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F 000	INITIAL COMMENTS Complaint Investigation #1642192/IL84987 - F157, F323 Complaint Investigation #1642152/IL84945 - F309, F314, F323 Complaint Investigation #1642254/IL85063 - No deficiencies	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

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

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

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to immediately inform a resident's family and physician of a fall for 1 of 4 residents (R4) reviewed for timely notification in the sample of 19.

Findings include:

An SBAR (Situation Background Assessment Recommendation) Communications Form and Progress Note, written by E4, License Practical Nurse (LPN), dated 4/22/16, documents R4 was sitting on the side of the bed when she slid to floor hitting the right side of her head. The form documents notification of Z5, R4's family member, and Z6, Physician, on 4/22/16, but fails to document the time of notification.

The Incident Report, dated 4/22/16 completed by E8, LPN, documents Z6 was notified at 3:40 AM on 4/22/16 and has 4 documented for Z5's notification time in a different hand writing, but doesn't indicate if it's AM or PM.

On 4/26/16 at 11:30 AM, Z7, R4's family member stated that Z5, R4's POA (power of attorney), was not notified until the following day when R4 had a drastic condition change and the facility called to notify them of that.

On 4/28/16 at 9:05 AM, E2, Director of Nurses

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F 157	Continued From page 2 (DON), confirmed that Z5, R4's POA, was not notified of the fall until the following day on 4/23/16 when they called about R4's condition change. E2 stated she looked at the documentation and spoke with the nurses and neither called, thinking the other had. The facility's Change in Condition or Status-Notification policy, dated 2016-03, documents the facility shall promptly notify the resident, his or her Attending Physician and Representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g. change in level of care, billing/payments, resident rights, etc.) Under Guidelines, it documents notification will be done when there has been an accident or incident involving the resident, a significant change in resident's physical/emotional/mental condition, a need to alter the medical treatment significantly, need to transfer the resident to hospital/treatment center and instructions to notify the physician of changes in condition in part. The Policy also indicates that notification will be done for family's/representative when the resident in involved in any accident or incident that results in injury or injuries of unknown origin.	F 157		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to identify/assess and monitor condition changes for 1 of 5 residents (R5) reviewed for change of condition in a sample of 19. This failure resulted in R5's hospitalization.

Findings include:

R5's Minimum Data Set (MDS), dated 4/11/16, documents that R5 is cognitively impaired, requires extensive assist of two for bed mobility and transfer, R5 does not ambulate, mobility per wheelchair. R5's MDS also documents that R5 is at high risk for falls, and pressure ulcers.
R5's hospital discharge record, dated 3/22/16, documents that R5 had a right leg above the knee amputation on 3/16/16 due to Vascular disease and, a "right fourth and fifth toe dry, gangrene, and non healing extremity arterial ulcers." It also documents that R5 was discharged back to the facility on 3/22/16 with orders for dressing changes daily and follow up appointments with Z3, Surgeon. R5's hospital record documents that R5 has a history of pressure ulcers. R5's facility records lack any documentation of gangrene on the right toes.

On 5/4/16 at 9:00 AM, E12 and E13, Wound Nurses, stated, "(R5) had no gangrene on the right toes when (R5) left here on 3/13/16 to be admitted to the hospital."

R5's Communication Form and Progress Note, dated 3/22/16, documents in part that R5 "was readmitted to facility with a right above the knee amputation surgical site. No notable open areas."

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R5's Nurses Notes, dated 4/11/16 at 10:15 PM and signed by E15, Licensed Practical Nurse (LPN), documents in part that R5 "fell out of bed and was found on floor, lying on (R5's) right side on the floor. Head to toe assessment done." This Nurses Note lacked any documentation of the right stump surgical site.

R5's Incident Report, dated 4/11/16 and signed by E15, documents that R5 fell out of bed and was found lying on R5's right side at 10:15 PM. The Incident Report documents that R5 sustained a raised area on the right forehead. The Incident Report documents that facility was unable to call R5's Physician so the on call service for the facility was notified. The Incident Report documents, "Assessed for injuries."

R5's on call service Episode Note, dated 4/12/16 at 12:25 AM, documents in part, "Evaluation of the patient after a fall. RN (E14, LPN) reports that fall was minimal. The patient had localized swelling to the right forehead. No other complaints reported. The patient rolled out of bed. Neuro checks per facility protocol." The Episode Note lacked any documentation of the right stump surgical site.

R5's Nurses Note, dated 4/12/16 at 11:10 AM, documents in part, that during a dressing change, it was noted that, "(R5's) right stump surgical site had a dehisce area (surgical site had opened up) about 1.3 cm (centimeters) by 3.0 cm by 0.4 cm." The Nurses Note also documents that (R5's) physician was notified.

R5's Nurses Note, dated 4/12/16 at 1:45 PM, documents in part, that Z4, Z3's Nurse, stated

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R5's incision must have opened up with the fall last night and Z3 would have expected the surgical site to be assessed at the time of R5's fall on 4/11/16.

R5's Nurse Notes, dated 4/11/16-4/14/16 day shift notes, document that R5's right stump surgical site was healing, clean, and intact.

The facility's Wound History Note, dated 4/7/16, lacks any documentation of R5's surgical site dehiscing. No drainage and healing.

Z3's Progress Note, dated 4/15/16, documents, "(R5's) Right above the knee stump is now open."

On 4/26/16 at 2:00 PM, E12, Wound Nurse/LPN, stated "I would expect the staff to do a head to toe assessment, including the right stump surgical site."

On 4/27/16 at 3:05 PM, E15 stated "I didn't do (R5's) assessment after the fall on 4/11/16. (E14, LPN) did the assessment and called the physician on call services. I just documented the incident in the Nurse Notes."

On 4/27/16 at 3:10 PM, E14 stated "I haven't assessed any falls for (R5) since (R5) returned from the hospital from having the right leg amputated (3/22/16). I never took any dressing off of (R5's) right leg stump and assessed the surgical wound after any falls."

On 4/27/16 at 3:25 PM, E15 stated, "I guess I did the assessment after I returned to the floor after (R5's) fall on the 4/11/16. I did a head to toe assessment. I did not take the dressing off and assess the right stump surgical site."

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On 4/27/16 at 11:00 AM-11:15 AM, Z4 stated, "(Z3) said (Z3) would have expected the facility to remove the right stump dressing and assess the surgical site at time of the 4/11/16 fall."

R5's Daily Skilled Nurse Note for 4/15/16, 11:00 PM-7:00 AM, has no documentation of R5 having a fever, abdominal pain, vomiting, poor appetite, or acting sleepy.

R5's Daily Skilled Nurse Note for 4/16/16 10:00 AM documents that pain medication was given and right stump dressing change done and right stump felt warm. The Note lacks any documentation of R5 having a fever, abdominal pain, vomiting, poor appetite, or acting sleepy.

The facility's Daily Assignment Sheet, dated 4/16/16 for the 7:00 AM-3:00 PM shift (no specific time documented), documents that R5's vital signs were 153/69, pulse=62, respirations=26 and temperature=103.8. Over those readings in a different type marker is written pulse=62, respirations=26 and temperature=99.8.

R5's Nurses Note, dated 4/16/16 1:20 PM, documents that family reported that R5 "was not acting right" and did not seem responsive. The Note documents Vital signs were Blood Pressure=136/72 Pulse=76, Respirations=22, and Temperature=99.8"

R5's Nurses Note, dated 4/16/16 1:50 PM, documents that the facility received orders to send R5 to the hospital for evaluation for possible wound infection and to insert a access line for antibiotics. The Note also documents R5 was sent to the hospital Emergency Department.

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R5's on call service Episode Note, dated 4/16/16 at 2:43 PM, documents in part, "Patient has a open area at Above the Knee Amputation (right leg stump). Today has poor appetite and fever, earlier to 103.8 and now 99.8. Patient sleepy. Wound stump on right is warm. Wound infection. Plan to start vancomycin (intravenous antibiotic) Will send to Emergency Department for access line."

R5's Hospital admission records, dated 4/16/16, document in part, "Patient presented to Emergency Department with abdominal pain and lethargy. Patient was admitted with acute cholecystitis (inflammation or infection of the gall bladder), pancreatitis (inflammation or infection of the pancreas), and possible sepsis (body/blood infection)."

On 4/27/16 at 11:00 AM, E16, Certified Nurses Aide (CNA), stated "I got (R5) up in the morning of 4/16/16. (R5) looked sleepy and did not look like (R5) felt well. (R5) didn't eat anything at breakfast and (R5) was laying (R5's) head on the dining room table. I told (E2, Director of Nursing) that (R5) did not look well, wasn't eating, and had what looked and smelled like vomit on the floor mat next to (R5's) bed when I got (R5) up. (E2) said to lay (R5) down. I also told all this to (E17, LPN) when (E17) came in to relieve (E2) later that morning."

On 4/27/16 at 11:30 AM, E17 stated that, "I did not know anything was wrong with (R5) on 4/16/16 until the family told me that afternoon. I was told nothing about a fever, lethargy, or vomiting"

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F 309	Continued From page 8 On 4/27/16 at 3:00 PM, E2 stated, "I was aware that (R5) didn't feel good that day. (R5) was not eating and was laying (R5's) head on the table during breakfast. I saw the floor mat that morning, but was not sure it was vomit. The 103 temperature that was written under the other vital signs on the Daily Assignment Sheet was from that morning, but I did not think that was accurate so they took it again and it was around 99 degrees. I had no report from the night shift that (R5) had vomited during the night. I did give report to (E17). I did not chart the incident or call the physician." The facility's policy titled, Change In Condition or Status Notification (Revised March 2016) documents in part, "If a significant change in the residents physical condition occurs, a comprehensive assessment of the residents condition will be conducted."	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement	F 314		

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preventative measures, timely identify, assess and treat pressure ulcers for 3 of 4 residents (R1, R2, R3) reviewed for pressure ulcers in the sample of 19. This failure resulted in R3 developing unstageable pressure ulcers in the coccyx, sacrum and heel within 12 days of admission.

Findings include:

1. On 4/26/16 from 9:15 AM-9:30 AM, based on continuous observation, R3 was in the 300 hall dining room. R3 was sitting in a wheelchair with lower half of his buttocks hanging off the wheelchair's seat. R3's pants were bunched up around the groin and coccyx area. E19, Certified Nurses Aide (CNA), was in the 300 hall dining room and E19, Registered Nurse (RN), was approximately 20 feet from R3 outside of the 300 hall dining room area. E18 and E19 were within viewing area of R3.

On 4/26/16 from 10:15 AM-10:30 AM, based on continuous observation, R3 was sitting in his wheelchair, in the 300 hallway, within 20 feet of the 300 hall Nurses Station. R3 was sitting in wheelchair with the lower half of his buttocks hanging off the wheelchair's seat. E19 walked by R3 at least twice without repositioning R3 during that time frame.

On 4/27/16 at 1:30 PM, R3 was lying in bed with both heels, buttocks, and back in contact with the mattress. R3 had a large adhesive bandage on the left heel. R3 lacked any elbow or heel protectors.

On 4/28/16 at 7:20 AM, R3 was in bed with no dressing on the left heel area, and R3's sacral

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dressing was unattached to his sacral area and saturated with red and yellow drainage. R3 lacked any sponge boots on feet, and elbow or heel protectors.

On 4/28/16 at 8:10 AM, R3's pressure areas were measured by E12, Wound Nurse, and E13, Wound Nurse as left heel area: 2.5 Centimeters (cm) by 2.2 cm, Sacrum area: 4 cm by 6 cm, Coccyx area: 3 cm by 1.5 cm. The sacrum area was excoriated, red and had layers of skin missing with in the area. The 4 cm by 6 cm sacral area contained 4 open areas within the 4 cm by 6 cm sacrum area. The Sacrum dressing was saturated with a large amount of red and yellow drainage. E12 and E13 did not measure the 4 open areas on the sacrum. R3 lacked any elbow or heel protectors.

R3's Minimum Data Set (MDS), dated 4/15/16, documents in part, that R3 was admitted on 4/8/16, requires extensive assistance of two for bed mobility, dressing, toileting, and personal hygiene. The MDS also documents R3 requires extensive assistance of one for transfer and locomotion in a wheel chair. R3's MDS also documents that R3 is incontinent of bowels and bladder, is cognitively impaired, and at high risk for pressure ulcers.

R3's Care Plan, dated 4/11/16, documents that R3 is at high risk for falls and pressure ulcers and has pressure ulcers. R3's Care Plan documents that R3 is to have elbow and heel protectors and wound care as ordered. R3's Care Plan documents that staff are to assist as needed to reposition/shift weight to relieve pressure. R3's Care Plan lacks any documentation of R3's tendency to slide down in wheelchair, or the use

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of sponge boots on feet.

The Facility's admission nursing assessment has no documentation that R3 had any open ulcers on admission on 4/8/16. The facility's Pressure Ulcer Report documents that R3 developed a coccyx and sacral pressure ulcers on 4/21/16, 13 days after admission to the facility. R3's hospital progress notes, dated 4/5/16, documents that R3 had no open areas.

The Facility's SBAR (Situation Background Assessment Recommendation)Communication Form for R3, dated 4/21/16, document in part, "Resident has two new unstageable pressure ulcers to sacrum measuring 5 cm by 3 cm and coccyx measures 3 cm by 3 cm. Moderate amount of drainage noted." The Facility's SBAR Communication Form for R3, dated 4/26/16, documents in part, "(R3) has a open area on the left medial heel measuring 1 cm by 2.5 cm."

R3's Physician Order Sheet (POS), dated 4/2016 documents that R3's left heel pressure area to have skin prep applied with an adhesive foam dressing daily. The POS also documents R3's sacral and coccyx pressure areas be cleansed with normal saline, apply Santyl (Debriding agent), and calcium alginate and cover with foam dressing daily.

Z2's, Facility Wound Physician's, Wound Notes for R3, dated 4/26/16, document in part, "Unstageable Tissue Injury of the left medial heel, duration one day, is healing, and measures 1.0 cm by 2.5 cm. Recommend sponge boot, float heels in bed and off load wound; Coccyx wound, stage 3 and one day in duration with moderate drainage, measures 2.5 cm by 3.0 cm by 0.3 cm;

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Sacrum pressure area is unstageable, is one day in duration and has moderate drainage. Sacral pressure area measures 3.0 cm by 2.5 cm."

R3's Registered Dietitian Note, dated 4/26/16, documents that R3 has a good appetite. There are no labs available for Total Protein or Albumin.

On 4/26/16 at 9:00 AM, E12 stated "All dressings should be checked during care to ensure they are clean dry and intact. All residents with open areas should be care planned and the care plan should be followed. "

On 4/26/16 at 10:30 AM, E18 stated, "(R3) slides down in the wheelchair all the time. (R3) wont fall out."

On 4/28/16 at 7:20 AM, E21, Licensed Practical Nurse (LPN), stated, "There is no dressing on (R3's) left heel pressure area and (R3's) sacrum's pressure area dressing is coming off. There should be dressings on both of those areas. (R3's) left heel area looks like a pressure area. (R3) does not have any elbow or heel protectors on."

On 4/28/16 at 8:20 AM, E12 stated, "(R3) should have a foam dressing on the left heel pressure ulcer and the sacral and coccyx areas at all times. (R3) was admitted 4/8/16 and developed the pressure areas while here. (Z2, Facility Wound Doctor) measured (R3's) areas on 4/26/16 and cleaned the middle open area on (R3's) sacrum with a nitrate stick. (Z2) did not debride the sacral or coccyx wound. (Z2) nor our wound staff measure each of (R3's) sacral open areas. We measure them as a cluster area."

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On 5/4/16 at 11:45 AM, E13 stated that she found R3's sacrum and coccyx ulcers originally on 4/21/16 and did not know why they would not have been identified by the direct care staff first. E13 stated that the areas had granulation present with beefy red appearance and some subcutaneous tissue visible when found. E13 also stated that she found the heel ulcer, as well, which was identified as a deep tissue ulcer measuring 1 cm x 2.5 cm and was purplish, but not mushy. E13 stated that the heel protectors were placed after she found the heel ulcer, not as a preventative measure upon admission from the hospital. E13 agreed that R3 slid down in the chair and also had loose stools upon admission to the facility which would play a part in the development of the sacrum and coccyx ulcer. E13 stated that daily skin checks were done on 3-11 shift for R3, but failed to identify the open areas the night before she discovered the ulcers.

On 5/4/16 at 12:30 PM, Z8, Facility Physician, stated "I possibly would have expected the staff to find the coccyx and sacral areas before they became such a significant size. Preventive measures may have benefited (R3). I would have expected staff to take preventive measures for the sliding down in the chair. The sliding may have contributed to the development of the open areas."

The Facility's Skin Management Guidelines policy, revised June 2016, documents in part, "If the resident is found to be at risk for pressure ulcers or has a history of pressure ulcers an initial care plan is developed and individualize interventions are intimated. Daily Skin Inspections: Skin evaluation should continue on a daily basis for all residents that are at risk for skin

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breakdown. It can be done by a Licensed Nurse or a CNA. Weekly Skin Evaluations: A weekly skin evaluation should be done on all residents. Minimize skin exposure to moisture: Moisture alone can make skin more susceptible to injury. Therefore it is necessary ensure that moisture form urine, stool, perspiration, and wound drainage is wiped away from the skin as much as possible. Friction and Shear: Friction and sheering are important contributing factors to the development of pressure ulcers. Proper positioning, transferring, and turning of residents will avoid injury due to friction and shear. Accurate Documentation: Accurate documentation is needed to ensure continuity of care. The care plan should directly address risk factors, pressure points, under nutrition and hydration deficits and moisture and its impact. All residents who are in bed and have been assessed to be at risk for skin breakdown. should be repositioning at least every 2 hours. This repositioning should also take place when residents are in a wheel chair."

2. R2's MDS, dated 3/12/16, documents R2 as being totally dependent on staff for all activities of daily living. The MDS also documents R2 has a urinary catheter and is incontinent of bowel.

R2's Care Plan, dated 2/10/16, identifies R2 as having a facility acquired stage IV pressure ulcer to his coccyx and trauma areas to right/left buttocks due to dressing removal. Interventions include turn every one hour and according to the turn schedule, provide heel and elbow protectors, low air mattress, and provide incontinence care when needed. There are no interventions written toward ensuring that dressing changes and treatment orders are followed and dressings

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remain intact at all times.

R2's April 2016 POS documents R2's current pressure ulcer treatment as: apply granulex spray to buttocks twice daily and "cleanse sacrum with NS (normal saline). Spray with granulex. Cover with ABD (abdominal) pad and secure with tegaderm."

On 4/26/16 at 9:05 AM, E12 and E13 rolled R2 to the left side. R2's Sacrum pressure ulcer dressing was saturated with a moderate amount of brownish drainage.

On 4/28/16 at 8:41 AM, E12 rolled R2 to his right side. R2's sacrum dressing was saturated with red blood and the top left corner and top left side of the dressing was not intact. There was a bath towel folded in thirds positioned directly under his sacrum which had smears of blood on it. Under the towel, there was a cloth incontinent pad and a quarter folded top sheet used as a turning sheet. E12 stated R4 did not have the correct dressing/treatment on as he should have an ABD on it which is more absorbent. E12 removed the dressing and washed her hands with soap and water after removing the dressing. E12 then cleansed the wound, sprayed it with Granulex and applied an ABD dressing which she covered with a large adhesive dressing. E12 stated the physician had just recently debrided the pressure sore which was a elongated open area directly over the coccyx. E12 stated that since the debridement, the area has been, as expected, bleeding a lot more.

3. R1's MDS, dated 4/18/16, documents R1 is cognitively intact and requires extensive assist of one staff for bed mobility and transfers.

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R1's Care Plan, dated 4/22/16, documents R1 is at risk for impaired skin integrity with the goal to have her skin remain intact through the next review (7/22/16). Interventions include report changes to physician, notify nurses of any new areas of skin breakdown during care, reposition resident per protocol, provide pressure relieving mattress and chair cushion, provide heel/elbow protectors, and incontinence care after episodes along with provide treatments and medications as ordered in part.

R1's Physician's Orders include a telephone order, dated 4/25/16, for staff to cleanse coccyx area with NS and apply a hydrocolloid dressing every three days.

On 4/26/16 at 8:52 AM, R1's Sacrum pressure ulcer dressing was rolled up and was not covering the sacral pressure area. E12 removed the sacral dressing and applied a new dressing to the area.

On 4/26/16 at 9:00 AM, E12 stated "All dressings should be checked during care to ensure they are clean, dry and intact. All residents with open areas should be care planned and the care plan should be followed. "

On 4/28/16 at 10:40 AM, R1 was sitting in her wheelchair at bedside. At 10:45 AM, R1 was laying in bed. R1 stated that the dressing came off "the second day" and when rolled over, her coccyx had a small slit in it with the surrounding areas being white as if from moisture. R1 had a disposable incontinent brief on which was clean and dry. The hydrocolloid dressing was not in her brief or in her bed.

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F 314	Continued From page 17 According to Admission Nursing Assessment, R1 had only a reddened area on her coccyx when admitted on 4/11/16. The Braden Scale (to assess level of risk for developing pressure ulcers) was dated 4/11/16, but was blank except for the date and R1's name. R1's Interim Care Plan, dated 4/11/16, has poor skin integrity checked along with "see risk analysis for interventions" and "See current PO (Physician's Orders)/TAR (treatment administration record) for current tx (treatment) as ordered by physician." The April 2016 TAR shows nothing until 4/13/16 when the hydrocolloid dressing was ordered. The TAR then has that order discontinued and an order to cleanse sacrum and apply Santyl, Calcium Alginate and cover with adhesive dressings which was initialed as done from 4/19 - 4/21/16. No treatment documented for 4/24/16, then the hydrocolloid dressing again started on 4/25/16. The daily skin checks are not initialed as occurring until 4/26/16, 15 days after admission.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		

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Based on interviews, observations and record review, the facility failed to adequately assess and develop an effective falls prevention plan, and failed to provide adequate supervision and devices to prevent accidents for 4 residents of 5 (R4, R5, R9 and R12)) reviewed for falls and fall prevention in a sample of 19. This failure resulted in R4 falling from the side of the bed after being left unassisted sustaining an intracranial bleed on 4/22/16.

Findings include:

1. R4's Admission Sheet documents R4 was admitted with diagnoses of Cerebral Vascular Accident (CVA), Right Hemiplegia, abnormal posture, and Dementia in part.

The April 2016 Physician's Order Sheet (POS) documents in part, that R4 receives Plavix, a blood thinner.

R4's Minimum Data Set (MDS), dated 8/7/16, 11/5/15 and 1/27/16 document R4 has moderate cognitive impairment and requires extensive assist of one staff for transfers and locomotion on and off her unit. R4's MDS also documents that when moving from a seated to standing position, and moving on/off toilet and surface to surface, R4 is "not steady, only able to stabilize with staff assistance."

R4's Care Plan, dated 11/15/15, identifies R4 as at risk for falls due to history of falls, with an annual review identifying R4 as having muscle weakness due to past Cerebral Vascular Accident and right hemiparesis with resident refuses therapy. The goal is for R4 to sustain no major injury from fall thru next review. Interventions

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include providing call light, area free from clutter, provide bed/chair alarm as ordered PRN (as needed)STATUS: active "current," 2/4/15 - educate resident and family that pillows in wheelchair is not appropriate, 3/22/15 - offer wheelchair cushion, 7/14/15, encourage fluids, use fall screen to identify fall factors, report falls to physician and responsible party, provide/monitor use of adaptive devices, remind resident and reinforce safety awareness, educate/remind resident to request assistance prior to ambulation, provide appropriate footwear in part.

R4's Incident Report, dated 7/14/15, documents R4 slipped out of her wheelchair and was found face down. The Report also documents R4 was transported to the emergency room due to complaining of neck and back pain. The Report documents R4 was a high fall risk at the time. R4 returned to the facility and a Z6's Physician's Note regarding R4, dated 8/1/15, documents "pt (patient) was hosp (hospitalized) p (after) fall from w c (wheelchair) in dining room. She 'did a face plant.' She still c/o (complains) of some pain to the right forehead and periorbital area." The Care Plan revisions, added 7/14/15 as a result of the fall, were to encourage fluids and encourage resident to not use pillow behind her back in the wheelchair. The etiology of the fall fails to identify a pillow as a causative factor of the fall.

R4's Incident Report, dated 9/21/15, documents R4 was "observed" on the floor in the dining room on right side with wheelchair next to her. R4 sustained a contusion right temporal region measuring 3 cm (Centimeters) x 3 cm. Fall risk included in the investigation documents R4 to be a low risk for falls even though she'd had a fall

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two months prior and one at the time of the evaluation. Z6 documents on 10/2/15 "pt fell a few days ago on face" and "significant bruising on face - is resolving." Z6 documented that the falls and Care Plan were reviewed with no interventions or revision added to the Care Plan for falls preventions as a result of this fall.

R4's Incident Report, dated 3/4/16, documents R4 fell at 6:15 AM as she was sitting in her wheelchair in front of the Nurses Station outside her room. No injury was noted. The evaluation documents R4 is alert with confusion. The fall risk at that time was 13 or "high." The witness statement is blank and there is no causative factor or etiology of the fall determined. The Care Plan documents an intervention added 3/4/16 for an Occupational Consult for w/c screening to be done for positioning and nothing else in terms of added supervision or assistive devices to prevent further falls.

R4's Rehabilitation Screen, dated 3/6/16, documents "res (resident) states 'she doesn't want any therapy.' I like my chair the way it is. Pillow under R (right) UE (upper extremely) for support. Sitting upright c (with) no leanings at this time."

According to the Nurses Notes, R4 was transferred to the hospital 3/16/16 for Pneumonia and was readmitted to the facility on 4/4/16. According to E2, Director of Nurses (DON) on 4/28/16 at 9:05 AM, R4 returned to the facility in a much weakened state than prior to her hospitalization requiring more assistance than she use to. E2 stated R4 was a one person assist prior to her hospitalization and when she returned, she herself had to get assistance from

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someone to move her one day. There is no documentation the facility reassessed R4's fall risk and needs and no revisions made to the Care Plan following her hospitalization to ensure added assistance and supervision was provided given her decline in functional ability.

R4's Occupational Therapy Note (OT), dated 4/5/16, documents "This 85 year old female admitted from acute care hospital setting presents to therapy with multiple conditions, including pneumonia, CVA, and COPD (Chronic Obstructive Pulmonary Disease). The Patient has shown a significant decline in wheelchair seating posture, positioning and right arm edema over recent hospitalization due to medically complex conditions resulting from current illness." The OT further documents "patient will have assistance of facility staff for w/c positioning an placement of appropriate adaptive seating devices for proper seating posture and right UE (upper extremity) placement for edema control." The OT note also documents "the patient demonstrates sitting balance of P+ dynamic (able to maintain balance with minimal assistance, moderate assist to reach ipsilateral side and unable to weight shift)." Current level of function at that time (4/5/16) was "near total dependence (90-95% assist)."

On 4/11/6 at 1815 (6:15 PM), an Incident Report documents R4 was "observed/witnessed sliding out of wheelchair and then sat on the floor." E6, LPN documents R4 was sitting in her wheelchair by the Nurses Station and slid out of the chair. Under Medical Conditions, E6 checked yes for "recent change in medical condition?" and describes it as "recently readmitted from hospital... had pneumonia." E6 documents R4

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has no injuries noted. Again, the witness statement is blank, fall risk is 11, less than it was 3/4/16 at 13, but still high. The Care Plan documents one intervention added 4/11/16 to "continue therapy, chair evaluated and adjusted after resident self manipulated, family and resident educated."

On 4/18/16, a quarterly MDS was completed for R4 and also documented a functional decline in transfer ability from a extensive assistance of one to extensive assist of two staff. Balance was documented as the same. Again, no evidence of assessment with revision and/or additions to the falls Care Plan to ensure safety.

R4's Incident Report, dated 4/22/16 at 2:30 AM, R4 is documented as falling from the side of the bed. The fall was witnessed by E7, CNA, who documented on a Statement sheet R4 "was on edge of bed, I turned around, she slipped off the bed and went down to the floor, she fell on right side of body hitting head and leaving a bruise. I got the nurse and got her up and got vitals on her." There is no indication E7 had another staff in the room with her during care of R4.

R4's Nurses Notes, dated 4/22/16 at 10:30 AM documents "resident up in wheelchair with (no) c/o (complaint of) pain. Monitoring bruising on forehead."

R4's Physician's Note by Z6, dated 4/22/16, documents "pt fell face forward out of her wheelchair early this am. She often will slump sideways or forward in chair. She has had several falls of this type. I am wondering if any adjustments to her wheelchair would help - a higher back reclined vs (verses) a slight

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backward seat tilt." Z6 also documents R4 to answer yes/no appropriately, "speech no diff (different) than usual." The note ends with Z6 documenting "I think she is somewhat post-concussion."

An SBAR (Situation Background Assessment Recommendation), dated 4/23/16 documented by E5, LPN, that E5 was notified that R4 "was not acting like her normal self" and when evaluated, R4 was incontinent which she never was, had slurred speech and was not verbalizing needs as normal. The physician was notified and R4 was transferred to the emergency room. On 4/24/16 at 9:20 AM, the Nurses Notes document that hospital was called and R4 was admitted with intracranial bleed.

R4's Hospital Record, dated 4/23/16, Cranial tomography (CT) scan of the brain documents R4 has an "Acute left frontoparietal subdural hemorrhage measuring up to 1 cm in width. Possible additional small right tentorial subdural hemorrhage."

On 4/28/16 at 9:30 AM, E2 stated that the physician was misinformed about R4 falling from her wheelchair, that she actually fell from the side of the bed and had one CNA in the room with her. E2 stated R4 would often want to sit on the side of her bed at night.

On 4/28/16 at 10:30 AM, R4's room was observed to have her wheelchair at bedside. The wheelchair had a pressure relieving cushion in its seat along with a piece of crumpled non skid material in it.

On 5/4/16 at 8:40 AM, Z6, Medical

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Director/Physician, stated that R4 was in a much weaker condition upon her return from the hospital the first part of April. Z6 stated that she assumed the facility reassessed R4's fall risk given her weakened condition and would have expected them to do so to ensure her safety. Z6 stated that she saw R4 the afternoon after the fall on 4/22/16 and she appeared okay at that point. Z6 stated R4 had had several falls with head injuries prior to 4/22/16 and she had talked with the nurses that afternoon about putting wedges, tilt back chair, something in place to prevent her from falling again. Z6 stated did not recall the nurse, but stated the nurse told her that it could be discussed in a meeting that afternoon.

On 5/4/16 at 9:00 AM, E7 stated she was the only CNA on 200 hall that night along with the nurse, E4, LPN, taking care of some 50 residents. E7 said on 4/22/16 she had changed R4's incontinent pad, sat her on the side of the bed, gave her a glass of water and went down the hall to help another resident. E7 said she heard someone fall and found R4 on the floor. E7 said she did not witness the fall nor was she in the room at the time. E7 stated R4's roommate was asleep and the curtain was pulled. E7 stated she had taken care of R4 before and knew she'd had a recent hospitalization but had not been told she was in a weaker condition. E7 stated when she found R4 on the floor, she noticed the bruise on the right side of her head.

The facility's policy entitled "Fall Management Guidelines," dated 10/2014, documents that the guidelines are a interdisciplinary process designed to assist in the development of systems to provide individualized person centered care, to assist the resident in obtaining and/or maintaining

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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
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their highest level of function and minimize the risk of falls and fall related injuries. Under Care Plan, the facility will review risk factors, environmental factors and other clinical conditions, the resident's initial care plan is updated or a comprehensive care plan is developed to include individualized person centered interventions. The team designs the plan to address the problem associated with potential or actual falls, measurable goal is developed with a target date and approaches are selected based on residents preferences, risk factors, co-morbid conditions and willingness to participate in the new plan. The policy documents "Regardless of the interventions that are put in place a key factor to success is the timely review of the interventions as the patient's condition and needs change.

2. R12's MDS, dated 4/7/16, documents R12 has cognitive impairment and requires extensive assist of one staff for transfer and locomotion. The MDS also documents R12's balance for moving from seated to standing position and surface to surface is not steady "only able to stabilize with staff assistance."

R12's Care Plan, dated 4/12/16, documents R12 is at risk for falls related to generalized weakness and Alzheimer's Disease with the goal not to have any major injury due to fall through next review (7/12/16.) Interventions do not include the type of transfer R12 currently is or how much assistance she needs.

On 4/27/16 at 2:07 PM, E19, CNA, assisted R12 into a standing position from the sofa in the lobby to her wheelchair without using a gait belt. R12 was not steady on her feet as she turned and sat

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	145160	A. BUILDING _____ B. WING _____	C 05/04/2016

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down in her wheelchair. E19 did not have a gait belt visible on her person at the time.

On 4/29/16 at 2:50 PM, E1, Administrator, confirmed that all pivot transfers are to be done with a gait belt according to their policy.

The facility's policy entitled "Safe lifting and movement" documents it's "the policy of the facility to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents." The Guidelines documents lifting of residents will be eliminated when feasible, staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices.

3. R5's MDS, dated 4/11/16, documents that R5 is cognitively impaired, requires extensive assist of two for bed mobility and transfer. The MDS also documents R5 does not ambulate and mobility is per wheelchair.

R5's Care Plan, dated 4/5/16, documents that R5 is at risk for falls, requires assistance for all staff for all Activities of Daily Living (ADL's), R5 sleeps in the wheel chair, and refuses to lay down in bed or use recliner. R5's Care Plan lacks any individualized fall interventions addressing right leg amputation and R5's tendency to fall asleep in the chair.

R5's Incident Report, dated 1/12/16, documents that R5 fell out of wheelchair due to slipped out of chair and was nodding off. R5 sustained injuries. On 1/13/16 R5's Care Plan was adjusted to include, offer 2 pillows when sitting in wheelchair

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for positioning. No other interventions were added to address sleeping in chair or slipping out of wheelchair.

R5's Incident Report, dated 1/14/16, documents that R5 fell out of recliner and sustained injuries. R5's Care Plan was not adjusted to include any added fall prevention interventions for this fall.

R5's Incident Report, dated 1/21/16, documents that R5 slid out of recliner and fell. On 1/21/16 R5's Care Plan was adjusted to include the removal of the recliner in which R5 liked to sleep.

R5's Incident Report, dated 2/10/16, documents that R5 leaned forward in wheelchair, fell and hit R5's head. R5's Care Plan was not adjusted to include Therapy to evaluate for wheelchair positioning. R5's file lacked any therapy evaluation for repositioning after the 2/10/16 fall.

R5's Incident Report, dated 4/11/16, documents that R5 fell at 10:15 PM by falling out of bed and was found lying on R5's right side. The Report documents that R5 sustained a raised area on the right forehead. R5's Care Plan was not adjusted after the 4/11/16 fall.

4. On 4/26/16 at 11:00 AM, R9 was transferred from the shower chair to the wheelchair with the assistance of E22, CNA, and a sit to stand mechanical lift.

R9's Care Plan, dated 1/13/16, documents that R9 is transferred with the assistance of 2 and a sit to stand mechanical lift.

On 4/26/14 at 11:05 AM, E22 stated "I transferred (R9) with the sit and stand and a gait belt."

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F 323	Continued From page 28 On 4/27/16 at 3:30 PM, E2 stated that the residents' Care Plans are to be followed, as well as the facility's policies when it comes to falls and accidents. The Facility's policy titled Fall Management Guidelines (10/2014) documented in part, "Fall reduction/injury prevention can be implemented upon admission. The approaches for fall prevention are clear, specific and individualized for the resident needs. Regardless of the interventions that are put into place a key factor to success is the timely review of the interventions as the patients condition and needs change. A comprehensive care plan is developed to include individualized person centered interventions."	F 323		