STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 06/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Division of Health Service Regulation conducted a complaint investigation survey on 05/27/2014 through 05/30/2014. Telephone interviews were conducted on 06/04/2014. Therefore, the survey exit date was changed to 06/04/2014.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, facility staff interviews, and record reviews the facility failed to ensure adequate maintenance services were preformed to ensure a safe, orderly, and comfortable interior for 3 of 3 resident halls (100, 200, and 300). The findings included: A) On 05/27/2014 at 9:55 a.m. an initial tour of the facility was conducted. During the tour the following areas were observed to be in need of repair: The resident common shower room by 200 hall nursing station - the toilet was loose on floor mount and could be easily moved 2-3 inches in either direction side to side when light pressure was placed on the toilet. The light in the shower stall next to the toilet/sink area was not operational and would not come on when the switch was turned on. On 05/28/2014 at 3:17 p.m. a 2nd observation	F 253	A.The toilets in the 200 hall shower room was repaired at the time of survey. The light bulb in the 200 hall shower room was replaced at the time of survey. B. The loose toilet in the 100 hall shower room was repaired at the time of the survey. The ceramic tile in the 100 hall shower room will be repaired by an outside contractor. C. The faucet in the 300 hall nourishment room will be repaired by facility maintenance staff. D. The toilet in therapy ADL bathroom will be repaired by facility maintenance staff. The grab bar in the therapy ADL bathroom will be repaired by facility maintenance staff.	7/2/14

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

Electronically Signed

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F 253	Continued From page 1 was made of the 200 hall's resident common shower room. The toilet was still loose on floor mount and could be easily moved and the light in the shower stall next to the toilet/sink area still would not come on when the switch was turned on. On 05/29/2014 at 10:40 a.m. a 3rd observation was made of the 200 hall's resident common shower room. The toilet was still loose on floor mount and could be easily moved and the light in the shower stall next to the toilet/sink area still would not come on when the switch was turned on. On 05/29/2014 at 11:00 a.m. and interview and record review was conducted with the facility's maintenance director. The maintenance director indicated he still had not had a chance to fix things as he had only been at the facility for four weeks. The maintenance director indicated it was his goal to put maintenance request information into the facility's computer system but he hadn't had time to get anything in yet. The maintenance director also indicated he was not very familiar with the program as he had not used it until coming to this facility and the staff had not been thoroughly trained to use the program yet and were not putting in electronic work orders yet. The maintenance director indicated there were 3 ways he and or his assistant were notified of maintenance repair/replacement work requested and needing to be done: 1) Housekeeping staff would keep notes on their daily sheets and turn them in daily to maintenance. 2) By word of mouth, staff would stop the	F 253	E. The headboard and foot board for the resident in room 306 will be repaired by facility maintenance staff. The walls behind the B bed in room 306 will be repaired by facility maintenance staff. F. The headboard in room 228A will be repaired by facility maintenance staff. G. Facility maintenance staff will repair the drawer handles on the night stand in room 304B H. Facility maintenance staff will repair the drawer handle on the nightstand in room 305A. Facility maintenance staff will conduct a full audit of all resident rooms and resident care areas and identify any lights, toilets, headboards, faucets, footboards, blinds, ceramic tiles, walls, grab bars, and nightstands in need of repair. All items identified to be in need of repair will be entered into the facilities electronic work order system. Facility maintenance staff with make identified repairs and sign them off as complete in the facility's electronic work order system. Facility administrative and nursing staff will be trained on identifying head boards, footboards, faucets, blinds, ceramic tile, walls, toilets, lights, grab bars and nightstands in need of repair and how to enter work orders for needed repairs into	

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F 253	Continued From page 2 maintenance director or his assistant in hallway and they would write down the information concerning the needed repairs/replacements. 3) The maintenance director indicated the facility's staff having access to the facility's computer system had access to the software program to electronically place work order requests in the system. The maintenance director indicated that when the facility's staff observed, or were told about a maintenance issue requiring repair or replacement etc. they were to enter the information into the computer program and this became the electronic work order. The maintenance director indicated he could access the program and see what needed to be repaired or replaced on a daily basis. A request to review all outstanding work orders (in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's work order software program and four completed work orders. A review of the electronic work orders indicated there was one uncompleted/deferred work order for the facility's kitchen listed. There were four completed work orders listed. The maintenance director indicated he had no paper maintenance work order requests or other documentation to show he or his staff had been notified of any items needing repair or replacement. The Maintenance manager indicated he had some notes in a notebook for some items however he could not produce any type of notebook or other written documentation to show he had a list of facility maintenance issues/items needing repair or replacement. The maintenance director indicated he kept a lot of the information in his head but it	F 253	the facility's electronic work order system as needed repairs are identified. Housekeeping staff will be trained in identifying head boards, footboards, faucets, blinds, ceramic tile, walls, lights, toilets, grab bars and nightstands in need of repair and will continue to note the need for any repairs on their daily sheets Maintenance director will review the notes from the housekeepers daily sheets ongoing, and enter any repairs noted on the daily sheets in the facility's electronic work order system. Facility maintenance staff with make identified repairs and sign them off as complete in the facility's electronic work order system ongoing. Administrative staff will complete rounds audits three times weekly identifying any headboard, footboard, grab bar, toilets, faucets, blinds, walls, lights, ceramic tile, and nightstands in need of repair . A QI rounds tool will be utilized. Maintenance director will review rounds tools three times weeks to ensure any item identified on administrative rounds have been entered in the facility's electronic work order system. All rounds tools and a report of completed and open work orders will be reviewed by the Quality Committee Monthly.	

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F 253	Continued From page 3 was not written down anywhere. On 05/30/2014 at 11:50 a.m. an interview was conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there were more work orders found in the facilities work order software program by his regional maintenance manager. A review of the electronic work orders was conducted with the facility's maintenance director and his regional maintenance manager. The regional maintenance manager pulled up the facility's work order software program to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The maintenance director indicated there was no other place any work order information was stored to show they were aware of any of the current items identified that needed repair or replacement. On 05/30/2014 at 11:55 a.m. a tour of the facility, specifically looking at the items noted and identified above was conducted with the facility's maintenance director and his regional maintenance manager. The tour observation identified of all of the items previously identified and noted above. The facility's maintenance director indicated the items observed/noted above were not documented on the facility's electronic work order software program or any other place and he did not have any other documentation to show the items had been identified as needing repair or replacement. B) On 05/27/2014 at 9:55 a.m. an initial tour of the facility was conducted. During the tour the following areas were observed to be in need of	F 253		

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F 253	Continued From page 4 repair: The resident common shower room by 100 hall nursing station - the toilet was loose on floor mount and could be easily moved 1- 2 inches rocking front to back and 1 - 2 inches side to side in either direction when light pressure was placed on the toilet. Six (6) ceramic tiles were observed to be broken/missing on the wall just above the floor between the shower stall and tub area. Additional ceramic tiles were observed to be broken on the adjacent shower stall wall just above the floor. On 05/28/2014 at 3:20 p.m. a 2nd observation was made of the 100 hall's resident common shower room. The toilet was loose on floor mount, the six (6) ceramic tiles were still missing and the additional ceramic tiles by the adjacent shower stall were still broken. On 05/29/2014 at 10:43 a.m. a 3rd observation was made of the 100 hall's resident common shower room. The toilet was loose on floor mount, the six (6) ceramic tiles were still missing and the additional ceramic tiles by the adjacent shower stall were still broken. On 05/29/2014 at 11:00 a.m. and interview and record review was conducted with the facility's maintenance director. The maintenance director indicated he still had not had a chance to fix things as he had only been at the facility for four weeks. The maintenance director indicated it was his goal to put maintenance request information into the facility's computer system but he hadn't had time to get anything in yet. The maintenance director also indicated he was not very familiar with the program as he had not used it until coming to this facility and the staff had not	F 253		

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been thoroughly trained to use the program yet and were not putting in electronic work orders yet. The maintenance director indicated there were 3 ways he and or his assistant were notified of maintenance repair/replacement work requested and needing to be done:

1) Housekeeping staff would keep notes on their daily sheets and turn them in daily to maintenance.

2) By word of mouth, staff would stop the maintenance director or his assistant in hallway and they would write down the information concerning the needed repairs/replacements.

3) The maintenance director indicated the facility's staff having access to the facility's computer system had access to the software program to electronically place work order requests in the system. The maintenance director indicated that when the facility's staff observed, or were told about a maintenance issue requiring repair or replacement etc. they were to enter the information into the computer program and this became the electronic work order. The maintenance director indicated he could access the program and see what needed to be repaired or replaced on a daily basis.

A request to review all outstanding work orders (in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's work order software program and four completed work orders. A review of the electronic work orders indicated there was one uncompleted/deferred work order for the facility's kitchen listed. There were four completed work

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orders listed. The maintenance director indicated he had no paper maintenance work order requests or other documentation to show he or his staff had been notified of any items needing repair or replacement. The Maintenance manager indicated he had some notes in a notebook for some items however he could not produce any type of notebook or other written documentation to show he had a list of facility maintenance issues/items needing repair or replacement. The maintenance director indicated he kept a lot of the information in his head but it was not written down anywhere.

On 05/30/2014 at 11:50 a.m. an interview was conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there were more work orders found in the facilities work order software program by his regional maintenance manager. A review of the electronic work orders was conducted with the facility's maintenance director and his regional maintenance manager. The regional maintenance manager pulled up the facility's work order software program to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The maintenance director indicated there was no other place any work order information was stored to show they were aware of any of the current items identified that needed repair or replacement.

On 05/30/2014 at 11:55 a.m. a tour of the facility, specifically looking at the items noted and identified above was conducted with the facility's maintenance director and his regional maintenance manager. The tour observation

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identified of all of the items previously identified and noted above. The facility's maintenance director indicated the items observed/noted above were not documented on the facility's electronic work order software program or any other place and he did not have any other documentation to show the items had been identified as needing repair or replacement.

C) On 05/27/2014 at 9:55 a.m. an initial tour of the facility was conducted. During the tour the following areas were observed to be in need of repair:
The nourishment room across from the 300 hall nurse's station - the sink's faucet had water continuously dripping/running from the faucet. An attempt to turn off the water was made. The faucet would not shut off the dripping/running water.

On 05/28/2014 at 3:23 p.m. a 2nd observation was made of the sink in the nourishment room across from the 300 hall's nursing station. The water was still dripping/running from the faucet and the faucet would not turn the water off.

On 05/29/2014 at 10:48 a.m. a 3rd observation was made of the sink in the nourishment room across from the 300 hall's nursing station. The water was still dripping/running from the faucet and the faucet would not turn the water off.

On 05/29/2014 at 11:00 a.m. and interview and record review was conducted with the facility's maintenance director. The maintenance director indicated he still had not had a chance to fix things as he had only been at the facility for four weeks. The maintenance director indicated it was his goal to put maintenance request

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information into the facility's computer system but he hadn't had time to get anything in yet. The maintenance director also indicated he was not very familiar with the program as he had not used it until coming to this facility and the staff had not been thoroughly trained to use the program yet and were not putting in electronic work orders yet. The maintenance director indicated there were 3 ways he and or his assistant were notified of maintenance repair/replacement work requested and needing to be done:

1) Housekeeping staff would keep notes on their daily sheets and turn them in daily to maintenance.

2) By word of mouth, staff would stop the maintenance director or his assistant in hallway and they would write down the information concerning the needed repairs/replacements.

3) The maintenance director indicated the facility's staff having access to the facility's computer system had access to the software program to electronically place work order requests in the system. The maintenance director indicated that when the facility's staff observed, or were told about a maintenance issue requiring repair or replacement etc. they were to enter the information into the computer program and this became the electronic work order. The maintenance director indicated he could access the program and see what needed to be repaired or replaced on a daily basis.

A request to review all outstanding work orders (in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's

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F 253	Continued From page 9 work order software program and four completed work orders. A review of the electronic work orders indicated there was one uncompleted/deferred work order for the facility's kitchen listed. There were four completed work orders listed. The maintenance director indicated he had no paper maintenance work order requests or other documentation to show he or his staff had been notified of any items needing repair or replacement. The Maintenance manager indicated he had some notes in a notebook for some items however he could not produce any type of notebook or other written documentation to show he had a list of facility maintenance issues/items needing repair or replacement. The maintenance director indicated he kept a lot of the information in his head but it was not written down anywhere. On 05/30/2014 at 11:50 a.m. an interview was conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there were more work orders found in the facilities work order software program by his regional maintenance manager. A review of the electronic work orders was conducted with the facility's maintenance director and his regional maintenance manager. The regional maintenance manager pulled up the facility's work order software program to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The maintenance director indicated there was no other place any work order information was stored to show they were aware of any of the current items identified that needed repair or replacement.	F 253		

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F 253	Continued From page 10 On 05/30/2014 at 11:55 a.m. a tour of the facility, specifically looking at the items noted and identified above was conducted with the facility's maintenance director and his regional maintenance manager. The tour observation identified of all of the items previously identified and noted above. The facility's maintenance director indicated the items observed/noted above were not documented in the facility's electronic work order software program or any other place and he did not have any other documentation to show the items had been identified as needing repair or replacement. D) On 05/27/2014 at 9:55 a.m. an initial tour of the facility was conducted. During the tour the following areas were observed to be in need of repair: The physical therapy department's resident training and activities of daily living (ADL) bathroom used by residents during physical and occupational therapy - the toilet was loose on floor mount and easily moved 2-3 inches in either direction when light pressure was placed on the toilet. The lower grab bar next to the toilet in the physical therapy departments ADL bath room was observed to have the mounting screws loose causing the grab bar to be loose on the wall mount and could easily be moved 1-2 inches up and down. On 05/28/2014 at 4:45 p.m. a 2nd observation was made of the physical therapy department's resident training and activities of daily living (ADL) bathroom. The toilet was still loose on the floor and the grab bar was still loose on the wall. On 05/29/2014 at 10:55 a.m. a 3rd observation was made of the physical therapy department's	F 253		

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resident training and activities of daily living (ADL) bathroom. The toilet was still loose on the floor and the grab bar was still loose on the wall.

On 05/29/2014 at 11:00 a.m. and interview and record review was conducted with the facility's maintenance director. The maintenance director indicated he still had not had a chance to fix things as he had only been at the facility for four weeks. The maintenance director indicated it was his goal to put maintenance request information into the facility's computer system but he hadn't had time to get anything in yet. The maintenance director also indicated he was not very familiar with the program as he had not used it until coming to this facility and the staff had not been thoroughly trained to use the program yet and were not putting in electronic work orders yet. The maintenance director indicated there were 3 ways he and or his assistant were notified of maintenance repair/replacement work requested and needing to be done:

1) Housekeeping staff would keep notes on their daily sheets and turn them in daily to maintenance.

2) By word of mouth, staff would stop the maintenance director or his assistant in hallway and they would write down the information concerning the needed repairs/replacements.

3) The maintenance director indicated the facility's staff having access to the facility's computer system had access to the software program to electronically place work order requests in the system. The maintenance director indicated that when the facility's staff observed, or were told about a maintenance

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issue requiring repair or replacement etc. they were to enter the information into the computer program and this became the electronic work order. The maintenance director indicated he could access the program and see what needed to be repaired or replaced on a daily basis.

A request to review all outstanding work orders (in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's work order software program and four completed work orders. A review of the electronic work orders indicated there was one uncompleted/deferred work order for the facility's kitchen listed. There were four completed work orders listed. The maintenance director indicated he had no paper maintenance work order requests or other documentation to show he or his staff had been notified of any items needing repair or replacement. The Maintenance manager indicated he had some notes in a notebook for some items however he could not produce any type of notebook or other written documentation to show he had a list of facility maintenance issues/items needing repair or replacement. The maintenance director indicated he kept a lot of the information in his head but it was not written down anywhere.

On 05/30/2014 at 11:50 a.m. an interview was conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there were more work orders found in the facilities work order software program by his regional maintenance manager. A review of the electronic work orders was conducted with the facility's maintenance director and his regional

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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maintenance manager. The regional maintenance manager pulled up the facility's work order software program to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The maintenance director indicated there was no other place any work order information was stored to show they were aware of any of the current items identified that needed repair or replacement.

On 05/30/2014 at 11:55 a.m. a tour of the facility, specifically looking at the items noted and identified above was conducted with the facility's maintenance director and his regional maintenance manager. The tour observation identified of all of the items previously identified and noted above. The facility's maintenance director indicated the items observed/noted above were not documented on the facility's electronic work order software program or any other place and he did not have any other documentation to show the items had been identified as needing repair or replacement.

E) On 05/27/2014 at 4:30 p.m. an observation of the headboard and footboard of the resident's bed in room 306B was observed to be loose on the bed frame and could be easily moved back and forth 5-6 inches. The wall behind the B bed was observed to have the sheetrock cracked and broken off the wall in a 1 foot x 1 foot area. The window blinds in room 306 were observed to be broken/bent and would not close allowing viewing access from the street into the resident ' s room.

On 05/28/2014 at 4:30 p.m. a 2nd observation was made of the headboard and footboard of the bed in room 306B. The headboard and

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F 253	Continued From page 14 footboards were observed to still be loose on the bed frame. The wall behind the B bed still had the sheetrock cracked and broken off the wall and the window blinds were still broken/bent and would not close allowing viewing access from the street into the resident's room. On 05/29/2014 at 10:30 a.m. a 3rd observation was made of the headboard and footboard of the bed in room 306B. The headboard and footboards were observed to still be loose on the bed frame. The wall behind the B bed still had the sheetrock cracked and broken off the wall and the window blinds were still broken/bent and would not close allowing viewing access from the street into the resident's room. On 05/29/2014 at 11:00 a.m. and interview and record review was conducted with the facility's maintenance director. The maintenance director indicated he still had not had a chance to fix things as he had only been at the facility for four weeks. The maintenance director indicated it was his goal to put maintenance request information into the facility's computer system but he hadn't had time to get anything in yet. The maintenance director also indicated he was not very familiar with the program as he had not used it until coming to this facility and the staff had not been thoroughly trained to use the program yet and were not putting in electronic work orders yet. The maintenance director indicated there were 3 ways he and or his assistant were notified of maintenance repair/replacement work requested and needing to be done: 1) Housekeeping staff would keep notes on their daily sheets and turn them in daily to maintenance.	F 253		

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2) By word of mouth, staff would stop the maintenance director or his assistant in hallway and they would write down the information concerning the needed repairs/replacements.

3) The maintenance director indicated the facility's staff having access to the facility's computer system had access to the software program to electronically place work order requests in the system. The maintenance director indicated that when the facility's staff observed, or were told about a maintenance issue requiring repair or replacement etc. they were to enter the information into the computer program and this became the electronic work order. The maintenance director indicated he could access the program and see what needed to be repaired or replaced on a daily basis.

A request to review all outstanding work orders (in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's work order softwareprogram and four completed work orders. A review of the electronic work orders indicated there was one uncompleted/deferred work order for the facility's kitchen listed. There were four completed work orders listed. The maintenance director indicated he had no paper maintenance work order requests or other documentation to show he or his staff had been notified of any items needing repair or replacement. The Maintenance manager indicated he had some notes in a notebook for some items however he could not produce any type of notebook or other written documentation to show he had a list of facility maintenance issues/items needing repair or

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replacement. The maintenance director indicated he kept a lot of the information in his head but it was not written down anywhere.

On 05/30/2014 at 11:50 a.m. an interview was conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there were more work orders found in the facilities work order software program by his regional maintenance manager. A review of the electronic work orders was conducted with the facility's maintenance director and his regional maintenance manager. The regional maintenance manager pulled up the facility's work order software program to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The maintenance director indicated there was no other place any work order information was stored to show they were aware of any of the current items identified that needed repair or replacement.

On 05/30/2014 at 11:55 a.m. a tour of the facility, specifically looking at the items noted and identified above was conducted with the facility's maintenance director and his regional maintenance manager. The tour observation identified of all of the items previously identified and noted above. The facility's maintenance director indicated the items observed/noted above were not documented on the facility's electronic work order software program or any other place and he did not have any other documentation to show the items had been identified as needing repair or replacement.

F) On 05/28/2014 at 9:07 a.m. an observation

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F 253	Continued From page 17 was made of the headboard being loose on bed frame in room 228A. On 05/29/2014 at 4:33 p.m. a 2nd observation was made of the bed in 228A. The headboard was still loose on the bed frame. On 05/30/2014 at 10:25 a.m. a 2nd observation was made of the bed in 228A. The headboard was still loose on the bed frame. On 05/29/2014 at 11:00 a.m. and interview and record review was conducted with the facility's maintenance director. The maintenance director indicated he still had not had a chance to fix things as he had only been at the facility for four weeks. The maintenance director indicated it was his goal to put maintenance request information into the facility's computer system but he hadn't had time to get anything in yet. The maintenance director also indicated he was not very familiar with the program as he had not used it until coming to this facility and the staff had not been thoroughly trained to use the program yet and were not putting in electronic work orders yet. The maintenance director indicated there were 3 ways he and or his assistant were notified of maintenance repair/replacement work requested and needing to be done: 1) Housekeeping staff would keep notes on their daily sheets and turn them in daily to maintenance. 2) By word of mouth, staff would stop the maintenance director or his assistant in hallway and they would write down the information concerning the needed repairs/replacements.	F 253		

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F 253	Continued From page 18 3) The maintenance director indicated the facility's staff having access to the facility's computer system had access to the software program to electronically place work order requests in the system. The maintenance director indicated that when the facility's staff observed, or were told about a maintenance issue requiring repair or replacement etc. they were to enter the information into the computer program and this became the electronic work order. The maintenance director indicated he could access the program and see what needed to be repaired or replaced on a daily basis. A request to review all outstanding work orders (in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's work order software program and four completed work orders. A review of the electronic work orders indicated there was one uncompleted/deferred work order for the facility's kitchen listed. There were four completed work orders listed. The maintenance director indicated he had no paper maintenance work order requests or other documentation to show he or his staff had been notified of any items needing repair or replacement. The Maintenance manager indicated he had some notes in a notebook for some items however he could not produce any type of notebook or other written documentation to show he had a list of facility maintenance issues/items needing repair or replacement. The maintenance director indicated he kept a lot of the information in his head but it was not written down anywhere. On 05/30/2014 at 11:50 a.m. an interview was conducted with the facility's maintenance director	F 253		

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and his regional maintenance manager. The facility's maintenance director indicated there were more work orders found in the facilities work order software program by his regional maintenance manager. A review of the electronic work orders was conducted with the facility's maintenance director and his regional maintenance manager. The regional maintenance manager pulled up the facility's work order software program to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The maintenance director indicated there was no other place any work order information was stored to show they were aware of any of the current items identified that needed repair or replacement.

On 05/30/2014 at 11:55 a.m. a tour of the facility, specifically looking at the items noted and identified above was conducted with the facility's maintenance director and his regional maintenance manager. The tour observation identified of all of the items previously identified and noted above. The facility's maintenance director indicated the items observed/noted above were not documented on the facility's electronic work order software program or any other place and he did not have any other documentation to show the items had been identified as needing repair or replacement.

G) On 05/28/2014 at 9:39 a.m. an observation was made in room 304B. The resident's nightstand and hutch assembly was observed to have two (2) missing drawer handles on nightstand. A drawer handle without screws was observed sitting on the top of the nightstand.

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F 253	Continued From page 20 On 05/28/2014 at 3:30 p.m. a 2nd observation was made of the nightstand and hutch assembly in room 304B. The drawer handles were still missing and the handle with out screws was still on the night stand. On 05/29/2014 at 10:34 a.m. a 3rd observation was made of the nightstand and hutch assembly in room 304B. The drawer handles were still missing and the handle with out screws was still on the night stand. On 05/29/2014 at 11:00 a.m. and interview and record review was conducted with the facility's maintenance director. The maintenance director indicated he still had not had a chance to fix things as he had only been at the facility for four weeks. The maintenance director indicated it was his goal to put maintenance request information into the facility's computer system but he hadn't had time to get anything in yet. The maintenance director also indicated he was not very familiar with the program as he had not used it until coming to this facility and the staff had not been thoroughly trained to use the program yet and were not putting in electronic work orders yet. The maintenance director indicated there were 3 ways he and or his assistant were notified of maintenance repair/replacement work requested and needing to be done: 1) Housekeeping staff would keep notes on their daily sheets and turn them in daily to maintenance. 2) By word of mouth, staff would stop the maintenance director or his assistant in hallway and they would write down the information concerning the needed repairs/replacements.	F 253		

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F 253	Continued From page 21 3) The maintenance director indicated the facility's staff having access to the facility's computer system had access to the software program to electronically place work order requests in the system. The maintenance director indicated that when the facility's staff observed, or were told about a maintenance issue requiring repair or replacement etc. they were to enter the information into the computer program and this became the electronic work order. The maintenance director indicated he could access the program and see what needed to be repaired or replaced on a daily basis. A request to review all outstanding work orders (in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's work order software program and four completed work orders. A review of the electronic work orders indicated there was one uncompleted/deferred work order for the facility's kitchen listed. There were four completed work orders listed. The maintenance director indicated he had no paper maintenance work order requests or other documentation to show he or his staff had been notified of any items needing repair or replacement. The Maintenance manager indicated he had some notes in a notebook for some items however he could not produce any type of notebook or other written documentation to show he had a list of facility maintenance issues/items needing repair or replacement. The maintenance director indicated he kept a lot of the information in his head but it was not written down anywhere. On 05/30/2014 at 11:50 a.m. an interview was	F 253		

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F 253	Continued From page 22 conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there were more work orders found in the facilities work order software program by his regional maintenance manager. A review of the electronic work orders was conducted with the facility's maintenance director and his regional maintenance manager. The regional maintenance manager pulled up the facility's work order software program to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The maintenance director indicated there was no other place any work order information was stored to show they were aware of any of the current items identified that needed repair or replacement. On 05/30/2014 at 11:55 a.m. a tour of the facility, specifically looking at the items noted and identified above was conducted with the facility's maintenance director and his regional maintenance manager. The tour observation identified of all of the items previously identified and noted above. The facility's maintenance director indicated the items observed/noted above were not documented on the facility's electronic work order software program or any other place and he did not have any other documentation to show the items had been identified as needing repair or replacement. H) On 05/28/2014 at 9:40 a.m. an observation was made of resident room 305A. The top drawer handle of the resident's dresser was observed to be hanging down 90 degrees. The handle was observed to only have 1 screw (loose) holding the handle to the drawer.	F 253		

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F 253	Continued From page 23 On 05/28/2014 at 4:35 p.m. a 2nd observation was made of resident room 305A. The top drawer handle of the resident's dresser was observed to still be hanging down 90 degrees and still only having 1 screw holding the handle to the drawer. On 05/29/2014 at 10:33 a.m. a 3rd observation was made of resident room 305A. The top drawer handle of the resident's dresser was observed to still be hanging down 90 degrees and still only having 1 screw holding the handle to the drawer. On 05/29/2014 at 11:00 a.m. and interview and record review was conducted with the facility's maintenance director. The maintenance director indicated he still had not had a chance to fix things as he had only been at the facility for four weeks. The maintenance director indicated it was his goal to put maintenance request information into the facility's computer system but he hadn't had time to get anything in yet. The maintenance director also indicated he was not very familiar with the program as he had not used it until coming to this facility and the staff had not been thoroughly trained to use the program yet and were not putting in electronic work orders yet. The maintenance director indicated there were 3 ways he and or his assistant were notified of maintenance repair/replacement work requested and needing to be done: 1) Housekeeping staff would keep notes on their daily sheets and turn them in daily to maintenance.	F 253		

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F 253	Continued From page 24 2) By word of mouth, staff would stop the maintenance director or his assistant in hallway and they would write down the information concerning the needed repairs/replacements. 3) The maintenance director indicated the facility's staff having access to the facility's computer system had access to the software program to electronically place work order requests in the system. The maintenance director indicated that when the facility's staff observed, or were told about a maintenance issue requiring repair or replacement etc. they were to enter the information into the computer program and this became the electronic work order. The maintenance director indicated he could access the program and see what needed to be repaired or replaced on a daily basis. A request to review all outstanding work orders (in any fashion - electronic, notes etc.) was made. The maintenance director indicated there was only one uncompleted work order in the facility's work order software program and four completed work orders. A review of the electronic work orders indicated there was one uncompleted/deferred work order for the facility's kitchen listed. There were four completed work orders listed. The maintenance director indicated he had no paper maintenance work order requests or other documentation to show he or his staff had been notified of any items needing repair or replacement. The Maintenance manager indicated he had some notes in a notebook for some items however he could not produce any type of notebook or other written documentation to show he had a list of facility maintenance issues/items needing repair or replacement. The maintenance director indicated	F 253		

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F 253	Continued From page 25 he kept a lot of the information in his head but it was not written down anywhere. On 05/30/2014 at 11:50 a.m. an interview was conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there were more work orders found in the facilities work order software program by his regional maintenance manager. A review of the electronic work orders was conducted with the facility's maintenance director and his regional maintenance manager. The regional maintenance manager pulled up the facility's work order software program to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The maintenance director indicated there was no other place any work order information was stored to show they were aware of any of the current items identified that needed repair or replacement. On 05/30/2014 at 11:55 a.m. a tour of the facility, specifically looking at the items noted and identified above was conducted with the facility's maintenance director and his regional maintenance manager. The tour observation identified of all of the items previously identified and noted above. The facility's maintenance director indicated the items observed/noted above were not documented on the facility's electronic work order software program or any other place and he did not have any other documentation to show the items had been identified as needing repair or replacement.	F 253		
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		7/2/14

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F 278	Continued From page 26 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately assess and include the active diagnosis of Psychosis for the use of psychotropic medication identified in the facility comprehensive assessments tool the Minimum Data Set (MDS) for 3 of 5 residents (Resident #40, Resident #152, Resident #21) reviewed for	F 278	The facility will ensure that any resident assessment accurately reflects the resident's status. Facility MDS nurse reviewed the most recent MDS for resident #152, resident #40, and resident #21. Facility MDS nurse	

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F 278	Continued From page 27 unnecessary medication usage. Findings Included: 1) Resident #40 was admitted to the facility on 6/14/2013. A record review of the facility most recent MDS for Resident #40 coded an annual [comprehensive] assessment dated 5/23/2014 did not include the active diagnosis of Psychosis or Anxiety in Section I Active Diagnosis. Section N for medications received included the use of an Antipsychotic, Antianxiety, and Antidepressant for 7 days of the 7 day look back period. Physician Orders for Resident #40 for the Month of May 2014 included Seroquel 12.5 mg by mouth at 1:00 PM for psychosis, Seroquel 12.5 mg by mouth at 9:00 PM for psychosis, Xanax 0.25 mg at hour of sleep for anxiety, Xanax 0.25 mg 1/2 tab in the AM and 1/2 tab at 4:00 PM for anxiety, and Cymbalta 60mg by mouth at hour of sleep for depression. An interview on 5/29/2014 at 3:00 PM with the MDS nurse revealed the active diagnosis of psychosis was not included in section I of the MDS because the first 9 diagnosis [coded] for skilled nursing care were populated into the MDS and she used those. An interview on 5/29/2014 at 3:00 PM with the Administrator revealed the diagnosis of psychosis should have been in section I of the MDS. An interview on 5/30/2014 at 10:00 AM with the Administrator revealed she considered medication a form of treatment for resident care	F 278	made corrections to the residents' most recent MDS's and submitted correction assessments as indicated. Facility MDS staff and administrative nursing staff will be educated on RAI manual and the guidelines for coding active diagnoses in section I of the MDS. Facility MDS nurse and administrative nursing staff will review section I for all residents and ensure all active diagnoses were accurately coded on the resident's most recent MDS. Facility MDS nurse will complete a corrections sheet as indicated. Facility QI nurse will audit MDS assessments randomly five times weekly to ensure accurate coding of assessments ongoing. A QI audit tool will be utilized. The facility Quality committee will review the results of the audit monthly.	

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and that if a resident was being treated with a psychotropic medication then an appropriate active diagnosis should have been coded in section I of the comprehensive MDS.

2) Resident #152 was admitted to the facility on 10/12/2013. Her admission diagnoses included Dementia and Psychosis.

A record review of the facility MDS for Resident #152 revealed her most recent MDS dated 3/25/2014 did not include the active diagnosis of Psychosis in Section I Active Diagnosis. Section N for medications received included the use of an Antipsychotic for 7 days of the 7 day look back period. The comprehensive MDS dated 10/19/2013 did not include the active diagnosis of Psychosis in Section I Active Diagnosis. Section N for medications received included the use of an Antipsychotic for 5 days of the 7 day look back period.

A record review of Physician Orders dated 2/14/2014 included Risperdal [antipsychotic] 0.25 mg (milligrams) by mouth at hour of sleep for Psychosis and dated 3/2/2014 Risperdal 0.25 mg by mouth twice a day.

An interview on 5/29/2014 at 3:00 PM with the MDS nurse revealed the active diagnosis of psychosis was not included in section I of the MDS because the first 9 diagnosis [coded] for skilled nursing care were populated into the MDS and she used those.

An interview on 5/29/2014 at 3:00 PM with the Administrator revealed the diagnosis of psychosis should have been in section I of the MDS.

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F 278	Continued From page 29 An interview on 5/30/2014 at 10:00 AM with the Administrator revealed she considered medication a form of treatment for resident care and that if a resident was being treated with a psychotropic medication then an appropriate active diagnosis should have been coded in section I of the comprehensive MDS. 3) Resident #21 was admitted to the facility on 9/13/2013. Her admission diagnosis included Anxiety and Schizophrenia. A record review of the facility MDS for Resident #21 revealed MDS dated 4/16/2014 included Section I Active Diagnosis checked Hypertension, Diabetes Mellitus, Hyperlipidemia, Anxiety disorder, and Asthma. Additional diagnoses were not included on the Section I Section N for Medications received included the use of Antipsychotic for 7 days, Diuretic for 7 days and Antidepressants for 7 days of the 7 day look back period. Physician Order for Psychiatric Service dated 2/12/2014. Physician Order for Risperdal 1mg by mouth twice a day dated 3/2/2014. Physician Order for Risperdal 1 mg tablet by mouth daily dated 3/19/2014. An interview on 5/29/2014 at 3:00 PM with the MDS nurse revealed the active diagnosis of psychosis was not included in section I of the MDS because the first 9 diagnosis [coded] for skilled nursing care were populated into the MDS and she used those.	F 278		

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F 278	Continued From page 30 An interview on 5/29/2014 at 3:00 PM with the Administrator revealed the diagnosis of psychosis should have been in section I of the MDS. An interview on 5/30/2014 at 10:00 AM with the Administrator revealed she considered medication a form of treatment for resident care and that if a resident was being treated with a psychotropic medication then an appropriate active diagnosis should have been coded in section I of the comprehensive MDS.	F 278		
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 observations, resident and facility staff interviews, and record reviews the facility failed to report a transfer incident to nursing and failed to assess a resident after she complained of pain and reported being dropped during a transfer for 1 of 1 residents (Resident #46) reviewed for assessment. The deficient practice started on 4/22/14. The facility identified the deficient practice and started implementing a corrective action plan on 4/26/14. The facility was in compliance as of 5/5/14.	F 309	Past noncompliance: no plan of correction required.	

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The findings included:

Resident #46 was admitted to the facility on 8/9/2011 Diagnosis included Muscle Weakness, Failure to Thrive and Osteoporosis.

The Minimum Data Set (MDS) dated 2/1/2014 revealed Resident #46 was moderately cognitively impaired and required extensive assist with two staff member physical assistance for bed mobility and transfers.

The Care Plan for Resident #46 dated 2/14/2014 revealed a plan of care for; self care deficits due to impaired mobility, Osteoarthritis, degenerative joint disease, and poor vision. The approach included transfer with stand-up lift. A second plan of care for; potential for falls due to impaired mobility, poor vision and past history of falls revealed an approach for stand up lift for safe transfers and low bed.

A record review of Nurse #7 ' s nurse note on 4/23/2014 at 7:16 AM revealed Resident #46 stated the Nurse Aide (NA) on the 3-11 shift dropped her while assisting her back to bed. Resident #46 stated that her body was partly on the bed and the floor. Incident reported to the Director of Nursing (DON).

An interview on 6/4/2014 at 4:34 PM with Nurse #7 who was the primary nurse for Resident # 46 on 4/22/2014 revealed she was on duty from 11 PM to 7 AM and Resident #46 did not say anything all night. It was after the change of shift in the morning that the 7AM NA called me to Resident #46 ' s room. Resident #46 reported that the NA [3-11 shift] dropped her while

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assisting her back to bed. Nurse #7 reported that she asked Resident #46 if she landed on the bed or the floor and Resident #46 reported she fell back on the bed and partially on the floor. Nurse #7 stated she did not do an assessment but reported it to the DON.

A record review of Nurse #8 ' s nurse note on 4/23/2014 at 8:17 AM documented the resident was asymptomatic to fall yesterday. She shows no signs of disorientation nor did she have any confusion. Staff will continue to assess her for pain and assess her for any behaviors such as increased confusion and or disorientation.

The nurse notes documented from the above 4/23/2014 note and 4/46/2014 note at 4:32 PM did not include assessments and read as below.

The nurse notes on 4/25/2014 at 7:52 AM read Medication Administration Tylenol.

The nurse note on 4/26/2014 at 7:15 AM read Medication Administration Tylenol.

The nurse note on 4/26/2014 at 1:34 PM read Medication Administration Tylenol.

A record review of Nurse #9 ' s nurse note documented on 4/26/2014 at 4:32 PM revealed during AM care on 4/26/2014 a staff NA called Nurse #9 to Resident #46 ' s room and indicated the resident complained of pain to her right ankle and foot. Nurse #9 noted bruising and swelling. Resident #46 reported yes to her ankle hurting and that it was very sore and tender when the nurse touched it. A radiology film was taken of the right ankle and revealed a positive ankle fracture [broken bone]. Nurse #9 reported the Director of

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Nursing further assessed bruising to the left ankle and Resident #46 was transferred to the hospital for further examination.

An observation and interview on 5/29/2014 10:00 AM with Resident #46 revealed she was in bed with her lower extremities elevated, bilateral lower leg splint boots. Resident #46 reported her feet hurt but she did receive pain medication.

An interview on 5/30/2014 at 2:42 PM with Resident #46 revealed she sustained injury during the process of being put to bed from the chair in her room. Resident #46 stated " I did not ask to go to bed; this fellow came in and put me to bed. He said he was putting everyone to bed. He asked me to do a few things I could not do like sit in a certain place and position. He picked me up and slammed me down on the table. I said you hurt me and he said I would be alright tomorrow. He left and then someone else put me to bed I guess? I was hurting. It was so sudden and my memory is bad and I can ' t remember how I was put in the bed " .

An interview on 5/30/2014 at 2:30 PM with Nurse #9 revealed the event was brought to her attention as an acute episode of pain from the NA during AM care and Nurse #9 agreed to her 4/26/2014 nurse note as accurate documentation.

An interview on 6/4/2014 at 4:41 PM with Nurse #10 who was Resident #46 ' s primary nurse on the 3-11 shift on 4/22/2014 revealed she assessed Resident #46 who was in bed around 9:30 PM and Resident #46 stated her arthritis was bothering her. Nurse #10 determined Resident #46 was not due for pain medication. Nurse #10 returned to Resident #46 and

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discussed the pain management. Resident #46 revealed her arthritis pain was not in her back and shoulder it was in her foot. Resident #46 then told Nurse #10 she was " manhandled " but to Nurse #10 the description of the transfer from chair to bed was not described in an unusual way. Nurse #10 reported she spoke to the NA involved in the transfer and he answered no to anything unusual or anything that may have hurt Resident #46. Nurse #10 reported with in the hour she returned to Resident #46 a third time and she was pain free. Nurse #10 reported she did not do an assessment on Resident #46 ' s foot.

The Nurse Aide involved in the event was not available for an interview.

A record review of the Resident Incident Report completed by the DON and back dated to 4/22/2014 but completed on 4/26/2014 revealed Resident #46 stated she was dropped while being transferred to bed. Bilateral bruising noted on both ankles on 4/26/2014. The report documented the immediate action taken included a complete skin assessment, a physician evaluation and a transfer to the hospital.

A record review of the radiology exam dated 4/26/2014 of the right ankle reported an acute fracture of the right distal fibula [one of the two lower leg bones that support the ankle] and medial malleolus [boney process on the inner side of the ankle] with modest displacement.

A record review of hospital radiology record dated 4/26/2014 for resident #46 revealed an oblique distal left fibular fracture and transverse medial malleolar fracture. And an oblique distal right fibular fracture and transverse medial malleolar

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F 309	Continued From page 35 fracture. A record review of the hospital Physician progress note from the emergency department revealed Resident #46 was placed in bilateral posterior splints, no surgery required and had an Orthopedic consult for follow up. The facility Action Plan dated 4/26/2014 was presented immediately upon request with the grievance log and included: Problem Description: Employee failed to use the lift resulting in a fall for 1 resident [Resident #46]. Fracture to resident ankle not identified until four days after resident alleged to have fallen. Root Cause: Staff did not identify the unintentional movement from one surface to another to be a fall. Staff member completing action was not forthcoming during investigation. Staff member disregarded the designated transfer technique for resident. Implementation steps for the resident included: Resident #46 was sent to the ED on 4/26/2014 to address ankle fractures. On 4/30/2014 Resident #46 was assessed upon readmission and designated to be a total lift related to her change in status. On 5/1/2014 Resident #46 ' s lift status was changed on the care plan and KARDEX (healthcare information tool). Implementation steps for all other residents at potential risk included: On 4/26/2014 the NA that completed the incorrect transfer technique was suspended pending investigation and then discharged from employment. On 4/28/2014 all staff was in-serviced on the definition of fall and no new residents were identified to have fallen through the communication. All residents reported to have fallen in the past 30 days were assessed for unknown injury. On 4/30/2014 all residents were reviewed for current report of pain.	F 309		

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F 309	Continued From page 36 All residents reporting pain were assessed for unidentified injury. All residents were reviewed for appropriate transfer technique and any questions regarding transfer technique of a resident was referred to therapy for review. On 5/5/2014 skin assessments were completed on all residents to identify residents with unidentified injury. Systemic Changes: On 4/28/2014 the nursing staff was in-serviced regarding transfer of residents according to the resident care plan and KARDEX. On 4/29/2014 the nursing staff was educated on assessment after alleged fall. On 4/30/2014 the licensed staff was in-serviced on assessments for a concern regarding resident condition and assessment for pain. On 5/1/2014 the nursing staff was in-serviced on the new implementation of the Stop and Watch form and process. On 5/5/2014 the NA staff preformed return demonstrations to the nursing administration team of a transfer using the mechanical lift. System Monitored: The administrative nursing staff cross referenced nursing notes, incidents, Stop and Watch forms, and the facility 24 hour report log daily to identify residents with alleged falls and assessment for pain. The cross reference was an ongoing assessment tool for accurate documentation and identification of falls and pain. The administrative nursing staff watched return demonstration of resident transfers five times a week ongoing to ensure staff adhered to the KARDEX for resident transfer. A record review revealed the completed in-services listed in the Action Plan; the completed clinical competency check list for transfer monitoring; the Stop and Watch form for NA use; the completed skin assessments and	F 309		

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F 309	Continued From page 37 pain assessments on all residents; the reviewed medical records used for cross reference of a fall or complaint of pain. On 05/29/2014 at 10:08:15 AM NA #1 revealed her knowledge of safety checks, the Stop and Watch form and resources for resident care i.e. Care Plan and KARDEX. On 5/29/2014 at 10:28 AM Nurse #9 revealed her knowledge of Resident #46 ' s status change for transfers, in-services on assessments, and the Stop and Watch tool. On 05/29/2014 at 10:56 AM Nurse #11 revealed her knowledge of the Stop and Watch tool, assessments, change of condition and the 24 hour report. On 5/29/2014 at 11:14 AM NA #2 revealed her knowledge of the Stop and Watch tool and the transfer in-service. On 6/4/2014 at 4:30 PM the facility Quality Assurance (QA) team meets quarterly. The last meeting was in February 2014 prior to the incident and the following QA meeting was to be held the last week in May 2014 but put on hold due to the federal survey. The QA agenda for May 2014 included review of all active monitoring tools.	F 309		
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	F 323		

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F 323	Continued From page 38 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and facility staff interviews, and record reviews the facility failed to use the mechanical lift and two person physical assist to transfer a resident causing two fractured ankles for 1 of 3 residents (Resident #46) reviewed for accidents. The deficient practice started on 4/22/14. The facility identified the deficient practice and started implementing a corrective action plan on 4/26/14. The facility was in compliance as of 5/5/14. The findings included: Resident #46 was admitted to the facility on 8/9/2011. Diagnosis included Muscle Weakness, Failure to Thrive and Osteoporosis. The Minimum Data Set (MDS) dated 2/1/2014 revealed Resident #46 was moderately cognitively impaired and required extensive assist with two staff member physical assistance for bed mobility and transfers. The Care Plan for Resident #46 dated 2/14/2014 revealed a plan of care for; self care deficits due to impaired mobility, Osteoarthritis, degenerative joint disease, and poor vision. The approach included transfer with stand-up lift. A second plan of care for; potential for falls due to impaired mobility, poor vision and past history of falls revealed an approach for stand up lift for safe	F 323	Past noncompliance: no plan of correction required.	

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F 323	Continued From page 39 transfers and low bed. A record review of Nurse #7 ' s nurse note on 4/23/2014 at 7:16 AM revealed Resident #46 stated the Nurse Aide (NA) on the 3-11 shift dropped her while assisting her back to bed. Resident #46 stated that her body was partly on the bed and the floor. Incident reported to the Director of Nursing (DON). A record review of Nurse #9 ' s nurse note documented on 4/26/2014 at 4:32 PM revealed during AM care a staff NA called Nurse #9 to Resident #46 ' s room and indicated the resident complained of pain to her right ankle and foot. Nurse #9 noted bruising and swelling. Resident #46 reported yes to her ankle hurting and that it was very sore and tender when the nurse touched it. A radiology film was taken of the right ankle and revealed a positive ankle fracture [broken bone]. Nurse #9 reported the Director of Nursing further assessed bruising to the left ankle and Resident #46 was transferred to the hospital for further examination. An observation and interview on 5/29/2014 10:00 AM with Resident #46 revealed she was in bed with her lower extremities elevated, bilateral lower leg splint boots. Resident #46 reported her feet hurt but she did receive pain medication. An interview on 5/30/2014 at 2:42 PM with Resident #46 revealed she sustained injury during the process of being put to bed from the chair in her room. Resident #46 stated " I did not ask to go to bed; this fellow came in and put me to bed. He said he was putting everyone to bed. He asked me to do a few things I could not do like sit in a certain place and position. He picked	F 323		

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me up and slammed me down on the table. I said you hurt me and he said I would be alright tomorrow. He left and then someone else put me to bed I guess? I was hurting. It was so sudden and my memory is bad and I can ' t remember how I was put in the bed " .

An interview on 5/30/2014 at 2:30 PM with Nurse #9 revealed the event was brought to her attention as an acute episode of pain from the NA during AM care and Nurse #9 agreed to her 4/26/2014 nurse note as accurate documentation.

An interview on 6/4/2014 at 4:34 PM with Nurse #7 revealed she was on duty from 11 PM to 7 AM and Resident #46 did not say anything all night. It was after the change of shift in the morning that the 7AM NA called me to Resident #46 ' s room. Resident #46 reported that the NA [3-11 shift] dropped her while assisting her back to bed. Nurse #7 reported that she asked Resident #46 if she landed on the bed or the floor and Resident #46 reported she fell back on the bed and partially on the floor. Nurse #7 stated she did not do an assessment but reported it to the DON.

An interview on 6/4/2014 at 4:41 PM with Nurse #10 who was Resident #46 ' s primary nurse on the 3-11 shift on 4/22/2014 revealed she assessed Resident #46 who was in bed around 9:30 PM and Resident #46 stated her arthritis was bothering her. Nurse #10 determined Resident #46 was not due for pain medication. Nurse #10 returned to Resident #46 and discussed the pain management. Resident #46 revealed her arthritis pain was not in her back and shoulder it was in her foot. Resident #46 then told Nurse #10 she was " manhandled " but to Nurse #10 the description of the transfer from

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chair to bed was not described in an unusual way. Nurse #10 reported she spoke to the NA involved in the transfer and he answered no to anything unusual or anything that may have hurt Resident #46. Nurse #10 reported with in the hour she returned to Resident #46 a third time and she was pain free. Nurse #10 reported she did not do an assessment on Resident #46 ' s foot.

The Nurse Aid involved in the event was unavailable for an interview.

A record review of the Resident Incident Report completed by the DON and back dated to 4/22/2014 but completed on 4/26/2014 revealed Resident #46 stated she was dropped while being transferred to bed. Bilateral bruising noted on both ankles on 4/26/2014. The report documented the immediate action taken included a complete skin assessment, a physician evaluation and a transfer to the hospital.

A record review of the radiology exam dated 4/26/2014 of the right ankle reported an acute fracture of the right distal fibula [one of the two lower leg bones that support the ankle] and medial malleolus [boney process on the inner side of the ankle] with modest displacement.

A record review of hospital radiology record dated 4/26/2014 for resident #46 revealed an oblique distal left fibular fracture and transverse medial malleolar fracture. And an oblique distal right fibular fracture and transverse medial malleolar fracture.
A record review of the hospital Physician progress note from the emergency department revealed Resident #46 was placed in bilateral posterior splints, no surgery required, and had an

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F 323	Continued From page 42 Orthopedic consult for follow up. An interview on 6/4/2014 at 4:30 PM with the Administrator revealed the NA involved in the incident was by himself during the transfer and had been trained in proper transfers. His skills checks were dated 8/23/2012 and 8/8/2013. He was in-serviced on 12/2/2013 for referring to the KARDEX for resident lift technique. The NA involved in the incident reported to the Administrator that he was standing the resident for incontinent care and a stand and pivot transfer and her legs buckled so he pushed her to bed. The facility Action Plan dated 4/26/2014 was presented immediately upon request with the grievance log and included: Problem Description: Employee failed to use the lift resulting in a fall for 1 resident [Resident #46]. Fracture to resident ankle not identified until four days after resident alleged to have fallen. Root Cause: Staff did not identify the unintentional movement from one surface to another to be a fall. Staff member completing action was not forthcoming during investigation. Staff member disregarded the designated transfer technique for resident. Implementation steps for the resident included: Resident #46 was sent to the ED on 4/26/2014 to address ankle fractures. On 4/30/2014 Resident #46 was assessed upon readmission and designated to be a total lift related to her change in status. On 5/1/2014 Resident #46 ' s lift status was changed on the care plan and KARDEX (healthcare information tool). Implementation steps for all other residents at potential risk included: On 4/26/2014 the NA that completed the incorrect transfer technique was suspended pending investigation and then	F 323		

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F 323	Continued From page 43 discharged from employment. On 4/28/2014 all staff was in-serviced on the definition of fall and no new residents were identified to have fallen through the communication. All residents reported to have fallen in the past 30 days were assessed for unknown injury. On 4/30/2014 all residents were reviewed for current report of pain. All residents reporting pain were assessed for unidentified injury. All residents were reviewed for appropriate transfer technique and any questions regarding transfer technique of a resident was referred to therapy for review. On 5/5/2014 skin assessments were completed on all residents to identify residents with unidentified injury. Systemic Changes: On 4/28/2014 the nursing staff was in-serviced regarding transfer of residents according to the resident care plan and KARDEX. On 4/29/2014 the nursing staff was educated on assessment after alleged fall. On 4/30/2014 the licensed staff was in-serviced on assessments for a concern regarding resident condition and assessment for pain. On 5/1/2014 the nursing staff was in-serviced on the new implementation of the Stop and Watch form and process. On 5/5/2014 the NA staff preformed return demonstrations to the nursing administration team of a transfer using the mechanical lift. System Monitored: The administrative nursing staff cross referenced nursing notes, incidents, Stop and Watch forms, and the facility 24 hour report log daily to identify residents with alleged falls and assessment for pain. The cross reference was an ongoing assessment tool for accurate documentation and identification of falls and pain. The administrative nursing staff watched return demonstration of resident transfers five times a week ongoing to ensure staff adhered to the KARDEX for resident	F 323		

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F 323	Continued From page 44 transfer. A record review revealed the completed in-services listed in the Action Plan; the completed clinical competency check list for transfer monitoring; the Stop and Watch form for NA use; the completed skin assessments and pain assessments on all residents; the reviewed medical records used for cross reference of a fall or complaint of pain. On 5/28/2014 at 8:15 AM a transfer with a mechanical lift was observed on Resident #47 and followed the resident care plan and proper transfer technique. On 05/29/2014 at 10:08:15 AM NA #1 revealed her knowledge of safety checks, the Stop and Watch form and resources for resident care i.e. Care Plan and KARDEX. On 5/29/2014 at 10:28 AM Nurse #9 revealed her knowledge of Resident #46 ' s status change for transfers, in-services on assessments, and the Stop and Watch tool. On 05/29/2014 at 10:56 AM Nurse #11 revealed her knowledge of the Stop and Watch tool, assessments, change of condition and the 24 hour report. On 5/29/2014 at 11:14 AM NA #2 revealed her knowledge of the Stop and Watch tool and the transfer in-service. On 6/4/2014 at 4:30 PM the facility Quality Assurance (QA) team meets quarterly. The last meeting was in February 2014 prior to the incident and the following QA meeting was to be	F 323		

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F 323	Continued From page 45 held the last week in May 2014 but put on hold due to the survey. The QA agenda for May 2014 included review of all active monitoring tools.	F 323		
F 460 SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations, facility staff interviews, and record reviews the facility failed to ensure window blinds were repaired or replaced to provide bedroom privacy for 1 of 82 resident rooms (# 306). The findings included: On 05/27/2014 at 4:30 p.m. an observation was made of resident room 306. The room was observed to be occupied by 2 residents. The window blinds were observed to be bent and broken and would not fully close allowing viewing access into the resident's room from persons walking by and cars passing the building. On 05/28/2014 at 4:30 p.m. a 2nd observation was made of the window blinds in room 306. The window blinds were still bent and broken and would not fully close to ensure privacy by allowing viewing access in the resident's room from	F 460	The broken blinds in room 306 will be replaced by facility maintenance staff. Facility maintenance staff will conduct a full audit of all resident rooms and resident care areas and identify any blinds in need of repair All items identified to be in need of repair will be entered into the facilities electronic work order system. Facility maintenance staff with make identified repairs and sign them off as complete in the facility's electronic work order system. Facility administrative and nursing staff will be trained on identifying blinds in need of repair and how to enter work orders for	7/2/14

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F 460	Continued From page 46 persons walking and cars passing the building. On 05/29/2014 at 10:30 a.m. a 3rd observation was made of the window blinds in room 306. The window blinds were still bent and broken and would not fully close to ensure privacy by allowing viewing access in the resident's room from persons walking and cars passing the building. On 05/29/2014 at 11:00 a.m. and interview and record review was conducted with the facility's maintenance director. The maintenance director indicated he still had not had a chance to fix things as he had only been at the facility for four weeks. The maintenance director indicated it was his goal to put maintenance request information into the facility's computer system but he hadn't had time to get anything in yet. The maintenance director also indicated he was not very familiar with the program as he had not used it until coming to this facility and the staff had not been thoroughly trained to use the program yet and were not putting in electronic work orders yet. The maintenance director indicated there were 3 ways he and or his assistant were notified of maintenance repair/replacement work requested and needing to be done: 1) Housekeeping staff would keep notes on their daily sheets and turn them in daily to the maintenance director. 2) By word of mouth - staff would stop the maintenance director or his assistant in hallway and they would write down the information concerning the needed repairs/replacements. 3) The maintenance director indicated the facility's staff having access to the facility's	F 460	needed repairs into the facility's electronic work order system as needed repairs are identified. Housekeeping staff will be trained in identifying blinds in need of repair and will continue to note the need for any repairs on their daily sheets Maintenance director will review the notes from the housekeepers daily sheets ongoing, and enter any repairs noted on the daily sheets in the facility's electronic work order system. Facility maintenance staff with make identified repairs and sign them off as complete in the facility's electronic work order system ongoing. Administrative staff will complete rounds audits three times weekly identifying blinds in need of repair . A QI rounds tool will be utilized. Maintenance director will review rounds tools three times weeks to ensure any item identified on administrative rounds have been entered in the facility's electronic work order system. All rounds tools and a report of completed and open work orders will be reviewed by the Quality Committee Monthly.	

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computer system had access to the software program to electronically place work order requests in the system. The maintenance director indicated that when the facility's staff observed, or were told about a maintenance issue requiring repair or replacement etc. they were to enter the information into the computer program and this became the electronic work order. The maintenance director indicated he could access the program and see what needed to be repaired or replaced on a daily basis.

A request to review all outstanding work orders (in any fashion - electronic, notes etc.) was made. The maintenance director indicated there were only one uncompleted work order in the facility's work order software program and four completed work orders. A review of the electronic work orders indicated there was one uncompleted/deferred work order for the facility's kitchen listed. There were four completed work orders listed. The maintenance director indicated he had no paper maintenance work order requests or other documentation to show he or his staff had been notified of the window blinds being in need of repair or replacement. The Maintenance director indicated he had some notes in a notebook for some items however he could not produce any type of notebook or other written documentation to show he had a list of facility maintenance issues/items needing repair or replacement. The maintenance director indicated he kept a lot of the information in his head but it was not written down anywhere.

On 05/30/2014 at 11:50 a.m. an interview was conducted with the facility's maintenance director and his regional maintenance manager. The facility's maintenance director indicated there

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F 460	Continued From page 48 were more work orders found in the facilities work order software program by his regional maintenance manager. A review of the electronic work orders was conducted with the facility's maintenance director and his regional maintenance manager. The regional maintenance manager pulled up the facility's work order software program to the page indicating all work orders (completed and uncompleted). There were no new uncompleted work orders. The facility's maintenance director indicated there was no other place any work order information was stored to show they were aware of the bent/broken blinds in room 306 needing repair or replacement. On 05/30/2014 at 11:55 a.m. a tour of the facility was conducted with the facility's maintenance director and his regional maintenance manager. The tour observation identified the bent/broken window blinds in room 306. The facility's maintenance director indicated the window blinds were not documented on the facility's electronic work order software program or any other place and he did not have any other documentation to show the window blinds in room 306 had been identified as needing repair or replacement.	F 460		