STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	C 02/03/2012

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GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 IDR was conducted 3/26/12. The IDR panel recommended to uphold F 157 but lower it to a G, to uphold F 309 but lower it to a G, and to delete F 323. CMS requested a review of the facility submitted written IDR materials. On 5/15/12 CMS informed the state survey agency the final decision is to keep all 3 tags and the s/s would be G for all 3 tags. Amended 2567 sent to facility. BW	F 000	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	
F 157 SS=G	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	F 157	F157 Failure to notify MD **How corrective action will be accomplished for each resident found to have been affected by the deficient practice –** Resident #2 had an order for an x-ray of the left lower extremity to rule out fracture on 12/25/11. Mobile X-ray called on 12/25 and 12/27, X-ray obtained 12/27/11. Results were sent via fax to the Facility on 12/27/11 and the Physician was notified of results on 12/27/11. New orders were received from MD. Letter received from X-ray Company dated January 5, 2012, facility received an apology letter from the x-ray company stating there was a breakdown in their system which caused the delay in the x-ray being completed. Verbal Coaching was completed for Licensed nurse involved during investigation process on resident #2 12/28/11. Resident #2 discharged home on 2/3/2012.	2/6/12

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

Administrator 05/31/12

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

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F 157	Continued From page 1 this section. 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 resident interviews, record reviews, staff interviews and physician interview the facility did not re- notify the physician that an ordered x-ray could not be done on the date of the original physician order, resulting in a delay of treatment of a resident for two days. The X-ray when completed on 12/27/11 showed that the resident had a fractured ankle in two places, This is for 1 of 3 residents, Resident #2. The facility failed to notify the resident's physician for 2 of 3 sampled residents that fell and hit their heads during falls (Resident #7 and #8). The findings included: Resident #2 was admitted to the facility on 12/2/11 with multiple diagnoses including diabetes mellitus, cerebrovascular accident (CVA), dysphagia, hypertension, history of gastrointestinal bleeding, foot ulcer, status-post right-above-the-knee amputation. Review of the resident's admission Minimum Data Set (MDS), dated 12/21/11 revealed the resident had short- and long-term memory problems and was moderately impaired in decision making. The MDS indicated the resident required one-person physical assistance for activities of daily living (ADLs), including bed	F 157	Resident #7 fell on 12/31/11 swelling noted on right side of head, ice applied, neuro checks done every 15 minutes x one hour, every 30 minutes x two hours, then every hour x four hours, doctor notified via communication form and placed in the doctor's box. Resident #7 got out of bed and did not buckle his "Smart Auto Reset" seatbelt on immediately. The seat belt was not alarming because the alarm had not been activated by buckling. The alarm is activated when each end of the seatbelt is buckled. The belt will then alarm when disconnected. Seat Belt checked on 2/3/12 after returned from Dialysis and the device was functioning properly. • Resident #8 received cut to forehead during a fall on 12/12/11. The nurse notified the doctor via a communication form and placed it in the doctor's box. The supervisor was notified via email. The cut was cleansed, Antibiotic ointment, and bandaged was placed. Neuro checks done every 15 minutes x one hour, every 30 minutes x two hours, then every hour x four hours. Site now healed. **How corrective action will be**	

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F 157	Continued From page 2 mobility, dressing, toilet use, personal hygiene, and bathing. The MDS indicated the resident had functional limitation in range of motion of his upper and lower extremities on one side. The resident's fall Care Area Assessment (CAA), dated 12/21/11, read in part: "per medical record resident is alert and oriented, however is confused at times. Requires extensive-to-dependent assistance with transfers. Right sided weakness secondary to CVA noted. Resident at risk for falls due to above information." The resident's ADL CAA, dated 12/21/11, read in part: "per medical record resident has right-sided weakness, analysis of findings - Requires extensive-to-dependent assistance with most ADLs. Resident at risk for complications related to ADL function and/or further decline in ADL functional status. " The resident's Care Plan, dated 12/8/11, indicated "resident is at risk for fall." The approaches included monitoring vital signs, administering medications as ordered, and arranging the environment for maximum functioning. Record review revealed a facility Incident/Accident Report dated 12/22/11. The description of the incident read, "Resident rolled out of bed during ADL care, Resident rolled on bedside mat. " The report indicated that the resident had no apparent injury. The resident's physician was notified of this fall on the same date of the fall.	F 157	**accomplished for those resident having potential to Be affected by the same deficient practice** ➢ 4 Step Plan of Correction initiated 12/28/11 which included: Review of all current residents on 12/28/11 for outstanding x-rays. No other outstanding x-rays found. New process initiated as part of plan of correction on 12/28/11: Upon new order for x-ray to rule out fracture, nurses will call mobile company to notify them of new order. The nurse will ask mobile company if x-ray to rule out fracture will be performed the same day. If mobile company unable to perform x-ray the same day, an order will be obtained to send resident out to hospital to obtain x-ray. If mobile company states the x-ray will be performed the same day, the nurse will document conversation with mobile company and follow-up to ensure x-ray is performed. Completion 01/17/2012	

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F 157	Continued From page 3 Nursing notes dated 12/23/11 at 6:22 pm read in part, " resident alert and verbal. No signs of distress. Resident had no further complications or falls during the shift. Respiration even and unlabored. " Nursing notes dated 12/24/11 at 10:48 am read in part, " patient is alert and verbal. Voiced no pain. Respiration non-labored. " Nursing notes dated 12/25/11 at 5:54 pm read in part, " resident alert and able to voice needs. Complained of left ankle pain, assessed area, swelling noted, tender to touch. Medical director received new order for x-ray of left ankle. Mobile x-ray called and aware of order. Pain medication given as needed. No further pain voiced. " Record review of telephone physician ' s order dated 12/25/11 at 5:00pm read in part, " x-ray left ankle related to pain and swelling. " Nursing notes dated 12/26/11 read in part, " resident alert and verbal. No signs of distress. Resident complained of left ankle pain. X-ray ordered for left ankle. Medication x 1 for complaint of pain. Continue to monitor. " Record review of radiology report dated 12/27/11: " Fracture of the distal fibula is noted. Fracture of the distal tibia is present. Soft tissue swelling is noted in the region of the ankle joint. " Nursing notes dated 12/27/11 read in part, " received x-ray results. Fracture of the distal tibia and fibular metaphysis are noted with no significant displacement. Medical director notified. New order to send resident to emergency room	F 157	➢ On 2/3/2012 Interim Administrator spoke to X-ray company representative, stated that they installed a system which records all incoming scheduling calls. During their morning meeting they review/listen to assure that all requested x-rays are scheduled. ➢ All new hired licensed nurses since 01/17/12 were provided education and received a written copy of the x-ray procedure. Completion 2/2/12. ➢ Upon new order for x-ray, nurses will call mobile company to notify them of new order. The nurse will ask the mobile company if x-ray will be performed the same day. If mobile company unable to perform x-ray the same day, an order will be obtained to send resident out to hospital to obtain x-ray. If the mobile company states the x-ray will be performed the same day, the nurse will document conversation with mobile company and follow-up to .	

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F 157	Continued From page 4 for further evaluation. Resident left facility via ambulance. " An Emergency Department report dated 12/27/11 revealed the resident was seen for an accidental fall on 12/22/11 resulting in distal tibia and fibula fracture. Nursing notes dated 12/27/11 read in part, " resident back from emergency department. Splint to the left leg. New order for norco 5/325 mg [medication used to relieve moderate to severe pain] 1-2 tablets by mouth every 4-6 hours as needed and to follow up with orthopedic doctor 1-2 days. No pain or discomfort upon return. Received x-ray results. Fracture of the distal tibia and fibular metaphysis are noted with no significant displacement. Medical director notified. " Review of radiology report dated 12/27/11 read in part, " the bones are demineralized. Fracture of the distal metaphysis of the the fibula is noted. Fracture of distal metaphysis of the tibia is present. Soft tissue swelling is noted in the region of ankle joint. " Review of orthopedic consultation report dated 12/29/11 read in part " Recommendation 4. Follow up 2 weeks for cast change. " Record review of the physician progress notes dated 1/5/12 read in part, " admitted status-post CVA with resultant dysphasia and right-side weakness who is seen today for routine follow-up. The patient had a fracture of the distal tibial and fibular metaphysis on the left side and is in a cast. He denies any symptoms except for pain in his	F 157	ensure x-ray is performed. ➢ MD will be notified whenever there is a change related to the care of the resident by the Charge nurse. Routine/Non emergency nursing information will be communicated on the "Nursing Communication to MD" form and placed in the nursing communication MD folder at nurse's station. MD will be notified of any falls, emergency, acute episode, change in condition, or critical lab result by telephone, this is for current as well as new admissions. ➢ The Unit Manager is responsible to ensure that notification of the MD has occurred and has been documented accurately. The Unit Manager will review the shift report daily to ensure that appropriate notification has occurred. In the event that the Unit Manager is not available, the other Unit Manager or DON (Director of Nursing) or Supervisor will assume the	

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F 157	Continued From page 5 left lower extremity. " In an interview on 1/17/12 at 2:44 pm the interim administrator stated that " an order for an x-ray was obtained from the medical director on 12/25/11. This x-ray was not done until 12/27/11 because on 12/25/11 the mobile x-ray unit was only doing stats and on 12/26/11 the scheduler for the mobile unit forgot to add the resident ' s name to the schedule. I have in-serviced my staff on the importance of having x-rays done in a timely manner. My expectations are that for any acute episode that might rule out bone fracture the x-ray must be done the same day. In event the x-ray company is not able to come the same day within a reasonable time frame, the medical director should be notified and the resident should be sent out to the hospital. " The interim administrator added that this was not done. In a telephone interview on 1/18/12 at 8:30 am the medical director stated that his expectations are that if an order is written by himself or an on-call physician for an x-ray, it should be done on the day it was written. He added that the mobile unit normally comes to the facility when requested, so it should be done within the day. If the x-ray is not done when ordered he expects communications from the facility immediately so the resident can be sent to the emergency department. In an interview on 1/18/12 at 10:38 am Nurse #2, the nurse responsible for the resident's care on 12/25/11, stated " I was on duty 12/25/11 and the resident's family member told me that [name of the resident] had fallen 3 days ago and the resident was in pain. I went in his room and	F 157	responsibility of the Unit Manager for notification. Completion 02/02/12. **Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur:** ➢ Weekly Quality Assurance Risk meeting includes review of data collected, and analyzing outcomes and trends from clinical indicators; current 4 step plan of corrections, which includes falls, notifications, and devices. Any concerns are reviewed for problem resolution at the meeting and at Monthly Quality Assessment and Assurance meetings for further review and resolution. ➢ To enhance shift to shift	

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F 157	Continued From page 6 assessed his ankle and it was swollen. I called the medical director and he gave me an order for an x-ray. I called the mobile x-ray unit and they told me that [name of the resident] would be seen the following day because it was not a stat order. I made the nurse coming on the next shift aware. " In an interview with the attending physician on 2/1/12 at 6:55 pm, he stated, " I think it was bad and unacceptable that the x-ray was not done in timely manner. But the resident was not walking on the ankle and the fracture was not displaced, so it did not impact his bone exceptionally. Hopefully, they would call and notify me that the x-ray was not done, but they never called. " The attending physician was asked, " How do you monitor x-ray results? " He answered that two doctors visit the facility 5 days a week; if there is a critical matter, the facility calls one of the doctors. If the situation is not critical, the facility puts the results in a box to be reviewed. The results normally stay in the box for up to two days, no more. During a follow-up visit 2/2/12 at 9:30 am, Nurse #1, a Licensed Practical Nurse stated that NA #1 " came and told me told that the resident rolled to the floor. She stated she was turning the resident and the resident rolled to the floor. When I went to the room, he was on his right side and his leg was extended. The resident said that he was experiencing no pain. I touched his legs; he had no pain. I did not do any range of motion checks. I believe I gave him pain medication. His legs were not bigger that normal [Resident #2 has routine edema]. Before we removed him from off the floor, we did vital signs and checked his	F 157	communication, if x-rays are ordered, the order will be placed on the MAR to encompass two entries 1) Block one: a) Type of x-ray, b) location of x-ray, c) date to be done. Once the x-ray is obtained the nurse will initial. Nurse will then annotate in medical record the order obtained for x-ray and save to shift report. 2) The second block to annotate when results are completed and physician notified. In-service completed on 2/6/2012. **Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be**	

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F 157	Continued From page 7 pupils and I asked him if he had pain. I did not assess him again. The expectation is that if the fall is witnessed, we do not have to assess again, but if it is not witnessed, we have to assess the resident for 3 days. On the 26th, the family told me that the resident fell, and he was supposed to have an x-ray, and it was not done. I called the x-ray company, and they came out that day to do the x-ray. " Record review showed the x-ray was not taken until 12/27/11. In an interview on 2/2/12 at 11:29 am with Nurse # 12, she stated, " no one told me that the resident had a fall. On 12/24/11 the family member came and told me that the resident fell and no one was doing anything about it. I told my DON and my nurse manager about the family ' s concerns. I looked in the nurses notes and I saw where they were elevating the resident ' s leg with a pillow. I checked the resident, and his leg was already elevated so I did nothing. I did not give him pain medication because he said he had no pain. On December 25, I gave him his medication, he had no pain, and his ankle was swollen. I did not do anything to the ankle because his arm and leg were always puffy. " She added, " as far as I know the x-ray was done. " Surveyor and Nurse #12 checked the nursing notes; there was no documentation of a swollen ankle. 2. Resident #8 was admitted on 5/28/10 and readmitted on 3/18/10. The resident cumulative diagnoses included hypertension and dementia. The quarterly Minimum Data Set(MDS) dated 11/14/11, assessment revealed that Resident #8 had short term and long term memory problems and severely impaired cognition for daily decision making.	F 157	**implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility:** ➢ Unit Managers or Supervisor will collect and review yellow carbon copies of telephone orders for x-ray orders and MARs checked to ensure that order has been placed on the MAR, daily X 2 weeks, 3x a week for 2 weeks, and 1x a week times one month. Any concerns are reviewed for problem resolution at the weekly Quality Assurance Risk Management meeting and monthly at the Quality Assessment and Assurance meetings for further review and resolution x 3 months. ➢ **Completion date 2/6/12**	

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F 157	Continued From page 8 Review of Nurses Notes revealed written by Nurse #15 on 12/12/2011 at 3:53am. The Nurse documented that Resident #8 was found lying on the fall mat beside the roommate's bed around 3:15am. The resident was previously in her wheelchair and refused to be helped to her bed. Nurse #15 documented that there was a 1/2 inch cut on the middle of Resident # 8's forehead and that the cut was cleaned, antibiotic ointment and a bandage was applied, the resident stated no pain. The Nurse documented vital signs and neurological checks were within normal limits. Communication was sent to the MD (medical doctor), email sent to unit manager and RP (responsible party) to be notified later in the morning. A Nurses Note at 6:55am indicated that Nurse #15 spoke to the RP about the resident's fall earlier in the night. An interview with Nurse #15 was unsuccessful by telephone and at the facility on 2/03/2012 at 3:10pm and again at 6pm. The Administrator said the nurse worked on 11pm-7am shift. A Review of the Incident/Accident Report dated 12/12/2011 at 3:15am, revealed the Physician was notified by "communication " (fax communication) on 12/12/2011 and no time was documented. A review of the clinical record conducted on 2/03/2012 at 10:00am, revealed there was not a copy of a communication form addressed to the physician related to Resident #8's fall on 12/12/2012. An interview on 2/03/2012 at 12:25pm, was conducted with the Interim Administrator. The Administrator checked the resident's medical	F 157		

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F 157	Continued From page 9	F 157		

record and confirmed that the communication form was not in the chart. The Administrator said the physician should have been called instead of a fax communication form because this was an injury. The Administrator said she would expect with an injury for the Charge Nurse to notify the RN on call by telephone and the MD to be called for orders.

3. Resident # 7 was admitted to the facility on 4/19/11, the Minimum Data Set dated 2/3/12, diagnosis include anemia, coronary artery disease, hypertension, peripheral vascular disease, gastroesophageal reflux disease , end stage renal disease, arthritis , cerebral vascular disease. He had good long and short term memory and was able to make his decisions and judgments for his daily care. He had fluctuating disorganized thinking, and had no behavioral symptoms, towards others.

Review of the Incident Accident Report dated Saturday 12/31/11 at 3:15p.m., indicated Resident #7 fell in his room which result in swelling above the right eye. The nurse supervisor had been notified via telephone 12/31/11 at 3:30p.m., the doctor was not notified and the responsible party was not notified.

During an interview on 2/3/12 at 2:25p.m., nurse #12 indicated she had thought she had completed a communication form regarding the fall 12/31/11(Saturday) to the doctor and put it into a folder for the doctor to read the next time he made rounds (during the week). She indicated she did not know where the notification forms were filed after they were placed in the doctor ' s folder. The nurse stated that she had not contacted the doctor by phone and she had

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F 157	Continued From page 10 thought she had written a note. She indicated she had called the nurse supervisor. She did not call the responsible party. During an interview on 2/3/12 at 2:28p.m., Nurse #9(nurse supervisor) indicated she was aware of the fall on 12/31/12 (Saturday) She indicated the doctor or the responsible party was not contacted about the fall on Saturday 12/31/11.	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. This REQUIREMENT is not met as evidenced by: Based on resident interviews, record reviews, staff interviews, and a physician interview, the facility failed to assess Resident #2's ankle on 12/22/11 resulting in a delay of treatment. The X-Ray of 12/27/11 showed: " Fracture of the distal fibula is noted. Fracture of the distal metaphysis of the tibia is present. Soft tissue swelling is noted in the region of the ankle joint." This is for 1 of 2 residents, Resident #2. The facility failed to assess the condition of a resident after two consecutive falls for 1 of 3 residents that fell hitting his head (Resident #7). The findings included:	F 309	**F 309** - Failure of Radiology to promptly assess condition of resident resulting in delay of treatment **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:** ➢ Resident #2 had an order for an x-ray of the left lower extremity to rule out fracture on 12/25/11. Mobile X-ray called on 12/25 and 12/27, X-ray obtained 12/27/11. Results were sent via fax to the	2/6/12

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F 309	Continued From page 11 1. Resident #2 was admitted to the facility on 12/2/11 with multiple diagnoses including diabetes mellitus, cerebrovascular accident (CVA), dysphagia, hypertension, history of gastrointestinal bleeding, foot ulcer, status-post right-above-the-knee amputation. Review of the resident's admission Minimum Data Set (MDS), dated 12/21/11 revealed the resident had short- and long-term memory problems and was moderately impaired in decision making. The MDS indicated the resident required one-person physical assistance for activities of daily living (ADLs), including bed mobility, dressing, toilet use, personal hygiene, and bathing. The MDS indicated the resident had functional limitation in range of motion of his upper and lower extremities on one side. The resident's fall Care Area Assessment (CAA), dated 12/21/11, read in part: "per medical record resident is alert and oriented, however is confused at times. Requires extensive-to-dependent assistance with transfers. Right sided weakness secondary to CVA noted. Resident at risk for falls due to above information." The resident's ADL CAA, dated 12/21/11, read in part: "per medical record resident has right-sided weakness, analysis of findings - Requires extensive-to-dependent assistance with most ADLs. Resident at risk for complications related to ADL function and/or further decline in ADL functional status. " The resident's Care Plan, dated 12/8/11, indicated "resident is at risk for fall." The	F 309	Facility on 12/27/11 and the Physician was notified of results on 12/27/11. New orders were received from MD. Letter received from X-ray Company dated January 5, 2012, facility received an apology letter from the x-ray company stating there was a breakdown in their system which caused the delay in the x-ray being completed. Verbal Coaching was completed for licensed nurse involved during investigation process on resident #2 12/28/11. Resident #2 discharged home on 2/3/2012. ➢ Resident #7 fell on 12/31/11 swelling noted on right side of head, ice applied. Frequent checks done on resident as evidenced by neurological checks done every 15 minutes x one hour, every 30 minutes x two hours, then every hour x four hours, doctor notified via communication form and placed in the doctor's box; Supervisor notified, and Resident is his own responsible party. Resident reminded to leave harness on. Nurse involved received	

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F 309	Continued From page 12 approaches included monitoring vital signs, administering medications as ordered, and arranging the environment for maximum functioning. Record review of the medication administration record, indicated that Vicodin was administered to Resident #2 on 12/12/11 to 12/13/11. On 12/15/11, 12/19/11 and 12/20/11 Narco x 1 [this is the brand name for acetaminophen and hydrocodone which is used for moderate pain] was administered to the resident. Record review revealed a facility Incident/Accident Report dated 12/22/11. The description of the incident read, "Resident rolled out of bed during ADL care, Resident rolled on bedside mat. " The report indicated that the resident had no apparent injury. In an interview on 1/17/11 at 11:00 am with Nurse #1, she stated that " on 12/22/11 the resident rolled off the bed to the fall mat during morning care. The aide that was giving care got me, we assisted the resident back to the bed. I assessed the resident I did neurological checks and asked him if he was having pain. He denied pain. He was able to move his lower extremity as well as upper extremity. I did not check his ankle because denied pain " Nurse #1 added that there was no bleeding, no bruising, no skin tears or swelling from fall, and NA #1 took the resident ' s vital signs. Record review of resident ' s medication administration record dated 12/22 to 12/27/11 read as follows: On 12/22/11 at 9:00 pm Vicodin was administered for pain, level 8 out of 10;	F 309	corrective action and education for nursing documentation and post fall assessment 1/6/12. . Resident fell on 1/2/12. Resident assessed and noted to have skin tear to left forearm. Skin tear cleansed and dressed. MD notified, resident is his own RP, and in addition an interested family member was notified. Frequent checks done on resident as evidenced by neurological checks done every 15 minutes x one hour, every 30 minutes x two hours, then every hour x four hours. Resident reminded to ask for assistance. Harness discontinued, Smart Alarm auto reset seat belt and bed alarm added. **How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:** 4 Step Plan of Correction initiated 12/28/11 during weekly Quality Assurance Risk meeting which included review of all other residents currently residing in house as of	

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F 309	Continued From page 13 recheck of pain level was 2/10. On 12/23/11 at 9:00 pm Vicodin was administered (reason: pain level 7/10; recheck, 2/10). On 12/24/11 at 8:30 am Vicodin was administered (reason: pain level 7/10; recheck, 2/10). On 12/25/11 at 8:30 am Vicodin was administered (reason: pain level 7/10; recheck, blank). On 12/25/11 at 4:00 pm Vicodin was administered (reason: pain level 8/10; recheck, 2/10). On 12/26/11 at 8:00 am Vicodin was administered (reason: pain level 8/10; recheck, 2/10. On 12/27/11 at 4:00 pm Vicodin was administered (reason: pain level 8/10; recheck, 2/10. Vicodin was administered due to the resident's phantom pain from his amputation on the left leg. Record review of physical therapy progress notes dated 12/23/11 at 1:02 pm read as follows: " pt [patient] rolled off bed on fall mat during ADL care on 12/2211. Pt recalled the incident. Nursing to place wing mattress to reduce risk of further falls. Physical therapy is ongoing to improve bed mobility skills/transfer skills and wheel mobility. " Nursing notes dated 12/23/11 at 6:22 pm read in part, " resident alert and verbal. No signs of distress. Resident had no further complications or falls during the shift. Respiration even and unlabored. " Record review of physical therapy progress notes dated 12/24/11 at 10:07 am read, " resident seen in bed for bed mobility tasks requires plus one [+1] max[imum] rolling to left side and moda/mina [person performing 50% or more or 40% or less] to right using right rail to pull self. Low-level exercises to left leg that appears swollen, resident reports sliding out of bed on	F 309	12/28/11. All were found to not have outstanding x-rays at this time from December 1, 2011 to December 12/31/2011. Completion 12/28/11 and 02/01/12. ➢ 4 Step POC dated 12/28/11 included: o No other resident found to have outstanding x-rays at this time. o An in-service was held for nurses concerning follow-up of x-rays to rule out fracture. Upon new order for x-ray the nurse will: 1. Call mobile company to notify them of the new order. 2. The nurse will ask the mobile company if the x-ray will be performed the same day. If the mobile company is unable to perform the x-ray on the same day then, 3. An order will be obtained to send resident out to the hospital to obtain x-ray. If the mobile company states the x-ray will be performed the same day, the nurse will document the conversation with the mobile company and follow-up to ensure	

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F 309	Continued From page 15 " Fracture of the distal fibula is noted. Fracture of the distal metaphysis of the tibia is present. Soft tissue swelling is noted in the region of the ankle joint. " Nursing notes dated 12/27/11 at 10:30 pm read in part, " received x-ray results. Fracture of the distal tibia and fibular metaphysis are noted with no significant displacement. Medical director notified. New order to send resident to emergency room for further evaluation. Resident left facility via ambulance. " An Emergency Department report dated 12/27/11 revealed the resident was seen for an accidental fall on 12/22/11 resulting in distal tibia and fibula fracture. Nursing notes dated 12/27/11 at 11:55pm read in part, " resident back from emergency department. Splint to the left leg. New order for norco 5/325 mg [medication used to relieve moderate to severe pain] 1-2 tablets by mouth every 4-6 hours as needed and to follow up with orthopedic doctor 1-2 days. No pain or discomfort upon return. Received x-ray results. Fracture of the distal tibia and fibular metaphysis are noted with no significant displacement. Medical director notified. " Review of radiology report dated 12/27/11 read in part, " the bones are demineralized. Fracture of the distal metaphysis of the the fibula is noted. Fracture of distal metaphysis of the tibia is present. Soft tissue swelling is noted in the region of ankle joint. " Review of orthopedic consultation report dated	F 309	1. Provide immediate care to address any injuries, and resident safety 2. Evaluate resident for any additional injury which would require medical intervention. Evaluation includes but is not limited to: o Vital Signs o Skin Evaluation o Musculoskeletal assessment o Change of Condition o Pain Assessment o Neurological assessment as indicated 3. Thoroughly document clinical findings in medical record 4. Interview resident and staff to determine if cause of fall can be determined. 5. Notify MD in person or by telephone of all falls and document in medical record. 6. Notify On-Call Administrative RN in person or by telephone of all falls and document	

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F 309	Continued From page 16 12/29/11 read in part " Recommendation 4. Follow up 2 weeks for cast change. " Record review of the physician progress notes dated 1/5/12 read in part, " admitted status-post CVA with resultant dysphasia and right-side weakness who is seen today for routine follow-up. The patient had a fracture of the distal tibial and fibular metaphysis on the left side and is in a cast. He denies any symptoms except for pain in his left lower extremity. " Record review of Nurse #5 ' s statement submitted as part of the investigation dated 1/12/12 read in part, " I [name of nurse, who no longer works in the facility] was the scheduled 11-7 nurse for [name of the resident] on December 23rd 24th, 25th, and 26th. He had fallen on December 22nd on 1st shift. When I came to work Friday night the 23rd the second shift nurse had given pain medication at 8:30 pm and he had no pain. He slept through the shift. Resident ' s extremities appear to be edematous most of the time. On Saturday the 24th resident had no pain all during shift. On Sunday the 25th resident complained of pain to the second shift nurse. An order received for x-ray to left ankle. The x-ray company was called by Nurse #2 [name of the nurse]. " This nurse told Nurse #3 that the x-ray company would not come out until 12/26/11. On 12/26/11 Nurse #2 told Nurse on the first shift that the x-ray was not done. The x-ray was not done until 12/27/12. " The surveyor attempted three times during the survey but was unable to contact Nurse #5. In an interview on 1/17/12 at 10:41 am NA #1 (nursing assistant) who was responsible for the	F 309	in medical record. 7. Notify family (RP) and document in medical record. 8. Complete post fall assessment and formulate interventions based off evaluated clinical information. 9. Communicate established interventions to the care giving staff 10. Document on fall every shift x 24 hours, then daily x 48 hours. ➢ The assessment findings will be called to the physician and the on-call administrative nurse. In-service completed 2/6/2012. ➢ In-service provided to rehab staff to contact nursing and use of the 24 hour shift report for communicating any change in condition identified during a resident's therapy session daily. **Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur:** ➢ All new hired licensed	

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F 309	Continued From page 17 resident's daily care, and who witnessed the fall, stated that " on 12/22/11, I was trying to turn the resident while doing his [morning] care and he rolled off the bed on to the floor mat. I went and got the nurse [Nurse #1] and two aides, and they assisted the resident to the bed. " NA #1 added that when the nurse asked the resident if he was experiencing pain, he denied any pain. She further stated that " I took his vital signs. " In an interview on 1/17/11 at 11:00 am with Nurse #1, she stated that " on 12/22/11 the resident rolled off the bed to the fall mat during morning care. The aide that was giving care got me, we assisted the resident back to the bed. I assessed the resident I did neurological checks and asked him if he was having pain. He denied pain. He was able to move his lower extremity as well as upper extremity. " Nurse #1 added that there was no bleeding, no bruising, no skin tears or swelling from fall, and NA #1 took the resident ' s vital signs. In an interview on 1/17/12 at 2:44 pm the interim administrator stated that " [name of the resident] rolled out of the bed to the floor mat on 12/22/11. I went to the the resident ' s room to discuss the incident with the resident. I performed a visual inspection of the resident ' s body, the resident ' s heel was bloated because he has a history of a wound to his heel. The resident was noted to have edema to the upper right arm and a trace of edema to left lower extremity. This was no different from any other day since admission. This resident had a history of lower extremity edema prior to admission. No misalignment was noted to the extremity. The family member was notified. On 12/25/11 the family member complained to	F 309	nurses will receive education in orientation on: To start 02/02/12 and with all new hires thereafter. 1. MD (Medical Doctor) will be notified whenever there is a change related to the care of the resident by the Charge nurse. Routine/Non emergency nursing information will be communicated on the "Nursing Communication to MD" tool and placed in nursing the communication MD folder at nurse's station. MD will be notified of any emergency, acute episode, change in condition, or critical results by Telephone. ➢ CNA's in-serviced to stay with the resident after the fall. . The resident is not to be moved until evaluated by the nurse. If a fall occurs the CNA will initiate the call light and immediately notify a Nurse by calling for assistance. In-service completed 2/6/2012. ➢ MD will be notified whenever there is a change related to the care of the resident by the Charge	

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F 309	Continued From page 18 the nurse who was in charge of the resident ' s care that the resident ' s ankle was swollen and he was experiencing pain. An order for an x-ray was obtained from the medical director on 12/25/11. This x-ray was not done until 12/27/11 because on 12/25/11 the mobile x-ray unit was only doing stats and on 12/26/11 the scheduler for the mobile unit forgot to add the resident ' s name to the schedule. I have in-serviced my staff on the importance of having x-rays done in a timely manner. My expectations are that for any acute episode that might rule out bone fracture the x-ray must be done the same day. In event the x-ray company is not able to come the same day within a reasonable time frame, the medical director should be notified and the resident should be sent out to the hospital. " The interim administrator added that this was not done. She further stated NA #1 had been in-serviced on the proper procedure for ADL care of residents with weakness in one or both sides. She further stated that the resident has not had another fall. In an interview on 1/17/12 at 3:44 pm, Resident #2 stated " I fell off my bed to the floor and broke my ankle. " He added the ankle was swollen and hurting. In a telephone interview on 1/18/12 at 8:30 am the medical director stated that his expectations are that if an order is written by himself or an on-call physician for an x-ray, it should be done on the day it was written. He added that the mobile unit normally comes to the facility when requested, so it should be done within the day. If the x-ray is not done when ordered he expects communications from the facility immediately so the resident can be sent to the emergency	F 309	nurse. Routine/Non emergency nursing will be communicated on "Nursing Communication to MD" tool and placed in nursing communication MD folder at nurse's station. MD will be notified of any admission, emergency, acute episode, change in condition, or critical lab result by telephone. **Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance System of the facility:** The Unit Manager is responsible to ensure that notification of the MD (Change in condition) has been communicated and has been documented accurately. The Unit Manager will	

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F 309	Continued From page 19 department. In an interview on 1/18/12 at 9:52 am, NA #2 stated that " I was responsible for the resident ' s care on 12/24/11; he did not experience any pain while I was giving care, but his ankle was swollen and I elevated the ankle with a pillow. " During a follow up telephone interview on 1/27/12 at 11:40am NA #2 she stated that an aide told her to elevate the resident ' s ankle with a pillow but she does not remember which aide. In an interview on 1/18/12 at 10:38 am Nurse #2, the nurse responsible for the resident's care on 12/25/11, stated " I was on duty 12/25/11 and the resident's family member told me that [name of the resident] had fallen 3 days ago and the resident was in pain. I went in his room and assessed his ankle and it was swollen. I called the medical director and he gave me an order for an x-ray. I called the mobile x-ray unit and they told me that [name of the resident] would be seen the following day because it was not a stat order. I made the nurse coming on the next shift aware. " During a telephone interview on 1/18/12 at 3:10 pm Nurse #4 who worked with the resident on 12/26/11, stated that the resident was alert and verbal. The resident was administered Vicodin for his phantom pain. The resident did not complain of any ankle pain, nor was the ankle swollen. In a telephone interview on 1/26/12 at 5:30 pm NA #1 stated that I was performing a bed bath, and after washing his back, I put a lot of lotion on him because he has very dry skin. I turned him away from me. The resident held on and began to	F 309	review the shift report daily to ensure that appropriate notification has occurred. In the event that the Unit Manager is not available, the other Unit Manager or DON (Director of Nursing) or Supervisor will assume the responsibility of the Unit Manager for notification. Completion 02/02/12 and daily thereafter. Change in Condition audit was started 2/02/12, completed by DON or Unit Manager or Supervisor, daily X 2 weeks, 3x a week for 2 weeks, and 1x a week times one month. Any concerns are reviewed for problem resolution at the weekly Quality Assurance Risk Management meeting and monthly at the Quality Assessment and Assurance meetings for further review and resolution x 3 months. ➢ The Director of Nursing and the Unit Managers are responsible	

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F 309	Continued From page 20 turn, and his lower body began to slide off the bed. My hands were greasy; I attempted to catch him but I was unable to, and the resident slid to the floor. I called my nurse, and she assisted him off the floor with the help of 2 aides. NA#1 further indicated the bed rails [small rails] opposite to where she would turn the resident were lowered, but the small rail away from her were raised, and the resident held on to the small rail and attempted to turn. The bed was in the normal position; she reiterated that the bed was not in the low position. In a telephone interview on 1/27/12 at 12:20 pm with the interim administrator , she stated that Resident #2 slid out of bed while ADL care was performed on 12/22/11. The resident care plan reflected a 1-person assist with ADLs for bed mobility. NA #1 is well aware of the care for Resident #2 as she has cared for him on multiple occasions prior to the incident. " The interim administrator further stated that Resident #2 was in bed. NA #1 was in his room with a fall mat on both sides of the bed. NA #1 was performing a bed bath on the resident and moisturizer his skin on the front side. After bathing and moisturizing the resident ' s front side, NA #1 began to turn the resident towards his left side as she needed to complete the bed bath. When NA #1 began to turn the resident, the resident ' s lower body slid out of the bed. NA #1 attempted to catch the resident but she was unable, and the resident rolled on the fall mat. Nurse #1 completed a full assessment of the resident. The resident declined pain. There was no new swelling or bruising. The family and the medical director were notified.	F 309	for the implementation and monitoring of the Falls Management Program. All fall occurrences are reviewed daily (Monday- Friday) at stand up meeting, weekly in Quality Assurance Risk Management meeting by the DON/Unit Managers and the Week-end Supervisor/On Call Administrative Registered Nurse on Saturday and Sunday. Any problems noted will be taken to the Quality Assurance Weekly Risk Management Meeting and Monthly Quality Assurance meeting for review and resolution, times 1 month and quarterly times two quarters thereafter, for further review and resolution. ➢ Therapy to report Change of condition to the floor nurse and on 24 shift report . Rehab Director will review 10% of Therapy Progress notes to verify change of condition on 24 hr shift report daily X 2 weeks, 3x a week for 2 weeks, and 1x a week times one month. Any concerns are reviewed for problem resolution at the weekly Quality Assurance	

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F 309	Continued From page 21 In a follow-up interview on 2/1/12 at 5:50 pm with Nurse # 2, the nurse stated that " 12/25/11 was the first time I ever worked with the resident. The resident ' s family member came and asked me to look at the resident ' s ankle because it was swollen and tender to the touch. The resident was in pain. I did not know that he had a fall until the family member told me. Vital signs were done; the resident was not hollering or in any acute distress. I gave the resident Vicodin, and afterwards he only had a small amount of pain. I called the attending physician and told him the resident a had swollen ankle. I explained that he had fallen a couple days prior, and he was in pain. The attending physician gave me an x-ray order. Because it was not a stat and it was Christmas Day, the x-ray company stated that they would be in the following the morning to do the x-ray. I did not call the attending physician back because we normally wait until the x-ray is done and because the x-ray company stated they would be coming the following day. I told this to the nurse who was coming on the next shift. " In a follow-up interview on 2/1/12 at 6:16 pm with Nurse #4, he stated, " to my knowledge on 12/23/11 the resident had no swelling, no pain, no bruising. Later in the shift the resident requested pain medication for phantom pain. " When the surveyor asked the nurse, " How do you know it was phantom pain, " he stated that the resident pointed to his stump. In an interview with the attending physician on 2/1/12 at 6:55 pm, he stated, " I think it was bad and unacceptable that the x-ray was not done in timely manner. But the resident was not walking on the ankle and the fracture was not displaced,	F 309	Risk Management meeting and monthly at the Quality Assessment and Assurance meetings for further review and resolution x 3 months.. ➢ Change in Condition audit was started 2/02/12, completed by DON, Unit Manager or Supervisor daily X 2 weeks, 3x a week for 2 weeks, and 1x a week times one month. Any concerns are reviewed for problem resolution at the weekly Quality Assurance Risk Management meeting and monthly at the Quality Assessment and Assurance meetings for further review and resolution x 3 months. ➢ **Completion 2/6/12.**	

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F 309	Continued From page 22 so it did not impact his bone exceptionally. Hopefully, they would call and notify me that the x-ray was not done, but they never called. " The surveyor asked the attending physician, " How do you monitor x-ray results? " He answered that two doctors visit the facility 5 days a week; if there is a critical matter, the facility calls one of the doctors. If the situation is not critical, the facility puts the results in a box to be reviewed. The results normally stay in the box for up to two days, no more. In a follow-up interview with the resident # 2 on 2/2/12 at 9:00 am [in the presence of NA #1 and nurse #3,] the resident stated that he had fallen and hurt his ankle sometime in December. " A lot of people came in the room, " he said. " I told them that my ankle hurt, but they did not give me anything until that night. I hurt for many days before they took care of it. " During a follow-up interview on 2/2/12 at 9:30 am, Nurse #1 stated that NA #1 " came and told me told that the resident rolled to the floor. She stated she was turning the resident and the resident rolled to the floor. When I went to the room, he was on his right side and his leg was extended. The resident said that he was experiencing no pain. I touched his legs; he had no pain. I did not do any range of motion checks. I believe I gave him pain medication. His legs were not bigger that normal [Nurse # 1 stated that Resident #2 has routine edema]. Before we removed him from off the floor, we did vital signs and checked his pupils and I asked him if he had pain. I did not assess him again. The expectation is that if the fall is witnessed, we do not have to assess again, but if it is not witnessed, we have	F 309		

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F 309	Continued From page 23 to assess the resident for 3 days. On the 26th, the family told me that the resident fell, and he was supposed to have an x-ray, and it was not done. I called the x-ray company, and they came out that day to do the x-ray. " Record review showed the x-ray was not taken until 12/27/11. In an interview on 2/2/12 at 11:29 am with Nurse # 12 , she stated, " no one told me that the resident had a fall. On 12/24/11 the family member came and told me that the resident fell and no one was doing anything about it. I told my DON and my nurse manager about the family ' s concerns. I looked in the nurses notes and I saw where they were elevating the resident ' s leg with a pillow. I checked the resident, and his leg was already elevated so I did nothing. I did not give him pain medication because he said he had no pain. On December 25, I gave him his medication, he had no pain, and his ankle was swollen. I did not do anything to the ankle because his arm and leg were always puffy. " She added, " as far as I know the x-ray was done. " Surveyor and Nurse # 12 checked the nursing notes; there was no documentation of a swollen ankle documented by this nurse. In an interview on 02/2/12 at 3:00 pm with the physical therapy supervisor, he stated, " On 12/24/11 the resident ' s ankle was observed to be swollen; it was bigger than normal. The resident stated that he was experiencing pain in the ankle and the physical therapy assistant, who was working on a per diem basis, told the morning nurse immediately. Several calls were made to the physical therapy assistant, but he never returned the call. "	F 309		

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F 309	Continued From page 24 During a follow up interview on 2/2/12 at 3:30 pm with the interim administrator, she stated that the facility was trying to get in touch with the physical therapy assistant to see who he spoke to. She further stated that " we have not heard from him and whenever we know something we will let me know. " The administrator never got back to the surveyor on that matter. During a telephone interview on 2/2/12 at 4:12 pm with the family member, he stated that on 12/25/11 at about 10:30 am, the resident told him he had fallen a couple days ago and his leg was hurting and swollen. " I spoke with the nurse and she told me she would get an x-ray order. I came back on 12/26/11, and the x-ray was not done. I came back on 12/27/11; the x-ray was not done. I got mad and left the facility. " 2. Resident # 7 was admitted to the facility on 4/19/11 current active diagnosis retrieved from the quarterly Minimum Data Set (MDS) dated 12/29/11, included anemia, coronary artery disease, hypertension, peripheral vascular disease, gastroesophageal reflux disease, end stage renal disease, arthritis, cerebral vascular disease. Review of the MDS revealed moderately impaired cognitive skills, long and short term memory problems. The assessment revealed no behavioral symptoms towards others. Resident #7 required extensive assistance of one person to physically assist him with transferring between the surfaces and toileting. Review of the Incident accident reported dated 12/31/11, indicated Resident #7 had an unwitnessed fall in his room at 3:15 p.m., which resulted in a swollen area above the right eye.	F 309		

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F 309	Continued From page 25 Review of the medical record revealed the Neurological Assessment was completed 12/31/11, began at 3:15p.m and was completed at 10:00p.m. No Post Fall Assessment was completed for 12/31/11. Review of the nursing notes to determine the continued monitoring of Resident #7 after the fall on 12/31/11 revealed: No nursing note addressing the actual fall on 12/31/11. No nursing note 12/31/11 during the 3p.m.-11 p.m. shift. No nursing note 1/1/12 during the 11p.m-7am shift. A nursing noted dated 1/1/12 2:12 p.m., read in part, " patient is alert and verbal, no c/o from f/u fall, " No nursing note during 1/1/12, 3p.m.-11p.m. shift. An Incident Accident Report Dated 1/2/12 indicated Resident #7 had an unwitnessed fall in his room at 2:48a.m., resulting in a black eye, skin tear to his left arm. A Neurological Assessment sheet dated 1/2/12 began at 2:45a.m., and was completed at 9:30a.m. A Post Fall Assessment sheet was completed 1/2/12. Review of the nursing noted dated 1/2/12 at 3:38 p.m., read, " was walking past resident room and heard a thumping /knocking sound coming(sic) from his room, found resident on bathroom floor, had a skin tear to the left upper	F 309		

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F 309	Continued From page 26 forearm and a right black eye, asked resident what happened, stated he was trying to get onto the toilet and fell, asked why didn't (sic) he yell out for help, resident stated " I don ' t know. ", showed him again how to use the call light...cont to monitor " Review of the nursing note dated 1/2/12 at 11:46a.m read in part, " Bruised, discolored swollen rt eye from(sic)post fall this morning. Rt eye sensitive to light covered eye with 4x4 gauze. " Review of the nursing note dated 1/2/12 at 5:55p.m. in part " Resident alert and verbal..No complaints voiced. " No nursing note dated 1/3/12, or 1/4/12. During an interview on 2/3/12 at 10:52a.m., nurse # 12 indicated she was the nurse who responded to the fall dated 12/31/11, she did not complete a Post Fall assessment form, and she thought she had completed a note on 12/31/11 but it did not save. During an interview on 2/3/12 at 11:18a.m., nurse#9 indicated there was no Post Fall Assessment document or nursing notes for monitoring dated 12/31/11, 1/1/12 during 3rd shift, 1/3/1 or 1/4/12. She concluded nurses notes should have been completed per the policy for each shift. The facility did not evaluate, monitor and document Resident #7 response per the policy for the first 24 /48 hours, after the fall as indicated in their policy.	F 309		

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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: Based on resident interviews,family interview, record reviews, staff interviews, and a physician interview, the facility failed to safely provide a resident a bed bath resulting in the resident rolling out of bed onto the floor for 1 of 1 resident [resident# 2] resulting in a fall with a fractured ankle. The X-Ray of 12/27/11 showed: " Fracture of the distal fibula is noted. Fracture of the distal metaphysis of the tibia is present. Soft tissue swelling is noted in the region of the ankle joint. " The facility failed to ensure safety device was in place to prevent falls from wheelchair for 1 of 3 residents.(Resident #7). The findings included: 1. Resident #2 was admitted to the facility on 12/2/11 with multiple diagnoses including diabetes mellitus, cerebrovascular accident (CVA), dysphagia, hypertension, history of gastrointestinal bleeding, foot ulcer, status-post right-above-the-knee amputation. Review of the resident's admission Minimum Data Set (MDS), dated 12/21/11 revealed the	F 323	**F-323** – Failure to supervise and prevent accidents. **Address how the corrective action will be accomplished for those**	2/6/12

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F 323	Continued From page 28 resident had short- and long-term memory problems and was moderately impaired in decision making. The MDS indicated the resident required one-person physical assistance for activities of daily living (ADLs), including bed mobility, dressing, toilet use, personal hygiene, and bathing. The MDS indicated the resident had functional limitation in range of motion of his upper and lower extremities on one side. The resident's fall Care Area Assessment (CAA), dated 12/21/11, read in part: "per medical record resident is alert and oriented, however is confused at times. Requires extensive-to-dependent assistance with transfers. Right sided weakness secondary to CVA noted. Resident at risk for falls due to above information." The resident's ADL CAA, dated 12/21/11, read in part: "per medical record resident has right-sided weakness, analysis of findings - Requires extensive-to-dependent assistance with most ADLs. Resident at risk for complications related to ADL function and/or further decline in ADL functional status. " The resident's Care Plan, dated 12/8/11, indicated "resident is at risk for fall." The approaches included monitoring vital signs, administering medications as ordered, and arranging the environment for maximum functioning. Record review revealed a facility Incident/Accident Report dated 12/22/11. The description of the incident read, "Resident rolled out of bed during ADL care, Resident rolled on	F 323	**residents found to have been affected by the deficient practice:** ➢ Resident #2 rolled towards left side and lower extremities began to slide out of bed causing fall to mat during ADL (Activity of Daily Living) care on 12/22/2011. Resident data gathering completed by LPN #1 (Licensed Practical Nurse) and no injury noted at that time. MD (Medical Doctor) notified 12/22/11. On 12/23/11 Geo mat with wings placed on bed Care Planned and Resident Care Guide was updated. Resident #2 incident was reviewed in Standup Meeting on 12/23/11 utilizing resident progress notes, Plan of Care, Post Fall Assessment, in-service Education Sheet. Resident reviewed during weekly Quality Assurance Risk Management Meeting (Fall Management Meeting) 12/28/11. The C.N.A (Certified Nurse Aide) involved in ADL care was in-serviced on 12/29/11 with verbal and return demonstration for safe rolling on side to side to reduce risk of rolling out of bed during ADL	

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F 323	Continued From page 29 bedside mat. " The report indicated that the resident had no apparent injury. Record review of resident ' s medication administration record dated 12/22 to 12/27/11 read as follows: On 12/22/11 at 9:00 pm Vicodin was administered for pain, level 8 out of 10; recheck of pain level was 2/10. On 12/23/11 at 9:00 pm Vicodin was administered (reason: pain level 7/10; recheck, 2/10). On 12/24/11 at 8:30 am Vicodin was administered (reason: pain level 7/10; recheck, 2/10). On 12/25/11 at 8:30 am Vicodin was administered (reason: pain level 7/10; recheck, blank). On 12/25/11 at 4:00 pm Vicodin was administered (reason: pain level 8/10; recheck, 2/10). On 12/26/11 at 8:00 am Vicodin was administered (reason: pain level 8/10; recheck, 2/10. On 12/27/11 at 4:00 pm Vicodin was administered (reason: pain level 8/10; recheck, 2/10. Record review of physical therapy progress notes dated 12/23/11 at 1:02 pm read as follows: " pt [patient] rolled off bed on fall mat during ADL care on 12/2211. Pt recalled the incident. Nursing to place wing mattress to reduce risk of further falls. Physical therapy is ongoing to improve bed mobility skills/transfer skills and wheel mobility. " There was no further assessment from nursing staff of the complaint of pain. Nursing notes dated 12/23/11 at 6:22 pm read in part, " resident alert and verbal. No signs of distress. Resident had no further complications or falls during the shift. Respiration even and unlabored. " Record review of physical therapy progress notes	F 323	care by the Rehabilitation Director. Resident #2 was discharged home on 2/3/12. ➢ Resident #7 fell on 12/31/11 swelling noted on right side of head, ice applied. Frequent checks done on resident as evidenced by neurological checks done every 15 minutes x one hour, every 30 minutes x two hours, then every hour x four hours, doctor notified via communication form and placed in the doctor's box; Supervisor notified, and Resident is his own responsible party. Resident reminded to leave harness on. Nurse involved received corrective action and education for nursing documentation and post fall assessment 1/6/12. . Resident fell on 1/2/12. Resident assessed and noted to have skin tear to left forearm. Skin tear cleansed and dressed. MD notified, resident is his own RP, and in addition an interested family member was notified. Frequent checks done on resident as evidenced by neurological checks done every 15 minutes x one hour, every 30	

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F 323	Continued From page 30 dated 12/24/11 at 10:07 am read, " resident seen in bed for bed mobility tasks requires plus one [+1] max[imum] rolling to left side and moda/mina [person performing 50% or more or 40% or less] to right using right rail to pull self. Low-level exercises to left leg that appears swollen, resident reports sliding out of bed on Thursday and injured, started to feel pain in the ankle. Nsg [nursing] told of this input. " Nursing notes dated 12/24/11 at 10:48 am read in part, " patient is alert and verbal. Voiced no pain. Respiration non-labored. " Nursing notes dated 12/25/11 at 5:54 pm read in part, " resident alert and able to voice needs. Complained of left ankle pain, assessed area, swelling noted, tender to touch. Medical director received new order for x-ray of left ankle. Mobile x-ray called and aware of order. Pain medication given as needed. No further pain voiced. " Record review of telephone physician ' s order dated 12/25/11 at 5:00pm read in part, " x-ray left ankle related to pain and swelling. " Nursing notes dated 12/26/11 at 1:29 pm read in part, " resident alert and verbal. No signs of distress. Resident complained of left ankle pain. X-ray ordered for left ankle. Medication x 1 for complaint of pain. Continue to monitor. " Nursing notes dated 12/27/11 at 10:30 pm read in part, " received x-ray results. Fracture of the distal tibia and fibular metaphysis are noted with no significant displacement. Medical director notified. New order to send resident to	F 323	minutes x two hours, then every hour x four hours. Resident reminded to ask for assistance. Harness discontinued, Smart Alarm auto reset seat belt and bed alarm added. The Smart alarm auto reset seat belt activates when each end of the seatbelt is buckled. The seat belt will then alarm when disconnected. Resident #7 Seat belt checked on 2/3/12 after returned from Dialysis and the device was functioning properly. **How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice:** ➢ A falls audit was completed on 2/3/12 of all in-house residents that had a fall in the past six months to ensure they were properly assessed with overview and assessment by the RN. No other missed assessments were found. ➢ A complete audit of all residents with devices was done on	

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F 323	Continued From page 31 emergency room for further evaluation. Resident left facility via ambulance. " Record review of radiology report dated 12/27/11: " Fracture of the distal fibula is noted. Fracture of the distal metaphysis of the tibia is present. Soft tissue swelling is noted in the region of the ankle joint. " An Emergency Department report dated 12/27/11 revealed the resident was seen for an accidental fall on 12/22/11 resulting in distal tibia and fibula fracture. Nursing notes dated 12/27/11 at 11:55pm read in part, " resident back from emergency department. Splint to the left leg. New order for norco 5/325 mg [medication used to relieve moderate to severe pain] 1-2 tablets by mouth every 4-6 hours as needed and to follow up with orthopedic doctor 1-2 days. No pain or discomfort upon return. " Review of radiology report dated 12/27/11 read in part, " the bones are demineralized. Fracture of the distal metaphysis of the the fibula is noted. Fracture of distal metaphysis of the tibia is present. Soft tissue swelling is noted in the region of ankle joint. " Review of orthopedic consultation report dated 12/29/11 read in part " Recommendation 4. Follow up 2 weeks for cast change. " Record review of the physician progress notes dated 1/5/12 read in part, " admitted status-post CVA with resultant dysphasia and right-side weakness who is seen today for routine follow-up.	F 323	2/6/12. All devices were on and functioning properly. ➢ Education of devices for all Licensed Staff and Certified Nurse Aides was completed on 2/6/12. ➢ On admission each resident will have a Fall Risk Assessment completed, if any items are checked during the assessment the resident is considered at risk for falls, they care planned and Device Assessment completed. Falls occurrences are reviewed during weekly Quality Assurance Risk Management Meeting (Fall Management Meeting). This is an on-going process as described in #3. ➢ Licensed Nurses and C.N.A's in-service began 12/28/11 by the Director of Therapy and Director of Nursing on "How to properly turn and reposition residents in bed". Completion 2/6/12 ➢ CNA's in-serviced to stay with the resident after the fall. . The resident is not to be moved until evaluated by the nurse. If a fall occurs the CNA will initiate the call	

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F 323	Continued From page 32 The patient had a fracture of the distal tibial and fibular metaphysis on the left side and is in a cast. He denies any symptoms except for pain in his left lower extremity. " Record review of Nurse #5 ' s statement submitted as part of the investigation dated 1/12/12 read in part, " I [name of nurse, who no longer works in the facility] was the scheduled 11-7 nurse for [name of the resident] on December 23rd 24th, 25th, and 26th. He had fallen on December 22nd on 1st shift. When I came to work Friday night the 23rd the second shift nurse had given pain medication at 8:30 pm and he had no pain. He slept through the shift. Resident ' s extremities appear to be edematous most of the time. On Saturday the 24th resident had no pain all during shift. On Sunday the 25th resident complained of pain to the second shift nurse. An order received for x-ray to left ankle. The x-ray company was called by Nurse #2 [name of the nurse]. " This nurse told Nurse #5 that the x-ray company would not come out until 12/26/11. On 12/26/11 Nurse #2 told Nurse on the first shift that the x-ray was not done. The x-ray was not done until 12/27/12. " The surveyor attempted three times during the survey but was unable to contact Nurse #5. In an interview on 1/17/12 at 10:41 am NA #1 (nursing assistant) who was responsible for the resident's daily care, and who witnessed the fall, stated that " on 12/22/11, I was trying to turn the resident while doing his [morning] care and he rolled off the bed on to the floor mat. I went and got the nurse [Nurse #1] and two aides, and they assisted the resident to the bed. " NA #1 added that when the nurse asked the resident if he was	F 323	light and immediately notify a Nurse by calling for assistance. In-service completed 2/6/2012. ➢ The charge nurse will gather information for injuries, consisting of vital signs, skin evaluation, musculoskeletal assessment, change in condition, pain assessment, and neurological assessment as indicated. This information will be called to the Medical Doctor for orders/instruction. The on-call Administrative Nurse will be notified of the physician's instructions and the Responsible Party will be notified of the incident and physician orders. Nurses and Certified Nursing Assistants were in-serviced beginning 2/4/2012. This process will be placed in the orientation packets for all new nurses and Certified Nursing Assistants starting on 2/4/2012. The signature sheet will be placed in the individual education file, starting 2/4/2012. ➢ In-service provided to charge nurses on 2/2/12. If a fall	

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F 323	Continued From page 33 experiencing pain, he denied any pain. She further stated that " I took his vital signs. " In an interview on 1/17/12 at 11:00 am with Nurse #1, she stated that " on 12/22/11 the resident rolled off the bed to the fall mat during morning care. The aide that was giving care got me, we assisted the resident back to the bed. I assessed the resident. I did neurological checks and asked him if he was having pain. He denied pain. He was able to move his lower extremity as well as upper extremity. " Nurse #1 added that there was no bleeding, no bruising, no skin tears or swelling from fall, and NA #1 took the resident ' s vital signs. In an interview on 1/17/12 at 2:44 pm the interim administrator stated that " [name of the resident] rolled out of the bed to the floor mat on 12/22/11. I went to the the resident ' s room to discuss the incident with the resident. I performed a visual inspection of the resident ' s body, the resident ' s heel was bloated because he has a history of a wound to his heel. The resident was noted to have edema to the upper right arm and a trace of edema to left lower extremity. This was no different from any other day since admission. This resident had a history of lower extremity edema prior to admission. No misalignment was noted to the extremity. The family member was notified. On 12/25/11 the family member complained to the nurse who was in charge of the resident ' s care that the resident ' s ankle was swollen and he was experiencing pain. An order for an x-ray was obtained from the medical director on 12/25/11. This x-ray was not done until 12/27/11 because on 12/25/11 the mobile x-ray unit was only doing stats and on 12/26/11 the scheduler for	F 323	occurs the nurse on duty will perform the following post fall actions: 1. Provide immediate care to address any injuries, and resident safety 2. Evaluate resident for any additional injury which would require medical intervention. Evaluation includes but is not limited to: o Vital Signs o Skin Evaluation o Musculoskeletal assessment o Change of Condition o Pain Assessment o Neurological assessment as indicated 3. Thoroughly document clinical findings in medical record 4. Interview resident and staff to determine if cause of fall can be determined. 5. Notify MD in person or by telephone of ALL falls and document	

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F 323	Continued From page 34 the mobile unit forgot to add the resident ' s name to the schedule. I have in-serviced my staff on the importance of having x-rays done in a timely manner. My expectations are that for any acute episode that might rule out bone fracture the x-ray must be done the same day. In event the x-ray company is not able to come the same day within a reasonable time frame, the medical director should be notified and the resident should be sent out to the hospital. " The interim administrator added that this was not done. She further stated NA #1 had been in-serviced on the proper procedure for ADL care of residents with weakness in one or both sides. She further stated that the resident has not had another fall. In an interview on 1/17/12 at 3:44 pm, Resident #2 stated " I fell off my bed to the floor and broke my ankle. " He added the ankle was swollen and hurting. In a telephone interview on 1/18/12 at 8:30 am the medical director stated that his expectations are that if an order is written by himself or an on-call physician for an x-ray, it should be done on the day it was written. He added that the mobile unit normally comes to the facility when requested, so it should be done within the day. If the x-ray is not done when ordered he expects communications from the facility immediately so the resident can be sent to the emergency department. In an interview on 1/18/12 at 9:52 am, NA #2 stated that " I was responsible for the resident ' s care on 12/24/11; he did not experience any pain while I was giving care, but his ankle was swollen and I elevated the ankle with a pillow. "	F 323	in medical record. 6. Notify On-Call Administrative RN in person or by telephone of ALL falls and document in medical record. 7. Notify family (RP) and document in medical record. 8. Complete post fall assessment and formulate interventions based off evaluated clinical information. 9. Communicate established interventions to the care giving staff 10. Document on all fall every shift x 24 hours, then daily x 48 hours. ➢ In-servicing completed for Licensed Nurses and C.N.A's on 02/02/12 by the, Therapy Director, on "How to properly turn and reposition residents in bed" including complaints of pain, change in ability to ambulate, how to care for residents with physical impairments and interventions that may be utilized in the care of the resident including obtaining assistance from	

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F 323	Continued From page 35 During a follow up telephone interview on 1/27/12 at 11:40am NA #2 stated that an aide told her to elevate the resident ' s ankle with a pillow but she does not remember which aide. In an interview on 1/18/12 at 10:38 am Nurse #2, the nurse responsible for the resident's care on 12/25/11, stated " I was on duty 12/25/11 and the resident's family member told me that [name of the resident] had fallen 3 days ago and the resident was in pain. I went in his room and assessed his ankle and it was swollen. I called the medical director and he gave me an order for an x-ray. I called the mobile x-ray unit and they told me that [name of the resident] would be seen the following day because it was not a stat order. I made the nurse coming on the next shift aware. " During a telephone interview on 1/18/12 at 3:10 pm Nurse #4 who worked with the resident on 12/26/11, stated that the resident was alert and verbal. The resident was administered Vicodin for his phantom pain. The resident did not complain of any ankle pain, nor was the ankle swollen. In a telephone interview on 1/26/12 at 5:30 pm NA #1 stated that I was performing a bed bath, and after washing his back, I put a lot of lotion on him because he has very dry skin. I turned him away from me. The resident held on and began to turn, and his lower body began to slide off the bed. My hands were greasy; I attempted to catch him but I was unable to, and the resident slid to the floor. I called my nurse, and she assisted him off the floor with the help of 2 aides. NA#1 further indicated the bed rails [small rails] opposite to	F 323	and pain assessment. Document findings. o Any areas of deficiency noted will be corrected. The staff involved will be provided education and or corrective action as indicated. ➢ Nursing Administration will review o progress notes, o Plan of Care, o Post Fall Assessment o Medication Administration Record for accuracy of documentation. ➢ Therapy will screen the resident after a fall if the resident is not already on therapy caseload. ➢ The Unit Managers or Supervisor will inform direct care staff of any new intervention utilizing the Device audit tool. ➢ The Weekly Falls Management Meeting: consist of the Administrator, Director of Nursing, Unit Manager, Therapy Representative, and Safety Director. Include o Direct care givers when possible. If direct caregivers are not available to attend the meeting the Unit Manager	

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F 323	Continued From page 36 where she would turn the resident were lowered, but the small rail away from her were raised, and the resident held on to the small rail and attempted to turn. The bed was in the normal position; she reiterated that the bed was not in the low position. In a follow up telephone interview on 1/27/12 at 12:20 pm with the interim, administrator she stated that Resident #2 slid out of bed while ADL care was performed on 12/22/11. The resident care plan reflected a 1-person assist with ADLs for bed mobility. NA #1 is well aware of the care for Resident #2 as she has cared for him on multiple occasions prior to the incident. " The interim administrator further stated that Resident #2 was in bed. NA #1 was in his room with a fall mat on both sides of the bed. NA #1 was performing a bed bath on the resident and used moisturizer on his skin on the front side. After bathing and moisturizing the resident ' s front side, NA #1 began to turn the resident towards his left side as she needed to complete the bed bath. When NA #1 began to turn the resident, the resident ' s lower body slid out of the bed. NA #1 attempted to catch the resident but she was unable, and the resident rolled on the fall mat. Nurse #1 completed a full assessment of the resident. The resident declined pain. There was no new swelling or bruising. The family and the medical director were notified. In a follow-up interview on 2/1/12 at 5:50 pm with Nurse # 2, the nurse stated that " 12/25/11 was the first time I ever worked with the resident. The resident ' s family member came and asked me to look at the resident ' s ankle because it was swollen and tender to the touch. The resident was	F 323	other staff member. An evaluation will be done with consideration for the resident's physical symptoms and visual cues, in addition to utilization of the pain scale. Interim Administrator and Staff Development Coordinator completed in-servicing of all licensed and certified staff on 2/6/2012. This process will be placed in the orientation packet for all new nurses and Certified Nursing Assistants starting on 2/4/2012. The signature sheet will be placed in the individual education file, starting 2/4/2012. ➢ Any staff member not trained will be removed from the schedule until training is completed. **Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur:** ➢ All fall occurrences are reviewed daily by Nursing Administration. Nursing Administration will validate no injuries by: o Perform a Head to Toe assessment	

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F 323	Continued From page 38 is a critical matter, the facility calls one of the doctors. If the situation is not critical, the facility puts the results in a box to be reviewed. The results normally stay in the box for up to two days, no more. In a follow-up interview with the resident # 2 on 2/2/12 at 9:00 am [in the presence of NA #1 and nurse #3], the resident stated that he had fallen and hurt his ankle sometime in December. " A lot of people came in the room, " he said. " I told them that my ankle hurt, but they did not give me anything until that night. I hurt for many days before they took care of it. " During a follow-up interview on 2/2/12 at 9:30 am, Nurse #1 stated that NA #1 " came and told me told that the resident rolled to the floor. She stated she was turning the resident and the resident rolled to the floor. When I went to the room, he was on his right side and his leg was extended. The resident said that he was experiencing no pain. I touched his legs; he had no pain. I did not do any range of motion checks. I believe I gave him pain medication. His legs were not bigger that normal [Nurse # 1 stated that Resident #2 has routine edema]. Before we removed him from off the floor, we did vital signs and checked his pupils and I asked him if he had pain. I did not assess him again. The expectation is that if the fall is witnessed, we do not have to assess again, but if it is not witnessed, we have to assess the resident for 3 days. On the 26th, the family told me that the resident fell, and he was supposed to have an x-ray, and it was not done. I called the x-ray company, and they came out that day to do the x-ray. " Record review showed the x-ray was not taken until 12/27/11.	F 323	office. Education of any further occurrences that involve safety during ADL care will be will be taken to daily stand up meeting, weekly Quality Assurance Risk Management Meeting (Falls Committee Meeting), and Quarterly Quality Assurance meeting for review and resolution times 1 month and quarterly thereafter times 3. Falls Management Committee and assessment of falls is included in new hire orientation and documented on the education specific training information, this will be placed in the employee education file for Licensed Nurses and Certified Nursing Assistants. Completion 2/2/12 ➢ All new employees will receive in-services to include, but not limited to, • care of residents with physical impairments, • turning and position • Falls Management program .	

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In an interview on 2/2/12 at 11:29 am with Nurse # 12 , she stated, " no one told me that the resident had a fall. On 12/24/11 the family member came and told me that the resident fell and no one was doing anything about it. I told my DON and my nurse manager about the family ' s concerns. I looked in the nurses notes and I saw where they were elevating the resident ' s leg with a pillow. I checked the resident, and his leg was already elevated so I did nothing. I did not give him pain medication because he said he had no pain. On December 25, I gave him his medication, he had no pain, and his ankle was swollen. I did not do anything to the ankle because his arm and leg were always puffy. " She added, " as far as I know the x-ray was done. " Surveyor and Nurse # 12 checked the nursing notes; there was no documentation of a swollen ankle on 12/24/11.

In an interview on 02/2/12 at 3:00 pm with the physical therapy supervisor, he stated, " On 12/24/11 the resident ' s ankle was observed to be swollen; it was bigger than normal. The resident stated that he was experiencing pain in the ankle and the physical therapy assistant, who was working on a per diem basis, told the morning nurse immediately. Several calls were made to the physical therapy assistant, but he never returned the call. "

During a follow up interview on 2/2/12 at 3:30 pm with the interim administrator, she stated that the facility was trying to get in touch with the physical therapy assistant to see who he spoke to. She further stated that " we have not heard from him

➢ The Unit Manager will audit and update the device List daily and make copies for each nurses and certified nurse aide. The Nurse aide will do a check on each of their assigned residents to ensure placement and functionality. If the device is not in place or does not function the Nurse Aide will notify the Charge Nurse. The nurse will obtain the appropriate device for placement on the resident. This process will be included in orientation for all licensed Staff and Nurse Aides.

Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility:

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F 323	Continued From page 40 and whenever we know something we will let me know. " The administrator never got back to the surveyor on that matter. During a telephone interview on 2/2/12 at 4:12 pm with the family member, he stated that on 12/25/11 at about 10:30 am, the resident told him he had fallen a couple days ago and his leg was hurting and swollen. " I spoke with the nurse and she told me she would get an x-ray order. I came back on 12/26/11, and the x-ray was not done. I came back on 12/27/11; the x-ray was not done. I got mad and left the facility. " Review of the facility documentation revealed: Review of the facility policy " Falls Management Program " effective dated 10/12/11, per the procedure in the Fall Occurrence section , in part, · Notify the physician, responsible party, and / or EMS as well as the Supervisor / Administrative personal as appropriate. 2. Resident # 7 was admitted to the facility on 4/19/11 current active diagnosis retrieved from the quarterly Minimum Data Set (MDS) dated 12/29/11, included anemia, coronary artery disease, hypertension, peripheral vascular disease, gastroesophageal reflux disease, end stage renal disease, arthritis, cerebral vascular disease. Review of the MDS revealed moderately impaired cognitive skills, long and short term memory problems. The assessment revealed no behavioral symptoms towards others. Resident #7 required extensive assistance of one person to physically assist him with transferring between the surfaces and toileting.	F 323	➢ Therapy to report Change of condition to the floor nurse and on 24 shift report . Rehab Director will review 10% of Therapy Progress notes to verify change of condition on 24 hr shift report daily X 2 weeks, 3x a week for 2 weeks, and 1x a week times one month. Any concerns are reviewed for problem resolution at the weekly Quality Assurance Risk Management meeting and monthly at the Quality Assessment and Assurance meetings for further review and resolution x 3 months.. ➢ The Director of Nursing/or Unit Managers will audit devices daily X 2 weeks, 3X a week for 2 weeks, and 1X a week times one month. Any concerns are reviewed for problem resolution at the weekly Quality Assurance Risk Management meeting and at the monthly Quality Assurance and Assessment meeting for further review and resolution X 3 months. ➢ The Director of Nursing and the Unit	

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F 323	Continued From page 41 The most recent Care Area Assessment Summary (CAA) dated 5/2/11, triggered falls, findings included in part; Resident had one fall while in the hospital. Resident has had 3 falls since admission, and did have some pain in his arm related to falls. Resident is currently working with both PT (physical therapy) and OT (occupational therapy). He also has a chair alarm in place. Staff will continue to monitor. The most recent Care Plan dated 12/23/11 in part, Problem Fall-ACT: Actual falls related to history of fall r/t (related to) bilateral AKA (above the knee amputation) and history of non complaint behaviors. Resident continues to transfer without notifying staff for assistance. Resident continues to get up without using self release harness and also removes it. Goal: Resident will be free from falls or injury by next review. Approaches: 12/23/11, 1. anticipate resident needs. 2. Frequent bed checks while in bed. 3. Frequent monitoring for placement of self-releases harness (a hook and loop harness that resident can remove) 4. Charge motorized wheelchair every night. 5. (Name brand) matt with wings. 6. Supervise & assist with transfers as indicted. 7. (Name brand) fall mat. 8. Motorized chair with self release harness for trunk control due to bilateral AKA. 9. Low bed position to aid in prevention of falls. 10. Instruct resident to call for assistance when getting out of bed or out of chair. 11. Call bell with reach. 12. Bedside commode frame moved to bathroom so resident can have privacy. 13. Bed alarm. (Added 1/2/12) Review of the Incident Accident Report dated 12/31/11,revealed Resident #7 fell in his room at 3:15p.m. on 12/31/11. His condition prior to	F 323	Managers are responsible for the implementation and monitoring of the Falls Management Program. All fall occurrences are reviewed daily (Monday- Friday) at stand up meeting, weekly in Quality Assurance Risk Management meeting by the DON/Unit Managers and the Week-end Supervisor/On Call Administrative Registered Nurse on Saturday and Sunday. Any problems noted will be taken to the Quality Assurance Weekly Risk Management Meeting and Monthly Quality Assurance meeting for review and resolution, times 1 month and quarterly times two quarters thereafter, for further review and resolution. • **Completion 2/6/12.**	

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F 323	Continued From page 42 incident was alert and chairbound. Restraint ordered restraint applied : (brand name) hook and loop safety strapes(sic) Description of incident : "Patient was found on floor in room by c.n.a. Patient stated he fell asleep and fell out chair. He took his safety belt a loose." Location of injury : picture indicated swollen above right eye. Result of Incident: Ice applied to area on right side of head. No Post Fall assessment dated 1/31/12 was completed by the nursing staff for the fall dated 12/31/11. Review of the second incident report dated 1/2/12, revealed revealed resident fell in his bathroom at 2:45a.m. Type of Incident check one or more : Fall/ Bruise Description of incident : Nurse was walking past room down the hall and heard a thumping knocking sound opened the door to ask if Resident #7 was alright his wheelchair was in the bathroom and Resident #7 was on the floor. Vital signs were taken Location of injury : Black eye , skin tear left arm. Result of Incident: First Aid Skin tear cleaned /dressed: Comment and follow up Skin tear on Left upper forearm and right black eye. A Post Fall Assessment dated 1/2/12 was completed by nursing. Falls Risk Assessment dated 1/12/12, revealed Risk areas medications (pain medications listed), Mobility bilateral AKA , unsafe behavior observed or history tries to stand, transfer, or walk alone unsafely. Tries to climb out of bed alone unsafely. History of falls the last six (6) months, chair bound and requires assistance with toileting , poor balance in wheelchair.	F 323		

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F 323	Continued From page 43 Device assessment dated 1/12/12, completed by Nurse #9 revealed Medical Diagnosis: end stage renal disease, diabetes mellitus, hypertension, bilateral above the knee amputations, coronary artery disease, and cerebral vascular disease. Symptoms: Poor balance, forgetful, confused at times. Devices: assist bars, bed alarm seat belt. Purpose of the Devices: (name brand) matt with wings to help define parameters of bed. Alarming seat belt to prevent falls. Bed position against wall for safety. Physician Order dated 1/12/12, Seat belt alarm to motorized wheelchair due to bilateral above the knee amputations, with poor balance, forgetfulness and confusion at times. Medical Reason for Restraint: Poor balance, forgetfulness, intermittent confusion Resident /RP(responsible party) Education , " Resident is aware that seat belt with alarm is on motorized wheelchair to remind him to ask for assistance. Resident is currently able to release seat belt on command. " Alternative: Self release harness to motorized wheelchair. Resident Response: Resident would release harness, fall asleep in the chair or attempt to transfer without assistance. Physician Order dated 1/12/12 Seat belt alarm to motorized wheelchair due to bilateral above the knee amputations, with poor balance, forgetfulness and confusion at times. Release every 2 hours. Resident #7 was observed on 2/2/12 at 11:34a.m., in his room sitting in his motorized wheelchair, engaged in watching a television	F 323		

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	345460	A. BUILDING _____ B. WING _____	C 02/03/2012

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F 323	Continued From page 44 show. He turned the television down and turned the wheelchair around. It was noted he was a bilateral above the knee amputee; he had a bandaged left hand and forearm. The wheel chair seat belt was dangling at the sides of the wheelchair. No alarm box was noted on the chair at this observation. When asked if he had fallen recently, he indicated he had, but could not recall the day. Resident #7 stated he had fallen when he had leaned forward to turn on the radio sitting on the night stand at the end of his bed. He rolled out forward of the wheelchair and hit his head on the end of the bed and gave himself a black eye. He demonstrated how he leaned forward, he then realized he did not have his seat belt fastened and he clicked it together. He indicated he knew he was suppose to keep his seatbelt fastened but would forget to buckle it. He indicated he had several falls because he thought it was buckled but it was not. He stated he fell once when he thought the belt was buckled, his shirt was covering it, and he had to go to the hospital. He chuckled, he continued by saying he used to use a harness to help him stay in the chair. The belt he likes much better. He concluded by saying he still forgets to keep it buckled. During an observation of Resident #7 on 2/3/12 at 8:38a.m., revealed sitting in his motorized wheelchair at his night table eating breakfast. An alarm box on the side of the chair was observed. The seat belt was buckled, and bed alarm was observed. Upon interview Resident #7 indicted the facility had added an alarm to his chair and to his bed to help him remember to ask for help. During an interview on 2/3/12 at 9:00a.m., Nurse #11 indicated he had a bed and chair alarm in his	F 323		

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F 323	Continued From page 45 wheelchair. This will alert the staff if Resident #7 was attempting to transfer. The assigned staff was checking on Resident #7 more often and when he was in bed his wheelchair would be placed out of his reach, to remind him to call for assistance when transferring. The aids check it when they transfer him it will alarm. The wheelchair was placed against the wall out of his reach to prevent him from transferring alone. During an interview on 2/3/12 at 10:52p.m., Nurse #12 indicated Resident #7 used a harness that he could remove. He fell asleep and he fell out of the chair. We would remind him to keep his harness buckled. During an interview on 2/3/12 at 11:49 a.m., the director of nursing indicated the self release seat belt was supposed to alarm when it was unbuckled. She indicated she did not know why the belt was not alarming on 2/2/12 during the observation the day before. During an interview on 2/3/12 at 12:13p.m., Nurse #9 indicated the self release hook loop harness was discontinued because there was no alarm on the harness. The seat belt was implemented because it alarmed. She indicated she had no other residents with this type of belt she did not know where the facility had gotten it. She indicated there was no documentation or monitoring tool to ensure the belt was working or monitored. When the resident told had buckled his seat belt yesterday during the observation and there was no alarm. She indicated she did not know why the belt had not alarmed. During an interview on 2/3/12 at 2:55pm, Aide #3	F 323		

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F 323	Continued From page 46 indicated she had worked with Resident #7 on and off prior to the last week and had him steady for this week. She indicated he had a self release seatbelt that he removed. She indicated the seatbelt alarm would go off if it was unlatched. She indicated the seat belt alarm worked this morning. She was asked to demonstrate the belt, she indicated Resident #7 was out of the building. Aid # 3 indicated she did not know of any other residents with that type of alarm. She indicated she does not check the alarm unless she removed it from the resident to provide care. The sound it makes was different from the bed alarm. She indicated the wheelchair was kept out of his reach when he was in bed to prevent him from getting into his chair on his own. She indicated she checked the alarm about lunch time, when she removed it to give him a whirl pool bath. During an interview on 2/3/12 at 4:21p.m., physical therapy director indicated a fall occurred on 12/31/11 (Saturday) and 1/2/12(Monday) and one physical therapy screen covered both falls. During the stand up meeting nursing had indicated they were going to implement a bed alarm and a seat belt alarm. He was not picked up for physical therapy services because he had no changes that warranted physical therapy services. All falls are screened by the physical therapy department the next business day, a screening does not indicate a resident will be picked up for an evaluation. The self release harness was the best option for Resident #7 at the time of the screening. Nursing had made the decision to discontinue the self release harness. He could not describe the new belt and indicated the physical therapy department had not supplied the belt. Therapy had seen Resident #7	F 323		

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F 323	Continued From page 47 previously for use of his bilateral prosthetic legs. During an interview via telephone on 2/4/12 at 10:00a.m., Aide #4 indicated Resident #7 came back from the hospital and was moved to his current room. Up until two weeks ago Resident #7 was able to transfer him self. He was no longer allowed to do so, the staff was to keep his wheelchair out of his reach and he was to call for assistance. She went on to say to keep him safe in the wheelchair a hook and loop vest was used that crisscrosses across him and the chair. If he took it off it would alarm, " it always works " . The vest goes around his shoulders and his waist. She indicated it was not checked regularly. She indicated when the vest was taken off and makes a loud noise. Recalling the fall on 1/2/12 she indicated Resident #7 was independent with his transferring at that time. She indicated he had taken himself to the toilet and was found by the nurse between the toilet and the wheelchair on the floor, he had a black eye left eye and a skin tear to his left arm. We got him up and put him to bed. We put a brief on him, and gave him a urinal and a bedpan. We told him to use the call bell for help. He was very confused he could not recall falling or how he had gotten the bruise. We watched him closely the rest of the night. There had been no changes in the type of belt and the belt does not alarm. The changes were the bed alarm and the pad that he sits in his wheel chair she could not recall the date this was changed. Since he fell on 1/2/12, the only difference was to keep the chair out of his reach. Otherwise everything was the same. During a telephone interview on 2/6/12 at 8:03a.m., Nurse #13 indicated prior to 1/10/12, he	F 323		

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F 323	Continued From page 48 had been independent with transferring and mobility. He had no measures in place to keep him safe. She always kept his door open to watch him. A bed alarm was put on his bed and the chair was to be kept away from his reach. She indicated she did not know if the alarm in the chair worked or not it was disabled at night. Nurse #13 indicated during the day Resident #7 wears a harness because he falls asleep in his wheelchair and falls forward and out of the chair. The belt on the chair doesn't alarm. There was a chair pad alarm in the wheelchair, it is flat and he sits on it. When he lifts himself forward off of the pad it alarms.	F 323		