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	345213	A. BUILDING _____ B. WING _____	C 04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE LILLINGTON	**1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546**

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F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to notify the physician of a newly identified pressure ulcer	F 157	The physician of resident # 4 was notified by Director of Nursing on April 16, 2014 of wound to inner buttock and orders	5/16/14

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

Electronically Signed | 05/09/2014

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F 157	Continued From page 1 upon discovery until the pressure ulcer progressed to tunneling of the wound for 1 of 2 residents (Resident #4) reviewed for pressure ulcers. The findings included: Review of the facility's policy titled "Standing Order for Wound Protocol" dated 3/26/14 revealed in part "Treatment order must include site, stage, cleansing agent, treatment, secondary dressing if used, frequency of change, and discontinue date if known, complete a pressure/non-pressure documentation form, notify physician/family, document all wounds and changes on the 24 hour report, telephone order must be written before initiating any wound orders." Resident #4 was admitted to the facility on 1/7/14 with medical diagnoses which included diabetes mellitus and hypertension. The most recent Minimum Data Set (MDS) dated 2/17/14 revealed the resident was cognitively intact. The assessment further revealed the resident was independent with bed mobility and transfers. The same assessment further indicated the resident has rejected care less than daily. The MDS assessment indicated Resident #4 was at risk for developing pressure ulcer and had a healed Stage 2 pressure ulcer on prior assessment, Review of the care plan for Resident #4 updated 2/19/14 revealed the resident was at risk for potential for skin breakdown, bruising and skin tears and pressure ulcer, excoriation related to decreased in mobility, incontinence. The goal	F 157	received for treatment of wounds to inner buttocks and scrotum. Orders initiated on April 15, 2014. All residents have the potential to be affected by the same alleged deficient practice. An audit was completed April 18, 2014 by Director of Nursing to ensure that the physician had been notified of the current status of all wounds. No other residents were identified to be affected. Licensed nurses will be in-serviced by Director of Nursing, Assistant Director of Nursing, or RN Supervisor by May 16, 2014 to notify attending physician of any change of condition and of any wouunds resulting in decline. Any resident change of condition, new wound, or wound decline will be discussed in daily Clinical meeting Monday through Friday and reviewed by weekend supervisor Saturday and Sunday. Director of Nursing, Assistant Director of Nursing, and Weekend supervisor will monitor documentation of physician notification of and change of status, new wound, and wound decline to ensure compliance. Any instance of lacked physician notification will be corrected immediately by notifying physician and providing one on one in-service with licensed nurse. Physician notification audits will be done by the Director of Nursing, Assistant	

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F 157	Continued From page 2 stated for the problem was the resident will maintain or develop clean and intact skin. The care plan indicated the following interventions: provide measures to decrease pressure/irritation to skin, Geo mattress, heel protectors, and w/c cushion as indicated, keep skin clean and dry and provide for baths per schedule and as needed, change incontinent pad as soon as possible after voiding or bowel movement and provide incontinent care after episodes, apply barrier cream or protective lotion after incontinence, assist resident to turn and reposition routinely, position with pads and cushions, pillows to prevent pressure, observe skin during personal cares and notify nurse/MD of any skin issues. During the wound care observation on 4/14/14 that began at 2:20 pm, the Wound Care Nurse stated to Resident #4 that she could see the new area that was reported from the weekend while pointing to an open area proximal to the second opened area to the left inner buttocks. The wound bed was pink with no drainage or odor. The Wound Care Nurse cleansed the area with wound cleanser and applied saline soaked gauze followed by dry gauze and tape. During the wound observation, the resident stated he was aware of a new area of skin breakdown to the scrotum identified over the weekend but not of a new area to the buttocks. Interview with the Wound Care Nurse at this time revealed the new area was identified over the past weekend by Nurse #1. She further indicated Nurse #1 had initiated the same treatment of wet to dry dressing for the proximal wound. The Wound Care Nurse did not have the treatment record available during the dressing change or interview. Review of the weekly interdisciplinary team	F 157	Director of Nursing, or Weekend Supervisor daily x 4 weeks then weekly x 4 weeks and then monthly x 4 months. Any identified concerns will be addressed immediately with attending physician as indicated. The Director of Nursing or Assistant Director of Nursing will report findings from audits to QAPI Committee monthly times 6 with revisions as necessary until otherwise determined by QAPI Committee.	

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F 157	Continued From page 3 progress notes dated 4/9/14 documented "Wound note-Stage 3 to inner buttock on scar tissue line reopened. Cleanse daily with wound cleanser and apply wet to dry dressing daily. Monitor for signs and symptoms of infection." Review of the April 2014 Treatment Record revealed an order to cleanse open area to left inner buttocks near the scrotum with wound cleanser and apply wet to dry dressing daily dated 4/4/14. Further review of the same treatment record revealed an order to clean area to scrotum with normal saline; apply triple antibiotic ointment and non adherent dressing dated 4/11/14. During an interview on 4/15/14 at 2:15 pm, the Wound Care Nurse stated the area to the buttocks previously identified on 4/14/14 had tunneled into one large area overnight. The resident refused to allow surveyor to do a second observation of wound care. The Wound Care Nurse stated she did not measure the new pressure area identified, notify the physician or initiate a treatment on 4/14/14 when she identified the area because she thought the area had been addressed by Nurse #1 over the weekend. She stated she just continued the same treatment of wet to dry that was already in place. The Wound Care Nurse was unable to provide documentation of wound assessment or physician notification at this time. She further stated she normally complete documentation on wounds at the time of discovery or assessment. On 4/15/14 at 3:10 pm in an interview, Nurse #1 stated she worked the weekend of 4/11/14-4/13/14 as the treatment nurse. She further indicated she did not see a new open area to the buttocks. Nurse #1 stated the area that she	F 157		

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F 157	Continued From page 4 identified and initiated treatment for was an open area on the scrotum for Resident #4. The nurse further stated she would not have written scrotum for an area that was on the buttock. On 4/15/14 at 5:30 pm, the facility (Wound Care Nurse) was unable to provide updated documentation on the changes in the status of the wound. During an interview on 4/15/14 at 5:40 pm, the Director of Nursing indicated it was her expectation for the Wound Care Nurse to follow the protocol and assess any new areas identified, notify the physician and the family.	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility restrained a resident without a medical symptom, for a resident that had a lap buddy since October 2013. This was for 1 of 1 resident (Resident #3). The findings included: Resident #3 was readmitted to the facility on 3/18/13 with medical diagnoses which included dementia, psychosis and depressive disorder. The most recent quarterly Minimum Data Set	F 221	Therapy referal for restraint reduction ordered April 16, 2014. Restraint reduction completed for Resident # 3 by Physical therapy on April 17, 2014, restraint (lap buddy) removed. All residents with restraints have the potential to be affected by the same alleged deficient practice. An audit was done by Director of Nursing on April 24, 2014. No other restraints are present in facility.	5/16/14

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F 221	Continued From page 5 (MDS) dated 12/13/13 revealed the resident was severely cognitively impaired. The same assessment further revealed the resident required extensive assistance with one person assistance for bed mobility and locomotion on unit. The same assessment further indicated the resident required extensive assistance with transfers with two plus person physical assistance. The section for falls indicated the resident had two or more falls since reentry. The section for functional mobility indicated the resident was not steady moving from seated to standing position and the resident was only able to stabilize with staff assistance. The MDS assessment revealed a restraint used daily in the chair. The care plan for Resident #3 updated 4/7/14 revealed the resident required assistance with Activities of Daily Living (ADL's) related to dementia, immobility, fall risk and post right hip fracture. The goal stated for the problem was the resident will have no further decline in ADL function. The interventions for this problem included staff to provide assistance with transfer/mobility needs. The same care plan further revealed the resident was at risk for falls and fall related injury related to dementia and immobility. The interventions for this problem included lap buddy to wheelchair when out of bed, release for meals, ADL's and activities as needed. Review of the facility "Physical Restraint Reduction Assessment "revealed " Restrained individuals should be reviewed at least quarterly to determine whether or not they are candidates for restraint reduction, less restrictive restraining measures, or total restraint elimination." Review	F 221	Licensed Nurses will be in-serviced by May 16, 2014 by Director of Nursing, Assistant Director of Nursing, or Weekend Supervisor on the resident Right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident□s medical symptoms. Interdiscipliary Team to complete restraint assessment with initiation of a restraint then quarterly and prn for possible restraint reduction and appropriate medical symptom. Audit for initiation of restraints to include appropriate medical symptoms as well as attempted restraint reduction quarterly by IDT to be completed monthly by Director of Nursing or Assistant Director of Nursing for 6 months. Any identified concerns will be addressed immediately with physician as indicated. The Director of Nursing or Assistant Director of Nursing will report findings from audits to QAPI Committee monthly times 6 months with revisions as necessary until otherwise determined by QAPI Committee.	

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F 221	Continued From page 6 of the same form for Resident #3 revealed the last documented restraint reduction attempt was on 10/22/13. Review of the telephone physician order dated 10/22/13 revealed "Lap buddy to wheelchair when resident is out of bed, release for meals, ADL's, and activities and as needed." A continuous meal observation on 4/15/14 that began at 11:45 am revealed Resident #3 with the lap buddy in place to the wheelchair. The resident was fed by the wound care nurse. During an interview on 4/16/14 at 5:50 pm, the Director of Nursing (DON) was unable to provide documentation of the medical symptoms for the lap buddy restraint for Resident #3. The DON further indicated she had not attempted a restraint reduction since the last noted documented attempt dated 10/22/13. The DON stated she and other members of the interdisciplinary team were responsible for ensuring restraint reduction attempts were completed quarterly.	F 221		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow the physician	F 282	Restraint reduction completed for Resident # 3 by Physical therapy on April	5/16/14

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F 282	Continued From page 7 orders that were documented on the care plan for the removal of lap buddy during meals for 1 of 1 resident (Resident #3) with a restraint. The findings included: Resident #3 was admitted to the facility on 3/18/13 with medical diagnoses which included dementia, psychosis and depressive disorder. The most recent quarterly Minimum Data Set (MDS) dated 12/13/13 revealed the resident was severely cognitively impaired. The same assessment further revealed the resident required extensive assistance with one person assistance for locomotion on unit. The same assessment further indicated the resident required extensive assistance with transfers with two plus person physical assistance. The section for falls indicated the resident had two or more falls since reentry. The section for functional mobility indicated the resident was not steady moving from seated to standing position and the resident was only able to stabilize with staff assistance. The MDS assessment revealed a restraint used daily in the chair. The care plan for Resident #3 updated 4/7/14 revealed the resident required assistance with Activities of Daily Living (ADL ' s) related to dementia, immobility, fall risk and post right hip fracture. The same care plan further revealed the resident was at risk for falls and fall related injury related to dementia and immobility. The interventions for this problem included lap buddy to wheelchair when out of bed. Release for meals, ADL ' s and activities as needed. Review of the telephone physician order dated 10/22/13 revealed " Lap buddy to wheelchair	F 282	17, 2014, restraint (lap buddy) removed. All residents who have a restraint have the potential to be affected by the same alleged deficient practice. An audit was done by Director of Nursing on April 16, 2014. No other restraints are present in facility. Nursing staff will be in-serviced by Director of Nursing, Assistant Director of Nursing or Weekend Supervisor by May 16, 2014 on reviewing care guides/care plans for restraint orders to remove restraints during meals. After review of physician orders and twenty four hour report the Director of Nursing, Assistant Director of Nursing or Weekend Supervisor will update care plan and care guide for all restraint orders daily. Care guides/ Care plans will be audited for restraint updates and obserations will completed for release of restraint per physician order by Director of Nursing, Assistant Director of Nursing, or Weekend Supervisor daily times four weeks, then weekly times 4 weeks, then monthly times 4 months. The Director of Nursing or Assistant Director of Nursing will report findings from audits to QAPI Committee monthly times 6 months with revisions as necessary until otherwise determined by QAPI Committee.	

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F 282	Continued From page 8 when the resident is out of bed, release for meals, ADL ' s, and activities and as needed. " A continuous meal observation on 4/15/14 that began at 11:45 am and ended at 12:30 pm revealed Resident #3 with the lap buddy in place to the wheelchair. Resident #3 was fed by the Wound Care Nurse. In an interview on 4/15/14 at 12:30 pm, the Wound Care Nurse stated she was not aware of the residents care plans or orders. She further stated she just tried to help the residents who required assistance with meals. The Wound Care Nurse further stated she did not have time to check the residents charts before she assist them with their meal. During a continuous meal observation on 4/16/14 that began at 11:49 am and ended at 12:40 pm, Resident #3 was observed in the dining room with the lap buddy in place to the wheelchair. Resident #3 was assisted during the meal by the Dietary Manager. In an interview on 4/16/14 at 12:40 pm, the Dietary Manager stated she was not aware of the orders for the resident to have the lap buddy removed during meals. She further stated the administrative staff normally just helped to set the resident ' s trays up for them. During an interview on 4/16/14 at 5:50 pm, the Director of Nursing (DON) stated it was her expectation for the staff to remove the lap buddy from Resident #3 ' s wheelchair during meals.	F 282		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		5/16/14

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F 314	Continued From page 9 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to assess a pressure ulcer upon discovery and failed to initiate a treatment for the pressure ulcer until the pressure ulcer progressed to tunneling of the wound for 1 of 2 residents (Resident #4) reviewed for pressure ulcers. The findings included: Review of the facility ' s policy titled Standing Order for Wound Protocol " dated 3/26/14 revealed in part " Treatment order must include site, stage, cleansing agent, treatment, secondary dressing if used, frequency of change, and discontinue date if known, complete a pressure/non-pressure documentation form, notify physician/family, document all wounds and changes on the 24 hour report, telephone order must be written before initiating any wound orders. " Resident #4 was admitted to the facility on 1/7/14 with medical diagnoses which included diabetes mellitus and hypertension.	F 314	The wound of Resident # 4 was assessed by licensed nurse on April 15, 2014 and treatment orders were received from physician and initiated on April 15, 2014. All residents have the potential to be affected by the same alleged deficient practice. Licensed nurse and Director of Nursing completed 100% skin audit on April 17, 2014. No other unidentified wounds were found. The Director of Nursing completed an audit of all Treatment Administration Records and performed wound observations on all current wounds on April 18, 2014 to ensure all treatments were being followed per physician order. No other residents were found to be affected. Licensed nurse assigned to treatments was reassigned to floor on April 17, 2014. Current Wound Nurse and Weekend Supervisor were in-serviced by the DON	

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F 314	Continued From page 10 The most recent Minimum Data Set (MDS) dated 2/17/14 revealed the resident was cognitively intact. The assessment further revealed the resident was independent with bed mobility and transfers. The same assessment further indicated the resident has rejected care less than daily. The MDS assessment indicated Resident #4 was at risk for developing pressure ulcer and had a healed Stage 2 pressure ulcer on prior assessment, Review of the care plan for Resident #4 updated 2/19/14 revealed the resident was at risk for potential for skin breakdown, bruising and skin tears and pressure ulcer, excoriation related to decreased in mobility, incontinence. The goal stated for the problem was the resident will maintain or develop clean and intact skin. The care plan indicated the following interventions: provide measures to decrease pressure/irritation to skin, Geo mattress, heel protectors, and w/c cushion as indicated, keep skin clean and dry and provide for baths per schedule and as needed, change incontinent pad as soon as possible after voiding or bowel movement and provide incontinent care after episodes, apply barrier cream or protective lotion after incontinence, assist resident to turn and reposition routinely, position with pads and cushions, pillows to prevent pressure, observe skin during personal cares and notify nurse/MD of any skin issues. Review of the weekly interdisciplinary team progress notes dated 4/9/14 documented " Wound note-Stage 3 to inner buttock on scar tissue line reopened. Cleanse daily with wound cleanser and apply wet to dry dressing daily. Monitor for signs and symptoms of infection. "	F 314	on April 25, 2014 regarding wound care system to include assessing pressure ulcer upon discovery of wound, notification of MD of new orders, wound decline and verification of treatment order of wounds per TAR prior to performing treatment. Director of Nursing or Assistant Director of Nursing will perform 3 wound observations 2 times week times 4 weeks, and then weekly times 5 months to ensure correct treatment of wounds administered. Any discrepancies found will be addressed as appropriate by Director of Nursing. Director of Nursing, Assistant Director of Nursing, and Weekend Supervisor will check TAR daily times 4 weeks, then weekly times 4 weeks, and then monthly times 4 months and perform random observations 2 times week times 4 weeks, and then weekly times 5 months. Any identified concerns will be addressed immediately with physician as indicated. The Director of Nursing or Assistant Director of Nursing will report findings from audits to QAPI Committee monthly times 6 months with revisions as necessary until otherwise determined by QAPI Committee.	

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F 314	Continued From page 11 Review of the April 2014 Treatment Record revealed an order to cleanse open area to left inner buttocks near the scrotum with wound cleanser and apply wet to dry dressing daily dated 4/4/14. Further review of the same treatment record revealed an order to clean area to scrotum with normal saline; apply triple antibiotic ointment and non adherent dressing dated 4/11/14. During the wound care observation on 4/14/14 that began at 2:20 pm, the Wound Care Nurse stated to Resident #4 that she could see the new area that was reported from the weekend while pointing to an open area proximal to the second opened area to the left inner buttocks. The wound bed was pink with no drainage or odor. The Wound Care Nurse cleansed the area with wound cleanser and applied saline soaked gauze followed by dry gauze and tape. During the wound observation, the resident stated he was aware of a new area of skin breakdown to the scrotum identified over the weekend but not of a new area to the buttocks. Interview with the Wound Care Nurse at this time revealed the new area was identified over the past weekend by Nurse #1. She further indicated Nurse #1 had initiated the same treatment of wet to dry dressing for the proximal wound. The Wound Care Nurse did not have the treatment record available during the dressing change or interview. During an interview on 4/15/14 at 2:15 pm, the Wound Care Nurse stated the area to the buttocks previously identified on 4/14/14 had tunneled into one large area overnight. The resident refused to allow surveyor to do a second observation of wound care. The Wound Care Nurse stated she did not measure the new	F 314		

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pressure area identified, notify the physician or initiate a treatment on 4/14/14 when she identified the area because she thought the area had been addressed by Nurse #1 over the weekend. She stated she just continued the same treatment of wet to dry that was already in place. The Wound Care Nurse was unable to provide documentation of wound assessment or physician notification at this time.

On 4/15/14 at 3:10 pm in an interview, Nurse #1 stated she worked the weekend of 4/11/14-4/13/14 as the treatment nurse. She further indicated she did not see a new open area to the buttocks. Nurse #1 stated the area that she identified and initiated treatment for was an open area on the scrotum for Resident #4. The nurse further stated she would not have written scrotum for an area that was on the buttock.

During an interview on 4/15/14 at 5:40 pm, the Director of Nursing indicated it was her expectation for the Wound Care Nurse to follow the protocol and assess any new areas identified, notify the physician and the family. Se further indicated the nurse was expected to document her assessment in the medical record. The DON further acknowledged she had been informed of the change of the wound identified as tunneling by the Wound Care Nurse.

In an interview on 4/16/14 at 5:35 pm, after reviewing the documentation by the wound care nurse for Resident #4 dated 4/15/14, the administrator stated she expected the wound care nurse to document her assessment of the wound, measure the wound and initiate a treatment for the wound when she initially identified the wound. The administrator further

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F 314	Continued From page 13 indicated the documentation needed to accurately describe the wound.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, physician and staff interviews, the facility failed to stop providing care and return at a later time, for a resident who was resistant to care which resulted in mouth injury for 1 of 2 sampled residents reviewed for accidents (Resident #2). Findings included Resident #2 was admitted to the facility on 7/16/2013 with diagnoses of muscle weakness, edema, joint pain-ankle, altered mental status and acute kidney failure. The current Minimum Data Set (MDS) dated 2/20/2014 indicated the resident's cognitive status was severely impaired, she was total dependent on staff for bed mobility, and she needed extensive assistance using one person with dressing and personal hygiene. The MDS did not indicate any behavioral problems. Review of the care plan dated 2/25/2014 revealed the resident was not care planned for resistance to care.	F 323	Resident #2 left lower lip bruise was assessed by Assistant Director of Nursing on April 8, 2014 and orders received from attending physician for an antibiotic which started on April 8, 2014 and dseen by dentist on April 9, 2014. Care plan was updated on April 14, 2014. All residents resistive to care have the potential to be affected by the same alleged deficient practice. Residents resistant to care were identified by reviewing MDS and 24 hour report. Licensed nurse completed 100% skin audit on identified residents resistive to care on April 14, 2014. No other residents identified as resistive to care had any bruising of unknown origin. Nursing Assistants were in-serviced by Director of Nursing, Assistant Director of Nursing, or Staff Development	5/16/14

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F 323	Continued From page 14 Review of the facility's staff meeting report dated 1/13/2014 revealed the staff were in-serviced as to how to care for residents who were resistive to care. The report documented "if a resident refuse care and/ or resist care, stop let nurse know or get someone else to try if you notice a change in condition you must report to nurse immediately." During a phone interview with Nurse's Aide # 4 on 4/15/2014 at 1:40 PM, She reported she was getting ready to dress the resident at around 8:00 AM on 4/8/2014. The resident was lying in bed with eyes open. The resident resisted being dressed up by swinging her hands. She wanted to finish with dressing the resident so she pushed the resident harder towards the side rails so she could dress the resident. She added the resident must have hit her mouth on the side rails when she (Nurse's Aide # 4) was trying to dress her. She stated both side rails were up during the time she was dressing the resident and the bed was next to the wall. Nurse's Aide # 4 further added she did not stop dressing the resident when she was resisting being dressed. She further added that she had been trained to stop providing care when the resident is resistive to care and notify the nurse then come back later. Nurse's Aide # 4 also reported that she did not have the reason as to why she did not tell a nurse and stop dressing the resident when the resident was resisting being dressed. She further stated the blood on the wall must have come from the resident's mouth and once she left the room the resident must have spit the blood on the wall. The bed was next to the wall. Nurse ' s Aide # 4 further reported she was aware before 4/8/2014 that the resident was resistive to being dressed in the	F 323	Coordinator on turning and repositioning and on providing care of residents who become resistive to care by stopping and returning at a later time and report to nurse. In-services began on April 9, 2014 and were completed on April 15 2014. Care plans and care guides for residents resistive to care will be updated as needed in daily clinical meeting by the Interdisciplinary Team Monday through Friday. Residents who become resistive to care on weekends will be evaluated by IDT on Monday as identified by the Director of Nursing from review of 24 hour report. Random observations of care being provided to residents identified as resistive to care will be completed 3 times a week times 4 weeks , then 2 times a week times 3 months by the Director of Nursing, Assistant Director of Nursing or RN Supervisor. Any identified concerns will be addressed immediately with attending physician as indicated. The Director of Nursing or Assistant Direcotr of Nursing will report findings from random observations to QAPI Committee monthly times 4 months with revisions as necessary.	

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morning but she could not explain why she did not stop dressing the resident on 4/8/2014.The Nurse's Aide # 4 reported that she was not aware that the resident had been injured when she left the resident ' s room.

Review of a written statement by Nurse's Aide # 1 as part of the facility investigation dated 4/8/2014 documented "was passing out tray, resident up on edge of bed can't remember if rail was up or down. Pants were partially up. Nurse's Aide # 2 passing by summoned to assist her (Resident # 2) to chair. Nurse's Aide # 2 came in and was in the process of transferring Resident # 2 to chair. Nurse's Aide # 2 noticed blood. It was bright red blood on the wall. Nurse's Aide # 2 went to get Nurse # 1."

Review of a written statement by Nurse # 1 as part of the facility's investigation dated 4/10/2014 documented " Resident was laying on her right side closer to the side rail. Nurse # 1 noted blood on wall, right side rails (rail was up) and sheet. Bed was pulled back and blood was noted on floor. When Nurse # 1 entered Resident # 2's room, the resident was laying on right side. "

During the interview with Nurse's Aide # 2 on 4/16/2014 at 11:00 AM, she reported that on 4/8/2014 at 8:30 AM, she was passing out trays. Resident # 2 was sitting on the side of bed. She and Nurse ' s Aide # 1 were passing trays. She and Nurse's Aide # 1 noticed blood on Resident # 2's wall and on the bed sheets. She left the room and asked Nurse # 1 to check the resident to see where the blood was coming from. She (Nurse's Aide #2) asked Nurse's Aide # 4 to come to the resident ' s room and showed her the blood on the wall.

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F 323	Continued From page 16 During the phone interview with Nurse's Aide # 5 on 4/16/2014 at 11:30 AM, She stated that she fed the resident on 4/8/2014 at 8:30 AM. She noticed stain on the wall which looked burgundy in color. She remembered it appeared like someone had tried to wipe it from the wall. The Nurse's Aide # 5 further reported it was her first time working with the resident. The resident was quite and did not eat much at all. She did not report the stain to anyone but just went on to feed another resident. During the interview with Nurse # 1 on 4/16/2014 at 10: 00 AM, She reported Nurse's Aide # 1 approached her at around 8: 30 AM on 4/8/2014 to report that Resident # 2 had blood on her wall. She checked on the resident. There was no bleeding noted on the resident ' s mouth. Nurse # 1 stated she saw the blood on the wall which was bright red in color splattered on the wall. Nurse # 1 added blood was noted on the resident's sheet on right side of bed and small clot in it. She asked her assigned nurse to check the resident as well. During the interview with Nurse # 2 on 4/16/2014 at 10:40 AM, she reported Nurse # 1 called her around 9:00 AM on 4/8/2014 to Resident # 2's room. She observed blood on the wall. She then asked the resident to open her mouth and she did not notice blood or anything in the resident ' s mouth Grievance report dated 4/8/2014 documented "family member (2nd contact) voiced concern in reference to a bruise to her mom ' s left corner lower lip. She stated "someone has hit her or something " also states "there is blood on the floor to right side of the bed sheet and wall."	F 323		

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F 323	Continued From page 17 Nurse's note written by Assistant Director of Nursing (ADON,) dated 4/8/2014 at 5:00 PM documented " Resident noted with discoloration to left side of bottom lip. Swelling noted upon inspection of mouth, inside of lip noted with discoloration and swelling. area is warm to touch. Resident does not open mouth completely on command. 2nd contact (family member) present in room. Voicing concerns Re: area, states wasn ' t present on day before. Resident does mimace when area palpated. Informed 2nd contact would follow up and notify 1st contact (family member) of findings. " Review of the dentist report dated 4/9/2014 documented "Resident was seen for a dental examination on 4/9/2014 due to chief complaint of lower left swelling and bruising outside the lip and cheek area in the lower left region. A large bruise measuring 4.4 cm (Centimeter) X 2.5cm was present extended below the lower left lip region on the exterior face. Inside the mouth a small laceration was noted (6 cm X 6 cm). In my professional opinion the lesion may have been the result of blunt force trauma causing the tissue to contact the edges of her teeth resulting in laceration, swelling and bruising. An odontogenic (tooth) infection would not present in this manner or travel in this pathway. Close monitoring, antibiotics therapy and a 7 day follow up evaluation is recommended. " During the interview with Resident # 2's Doctor on 4/16/2014 at 2:00 PM, he stated he saw the resident on 4/9/2014. The resident had a left lower lip bruise. He added that he could not explain how the resident got the bruise	F 323		

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F 323	Continued From page 18 Observation of the resident on 4/16/2014 at 9:30 AM revealed the resident sitting in her wheel chair in front of the nurse's station. The resident was calm and pleasant. A slight sign of bruising was noted on the left lip. Resident # 2's care plan last updated 4/16/2014 indicated the resident was " resistive with Activity of Daily Living (ADL) care and the resident becomes combative towards staff during ADL care trying to hit the staff, spits at the staff. " The goal was " have all needs anticipated and met without incident/injury through next review. " The Approach for this problem was " approach with a calm and quiet demeanor, monitor and document behaviors, do not argue with resident and when resident becomes combative/ resistive , leave resident safely in wheelchair or bed , and reproach when she as calmed down. " During the interview with Assistant Director of Nurse (ADON) on 4/16/2014 at 3:00 PM, She stated the family approached her on 4/8/2014 at around 5: 00 PM stating there was blood on resident's mouth, wall and the bed rail. She (ADON) went to investigate and she saw the blood on the resident ' s wall, side rails and shirt. She (ADON) also observed a bruise on the resident mouth and began an investigation. She concluded that Nurse's Aide # 4 was dressing the resident and she (Resident #2) was resistive to care and Nurse's aide # 4 continued to dress the resident anyway. The side rails were up. ADON further reported Nurse's Aide # 4 did not report the incident to any staff at the facility. ADON added the resident was resistive to care and got bruised due to improper repositioning technique by Nurse's Aide # 4. . Nurse's Aide # 4 was	F 323		

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F 323	Continued From page 19 suspended and 24 hour report was completed and faxed timely to the state agency. The ADON also reported her expectation of the staff was when a resident is resistive to care, the staff was to leave the room and notify the nurse then come later to the resident ' s room. She added that no staff reported to her that there was blood on the resident's wall on 4/8/2014. The blood had been on the wall starting at around 8:00 AM until at 5PM when the family member reported that they saw the blood on the resident's mouth, wall and side rails. During the interview with Director of Nursing (DON) on 4/16/2014 at 4:00 PM, She reported her expectation of the staff when a resident was resistive to care was to stop providing care and report the incident to the nurse. DON added the staff may go back to the resident ' s room later to try to give care. She (DON) also added all the staff at the facility was trained that if they do not stop providing care when the resident is restive to care, they may injure the resident which would be abuse.	F 323		