STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 10/02/2012

OCT 25 2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD FAYETTEVILLE, NC 28306

(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 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to revise the care plan for one(1) of one (1)cognitively impaired resident who was identified as being a high risk falls.(Resident # 1) Findings include: Resident # 1 was admitted to the facility on 1/23/2012 with diagnoses of Depressive Disorder, Personal History of Falls, Hypothyroidism, End-Stage Renal Disease, Hyperkalemia,	F 279	Cumberland Nursing & Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of correction is submitted as a written allegation of compliance. Cumberland Nursing and Rehabilitation Center's response to the Statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further Cumberland Nursing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Candice Brown-Baldwin	RN - ANHA	10-23-12

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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CUMBERLAND NURSING AND REHABILITATION CENTER	2481 LEGION ROAD FAYETTEVILLE, NC 28306

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F 279	Continued From page 1 Hypertension, Diabetes Mellitus, Paralysis, Parkinson Disease and Cerebrovascular Accident (CVA). The most current MDS (Minimum data Set) dated 8/9/2012 revealed the resident 's cognition as severely impaired, she needed extensive assistance with bed mobility, transfer and walking in corridor. MDS further indicated the resident also as totally dependent on staff for locomotion on unit and toileting use. MDS also indicated the resident as not steady with moving from seated to standing position and walking. MDS further revealed the resident had impairment on one side upper extremity and impairment on one side lower extremity. Review of Resident # 1's current care guide dated 2/29/2012 revealed the resident was non-ambulatory, needed a mechanical lift for transfers, used a diaper for incontinence and used a bed alarm. CAA (Care Area Assessments) worksheet dated 6/7/2012 indicated the resident "flagged for Cognitive loss/ Dementia due to a BIMS (Brief Interview for Mental Status) score of less than 13.The resident presents with noted confusion-she will at time make simple decisions regarding her wants/needs, but for the most part, staff anticipates and provide for her care as needed. Resident displays impaired safety awareness and requires frequent monitoring of staff. "CAA worksheet also indicated the resident "is at increased risk for falls/injury secondary to right sided blindness." The ADLs (Activity of Daily Living) 'CAA documented resident requires "extensive assistance with bed mobility, locomotion on and off unit, dressing, eating, toileting, personal hygiene, bathing and	F 279	and Rehabilitation Center reserves the right to refute any of the deficiencies on this statement through informal dispute resolution, formal appeal procedure, and or any other administrative legal proceedings. Resident #1 is no longer in the facility A 100% audit of all residents to include residents that are identified at high risk for falls, care plans and care guides, were reviewed by the DON, ADON, Staff Facilitator, MDS Nurses, and QI Nurse on 10/08/12 for accuracy of appropriate interventions to include mats, bed alarms and low beds. All identified	10/08/12

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F 279	Continued From page 2 transfers." The Fall CAA indicated the resident "requires extensive assistance from staff for all mobility needs. Resident does have a history of falls- she demonstrates decreased safety awareness secondary to impaired cognition that increase 's her risk for fall/injury. Staff currently transfer resident via the lift." Review of Resident # 1's fall risk evaluation dated 6/7/2012 documented the resident had a score of 19 which indicated the resident was a high risk for falls. The fall risk evaluation further documented the resident was total assist with transport with a fall in the past 30 days and the resident ' s vision was severely impaired.The fall risk assessment also documented the resident "currently has a bed alarm. Mat on the floor beside her bed and a low bed." Review of the Resident # 1's fall risk evaluation dated 8/15/2012 documented the resident had a score of 15 which indicated the resident was at high risk for falls. The intervention was for Resident # 1 to be on " fall risk precaution. " Resident #1's care plan dated 8/17/2012 documented the resident required assistance with transferring from one position to another related to her physical limitation. The care plan documented the following intervention: "Resident can weight bear, mechanical lift and Monitor for safety awareness." The care plan further documented the "resident was at risk for falls characterized by history of falls/ actual, falls, injury, multiple risk factors related to: Disease process: Blindness, incontinence, impaired balance, impaired mobility and pain." The interventions were "assist during transfer and mobility, Ensure environment is free of clutter, fall	F 279	areas of concerns related to care plans and care guides were immediately addressed by the MDS Nurses. The MDS Nurses were Educated on 10/16/12 by the Administrator on the utilization of assessment data for accurate care plan development for all residents to include residents that were identified as high risk for falls, formulating care plans, updating the care plan, and including implementation of new preventative interventions to include low beds, mats , and bed alarms. The MDS Nurses were Educated on 10/17/12 via video training module the MDS 3.0 care area assessment process and care planning.	10/16/12 10/17/12

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F 279	Continued From page 3 risk protocol and Mechanical lift." Further review of the care plan dated 6/7/2012 and 8/17/2012 revealed it was not updated to include a bed alarm and floor mat as indicated in the resident 's Fall Risk evaluation dated 6/7/2012. Nurse's note dated 9/22/2012 documented "Patient did yell and scream at 6:45 this morning and was found lying on the floor besides her bed. Resident was brought back to bed with NA (Nurse Assistant), (resident) stated she wanted to walk to get some water. On inspection, left hip slightly swollen, no bruises or bleeding assessed." Review of the incident and accident report dated 9/22/2012 documented "On 9/22/2012 patient was yelling and hollering at 6:50 AM in her room, was found lying on floor besides her bed. Bed was in lowest position. Cable to bed alarm was unplugged. No floor mattress was in place. Patient was brought back to bed and alarm was reapplied." The Incident report further revealed the resident had " Muscle weakness, impaired standing balance, decreased functional status, decreased mobility, fatigue secondary to disease process and reaching for objects, acute episode with altered mental status, Decreased safety awareness, psychosis, and decline in mental status, mental illness and diabetes mellitus." Review of the hospital record dated 9/22/2012 documented the resident was admitted due to left femur fracture. The hospital record further documented the resident "apparently climbed out of bed today and had a fall. She presented to the emergency department with deformity of the left lower extremity. She was seen by emergency	F 279	An in-service was initiated for all licensed nurses on 10/22/12 by the Staff Facilitator regarding notifying the MDS Nurses of changes in preventative interventions; to include bed alarms, low beds, and mats; by submitting a copy of the updated resident care guide of any changes to the MDS Nurses. All newly hired licensed nurses will be in serviced regarding notifying the MDS Nurses of changes and preventative interventions to include bed alarms,low beds and mats by submitting a copy of the updated resident care guide of any changes to the MDS Nurses during the orientation process by the Staff Facilitator.	10/22/12

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F 279	Continued From page 4 department physician and found to have a fracture of the femur. Patient has significant dementia and is unable to provide any history." The hospital record further documented "A-9 point review of systems was reviewed with her daughter. It is negative with the exception of musculoskeletal. Which is significant for left femur pain." The hospital record also documented "The x- rays of the left femur reveal a fracture of the femoral shaft in the upper one-third. There is displacement and shortening." The hospital record further documented "we will take her this evening for intramedullary nail fixation. I have explained to the daughter the risks and benefits of surgery. The risks include bleeding, infection, damage to nerves or blood vessels, failure of the fracture to heal, need for more surgery, heart attack, stroke, and death." During the interview on 10/2/2012 at 12:30 PM, NA#1 reported that she took care of Resident # 1 on the night of 9/22/2012. NA#1 stated that she checked the resident at 11:00 PM, 1:00 AM and 5:00 AM. NA #1 further added that she did not see the bed alarm on the Resident # 1's bed during the times that she checked on her. NA#1 further reported that Resident # 1's Care guide indicated that the resident should have a bed alarm but she did not see one on the day she took care of the resident on 9/22/2012. During the phone interview on 10/2/2012 at 1:45 PM, day Nurse # 1 reported she had a loud voice coming from Resident # 1's room in the morning of 9/22/2012. The resident was yelling and was on the floor.Nurse # 1 added Resident #1 had just fallen from her bed.Nurse # 1further reported the bed alarm did not go off before or after the	F 279	An in-service was Initiated on 10/22/12 by the DON with the MDS Nurses regarding the completion of care plans for all residents to include residents that are identified as being at high risk for falls through the RAI process on admission, quarterly, annually,or with any significant change. Licensed Nurses will notify the MDS Nurses of changes And preventative interventions to include bed alarms, low beds and mats as appropiate by submitting a copy of the updated resident care guide with any changes to the MDS Nurses.	10/22/12

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F 279	Continued From page 5 resident fell on the floor. Nurse # 1 also reported she found out the bed alarm cable was not connected all the way while attached beside the bed. Nurse # 1 further added her normal routine was to check the residents bed alarms at the facility to make sure they were functioning correctly at the beginning of her shift. She added she did not check Resident # 1's bed alarm at the beginning of the shift on the night of 9/22/2012. During the interview on 10/2/2012 at 2:30 PM, MDS nurse #1 reported she was responsible for completing the annual assessments at the facility. She added she completed the annual fall risk assessment for Resident # 1 on 6/7/2012 and the resident scored as high risk on her annual fall risk assessment. MDS nurse #1 also added she could not explain why the annual care plan dated 6/7/2012 for Resident # 1 was not updated to include bed alarm, floor mat and a low bed. MDS nurse #1 further reported that she was not responsible for completing the quarterly updates on the care plans at the facility so she could not explain why the quarterly careplan for Resident # 1 dated 8/17/2012 did not include bed alarm, floor mattress and low bed. During the interview on 10/2/2012 at 3:30 PM, MDS nurse # 2 reported she was responsible for completing the residents quarterly assessmnents at the facility. MDS nurse # 2 was asked why the current careplan for Resident # 1 was not updated with the use of bed alarm and floor matress. MDS nurse # 2 answered it was an oversight.	F 279	The MDS Nurses will revise the care plan for all residents upon the receipt of the revised resident care guide. with identified changes and/or new preventative interventions to include low beds, alarms,and mats. The DON or ADON will review the care plans of all residents with new preventative interventions and/or changes to ensure care plans have been revised by utilization of the care plan interventions QI tool 5 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times a week for 4 weeks, weekly for 4 weeks, Then monthly times 2 months. The DON or ADON will follow up immediately upon identication of any potential concern.	
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			

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F 323	Continued From page 6 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 record reviews and staff interviews, the facility failed to implement fall interventions for one (1) of three (3) cognitively impaired residents, who were assessed as being at risk for falls. (Resident # 1) Findings include: Resident # 1 was admitted to the facility on 1/23/2012 with diagnoses of Depressive Disorder, Personal History of Falls, End- Stage Renal Disease, Hypertension, Diabetes Mellitus, Paralysis, Parkinson Disease and Cerebrovascular Accident (CVA). The most current MDS (Minimum data Set) dated 8/9/2012 revealed the resident ' s cognition as severely impaired; she needed extensive assistance with bed mobility, transfer and walking in corridor. MDS further indicated the resident also as totally dependent on staff for locomotion on unit and toileting use. MDS also indicated the resident as not steady with moving from seated to standing position and walking. MDS further revealed the resident had impairment on one side upper extremity and impairment on one side lower extremity. The MDS revealed the resident was not coded for side rails restraint. Review of Resident # 1's current care guide dated 2/29/2012 revealed the resident was non-ambulatory, needed a mechanical lift for transfers, and used a bed alarm.	F323	The findings of the Preventative Intervention QI audit tools will be forwarded to the QI committee for review quarterly for the identification of trends,development of action plans as indicated, and to determine frequency of continued QI monitoring. Resident #1 no longer resides at the facility. A 100% audit was completed On 9/22/12 by the DON to Ensure preventative Interventions for all residents identified at high risk for falls were in place and functional per the resident care guide, to include low beds, alarms,and mats. All identified areas of concerns were immediately addressed by the DON.	9/22/12

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F 323	Continued From page 7 CAA (Care Area Assessments) worksheet dated 6/7/2012 indicated the resident "flagged for Cognitive loss/ Dementia due to a BIMS (Brief Interview for Mental Status) score of less than 13.The resident presents with noted confusion- she will at time make simple decisions regarding her wants/needs, but for the most part, staff anticipates and provide for her care as needed. Resident displays impaired safety awareness and requires frequent monitoring of staff. "CAA worksheet also indicated the resident " is at increased risk for falls/injury secondary to right sided blindness." The ADLs (Activity of Daily Living) ' CAA documented resident requires "extensive assistance with bed mobility, locomotion on and off unit, dressing, eating, toileting, personal hygiene, bathing and transfers." The Fall CAA indicated the resident "requires extensive assistance from staff for all mobility needs. Resident does have a history of falls- she demonstrates decreased safety awareness secondary to impaired cognition that increase's her risk for fall/injury. Staff currently transfer resident via the lift." Review of Resident # 1's fall risk evaluation dated 6/7/2012 documented the resident had a score of 19 which indicated the resident was a high risk for falls. The fall risk evaluation further documented the resident was total assist with transport with a fall in the past 30 days and the resident ' s vision was severely impaired. "The fall risk assessment also documented the resident " currently has a bed alarm. Mat on the floor beside her bed and a low bed." Review of the Resident # 1's fall risk evaluation dated 8/15/2012 documented the resident had a score of 15 which indicated the resident was at high risk for falls. The intervention was for	F 323	An in service was initiated on 10/19/12 by the Staff Facilitator with Certified Nursing Assistants regarding checking the resident care guide, for all residents to include residents identified for high risk for falls to ensure that all preventative interventions toinclude mats,alarms, and low beds are in place and functioning prior to rendering care. All newly hired Certified Nursing Assistants will be trained on checking the resident care guide to ensure all preventative interventions to include mats, alarms, and low beds are in place and functioning prior to rendering care during orientation by Staff Facilitator .	10/19/12

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F 323	Continued From page 8 Resident # 1 to be on "fall risk precaution." Resident #1's care plan dated 8/17/2012 documented the resident required assistance with transferring from one position to another related to her physical limitation. The care plan documented the following intervention: "Resident can weight bear, mechanical lift and Monitor for safety awareness." The care plan further documented the resident was at risk for falls characterized by history of falls/ actual, falls, injury, multiple risk factors related to: Disease process: Blindness, incontinence, impaired balance, impaired mobility and pain." The interventions were "assist during transfer and mobility, Ensure environment is free of clutter, fall risk protocol and Mechanical lift." Further review of the care plan dated 6/7/2012 and 8/17/2012 revealed it was not updated to include a bed alarm and floor mattress as indicated in the resident's Fall Risk evaluation dated 6/7/2012. Nurse's note dated 9/22/2012 documented "Patient did yell and scream at 6:45 this morning and was found lying on the floor besides her bed. Resident was brought back to bed with NA (Nurse Assistant), (resident) stated she wanted to walk to get some water. On inspection, left hip slightly swollen, no bruises or bleeding assessed." Review of the incident and accident report dated 9/22/2012 documented "On 9/22/2012 patient was yelling and hollering at 6:50 AM in her room, was found lying on floor besides her bed. Bed was in lowest position. Cable to bed alarm was unplugged. No floor mattress was in place. Patient was brought back to bed and alarm was reapplied." The Incident report further revealed the resident had "Muscle weakness, impaired standing balance, decreased functional status,	F 323	A preventative intervention list was implemented by the DON on 10/22/12 to ensure that all Licensed Nurses are aware of current interventions in place for all residents to include residents that are identified as high risk for falls. This list will be updated and placed in a notebook at the main nurse's station daily and weekends by DON and/or Staff Nurses.	10/22/12

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F 323	Continued From page 9 decreased mobility, fatigue secondary to disease process and reaching for objects, acute episode with altered mental status, Decreased safety awareness, psychosis, and decline in mental status, mental illness and diabetes mellitus." Review of the hospital record dated 9/22/2012 documented the resident was admitted due to left femur fracture. The hospital record further documented the resident "apparently climbed out of bed today and had a fall. She presented to the emergency department with deformity of the left lower extremity. She was seen by emergency department physician and found to have a fracture of the femur. Patient has significant dementia and is unable to provide any history." The hospital record further documented "A-9 point review of systems was reviewed with the family member. It is negative with the exception of musculoskeletal. Which is significant for left femur pain." The hospital record also documented "The x- rays of the left femur reveal a fracture of the femoral shaft in the upper one-third. There is displacement and shortening." The hospital record further documented "we will take her this evening for intramedullary nail fixation. I have explained to the family member the risks and benefits of surgery. The risks include bleeding, infection, damage to nerves or blood vessels, failure of the fracture to heal, need for more surgery, heart attack, stroke, and death." Review of the hospital's consultation report dated 9/23/2012 documented the resident was "brought to the emergency department (ED) after she fell. On presentation she was found to have a deformity of her left lower extremity. She was found to have a fracture of the femur. She has since then undergone intramedullary nail fixation of her fracture."Further review of the medical	F 323	An in service was initiated on 10/22/12 by the Staff Facilitator regarding utilizing the preventative intervention check list during their shift to ensure preventative interventions are in place and functioning properly. All newly hired Licensed Nurses will be inserviced regarding utilizing the preventative intervention check list during their shift to ensure preventative interventions are in place and functioning properly during orientation	10/22/12

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F 323	Continued From page 10 record revealed the resident was admitted at the hospital after the surgery on 9/23/2012. Review of the hospital's Discharge Summary dated 10/1/2012 documented "the resident was admitted to hospital on 9/22/2012, after patient was found to have a left femur fracture. Patient was immediately evaluated by orthopedic services and admitted to their services and had open reduction and internal fixation and had an intramedullary nail placement of the left femur fracture after discussion with family." Further review of the Discharge Summary revealed the resident was discharged from the hospital to another long term care facility on 10/1/2012 Review of Resident #1's medical record revealed the resident had not been readmitted back to the facility. Review of Resident # 1's current care guide dated 2/29/2012 revealed the resident was non-ambulatory, needed a mechanical lift for transfers, and used a bed alarm. Review of the facility 's disciplinary warning dated 9/24/2012 for day Nurse # 1 who was working with Resident # 1 on 9/22/2012 revealed Nurse #1 was disciplined for "failure to notify (DON) Director of Nursing that a resident fell out of bed and sustained an injury. Failure to have resident sent to the hospital in a timely manner. Resident found on floor at 6:45 AM and sent to hospital at 10:00AM due to unable to reach MD (Medical Doctor) per employee. Failure to check alarm and Resident care Guide during rounds. This occurred 9/22/2012." Review of the facility 's disciplinary warning dated 9//25/2012 for night Nurse # 2 revealed Nurse # 2 was disciplined due to Failure to ensure intervention provided for safety in place and functioning properly. Resident fell out of bed and	F 323	The Staff Nurse will ensure all preventative interventions are in place and functioning to include mats, low beds and alarms during every shift utilizing the preventative intervention checklist. The DON and/or ADON will review the preventative intervention checklist for completion 5 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times a week for 4 weeks, weekly for 4 weeks, then monthly times 2.The DON or ADON will follow up immediately upon identification of any potential concern.	

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	345376	A. BUILDING _____ B. WING _____	C 10/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 11 sustained a left femoral fracture. The resident's alarm wasn't connected nor was a floor mat beside the bed. Resident care Guide intervention not implemented." During the interview on 10/2/2012 at 12:30 PM, NA#1 reported that she took care of Resident # 1 on the night of 9/22/2012. NA#1 stated that she checked the resident at 11:00 PM, 1:00 AM and 5:00 AM. NA #1 further added that she did not see the bed alarm on the Resident # 's bed during the times that she checked on her. NA#1 further reported that Resident # 1's Care guide indicated that the resident should have a bed alarm but she did not see one on the day she took care of the resident on 9/22/2012. During a phone interview on 10/2/2012 at 1:00 PM, NA#2 reported she was not assigned to Resident #1 on 9/22/2012 but she was asked by Nurse # 1 to assist in lifting the resident from the floor. NA # 2 added the bed alarm did not go off before or after Resident #1 fell on the floor. She added, the bed alarm cord was disconnected. During the interview on 10/2/2012 at 1:30 PM, NA #3 reported that Resident # 1 was a fall risk per her Care Guide. She added the resident was required to have a bed alarm which she (NA#3) was required to check every day at the beginning of her shift to make sure it was functioning properly. NA#3 was asked whether the resident had a mattress on the floor beside her bed. NA# 3 answered that she had not seen a mattress besides the resident ' s bed. During the phone interview on 10/2/2012 at 1:45 PM, day Nurse # 1 reported she had a loud voice coming from Resident # 1's room in the morning of 9/22/2012. The resident was yelling and was on the floor. Nurse #1 added Resident #1 had just fallen from her bed. Nurse # 1 further reported	F 323	Findings of the preventative Interventions checklist audits will be forwarded to The QI committee for review quarterly for the identification of trends, development of action plans as indicated, and to determine frequency of continued QI monitoring.	

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F 323	Continued From page 12 the bed alarm did not go off before or after the resident fell on the floor. Nurse # 1 also reported she found out the bed alarm cable was not connected all the way while attached beside the bed. Nurse # 1 further added her normal routine was to check the residents ' bed alarms at the facility to make sure they were functioning correctly at the beginning of her shift. She added she did not check Resident # 1's bed alarm at the beginning of the shift on the night of 9/22/2012. Nurse #1 added she did not check Resident #1's bed alarm to make sure it was functioning properly at the beginning of the shift because she was busy with other residents. During the interview on 10/2/2012 at 2:01PM, Nurse # 3 reported that Resident #1 was a fall risk and she had a bed alarm on her bed. Nurse # 3 added at the beginning of the shift her usual practice was to check the Resident # 1's bed alarm to make sure it was functioning properly. Nurse # 3 further reported she did not recall seeing a fall mattress beside Resident # 1's bed. During the interview on 10/2/2012 at 2:30 PM, MDS nurse #1 reported she was responsible for completing the annual assessments at the facility. She added she completed the annual fall risk assessment for Resident # 1 on 6/7/2012 and the resident scored as high risk on her annual fall risk assessment. MDS nurse #1 also added she could not explain why the annual care plan dated 6/7/2012 for Resident # 1 was not updated to include bed alarm, floor mat and a low bed. MDS nurse #1 further reported that she was not responsible for completing the quarterly updates on the care plans at the facility so she could not explain why the quarterly care plan for Resident # 1 dated 8/17/2012 did not include bed alarm, floor mattress and low bed.	F 323	Education Training Module: "Mobility and safe Movement of the Elderly, Improving Your Skills to Prevent Injuries and reduce Falls With Teepa Snow,MS, OTR/L,FAOTA. Dementia Care & Training Specialist Positive Approach, LLC. Falls Prevention DVD Was presented to all facility staff members to include all CNAs, Licensed Nurses, Activity Department, Medical Records, Dietary Staff,Social Services, Plant Operations, Therapy Department, Housekeeping staff, Hospice staff and Administrator this DVD was initiated on 10/16/12 and completed on 10/19/12.	10/16/12 ~ 10/19/12

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F 323	Continued From page 13 During the interview on 10/2/2012 at 3:30 PM, MDS nurse # 2 reported she was responsible for completing the residents ' quarterly assessments at the facility. MDS nurse # 2 was asked why the current care plan for Resident # 1 was not updated with the use of bed alarm, low bed and floor mattress. MDS nurse # 2 answered it was an oversight." During a phone interview on 10/2/2012 at 3:45 PM, night Nurse # 2 who was assigned to Resident # 1 on third shift the day the resident fell reported that she did not witness Resident # 1's fall on 9/22/2012. She added the resident had a quiet night. Nurse # 2 added she saw the bed alarm on the resident bed at the beginning of the shift but she did not check to make sure it was functioning properly at the beginning of the shift. Nurse # 2 added the resident had her own private bed which her family member brought from home. She (Nurse # 2) also reported the bed had side rails which did not prevent Resident # 1 from getting out of bed. Nurse # 2 reported the rails were not on the resident's way whenever she tried to get out of bed. She further added the rails were on one side of the bed and the other side of the bed was against the wall. Nurse # 2 further added the resident was normally very confused and she (Resident # 1) thought she could walk. She (Nurse # 4) added she regularly reminded the resident that she could not walk. During the interview with DON on 10/2/2012 at 4:00 PM, she reported her expectation of her staff was to check the residents ' bed alarms at the facility at the beginning of the shift to make sure they were functioning properly. DON further added she expected the third and first shift nurses to have checked Resident #1's bed alarm to make sure it was functioning properly at the	F 323		

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F 323	Continued From page 14 beginning of their shifts on the night of 9/22/2012. DON added that disciplinary warning notice was given to the third and first shift nurse for failing to check Resident # 1's bed alarm on 9/22/2012 at the beginning of their shifts to make sure it was functioning properly. DON also reported the resident fell and sustained a left femoral fracture due to the fall on 9/22/2012. The DON further reported that a plan of correction was put in place following Resident # 1 falls on 9/22/2012. She reported the staff at the facility were in serviced on 9/25/2012 in reference to checking bed alarms throughout the facility, audit for bed alarms was completed on 9/25/2012, and order for 15 bed alarms with box and chair alarms with box was made on 9/25/2012. During a phone interview on 10/10/2012 at 9:12AM, the family member reported that she was not made aware by the facility staff that her mother was to have a low bed. Family member stated she was never involved in developing the interventions to prevent falls and injuries. She also added she never saw the mattress on the floor during the times she visited the facility. Family member also reported the bed was positioned against the wall. Report provided by the administrator on 10/10/2012 revealed Resident # 1 utilized her own bed. The report further revealed "the bed remained in a fixed height position- approximately 20 inches from floor. Height was not adjustable. The bed had ¾ side rails. Bed positioned against the wall (left side rail flush with wall.).She has had her own bed since admission 5/26/11."	F 323		