fall investigation did not identify when staff last saw or toileted the resident.

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F 689	Continued From page 19 An incident report dated 11/15/17 at 11:15 a.m. revealed the resident tried to get up per self. Staff observed the resident lying beside the bed with his head at the foot of the bed. The resident wore gripper socks. The resident's bed contained a waffle mattress that elevated the height of the bed. Staff assessed a 3 inch red area on the left side of the coccyx that resolved after staff lifted the resident from the floor. The resident was incontinent of bowel. The resident stated he needed to use the bathroom so he tried to get there. (Bathroom related) The intervention following the incident was to remove the waffle mattress and get a PT evaluation. The fall investigation did not identify when staff last saw or toileted the resident. An incident report dated 12/6/17 at 12:30 a.m. revealed the resident rolled out of bed. Staff observed a superficial abrasion to the top of the scalp 4 centimeters (cm.) in diameter with slight swelling. The resident stated he tried to get more comfortable because his back hurt and then he was on the floor. The intervention was 1 hour checks and offer Tylenol PM at the earliest nonverbal signs of pain. A care plan dated 6/2/17 identified the 1 hour checks done for 24 hours only. On 1/10/18 at 1:30 p.m. the care plan nurse confirmed the hourly checks were for 24 hours only. The fall investigation did not identify siderail use or when staff last saw or toileted the resident. An incident report dated 12/9/17 at 2:23 p.m. revealed the resident fell at his wife's apartment when the resident attempted to stand up. The resident did not sustain injury. The resident stated he was going to the bathroom. (Bathroom related) The fall investigation did not identify when staff	F 689		

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last toileted the resident. The intervention for the incident was to ensure the resident's foot pedals were on and wheelchair locked when the resident worked on projects.

An incident report dated 12/12/17 at 9:15 p.m. revealed the resident was lying on the floor parallel to the bed. The resident did not sustain injury. The resident exhibited confusion stating his bed was sold and he needed to clean it up before it was picked up. The fall investigation did not identify siderail use or when staff last saw or toileted the resident. The intervention was 1 hour checks for 24 hours.

A care plan dated 6/2/17 identified the resident with a problem of falls due to stroke that left the resident unable to use his left side. The care plan directed staff to transfer with 2 or more staff and a gait belt. The care plan directive for toileting was 1 or more staff assist the resident with toileting. There was no frequency identified or any change in the toileting plan even though the resident had falls related to bathroom needs. The care plan did not contain any information about siderails.

Observation showed on 1/8/18 at 1:07 p.m. one staff transfer the resident to the toilet with a gait belt. On 1/10/18 at 3:30 p.m. the DON (director of nursing) stated the facility asked PT reevaluate the resident today for transfer needs and the PT was going to change the resident from needing 2 staff to assist with transfers to 1 staff for transfers.

Observation showed on 1/8/18 at 2:57 p.m. the resident in bed which was at regular height with siderails up on each side of the bed. The siderails

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F 689	Continued From page 21 covered the center portions of the bed on each side with a small open space at the foot and head of bed on both sides.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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). §483.35(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. §483.35(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. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility record review, observations and resident and staff interviews, the facility failed answer call lights in a	F 725	F 725 Without waiving the foregoing statement, the facility states that with respect to resident #2, #4, #5, #8, and #9, and all similarly situated residents, the facility has reviewed and revised where appropriate facility practices and policies related to the processes of use of call lights, the Elpas System, and implementation of call light response in a timely manner. The Director of Nursing and Assistant Director of Nursing have re-educated nurses and direct care staff on the requirement to processes of use of call lights, the Elpas system, and implementation of call light response in a timely manner. Completed: February 7, 2018 The Director of Nursing and/or their designee will monitor call light response and perform random audits to ensure the appropriate processes of use of call lights, the Elpas System, and implementation of call light response in a timely manner are being utilized. ONGOING	

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timely manner to meet the needs of 5 of 10 residents reviewed (#2, #4, #5, #8 and #9). The facility identified a census of 51 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 10/20/17 assessed Resident #4 with a brief interview for mental status (BIMS) score of 15 indicating no cognitive impairment. The resident required the assistance of one with dressing and bathing and transferred, walked and used the toilet independently.

A care plan dated 3/21/17 identified the resident had residual effects of stroke and weakness. The care plan directed staff to ensure the resident's call light was in place and instruct/remind/encourage the resident to utilize it for assistance.

On 1/8/18 at 11:15 a.m. Resident #4 stated once in a while it takes a while to get help. He did not time it.

Review of call light response revealed the following dates and lengths of response for his activated call light:

12/1/17 9:28 p.m. to 10:33 p.m.= 1 hour 4 minutes
12/11/17 9:08 a.m. to 9:30 a.m.=21 minutes 56 seconds
12/12/17 8:09 a.m. to 8:33 a.m.=24 minutes 3 seconds
12/14/17 4:49 p.m. to 5:06 p.m.=17 minutes 43 seconds
12/16/17 8:22 a.m. to 8:45 a.m.=23 minutes
12/19/17 4:44 p.m. to 5:18 p.m.=34 minutes and

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F 725	Continued From page 23 27 seconds 12/21/17 5:34 p.m. to 5:50 p.m.= 16 minutes 57 seconds 12/23/17 7:49 p.m. to 9:19 p.m.= 1 hour 30 minutes 12/24/17 4:59 p.m. to 5:19 p.m.=20 minutes 1/6/18 10:52 a.m. to 11:42 a.m.=49 minutes 32 seconds 1/6/18 12:05 p.m. to 12:23 p.m. 18 minutes 11 seconds Review of the resident's Progress Notes revealed he had loose stools on 1/6/18. There was no other documentation of illness in January 2018. 2. The MDS assessment dated 10/11/17 assessed Resident #5 with a BIMS score of 15. The resident required the assistance of one staff with transfers and toilet use and she did not walk. A care plan dated 2/20/17 identified the resident at risk for falls related to weakness, pain, and instability with surface to surface transfers. The care plan directed staff to be sure the resident's call pendant or bracelet was in reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. On 1/8/18 at 12:45 p.m. the resident informed the surveyor she needed help and couldn't get any. When asked if she activated the call button on her wrist band, the resident said she had. Review of the resident's call light report revealed the resident activated the call button at 12:30 p.m. and staff turned it off at 12:31 p.m. On 1/10/18 at 9 a.m. the DON (Director of Nursing) stated Staff G CNA (certified nursing	F 725		

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F 725	Continued From page 24 assistant) turned the call light off and was on her way to help the resident. On 1/10/18 at 9:12 a.m. Staff G denied turning the call light off. She stated she was in a room with a resident and didn't know a call light was on. She did not have a tablet to use so the only way she could see if a resident needed help would be to to look at a computer. On 1/10/18 at 9:24 a.m. the DON said the facility ordered more tablets. According to call light print out dated 1/8/18, the resident activated her call light at 6:43 p.m. and staff responded to it at 7:06 p.m. (22 minutes 52 seconds). 3. The MDS assessment dated 11/17/17 assessed Resident #8 with a BIMS score of 15. The resident required the assistance of one with transfers, dressing and bathing. A care plan dated 6/30/16 identified the resident at risk for falls related to age, medications, disease process and mechanical devices. The care plan directed staff to ensure the resident's call light was in reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. During interview on 1/8/18 at 9:50 a.m. the resident stated there were long waits for her call light response. The resident did not time it and did not have any incontinent episodes waiting. Review of the resident's Call light response record revealed:	F 725		

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F 725	Continued From page 25 a. 12/1/17 8:41 a.m. to 9:02 a.m.=21 minutes 30 seconds b. 1/7/18 6:48 p.m. to 7:26 p.m.=37 minutes 52 seconds 4. The MDS assessment dated 11/17/17 assessed Resident #9 with a BIMS score of 9, indicating moderate cognitive and memory impairment. The resident required the assistance of one with transfers and toilet use. A care plan dated 6/25/13 identified the resident at risk for falls related to age, diagnoses and limitations. The care plan directed staff to ensure the resident's call light was in reach and encourage the resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance. During interview on 1/8/18 at 10:10 a.m. the resident stated it takes awhile to get help. The resident denied accidents waiting for staff assist. Review of the resident's Call light response record revealed: 12/2/17 5:01 p.m. to 5:21 p.m. 19 minutes 44 seconds 12/3/17 1:17 p.m. to 1:34 p.m.=16 minutes 54 seconds 12/3/17 6:41 p.m. to 7:15 p.m. 34 minutes 12/7/17 6:07 p.m. to 6:50 p.m. 43 minutes 1 second 12/10/17 6:34 p.m. to 6;50 p.m. 16 minutes 33 seconds 12/15/17 11:47 a.m. to 12:29 p.m. 41 minutes 45 seconds 12/17/17 11:40 a.m. to 12:05 p.m. 24 minutes 9	F 725		

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F 725	Continued From page 26 seconds 12/20/17 6:43 a.m. to 7:04 a.m. 20 minutes 24 seconds 12/20/17 7:12 a.m. to 7:33 a.m. 20 minutes 9 seconds 12/20/17 6:43 p.m. to 7 p.m.=16 minutes 35 seconds 12/20/17 7 p.m. to 7:17 p.m. 17 minutes 6 seconds 12/23/17 12:43 p.m. to 1:03 p.m.= 19 minutes 44 seconds 12/24/17 8:27 p.m. to 8:56 p.m.= 29 minutes 4 seconds 12/26/17 9:13 a.m. to 9:31 a.m.=17 minutes 35 seconds 1/3/18 3:19 p.m. to 3:41 p.m. =20 minutes 6 seconds 1/5/18 6:20 p.m. to 6:38 p.m.=17 minutes 45 seconds 1/6/18 10:38 a.m. to 10:59 a.m. =21 minutes 2 seconds 1/6/18 3:41 p.m. to 3:59 p.m.=17 minutes 17 seconds 1/6/18 4:49 p.m. to 5:06 p.m.=17 minutes 8 seconds 1/7/18 11:48 a.m. to 12:10 p.m.=21 minutes 54 seconds 5. The MDS assessment dated 11/17/17 assessed Resident #2 with a BIMS score of 11, indicating moderate cognitive and memory impairment. The resident required the assistance of two staff with bed mobility and transfers and the assistance of one with dressing, personal hygiene and bathing. Resident #2 did not walk and had functional limitations in range of motion on one side of the upper and lower extremities. The resident had a diagnosis of stroke with left side weakness.	F 725		

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F 725	Continued From page 27 The resident's care plan dated 6/20/17 did not address his call light use. The care plan documented he required the assistance of one or more staff with bed mobility and the assistance of two or more staff to transfer. On 1/8/18 at 10:02 a.m. Resident #2 stated he had a long wait for the call light that morning. He times it with a clock and he thought it was on from 5:55 a.m. to 6:30 a.m. He stated he made it in time to the bathroom. Review of the resident's Call light response record revealed: 12/1/17 9:06 a.m. to 9:22 a.m.=16 minutes 12 seconds 12/15/17 7:59 a.m. to 8:34 a.m.=35 minutes 19 seconds 12/21/17 8:47 a.m. to 9:07 a.m.=19 minutes 9 seconds 12/23/17 6:55 p.m. to 7:20 p.m.=25 minutes 12 seconds 12/24/17 8:52 a.m. to 9:20 a.m.=28 minutes 37 seconds 1/1/8 8:55 a.m. to 9:19 a.m.=23 minutes 55 seconds 1/7/18 8:35 a.m. 8:59 a.m.=23 minutes 43 seconds 1/8/18 8:15 a.m. to 8:35 a.m.=19 minutes 33 seconds A call light policy dated 1/27/16 instructed when the call light goes off the staff will answer the call for help as quickly as possible. Maximum wait time for any resident is to be less than 15 minutes. If the call light isn't answered in 2 minutes time, all those with tablets will be notified	F 725		

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F 725	Continued From page 28 of the need for help. If the call light isn't answered in 5 minutes time, this will show on the tablet as well and the charge nurse will investigate the reason for the wait time. If the call light isn't answered in 10 minutes time the DON and all other administrative staff will receive notification on their computers. Staff are not to turn off any call light before they are in the resident's room or direct proximity of the resident. This can be tracked and disciplinary action will be taken if this happens. If the call light isn't working properly or becomes damaged the DON or designee will replace the call light with a new one and test it before giving it to the resident. The expectation is to cancel the call light at the resident's door. On 1/10/18 at 9 a.m. the DON stated the call lights showed they were longer than 15 minutes because staff did not cancel the call light properly on the computer or tablet. On the same date at 9:30 p.m. the ADON stated if staff did not cancel the original (first) notification of a call light, then it would show the call light was not canceled. She stated staff are trained but they don't always do it correctly.	F 725		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 919		

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F 919	Continued From page 29 Based on clinical record review, observations and resident and staff interviews and observations, the facility failed to ensure a working call system was in place for 3 of 10 residents reviewed (Residents #4, #6 and #7). The facility identified a census of 51 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 10/20/17 assessed Resident #4 with a brief interview for mental status (BIMS) score of 15 indicating no cognitive impairment. The resident required the assistance of one with dressing and bathing and transferred, walked and used the toilet independently. A care plan dated 3/21/17 identified the resident had residual effects of a stroke and weakness. The care plan directed staff to ensure his call light was in place and instruct/remind/encourage to use it for assistance. On 1/8/18 at 11:15 a.m. Resident #4 stated the other night he got sick and kept pushing his call button. He needed a nurse and couldn't get one. He stated the battery on the wrist call band was dead. He stated he happened to see a staff member in the hall so he got help. Review of call light response revealed: 1/4/18 10:42 p.m. low battery 1/5/18 4:54 a.m. low battery 1/5/18 9:38 a.m. low battery 1/5/18 2:14 p.m. low battery 1/5/18 5:16 p.m. low battery Review of the resident's progress notes revealed	F 919	F 919 Without waiving the foregoing statement, the facility states that with respect to resident #4, #6, and #7, and all similarly situated residents, the facility has reviewed and revised where appropriate facility practices and policies related to the processes of maintenance and operational function of call lights and the proper use of the Elpas system. The Director of Nursing and Assistant Director of Nursing have re-educated nurses and direct care staff on the processes of maintenance and operational function of call lights and the use of the Elpas system to prevent non-operational call lights. Completed: February 7, 2018 Protocol developed and implemented to monitor call light battery levels each shift to ensure compliance with the processes of maintenance and operational function of call lights. Completed: February 7, 2018 The Director of Nursing and/or their designee will monitor compliance with the maintenance and operational function of call lights and the proper use of the Elpas system. ONGOING	

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F 919	Continued From page 30	F 919		

he had loose stools on 1/6/18. There was no other documentation of illness in January 2018.

2. The MDS assessment dated 12/15/17 assessed Resident # 6 with a BIMS score of 15, indicating no cognitive impairment. The resident's diagnoses included high blood pressure and diabetes mellitus.

The care plan dated 4/3/17 identified the resident as alert and oriented with limitations in his shoulder. The resident remained relatively independent and difficulty with his socks. The care plan directed staff to instruct/encourage the resident to use the call light for assistance.

During interview on 1/8/18 at 10:15 a.m. Resident #6 stated sometimes staff doesn't show up at all when he activates the call button. He stated he figured out the battery is dead when that happens. He stated he never knows if the call button actually works or not and has waited 20 minutes to an hour.

3. A MDS with assessment reference date of 12/9/17 assessed Resident #7 with a BIMS score of 15. The resident required the assistance of one with bed mobility and bathing.

A care plan dated 2/26/16 identified the resident with an ADL (activities of daily living)/rehab problem related to chronic and acute pain, weakness. The care plan directed staff to ensure the call light was in place and instruct/encourage/remind the resident to utilize it for assistance.

On 1/8/18 at 11:22 a.m. the resident stated she used the call light and not long ago, she had the

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F 919	Continued From page 31	F 919		

call light on for an hour. She thought it was in the last week. She stated the battery was dead in the call button bracelet and she didn't know it. She denied incontinence from waiting for assistance.

On 1/8/18 at 3:50 p.m. the surveyor checked the Elpas call light system with Staff H RN (registered nurse), The viewing showed one resident had a wrist band with a dead battery and another resident's device was missing since 1/3/18 at 8:52 a.m. At the time of the check, the care plan nurse stated the system should be checked every shift for dead batteries or missing devices but the facility had no policy. Nurses have never been told to check the system and the ADON (assistant DON) checks it on Fridays. After viewing the system and seeing a resident had a dead battery, the surveyor and Staff H RN went to the resident and confirmed the battery in the wrist band was dead. They also checked the resident that had a missing device and did not find a device on the resident. Both residents lived on the CCDI (chronic confusion and dementing illness) unit. Staff H stated, even though there was a solid red line present on the system, she thought the battery was Ok because the battery showed up green and the system said it was OK

On 1/8/18 at 4:03 p.m. Staff A RN stated the Elpas system was not assigned to the nurses to check and office staff do the checks. She stated the care plan nurse tells her if she needs to check it. When she checks it, she stated she looks for the green battery signal and also checks for when a device was last identified by the system. If its been a couple days, she checks the wrist device.

A call light policy dated 1/27/16 directed when the call light goes off the staff will answer the call for

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F 919	Continued From page 32 help as quickly as possible. An addendum to the policy dated 1/8/18 directed that call lights will be checked every shift by Charge Nurse 1 and the battery changed if a solid red line shows on the screen.	F 919		