STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	09/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL RD AYDEN, NC 28513

(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 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 medical record review, observations, and staff interviews, the facility failed to provide hand hygiene, passive range of motion exercises, and splinting services to prevent the development of two wounds on the left hand for one of one resident, (Resident # 57.) The facility also failed to correctly calculate and assess the protein needs and provide an appetite stimulant ordered for one of one sampled resident (Resident # 21) who developed a necrotic toe during his nursing home stay. Findings included: 1. Resident # 57 was admitted to the facility on 05/20/13 with multiple diagnoses including hypertension, diabetes mellitus, dementia, and hemiplegia/hemiparesis. A review of the Significant Change in Status Assessment dated 05/28/13 revealed the resident had additional diagnoses of contractures of the hands and in other multiple sights. A review of Resident # 57's nursing care plan initiated on 05/29/13 revealed the resident was at risk for worsening of present contractures related	F 309	Ayden Court 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. Ayden Court Nursing & 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 Ayden Court Nursing & 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Orlie C. Daughtry

TITLE: Administrator

(X6) DATE: 10/18/13

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 309	Continued From page 1 to bilateral hand contractures. The goal stated for this problem was that the bilateral hand contractures would not worsen by the next review date of 08/29/13. Interventions listed for this problem included application of bilateral hand protectors 6-8 hours daily, monitoring of skin integrity under the applied brace, and documentation if the resident did not participate in the splint/brace program. A review of the medical record revealed that the resident received an Occupational Therapy (OT) evaluation on 05/21/13 and OT treatment from 05/21/13 until 06/10/13. The OT Discharge Summary revealed the resident had been provided with therapeutic exercises and activities, orthotics, manual therapy for bilateral hand contractures and maintenance of skin integrity. The same discharge note stated the resident had demonstrated progress toward goals, and that restorative nursing had been educated on providing passive range of motion to both hands, skin hygiene, and hand orthotics. The discharge note from OT was signed by the Occupational Therapist on 06/10/13. In an interview with the Occupational Therapist (OT) at 11:44 AM on 09/25/13, she stated that the goals for the resident's OT treatment in May and June of 2013 were: 1) to fit the resident with a soft support called a palm protector, and 2) to train restorative nursing staff to clean the area around his left hand pressure wounds, to perform passive range of motion (PROM) with both hands, and to apply the palm protector daily. The OT stated she provided education regarding the named goals and that the staff demonstrated they had appropriate understanding to perform the care for Resident #	F 309	Resident #57 was assessed by treatment nurse on 09/10/13 with treatment plan implemented. Resident #57 skin integrity will be observed daily by treatment nurse with documentation on the Treatment Administration Record (TAR). A 100% audit was conducted by DON on 09/10/13 of all residents in facility with skin protectors/ contracture prevention/splinting/immobilizers with no skin integrity issues identified. An inservice was initiated with 100% of nursing staff on 09/10/13 by DON and her designee to include that all resident with hand protectors, splints, braces are to have them placed for 6-8 hours only then removed unless otherwise specified. Splints/ braces/hand protectors are to be removed, skin is to be cleaned, dried and assessed for any abnormalities, the reporting of potential and/or actual potential skin to the unit nurse, and referrals to Treatment Nurses for evaluation and implementation of treatments as appropriate and the documentation of application and check of skin integrity daily on the TAR and in POC. An audit to include Resident #57 and new admissions to the facility with skin protectors/contracture prevention/splinting/immobilizers will be conducted twice a week for 2 weeks, weekly for 2 weeks, and monthly for 3 months by DON/Treatment Nurse and Administrator to ensure skin integrity for affected residents is checked and recorded on the TAR utilizing a QI tool. The DON and/or Administrator will follow up on potential concerns immediately upon identification as necessary. The Audit results will be forwarded to the Executive QI Committee by the DON monthly x 3 then quarterly for review, follow up action as deemed appropriate, and to determine the need for and/or frequency of continued monitoring. Corrective action will be completed by 10/24/13.	10/24/13

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F 309	Continued From page 2 57. In an interview with the Restorative/Rehabilitation Nurse # 8 on 09/26/13 at 2:20 PM, Nurse # 8 stated there should be a problem, goal, and interventions on the resident ' s care plan as follow through for the recommendations made by the OT. Nurse # 8 revealed in the electronic medical record that the resident was to receive bilateral hand protectors on 05/29/13 for 6-8 hours daily. Nurse # 8 reviewed the restorative care plans for Resident # 57 and stated she was unable to find interventions or directives to provide passive range of motion services for the resident. She also stated documentation for the PROM exercises or splint services provided for Resident # 57 would be completed by the assigned restorative nursing assistant (NA) in the electronic care tracker system. A review of the Resident Care Guide documentation in the electronic Care Tracker System revealed that no passive range of motion (PROM) or active range of motion AROM) care was entered into the electronic medical record in the months of May through September, 2013. In an interview with a restorative NA # 7 on 09/25/13 at 3:00 PM, she stated she always performed range of motion with Resident # 57's arms, but not his hands. She also stated she could not remember when she last time she provided any PROM or ROM with the resident. She further stated that if she tried to do provide PROM with the resident's hands, he would resist the care. A review of the nursing care plan initiated on 08/13/13 revealed that Resident # 57 was at risk	F 309		

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F 309	Continued From page 3 for skin breakdown or development of further pressure ulcers related to bowel and/or bladder incontinence and immobility. The goal listed for this problem on the same nursing care plan was that the resident would have no further development of pressure ulcers through the next review of 09/25/13. Interventions listed on the care plan included: skin monitoring, ensuring that appropriate pressure relieving devices were in place during repositioning, lubricating the skin with moisturizing lotion, and providing supplements ordered by the physician. A review of the Quarterly Minimum Data Set (MDS) assessment dated 08/22/13 revealed that Resident # 57 was at high risk for the development of pressure ulcers. The same assessment revealed that the resident required extensive assistance for dressing, personal hygiene, eating, and toileting, and that the resident had bilateral limitations for range of motion. An interview was conducted with Nursing Assistant (NA) # 3 on 09/27/13 at 10:40 AM in the presence of The Occupational Therapist. In the interview, NA #3 stated she discovered the wound on the resident's hand on 09/10/13 and immediately notified her supervisor. She also stated that when she came to provide care to Resident # 57, the resident was wearing the palm protector incorrectly and that the soft side of the palm protector was facing the back of the hand. NA # 3 demonstrated how the palm protector was found on the resident by placing it on the Occupational Therapist's hand. NA # 3 also stated that the trimming of and cleaning of the resident's fingernails was to be completed by a nurse because the resident is diabetic.	F 309		

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F 309	Continued From page 4 A review of the Wound/Ulcer Flow Sheet dated 09/10/13 and signed by Nurse # 6 revealed that the resident had one stage 2 pressure ulcer and one stage 3 pressure ulcer located on his right hand and that both wounds had an odor and pain associated with it. A review of the facility Incident Note dated 9/10/13 revealed that upon removal of the resident's bilateral hand protectors, there was noted to be a bleeding wound to the webbing between the left thumb and forefinger of Resident # 57. The same incident note revealed the area was actively bleeding and that the resident was provided with pain medication. In addition the note stated that a stage 2 wound was located on the pad portion of the left middle finger which was severely contracted and tucked under the other fingers of his left hand. The same note dated 09/10/13 revealed the wounds of left hand were treated per protocol and that the physician and the responsible party (RP) were notified. A review of the MDS Significant Change in Assessment dated 09/16/13 revealed that Resident # 57 had developed one stage 2 pressure ulcer and one stage 3 pressure ulcer, both of which were not present on the previous quarterly MDS assessment dated 08/22/13. A review of the Care Area Assessment Worksheet dated 09/17/13 revealed that the limitation in range of motion was a factor that could cause complications or increase the risk of the pressure ulcers. A review of the Wound/Ulcer Flow Sheet dated 09/19/13 and signed by Nurse # 7 revealed a	F 309		

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F 309	Continued From page 5 clarification regarding the location and stages of both pressure ulcers. This flow sheet indicated that the correct location of the stage 2 pressure ulcer was on the left hand between the thumb and tip of the forefinger, and that the correct location of the stage 3 pressure ulcer was on the third finger of the left hand. Further review of the Wound/Ulcer Flow Sheet dated 09/19/13 indicated that both wounds were facility acquired and that the measurements of the stage 2 pressure wound located between the thumb and pointing finger of the left hand were 2.5 centimeters (cm) in length, 0.8 cm in width, and 0.1 cm in depth. The same Wound/Ulcer Flow Sheet indicated that the measurement of the stage 3 pressure ulcer located on the fourth finger of the left hand were 0.5 cm in length, 0.5 cm in width, and 0.1 cm in depth. A review of the resident's nursing care plan initiated on 09/10/13 indicated that the resident had ulceration or interference with structural integrity of layers of skin caused by prolonged pressure. The goal associated with this problem was that the current pressure ulcer would not worsen through the next review scheduled for 09/25/13. Interventions included: 1) Staff to report any red or open areas, 2) Apply protective barrier cream, 3) Cleanse perineal area with each incontinence episode, 4) Diet as ordered by physician, 5) Dietary consult, 6) Follow facility protocol/regime for treating breaks in skin integrity/pressure ulcers left hand and middle digit, 8) Monitor skin daily during care for any changes. Report any abnormal observations to nurse, 9) Record amount taken of supplemental nutrition consumed, 10) Vitamin C, Zinc, Multivitamin as ordered by physician, 11) Weekly	F 309		

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F 309	Continued From page 6 assessment of wound/ulcer. Notify physician of changes as indicated. A review of the Treatment Record dated 09/10/13 through 09/18/13 revealed Resident # 57 received the following pressure ulcer treatments: clean both pressure ulcers with normal saline, apply Aquacel AG to both sights, and wrap both sights with Kerlix every other day. The Treatment Record also revealed that on 09/19/13 through 09/25/13 Resident # 57 received Lidocaine 5% ointment to the left hand before/during any treatments. In addition, the Treatment Record revealed that the resident received Ultram 50 mg 30 minutes prior to treatment care to the left hand wounds and/or 30 minutes before care to the contractured hands. The Treatment Record indicated that monitoring of the skin integrity of the resident's bilaterally contractured hands began on 09/19/13. A review of the medical record revealed physician's orders dated 09/10/13 and 09/19/13 for the prescribed treatment found on the Treatment Record for the resident's pressure wounds on his left hand. An observation of the resident's left and right hands was made on 09/25/13 at 9:25 AM during hand care provided by the Treatment Nurse, Nurse # 7. She removed the dressing to the resident's contractured left hand and partially extended the fingers on that hand. The resident's fingernails on the left hand were observed to be long and uneven and had black matter underneath them. A small amount of blood was observed when the nurse applied Lidocaine under the left third finger. The palm of the left hand was reddened in the area where the fingertips had	F 309		

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F 309	Continued From page 7 pressed into the left palm, and the fingernail on the third finger was missing. There was an ulcerated area noted in the crease between the left pointing finder and the left thumb. No odor was detected. At 2:30 PM on 09/25/13, the Administrator and the Facility's Consultant Nurse stated that they had realized there might be a problem with splint applications for residents in the facility and that they had initiated a plan of correction on 09/10/13. A review of the Plan of Correction (POC) dated 09/10/13 revealed that Resident # 57 was the only resident affected by the skin splint application, and that the wound was identified and a treatment plan is currently in place. It also stated that the skin integrity check has been placed on the Treatment Administration Record for the treatment nurse to document that skin integrity is checked daily. In addition, the POC stated that a 100% audit of the facility was conducted and there were nine other residents found in the facility with skin protectors/contracture prevention/splinting/immobilizers in place. An audit was conducted of these individuals to check skin integrity, skin protectors/contracture prevention/splinting/immobilizers in place. The POC also indicated that an in-service training was conducted with 100% of nursing staff to educate them that all residents with hand protectors, splints, and braces are to have them placed for 6-8 hours only then removed unless otherwise specified. The in-service training also educated the nurses that the splints, braces, hand protectors are to be removed, skin is to be cleaned, dried, and assessed for any	F 309		

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F 309	Continued From page 8 abnormalities. The POC further stated that if anything abnormal is noted, it should be reported to a charge nurse and/or treatment nurse who will initiate a skin referral and follow up by the treatment nurse. The POC also indicated that an audit would be conducted twice a week for 2 weeks, weekly for 2 weeks, and monthly for 3 months by the DON and Administrator to (monitor) skin integrity for affected residents. The monitoring is to be checked and recorded on the Treatment Administration Record. The POC further stated that all audits will be taken to the Quarterly Quality Improvement meeting for review and adjustments to the audit schedule are to be made as needed. The last statement on the POC was, "Corrective action will be completed by September 19, 2013." Further review of the POC dated 09/10/13 revealed that education was not provided to the staff regarding trimming and cleaning the resident's fingernails. 2. a. Resident #21 was admitted to the facility on 08/09/13 and readmitted on 08/30/13. The resident's documented diagnoses included peripheral vascular disease (PVD), amputation of right second toe, and cerebrovascular accident with hemiplegia. A 08/09/13 hospital discharge summary did not document any problems with toes on Resident #21's right foot other than the removal of the second toe due to dry gangrene. The resident was admitted to the facility on 08/09/13 receiving vitamin C, Zinc, and a multi-vitamin to promote wound healing.	F 309	Resident's #57's nails were cleaned and proper nail care was provided on 09/30/13 by treatment nurse. A 100% audit of residents' nails was conducted by DON on 10/02/13 with nail care provided by aides and nurses to residents upon identification of any nail care issues. The DON or administrative nurses will observe nail care to include Resident #57 utilizing a QI tool for five days for 1 week , then weekly for four weeks, then monthly for three months. The DON or the administrative nurses will follow up on any potential concerns upon identification and will provide training with the involved staff member as indicated. The results of the nail care audits will be forwarded to the Executive QI committee by the DON monthly for three months then quarterly for review and follow up as deemed necessary for any potential trends and to determine the frequency and/or need for continued monitoring. Corrective action will be completed by 10/24/13.	10/24/13

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F 309	Continued From page 9 A 08/09/13 Wound/Ulcer Flowsheet documented the resident was admitted with a surgical incision secondary to amputation of the right second toe and a stage II pressure ulcer to the sacrum. A 08/13/13 Dietary Supplemental Assessment, completed by the facility's dietary manager (DM), documented Resident #21 was on a regular no-added salt diet, was eating 46% of meals, weighed 116 pounds, and required 53 grams of protein, but was actually only receiving 46 grams of protein through his diet. The resident's 08/16/13 Admission Minimum Data Set (MDS) documented the resident's cognition was intact, eating only occurred once or twice during the assessment look back period, and the resident experienced a weight loss of 5% or more in the last month or 10% or more in the last six months. 08/19/13 lab results documented Resident #21's total protein and albumin were low. The resident's total protein was 5.1 grams/deciliter (g/L), with normal being 6.2 - 8.3 g/dL and albumin level was 2.9 g/dL, with normal being 3.4 - 4.9 g/dL. A 08/19/13 care plan identified "At risk for skin breakdown or development of further pressure ulcers related to PVD" and "State of nourishment less than body requirement characterized by weight loss prior to admission, inadequate intake, decreased appetite" as problems. Interventions to these problems included, "Monitor status of wound healing and re-evaluate nutritional requirements as needed" and "Refer to dietitian for evaluation/recommendations."	F 309	Resident's #21 protein needs were reviewed by the RD with the implementation of recommendations to ensure adequate nutrition to promote wound healing on 09/30/13. A 100% audit was completed on 09/30/13 by treatment nurse to identify all other residents with wounds. All residents with wounds were reviewed by the RD to ensure proper nutritional interventions were in place to provide adequate nutrition to promote wound healing. The RD provided inservice training to the Dietary Manager on 09/30/13 on how to calculate proper nutrition needs to promote wound healing with return calculation demonstration by the Dietary Manager. The Dietary Manager will assess residents for nutritional requirements upon admission and/or upon wound development. Current residents with wounds to include Resident #21 will be re-assessed for nutritional requirements at least quarterly and/or as necessary. The RD will review all wounded residents monthly to ensure that nutritional requirements are being met with recommendation made as appropriate. The results of the monthly RD audits will be forwarded by the Dietary Manager to the Executive QI committee monthly for three months then quarterly for review and follow up as deemed necessary for any potential trends and to determine the frequency and/or need for continued monitoring. Corrective action will be completed by 10/24/13.	10/24/13

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F 309	Continued From page 10 A 08/20/13 Skin/Wound/Treatment Note documented, "...purple hard/soft blister to 3rd toe; purple discoloration underneath toe, mild swelling to top of right foot." A 08/22/13 Dietary Supplemental Assessment, completed by the facility's DM, documented Resident #21's current body weight was 117 pounds, he was eating 51 - 75% of his meals, required 53 grams of protein, and was receiving 72 grams of protein through his diet (average intake of meals recorded in the electronic record keeping system for 08/09/13 through 08/21/13 was 58%). A 08/23/13 vascular surgery clinic note documented, "...his wound today has not improved; in fact, his right third toe has become ischemic.... " A hospital discharge summary documented Resident #21 was hospitalized between 08/26/13 and 08/30/13 for a axillobifemoral bypass and aftercare. A 08/30/13 Wound/Ulcer Flowsheet documented there was bruising and necrotic tissue to the side and between the second and third toe and underneath the second toe of the right foot, and Resident #21 still had a stage II sacral pressure ulcer. A 09/05/13 Dietary Supplemental Assessment, completed by the facility's DM, documented Resident #21's current body weight was 126 pounds, he was eating 51 - 75% of his meals, required 57 grams of protein, and was receiving 55 grams of protein through his diet.	F 309		

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F 309	Continued From page 11 A 09/06/13 Wound/Ulcer Flowsheet documented Resident #21 right third toe was unstageable and presented as 100% hard black necrotic tissue. A 09/12/13 Dietary Supplemental Assessment, completed by the facility's DM, documented Resident #21's current body weight was 126 pounds, he was eating 51 - 75% of his meals, required 57 grams of protein, and was receiving 71 grams of protein through his diet. At 2:20 PM on 09/26/13 the DM reported the facility's registered dietitian (RD) assessed residents in the facility once a month. She stated the RD was in the building on 08/26/13 and 09/24/13. According to the DM, the RD prepared her own list of residents to be assessed, but commented she had some input if there were specific residents she wanted assessments completed on. The DM commented the RD completed assessments on residents who experienced significant weight loss, who were fed by tube, and who had wounds each time she visited the facility. The DM stated she was responsible for completing the Dietary Supplemental Assessments. She reported she was not aware that in the electronic calculation of resident nutritional needs (a part of the Dietary Supplemental Assessment) she was supposed to adjust the protein factor based on conditions listed in the electronic worksheet (including using a protein factor of 1 - 1.2 grams per kilogram of body weight for albumin levels 2.8 - 3.5, and a factor of 1 - 2 grams per kilogram of body weight for surgery, and a factor of 1.2 grams per kilogram for body weight for a stage II wound). She explained she was using the protein factor of 1, which automatically populated in the program, for all residents regardless of nutrition issues	F 309		

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F 309	Continued From page 12 such as wounds, low albumin levels, and post-surgery recovery. Review of Resident #21's paper and electronic medical records revealed as of 09/26/13 the resident had not been assessed by the facility's RD. Review of the Dietary Supplemental Assessments completed for Resident #21 revealed a more accurate protein factor was 1.5 (see interview with RD below). The resident received inadequate dietary protein, and there was no provision of protein supplementation. On 08/13/13 Resident #21's protein needs should have been 78 grams of protein with the DM reporting the resident was receiving 46 grams through his diet. On 08/22/13 Resident #21's protein needs should have been 78 grams of protein with the DM reporting the resident was receiving 72 grams through his diet. On 09/05/13 Resident #21's protein needs should have been 85 grams of protein with the DM reporting the resident was receiving 55 grams through his diet. On 09/12/13 Resident #21's protein needs should have been 85 grams of protein with the DM reporting the resident was receiving 71 grams through his diet. At 5:05 PM on 09/26/13, during a telephone interview with the facility's RD, she stated she used the facility's corporate nutrition-related factors in determining the protein factor to be used for each resident. She commented a resident with a surgical amputation, unstageable necrotic toe, and a stage II sacral ulcer would probably require a protein factor of 1.5. During each facility visit the RD reported she completed assessment on residents who were newly	F 309		

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F 309	Continued From page 13 admitted, readmitted, and those experiencing significant weight loss. She explained she only assessed residents who were fed by tube or who had wounds quarterly unless they experienced significant weight loss or their wounds deteriorated. The RD reported she would be back in the facility on 10/01/13. At 12:54 PM on 09/27/13, during a telephone interview with the facility's RD, she stated the facility staff knew they could contact her between her monthly visits if there were changes in resident condition which might require new nutritional intervention. She reported she would consider the worsening or formation of new wounds to be a reason to contact her between visits. She explained nutritional interventions could help speed up the healing process and boost the immune system to help prevent the formation of new ulcers. At 4:35 PM on 09/27/13 the facility's director of nursing (DON) stated the RD visited monthly. She reported she was unsure if all facility staff knew they could contact her between her monthly visits, but definitely, she expected the DM who attended weekly wound meetings, to contact her if nutrition interventions needed to be put in place to promote wound healing or to prevent the formation of new ulcers. b. Resident #21 was admitted to the facility on 08/09/13 and readmitted on 08/30/13. The resident's documented diagnoses included peripheral vascular disease (PVD), amputation of right second toe, and cerebrovascular accident with hemiplegia. A 08/09/13 hospital discharge summary	F 309		

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F 309	Continued From page 14 documented the resident's right second toe was amputated because of dry gangrene. The resident was admitted to the facility on 08/09/13 receiving vitamin C, Zinc, and a multi-vitamin to promote wound healing. The resident was also receiving 800 milligrams (mg) or 20 cubic centimeters (cc) of Megace (appetite stimulant) daily. Resident #21's weight record documented he weighed 117 pounds on 08/14/13. The resident's 08/16/13 Admission Minimum Data Set (MDS) documented the resident's cognition was intact, eating only occurred once or twice during the assessment look back period, and the resident experienced a weight loss of 5% or more in the last month or 10% or more in the last six months. A 08/19/13 care plan identified "State of nourishment less than body requirement characterized by weight loss prior to admission, inadequate intake, decreased appetite" as a problem. Interventions to these problems included diet as ordered, supplements as needed, and refer to dietitian for evaluation/recommendations. A 08/21/13 physician order discontinued Resident #21's Megace. The electronic record keeping system documented the resident's average meal intake between 08/09/13 and 08/21/13 was 58%. A hospital discharge summary documented Resident #21 was hospitalized between 08/26/13	F 309	Resident #21's MAR was reviewed by the hall nurse on 09/30/13 with order for Megace transcribed as indicated. A 100% audit of all facility MARs was conducted by first and second shift nurse supervisors on 09/30/13 during the end of month change over to new MARs. All MARs were reviewed to ensure accuracy in medication orders as compared to the physician orders on the chart with follow up taken as necessary. An inservice was initiated with 100% of nursing staff by DON and designee on 10/17/13 on the importance of ensuring medication orders are correctly transcribed and documented. A triple check process for MARs was also put into place to be performed monthly. The MARs to include Resident #21 will be checked first by the second shift nurse supervisor against the physician orders on the chart. The second check will be completed by the hall nurses and the third check will be completed by administrative nurses. The checks will be completed to ensure all medication orders are correct. Any new admission or readmission resident will also go through a triple check process of first the admitting nurse, second the hall nurse, and third an administrative nurse to ensure the orders are accurate. The results of the monthly MAR checks will be forwarded by the DON to the Executive QI committee monthly for three months then quarterly for review and follow up as deemed necessary for any potential trends and to determine the frequency and/or need for continued monitoring. Corrective action will be completed by 10/24/13.	10/24/13

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F 309	Continued From page 15 and 08/30/13 for a axillobifemoral bypass and aftercare. The resident was readmitted to the facility on 08/30/13 with physician orders to once again begin the resident on Megace 800 mg or 20 cc daily. Resident #21's August 2013 medication administration record (MAR) documented the resident received his Megace on 08/30/13. However, Megace was not carried forward to the September 2013 MAR so the resident did not receive his appetite stimulant from 09/01/13 through 09/26/13. The resident's Weight Record documented he weighed 126 pounds on 08/30/13. Resident #21's weight record documented he weighed 128 pounds on 09/24/13. The electronic record keeping system documented the resident's average meal intake between 08/22/13 and 09/25/13 was 55%. Review of Resident #21's paper and electronic medical records revealed as of 09/26/13 the resident had not been assessed by the facility's RD. At 5:22 PM on 09/26/13 the director of nursing (DON) stated she was not sure how the transcription error occurred that caused Resident #21's Megace not to be carried forward to his September 2013 MAR. She explained a 2-check process was in place to help prevent such errors. She explained when residents were admitted or readmitted at the end of the month a call was	F 309		

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F 309	Continued From page 16 placed to the pharmacy to request a printed MAR for the upcoming month. She reported two different nurses checked this new MAR for accuracy, making sure all orders from the month before were carried forward and to make sure all the orders were accurate by matching them against the hospital discharge summary.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, and staff interviews, the facility failed to provide personal hygiene services for one of one resident, Resident # 57. Findings included: Resident # 57 was admitted to the facility on 05/20/13 with multiple diagnoses including hypertension, diabetes mellitus, dementia, and hemiplegia/hemiparesis. A review of the Quarterly Minimum Data Set (MDS) assessment dated 08/22/13 revealed that Resident # 57 was at high risk for the development of pressure ulcers. This assessment revealed that the resident required extensive assistance for dressing, personal hygiene, bathing, and that the resident had bilateral limitations for range of motion.	F 312	Resident's #57's nails were cleaned and proper nail care was provided on 09/10/13 by the treatment nurse. A 100% audit of residents' nails was conducted by DON on 09/10/13 with nail care provided by aides and nurses to residents upon identification of any The DON or administrative nurses will observe nail care to include Resident #57 utilizing a QI tool for five days for 1 week , then weekly for four weeks, then monthly for three months. The DON or the administrative nurses will follow up on any potential concerns upon identification and will provide training with the involved staff member as indicated. The results of the nail care audits will be forwarded to the Executive QI committee by DON monthly for three months then quarterly for review and follow up as deemed necessary for any potential trends and to determine the frequency and/or need for continued monitoring. Corrective action will be completed by 10/24/13.	10/24/13

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F 312	Continued From page 17 A review of the Significant Change in Condition Assessment dated 09/16/13 revealed the resident required total dependence for dressing, personal hygiene, and bathing, and that he had developed 2 pressure ulcers. An observation of the resident's left and right hands was made on 09/25/13 at 9:25 AM during hand care provided by the Treatment Nurse, Nurse # 7. She removed the dressing to the resident's contractured left hand and partially extended the fingers on that hand. All the fingernails on the left hand except the third fingernail were observed to be long and uneven and had black matter underneath them. A small amount of blood was observed when the nurse applied Lidocaine under the left third finger. The palm of the left hand was reddened in the area where the fingertips had pressed into the left palm, and the fingernail on the third finger was missing. There was an ulcerated area noted in the crease between the left pointing finder and the left thumb. No odor was detected. In an interview with the Minimum Data Set Nurse, Nurse # 11, on 09/25/13 at 3:28 PM, she stated there is no documentation made by nursing assistants when they provide nail or hand care for a resident. She explained that nursing assistants check off tasks in the Point of Service (POS) electronic medical record when they have provided baths or other activities of daily living for the residents. In an interview with NA # 7 on 09/26/13 at 9:28 AM, she stated that diabetic residents have their fingernails trimmed by a nurse, but that the NA can clean nails for diabetics unless the nails are reddened or inflamed. She also stated that if	F 312		

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F 312	Continued From page 18 resident had pain in his hands and fingers, then all nail care would be provided by a nurse. In an interview with Nurse # 7 on 09/26/13 at 2:15 PM, she stated that she agreed the resident's nails were long, uneven, and had dark matter under them when we observed his hands on 09/25/13. She also stated that nail care for Resident # 57 should be administered by a nurse because the resident is diabetic, and that she was not sure when the resident's nails had been trimmed last. She also stated she could not provide documentation to show when the resident ' s nails were trimmed or cleaned. In an interview was conducted with NA (Nursing Assistant) # 3 on 09/27/13 at 10:40 AM she stated that the trimming of and cleaning of the resident's fingernails was to be completed by a nurse because the resident is diabetic. NA #3 also stated she does not wash the resident's hands if the resident has pain because she is afraid the resident might become combative. She added that she had not washed his hands today because he did not want her to touch him. In an interview with the Director of Nursing on 09/27/13 at 4:30 PM, she stated that nail care should be done on shower days which are Monday and Thursday, Tuesday and Fridays, or Wednesdays and Saturdays. She also stated that nail care should be given on days in between showers if they are dirty, and that if the resident refused nail care, it should be documented by the nursing staff.	F 312		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 19 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 observation, record review and staff interviews, the facility failed to implement effective fall interventions for prevention of falls for 3 of 6 residents (Resident #24, #64, and #109) who had a history of falls that resulted in a fracture. The facility also failed to monitor and/or evaluate the effectiveness of the fall interventions for 4 of the 6 residents (Resident #24, #64, #93, and #109) who were reviewed for falls. Findings included: 1. Resident #109 was admitted to the facility with a history of falls on 06/04/13 following a left hip fracture. She was sent out on 06/27/13 as a result of a fall and was re-admitted on 07/01/13 with a right hip fracture. She was discharged on 08/02/13. Cumulative diagnoses included fracture of the left and right hip, atrial fibrillation and dementia. The Admission Minimum Data Set (MDS) of 06/21/13 indicated she had long and short term memory problems as well as impaired decision making skills. She needed extensive assistance from one person for transfers and toilet use. Resident #109 was not able to stabilize without the assistance of staff when moving from seated to standing position. Her balance was not steady	F 323	Resident #109 is no longer at facility. All residents to include #24, #64, #21, and #93 that have been determined to be at risk for falls had been reassessed per the facility fall risk assessment to ensure current interventions continue to be effective by MDS nurses and QA nurse on 10/01/13. Any interventions deemed to no longer be effective were re-evaluated by QA and Therapy as indicated and updated per individual resident need. These interventions were updated in the care plan and placed on the care guide as direction for all staff by MDS nurses on 10/01/13-10/02/13. The Administrator, DON, Administrative nurses, Department Heads and QA nurse will make rounds to include residents #24, #64, #21, and #93 and document findings per a fall audit tool 5 times a week x30 days, and 3 times a week x 30 days, and then at least weekly to ensure staff are using intervention per care guide. Any areas found to be no longer effective will be reviewed and updated as needed upon identification by facility staff. All residents will be evaluated per the facility fall risk assessment on admissions, per quarterly reviews and as otherwise indicated by facility staff. Any resident identified as being at risk for falls will be screened by Therapy and recommended interventions will be put in place as appropriate. Care plans and resident care guides will be updated as new interventions are indicated by MDS nurses. Any resident that sustains a fall will be evaluated to include an assessment of resident, witness statements describing the event, what caused the fall, current interventions, notification of appropriate Administrative staff, MD, and Family member and interventions updated as indicated by hall nurses.	

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F 323	Continued From page 20 when moving on and off the toilet and she needed assistance to stabilize. It was noted that Resident #109 had two or more falls since admission. According to the Care Area Assessment (CAA) detail, Resident #109 triggered in 6 areas including falls. Falls were to be carried to the care plan as she was identified as being at risk. A falls risk evaluation of 06/04/13 indicated Resident #109 was at high risk for falls with a score of 13. According to the risk evaluation any score above 10 placed the resident at a high risk for falls. It was noted that her last fall was prior to admission and fall precautions were in place. A falls risk evaluation of 06/17/13 indicated Resident #109 was at risk for falls with a score of 13. It was noted that her last fall was 06/27/13 and fall precautions were in place. An incident note of 06/22/13 at 8:30 PM written by Nurse #5 indicated Resident #109 had an unobserved fall from her low bed to the floor. Her wheelchair was beside the bed and she was found sitting on the floor between the bed and the wheelchair by staff. She complained of right ankle pain when touched. The physician was notified and gave orders to apply ice packs. A telephone interview was conducted with Nurse #5 on 09/27/13 at 9:00 AM. She stated she remember the incident of 06/22/13. Nurse #5 stated an incident report was completed. Nurse #5 stated when a resident was on fall precautions they were at risk for falling and were to be monitored more closely which meant that whenever staff walked past her room they were to look in on her. Nurse #5 stated that when the	F 323	All nursing staff were provided with training on where changes in fall interventions are located, the importance of consistent utilization of fall prevention intervention and the reporting of changes in a resident condition that could increase a resident's risk of falls by DON or designee. The QA Nurse was serviced on tracking and trending falls in an effort to determine cause and interventions by nurse consultant on 10/03/13. Any falls will be reviewed by the Event/Incidents QI committee weekly x 2 months, bi-weekly x 2 months, and then monthly or as indicated to ensure intervention currently in place continue to be effective-Identified areas of concern will be update per individual residents as indicated per the QA team. The results of the rounds audits will be forwarded to the Executive QI committee by QA nurse quarterly for review and follow up as deemed necessary for any potential trends and to determine the frequency and/or need for continued monitoring. Corrective action will be completed by 10/24/13.	10/24/13

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F 323	Continued From page 21 incident report was completed and footwear was checked it meant that the resident was not wearing the appropriate footwear. According to the June 2013 medication administration record (MAR), Resident #109 was receiving Macrobid (antibiotic) 100 milligrams twice daily for treatment of a urinary tract infection for 10 days as of 06/24/13. Resident #109's care plan of 06/25/13 identified her as being at risk for falls due to a history of falls and multiple risk factors related to impaired mobility as evidenced by a recent left femoral neck fracture. According to documentation in the intervention column, a winged mattress had been placed on 06/25/13, wear non slip footwear was initiated on 06/25/13. It was also noted on 06/25/13 for staff to provide frequent observation of Resident #109. It was noted that prompted toileting had been resolved as of 07/02/13. On 07/05/13, one on one supervision was implemented. An incident note written by Nurse #4 of 06/24/13 at 3:33 PM indicated Resident #109 was observed sitting on her buttocks beside the bed due to sliding out of bed. There were no injuries and she denied pain. Resident #109 was transferred to a low bed and non-skid socks were applied. Nurse #4 was interviewed on 09/26/13 at 4:35 PM. She stated she was working the night of 06/24/13 when Resident #109 fell. She stated Resident #109 was confused and would try to get up unassisted. Nurse #4 stated when she fell she was not wearing the non-skid socks. She added that Resident #109's family had been educated	F 323		

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F 323	Continued From page 22 not to bring in socks due to someone had put regular socks on her feet instead of the non-skid socks. Nurse #4 commented Resident #109 had been placed on one on one supervision due to her unassisted transfers but was not sure when it was implemented. A health status note of 06/27/13 indicated that at 1:40 AM Resident #109 was sitting at the nurse's station in a recliner. It was noted that she had fallen out of the chair onto her right side and complained of right shoulder pain, right hip pain and pain to the back of her head. The physician was notified and gave orders to send her out for evaluation. She left the facility at 2:05 AM. An unsigned witness statement for the fall of 06/27/13, which appeared to be from the nurse working the night of 06/27/13, indicated Resident #109 was sitting in a recliner across from the nurse's station. NA #5 was sitting at the nurse's station. NA #4 was walking down the 400 hall towards the nurse's station when she yelled out, " --- (nurse's name) the patient is on the floor." The statement indicated the writer was in the office behind the nurse's station. The writer indicated a telephone call was made to the physician on call and orders given to send her out for evaluation. A telephone interview was conducted on 09/25/13 at 11:06 AM with the nurse aide (NA#4) who observed Resident #109 when she fell on 06/27/13. She stated she was not assigned to work with Resident #109 that night. She stated Resident #109 was confused at times and wasn't aware of her having a history of falling. NA #4 stated she was walking down the hall that night and saw her sitting in a wheelchair at the nurse's	F 323		

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F 323	Continued From page 23 desk. She stated the nurse was passing medications on the hall. NA #4 stated someone was working at the nurse's station but their head was down and she didn't remember who it was. NA #4 stated she observed Resident #109 attempt to rise from the chair and yelled out "no" but by the time she got to her she had already fallen. When questioned as to non-skid footwear being in place, NA #4 she wasn't sure if she was wearing non-skid socks or not. A telephone interview was conducted on 09/26/13 at 12:00 PM with the nurse aide (NA #5) who was assigned to work with Resident #109 on 06/27/13. She stated Resident #109 was total care and had to be monitored due to her attempts to get up unassisted. She stated she didn't remember if she had placed non-skid footwear on her that night or not but she did have a pair of yellow gripper socks. NA #5 stated when she came to work that night, Resident #109 was already in bed. NA #5 did report that Resident #109 was agitated at some point that night and she did get her out of bed and placed her in a chair at the nurse's station. NA #5 commented that she would have checked on her every 2 hours during incontinence rounds. A QI note from the QI nurse of 06/28/13 at 11:35 AM indicated Resident #109 had been admitted after a fall with a left hip fracture. It was noted that Resident #109 had intermittent confusion and decreased safety awareness. She had been placed on a low bed upon admission. It was noted she had multiple falls since admission from her low bed. According to this note, she had slid out of bed on 06/22/13 and 06/24/13. Action was to instruct staff to have Resident #109 out of the room for supervision if out of bed. She had not	F 323		

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F 323	Continued From page 24 been wearing non-skid footwear with either fall. It was noted that all socks had been removed except the non-skid socks and staff were instructed to ensure non-skid footwear was in place. Posey lateral bolsters which were collapsible were placed on the low bed to prevent her from sliding off the foot of the bed and would not prevent her from getting out of bed. Another QI note from the QI nurse of 06/28/13 at 2:04 PM indicated Resident #109 had a fall on 06/27/13 from her wheelchair while sitting at the nurse's station for supervision. She noted that the nurse turned "her head for a split second" and Resident #109 attempted to stand from the wheelchair and fell. Resident #109 was sent out for evaluation. The action taken included all socks had been replaced with non-skid socks, posey lateral bolsters (pads that slip over the side rails) were placed on her bed as visual boundary but would not prevent her from transferring as they were collapsible. It was noted that Resident #109 was to be out of her room for supervision due to recurrent attempted unassisted transfers. It was noted that fall precautions were in place as well as therapy. A hospital discharge summary of 07/01/13 indicated Resident #109 was being sent back to the facility after a right hip hemiarthroplasty following a fracture of the right femoral neck on 06/27/13. It was noted that she had a history of a left hip hemiarthroplasty. Activity was noted as weight bearing as tolerated with universal hip precautions. A fall risk evaluation of 07/01/13 indicated Resident #109 was at risk for falls with a score of 13. It was noted that she ambulated	F 323		

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independently with device and had fallen within the past 30 days. Fall precautions were in place which included bed in lowest position, a high winged mattress and appropriate footwear. The last fall was noted to be 06/27/13.

A health status note from Nurse #9 of 07/04/13 at 4:31 PM indicated Resident #109 was found on the floor and complained of left hip and left shoulder pain. There was no other information included in this note.

A physician's telephone order of 07/04/13 indicated to send Resident #109 to the emergency room for evaluation of possible left shoulder fracture and left hip.

According to information provided by the facility, one on one supervision was implemented after her return from the emergency room on 07/04/13 at 10:19 PM.

Nurse #9 was interviewed on 09/25/13 at 2:40 PM in reference to her note regarding Resident #109's fall of 07/04/13. She stated Resident #109 had a history of falling. She commented she didn't remember what happened and needed to read Resident 109's electronic chart. After reviewing her chart, she stated Resident #109 was confused and attempted to get up unassisted on a constant basis. She stated she was usually at the nurse's station for close monitoring. Nurse #9 stated Resident #109 had been found on the floor beside her bed. She did not remember if she was wearing non-skid footwear. She did not remember who found her. Nurse #9 stated that the details of the incident would be included in the incident report that she completed on 07/04/13. Nurse #9 commented Resident #109 had been

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F 323	Continued From page 26 placed on one on one supervision but was not sure when it started. The QI note written by the QI nurse of 07/17/13 at 1:39 PM indicated Resident #109 was high risk for falls. It was noted that she fell on 07/04/13 due to an unassisted transfer. There were no other details describing the incident noted. It was also noted that staff were unable to redirect her due to her cognitive status. She was sent out for evaluation due to complaints of left shoulder pain. It was noted that upon return from the hospital there were no injuries. It was noted that Resident #109 was currently working with therapy and was on a low bed with a high winged mattress. One on one supervision was implemented upon her return due to the inability to stop unassisted transfers. The QI nurse was interviewed on 09/27/13 at 11:10 AM. She stated if a resident was admitted with a history of falls they were placed on a bed that was to be in the lowest position. She commented that all of the beds in the facility were such beds. The QI nurse reported using low beds which were in a fixed position and could not be raised. The QI nurse commented when she conducted her investigation of a fall, she reviewed the medical record for possible medications that might contribute to falling as well as any medical acute condition such as urinary tract infections that might place them at risk. The QI nurse stated if the resident was on therapy caseload she would discuss the fall with the therapy staff. The QI nurse stated if it was felt that there were equipment issues that might be altered, she worked with therapy to discuss options such as wedges, pommel cushions, scoot chairs, broda chairs or rock-n-go chairs	F 323		

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F 323	Continued From page 27 depending upon the resident's status. As the interview continued, the QI nurse reported the process for fall investigation included an incident report which was completed by the staff person who responded to the resident fall. The QI nurse stated the nurse should have a thorough description on the incident report of what happened. She added that in order to do a complete investigation, she needed to know what the resident's vital signs were when found, what position the bed was in, if they were wearing non-skid footwear, any lighting issues, any spills on the floor and if possible what activity the resident was engaged in just prior to the fall. The QI nurse reported that the incident reports were given to her for review and investigation. She stated during her investigation she attempted to interview staff. If she did interview staff, she included their information in her QI note in the electronic record. The QI nurse stated once she had completed the investigation, she would make recommendations as to the appropriate intervention and the report was passed on to the Director of Nurses (DON) and the Administrator for final approval. The QI nurse reported that the facility was alarm free and only used physical restraints as a last resort. The QI nurse stated she reviewed effectiveness of the interventions on a quarterly basis but at one time she reviewed them weekly. She commented she was no longer able to review weekly due to having other duties in the facility. During the same interview of 09/27/13 at 11:10 AM, the QI nurse reported Resident #109 had been admitted after a fall at home. She stated Resident #109 had falls shortly after admission and was supposed to be wearing non-skid footwear and was not wearing at the time of the	F 323		

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fall on 06/22/13 or the fall of 06/24/13. She reported Resident #109 was to be out of her room for supervision to prevent further falls. The QI nurse stated she educated the day shift staff as to the non-skid footwear and out of room supervision and she expected them to pass it on verbally from shift to shift. She had not provided any in-service or meeting to pass the information on. When questioned as to her idea of what out of room supervision meant, she commented that in her opinion and if she was the hall nurse, she would have her eyes on the resident even during medication pass. She stated the resident would be with her at the medication cart or a nurse aide would be asked to watch her. The QI nurse commented that currently when staff were monitoring more closely, staff were expected to "peep" in on the resident if they were in their room and to keep an eye on them if they were in the halls. She added that for out of room supervision, she recommends placing the resident in an area where they can be visually observed while out of the room. The QI nurse stated that after the fall of 06/24/13, bolster pads were added to her bed and out of room supervision was still an appropriate intervention. When questioned about the fall of 06/27/13, she responded that was the first fall from a chair and the out of room supervision intervention was an appropriate intervention. She stated a winged mattress was placed on her bed after that fall to prevent her from falling from her bed. The QI nurse stated Resident #109 had been placed on 1:1 (one on one) supervision after her last fall. The QI nurse agreed that Resident #109 had continued to have falls and the out of room supervision intervention was not effective in preventing her from falling. The QI nurse stated she had concerns regarding the frequency of the falls in the facility as well as

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F 323	Continued From page 29 the number of fractures sustained as a result of the falls and she had mentioned it during the morning meetings. Physical Therapist (PT #1) was interviewed on 09/25/13 at 12:10 PM. She stated she remembered working with Resident #109. She stated she was modified independence when she lived at home and fell. She stated she was sent to the facility for rehabilitation after a hip fracture. PT #1 stated cognition was her major issue as she had no carry over with instructions provided. When questioned about falls, she responded that she was working with her during the times of her falls but she did not make recommendations for interventions after falls. She added that therapy was involved in the process but it was the nursing department's responsibility to make that decision since it was based on the resident's situation. PT #1 reported Resident #109 would try to get up unassisted because that was the way she was before she fell and came here. PT #1 added that she had been sent out at some point with a fracture of the other hip and had a sitter as a reminder not to get up unassisted. She stated she knew her mattress was changed to a high winged mattress but she didn't know when. NA #10 was interviewed on 09/26/13 at 4:45 PM. She stated she had worked with Resident #109 and she was always trying to get up unassisted. She stated she was the aide who found her after one of her falls as she was trying to get out of bed and she found her on the floor on her right side. NA #10 stated she stated she was in a low bed and was identified as being high risk for falls. She commented that after several falls she was placed on 1:1 supervision. NA #10 stated Resident #109 did have gripper socks and wore	F 323		

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them sometimes but not all the time. She stated she placed them on her if she was agitated. NA #10 remarked that close supervision meant to peak in on her every time she walked down the hall.

The Director of Nurses (DON) was interviewed on 09/27/13 at 4:29 PM. She stated she was advised about all falls and if the fall occurred during off hours she would instruct staff on which immediate intervention they were to implement. The DON stated she gets the incident report online once the QI nurse has completed her investigation. She stated she expected staff to be thorough with their description of the incident. The DON stated the staff person should include where the resident was found, what the body position was, if pain was present, and whether or not range of motion was affected. She also commented any note about what it appeared that the resident was doing prior to the fall if it could be determined would be helpful. She stated she would expect staff to document any intervention such as non-skid footwear that was in place or not in place at the time of the fall. The DON stated the nurse should do a complete head to toe assessment. When questioned as to the meaning of out of room supervision, the DON responded that residents were to be placed in a place within the building where there was a lot of activity so they could be watched more closely. She commented those residents were usually sitting at the nurse's station. She added that keeping your eye on someone was not the same as one on one supervision. The DON commented that Resident #109 had been taken to the nurse's station for supervision and fell anyway. She stated she expected staff to ensure that interventions were in place and monitored for

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F 323	Continued From page 31 effectiveness. She remarked that she was aware that the frequency of falls had increased over the last quarter as several residents were falling during the same time frames. She also stated she was aware that Resident #109 had fallen several times and did sustain a fracture. The DON stated she relied upon the QI nurse to make sure the appropriate interventions were in place and only implemented physical restraints as a last resort. She also stated she expected the QI nurse to track and trend falls and report findings to her to discuss. The DON stated falls were discussed in the morning meetings. The DON stated that the out of room supervision had not been an effective tool to prevent Resident #109 from falling since apparently staff follow through did not occur. 2. Resident #64 was admitted to the facility following a fall on 06/20/13. Cumulative diagnoses included bi-polar disease, anxiety, neurogenic bladder with suprapubic catheter, history of L5-6 fracture and rheumatoid arthritis. The Resident Care Guide for Resident #64, dated 06/20/13, indicated she was non-ambulatory. Interventions included non-skid footwear, winged mattress (added 6/25/13), prompted toileting for bowel every 4 hours initiated on 08/29/13. The Admission 5 day Minimum Data Set (MDS) assessment of 06/27/13 indicated she had cognitive loss and was moderately impaired with decision making. There were no behaviors noted. She required extensive assistance with bed mobility, transfer, toilet use and hygiene. It was noted that she had an indwelling urinary catheter and had a fall prior to admission. The Care Area Assessment (CAA) detail indicated she	F 323		

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F 323	Continued From page 32 triggered in 8 areas including falls as she was identified as being at risk. Falls was to be carried to her care plan. Resident #64's care plan, last revised on 09/10/13, identified her as being at risk for falls characterized by history of falls with multiple risk factors related to unsteady gait and poor safety awareness. There was no mention of out of room supervision in the intervention section. According to the interventions mentioned in this care plan, the list contained: . 06/21/13 referral to therapy . 06/21/13 fall risk protocol . 06/21/13 have commonly used articles within easy reach . 06/21/13 keep call light within reach and answer timely . 06/21/13 provide frequent reminders to call for assistance before getting up . 06/25/13 lateral bolsters to bed (this was resolved on 07/02/13) . 06/26/13 prompted toileting every hour (this was resolved on 07/02/13) . 07/11/13 enabler/self release belt while up in wheelchair, can release . 07/25/13 winged mattress A health status note of 06/21/13 at 10:09 PM indicated Resident #64 had attempted to get out of the wheelchair several times on this shift. She was found standing at the nurse's station with a piece of paper in her mouth stating she was smoking a cigarette. It was noted that Resident #64 stated several times she wanted to go home. She was redirected and encouraged to ask for assistance before getting out of the wheelchair. A health status note written by the Director of	F 323		

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F 323	Continued From page 33 Nurses (DON) of 06/24/13 at 4:35 PM indicated Resident #64 was not on 1:1 (one on one) observation. It was noted that she was under close supervision at the nurse's station and by other staff. It was noted Resident #64 still continued to make multiple attempts to stand independently and had fallen. The DON indicated to continue to monitor under supervision due to the lack of safety recognition. A Quality Improvement (QI) note written by the QI nurse on 06/26/13 indicated Resident #64 had an unassisted fall on 06/19/13 (prior to her admission) and was admitted on 06/20/13. It was noted that staff were instructed to ensure non-skid footwear in place and Resident #64 was to be out of the room while awake for supervision. A health status note of 06/26/13 by Nurse #11 at 7:27 AM indicated that the writer was passing medications at 5:10 AM when she found Resident #64 on the floor in her room on her side. It was noted that she was barefoot. A telephone interview was conducted with Nurse #11 on 09/27/13 at 9:10 AM. She stated she remembered working with Resident #64 but did not remember the circumstances regarding the fall of 06/26/13. Nurse #11 reported Resident #64 was usually in bed on her shift as she worked third shift. She stated Resident #64 had a self release seat belt on her wheelchair that she could release at will. Nurse #11 stated she also had a winged mattress on her bed. She stated she was aware that if Resident #64 was out of bed she needed supervision. Nurse #11 remarked she was at high risk for falling, was anxious and yelled out for help at times. She couldn't remember if the bolsters were in place or not at the time of the	F 323		

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F 323	Continued From page 34 fall on 06/26/13. A Quality Improvement (QI) note written by the QI nurse on 06/28/13 indicated Resident #64 had a fall from her low bed on 06/26/13. It was noted that lateral bolsters were supposed to be in place prior to the fall. According to the note, the lateral bolsters were not in place at the time of this fall as the room had been cleaned on 06/25/13 and the bolsters were not placed back on the bed. Staff was educated to report any intervention that was not in place to the nurse so the intervention could be placed. Staff was also educated to have resident out of room when awake for supervision. A bowel prompting toileting program was started. During an interview with the QI nurse on 09/26/13 at 11:40 AM, she stated during her investigation it was discovered that the lateral bolsters had been removed and were not replaced prior to the fall of 06/26/13. A QI falls review note from the QI nurse of 07/02/13 at 8:37 AM indicated Resident #64 was at high risk for falls. It was noted that she had a second fall on 06/29/13 at 11:05 AM. She had rolled out of bed with lateral bolsters in place and functioning. The bolsters were removed and the high winged mattress placed. It was noted that fall precautions remain. A health status note written by Nurse #6 on 07/03/13 at 10:30 AM indicated Resident #64 was found on the floor on her left side and was attempting to ambulate unassisted. She lost her balance and fell to the floor. She complained of right arm pain and stated she had hit her head. She was sent out for evaluation.	F 323		

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F 323	Continued From page 35 The investigation follow-up written by Nurse #6 for the fall of 07/03/13 indicated Resident #64 was attempting to ambulate to the bathroom unassisted when she lost her balance and fell. She was in her room in her wheelchair and was wearing tennis shoes. It was noted that she had been sitting in the wheelchair prior to the fall. In the intervention taken to prevent reoccurrence section it was noted to continue therapy, to be out of her room for supervision when awake and continue the low bed with the high winged mattress. Neurological checks were started. The QI falls review note of 07/03/13 at 3:50 PM indicated Resident #64 had a fall on 07/03/13 while attempting to ambulate in her room unassisted. It was noted her cognition was impaired as well as her balance. It was noted that redirection was unsuccessful and she continued to make unsafe decisions. The action taken was that Resident #64 required supervision when awake. The QI nurse indicated she was on a low/low bed with a high winged mattress due to multiple falls from the bed. She was currently working with therapy and being treated for a urinary tract infection (UTI). Fall precautions were to remain. A health status note written by Nurse #4 on 07/07/13 at 11:52 AM indicated Resident #64 was observed at 11:15 AM sitting on her buttocks on the floor beside her bed in her room. It was noted that Resident #64 was trying to get into bed from the wheelchair and lost her balance. No injuries were noted. Nurse #4 noted that close supervision was in place. A health status note written by Nurse #4 on 07/08/13 indicated Resident #64 was found at	F 323		

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8:00 AM on her left side in the floor in her room. She noted that Resident #64 stated she was trying to walk to the bathroom and fell. She was transferred to the wheelchair with close supervision. No injuries were noted.

A telephone interview was conducted with Nurse #4 on 09/26/13 at 4:35 PM. She stated Resident #64 was confused and constantly attempted to get up unassisted. She stated she was not to be left in her room without supervision due to having several falls.

A handwritten fall review form for the fall of 07/08/13 indicated Resident #64 was wearing shoes and at the time of the fall was in her wheelchair. It was noted that she reported she was trying to get to the bathroom.

A health status note written by Nurse #6 on 07/10/13 at 3:48 PM indicated she responded to a code green and found Resident #64 lying on the floor on her right side underneath the bed of her roommate with the bedside table across her head. It was noted that Resident #64 stated she had hit her head and complained of head pain so was sent out for evaluation.

A health status note of 07/10/13 at 8:06 PM indicated Resident #64 was shown how the safety belt worked on her wheelchair and was shown how to release it. It was noted she was able to release it 3 times and was told it was for safety only and could still get up if she released the belt.

Nurse #6 was interviewed on 09/25/13 at 10:15 AM. She stated she had concerns about the number of falls that Resident #64 had since her admission in June 2013. She stated Resident

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F 323	Continued From page 37 #64 had bipolar disease and her psychiatry physician had been working with her on adjustment of her medications in an effort to decrease her symptoms. Nurse #6 stated she had spoken with management about the use of some type of physical restraint due to the number of falls and the frequency of them but management didn't want to use restraints of any kind. She added that sometimes that was the only intervention to prevent falls. Nurse #6 stated she had placed the self release seat belt on Resident #64 out of concern for her well-being and her frequency of falls. She stated since the self release seat belt had been applied to Resident #64's wheelchair, the falls had decreased but she was still falling and had sustained rib fractures. She stated Resident #64 could release the belt whenever she wanted to get up and she had concerns about her falling. Nurse #6 reported one of the falls that she responded to was on 07/10/13. She stated when she entered the room, the bedside table had been turned over and was positioned on top of Resident #64 who was under the roommate's bed. When questioned about fall interventions in place when Resident #64 was in bed, she stated the bed was to be in the lowest position, a winged mattress, nonskid footwear and call bell in reach. Nurse #6 commented that the facility did not use alarms of any kind. She stated there was nothing written for Resident #64 to be at the nurse's station for observation but she chose to have her there so she could watch her. Nurse #6 could not remember if any other types of chairs had been used for Resident #64. She reported there was a care guide inside each resident's closet which indicated care needs for the residents and the nurse aides were to follow those guides when providing care.	F 323		

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F 323	Continued From page 38 An incident note of 07/15/13 at 7:05 PM indicated Resident #64 was found on the floor in her room following dinner. There were no other details included in the note. The investigation follow-up for the fall of 07/15/13 indicated that Resident #64 was on her side on the floor. It was noted in the contributing factors section that she "attempts task she is unable to perform if left unsupervised." The intervention taken to prevent reoccurrence was to be out of the room for supervision and to only be in her room for care and to sleep. It was noted that fall precautions of low bed with a high winged mattress, the enabler and therapy were in place. The witness statement from the nurse who found her indicated Resident #64 had slid on the floor and was wearing sneakers. The QI falls review note of 07/17/13 written by the QI nurse indicated the Resident #64's falls were reviewed. It was noted that she was at high risk for falls and had fallen on 07/07/13 and 07/08/13 due to unassisted transfers and unassisted ambulation. She had decreased safety awareness and was unable to be redirected due to her cognitive status. It was noted that her balance was impaired, she had an unsteady gait and was currently being treated for a UTI. It was also noted that therapy was currently working with her. Once again, the action taken included staff was instructed to have her out of her room for supervision while awake. A QI falls review note of 07/17/13 at 3:16 PM indicated the QI nurse had reviewed falls risk for Resident #64. She was at high risk for falls and had a fall on 07/10/13 ambulating in her room	F 323		

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F 323	Continued From page 39 without assistance. It was noted she was sent out for evaluation and no injuries were reported. It was noted in the action section as follows: She was currently working with therapy. Fall precautions were in place with a winged mattress on a low/low bed. She had completed treatment for a urinary tract infection on 07/10/13. She had an enabler (Velcro belt) placed on the wheelchair with instruction for Resident #64 to be out of her room in an area of direct supervision while awake. It was also noted that she was capable of releasing the seat belt at will. A QI falls review note of 07/19/13 at 8:41 AM indicated Resident #64's falls had been reviewed. It was noted that she had a fall in her room on 07/15/13 and had impaired balance and decreased safety awareness. Action taken was to continue the fall precautions of a low bed with a high winged mattress. She had an enabler due to her history of falls and was able to release it. It was noted she was usually positioned in the hallway during waking hours for supervision. The QI nurse had requested a prophylactic antibiotic from the physician in an effort to reduce risk of UTIs and she was started on a prompted toileting bowel program to decrease contamination. It was noted that Resident #64 had a suprapubic catheter and was occasionally incontinent of bowel. A QI restraint/enabler review of 08/02/13 indicated Resident #64 was currently in a wheelchair with a Velcro belt due to repeated falls with injury due to poor safety awareness. Falls from her bed have been addressed and have stopped since placement of the high winged mattress. A note in the action taken section indicated Resident #64 was capable of releasing	F 323		

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F 323	Continued From page 40 the seat belt and several equipment changes had been attempted without success. A health status note of 08/22/13 at 4:30 PM from Nurse #3 indicated Resident #64 had an unobserved fall at 4:30 PM. The physician and family were notified. It was noted that she reported trying to clean the wall when she fell to the floor. It was noted that she had unfastened her seat belt. Resident #64 complained of left hip pain and was sent out for evaluation. The hospital discharge summary of 08/23/13 indicated Resident #64 was seen for a fall from her wheelchair and sustained a fracture of her L5-6 spine (the lumbar area of the spine) as well as subacute fractures of other ribs and scapula. A health status note of 08/23/13 indicated Resident #64 had returned from the hospital at 5:25 PM. A telephone interview was conducted with Nurse #3 on 09/26/13 at 11:35 AM. She stated Resident #64 was alert with confusion. She stated she had to keep reminding her not to get up unassisted on 08/22/13. She stated staff was to monitor her more closely as she had a history of falling. When questioned about the fall of 08/22/13, Nurse #3 stated she was working on 08/22/13 and remembered Resident #64 to be continually unfastening her seat belt saying she wanted to go home. Nurse #3 stated she kept reminding her not to unfasten the belt or she might fall. She stated she started her medication pass with Resident #64 sitting at the nurse's station. She had gotten to room 100 (which was about 70 feet from the nurse's station) when she heard someone yelling, "help! help!" Nurse #3	F 323		

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F 323	Continued From page 41 commented that she turned around and headed back up to the nurse's station and found Resident #64 on the floor. She commented she did not observe the fall because she was already on the floor when she got to the nurse's station. When questioned as to any specific instructions for Resident #64 to be out of her room for supervision, she responded she had not been given any specific instructions about out of room supervision as Resident #64 was already sitting at the nurse's station when she came on duty that day. Nurse #3 stated being aware that Resident #64 had several falls and she didn't think the self release seat belt was working for her and felt a new intervention needed to be placed. Nurse #3 added that Resident #64 came back from the hospital with fractured ribs from that fall. A QI fall review note written by the QI nurse of 08/28/13 at 3:09 PM indicated Resident #64 was at high risk for falls and had fallen on the 3:00 PM - 11:00 PM shift. It was noted that she was sent out for evaluation. It was noted that fall precautions were in place which consisted of a low bed with a high winged mattress and an enabler (the self release seat belt) due to her history of falls. The QI note indicated she was capable of releasing the belt and was usually positioned in the hallway during waking hours. It was noted that she had a history of recurrent UTIs and had been placed on Macrobid (an antibiotic) twice daily on 08/20/13. A Significant Change MDS of 08/30/13 indicated she had declined significantly in cognition but still required extensive assistance with bed mobility, transfer, toilet use and hygiene. She had 2 or more falls noted. The CAA detail indicated she triggered in 8 areas including falls which was	F 323		

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F 323	Continued From page 42 carried to care plan due to being identified as being at risk. According to the BOWEL/BLADDER MONITORING form for prompted bowel toileting for Resident #64, it was initiated on 08/29/13. Resident #64 had a bowel movement at 10:00 AM on 08/29/13. All the blocks for 08/30/13, 08/31/13 and 09/02/13 were blank. It was noted that she was incontinent at 3:00 PM on 09/01/13. She had bowel movements on 09/03/13 at 10:00 AM and on 09/04/13 at 9:00 AM and 2:00 PM. It was noted that Resident #64 was not voiding due to a suprapubic catheter. Instructions included to prompt and provide toileting for bowel every 4 hours. A health status note written by Nurse #1 on 09/02/13 at 8:10 PM indicated the writer heard a noise at 7:30 PM in the bathroom between Room 106 and Room 104. When she opened the door, Resident #64 was on the floor by the commode with Nurse Aide #9 (NA #9) in the room with her. NA #9 reported that she was assisting Resident #64 to the commode and stepped to the side to get disposable wipes and before she could react, Resident #64 was on the floor. It was noted that Resident #64 had hit her head so was sent out for evaluation. According to emergency room notes for the 09/02/13 visit following the fall of 09/02/13, all tests and laboratory results were normal. A health status note of 09/03/13 at 1:32 AM indicated Resident #64 had returned from the emergency room at 12:45 AM with no new orders. Neurological checks were initiated.	F 323		

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F 323	Continued From page 43 NA #9 was interviewed on 09/26/13 at 3:49 PM. She stated Resident #64 was confused and she had to keep her eye on her as she would attempt to stand unassisted. She also reported Resident #64 was not to be left in her room alone. NA #9 stated there was a winged mattress on her bed to keep her from rolling off and she had a belt on her wheelchair that she was capable of releasing. NA #9 stated at one time she had bolsters on her bed but she had told the nurse the bolsters didn't work. She stated at one time Resident #64 had been on a prompted toilet plan for her bowels. When questioned about the fall of 09/02/13, NA #9 responded that she had taken Resident #64 in her wheelchair into the bathroom for her to have a bowel movement. She stated she didn't sit straight on the toilet and usually sat sideways but would hold onto the rail. NA #9 added that day Resident #64 wasn't feeling well. NA #9 stated she realized she didn't have any disposable wipes in the bathroom so she left her sitting on the commode to go to her table which was by her bed to get the wipes. She stated Resident #64 would usually hold onto the rail by the commode. She stated she heard a yell and she went back into the bathroom. NA #9 stated Resident #64 fell backwards off the commode onto the floor. NA #9 stated the fall could have been prevented if she had taken the wipes into the bathroom with her rather than leaving Resident #64 unattended on the commode. Nurse #1 was interviewed on 09/25/13 at 4:00 PM. She stated Resident #64 was very confused and had over 12 falls over the last month. She stated she would roll off the bed onto the floor so her bed was to be kept in the lowest position. She stated when she worked she usually kept her sitting at the nurse's station so she could keep an	F 323		

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eye on her. Nurse #1 stated NA #9 had reported to her that she left Resident #64 on the commode and walked to the shelf in the bathroom to obtain the wipes. Nurse #1 stated NA #9 had instructed Resident #64 to hold onto the safety rail by the commode but she must have let go. Nurse #1 stated while Resident #64 was out to the hospital she switched her mattress to a winged mattress. She remarked that a new chair was being tried today for Resident #64 to see if would prevent her from getting up unassisted as she had fallen recently and had fractured ribs as a result of the fall.

Resident #64's care plan was updated as of 09/03/13 to include pain related to recent fractures.

A psychiatric evaluation of 09/04/13 indicated Resident #64 appeared to be more confused and anxious. It was noted that she continued to have falls due to unassisted ambulation attempts. It was noted that the number of falls had greatly improved with the use of the self release belt. Librium had recently been adjusted.

A QI note of 09/06/13 at 7:36 AM indicated Resident #64 was at high risk for falls. It was noted that she had fallen on 09/02/13 while in the bathroom with NA #9. It was noted that NA #9 had turned to retrieve wipes and Resident #64 fell off the commode. She was sent out for evaluation and returned with a report of no injuries. She was placed on a prompted toileting program due to bowel incontinence and a potential for contamination of the vaginal area. It was noted she was on a low bed with a winged mattress and was currently working with therapy. Resident #64 had been referred to Urology for

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F 323	Continued From page 45 recurrent UTIs. The QI nurse also indicated she felt the most recent falls were as a result of UTI for which treatment was completed on 08/30/13. A falls risk evaluation of 09/19/13 indicated Resident #64 was at high risk for falls with a score of 15 (greater than 10 indicated high risk). It was noted that she ambulated independently with device, had fallen in the past 30 days and her last fall was 09/02/13. Fall precautions in place included low bed with a high winged mattress. Resident #64 was observed in bed which appeared to be in low position with a winged mattress in place on 09/25/13 at 8:50 AM. During an interview with PT #1 on 09/25/13 at 12:20 PM, she stated Resident #64 had a lot of anxiety and frequent urinary tract infections. She stated she had declined both mentally and physically since her admission and had several falls due to the decline. PT #1 reported Resident #64 appeared to understand direction but wasn't able to process the information. She also stated she had a problem with motor control and motor planning. PT #1 stated she would get anxious and begins to shake resulting in becoming very rigid. PT #1 reported Resident #64's anxiety and her mental status had prohibited her from making progress in transfers. When questioned as to fall interventions, PT #1 stated therapy did get referrals for evaluation following falls and usually worked on strength, gait and endurance with them. She added that she really didn't make recommendations as to fall interventions as that was up to the nursing department. PT #1 commented that she did attend the morning meetings and falls were discussed.	F 323		

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F 323	Continued From page 46 During an observation of Resident #64, she was sitting in the hallway outside the rehabilitation therapy room at 2:00 PM on 09/25/13. Physical Therapist #1 (PT #1) and Nurse # 6 were standing with her. It was reported by PT #1 that she had placed Resident #64 in a broda chair to see if she would be more comfortable. NA #8 was interviewed on 09/25/13 at 2:30 PM. She stated Resident #64 was confused at times. She reported using the mechanical lift to get her out of bed since she was not able to stand alone. NA #8 stated she had become more rigid lately and very stiff when she worked with her. She commented that Resident #64 had a self release belt in her wheelchair that she could remove. NA #8 stated Resident #64 had falls in the past. She reported that she had a winged mattress on her bed but didn't remember when it was placed. NA #8 stated she used the care guide in her closet to find out what needs Resident #64 had. Resident #64 was observed sitting quietly in the broad chair in the hallway outside the therapy room across from the nurse's station on 09/25/13 at 4:30 PM. She was noted to be alert but confused when spoken to. During an observation on 09/26/13 at 1:35 PM, a Care guide which was dated 07/11/13 was noted inside Resident #64's closet. It was noted that she was non-ambulatory with the aid of one staff. Non-skid footwear, winged mattress and enabler self release belt while up in wheelchair was documented on the guide. There was no mention of out of room supervision while awake. Resident #64 was awake in her room alone sitting	F 323		

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F 323	Continued From page 47 in her broda chair wearing black slip-on shoes at 3:00 PM on 09/26/13. There was no staff noted in the hallways, no one at the nurse's station and no staff noted in any of the rooms on her end of the hall. The QI nurse was interviewed on 09/27/13 at 11:10 AM. She stated if a resident was admitted with a history of falls they were placed on a bed that was to be in the lowest position. She commented that all of the beds in the facility were such beds. The QI nurse reported using low beds which were in a fixed position and could not be raised. The QI nurse commented when she conducted her investigation of a fall, she reviewed the medical record for possible medications that might contribute to falling as well as any medical acute condition such as urinary tract infections that might place them at risk. The QI nurse stated if the resident was on therapy caseload she would discuss the fall with the therapy staff. The QI nurse stated if it was felt that there were equipment issues that might be altered, she worked with therapy to discuss options such as wedges, pommel cushions, scoot chairs, broda chairs or rock-n-go chairs depending upon the resident's status. She commented that therapy would trial the resident in a merry walker if they felt it would be appropriate. As the interview continued, the QI nurse reported the process for fall investigation included an incident report which was completed by the staff person who responded to the resident fall. The QI nurse stated the nurse should have a thorough description on the incident report of what happened. She added that in order to do a complete investigation, she needed to know what the resident's vital signs were when found, what position the bed was in, if they were wearing	F 323		

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F 323	Continued From page 48 non-skid footwear, any lighting issues, any spills on the floor and if possible what activity the resident was engaged in just prior to the fall. The QI nurse reported that the incident reports were given to her for review and investigation. She stated during her investigation she attempted to interview staff. If she did interview staff, she included their information in her QI note in the electronic record. The QI nurse stated once she had completed the investigation, she would make recommendations as to the appropriate intervention and the report was passed on to the Director of Nurses (DON) and the Administrator for final approval. The QI nurse reported that the facility was alarm free and only used physical restraints as a last resort. The QI nurse stated she reviewed effectiveness of the interventions on a quarterly basis but at one time she reviewed them weekly. She commented she was no longer able to review weekly due to having other duties in the facility. Resident #64 was awake and sitting in the specialty broda chair alone in her room on 09/27/13 at 2:30 PM. There was no staff member noted in the hallway and none noted in the rooms providing care as all of the resident's room doors were open. Nurse #1 was interviewed on 09/27/13 at 2:45 PM. She stated close supervision to her meant Resident #64 should be within visual observation. She added that at one time she rolled her down the hall with her when she was passing medications. Nurse #1 commented that she had noticed Resident #64 was sitting in her room alone and she would roll her out into the hall in a little while.	F 323		

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F 323	Continued From page 49 Resident #64 was observed in her room alone sitting in the broda chair at 4:15 PM on 09/27/13. There was no staff in rooms on the hall and no staff noted in the hall or at the nurse's station. The Director of Nurses (DON) was interviewed on 09/27/13 at 4:29 PM. She stated she was advised about all falls and if the fall occurred during off hours she would instruct staff on which immediate intervention they were to implement. The DON stated she gets the incident report online once the QI nurse has completed her investigation. She stated she expected staff to be thorough with their description of the incident. The DON stated the staff person should include where the resident was found, what the body position was, if pain was present, and whether or not range of motion was affected. She also commented any note about what it appeared that the resident was doing prior to the fall if it could be determined would be helpful. She stated she would expect staff to document any intervention such as non-skid footwear that was in place or not in place at the time of the fall. The DON stated the nurse should do a complete head to toe assessment. When questioned as to the meaning of out of room supervision, the DON responded that residents were to be placed in a place within the building where there was a lot of activity so they could be watched more closely. She commented those residents were usually sitting at the nurse's station. She added that keeping your eye on someone was not the same as 1:1 (one on one) supervision. The DON stated it was the responsibility of the QI nurse to make sure the interventions were in place. She stated physical restraints were only used as a last resort to prevent falls.	F 323		

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F 323	Continued From page 50 As the interview of 09/27/13 continued, the DON stated Resident #64 appeared to be cycling with her bi-polar diagnosis. She stated she was beginning to be very rigid. The DON commented she felt Resident #64 was in a cycle of depression due to her bipolar disease and the self release belt was placed due to anxiousness and shaking. The DON stated therapy was working with her on mobility. She stated Resident #64's initial falls were from the bed so they added the high winged mattress but then she started falling from her wheelchair. Once the self release belt was added to Resident #64's wheelchair, she thought they had solved the issue of falling. She commented the interventions that were supposed to be in place didn't appear to be in place as indicated by the lack of staff follow through with the out of room supervision of Resident #64. The DON stated she was aware of 2 residents who had fallen and sustained fractures as a result of the falls. She stated there had been an increase in the number of falls but she had not taken it to their Quality Improvement committee as yet. She remarked that she expected the QI nurse to track and trend the falls and come to her with the results for discussion. The DON commented she knew there was a system problem but was not sure where the problem was.	F 323		

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3. Resident #93 was admitted to the facility on 11/14/2012 with multiple diagnoses including: Difficulty in Walking, Muscle Weakness (Generalized), Dementia in Conditions Classified Elsewhere with Behavior Disturbances, Senile Dementia with Delusional Features, Alzheimer's disease, and Syncope and Collapse. The quarterly Minimum Data Set (MDS) assessment dated 08/06/2013 indicated that the resident had memory and decision making problems, required extensive assistance with transfers, was occasionally incontinent of bladder, and had a history of falls.

Review of the nurse's notes and the incidents reports revealed that the resident had 23 falls from the date of admission, 11/14/2012 through 09/26/2013.

The care plan for falls dated 08/09/2013 was reviewed.

The care plan focus for falls was, "Risk for falls characterized by history of falls/injury, multiple risk factors related to: Deconditioning; Poor safety awareness/unaware of safety needs."

The care plan goal was, " Resident will be free of falls through next review. "

The care plan interventions were listed as follows: 1.Bed in lowest position. 2. Call bell pinned to gown when in bed. 3. Encourage residents to wear glasses. 4. Encourage residents to wear hearing aid.
5. Rehab therapy referral. 6. Ensure environment

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F 323	Continued From page 52 is free of clutter. 7. Fall Risk Protocol. 8. Have commonly used articles within easy reach. 9. Keep call light within reach and answer timely. 10. Low bed. 11. Monitor and intervene for factors causing falls, i.e., bowel/bladder needs, mobility, transfers, etc. 12. Resident to wear proper and non- slip footwear. 13. Wheelchair when out of bed. All interventions had been listed on the resident's care plan since 11/27/12, when the original care plan was drafted, with the exception of the anti-rollback stops added to the standard wheelchair, which was added on 02/21/2013. A nurse's note dated 09/01/2013 at 9:55 PM indicated that the nursing assistant told the nurse that the resident was on the floor and was found on her left side facing away from the closet door. A head to toe assessment was completed and the resident was sent to the emergency department (ED) for evaluation. The resident returned to the facility on 09/03/2013 at 01:30 AM with some bruising to her right arm. A review of the Quality Improvement (QI) nursing note and incident report, both dated 09/05/2013, revealed that the resident fell on 09/01/2013 and was send to the ED for evaluation, but did not sustain any injury. There was no recommendation made to change the resident's care plan for further prevention at that time other than a discussion with therapy to screen the resident for any decline or need for additional therapy. A nurse's note on 09/03/2013 at 3:13 PM indicated that the floor nurse on duty for Resident #93 responded to a code green call for her room and found the resident on the floor beside her	F 323		

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F 323	Continued From page 53 bed with her eyes open and her comforter under her head. The note also indicated that the resident was non-verbal and unresponsive for approximately 15 minutes. The nurse completed a head to toe assessment and found no visible or palpable injuries, but called emergency medical services (EMS) to have resident transported to the ED given her non-verbal, unresponsive disposition. A nurse's note on 09/03/2013 at 10:00 PM indicated that Resident #93 had returned to the facility by stretcher and was in bed resting. On 09/25/13 at 9:00 AM, Resident #93 was observed lying in bed reaching for an object on her bedside table. The resident's bedside table was located on the distal side of her bed and her wheelchair was sitting on the proximal side of her bed. The resident's bed was not in the lowest position and the area immediate surrounding the resident's bed was cluttered with furniture and assistive devices making it a hazardous environment for ambulation. A review of the QI review note and incident report, both dated 09/06/2013, revealed that the resident had fallen on 09/03/2013 and was sent to the ED for evaluation but did not sustain injury. There was no corrective or preventive action initiated and it was recommended to continue with the POC that was in place related to falls for this resident. The note also mentioned the therapy assessment that had previously discussed, but had not been initiated. A nurse's note on 09/26/2013 at 1:22 AM indicated that at 1:00 AM Resident# 93 was found on the floor on her left side with her chair behind	F 323		

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F 323	Continued From page 54 her and her bed in front of her. She was not speaking, but was waving her arms at staff. The resident had taken her non-skid socks off and did not have anything on her feet. The nurse on duty for this resident attempted to assess resident, but she refused and requested to be sent to the hospital for evaluation. Resident #93 was sent to the ED via stretcher at 1:20 AM. A review of the QI review note and incident report, both dated 09/26/2013, revealed that the resident had a fall at 1:00 AM and had refused assistance or assessment and requested to be sent to the ED for evaluation for fear that she had broken a bone. The note and report also indicated that the resident was not wearing her non-skid shoes or socks at the time of the fall. On 09/26/13 at 12:10 PM, Physical Therapist #1 stated that Resident #93 had not been seen by therapy since she was discharged from services in May 2013, nor had they received a referral for further evaluation or treatment since that time. On 09/26/2013 at 2:42 PM, nursing assistant #6 stated that she provided Resident #93 with activities of daily living (ADL) care and that she sometimes had good days as well as bad days. Nursing assistant #6 indicated that the resident was usually confused and that she would always use 2 people to assist her with transferring. She stated that it seemed like the resident's legs were always weak but she would try to transfer herself. Nursing assistant #6 said that she believed the resident had a mat on the floor and non-skid shoes or socks in place as interventions, but she had not seen a cane or walker in her room. On 09/26/2013 at 3:11 PM, Nurse #6 stated that	F 323		

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F 323	Continued From page 55 Resident #93 was very clear some days and other days she was very confused and she had had recurrent urinary tract infection (UTIs) which had added to her confusion and agitation. She reported that the resident had a lot of knee pain, but attempted to ambulate although she was not able due to her pain. She stated that the resident had poor safety awareness and had worked with therapy for ambulation. Nurse #6 reported that Resident #93 received scheduled Tylenol and Percocet as needed (PRN) as well as Lidoderm patches. She also stated that staff had suggested an orthopedics consult to family, but they refused. Nurse #6 confirmed that Resident #93 was a high falls risk and she had been care planned for falls precautions. She reported that the facility had a no alarms and no restraints policy, so interventions for this resident included a low bed and modified wheelchair. She also reported that the resident did not have many falls on first shift and staffing issues may have contributed to the amount of falls on other shifts. On 09/27/2013 at 11:08 AM the QI Nurse stated that a resident's fall precautions depended on the nature of the falls history prior to the resident being admitted to the facility. She stated that all high risk residents were care planned for low beds with half rails and that therapy usually evaluated resident within 24 hours of being admitted to the facility. She stated that if a resident had a history of crawling or falling out of bed, they would be care planned for a winged mattress, but the facility did not use floor mats or bed alarms for falls precautions. She reported that after each fall she would go back through the resident's medical record to review any medications that would potentially cause falls, any diagnoses, and any environmental issues that	F 323		

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F 323	Continued From page 56 may have contributed to the fall. She said that she may also speak with therapy regarding the resident's needs for intervention. If there were additional falls after initial interventions in place, she stated that the facility had a clinical meeting and discussed other options available as a team and that residents were discussed in daily morning meetings during which new interventions would be decided upon. At 12:30 PM, the QI Nurse stated that she agreed that Resident #93 was doing better when she was involved with therapy and the restorative ambulation program and that she was not sure why the referral to therapy was never followed up. She reported that about 60 days ago, the facility changed the referral process to therapy from a verbal referral system to electronic and she could not remember if they discussed Resident #93's referral in the clinical meeting or if the MDS nurse was supposed to make the formal referral electronically. She also stated that all hospital discharge summaries were faxed to the doctor for him or her to view and sign off and she was not sure why the doctor would not follow up on an order or recommendation to see the resident after being seen in the emergency room. On 09/27/2013 at 4:00 PM, Nurse #10 reported that when a referral request for therapy was received by the MDS nurse, the nurse would make the referral to therapy electronically and the referral then goes directly into therapy's system, called their " Dashboard. " On 09/27/2013 at 4:29 PM, the Director of Nursing (DON) stated that staff discussed falls each day in the morning clinical meeting and discussed causes and possible interventions. She stated that she realized that there was a systemic	F 323		

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F 323	Continued From page 57 issue with falls in the facility and that she was frustrated to learn that some of the falls were due to interventions not being monitored and in place appropriately. She stated that the falls issues had not been taken to the Quality Assurance (QA) Committee, but her expectation would be for staff to ensure that interventions were in place at all times and that they would be monitored for effectiveness and updated as needed for each resident who was a high risk for falls. 4. Resident #24 was admitted to the facility on 11/17/05. Her documented diagnoses included dementia, difficulty walking, glaucoma, and osteoporosis. A 08/29/12 Quality Improvement (QI) Falls Review documented Resident #24's last fall was on 07/29/12 due to an unassisted transfer. It also documented the resident was at high risk for falls, used a wheel chair for long distances outside her room, used a quad cane in her room (although she was observed holding onto furniture rather than utilizing her cane), had impaired cognition with decreased safety awareness, and had a low bed/low hemi-light wheelchair/anti-rollbacks on her wheelchair. A 11/03/12 progress note documented Resident #24 was found on the bathroom floor at 8:50 PM, and sustained a skin tear to her left hand. A 11/05/12 QI Falls Review documented Resident #24 was at high risk for falls, experienced a fall on 11/03/12 due to an unassisted transfer, and her fall precautions included bed in the low position, anti-rollbacks on her hemi-light wheelchair, bedside commode which the resident	F 323		

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F 323	Continued From page 58 did not use consistently, and a raised toilet seat. A 11/05/12 10:32 AM progress note documented Resident #24 was observed lying on the floor of her room between the bed and her wheelchair. The resident stated she was trying to get of out her bed and into her wheelchair. She complained of back pain, and Tylenol was administered which proved to be effective in relieving the pain. A 11/06/12 QI Falls Review documented Resident #24 was noncompliant with calling for staff assistance, was involved in restorative ambulation (involved in this program since 01/09/12), and had a urinalysis drawn (subsequently treated with an antibiotic due to an urinary tract infection.) The resident's 04/16/13 Annual Minimum Data Set (MDS) assessment documented the resident's short and long term memory was impaired, she was moderately impaired in decision making, she had impaired vision, she required supervision by a staff member for transfers/walking in the room and corridor/locomotion on and off the unit, and she was not steady but able to stabilize herself without staff assistance when walking/getting on and off the toilet/transferring from surface to surface/moving from a seated to a standing position. The resident's 07/02/13 Quarterly MDS assessment documented the resident's cognition was severely impaired, she had impaired vision, she required extensive assistance by two staff members for transfers, she required supervision by a staff member when walking in the room and corridor and for locomotion on and off the unit,	F 323		

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F 323	Continued From page 59 and she steady at all times when walking/getting on and off the toilet/transferring from surface to surface/moving from a seated to a standing position. The resident's 04/29/13 and 07/24/13 care plans documented the same problem and interventions for fall risk. "Trauma, potential r/t (in regard to) fall risk" was identified as a problem. Interventions on both care plans were anti-rollback on wheelchair, assist during transfer and mobility, keep assistive ambulation devices (wheelchair and quad cane) within reach of the resident, keep call light within reach and answer timely, low bed and non-skid mat at bedside, monitor and intervene for factors causing prior fall (including bowel/bladder urgency, mobility, and transfers), per resident request bed not in lowest position, provide appropriate footwear for resident, and provide frequent reminders to resident to call for assistance before getting up. A 08/15/13 progress note documented at 10:00 PM Resident #24 was found lying on the floor in front of her roommate's bed. Later when the resident began complaining of pain in her left leg, a x-ray revealed she had a left tibial plateau fracture. A 08/15/13 Incident/Accident Report documented the resident was independent in her wheelchair, but was supposed to be supervised when getting up due to instability. It was also noted that the resident was wearing bedroom shoes which felt slippery on the facility floor. A 08/21/13 QI Falls Review documented Resident #24 was high risk for falls, had a history of falls and would not use the call bell for assistance,	F 323		

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F 323	Continued From page 60 was observed transferring and ambulating by holding onto furniture, had a wheelchair which was used only when she was out of the room, and had a gait which was unsteady. At 3:48 PM on 09/25/13 Nurse #1, who responded to the overhead page and completed the fall report on 08/15/13, stated Resident #24 was not on her assignment that night, but when she responded and entered the room the resident's wheelchair was beside her own bed, but the resident was found in front of her roommate's bed on the floor. She explained it did not seem apparent that the resident attempted to use her wheelchair as part of a transfer. This nurse stated she was unsure where the resident was or what she was doing before the fall. According to Nurse #1, when questioned, the resident commented, "I was trying to get up." The nurse did not remember seeing a quad cane in the resident's room, and was unsure if the bed was in the low position or if a mat was in place on the floor. At 9:32 AM on 09/25/13 the Administrator stated the nursing assistant (NA) who was assigned to care for Resident #24 on the evening of her 08/15/13 fall was on leave, and was not available for interview. At 10:18 AM on 09/26/13 Nurse #2, who cared for Resident #24 on first shift, stated the resident was confused, and would occasionally yell out. She reported the resident would be up and down unassisted on a daily basis. This nurse commented the resident would not use the call bell, and would navigate in her room by holding onto furniture. She explained fall interventions did not seem to be working for the resident	F 323		

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F 323	Continued From page 61 because she was so confused, and did not realize she had lost a lot of her independence. At 10:45 AM on 09/26/13 NA #1, who cared for Resident #24 on first shift, stated the resident would not ring the call bell and ask for assistance. She reported the resident was wobbly and had gait problems. She commented there were times in the past when she saw a cane and a walker in the resident's room, but she did not think that the resident used them. According to NA #1, the resident was always trying to go to the bathroom by herself. During a telephone conversation at 11:46 AM on 09/26/13 Nurse #3, who cared for Resident #24 on second shift, stated the resident was alert but confused. She explained the resident was alert enough to realize she wanted to accomplish certain tasks such as going to the bathroom or going out into the hall, but was too confused to realize that she could no longer transfer or walk unassisted. The nurse reported this was a dangerous combination. She commented the only assistive device the facility had any luck getting the resident to use was her wheelchair, but again she commented the problem remained getting the resident the assistance she needed to transfer in and out of the wheelchair safely. According to Nurse #3, Resident #24 would not use the call bell to request assistance. At 11:57 AM on 09/26/13 NA #2, who cared for Resident #24 on second shift, stated the resident continually got out of bed and wheelchair unassisted. She reported the resident had had a light weight wheelchair which was low to the ground for a very long time, and she placed the resident's bed in the lowest position. The NA	F 323		

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F 323	Continued From page 62 commented she had not seen a quad cane or a walker in the resident's room in at least the last three months, probably longer. According to NA #2, the resident had a bedside commode and raised toilet seat a long time ago, but were discontinued because the resident refused to use them. At 12:07 PM on 09/26/13 physical therapist (PT) #1 stated physical therapy worked with Resident #24 between 11/14/11 and 01/12/12, and discharged her to restorative for ambulation and recommended a quad cane to be used in the resident's room and a rolling walker for long distances. She reported the resident also received physical therapy between 11/07/12 and 12/12/12 due to multiple unassisted falls in one week. The PT commented the resident made some progress during this period with her transfers, going from care giver assist to stand-by assist or modified independence. She explained this meant that there were times when the resident needed someone there to assist her with transfers. According to PT #1 the problem was the resident would not use the call bell. The PT explained therapy attempted behavior modification with the resident in attempts to persuade the resident to call for assistance. She stated, however, these attempts were unsuccessful. The PT reported upon her 12/12/12 discharge it was recommended Resident #24 continue with restorative ambulation. She commented physical therapy did not recommend any assistive devices because by this time it was quite obvious the resident was not going to use any of them because of her cognitive problems. During a telephone conversation at 4:18 PM on	F 323		

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F 323	Continued From page 63 09/26/13 Nurse #4, the hall nurse assigned to care for Resident #24 on the night of her 08/15/13 fall, stated as long as she had worked with the resident the resident would not use her call bell and tried to transfer unassisted. She reported, other than her wheelchair and low bed, she had not seen any other fall interventions for the resident. At 10:13 AM on 09/27/13 PT #1 stated she was not aware of Resident #24 being trialed on any potential devices including belts, lap cushions, or Meri-walkers. She reported the last devices she could remember being tried for the resident were the quad cane and bedside commode, neither of which the resident would use. The PT commented the resident used a rolling walker in restorative ambulation while supervised, but this walker was not to be left in the resident's room. At 10:40 AM on 09/27/13 Nurse #1, who responded to the overhead page and completed the fall report on 08/15/13, stated at the time of this fall Resident #24 had slipper socks on down inside of bedroom slippers which were slick on the bottom. She commented the slipper socks were not doing the resident a lot of good. The nurse explained the bedroom shoes had rubbery ridges on them at one time, but had been worn off, and the bottoms were smooth and slippery. She reported she was told that the resident's family was notified, and the bedroom slippers were replaced with new ones which had non-skid soles. At 11:08 AM on 09/27/13 the Quality Improvement (QI) Nurse stated the facility was mat and alarm free. She reported positioning devices such as wedges and pommel cushions	F 323		

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F 323	Continued From page 64	F 323		

and alternate chairs such as Rock-N-Goes and scoot chairs were used in the facility. She commented restraints were used in the facility, but only as a last resort. This nurse stated there were a couple of residents in the facility currently with self-release seat belts and one resident with a Meri-walker. She remarked the Meri-walker worked well for cognitively impaired residents who were active but who would not use other devices and equipment which had been tried. According to the QI Nurse, falls were discussed in the daily morning meetings where multi-disciplinary input could be obtained for recommended interventions. She explained the facility attempted to place new interventions in place after each fall and replace interventions which were not working with new ones. She stated it was important for staff to document what fall interventions were in place and what the resident was doing before the fall (interviewing staff about what the resident was doing if the resident was cognitively impaired) in incident accident reports or progress notes. The nurse reported this was important in determining what interventions were not working, and what new interventions to try. According to the QI Nurse, Resident #24 was at high risk for falls due to a history of falls, impaired cognition, and poor safety awareness. She stated therapy had worked with the resident multiple times, but were unable to overcome her cognitive issues. She reported the bedside commode and raised toilet seat were discontinued for the resident because of non-use. She also commented Resident #24 did not use her quad cane or rolling walker. The nurse explained, instead, the resident was getting up unassisted and using furniture to hold onto as she attempted to go to the bathroom or outside of her room. According to the QI Nurse, the only

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F 323	Continued From page 65 intervention for cognitively impaired residents who would not use assistive devices or call for help before transferring was frequent checks on the residents. She commented that her personal expectation for frequent checks was every 10 - 15 minutes. As well as she could remember, the QI nurse stated she did not think Resident #24 had been evaluated for the use of any interventions, assistive devices, or equipment other than the walker, quad cane, bedside commode, raised toilet seat, and hemi-light wheelchair with anti-roll backs. At 11:48 AM on 09/27/13 NA #1 stated she thought the NA staff usually checked on Resident #24 hourly to make sure she was okay unless there were other residents in their assignments who were having problems that required more of their attention. At 3:05 PM on 09/27/13 the Administrator stated she was unable to find any investigation follow-up interviews concerning Resident #24's 08/15/13 fall which might shed some light on what the resident was doing before her fall. At 4:35 PM the director of nursing (DON) stated the facility tried to put new interventions in place when current interventions were proven to be ineffective. She reported that recently there had been more problems with accidents involving mobile residents who were cognitively impaired and would not ask for staff assistance. She commented some of the fall interventions that could be used for these cognitively impaired residents were the Meri-walker, Rock-N-Go or Broda chairs, belts, activities from past-life screenings, and therapy. As a last resort, she explained the facility would try restraints.	F 323		

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F 323	Continued From page 66 According to the DON, Resident #24 would not use her quad cane. The DON reported she was unsure whether Resident #24 had been trialed for other interventions such as belts, a Meri-walker, or special chairs that preserved mobility. Review of Resident #24's electronic and paper charts, revealed no documentation of assessing or trialing the resident on interventions, devices, or equipment other than the hemi-light wheelchair with anti-roll backs, bedside commode, raised toilet seat, walker, and quad cane.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain final rinse temperatures of 180 degrees Fahrenheit or higher at the dish machine. The facility also failed to label and date opened food items and dispose of outdated food items in multiple storage areas. Findings included: 1. Between 9:20 AM and 9:38 AM on 09/25/13, as six racks of kitchenware passed through the	F 371	The dish machine was serviced by a technician on 9/25/13. Upon review by the Dietary Manager on 09/25/13 the final rinse temperature was above 180 degrees Fahrenheit. All dietary staff were inserviced on the dish machine protocol, the correct temperatures of the dish machine, documentation, and what to do in the event the temperatures are not above 180 degrees Fahrenheit during usage of the machine by the Dietary Manager on 10/03/13-10/04/13. The dietary staff will document the dish machine temperatures on a daily log. Any staff member that identifies an issue with the temperature of the dish machine will report it immediately to the Dietary Manager. The Dietary Manager will review the temperature log and monitor dish machine temperatures daily for five days, using the daily rounds tool, then weekly for four weeks, then monthly for three months. The Dietary Manager will take action for any potential concern upon identification to include re-training for staff as necessary.	

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F 371	Continued From page 67 dish machine, the final rinse temperature only registered between 168 and 170 degrees Fahrenheit. The two dietary employees running the dish machine were not watching the temperature gauges during the operation of the dish machine. At 2:54 PM on 09/25/13 a service representative reported that he found part of an air pot caught up in the dish machine which was probably prohibiting the proper function of the arm which triggered the final rinse to kick in. He stated he thought this problem was responsible for the low final rinse temperatures since after removing the air pot part, all final rinse temperatures at the dish machine were above 180 degrees Fahrenheit. At 9:56 AM on 09/26/13 the facility's dietary manager (DM) stated the final rinse temperature needed to be at least 180 degrees Fahrenheit to sanitized the kitchenware being run through the dish machine. She reported that staff had been in-serviced to monitor the wash and final rinse temperatures when the dish machine first started up after each meal and to record these temperatures in a log book. However, the DM commented she did not think that staff were educated to watch the temperature gauges throughout the entire dish machine process. At 10:04 AM on 09/26/13 a dietary employee stated she thought a couple of years ago the dietary staff was told to watch the temperature gauges each time racks exited the dish machine. She reported currently the wash and final rinse temperatures were being recorded in a log book as the dish machine process began and finished up.	F 371	The results of the dish machine temperature audits will be forwarded by the Dietary Manager to the Executive QI monthly for three months then quarterly for review and follow up as deemed necessary for any potential trends and to determine the frequency and/or need for continued monitoring. Corrective action will be completed by 10/24/13.	10/24/13

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F 371	Continued From page 68 2. During the initial tour of the kitchen, beginning at 5:10 PM on 09/22/13, in the dry storage room a 24-ounce packet of raspberry gelatin, a 24-ounce packet of cherry gelatin, a 16-ounce packet of cheese sauce mix, and a 12-ounce packet of turkey flavored gravy mix were found opened but without a label and a date. In the reach-in refrigerator the date on a baggie of white sliced cheese was not readable, a side dish of sliced onion was not labeled and dated, and pudding with a discard date of 09/21/13, fruit cocktail with a discard date of 09/19/13, sliced apples with a discard date of 09/17/13, and an opened half-gallon of buttermilk with a use-by date of 09/11/13 were found. Two more opened half-gallon containers of buttermilk with a use-by date of 09/11/13 were found in the walk-in refrigerator. Bags of green peppers and cauliflower which were opened and stored in the walk-in freezer were without labels and dates. During a follow-up tour of the kitchen, beginning at 9:25 AM on 09/25/13, a 24-ounce packet of fruit punch mix, a 24-ounce packet of raspberry gelatin, a 24-ounce packet of cherry gelatin, a 16-oz packet of low sodium chicken flavored gravy mix, and a 16-ounce packet of cheese sauce were found opened but without labels and dates in the dry storage room. Bags of green peppers and cauliflower which were opened and stored in the walk-in freezer were still without labels and dates. At 9:56 AM on 09/26/13 the facility's dietary manager (DM) stated once a week the stock person checked all storage areas to make sure opened food items were labeled and dated and to make sure all items past their use-by and discard dates were disposed of. She also reported that	F 371	All items in the kitchen, both dry storage and walk-in refrigerator and freezer, were checked to determine if they were properly dated and labeled and within use-by date with all items that were not properly dated and labeled or were not within use-by date were disposed of by the Dietary Manager on 09/25/13. All dietary staff was inserviced on how to properly date and label items in the kitchen and how to assess for proper use-by date by the Dietary Manager on 09/25/13. To ensure that all items in the kitchen are properly dated and labeled and disposed of by the use-by date, the Dietary Manager or Dietary staff will observe all storage areas for five days, using the daily rounds tool, then weekly for four weeks, then monthly for three months. The Dietary Manager or dietary staff will take action as appropriate upon the identification of any potential issue. The results of the date/label and use-by audits will be forwarded by the Dietary Manager to the Executive QI monthly for three months then quarterly for review and follow up as deemed necessary for any potential trends and to determine the frequency and/or need for continued monitoring. Corrective action will be completed by 10/24/13.	10/24/13

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F 371	Continued From page 69 officially a rotated dietary aide was assigned the storage areas on a weekly basis. However, the DM commented that all employees who went into the storage areas should be monitoring them, and anyone who put opened food items back into storage was supposed to bundle the items in plastic wrap, place them in a zip lock storage bag, and place a label and date on them. She stated the labels were supposed to document the date the opened food items entered storage and the date they were to be removed from storage and disposed of. According to the DM, she also monitored all her storage areas every morning that she worked. At 10:04 AM on 09/26/13 a dietary employee stated the cooks were responsible for monitoring the storage areas on a daily basis. She reported that all opened food items, all food items removed from their original packaging, and all leftovers were supposed to have labels and dates on them. She commented that the DM also toured the storage areas when she had the time. Depending on what type of food item was being stored, the employee commented leftovers were only usually held for 3 to 5 days. She also stated that the facility did not use any food products which were past the use-by or discard date.	F 371		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		

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F 520	Continued From page 70 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to track a trend of increased falls and/or falls with fractures within the resident population and to refer the trend to the Quality Improvement Committee. Findings included: A review of the Fall Risk Protocol for the facility revealed that a Falls Risk Evaluation would be completed on the day of admission and on re-entry to the facility, and that if a resident's score was 10 or greater, the following guidelines would be instituted: A) The resident will be placed on the Fall Risk Protocol, B) An initial care plan for the resident at risk for falls would be completed and available on the resident ' s medical record. The care plan would include measurable goals and interventions to ensure the resident's safety. C) The Resident Care Guide	F 520	All residents that have been determined to be at risk for falls were reassessed per the facility fall risk assessment to ensure current interventions continue to be effective by MDS nurses and QA nurse on 10/01/13. Any interventions deemed to no longer be effective were re-evaluated by QA and Therapy as indicated and updated per individual resident need. These interventions were updated in the care plan and placed on the care guide as direction for all staff by MDS nurses on 10/01/13-10/02/13. The Administrator, DON, Administrative nurses, Department Heads and QA nurse will make rounds and document findings per a fall audit tool 5 times a week x30 days, and 3 times a week x 30 days, and then at least weekly to ensure staff are using intervention per care guide. Any areas found to be no longer effective will be reviewed and updated as needed. 100% audit has been completed of all residents per the facility falls risk assessment to ensure residents have appropriate interventions in place as indicated by MDS nurse/QA nurse on 10/01/13-10/02/13. All residents will be evaluated per the facility fall risk assessment on admissions, per quarterly reviews and as otherwise indicated by facility staff. Any resident identified as being at risk for falls will be screened by Therapy and recommended interventions will be put in place as appropriate. Care plans and resident care guides will be updated as new interventions are indicated by MDS nurses. Any resident that sustains a fall will be evaluate to include an assessment of resident, witness statements describing the event, what caused the fall, current interventions, notification of appropriate Administrative staff, MD, and Family member and interventions undated as indicated by hall nurses.	

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F 520	Continued From page 71 should be completed on admission and/or upon re-entry with interventions related to the resident's risk for falls addressed. The Resident Care Guide should be reviewed and updated periodically or as needed related to each resident's fall risk with interventions noted. D) The staff would be notified by the DON or designee of the resident's fall risk after the completion of evaluation. This information should be placed on each resident's care guide. E) A Falls Risk Evaluation should be completed on all residents quarterly. If less than 10 was scored on the Falls Risk Evaluation, staff may discontinue the protocol. A Falls Risk Evaluation may also be completed upon a significant change in a resident's condition or as indicated. F) Residents at risk for falls would be followed by the Event/Incident QI Committee. The Committee should review the Incident Analysis Report for the current month and the 6 to 9 months period preceding for any patterns or trends in residents' falls. The Committee should then assure the utilization of the Falls Risk Protocol and the residents' safety through the implementation of or change in the preventive interventions. In an interview with Quality Improvement (QI) Nurse at 2:30 PM on 09/27/13, she stated she had a concern about the increased number of falls among the residents over the last quarter and that she discussed this concern in the daily clinical meetings. She added that she did not bring her concern about the falls to the attention of the Director of Nursing (DON) or the Administrator in a one on one meeting to recommend a Quality Improvement Committee referral. In an interview with the DON on 09/27/13 at 4:30	F 520	The QA Nurse has been in serviced by nurse consultant on 10/03/13 on tracking and trending falls and the use of the QA round tool in an effort to determine the root cause of any identified areas of concern and interventions updated as indicated. All nursing staff were in-serviced on where changes in fall interventions are located, the importance of consistent utilization of fall prevention intervention and the reporting of changes in a resident condition that could increase a resident's risk of falls by DON or designee beginning on 10/02/13. Any falls will be reviewed during weekly Event/Incident QI meetings x 2 months, bi-weekly x 2 months, and then monthly or as indicated to ensure intervention currently in place continue to be effective-Identified areas of concern will be update per individual residents as indicated per the QI team. These areas will be reviewed monthly or as indicated by the RVP and Corporate Clinical Nurse Consultant with action taken as necessary for any potential areas of concern. Any identified areas of concern will be reviewed during the Quarterly Executive QA meeting for any changes to the plan to include monitoring frequency, continuation and/or interventions as indicated. Corrective action will be completed by 10/24/13.	10/24/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	09/27/2013

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F 520	Continued From page 72 PM, she stated that she was aware of the increased rate of falls over the most recent quarter among the facility's resident population. The DON stated that the out of room supervision had not been an effective tool to prevent some residents from falling since apparently staff follow through did not occur. She also stated she expected the QI nurse to track and trend falls and report findings to her to discuss. The DON stated falls were discussed in the daily clinical meetings. She also remarked that when a resident falls, the DON is called, even if the fall occurs during night or weekend hours, and that she expects to see an incident report completed by the next morning. In addition, she stated that the QI Nurse receives a printed incident report and that she investigates the fall. The DON added that after the QI nurse completes her investigation of the fall, she sends her final report to the DON. She further stated that it is her expectation that the incident report should include the facts regarding when the fall happened, the body position of the resident when found, where the resident was coming from, whether there is a head injury, whether the resident can perform range of motion after the fall. The DON added that falls interventions for residents had not been working very well. During the same interview with the DON on 09/27/13, she stated that any staff member can identify an issue that needs to be reviewed by the Quality Improvement (QI) Committee. She stated that the QI Nurse had not brought up falls as a concern for the QI committee to study. She added that when a staff member mentions an issue during the daily clinical meetings, it does not automatically go the QI Committee. She explained that the identified issue needs to be identified in a one on one meeting with the DON	F 520		

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F 520	Continued From page 73 and/or Administrator, and that all statistics and other information regarding the issue must be complete to show that the issue needs to be followed by the QI Committee. The DON stated that she herself had not initiated a QI meeting to address the fall rate issue. The DON indicated that the members of the QI Committee include the QI Nurse, who is the coordinator of the QI committee, the facility physician, the pharmacy consultant, the Minimum Date Set nurses, the Staff Development Nurse, the medical records coordinator, the Administrator, and the DON. She also stated that the QI Committee meets quarterly, and that the last meeting was in July 2013. In addition she stated that the increased rate of falls might be reviewed by the committee in November, 2013.	F 520		

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	345490	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/30/2013

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V (211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Ayden Court 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. Ayden Court Nursing & Rehabilitation Center's response to the statement of deficiencies does not denote agreement of deficiencies nor does it	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: storage room door in kitchen did not latch for smoke tight seal. 42 CFR 483.70(a)	K 029	constitute an admission that any deficiency is accurate. Further Ayden Court Nursing & 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. The storage room door in the kitchen was adjusted to latch for a smoke tight seal on 11/5/13. A 100% audit of all facility doors was conducted between 11/5/13 and 11/14/13 to identify any other doors that were not latching to create a smoke tight seal. The Maintenance Director will be adjusting the doors as needed to correct any issues identified. The maintenance director, housekeeping supervisor, administrator or designee will conduct random weekly audits of doors throughout the facility for three months as part of the preventive maintenance program. All audits will be taken to the Quarterly QI meeting for review. Adjustments to the audit schedule are to be made as needed.	12/14/13
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 069		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/19/13

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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K 069	Continued From page 1 Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: deep fat fryer in kitchen is not 16 inches from adjacent equipment. Therefore, splash guard be installed at a minimum of 8 inches on fryer. 42 CFR 483.70(a)	K 069	A splash guard was installed on the right side of the fryer on 11/4/13. The Dietary manager conducted an inservice of all staff beginning on 11/18/13 regarding the new splash guard and safety concerns. The Dietary manager and Maintenance Director will monitor the deep fryer for any potential issues associated with the splash guard weekly for one month and then monthly for two months. All audits will be taken to the Quarterly QI meeting for review. Adjustments to the audit schedule are to be made as needed.	12/14/13