

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/07/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - TARBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESTERN BOULEVARD TARBORO, NC 27886		
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F 000	INITIAL COMMENTS	F 000			
F 309 SS=D	<p>No deficiencies were cited as a result of the complaint investigation. Event ID #87X411.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to identify and/or review medications for 1 of 1 residents (Resident #19) who had an acute change in condition with nausea, vomiting and diarrhea and continued to receive a laxative/stool softener daily for constipation. Findings included:</p> <p>Resident #19 was admitted to the facility on 03/10/14 after a fracture of the left femur and re-admitted on 04/19/14 after hospitalization for gastroenteritis, C. Diff (clostridium difficile toxin), UTI (urinary tract infection) and hypoglycemia. Other diagnoses included diabetes mellitus, colon carcinoma and hypertension. Resident #19 was discharged from the facility on 05/15/14.</p> <p>It was noted in Resident #19's Admission Minimum Data Set (MDS) assessment of 03/17/14 that he was cognitively intact. Resident #19 required extensive to total assistance from</p>	F 309	<p>"Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of truth of the facts, alleged or confusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws."</p> <p>F309 As is our practice, the facility will assure each resident receives and the facility provides 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.</p> <p>This was a closed record. Resident was no longer in facility, discharged home 5-15-2014</p>	9/4/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/27/2014

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

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F 309	<p>Continued From page 1 staff for all ADLs (activities of daily living). He was frequently incontinent of bowel.</p> <p>The April 2014 physician's orders for Resident #19 included 17 grams of Miralax Powder 3350 (used as a laxative) which was to be given daily for constipation.</p> <p>Upon review of the April 2014 Resident Contenance Log, it was noted that Resident #19 was continent and had a medium size bowel movement (noted as "M") on the 7:30 AM-3:30 PM shift on 04/12/14. The resident had 2 medium size bowel movements documented on the 3:30 PM-11:30 PM shift on 04/12/14.</p> <p>According to the third shift entry on the 24 hour report of 04/12/14, Resident #19 had been given Zofran for nausea, vomiting and diarrhea which was noted as "N/V/D".</p> <p>The meal intake record for Resident #19 documented the resident consumed 100% of breakfast, lunch and dinner on 04/12/14.</p> <p>A general note of 04/13/14 at 2:44 AM indicated Resident #19 was in bed. The resident had 2 episodes of nausea with vomiting of a moderate amount of brownish liquid with undigested food. It was noted that Resident #19 had received Maalox earlier. Vital signs were taken. The writer noted a blood pressure reading of 115/54, a temperature of 98.1 degrees Fahrenheit, pulse of 90 and respirations of 18.</p> <p>An entry into the electronic chart of 04/13/14 at 5:45 AM indicated Resident #19 had received Zofran (an anti-emetic given for nausea) for nausea and vomiting. It also indicated the</p>	F 309	<p>Reviewed other residents who were on scheduled laxatives for any acute episodes.</p> <p>Inservice CNA's and Nurses</p> <p>Did audit of residents receiving scheduled laxatives and added to the order to hold if diarrhea and call MD.</p> <p>Wing Managers along with Charge Nurses will monitor acute episodes related to any scheduled doses of laxatives.</p> <p>The results of the monitoring will be discussed at our QAPI meeting for any recommendations and continued education.</p> <p>DNS/ADNS will be responsible for overall compliance.</p>	

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F 309	<p>Continued From page 2 resident reported feeling better.</p> <p>Upon review of the April 2014 Resident Contenance Log, Resident #19 had diarrhea documented as "D" on the 11:30 PM-7:30 AM shift on 04/13/14.</p> <p>According to the 24 hour report for first shift (7:30 AM-3:30 PM) on 04/13/14, there was an entry of "N/V/D" (nausea/vomiting/diarrhea) for Resident #19.</p> <p>The electronic Medication Administration Record (eMAR) noted that Miralax (a laxative) was given on 04/13/14 at 10:30 AM.</p> <p>A nurse progress note written by Nurse #1 of 04/13/14 at 11:37 AM indicated that Resident #19 was out of bed in a chair in his room. It was noted that there were no signs or symptoms of nausea and he had one loose stool this morning. It also was noted that the nurse aide had reported Resident #19 had chills. The plan was to continue monitoring.</p> <p>Upon review of the April 2014 Resident Contenance Log, Resident #19 had diarrhea documented as "D" on the 7:30 AM-3:30 PM shift on 04/13/14.</p> <p>A general note of 04/13/14 at 7:38 PM indicated Resident #19 had a quiet day and had not had any nausea or vomiting.</p> <p>According to the meal intake record, Resident #19 ate 50% of breakfast, 50% of lunch and 25% of dinner on 04/13/14.</p> <p>Upon review of the April 2014 Resident</p>	F 309			

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F 309	<p>Continued From page 3</p> <p>Continance Log, Resident #19 had diarrhea documented as "D" on the 3:30 PM-11:30 PM shift on 04/13/14.</p> <p>The April 2014 Resident Continance Log for Resident #19 documented the resident had a large bowel movement (noted as "L") on the 11:30 PM-7:30 AM shift on 04/14/14.</p> <p>It was noted on the 24 hour report for first shift (7:30 AM-3:30 PM) on 04/14/14, Resident #19 was to be monitored for "N/V/D" and had no diarrhea but had vomited twice and Zofran had been given.</p> <p>According to documentation in the eMAR, Resident #19's finger stick blood glucose was 80 at 7:30 AM on 04/14/14.</p> <p>A general note of 04/14/14 at 7:57 AM noted Resident #19 was in bed and had no nausea, vomiting or diarrhea during the night. Vital signs were taken. Resident #19's blood pressure was 121/57. He had a pulse of 82, respirations of 18 and a temperature of 98.8 degrees Fahrenheit.</p> <p>A general note of 04/14/14 at 11:45 AM indicated Resident #19 had a finger stick blood glucose of 80 and had eaten 100% of breakfast. It was noted that the resident was out of bed with family visiting. Family had reported Resident #19 had vomited 3 times. The medication nurse had administered Zofran.</p> <p>Upon review of the April 2014 Resident Continance Log, it was noted that Resident #19 had diarrhea documented as "D" on the 7:30 AM-3:30 PM shift on 04/14/14.</p>	F 309			

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F 309	<p>Continued From page 4</p> <p>The electronic Medication Administration Record (eMAR) noted that Miralax (a laxative) was given on 04/14/14 at 10:30 AM.</p> <p>A general note of 04/14/14 at 2:03 PM indicated that medication for nausea had been given at 1:00 PM.</p> <p>The electronic Medication Administration Record (eMAR) indicated Zofran (a medication given for nausea) had been administered at 2:03 PM on 04/14/14.</p> <p>Another general note of 04/14/14 at 2:37 PM indicated Resident #19's finger stick blood glucose was 96. It was noted that the resident had no signs or symptoms of high or low blood glucose. It was also noted that the nurse aide had reported the resident was eating snacks at bedside of candy, candy bars and gummies. The resident consumed 75% of his lunch with a fluid intake of 960 ml. It was documented in this note that Resident #19 had 1 regular bowel movement.</p> <p>Upon review of the 2014 Resident Continence Log, it was noted that Resident #19 had diarrhea documented as "D" on the 3:30 PM-11:30 PM shift on 04/14/14.</p> <p>According to the eMAR, Resident #19's finger stick blood glucose was 43 at 4:30 PM on 04/14/14.</p> <p>On 04/14/14 at 5:54 PM, a general note indicated a change in condition had occurred with Resident #19. The resident was alert and verbal with a finger stick blood glucose of 43. It was noted that the resident exhibited no signs or symptoms of</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>hypoglycemia. Glucoburst (an oral substance given to elevate blood glucose levels) was given. Upon recheck, the blood glucose was 58. The physician was made aware.</p> <p>According to the eMAR, Resident #19 ' s finger stick blood glucose was 65 at 9:00 PM on 04/14/14.</p> <p>On 04/14/14 at 10:41 PM, a general note indicated Resident #19 ' s finger stick blood glucose was 65 with no signs or symptoms of hypoglycemia. The resident was alert with no nausea or vomiting. The physician was made aware and instructions were given to provide a snack. Peanut butter crackers were provided. It was noted that Resident #19 ate a bowl of soup and some crackers.</p> <p>It was documented on the 24 hour shift report of 04/14/14 for the 3:30 PM-11:30PM shift that Resident #19 had a low blood glucose level, nausea, vomiting and diarrhea. It was noted that a snack was given and the blood glucose levels were 43, 58, 35 and 65.</p> <p>According to the meal intake record of 04/14/14, Resident #19 consumed 100% of breakfast, 75% of lunch and 25% of dinner.</p> <p>A general note of 04/15/14 at 12:49 AM indicated Resident #19 was in bed and easily aroused. The resident was alert and verbal. The writer was monitoring for nausea and vomiting with none noted. The resident was also being monitored for decreased blood glucose levels with no signs or symptoms of hypoglycemia noted. Juice was given during the night to help prevent decreased finger stick blood glucoses.</p>	F 309			

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F 309	<p>Continued From page 6</p> <p>A general note of 04/15/14 at 5:45 AM indicated Resident #19 had received Zofran for nausea and vomiting and reported to be feeling better.</p> <p>A general note of 04/15/14 at 5:55 AM noted Resident #19 had several loose watery stools throughout the night. It was documented that the resident was given juice several times to help prevent decreased finger stick blood glucoses and dehydration. It was documented the finger stick blood glucose was 78 and a pudding snack and juice was given.</p> <p>It was noted on the 24 hour report that on 04/14/14 during the 11:30 PM-7:30 AM shift, Resident #19 had multiple loose stools, no nausea or vomiting. It was also noted that the resident had a low finger stick blood glucose and juice was given.</p> <p>Upon review of the 2014 Resident Continence Log, it was noted that Resident #19 had diarrhea documented as "D" on the 7:30 PM-3:30 PM shift on 04/15/14.</p> <p>According to the electronic Medication Administration Record (eMAR) Zofran (medication given for nausea) was given at 9:47 AM on 04/15/14.</p> <p>The electronic Medication Administration Record (eMAR) noted that Miralax (used as a laxative) was given on 04/15/14 at 10:30 AM.</p> <p>According to the meal intake record for 04/15/14, Resident #19 consumed none of the breakfast or lunch meals.</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>A general note of 04/15/14 at 2:24 PM indicated Resident #19 had bowel sounds present in 4 quadrants and continued to complain of feeling sick on the stomach. It was documented that the resident had diarrhea 3 times today and refused breakfast. The resident was given Gatorade. The finger stick blood glucose was 116 and 74 with no signs or symptoms of low blood glucose levels. The family nurse practitioner was informed and gave orders for a clear liquid diet for 24 hours and the physician was to see the resident on 04/17/14. Oral intake was noted to be 840 ml.</p> <p>A physician's telephone order of 04/15/14 indicated to place Resident #19 on a clear liquid diet for 14 hours and progress as tolerated. It also documented to re-schedule the physician's appointment due to gastrointestinal virus.</p> <p>It was noted on the 24 hour shift report for the 7:30 PM-3:30 PM shift on 04/15/14 that Resident #19 had loose stools and the resident was to be monitored for diarrhea.</p> <p>A general note of 04/15/14 at 6:50 PM indicated Resident #19 was in bed without distress. The finger stick blood glucose was performed and found to be 45. It was noted that the resident exhibited no signs or symptoms of hypoglycemia. The resident was given Glucoburst and Gatorade. Upon recheck, the blood glucose was 58. It was noted that Resident #19 had no nausea, vomiting or diarrhea thus far this shift. It was noted that another finger stick blood glucose was performed and found to be 38 with no signs or symptoms of hypoglycemia. Glucoburst was given and the physician was telephoned. The writer informed the physician of Resident #19's history and being</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>asymptomatic. The physician gave orders to administer 2 packs of Glucoburst and to send Resident #19 out for evaluation if the blood glucose level did not increase. Upon recheck, the resident's blood glucose was 49. The family was informed of the resident's condition and emergency transport was called to transport the resident out for evaluation. It was documented that Resident #19 was alert.</p> <p>A physician's order of 04/15/14 to give 2 packs of glucoburst for low finger stick blood glucose was noted on the eMAR. It was also noted in the eMAR that if the resident's blood glucose level was below 70, the resident was to be given 15 grams of glucose gel and the physician was to be notified.</p> <p>According to the hospital history and physical of 04/15/14, Resident #19 presented at the emergency room with hypoglycemia. Resident #19's blood glucose was in the 40's. Family reported Resident #19 had an onset of vomiting 4 days ago. It was noted that the hypoglycemia was due to poor oral intake, nausea, vomiting, diarrhea and administration of oral medications. The diarrhea was described as profuse, watery, green and foul smelling. The initial diagnosis was gastroenteritis. The plan was to check stools for C. Diff as well as stool cultures.</p> <p>The hospital discharge summary of 04/19/14 noted that Resident #19 had been diagnosed with C. Diff (clostridium difficile toxin) and was treated with Flagyl (a medication administered for C. Diff). It was also noted that Resident #19 had a UTI and was treated with antibiotics. The hypoglycemia resolved with holding the oral hyperglycemic agents.</p>	F 309			

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F 309	<p>Continued From page 9</p> <p>Resident #19's care plan of 04/19/14 identified a problem with C. Diff, UTI, and gastroenteritis with interventions to administer antibiotics as ordered and monitor vital signs.</p> <p>Resident #19's physician progress note of 04/22/14 indicated the resident had been out to the hospital on the 15th (04/15/14) with persistent hypoglycemia and diarrhea. The resident's blood glucose was apparently in the 40's. Resident #19 had some vomiting over previous days. Resident #19's diarrhea was described as profuse, watery, and foul smelling. The physician further noted that a stool sample of 04/15/14 had been negative for clostridium difficile antigen but on the 16th (04/16/14) Resident #19's stool was positive for clostridium difficile antigen. Resident #19 also had a morganella morganii urinary tract infection and hypoglycemia.</p> <p>Nurse #1 was interviewed about Resident #19 on 08/07/14 at 11:40 AM. Nurse #1 had administered Miralax to Resident #19 on 04/14/14 and 04/15/14 per the eMAR. She stated she remembered Resident #19 and had worked with him during the week of 04/15/14. She commented that when she worked with Resident #19 just prior to being sent out to the hospital he was having stomach discomfort but that was all she could remember. She stated medications were not held without obtaining instructions from the physician. She also stated that it would also depend upon the resident and their condition. Nurse #1 stated if a resident only had one loose stool that was not justification to telephone the physician about holding any stool softeners and/or laxatives. When questioned what would be justification, she stated having 2 or more loose</p>	F 309			

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F 309	<p>Continued From page 10</p> <p>stools. Nurse #1 reported she was the medication nurse during the time the resident was having nausea and vomiting. She commented that she was not informed that Resident #19 was having diarrhea because she would have talked with the physician about holding the Miralax. Nurse #1 also reported if someone was having diarrhea, the physician should be notified about the diarrhea and that the resident was receiving a laxative and/or a stool softener. She stated any change in a resident's condition was written on the 24 hour report and passed on to each shift through report. Nurse #1 reported that the nurse aides were usually the ones who would report the diarrhea since they worked directly with the residents. She also commented that the nurses did have the ability to review bowel movement records if needed. Nurse #1 reported the protocol was to give Glucoburst if a diabetic resident had finger stick blood glucose levels below 60 but that had been changed to a finger stick glucose level below 70. She also stated the nurse was to notify the physician.</p> <p>Nurse #2 was interviewed on 08/07/14 at 2:15 PM. She stated she was the charge nurse on one of the days before Resident #19 was sent out to the hospital. She reported if a resident was experiencing several loose stools, nursing judgment would be not to give Miralax. She stated the medication nurse was responsible for administering medications and the charge nurse was responsible for assessing residents as well as any follow up that would be required if there was a change of condition. Nurse #2 reported any change in a resident's condition was written on the 24 hour report per each shift and reviewed by the oncoming shift. Nurse #2 also stated if the nurse was not comfortable with holding a</p>	F 309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/07/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - TARBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WESTERN BOULEVARD TARBORO, NC 27886		
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F 309	<p>Continued From page 11</p> <p>medication such as Miralax, she should telephone the physician and ask if the medication could be held. Nurse #2 reported she had not been made aware that Resident #19 had been having issues with diarrhea and/or loose stools. She commented she had been made aware that the resident was having nausea and vomiting. Nurse #2 stated the nurse aide was usually the one who reported changes in the resident's condition since they worked directly with the resident.</p> <p>Resident #19's physician was interviewed on 08/07/14 at 3:10 PM. He stated giving Miralax when someone was having diarrhea might have made the diarrhea worse. He stated he was not called about Resident #19 as someone else had been notified. The physician also stated that when nursing staff telephoned him to report nausea and/or vomiting he didn't usually think about the fact that they were receiving laxatives and/or stool softeners. He also commented that when a resident was having diarrhea or loose stools, he considered the cause to be clostridium difficile until proven otherwise.</p> <p>Nurse Aide #1 (NA #1) was interviewed on 08/07/14 at 3:50 PM. She had worked with Resident #19 during the week of 04/15/14. When questioned about the resident, she reported that she remembered him and had worked with him the week he was sent out. NA #1 stated Resident #19 was usually continent of bowel but that week he was incontinent due to having lots of watery stools. She commented the stools smelled like stale corn. She also commented that the diarrhea was so bad each time that she had to change his linens at least 4 times during her shift. NA #1 stated she reported the loose stools to</p>	F 309			

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F 309	<p>Continued From page 12</p> <p>Nurse #3. When questioned as to how the stools were documented, she reported that there was one place per shift for the nurse aide to indicate if a resident had a stool. She stated she documented "D" if the resident had diarrhea and/or loose stools but there was no way to indicate the number of stools unless the resident was being monitored for multiple stools. She commented Resident #19 was not.</p> <p>Nurse #3 was interviewed on 08/07/14 at 4:00 PM. She stated she remembered Resident #19. She reported the aide did come to her to report diarrhea. She stated Resident #19 also had low blood glucoses as well. Nurse #3 stated she telephoned the physician and reported the issues and the physician gave orders to send him out for evaluation. Nurse #3 stated she would review the medications if a resident was having diarrhea and/or loose stools and if the resident was receiving Miralax or other stool softeners/laxatives she would ask the physician if the medication could be held.</p> <p>The Director of Nursing Services (DNS) was interviewed on 08/07/14 at 5:00 PM. She stated the nurse aides should report any abnormal findings to the nurses. She stated they completed round reports at the beginning of each shift and any changes in residents' conditions were discussed. The DNS stated she would have expected the nurse to telephone the physician if there was a concern with the diarrhea and the stool softener. The DNS also stated staff did contact the nurse practitioner who placed Resident #19 on a clear liquid diet earlier that day but she felt if the staff had telephoned the physician he would have sent Resident #19 out at that time.</p>	F 309			

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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review, the facility failed to make a referral to restorative nursing services as recommended by the physical therapist to decrease the risk for falls for one of one resident, Resident # 198.</p> <p>Findings included:</p> <p>A review of the Quarterly Minimum Data Set Assessment dated 06/10/2014 revealed that Resident # 198 was admitted to the facility on 12/12/2013 with multiple diagnoses which included, but were not limited to, anemia, peripheral neuropathy, ischemic heart disease, and osteoarthritis. Further review of the same assessment revealed that Resident # 198 required the use of a walker and/or wheelchair.</p> <p>The resident's Nursing Care Plan which was initiated 12/26/2013 and last updated on 06/17/2014 included goals and interventions related to the resident's risk for falls and for her physical function deficit related to her self care impairment and mobility impairment. Some of the interventions to prevent the resident's risk for falls</p>	F 323	<p>F323 As is our practice, the facility will ensure the residents environment remains as free of accident hazards and receives adequate supervision and assistance devices to prevent accidents.</p> <p>Resident was discharged from therapy 7-14-2014 and was screened by therapy 8-5-2014 after after fall occurred on 8-1-2014 with no functional change noted from 7-14-2014.</p> <p>Audit was done on discharge forms to check for transfers to restorative on other residents.</p> <p>Inservice therapists</p> <p>DRS will monitor discharge paperwork to ensure no missed programs. Restorative programs to be reviewed weekly at Utilization Review Meeting.</p> <p>The results of the monitoring will be discussed monthly at our QAPI meeting for any recommendations and continued</p>	9/4/14	

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F 323	<p>Continued From page 14 included a therapy referral and education of the resident to call for assistance. In addition, other interventions related to the resident's self care and mobility impairments included transfer assistance as needed and the use of an assistive rolling walker and wheelchair.</p> <p>Per review of the Restorative (Nursing) Log in the resident's paper chart, Restorative Nursing Care discontinued June 3, 2014.</p> <p>A review of the Physical Therapy Plan of Care (PTPC) dated 06/03/2014 revealed that physical therapy was initiated to treat muscle weakness and for the history of a fall. Some of the goals listed on the PTPC included:</p> <p>1) Gross bilateral lower extremities will increase one grade or higher as noted with improved stability and decrease fall risk on all functional transfers and ambulation within skilled nursing facility.</p> <p>2) The patient will increase balance as exhibited by improving the Timed Up & Go score to 60 seconds, correlating to a decrease in risk for falls to safely perform transfers and ambulation.</p> <p>The Physical Therapy Plan of Care was signed by the Physical Therapist #1 on 06/03/2014 and by the Physician on 06/27/2014.</p> <p>A review of the Physical Therapy - Therapist Progress & Discharge Summary dated 07/14/2014 revealed Resident #198 had performed various rehabilitative exercises to work toward the goals stated in the Physical Therapy</p>	F 323	<p>education.</p> <p>DRS/DNS will be responsible for overall compliance.</p>		

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F 323	<p>Continued From page 15</p> <p>Plan of Care, and also indicated that the discharge plan and instructions were as follows: "DC (discharged) to same SNF (skilled nursing facility) and referred to restorative nursing for ambulation program and exercise/s." The document was signed by the Physical Therapist on 07/14/2014.</p> <p>An interview was conducted with the nurse who was the coordinator for Restorative Nursing Services (RNS) Nurse #4 on 08/07/2014 at 11:00 AM. Nurse # 4 stated that Resident #198 was discontinued from RNS on 06/04/2014, and that there had been no referral to RNS since that date.</p> <p>In an interview on 08/07/2014 with the Director of Rehabilitation Services at 11:51 AM, she stated she could not explain why the referral had not been made to Restorative Nursing Services as stated in the Physical Therapy Progress & Discharge Summary. She explained that ordinarily, when a referral is made to RNS, a form was filled out by the Physical Therapist (PT) and delivered to the RNS coordinator, and that the PT would train the Restorative Nurse Aide regarding the exercises to be completed with the resident. She stated she did not know why the process for referral did not flow as it should have, but added that the physical therapist who worked with Resident #198 no longer worked for the facility and that she left shortly after the end of the resident's discharge from Physical Therapy. She stated that she would have expected the physical therapist to follow through, write the referral to RNS, and deliver it to Nurse # 4 so that RNS could be initiated.</p> <p>A review of the Post Fall Analysis/Plan for</p>	F 323			

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F 323	<p>Continued From page 16</p> <p>Resident #198 revealed that she had a fall on 08/01/2014 at 7:50 AM while she was transferring from her bed to her wheelchair. The same document revealed that possible causal factors were that the resident did not call for assistance, attempted a self transfer, the resident's Dysthymic Disorder, and that the resident stated the brakes did not hold. There were no injuries to the resident as a result of the fall.</p> <p>In an interview with Resident # 198 on 8/7/14 at 12:10 PM, she stated she remembered her fall, and that the wheelchair was not locked when she tried to transfer into it from her bed. She also stated that she preferred using her wheelchair because she did not feel strong enough to use her walker. In addition she stated she had received exercises in the past for increasing her strength, but she was not currently receiving those exercises.</p> <p>In an interview with the Director of Nursing Services (DNS) and the Administrator on 08/07/2014 at 5:08 PM, the DNS stated she would have expected for the Physical Therapist to follow through and write the referral to RNS and to train the RNS Aide regarding the exercises to provide for Resident # 198. The DNS also stated that restorative nursing could have been provided if a referral had been received.</p>	F 323			