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F 000	INITIAL COMMENTS 483.25 (F323) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had a fall from a lift when the sling he was sitting in ripped and he fell onto the floor. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.	F 000		

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

Electronically Signed | 08/04/2014

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F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, physician and staff interviews the facility failed to notify the physician of a resident's x-ray results and	F 157	Resident #17 - The physician was notified by the Director of Nursing (DON) regarding the resident□s' change in	8/10/14

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F 157	Continued From page 2 continued complaints of left knee pain for 1 of 2 residents who had a falls from lifts (Resident #17); and failed to notify the physician that nursing staff was unable to administer a resident's medications (Resident #18); and failed to notify the physician of a resident's discontinuation of skilled therapy services (Resident #14) for 2 of 3 sampled residents. The findings included: 1. Resident #17 was admitted to the facility on 01/30/14 with diagnoses which included generalized weakness, arthritis, high blood pressure, diabetes, thyroid disease and depression. The most recent quarterly Minimum Data Set (MDS) dated 04/26/14 indicated Resident #17 had no short or long term memory problems, was cognitively intact for daily decision making and was totally dependent on staff for transfers. A review of a nurse's note dated 06/23/14 at 2:59 PM indicated a change of status which revealed Resident #17 was being lifted out of a recliner chair with a mechanical lift and the lift pad ripped at the left front corner. The notes indicated Resident #17 fell back into the chair approximately 6 inches with no apparent injury noted. A review of a nurse's note dated 06/24/14 at 7:46 AM indicated a late entry note for 6:00 AM that Resident #17 was complaining of left knee pain and was given as needed (PRN) pain medication. A review of a physician's order dated 06/24/14 at 1:30 PM indicated x-ray of left knee due to pain.	F 157	condition related to pain and the results of the x-ray and MRI on 7/7/14. Resident # 17 continues to receive pain medications per physicians order, no further x-rays or tests had been ordered. The care plan was reviewed and updated by the MDS as needed and staff were educated. Resident #17 was discharged to home on 7/28/14. Resident# 18 - The physician was notified of the resident change in condition at 1:20 pm on 6/16/14 by a licensed nurse at which time the physician reviewed the resident□s labs and did not give any further orders. At 7:17 pm, the resident□s change of condition continued and the on-call physician was notified by the licensed nurse. New orders were received to transfer to the hospital for evaluation. All licensed Nurses staff have been re-educated on the change of condition policy which includes notifying the primary physician or on-call physician, and the Administrative Nurse on call by DON and SDC between 7-17-14 and 8-9-14. Resident#14 is currently receiving therapy services per physician order. She has the appropriate wheelchair for her needs. Her care plan has been updated and all licensed Nurses staff has been re-educated. Any resident having a change in condition can be affected by this practice. Therefore, the Regional Clinical Nurse and the DON audited the	

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F 157	Continued From page 3 A review of a radiology report dated 06/24/14 at 5:44 PM indicated left knee x-ray indicated no fractures but moderate osteoarthritis in the left knee. A review of a nurse's note dated 06/25/14 at 1:35 AM revealed at 1:00 AM Resident #17 continued to verbalize that her left knee was painful or sore especially with activity and the area was guarded. The notes further revealed Resident #17's left knee had no redness, no bruising and no swelling. A review of a physician's progress note dated 06/25/14 indicated the physician who was also the facility medical director documented he was asked to see Resident #17 because of the onset of severe left knee pain. The notes revealed Resident #17 fell into her recliner while staff was using a lift and the fall was from about 6 inches above the level of the recliner. The notes further revealed Resident #17 stated her left leg hit the floor first and she suddenly developed left knee pain and today at the time of the examination she had significant tenderness in the distal thigh, knee region and proximal (central point) of her foreleg on her left leg but there was no deformity, no significant swelling or redness of the skin but she had markedly reduced range of motion. The notes indicated Resident #17 had been receiving Oxycodone by mouth twice a day and every six hours on a PRN basis for pain. The progress notes also indicated Resident #17 was in distress due to severe pain on left knee. A section titled diagnosis, assessment and plan indicated Resident #17 had a history of severe degenerative joint disease, and had been followed by orthopedic surgery because of chronic right knee pain. The notes further	F 157	24-hour report on 7/17/14 for the previous 60 days to ensure that changes in condition were addressed by the nursing staff and that the physician and RP were notified of the change in condition. The Therapy Department will notify the nursing department in the Medicare meeting and morning clinical meeting when a resident is being discharged from Therapy. The therapy Department will call the physician to update on the resident□s progress and to obtain an order for discharge from therapy service. All Licensed therapist and all licensed nursing staff were re-educated on this procedure on 8/4/14. Between 7-17-2014 to 8/9/14 The DON and SDC re-educated all licensed Nurses staff regarding the facility policy on notification of a change in a resident□s condition. The Federal Regulation regarding Notification of Change in Condition was provided to all licensed Nurses staff for educational purposes between 7/17/14 and 8/9/14. Physician□ orders are copied each day by the medical records clerk and a copy given to the DON for follow-up. All medication record are audited daily for missed charting and the nurses are called to return to the facility to complete charting on the medication record. The above named re-education was 100% or the licensed nursing staff that has not attended the in-service will not work until re-education is completed.	

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F 157	Continued From page 4 indicated the physician had requested a complete bone survey of the left lower leg to assess for possible fractures and would await x-ray evaluation before deciding further intervention if needed. A review of a physician's order dated 06/25/14 at 2:00 PM indicated x-ray full left hip and whole left leg due to pain and change Oxycodone to 5 milligrams (mg) by mouth twice a day and 5 mg by mouth every 6 hours PRN for pain. A review of a physician's order dated 06/25/14 with no time indicated an order clarification to obtain left leg x-rays of the hip, tibia (shin bone) /fibula (calf bone) and femur (thigh bone) with 2 views on each. A review of a nurse's note dated 06/25/14 at 2:52 PM revealed Resident #17 was assessed by the physician and continued to complain of left knee pain. The notes further revealed physician orders were received for scheduled pain medication and x-ray of full leg and hip. A review of a radiology report dated 06/25/14 indicated moderate osteoarthritis of the left hip and no acute fracture, dislocation or destructive lesions in the left femur. A review of a nurse's note dated 06/26/14 at 10:25 AM revealed Resident #17 had a fall into a recliner from a lift and x-ray results of her left hip, femur, and tibia/fibula were negative. The notes further revealed Resident #17 continued to complain of left leg pain and medication scheduled for pain was given and there was no documentation in the notes that the physician was notified.	F 157	The DON, RN Supervisor, QA Nurse will audit for Changes in Condition utilizing the 24-hour report Monday thru Friday for six months to assure continued compliance. The Medical Record clerk will audit the charts on a quarterly basis and make any changes on the face sheet that need to be made. She will then replace the face sheet with the updated one in the medical record. The results of these audits will be taken to the QAPI Meeting monthly by the DON x 6 months or until compliance is achieved.	

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A review of a nurse's note dated 06/27/14 at 3:25 PM indicated Resident #17 continued to complain of left knee pain and moderate relief was obtained from pain medication. There was no documentation in the notes that the physician was notified.

A review of a physician's order dated 07/07/14 indicated a Magnetic Resonance Imaging (MRI) x-ray of left knee status post injury due to severely decreased range of motion and normal x-rays.

A review of a physician's order dated 07/07/14 indicated a clarification order for MRI of left knee without contrast due to injury with severely decreased range of motion and normal x-rays.

A review of a nurse's note dated 07/08/14 at 1:17 PM revealed Resident #17 was out of the facility for a MRI of left knee due to severely decreased range of motion.

A review of an x-ray report titled MRI left knee without contrast dated 07/08/14 at 2:30 PM had a facsimile (faxed) date of 07/11/14 and time stamped at 12:46 PM in the top left corner of the report. The report indicated the following impression:
1. Moderate to severe osteoarthritis of the medial (middle) compartment associated with contusions.
2. The medial meniscus (a semicircular cartilage that provides structural integrity to the knee) is extruded (pushed out) and there is a probable tear of the extruded body.
3. Findings suggest a grade 1 sprain of the medial collateral ligament (MCL) on the inner part

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of the knee.
4. Moderate intramuscular swelling within the vastus medialis (large muscle located on the front of the thigh).

A further review of the MRI report with the faxed date of 07/11/14 at 12:46 PM revealed a hand written note that was not signed which indicated reported to physician. Orthopedic referral to bone and joint specialist on Monday 07/21/14 at 2:00 PM.

A review of a physician's order dated 07/11/14 at 3:15 PM indicated to refer Resident #17 to a bone and joint specialist on 07/21/14.

During an interview on 07/02/14 at 11:30 AM Resident #17 explained on 06/23/14 she was sitting in a recliner chair in her room and called for staff to transfer her back to bed and Nurse Aide (NA) #3 and NA #15 went to go find a lift. She stated Nurse Aide (NA) #3 and NA#15 came back into her room with the lift and connected the hooks located on each corner of the sling to the lift arms and started to raise her up out of her chair. She explained when they raised her up off the chair the entire front left corner of the sling toward her feet ripped apart and she fell from the lift back into the recliner chair. She further explained when she started to fall NA #15 was standing next to her on her left side and pushed her back toward the chair so she would fall into the chair instead of falling on the floor. She stated her left leg hit the floor and she was in so much pain and was crying and NA #3 and NA #15 called for Nurse #2 to come to the room and they got another sling and lifted her from the recliner chair back into bed. She explained the physician ordered x-rays of her left knee on Tuesday

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06/24/14 and they were negative. She stated the physician saw her on Wednesday 06/25/14 because she was having so much pain in her left knee and since the previous x-rays were negative he ordered x-rays of her left hip and leg and and she was told they were also negative. Resident #17 further stated she felt something was wrong with her left knee and thought she should have a MRI because she had not had pain in that knee before she fell from the lift and now had to take pain medication daily on a regular basis.

During an interview on 07/08/14 at 9:34 AM with Nurse #2 she stated on 06/23/14 during the afternoon she was at the nurse's desk and heard screaming coming from Resident #17's room. She explained she ran into the room and Resident #17 was in her recliner chair screaming that her left foot was stuck between her recliner and the mechanical lift. She stated she pulled the lift back and Resident #17 stopped screaming. She explained she assessed Resident #17 but she could not find any redness or swelling or bruising. She stated she asked Resident #17 what what had happened and she said the sling had ripped at the left front corner and she dropped approximately 6 inches back down in the recliner. She further stated Resident #17 was sitting in the recliner with the sling still hooked to the mechanical lift and Nurse #2 verified the left front corner of the sling had totally ripped off the sling. She explained Resident #17 had a left knee x-ray done on 06/24/14 and the results were negative and then she had x-rays of her left hip and left leg on 06/25/14 and the results were negative. She stated Resident #17 was supposed to have been discharged to go home on 06/26/14 but her discharge was put on hold because of her left knee pain. She explained she

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had not talked with the physician about x-ray results until the DON told her to call him to request a MRI on 07/07/14 since Resident #17 was still complaining of pain in her left knee. She stated she called the physician and he gave a verbal order to schedule Resident #17 for an MRI and Resident #17's appointment was scheduled for this afternoon because that was the next available appointment date and time.

During an interview on 07/08/14 at 5:16 PM the DON explained she talked with Resident #17 on 06/24/14 as part of her investigation regarding her fall from a lift and the resident complained that her left knee was hurting. The DON stated she told Nurse #2 to call the physician to get an order for a left knee x-ray. She explained the x-ray results were negative but Resident #17 was still complaining of pain in her left knee on 06/25/14 and the physician examined her and ordered full x-rays of her left leg but they were also negative. She stated on 07/07/14 she was made aware that Resident #17 was still complaining of left knee pain and she told Nurse #2 to call the physician because she thought the physician should order a MRI. She confirmed Resident #17 went to get the MRI done this afternoon but she did not know what the results were.

During an interview on 07/09/14 at 12:47 PM Resident #17's physician who was also the facility Medical Director verified he was asked to see Resident #17 after she had a fall from a lift and complained of severe pain in her left knee. He confirmed Resident #17 had a history of pain in her right knee due to severe osteoarthritis but he was not aware Resident #17 had any problems with her left knee or had complained of pain in

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her left knee before she fell from the lift. He explained he was asked by nursing staff while making rounds in the facility to see Resident #17 on Wednesday 06/25/15 and she was complaining of severe pain and tenderness and had decreased range of motion in her left knee. He stated he first ordered x-rays of her left knee and those results were negative and then he ordered x-rays of her left hip and leg and was waiting on the results so he could determine the appropriate treatment. He stated he was next called by nursing staff but did not remember the exact date because they wanted orders for a MRI because the left leg and hip x-rays were negative. He stated that he had not been called about the results of the MRI and was waiting for the results so he could determine appropriate treatment for Resident #17. The physician stated it was his expectation for the nurses in the facility to be his eyes and ears when he was not there. He further stated he expected for nurses to communicate with him when x-ray results came back or if the resident continued to complain of pain or had a change in their condition and he thought the communication could be improved.

During a follow up interview on 07/11/14 at 3:06 PM the DON stated she had not seen the results of Resident #17's MRI but she thought nursing staff had called earlier that day for the results. The DON obtained a copy of the MRI results and after she read the impression of the report out loud she stated the report indicated Resident #17 had a torn meniscus of her left knee and the physician needed to be notified.

2. Resident #18 was admitted to the facility on 12/18/13 with diagnoses which included high blood pressure, depression, and traumatic brain injury which resulted in left sided paralysis and

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bilateral leg paralysis.

The most recent quarterly Minimum Data Set (MDS) dated 03/24/14 indicated Resident #18 had no short or long term memory problem, was cognitively intact for daily decision making, and was totally dependent on staff for most of his activities of daily living (ADLs).

A note written by the night shift nurse, Nurse #5, dated 06/16/14 at 8:03 AM indicated it was a late entry note for a 7:00 AM assessment that Resident #18 would not respond to external stimulus, his vital signs were within normal limits, and he had no signs or symptoms of distress. The note revealed that all of Resident #18's 6:00 AM medications were held because Resident #18 was unable to be awakened. The note further revealed Resident #18's condition was reported to the first shift nurse.

Nurse #5 was interviewed on 07/08/14 at 6:22 PM. Nurse #5 stated Resident #18 had a history of periods of unawakening episodes and no response to external stimuli. She verified she was unable to give Resident #18 his medications the morning of 06/16/14. She indicated she gave report to the oncoming nurse of Resident #18's condition but had not contacted the on-call physician because this was not unusual for Resident #18.

On 07/10/14 at 9:59 AM Nurse #6 was interviewed. She stated that Resident #18 would have episodes where he would ignore staff by acting as if he were in a deep sleep even if you called his name, but he would be ignoring you and would sometimes peek at you.

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Nurse #1 was interviewed on 07/09/14 at 1:35 PM. She stated she came on duty on 06/16/14 and worked from 7 AM to 3 PM. She stated that Resident #18 had a history of lethargic episodes on some days in which he appeared to be in a deep sleep and would not wake up if you tried to wake him. She stated later he would be back to his baseline, awake and talking. She stated when Nurse #5 reported the resident's condition to her on 06/16/14 that Nurse #5 told her "He is doing it again," meaning he would not wake up to take his medications. Nurse #1 stated that after report she checked on Resident #18 whose vital signs and oxygen saturation were within normal limits. She stated she shook him and held his face and rubbed his cheeks and he did not awaken so she let him sleep. Nurse #1 stated she checked on the resident later in her shift before lunch and he was still in what appeared to be a deep sleep, and would not waken or open his eyes. She stated his vital signs and oxygen saturation were within normal limits at that time. She stated she had seen the resident in this state multiple times before so did not consider this to be a change in condition for him.

Nurse #1 stated she contacted the physician at 1:20 PM and informed him of results of labs that were ordered for Resident #18 on 06/15/14. She informed the physician at that time of the resident's condition that morning. She stated the physician gave her orders for additional labs for 06/17/14, but gave no further orders regarding Resident #18.

A review of a nurse's note dated 06/16/14 at 1:20 PM indicated the physician was notified of Resident #18's continued periods of no response to external stimuli and the physician inquired

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about the results of Resident #18's recently ordered labs. The note further indicated Nurse #1 informed the physician the lab work would be repeated on 06/17/14. Continued review of the nurse's note indicated no new orders were received from the physician. Further review of the nurse's note revealed Resident #18's oral medications were not given and his meals were held related to the resident's somnolence.

During an interview on 07/09/14 at 12:45 PM, the physician indicated he was made aware of Resident #18's periods of unawakening episodes on Monday 06/16/14 at 1:20 PM. He stated the resident had a history of non-compliance with and refusal of care, and that he had had episodes similar to this in the past, sometimes in association with a urinary tract infection. The physician stated that he would have expected to be notified of Resident #18's condition when the nurse was unable to administer his 6:00 AM medications.

3. Resident #14 was admitted to the facility on 12/05/13 with pressure ulcers, diabetes, and chronic obstructive pulmonary disease. Review of the FL2 form with a faxed date of 12/03/13 revealed she required skilled nursing care, was nonambulatory, required personal care assistance for bathing and dressing, was to receive physical therapy daily and had specialized needs related to weight.

The physician orders revealed physical therapy (PT) was ordered 5 times per week times 4 weeks on 12/06/13 for gait training, therapeutic exercises and activities, manual therapy, neuromuscular re-education, and home visit as

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needed. The evaluation completed on 12/06/13 included a short term goal to increase time out of bed to 4 hours and a long term goal to complete gait training with rolling walker.

The physician orders revealed occupational therapy (OT) was ordered 5 to 7 times per week for 8 weeks on 12/06/13 for therapeutic activity, activities of daily living/self care, therapeutic exercises, neuro re-education, thermal modalities as needed, wheelchair management, manual treatment, nurse/caregiver education, and nursing education. The evaluation dated 12/07/13 included a short term goal to complete wheelchair transfers with maximum assistance of one with appropriate device and safety.

The admission Minimum Data Set (MDS) dated 12/12/13 coded her with intact cognition, total assistance needed for bed mobility, dressing, and toileting. Walking and transfers did not occur during this assessment period. She was coded as receiving PT and OT. The MDS noted there was a discharge plan for Resident #14 to return to the community.

PT notes dated 12/17/13 revealed Resident #14's family brought in a wheelchair from home which appeared too small for her and could cause pressure areas on lateral hips. PT notes dated 12/18/13, 12/19/13, 01/01/14, and 01/02/14 revealed attempts to utilize equipment in the facility to assist Resident #14 out of bed and more active in therapy and that the lack of appropriate equipment had been discussed with facility management.

On 01/06/14, the physician ordered skilled PT to continue 5 times per week times 4 weeks for

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therapeutic exercises, therapeutic activities, neuromuscular re-education, wheelchair management, manual therapy, gait training, home visit as needed.

Review of the physician progress notes dated 01/07/14 stated the facility was having difficulty getting her out of bed and the facility was working on getting her a larger size wheelchair so she can get up on a regular basis. Her plan was noted as continuing PT and OT to maximize function and independence in activities of daily living and mobility. Physician progress notes dated 01/14/14 noted Resident #14 was making "very small gains" in PT and OT as they were having continued difficulty mobilizing her. Her plan at this time was for continued PT and OT.

The PT discharge summary dated 01/27/14 stated the resident had not achieved her goals "due to lack of appropriate equipment to allow pt (patient) to get oob (out of bed)" and that the facility was in the process of obtaining appropriate seating. The note continued that therapy will reassess if indicated for further skill. Discharge instructions was for a home exercise program. This discharge summary was not signed by the physician and there was no discharge order signed by the physician in the medical record.

On 01/27/14 the OT discharge summary stated Resident #14 was limited to in bed activity and she was unable to access the therapy gym at this time. The note stated the facility was awaiting approval for a bariatric wheelchair and the resident was currently unable to sit at the edge of the bed secondary to the air mattress required for multiple skin ulcers. OT would re-evaluate when the wheelchair arrives.

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Review of physician progress notes dated 02/11/14 noted that Resident #14 was working with PT but she was unable to get out of bed as she does not have a wheelchair that can accommodate her. The note stated she was doing some strengthening exercises in bed. The plan stated she was to continue with PT for endurance and strength training as she awaited a wheelchair that can accommodate her. This note did not indicate knowledge that the physician was aware skilled therapy services had been discontinued.

Physician progress notes dated 04/14/14 stated the chief complaint was that Resident #14 had significant concerns regarding continued bedridden status and she was requesting an evaluation by PT. The resident reported she did not want to be bed ridden. The plan included asking PT to evaluate her and that she needed a "bariatric wheelchair to make any kind of functional gains."

The quarterly MDS dated 05/09/14 revealed Resident #14 was cognitively intact and did not transfer, walk, or do any locomotion during the 7 day assessment period. The mobility device normally used was noted as a wheelchair.

Physician orders dated 05/22/14 included OT to evaluate and treat Resident #14. OT physician orders dated 05/22/14 included OT to treat 3 times per week for 30 days for therapeutic exercises, therapeutic activities, neuromuscular re-education, self care/ADLs, wheelchair management and modalities as needed.

On 06/30/14 at 10:41 AM, Resident #14 stated

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that for a while they did not get her out of bed and therapy stopped when she had no wheelchair to fit her. She stated she has a wheelchair now from another facility that fits her. She stated she generally got up around 2:45 PM and returned to bed around 4:15 PM.

On 07/01/14 at 3:01 PM Resident #14 was observed propelling herself in a wheelchair using her feet down the hall. On 07/01/14 at 3:20 PM Resident #14 was observed in the therapy gym doing arm exercises.

On 07/02/14 at 12:03 the social worker stated that initially Resident #14 did not come to the facility with a wheelchair. The resident's family or a friend later brought one from home however therapy determined it did not fit the resident properly.

Resident #14 stated on 07/02/14 at 2:57 PM that she started in therapy when she first arrived. She stated therapy had asked her if she had a wheelchair at home and she had a friend bring her wheelchair from home to the facility. She reported that therapy determined that wheelchair was too small.

On 07/03/14 at 9:54 AM, the Administrator was interviewed and stated that the facility had been looking for months to find a wheelchair to accommodate Resident #14. He stated the current wheelchair she was using was loaned by another facility. He further stated that when the new therapy company came in (beginning in April) the new rehab manager stated there was a larger bariatric wheelchair at another facility he had been at previously, so the facility obtained that wheelchair for Resident #14 to use.

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F 157	Continued From page 17 Interview on 07/03/14 at 4:15 PM with the rehab manager revealed a new therapy company began in the facility on 04/01/14. He became the rehab manager on 05/12/14. At that time he became involved in the morning management meetings. During the morning management meeting, there had been a discussion of a resident who needed an extra wide wheelchair. The rehab manager stated he was aware of one at another facility and suggested they try to borrow that wheelchair for her. The rehab manager stated they obtained the extra wide wheelchair the next day and Resident #14 began therapy again. An interview was conducted with OT and PT on 07/10/14 at 10:08 AM. Both OT and PT stated they had worked with Resident #14 prior to the therapy company change in April 2014 and continued on with the new therapy company since April. OT stated that Resident #14 was unable to walk and she could not access the therapy gym due to no wheelchair available to fit her properly. She further stated that she was unable to do therapy and exercises at bedside due to her using an air mattress and sitting on the edge of the air mattress was a fall risk. Both OT and PT stated therapy services ended due to the facility not having the correct wheelchair for her to access the therapy gym. There was no indication in the medical record that Resident #14's physician was notified or involved in the discontinuation of skilled therapy services and/or the attempts the facility was making to obtain the appropriate size wheelchair in order to treat her.	F 157		
F 166	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO	F 166		8/10/14

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F 166 SS=E	Continued From page 18 RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, residen, family, and staff interviews, and medical record review, the facility failed to monitor and effectively resolve a pattern of grievances regarding residents having to wait extended periods of time for care for 2 of 5 residents. (Resident #21 and #15). The findings included: 1. Resident #21 was admitted to the facility on 03/15/13 with diagnoses including hypertension, gastroesophageal reflux disease, diabetes mellitus, other fracture, anxiety disorder and depression. Resident #21 was assessed on the most recent Minimum Data Set (MDS) dated 03/19/14 as cognitively intact requiring extensive assistance with 1 person assist for most activities of daily living (ADL). An interview was conducted on 07/01/14 at 8:00 AM with the Director of Social Services. She revealed that she has written up grievances reported to her but does not investigate them. She said once she has received a grievance she logs it and makes a copy to give to the department who will be handling it. She stated most of the grievances received have been nursing issues. She reported the Assistant	F 166	The Administrator, Senior Administrator, DON and Social Services Director met with Resident #15 and the resident's daughter,(RP) to review concerns/grievances on 7/28/14 to determine a resolution. The Senior Administrator explained to RP that she could voice her concerns to the Administrator, DON, RN Supervisor or Social Services Director or by filling out the grievance form available throughout the facility so that the concerns can be addressed by the appropriate department. The facility Administrator gave his personal cell phone number to the RP who stated understanding. Resident #21 was interviewed on 7/28/14 by the Administrator concerning past concerns/grievances. Resident #21 states that she is happy with her current treatment nurse and is treated with kindness, dignity and respect by current treatment nurse as well as other staff members. Any resident that has a grievance or concern could be affected by this practice. Therefore, all	

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F 166	Continued From page 19 Director of Nursing /Unit Manager had followed up on grievances by interviewing residents, family members and staff as part of the investigation to resolve the grievance. The Director of Social Services stated she did recall receiving complaints from residents and from family members about residents having to wait for long periods of time for wound care, preventing them from being able to attend activities and therapy. On 07/02/14 at 4:53 PM an interview was conducted with Resident #21. The resident revealed she had filed multiple grievances concerning having to wait in bed for hours for Nurse #7 to complete wound care. Resident #21 stated again today, she had been told at 9:30 AM by the nurse aide to stay in bed and wait for Nurse #7 to provide wound care and she was still waiting at 4:53 PM. Resident #21 stated she had been instructed to stay in bed and keep water proof lotion on the wounds until Nurse #7 arrived. Resident #21 stated this happened at least weekly with Nurse #7, and she had complained both verbally and in writing to nurse aides, other nurses, the facility director of social services, and the assistant director of nursing/unit manager (ADON/UM). Resident #21 stated nothing had changed and she still had to wait all day for wound care. An interview was conducted on 07/03/14 at 9:35 AM with the Physician Assistant (PA), who completed rounds with Nurse #7 each week to assess wounds. The PA said Resident #21 had complained to her that she had not received her wound treatments timely. An interview was conducted on 07/07/14 at 5:04 PM with the Director of Nursing (DON). She	F 166	grievances were audited by the Social Services Director, DON and the Corporate Nurse Consultant for the past 6 months on 7/16/14. All grievances were found to have a resolution. On 7/22/14 the Regional Clinical Nurse re-educated the Administrator and department managers concerning the grievance resolution policies and procedures. From 7/17/14 thru 8/9/14, the DON/SDC in-serviced Housekeeping/Laundry staff, Maintenance/Floor tech staff, Dietary staff, all licensed Nursing staff, all certified nursing assistants , all certified medication aides, all department heads (Dietary Manager, Maintenance Director, Housekeeping/Laundry Supervisor, Business Office Manager, Medical Records Director, Marketing Director, Social Services Director, Assistant Director of Nursing, Staff Development Coordinator, Quality Assurance Nurse, Activity Director, Administrator, Therapy Director)Physical Therapist, Occupational Therapist, Speech Therapist, Occupational Therapist Assistant, Physical Therapist Assistant, Office Assistant, Human Resource Director, regarding reporting to their immediate supervisor any grievance/concern brought to them by a resident or family member. Instructions on how to report a concern or grievance is posted on each unit on the wall by the nursing stations. All grievances will be given to the Administrator who will follow up with the	

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F 166	Continued From page 20 stated she had been the new DON for about 3 weeks and had only been given grievances to investigate a week ago. She said she had not received grievances from residents about residents having to wait a long time for wound care. The DON stated it was her expectation that residents would receive wound care in a timely manner, and if a resident filed a grievance about having to wait a long time for wound care, it would be investigated and resolved with the appropriate nurse. Interview with Nurse #2 on 07/09/14 at 10:21 AM revealed residents frequently complained about having to wait hours for wound care. Nurse #2 stated she had passed on resident complaints to the nursing supervisor and to the administrator about residents having to wait hours for therapy because they were waiting for wound care. Nurse #2 stated the situation hadn't improved or changed in the past year. Interview with Nurse #1 on 07/09/14 at 10:30 AM revealed she had reported to the administrator several times that residents were complaining about having to wait too long for wound care. Nurse #1 stated she keeps the residents medicated while waiting so they are not in pain, but their therapy and activities are delayed some days for hours while they wait for Nurse #7 to provide wound care. 2. Resident #15 was admitted to the facility on 10/24/11 with diagnoses including acute respiratory failure, cardiomegaly, heart failure, and acute renal failure. The most recent Minimum Data Set (MDS) quarterly assessment dated 06/13/14 revealed Resident #15 was severely cognitively impaired and usually able to	F 166	appropriate department manager for a resolution. When the Administrator is made aware of a grievance, the appropriate department manager will address the grievance and provide documented resolution to the Administrator. The Administrator will ensure follow-up has been discussed by the person filing the grievance. The resolution will then be maintained in a grievance book and logged on a grievance log. Beginning 7/17/14, the Social Services Director and the Activity Director are interviewing 12 alert and oriented residents per week x 6months regarding the grievance process and outcomes by utilizing a Resident Satisfaction Survey. Any negative feedback will be reported to the Administrator immediately for follow-up. The Administrator will present the grievance log to the QAPI Committee x 6months to identify any patterns in the grievance process. If patterns are identified, applicable staff will be re-educated at that time.	

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be understood.

Review of grievance reports revealed the family member of Resident #15 had filed the following grievances:
a. Grievance filed on 04/09/14 by the family member revealed Resident #15 had not being checked and turned every 2-4 hours. Family member stated she had observed him going for hours without being checked or turned when he needed to be changed. The grievance also revealed the family member felt staff had been physically rough with Resident #15, causing him excessive pain during care.
b. Grievance filed on 06/06/14 by the family member revealed she had observed Resident #15 waiting several hours to be changed on 06/05/14. The grievance also revealed the family member felt staff had been physically rough with Resident #15, causing him excessive pain during care.
c. Grievance filed on 06/06/14 (separate from above) by the family member revealed family member was unhappy with wound care.
d. Grievance filed on 06/08/14 by the family member revealed she had observed Resident #15, who had slid down at the bottom of his bed, unable to get up to the top or to call for assistance. The grievance revealed staff had not pulled Resident #15 up to top of bed to eat, and he had not been able to eat his dinner.
e. Grievance filed on 06/10/14 by the family member revealed Resident #15's unplugged oxygen tubing and concentrator had not been checked in several hours which had resulted in Resident #15 going without oxygen for several hours. The grievance revealed the family member had reported this occurring "7 or 8" times previously without resolution and staff was

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still not checking his oxygen frequently enough.

An interview was conducted on 07/01/14 at 8:00 AM with the Director of Social Services. She revealed that she had written up and verbally informed other team members about grievances reported to her but did not investigate them. She said once she has received a grievance she logged it and made a copy to give to the department who would be handling it. She stated most of the grievances received had been nursing issues. She reported the Assistant Director of Nursing /Unit Manager (ADON/UM) had followed up on grievances by interviewing residents, family members and staff as part of the investigation to resolve the grievance.

An interview was conducted on 07/01/14 at 4:46 PM with ADON/UM. She revealed the Social Worker had written grievances on forms and had given the forms to the department related to the grievance issue to be investigated. The ADON/UM also stated some grievances were not in writing but oral. Nursing grievances have been investigated by the nurse unit managers. The ADON/UM stated she had at different times interviewed residents, family members and staff and had provided staff education related to grievance care issues. The ADON/UM said after she had completed interviews with residents, family members and staff she had discussed the findings with the complainant. She said if the complainant had agreed the grievance had been resolved the complainant signed the form. The ADON/UM revealed she had received chronic complaints from the family member of Resident #15. When shown the grievance filed by the family member of Resident #15 on 04/09/14, the ADON/UM stated she had talked to all the nurse

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aides from day shift about turning and changing residents on a routine basis. The ADON/UM stated she had not interviewed the staff who had worked with Resident #15 on the day mentioned regarding the length of time he was left without care or the allegation of roughness. The ADON/UM also stated she had not interviewed other residents, other nurse aides, or other family members about similar care issues or concerns. When shown the two grievances filed by the family member of Resident #15 on 06/06/14, the ADON/UM stated she had placed an inservice sheet at each nurse's station for all nurse aides to read and sign. The ADON/UM stated she had not interviewed the staff who had worked with Resident #15 on the day mentioned regarding Resident #15 waiting several hours to be changed or the roughness of staff toward Resident #15. The ADON/UM also stated she had not interviewed other residents, other nurse aides, or other family members about similar care issues or concerns. The ADON/UM stated she wasn't aware of the grievance dated 06/06/14 involving the wound care because it had been handled by the administrator. When shown the grievance filed by the family member of Resident #15 on 06/08/14, the ADON/UM stated she had placed an inservice sheet at each nurse's station for all nurse aides to read and sign. The ADON/UM stated she had not interviewed the staff who had worked with Resident #15 on the day mentioned regarding Resident #15 being left at the foot of the bed unable to eat dinner. The ADON/UM also stated she had not interviewed other residents, other nurse aides, or other family members about similar care issues or concerns. When shown the grievance filed by the family member of Resident #15 on 06/10/14, the ADON/UM stated she had gone and found the

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oxygen tubing had been unplugged and she had heard complaints about this previously by the family member of Resident #15. The ADON/UM stated she had placed an inservice sheet at the nurse's stations for all nurse aides to sign to remind them to initial and date oxygen tubing and to make sure it is plugged in. The ADON/UM stated she had not interviewed the specific nurse aides who had worked with Resident #15 during the incident. The ADON/UM also stated she had not interviewed other residents, other nurse aides, or other family members about similar care issues or concerns.

Interview with family member of Resident #15 on 07/03/14 at 3:49 PM revealed she had filed many grievances, both orally and in writing, during the past 6 months to complain about the roughness of care she had observed Resident #15 receive at the facility, as well as the length of time Resident #15 had to wait for care and the quality of the care he received. The family member stated although she submitted repeated grievances and spoke to staff almost daily about these concerns, she felt the staff were never able to resolve the problems more than temporarily and she her complaints fell on deaf ears.

Follow up interview with family member of Resident #15 on 07/10/14 at 4:04 PM revealed family member had voiced her concerns about the wound care nurse being too physically rough when providing wound care, the staff not checking Resident #15 enough, resulting in him being left wet, without oxygen, and in a position where he couldn't eat his meal, to the administrator, to the facility Director of Social Services, to the Director of Nursing (DON), and to the ADON/UM many times aside from the written

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grievances. The family member stated each time she was told they would take care of the problem, but nothing ever changed. The family member stated she had to stay with Resident #15 most days to make sure he wasn't harmed or neglected because she didn't feel the facility staff made changes after her complaints. The family member stated she had been asked to sign the grievances after facility staff reviewed the grievances with her, but she had never felt they were resolved. The family member stated she knew they had given customer service training to some staff and had put papers out at nurse's desks to remind staff to provide prompt care but nothing had changed and she was extremely frustrated.

An interview was conducted on 07/07/14 at 5:04 PM with the DON. She stated she had been the new DON for about 3 weeks and had only been given grievances to investigate a week ago. She said she had not received grievances from residents about rough treatment by the staff. The DON was shown grievances filed and written by the ADON/UM that alleged the wound nurse was rough. The DON commented after she had read the grievances that the ADON/UM had not completed a thorough investigation of the alleged complaints of roughness by not interviewing residents involved to determine what residents described as rough treatment. The DON also stated she was aware the family member of Resident #15 was still unhappy with the care Resident #15 had been receiving and the DON felt the grievances she had filed should have been more thoroughly investigated.

An interview was conducted on 07/07/14 at 5:42 PM with the Administrator. He stated if he had

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F 166	Continued From page 26 received grievances from residents and staff members about staff being rough he had turned over the grievances to his clinical nursing staff for them to investigate and report back to him their findings. The Administrator stated his expectation was that the ADON and DON would thoroughly investigate all grievances about care which would include interviewing individual staff, the resident involved, and other residents living on the same unit.	F 166		
F 224 SS=H	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident and family interviews and record review, the facility staff failed to administer wound care to meet the physical and emotional needs of 5 of 5 residents who described the process as unnecessarily rough, rude and painful. The facility failed to oversee the provision of wound care for 5 of 5 residents who had concerns. (Resident #19, #20, #7, #21, and #15). 1. Resident #19 was admitted to the facility on 07/19/13 with diagnoses including, pressure ulcers, wound infections, and diabetes. The most recent Minimum Data Set (MDS), a significant	F 224	A record review for residents #19, #20, #7, #21 and #15 was completed. All residents are receiving treatments per physician□s orders. All residents had a new pain assessment completed. Residents affected were interviewed by the Regional Clinical Nurse on 7/29/14 regarding the care they received during the current treatment process. The treatment physicians□ orders have been reviewed by the DON, ADON, The Regional Clinical Nurse and the weekend RN Supervisor from 7/15/14 through 7/19/14 and have been found to be	8/10/14

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F 224	Continued From page 27 change assessment dated 05/04/14, revealed Resident #19 was cognitively intact, able to understand and be understood. Interview with Resident #19 on 07/02/14 at 2:58 PM revealed although she felt pain at all times during movement and especially during wound care, she felt the wound care provided by Nurse #7 was exceptionally painful. Resident #19 stated when Nurse #7 provided wound care, it felt as though the wound is pinched together extremely tightly to get the gauze or packing into it. Resident #19 stated Nurse #7 is not gentle with the wound when she provides care. Resident #19 stated when any other nurse provides wound care, including the wound care physician's assistant, it is painful but not excruciatingly painful as it is when Nurse #7 provides wound care. Resident #19 stated when Nurse #7 provided wound care, it felt as though she was out to hurt her, and the other staff that provided wound care provided it in a way that caused pain but it did not feel like they were trying to make it hurt. Resident #19 stated she cries frequently because of all the times she's been hurt by Nurse #7. Resident #19 stated she had told Nurse #7 how much it hurt like the wound was being pinched and to stop, but Nurse #7 had responded to Resident #19 that the wound had to be done like that to get the gauze in, and she didn't stop. Resident #19 stated she had complained about the roughness shown by Nurse #7 several months earlier to the director of social services (DSS) and had asked to not be treated by Nurse #7, and as a result, Nurse #7 had not provided care for her for a few weeks. Resident #19 stated after a few weeks, however, Nurse #7 had begun to provide wound care for Resident #19 again. Resident #19 stated no staff had	F 224	appropriate for these residents. All physician□ orders were clarified, reviewed and approved by the Medical Director. After all interviews were complete, the facility sent a 24-hr and a 5-day abuse report to the North Carolina Nurse Aide Registry concerning the previous wound care nurse. Any other resident with a treatment order can be affected by this practice. Therefore, the Regional Clinical Nurse reviewed all treatment orders for residents in the facility from 7/15/14 through 7/21/14 and they have been found to be appropriate for these residents. All physician orders were clarified, reviewed and approved by the Medical Director. All Licensed Nursing Staff have been have re-educated on dignity, respect, gentleness and pain management during wound care on 7/17/14 and 8/9/14 by the DON and the Staff Development Coordinator (SDC). A Qualified Clinical Education Manager was been obtained to provide directed in-service training in all aspects of wound care, including physician□s orders, provision of care technique, wound care products and accurate documentation to all licensed nurses and medication aides. These in-service were conducted from 8-01-14 to 8-9-14. All licensed nurses have been re-educated on the facility Abuse Policy and Procedure and Prevention	

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F 224	Continued From page 28 talked to her and asked her to describe the wound care provided by Nurse #7 when she complained about the roughness of Nurse #7, and no staff member had come to explain to her why Nurse #7 was providing care for her again. Resident #19 stated she had stopped complaining to staff about the rough way it felt when Nurse #7 provided wound care because she felt complaining wouldn't make a difference. Interview with Nurse #7 on 07/07/14 at 2:15 PM revealed she usually asked residents if the wound care hurt during the care. Nurse #7 stated she would report it to the wound doctor and floor nurse after the care if the resident had said the care was painful. Nurse #7 stated Resident #19 had complained about the excessive pain, but that Resident #19 was always in pain, even if she touched the bed. Interview with Unit Manager (UM) on 07/07/14 at 12:18 PM revealed she had been told Resident #19 had complained about Nurse #7 being rough during wound care, but Resident #19 was so sensitive to movement and said everything hurt, so she had not interviewed Resident #19 in response to the complaints. 2. Resident #20 was admitted to the facility on 05/15/13 with diagnoses including diabetes, depression, dementia, and hypertension. The most recent Minimum Data Set (MDS) quarterly assessment dated 05/15/14 revealed Resident #20 was cognitively intact, able to understand others and able to be understood. Interview with Resident #20 on 07/03/14 at 9:30 AM revealed when Nurse #7 provided wound care, she worked very quickly and very roughly.	F 224	and the nurse□s responsibility to resident comfort during treatment and the reporting procedures to the Administrator or DON when abuse is alleged from 7-17-14 to 8-9-14 by the DON and the SDC. The Quality Assurance Nurse (QA Nurse) will interview all interviewable residents who have a physicians order for wound treatments to ensure they are treated with dignity, respect, kindness and gentleness during their wound care and are assessed for pain as needed each month x 4 months prior to the monthly QAPI Meeting. If any allegations are made, they will be brought to the Administrator and DON immediately for resolution. Results of these interviews will be presented at the monthly QAPI meeting x 4 months.	

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Resident #20 stated Nurse #7 was always talking and laughing with other staff while providing wound care to her. Resident #20 stated Nurse #7 never asked her what her pain level was or if she was in pain during the care, but when Resident #20 would interrupt Nurse #7's talking by yelling that she was hurting her, Nurse #7 wound not stop but say I'm about through, I'm about through," and would keep on scrubbing. Resident #20 stated Nurse #7 rarely spoke to her at all while providing wound care, but when she did speak to her, she spoke very harshly and rudely.

Interview with Nurse #7 on 07/07/14 at 2:15 PM revealed she usually asked residents if the wound care hurt during the care. Nurse #7 stated she would report it to the wound doctor and floor nurse after the care if the resident had said the care was painful. Nurse #7 stated she did not recall Resident #20 complaining about excessive pain during wound care but she expected pain during the care because of the nature of the care and the wounds. Nurse #7 stated many residents didn't like her providing care for them, but wound care was painful and residents didn't like the care in general.

3. Resident #7 was admitted to the facility on 12/11/07 with diagnoses including diabetes, chronic airway obstruction, neuropathy, and hypothyroidism. The most recent Minimum Data Set quarterly assessment dated 05/19/14 revealed Resident #7 was moderately cognitively impaired for daily decision making with no short or long term memory problems and able to understand and to be understood.

Interview with Resident #7 on 07/02/14 at 5:15 PM revealed her opinion that Nurse #7 was not

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someone who should be providing care for older people because she had no patience. Resident #7 stated Nurse #7 would come flying into her room without knocking, yell out to people in the hall while she was in Resident #7's room, and provide wound care that was excessively rough. Resident #7 stated she had complained to the administrator about Nurse #7 being rough and rude when providing wound care. Resident #7 stated she had told the administrator that Nurse #7 had come in her room when she was sleeping, jerked her covers off, jerked her leg up, yanked off her boot and yelled "Put that leg up!" Resident #7 stated she would try to keep her own leg up as she gradually awakened, but Nurse #7 would scrub her wound with excessive force and speed. Resident #7 stated she would cry, tell Nurse #7 how much it hurt, and ask her to stop, but Nurse #7 would tell her that it was good for the wound to bleed, that Nurse #7 needed to make it bleed, and it was good for it to hurt. Resident #7 stated Nurse #7 never asked for her pain level during care. Resident #7 stated when any other nurse provided wound care, it caused pain but not nearly the amount of pain caused when Nurse #7 provided the wound care.

Interview with Nurse #7 on 07/07/14 at 2:15 PM revealed she usually asked residents if the wound care hurt during the care. Nurse #7 stated she would report it to the wound doctor and floor nurse after the care if the resident had said the care was painful. Nurse #7 stated she did not recall Resident #7 complaining about excessive pain during wound care but she expected pain during the care because of the nature of the care and the wounds. Nurse #7 stated many residents didn't like her providing care for them, but wound care was painful and residents didn't like the care

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in general.

4. Resident #21 was admitted to the facility on 03/14/13 with diagnoses including diabetes, fracture, hypertension, and anxiety. The most recent Minimum Data Set quarterly assessment dated 03/19/14 revealed Resident #21 was cognitively intact, able to understand others and to be understood by others.

Interview with Resident #21 on 07/02/14 at 4:53 PM revealed Nurse #7 was very rude while providing wound care, cussing and talking hatefully. Resident #21 stated she told Nurse #7 regularly to get out of her room because she was saying rude things and treating her with disrespect. Resident #21 stated she told Nurse #7 " that hurts! " when she hurt her during wound care, but Nurse #7 would laugh and keep going. Resident #21 stated she had complained about the care of Nurse #7 to several nurses.

Interview with Nurse #7 on 07/07/14 at 2:15 PM revealed she usually asked residents if the wound care hurt during the care. Nurse #7 stated she would report it to the wound doctor and floor nurse after the care if the resident had said the care was painful. Nurse #7 stated she did not recall Resident #21 complaining about excessive pain during wound care but she expected pain during the care because of the nature of the care and the wounds. Nurse #7 stated many residents didn't like her providing care for them, but wound care was painful and residents didn't like the care in general.

5. Resident #15 was admitted to the facility on 10/24/11 with diagnoses including acute respiratory failure, cardiomegaly, heart failure,

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and acute renal failure. The most recent Minimum Data Set (MDS) quarterly assessment dated 06/13/14 revealed Resident #15 was severely cognitively impaired and usually able to be understood and usually understood.

Interview with family member of Resident #15 on 07/03/14 at 3:49 PM revealed she observed wound care being provided to Resident #15 by different staff members frequently, and she had witnessed Nurse #7 being a lot rougher with Resident #15 than any of the other staff members. The family member stated Nurse #7 would grab Resident #15, turn him and pull in very roughly, causing Resident #15 to cry out in pain. The family member stated she had told Nurse #7 to stop and to move Resident #15 more gently, but Nurse #7 had said she had to move him that way. The family member stated she had reported the roughness several times to the facility social services director as well as directly to the wound care physician's assistant (WPA) but nothing had been done about it.

Interview with Nurse #7 on 07/07/14 at 2:15 PM revealed she usually asked residents if the wound care hurt during the care. Nurse #7 stated she would report it to the wound doctor and floor nurse after the care if the resident had said the care was painful. Nurse #7 stated she did not recall the family member of Resident #15 complaining about excessive pain during wound care but she said the family member of Resident #15 complained frequently about care in general and so she had learned to ignore most of her complaints. Nurse #7 stated many residents didn't like her providing care for them, but wound care was painful and residents didn't like the care in general.

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Interview with facility Director of Social Services (DSS) on 07/01/14 at 8:00 AM revealed she had heard different residents complain about Nurse #7 being rough and rude. The facility DSS stated when she was told of complaints about Nurse #7, she had informed the Assistant Director of Nursing/Unit Manager (ADON/UM), the Director of Nursing (DON), and the Administrator during morning meeting, which they had each morning. The DSS further stated that it was the ADON/UM who investigated all concerns regarding nurses.

Interview with ADON/UM on 07/01/14 at 4:46 PM revealed she had received information about different residents' complaints about Nurse #7 being rude to them and rough with them during care. The ADON/UM stated she discussed the complaints with the DON and the Administrator each morning during morning meeting. The ADON/UM stated she understood that different staff had different ways of doing things, so when she received the complaints about Nurse #7 being rough or rude, she would do some education with Nurse #7 so that she didn't need to do further investigation.

Interview with the Regional Ombudsman (RO) on 7/02/14 at 10:25 AM revealed she had received chronic complaints from various residents about the care they received from Nurse #7. The RO said she had reported the complaints to the facility administrator. The RO also stated she had received complaints about the care provided by Nurse #7 by the facility Director of Social Services which she had also informed the administrator about.

Interview with physician's assistant (PA) on

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07/03/14 at 1:30 PM revealed she had heard quite a few residents report Nurse #7 was rough, loud, and rude. When asked what she did when residents complained to her about the care they received from Nurse #7, the PA stated each time she asked Nurse #7 about it and Nurse #7 would say she didn't think she was being rude or too rough with the residents.

Follow up interview with ADON/UM on 07/07/14 at 12:18 PM revealed she had not looked for patterns of resident complaints and she did not know who did. The ADON/UM stated the DON and Administrator always knew about every resident complaint because they were discussed each day at the morning meeting. The ADON/UM stated all department heads were also at that meeting each morning, and at each meeting, the Administrator would ask for information on any new grievances, and what was the status of any grievances being investigated.

Interview with the DON on 7/7/14 at 4:30 PM revealed her expectations that when any resident or family member expressed concern about a staff member being rough or rude while providing care, the staff member would immediately be moved from care of residents while the resident and staff person named were interviewed to get additional information. The DON stated she would also interview other residents who received care from that staff member, and other staff members who worked alongside the staff member in question. The DON stated she would thoroughly investigate any such concern until the resident or family member was satisfied the staff member would no longer be rough or rude with them or other residents. The DON stated she was not aware of any complaints by residents or

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family members about any staff member being rough or rude during care. The DON stated she had been working in the facility for three weeks.

Interview with Administrator on 07/07/14 at 5:42 PM revealed his expectation that when any resident or family member expressed concern about a staff member being rough when providing care, his clinical team, led by the DON would thoroughly investigate the complaint, including talking to that and other residents, that and other staff members, and looking for patterns of expressed concerns in the area. The administrator stated he also expected follow up monitoring to be done on the named staff person even if the investigation revealed no evidence of rough care. The administrator stated he was unaware of any grievance that had been expressed by a resident or family member about the treatment by a staff member that had not been thoroughly investigated to the satisfaction of the resident or family member.

Interview with Nurse #2 on 07/09/14 at 10:21 AM revealed several different residents had complained to her about Nurse #7 being rough and verbally rude to them. When asked what she had done, Nurse #2 stated she had told them to report the rudeness and roughness to the DSS, and she knew several of them had filed grievances with the DSS. Nurse #2 stated she had also gone directly to the Administrator and to the DON to report that she had received numerous complaints from residents about Nurse #7 being rough and rude with them during wound care and had been told they would take care of the complaints.

Interview with Nurse #1 on 07/09/14 at 10:30 AM

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F 224	Continued From page 36 revealed she had been complained to by several residents about the way they were treated by Nurse #7 during wound care. Nurse #1 stated every day Nurse #7 worked with residents, at least one resident would complain about the care they had received. Nurse #1 stated she had told the ADON/UM and the facility DSS about the complaints before and knew they were aware of the frequency of resident concerns.	F 224		
F 241 SS=H	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident, and family interviews, and record review, the facility staff failed to provide wound care in a manner that was sensitive to resident emotional and physical needs for 5 of 5 residents (Residents #7, #15, #19, #20, and #21). The facility staff failed to knock and ask for permission to enter resident rooms for 7 of 7 residents (Residents #7, #11, #12, #22, #24, #25, and #27). The facility staff seated a resident at a counter instead of a table and stood over the resident while feeding the resident for 1 of 1 resident (Resident #1). The findings included: 1. Resident #19 was admitted to the facility on 07/19/13 with diagnoses including pressure ulcers, wound infections, and diabetes. The most	F 241	A record review for residents #19, #20, #7, #21, and #15 was completed. All residents are receiving treatments per physician orders. All residents had a new pain assessment completed by the DON,SDC, and RN Supervisor on 7/29/14. The wound care physician orders have been reviewed by the DON, ADON and, the Regional Clinical Nurse and the weekend RN Supervisor from 7/15/14 through 7/19/14 and have been found to be appropriate for these residents. All physicians orders were clarified, reviewed and approved by the Medical Director. Resident #11,#12,#22,#24,#25,#26 Housekeeping/Laundry Staff,	8/10/14

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F 241	Continued From page 37 recent Minimum Data Set (MDS), a significant change assessment dated 05/04/14 revealed Resident #19 was cognitively intact, able to understand and be understood. Interview with Resident #19 on 07/02/14 at 2:58 PM revealed although she felt pain at all times during movement and especially during wound care, she felt the wound care provided by Nurse #7 was exceptionally painful. Resident #19 stated when Nurse #7 provided wound care, it felt as though the wound was pinched together extremely tightly to get the gauze or packing into it. Resident #19 stated Nurse #7 was not gentle with the wound when she provided care. Resident #19 stated when Nurse #7 provided wound care, Resident #19 screamed and cried the whole time, and felt Nurse #7 didn't care that it hurt because she never stopped or checked on her. Resident #19 stated she couldn't tolerate that pain and all she could do was to scream but Nurse #7 would just keep pinching and scrubbing. Resident #19 stated when any other nurse provided wound care, including the wound care physician's assistant, it was painful but not excruciatingly painful as it is when Nurse #7 provided wound care. Resident #19 stated when Nurse #7 provided wound care, it felt as though she was out to hurt her, and the other staff that provided wound care provided it in a way that caused pain but not as though they were trying to make it hurt. Resident #19 stated she cried frequently, even at night when it wasn't time for wound care, because of all the times she had been hurt by Nurse #7. Resident #19 stated she had told Nurse #7 how much it hurt like the wound was being pinched and to stop, but Nurse #7 had responded to Resident #19 that the wound had to be done like that to get the gauze	F 241	Maintenance/Floor Tech Staff, Dietary Staff, all Licensed Nursing Staff, all Certified Nursing Assistants , all Certified Medication Aides, all Department Heads (Dietary Manager, Maintenance Director, Housekeeping/Laundry Supervisor, Business Office Manager, Medical Records Director, Marketing Director, Social Services Director, Assistant Director of Nursing, Staff Development Coordinator, Quality Assurance Nurse, Activity Director, Administrator, Therapy Director)Physical Therapist, Occupational Therapist, Speech Therapist, Occupational Therapist Assistant, Physical Therapist Assistant, Office Assistant, Human Resource Director were re-educated by the DON from 7/17/14 and 8/9/14 addressing knocking and announcing when entering a resident room. Interviews by the Social Services Director and the Activity Director with 12 alert and oriented residents per week began on 7/17/1 4 which specifically ask about knocking on doors. Resident #1 is being assisted with dining by a Certified Nursing Assistant (C.N.A.) seated next to the resident. Any other resident with a treatment order can be affected by this practice. Therefore, the Regional Clinical Nurse reviewed all treatment orders for residents in the facility from 7/15/14 through 7/21/14 and was found to be appropriate for these residents. All physician orders were clarified, reviewed and approved by the Medical Director.	

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F 241	Continued From page 38 in, and she didn't stop or take breaks. Resident #19 stated she had complained about the roughness shown by Nurse #7 several months earlier to the facility Director of Social Services (DSS) and had asked to not be treated by Nurse #7, and as a result, Nurse #7 had not provided care for her for a few weeks. Resident #19 stated after a few weeks, however, Nurse #7 had began to provide wound care for Resident #19 again. Resident #19 stated no staff had talked to her and asked her to describe the wound care provided by Nurse #7 when she complained about the roughness of Nurse #7, and no staff member had come to explain to her why Nurse #7 was providing care for her again. Resident #19 stated she had stopped complaining to staff about the rough way felt when Nurse #7 provided wound care because she felt complaining wouldn't make a difference. Interview with Nurse #7 on 07/07/14 at 2:15 PM revealed she usually asked residents if the wound care hurt during the care. Nurse #7 stated she would report it to the wound doctor and floor nurse after the care if the resident had said the care was painful. Nurse #7 stated Resident #19 had complained about the excessive pain, but that Resident #19 was always in pain, even if she touched the bed. Interview with Assistant Director of Nursing/Unit Manager (ADON/UM) on 07/07/14 at 12:18 PM revealed she had been told Resident #19 had complained about Nurse #7 being rough during wound care, but Resident #19 was sensitive to movement and said everything hurt, so she had not interviewed Resident #19 in response to the complaints.	F 241	Any resident can be affected by the practice. Therefore, interviews by the Social Services Director and the Activity Director with 12 alert and oriented residents per week began on 7/17/1 4 which specifically ask about knocking on doors. An observation audit will be completed weekly x 4 weeks evaluating performance of knocking on doors prior to entering rooms. Any resident requiring feeding assistance can be affected by this practice. Therefore, the Registered Dietician (RD) and the MDS Team audited all residents needing feeding assistance on 8/4/14. The Licensed Nursing Staff were educated on dignity, respect and gentleness during treatments from 7/17/14 to 8/9/14 by the DON and the Staff Development Coordinator (SDC). A Qualified Clinical Education Manager was been obtained to provide directed in-service training in all aspects of wound care, including physician□s orders, provision of care technique, wound care products and accurate documentation to all licensed nurses and medication aides. These in-service were conducted from 8-01-14 to 8-9-14. All licensed nurses have been re-educated by the DON and SDC from 7/17/14 to 8/9/14 on the facility Abuse Policy and Procedure and Prevention and the nurse□s responsibility	

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F 241	Continued From page 39 2. Resident #20 was admitted to the facility on 05/15/13 with diagnoses including diabetes, depression, dementia, and hypertension. The most recent Minimum Data Set (MDS), a quarterly assessment dated 05/15/14 revealed Resident #20 was cognitively intact, able to understand others and able to be understood. Interview with Resident #20 on 07/03/14 at 9:30 AM revealed when Nurse #7 provided wound care, she worked very quickly and very roughly. Resident #20 stated Nurse #7 was always talking and laughing with other staff while providing wound care to her. Resident #20 stated she would yell at Nurse #7, cuss at her, and beg her to stop but Nurse #7 would keep going. Resident #20 got tearful when she stated she was frightened of the pain the residents must feel who get the same treatment from Nurse #7 and are not able to speak or cry out. Resident #20 stated Nurse #7 never asked her what her pain level was or if she was in pain during the care, but when Resident #20 would interrupt Nurse #7's talking by yelling that she was hurting her, Nurse #7 wound not stop but say "I'm about through, I'm about through," and would keep on scrubbing. Resident #20 stated Nurse #7 rarely spoke to her at all while providing wound care, but when she did speak to her, she spoke very harshly and rudely. Interview with Nurse #7 on 07/07/14 at 2:15 PM revealed she usually asked residents if the wound care hurt during the care. Nurse #7 stated she would report it to the Physician's Assistant (PA) and floor nurse after the care if the resident had said the care was painful. Nurse #7 stated she did not recall Resident #20 complaining about excessive pain during wound care but she	F 241	to resident comfort during treatment and the reporting procedures to the Administrator and DON. Housekeeping/Laundry staff, Maintenance/Floor Tech Staff, Dietary Staff, all Licensed Nursing Staff, all Certified Nursing Assistants , all Certified Medication Aides, all Department Heads (Dietary Manager, Maintenance Director, Housekeeping/Laundry Supervisor, Business Office Manager, Medical Records Director, Marketing Director, Social Services Director, Assistant Director of Nursing, Staff Development Coordinator, Quality Assurance Nurse, Activity Director, Administrator, Therapy Director)Physical Therapist, Occupational Therapist, Speech Therapist, Occupational Therapist Assistant, Physical Therapist Assistant, Office Assistant, Human Resource Director were re-educated by the DON and SDC from 7/17/14 to 8/9/14 concerning the responsibility of announcing and knocking on resident doors before entering. All new employees will be re-educated upon hire. The staff were re-educated by the DON and SDC from 7/17/14 to 8/9/14 regarding assisting residents during their dining experience in a dignified manner. The Quality Assurance Nurse (QA Nurse) will interview all interviewable residents who have a physicians order for wound treatments to ensure they are treated with dignity, respect, kindness and gentleness during their wound care treatment and are	

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F 241	Continued From page 40 expected pain during the care because of the nature of the care and the wounds. Nurse #7 stated many residents didn't like her providing care for them, but wound care was painful and residents didn't like the care in general. 3.a. Resident #7 was admitted to the facility on 12/11/07 with diagnoses including diabetes, chronic airway obstruction, neuropathy, and hypothyroidism. The most recent Minimum Data Set (MDS) quarterly assessment dated 05/19/14 revealed Resident #7 was moderately cognitively impaired for daily decision making with no short or long term memory problems and able to understand and to be understood. Interview with Resident #7 on 07/02/14 at 5:15 PM revealed her opinion that Nurse #7 was not someone who should be providing care for older people because she had no patience. Resident #7 stated Nurse #7 would come flying into her room without knocking, yell out to people in the hall while she was in Resident #7's room, and provide wound care that was excessively rough. Resident #7 stated she had complained to the Administrator about Nurse #7 being rough and rude when providing wound care. Resident #7 stated she had told the Administrator that Nurse #7 had come in her room when she was sleeping, jerked her covers off, jerked her leg up, yanked off her boot and yelled "Put that leg up!". With tears in her eyes, Resident #7 stated she would try to keep her own leg up as she gradually awakened, but Nurse #7 would scrub her wound with excessive force and speed and she felt Nurse #7 was taking out her frustrations on her by being mean. Resident #7 stated she would cry, tell Nurse #7 how much it hurt, and ask her to stop, but Nurse #7 would tell her that it was good	F 241	assessed for pain as needed each month x 4 months prior to the monthly QAPI meeting. If any allegations are made, they will be brought to the Administrator and DON immediately for resolution. Results of the interviews will be presented. Interviews by the Social Services Director and the Activity Director with 12 alert and oriented residents per week began on 7/17/1 4 which specifically ask about knocking on doors. These interviews will be conducted weekly x 6 months and results taken to the monthly QAPI meeting by the Social Services Director x 6 months. An observation audit will be completed weekly x 4 weeks evaluating performance of knocking on doors prior to entering rooms and will be submitted to the QAPI Committee for review and recommendations. The assisted feeding residents dining areas will be monitored by the MDS Coordinators/RN Supevisor during meal times x twice daily x 6 months for appropriateness of staff while assisting the resident to eat. The RN Supervisor will round daily during a meal to assess assistance with eating in resident rooms. Results will be taken to the monthly QAPI meetings by the MDS Coordinators for review and recommendations x 6 months.	

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for the wound to bleed, that Nurse #7 needed to make it bleed, and it was good for it to hurt. Resident #7 stated she hated to have Nurse #7 enter her room at all because she knew she would be hurt and treated roughly and rudely. Resident #7 stated she felt very angry that the facility continued to send Nurse #7 to provide care for her and other elderly patients who were already in pain. Resident #7 stated further stated she became extremely upset any time Nurse #7 even entered her room because of the way she was treated. Resident #7 said Nurse #7 never asked for her pain level during care and in fact Resident #7 stated she felt Nurse #7 laughed and encouraged Resident #7 to express her pain and frustration during the wound care. Resident #7 stated when any other nurse provided wound care, it caused pain but not nearly the amount of pain caused when Nurse #7 provided the wound care.

Interview with Nurse #7 on 07/07/14 at 2:15 PM revealed she usually asked residents if the wound care hurt during the care. Nurse #7 stated she would report it to the Physician's Assistant (PA) and floor nurse after the care if the resident had said the care was painful. Nurse #7 stated she did not recall Resident #7 complaining about excessive pain during wound care but she expected pain during the care because of the nature of the care and the wounds. Nurse #7 stated many residents didn't like her providing care for them, but wound care was painful and residents didn't like the care in general.

3.b. Record review revealed Resident #7 was admitted to the facility on 12/11/07 and readmitted on 08/17/12 with diagnoses including diabetes mellitus, and chronic airway obstruction. Record

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review of resident #7's Minimum Data Set (MDS) dated 05/19/14 revealed she was assessed as moderately cognitively intact for daily decision making.

Resident #7 was interviewed on 06/30/14 at 2:45 PM in her room. At approximately 2:55 PM Nurse Aide (NA) #19 flung the door open and entered the resident's room without knocking or gaining permission to enter. Resident #7 stated staff does not knock anymore and she said she had told staff to knock. Also, during the interview with Resident #7 at 3:22 PM the Activity Director lightly tapped Resident #7's door and entered the room without gaining permission to enter. She was observed to place the activity calendar on the first bed in the room which was vacant and left the room. Resident #7 was asked how it made her feel when staff do not knock and wait for permission to enter the room. Resident #7 stated it has made her feel small and embarrassed because she might be undressed or getting dressed.

On 07/02/14 at 12:50 PM NA #19 was interviewed concerning knocking before entering resident rooms. She stated she had not knocked on Resident #7's room or gained permission from the resident to enter. NA #19 revealed she should knock and wait to gain permission to enter the resident's room and Resident #7 had told her she needed to knock.

On 06/30/14 at 3:52 PM the Activity Director was interviewed. She stated she should have knocked on the door and waited for permission to enter. She said she did not know why she had not waited for Resident #7 to give her permission to enter the room.

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On 07/03/14 at 10:37 AM an interview was conducted with the Director of Nursing (DON). She stated she would expect staff to knock on a resident's door and wait for a response before entering the room.

3.c. Resident #7 was re-admitted to the facility on 08/17/12 with diagnoses which included diabetes, lung disease, and thyroid disease. The most recent quarterly Minimum Data Set (MDS) dated 05/19/14 indicated Resident #7 had no short or long term memory problems and was cognitively intact for daily decision making. Section M of the MDS indicated Resident #7 had other skin problems listed as infection of foot.

During an observation of wound care on 07/01/14 at 2:13 PM Nurse #7 who was the wound care nurse gathered supplies for a dressing change at a treatment cart in the hallway outside of Resident #7's room and Nurse #4 was standing next to her. The door of Resident #7's room was open but the privacy curtain was partially pulled so that Resident #7 was not visible from the hallway and there was no roommate in the room. Nurse #7 and Nurse #4 walked into Resident #7's room without knocking on the door, did not announce they were entering the room and did not ask for permission to enter the room. Nurse #4 announced to Resident #7 as she pulled the privacy curtain open at the foot of the bed that they were ready to do a dressing change on her left heel. Resident #7 stated "you should have knocked before you came in." Nurse #7 stated to Resident #7 that she thought the resident had heard them talking in the hallway outside of her door and knew they were ready to do her dressing change. Resident #7 then stated she

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wasn't ready to have the dressing changed but she guessed they could go ahead and do it. Nurse #4 held Resident #7's left leg while Nurse #7 washed her hands, put on gloves and changed the dressing on Resident #7's left heel. Nurse #7 then discarded supplies, washed her hands and left Resident #7's room.

During an interview on 07/01/14 at 2:40 PM with Resident #7 she stated it was routine for Nurse #7 to just walk in her room without knocking on the door. She explained she had not been feeling well and had been nauseated earlier in the day. She stated when Nurse #7 and Nurse #4 came into her room she was not ready to have the dressing changed on her left heel because she had just gotten off the toilet and was trying to get herself together. She stated she was so aggravated when Nurse #4 and Nurse #7 walked in that she told them to go ahead and do the dressing change to get it over with. Resident #7 stated it made her feel bad and was it totally unacceptable when Nurse #7 entered her room without knocking or did not ask for permission to enter her room.

During an interview on 07/02/14 at 12:35 PM with Nurse #7 she stated she was aware she was supposed to knock on the resident's door before she entered resident rooms. She verified she did not knock on Resident #7's door yesterday before she went in to do the dressing change because she was talking with Nurse #4 in the hallway outside of Resident #7's door and she thought Resident #7 already knew they were getting ready to do her dressing change.

During an interview on 07/11/14 at 3:06 PM the Director of Nursing stated it was her expectation

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that staff knock on resident doors and announce themselves before they entered a resident room. She further stated staff should ask permission to enter resident rooms and should explain to the resident what they needed to do.

4. Resident #21 was admitted to the facility on 03/14/13 with diagnoses including diabetes, fracture, hypertension, and anxiety. The most recent Minimum Data Set quarterly assessment dated 03/19/14 revealed Resident #21 was cognitively intact, able to understand and to be understood by others.

Interview with Resident #21 on 07/02/14 at 4:53 PM revealed Nurse #7 was very rude while providing wound care, cussing and talking hatefully. Resident #21 stated she told Nurse #7 regularly to get out of her room because she was saying rude things and treating her with disrespect. Resident #21 stated she told Nurse #7 "that hurts!" when she hurt her during wound care, but Nurse #7 would laugh and keep going. Resident #21 stated she had complained about the care of Nurse #7 to several nurses.

Interview with Nurse #7 on 07/07/14 at 2:15 PM revealed she usually asked residents if the wound care hurt during the care. Nurse #7 stated she would report it to the Physician's Assistant (PA) and floor nurse after the care if the resident had said the care was painful. Nurse #7 stated she did not recall Resident #21 complaining about excessive pain during wound care but she expected pain during the care because of the nature of the care and the wounds. Nurse #7 stated many residents didn't like her providing care for them, but wound care was painful and residents didn't like the care in general.

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5. Resident #15 was admitted to the facility on 10/24/11 with diagnoses including acute respiratory failure, cardiomegaly, heart failure, and acute renal failure. The most recent Minimum Data Set (MDS) quarterly assessment dated 06/13/14 revealed Resident #15 was severely cognitively impaired and usually able to be understood and usually understood.

Interview with family member of Resident #15 on 07/03/14 at 3:49 PM revealed she observed wound care being provided to Resident #15 by different staff members frequently, and she had witnessed Nurse #7 being a lot rougher with Resident #15 than any of the other staff members. The family member stated Nurse #7 would grab Resident #15, turn him and pull in very roughly, causing Resident #15 to cry out in pain. The family member stated Resident #15 did not cry out, wince, and jump when anyone else provided wound care, and it hurt her to see him in such pain. The family member stated she had told Nurse #7 to stop and to move Resident #15 more gently, but Nurse #7 had said she had to move him that way. The family member stated she had reported the roughness several times to the facility Social Services Director as well as directly to the Physician's Assistant (PA) but nothing had been done about it.

Interview with Nurse #7 on 07/07/14 at 2:15 PM revealed she usually asked residents if the wound care hurt during the care. Nurse #7 stated she would report it to the Physician's Assistant (PA) and floor nurse after the care if the resident had said the care was painful. Nurse #7 stated she did not recall the family member of Resident #15 complaining about excessive pain during wound

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care but she said the family member of Resident #15 complained frequently about care in general and so she had learned to ignore most of her complaints. Nurse #7 stated many residents didn't like her providing care for them, but wound care was painful and residents didn't like the care in general.

6. During an observation on 06/30/14 at 10:41 AM the floor technician was cleaning floors on the 100 resident hallway with an electric buffing machine. The floor technician walked behind the buffing machine in the hallway and then into resident room number 108 whose door was partially open without knocking on the door and did not ask for the resident's permission to enter the room. The floor technician also did not speak to either Resident #25 or Resident #11 who were in bed in the room and operated the machine at the foot of the resident's beds, between the beds and then walked behind the buffing machine out of the room and into the hallway. A review of Resident #25's most recent quarterly Minimum Data Set (MDS) dated 04/19/14 indicated she had short term and long term memory problems and was moderately impaired for daily decision making and a review Resident #11's most recent quarterly MDS dated 04/29/14 indicated she had short term and long term memory problems and was severely impaired in cognition for daily decision making.

During an observation on 06/30/14 at 10:52 AM the floor technician walked behind the floor buffing machine into resident room 105 whose door was partially open without knocking on the door and did not ask for the resident's permission to enter the room. The floor technician also did not speak to either Resident #22 or #24 who were

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in bed in the room and operated the machine at the foot of the resident's beds, between the beds and then walked behind the buffing machine out of the room and into the hallway. A review of Resident #22's most recent annual MDS dated 06/13/14 indicated she had no short or long term memory problems and was cognitively intact for daily decision making, and a review of Resident #24's most recent quarterly MDS dated 05/14/14 indicated she had no short term or long term memory problems and was cognitively intact for daily decision making.

During an observation on 06/30/14 at 10:58 AM the floor technician walked behind the floor buffing machine into resident room 104 whose door was partially open without knocking on the door and did not ask for the resident's permission to enter the room. Resident #12 was alone in the room in bed and the floor technician did not speak to her and operated the machine at the foot of the resident's beds, between the beds and then walked behind the buffing machine out of the room and into the hallway. A review of Resident #12's most recent quarterly MDS dated 05/13/14 indicated she had short term and long term memory problems and was severely impaired for daily decision making.

During an observation on 06/30/14 at 11:06 AM the floor technician walked behind the electric buffing machine into resident room 101 whose door was partially open without knocking on the door and did not ask for the resident's permission to enter the room. Resident #27 was alone in the room in bed and the floor technician did not speak to him and operated the machine at the foot of the resident's beds, between the beds and then walked behind the buffing machine out of the

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room and into the hallway. A review of the most recent annual MDS dated 06/17/14 indicated Resident #27 had no short term or long term memory problems and was cognitively intact for daily decision making.

During an interview on 07/03/14 at 9:42 AM the floor technician stated he had only worked in the facility for 3 months. He verified he received orientation and training for his job as a floor technician but stated he did not remember training to knock on resident doors and was not aware he was supposed ask and wait for residents to give permission before he entered their room.

During an interview on 07/03/14 at 9:46 AM the Environmental Services Director stated he was responsible for hiring and training environmental services staff which included the floor technician. He explained the floor technician should have knocked on resident's doors and should have asked and waited for permission to enter before he took the electric buffing machine into their room. He stated it was his expectation for environmental services staff to knock on resident doors and wait for the resident to respond before they entered the room and it was also his expectation for them to announce who they were and what they needed to do in the resident's room before they entered the room.

During an interview on 07/03/14 at 10:23 AM with Resident #27 he stated he had not paid attention when the floor technician entered his room without knocking on his door and wasn't sure if it bothered him or not.

During an interview on 07/06/14 at 3:45 PM with

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Resident #24 she stated she did not like for anyone to enter her room without knocking on the door first because sometimes she was getting dressed or was in the bathroom and wanted privacy. She further stated she expected for staff to knock and tell her who they were before they came in her room especially if she had not seen them before.

During an interview on 07/07/14 at 10:39 AM with Resident #22 stated she had noticed the floor technician had not knocked on her door or other resident doors before he entered their room with the buffing machine to clean the floors. She explained she had also noticed that he did not speak to her or her roommate when he came into the room. She stated she expected for staff to knock on her door and wait for permission to enter before they came in because sometimes she was taking a bath or getting dressed and needed privacy. She further stated many of the residents who lived on the 100 hallway were not able to communicate their needs. Resident #22 explained she thought all staff should definitely knock on the door of residents who were unable to voice their needs and staff should introduce themselves and tell the resident why they needed to enter the room. She stated she felt that was just common courtesy and it should always be done because she wanted to know why staff were coming into her room especially if she didn't know who they were or what they were planning to do.

7. Resident #1 was admitted to the facility on 12/13/04.

The most recent Minimum Data Set, a quarterly dated 05/16/14, coded him with long and short term memory impairment and having modified

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decision making skills. He was coded as needing extensive assistance with eating.

On 07/01/14 at 12:26 PM, Resident #1 was in the assisted dining room where other residents were eating. Resident #1 was seated in a low wheelchair close to the counter. His tray, all food in bowls, was located on the counter. At 12:27 PM, Nurse Aide (NA) #19 placed a towel in his lap where he was sitting by the counter. NA #19 stood next to Resident #1 and fed him. Due to the resident's small stature and low wheelchair, the resident's head/face was at the same height as the NA's waist. NA #19 proceeded to feed him one bowl of food after another while standing next to him as he sat in his wheelchair next to the counter. Once he was finished eating all 3 bowls of food, then she handed him his cups of fluids (2) which he drank independently all while she stood and he sat in his wheelchair by the room's counter. Observations during this time revealed there was a square table with only one resident seated at one side of the table and 4 empty chairs around the room.

After Resident #1 finished eating, an interview with NA #19 was conducted at 07/01/14 at 12:37 PM. NA #19 revealed that she was trained to sit at a table if one was available when feeding a resident. When asked why she did not sit with Resident #1 at a table, she replied she was working another hall and was just called to assist in the dining room. She further stated she should have sat with Resident #1 at a table when she assisted him to eat.

Interview with the Director of Nursing on 07/02/14 at 11:26 AM revealed she expected staff to seat residents at a table and face the resident when

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F 241	Continued From page 52 assisting them to eat.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to act upon concerns raised by the resident council regarding not answering call bells quickly. Findings included: Record review of the Resident Council minutes dated 10/07/13 revealed residents' concerns from previous months that call bells were not being answered in a timely manner. Record review of the Resident Council minutes dated 11/04/13 revealed residents' concerns regarding the length of time residents had to wait during third shift for care. Record review of the Resident Council minutes dated 02/03/14 revealed residents' concerns regarding waiting too long for nursing care. Record review of the Resident Council minutes dated 04/07/14 revealed residents' concerns regarding consistency and quality of care	F 244	No specific resident was named in this citation. Any resident residing in the facility can be affected by this concern. The Social Services Director met with the Resident Council President regarding the process of identifying concerns for follow-up in resident council and on the call bell response times on 7/29/14. All Department Managers were re-educated by the Regional Clinical Director regarding grievance resolution on 7/22/14. Housekeeping/Laundry Staff, Maintenance/Floor Tech Staff, Dietary Staff, all Licensed Nursing Staff, all Certified Nursing Assistants , all Certified Medication Aides, all Department Heads (Dietary Manager, Maintenance Director, Housekeeping/Laundry Supervisor, Business Office Manager, Medical Records Director, Marketing Director,	8/10/14

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F 244	Continued From page 53 provided by nurses and nurse aides. Record review of the Resident Council minutes dated 05/05/14 revealed residents' concerns regarding waiting too long for nursing care, especially during third shift. Record review of the Resident Council minutes dated 06/02/14 revealed residents' concerns regarding call bell response time. Interview with the facility Director of Social Services (DSS) on 07/01/14 at 8:00 AM revealed she and the Activities Director (AD) attended the monthly Resident Council meetings. When asked how concerns brought up by residents at the Resident Council were handled at the facility, the facility DSS stated that at each meeting the concerns from the previous meeting were reviewed to see if residents had seen improvement during the month. The facility DSS stated some concerns from Resident Council went on a grievance form, which went to the department head to manage. The facility DSS stated the concerns residents had expressed about call bell response time, waiting too long for nursing care, and the consistency and quality of nursing care had not been transferred to grievance forms. The facility DSS stated the residents made complaints at every Resident Council meeting. The facility DSS further stated that any grievances involving nursing were given to the Assistant Director of Nursing/Unit Manager (ADON/UM) to investigate. Interview with the ADON/UM on 07/01/14 at 4:46 PM revealed she had never been informed of any complaint or grievance made by the Resident Council in the years she had worked as nursing	F 244	Social Services Director, Assistant Director of Nursing, Staff Development Coordinator, Quality Assurance Nurse, Activity Director, Administrator, Therapy Director)Physical Therapist, Occupational Therapist, Speech Therapist, Occupational Therapist Assistant, Physical Therapist Assistant, Office Assistant, Human Resource Director were re-educated by the DON between 7/17/14 to 8/9/14 regarding grievance reporting including follow-up on resident council concerns. The Administrator is now keeping the Grievance Logs and distributes grievances to the Department Managers for follow-up. The Social Service Director and Activity Director will review all concerns from Resident Council with the Administrator for logging and resolution after each resident council meeting. Re-education on answering call lights in a timely manner will be done on between 7/17/14 to 8/9/14 by the Administrator and the DON. The Social Service Director and Activity Director will interview 12 residents per week x 6 months for timely response to answering call lights. The Social Service Director will bring results of these audits to QAPI monthly x 6 months for review and recommendation. The Resident Council minutes will be submitted to the QAPI monthly for review and recommendation.	

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supervisor.

Resident #20 was admitted to the facility on 05/15/13 with diagnoses including diabetes, depression, dementia, and hypertension. The most recent Minimum Data Set (MDS) quarterly assessment dated 05/15/14 revealed Resident #20 was cognitively intact, able to understand others and able to be understood.

Interview with Resident #20 on 07/04/14 at 9:30 AM revealed she had attended every Resident Council meeting in the last year. Resident #20 stated that residents had complained to the facility DSS and the AD about the length of time residents had to wait for care and the quality of nursing and nurse aide care at every meeting during the past year. Resident #20 stated that when the Resident Council minutes stated the problem had improved, it meant it had improved on one shift, but not on others. Resident #20 stated when they did see improvement of wait times, it was only temporary. Resident #20 stated the residents who attended the Resident Council had expressed their belief that waiting a long time for care was the way it would always be in the facility. Resident #20 stated she could not remember a Resident Council meeting when residents had not expressed concerns about call bell response and nurse aide care in the last year. Resident #20 stated the concerns were brought up each month at the meeting, but the problems had never changed and she didn't have hope they ever would. Resident #20 stated she felt complaints about nursing care in this facility fell on deaf ears.

Interview with the AD on 07/10/14 at 12:14 PM revealed she attended all the monthly Resident

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F 244	Continued From page 55 Council meetings with the facility DSS. The AD stated the residents who attended the Resident Council had many of the same complaints every meeting, including call bell response.	F 244		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and facility documentation, the facility failed to accommodate the needs for 2 of 5 sampled residents by providing appropriate fitting equipment in order to get out of bed. Resident #14 was not provided a wheelchair of the appropriate size to allow her to go to the therapy gym and Resident #17 was not provided a mechanical lift sling of the appropriate size to allow her to get out of bed for 8 days. The findings included: 1. Resident #14 was admitted to the facility on 12/05/13 with pressure ulcers, diabetes, chronic obstructive pulmonary disease and had specialized needs related to weight. Review of the FL2 form with a faxed date of 12/03/13 revealed she required skilled nursing care, was nonambulatory, required personal care	F 246	Resident #14 was provided a pressure reducing mattress, a shower gurney, a sling, a walker, a wheelchair and a bed-side commode. All of the equipment listed above was provided on or before 7/25/14. Resident # 17 was provided an appropriate lift sling on 7/03/14 to accommodate her weight needs. Resident was discharged home from the facility on 7/28/14. Any resident requiring specialized equipment can be affected by this practice. Therefore, the therapy department audited all residents to determine equipment needs and obtained equipment when the need for specialized equipment was identified. All care plans were updated by the MDS staff	8/10/14

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F 246	Continued From page 56 assistance for bathing and dressing, and was to receive physical therapy daily. The physician orders revealed physical therapy (PT) was ordered 5 times per week for 4 weeks on 12/06/13 for gait training, therapeutic exercises and activities, manual therapy, neuromuscular re-education, and home visit as needed. The evaluation completed on 12/06/13 included a short term goal to increase time out of bed to 4 hours and a long term goal to complete gait training with rolling walker. The physician orders revealed occupational therapy (OT) was ordered 5 to 7 times per week for 8 weeks on 12/06/13 for therapeutic activity, activities of daily living/self care, therapeutic exercises, neuro re-education, thermal modalities as needed, wheelchair management, manual treatment, nurse/caregiver education, and nursing education. The evaluation dated 12/07/13 included a short term goal to complete wheelchair transfers with maximum assistance of one with appropriate device and safety. The admission Minimum Data Set (MDS) dated 12/12/13 coded her with intact cognition, total assistance needed for bed mobility, dressing, and toileting. Walking and transfers did not occur during this assessment period. She was coded as receiving PT and OT. The MDS noted there was a discharge plan for Resident #14 to return to the community. PT notes dated 12/17/13 revealed Resident #14's family brought in a wheelchair from home which appeared too small for her and could cause pressure areas on lateral hips. PT notes dated 12/18/13 stated the resident was transferred to a	F 246	as needed and Housekeeping/Laundry Staff, Maintenance/Floor Tech Staff, Dietary Staff, all Licensed Nursing Staff, all Certified Nursing Assistants , all Certified Medication Aides, all Department Heads (Dietary Manager, Maintenance Director, Housekeeping/Laundry Supervisor, Business Office Manager, Medical Records Director, Marketing Director, Social Services Director, Assistant Director of Nursing, Staff Development Coordinator, Quality Assurance Nurse, Activity Director, Administrator, Therapy Director)Physical Therapist, Occupational Therapist, Speech Therapist, Occupational Therapist Assistant, Physical Therapist Assistant, Office Assistant, Human Resource Director were were educated on updates by the DON. The Therapy Department Manager, Admission Nurse and the DON were re-educated by the Regional Clinical Nurse on 7-23-14 regarding special equipment needs of newly admitted residents. All Therapy Staff were in-serviced to refer any equipment needs to the Administrator on 7/23/14 by the Therapy Manager. The DON, RN Supervisor and QA Nurse will audit 4 residents per week x 6 months to assure equipment needs are met. Audits will be submitted to the QAPI committee by the DON for review and recommendation for 6 months.	

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bariatric gerichair that was also too small for her. PT notes dated 12/19/13 stated that the small gerichair was discussed with the rehab manager who reported that management was working on ordering a wider gerichair for the resident. PT notes dated 01/01/14 revealed that the therapist communicated with the rehab manager regarding the status of a wheelchair or gerichair for Resident #14. The rehab manager reported he had price quotes but ordering a chair was under review of the facility management. PT notes dated 01/02/14 revealed there was no wider wheelchair in the facility for Resident #14 to use and that she was very eager to get out of bed and work on standing in the parallel bars.

On 01/06/14, the physician ordered skilled PT to continue 5 times per week for 4 weeks for therapeutic exercises, therapeutic activities, neuromuscular re-education, wheelchair management, manual therapy, gait training, home visit as needed.

The PT discharge summary dated 01/27/14 stated the resident had not achieved her goals "due to lack of appropriate equipment to allow pt (patient) to get oob (out of bed)" and that the facility was in the process of obtaining appropriate seating. The note continued stating that therapy would reassess if indicated. Discharge instructions was for a home exercise program.

On 01/27/14 the OT discharge summary stated Resident #14 was limited to in bed activity and she was unable to access the therapy gym at this time. The note stated the facility was awaiting approval for a bariatric wheelchair and the resident was currently unable to sit at the edge of the bed safely secondary to the air mattress

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required for multiple skin ulcers. The note stated OT would re-evaluate when the wheelchair arrived.

The quarterly MDS dated 05/09/14 revealed Resident #14 was cognitively intact and did not transfer, walk, or did any locomotion during the 7 day assessment period. The mobility device normally used was noted as a wheelchair.

Physician orders dated 05/22/14 included OT to evaluate and treat Resident #14. OT physician orders dated 05/22/14 included OT to treat 3 times per week for 30 days for therapeutic exercises, therapeutic activities, neuromuscular re-education, self care/ADLs, wheelchair management and modalities as needed.

On 06/30/14 at 10:41 AM, Resident #14 stated that for awhile they did not get her out of bed but that now she has a wheelchair from another facility that fit her. She stated she generally got up around 2:45 PM and returned to bed around 4:15 PM.

On 07/01/14 at 3:01 PM Resident #14 was observed propelling herself in a wheelchair using her feet down the hall. On 07/01/14 at 3:20 PM Resident #41 was observed in the therapy gym doing arm exercises.

On 07/02/14 at 12:03 PM, the social worker stated that Resident #14 did not come in the facility with a wheelchair. The resident's family or a friend later brought one from home however therapy determined it did not fit the resident properly.

Resident #14 stated on 07/02/14 at 2:57 PM that

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she started in therapy when she first arrived. She stated therapy had asked her if she had a wheelchair at home and she had a friend bring her wheelchair from home to the facility. She reported that therapy determined that wheelchair was too small.

On 07/03/14 at 9:54 AM, the Administrator was interviewed and stated that the the facility had been looking for months to find a wheelchair to accommodate Resident #14. He stated the current wheelchair she was using was a wheelchair that was loaned by another facility. He further stated that when the new therapy company came in (beginning in April) the new rehab manager stated there was a larger bariatric wheelchair at another facility he had been at previously, so the facility obtained that wheelchair for Resident #14 to use. When asked to provide evidence of the facility's attempts to obtain an appropriate sized wheelchair to meet Resident #14's needs the following was provided:
a. an email to a supply company on 01/13/14 requesting a bariatric wheelchair 40 inches by 22 inches and 18 inches high.
b. an email from the supply company on 01/13/14 stating 40 inches sounded way too wide.
c. an email from the supply company on 01/30/14 with a picture of a high back wheelchair with no additional information attached.
d. an undated computer print out of a specific brand of extra wide wheelchair with widths of 26 inches, 28 inches and 30 inches.
e. a computer print out dated 04/17/14 of the same brand of extra wide wheelchair with a seat width up to 30 inches.
f. an email dated 04/18/14 from a facility corporate staff who wrote that the wheelchair found for Resident #14 would not be covered by

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insurance. Attached were two examples of wheelchairs found via internet.

Interview on 07/03/14 at 4:15 PM with the rehab manager revealed a new therapy company began in the facility on 04/01/14. He became the rehab manager on 05/12/14. At that time, he became involved in the morning management meetings. During the morning management meeting, there had been a discussion of a resident who needed an extra wide wheelchair. The rehab manager stated he was aware of one at another facility and suggested the facility borrow that wheelchair for her. The rehab manager stated they obtained the extra wide wheelchair the next day and Resident #14 began therapy again.

An interview was conducted with OT and PT on 07/10/14 at 10:08 AM. Both OT and PT stated they had worked with Resident #14 prior to the therapy company change in April 2014 and continued on with the new therapy company since April. OT stated that Resident #14 was unable to walk and she could not access the therapy gym due no wheelchair was available to fit her properly. She further stated that she was unable to do therapy and exercises at bedside due to her using an air mattress and sitting on the edge of the air mattress was a fall risk. Both OT and PT stated therapy services ended due to the facility not having the correct wheelchair for her to access the therapy gym.

2. Resident #17 was admitted to the facility on 01/30/14 with diagnoses which included generalized weakness, arthritis, high blood pressure, diabetes, thyroid disease and depression. The most recent quarterly Minimum Data Set (MDS) dated 04/26/14 indicated Resident #17 had no short or long term memory

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problems, was cognitively intact for daily decision making and was totally dependent on staff for transfers.

A review of a care plan with a revised date of 04/30/14 indicated a problem statement that Resident #17 required assistance with activities of daily living and included a handwritten note to use a full body lift to transfer with 2 people.

A review of a nurse's note dated 06/23/14 at 2:59 PM indicated a change of status which revealed Resident #17 was being lifted out of a recliner chair with a mechanical lift and the lift pad ripped at the left front corner. The notes indicated Resident #17 fell back into chair approximately 6 inches and there was no apparent injury noted.

A review of a purchase order dated 06/30/14 indicated 4 extra large full body slings were ordered from a supply company.

During an interview on 07/02/14 at 11:30 AM Resident #17 explained on 06/23/14 she had a fall from a lift when the entire left front corner of the sling she was sitting on ripped apart and she fell into a recliner chair. She stated another sling was brought to her room for Nurse Aide (NA) #3 and NA #15 to put her back to bed. She explained after they put her back to bed on 06/23/14 she had to stay in bed for 8 days until they could get a lift sling that was large enough to lift her out of bed. She further explained while she was in bed she had to lay in the same position most of the time because she could not turn herself onto her left side and could only turn herself slightly to the right side. She stated she felt weak from staying in bed for so long and was frustrated because her overall strength had

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decreased and she felt her ability to care for herself had declined.

During an interview on 07/08/14 at 9:34 AM with Nurse #2 she stated on 06/23/14 Resident #17 had a fall from a mechanical lift when the sling that she was sitting on ripped at the left front corner and she dropped approximately 6 inches down in a recliner chair. She explained Resident #17 was in bed for 8 days after her fall because the nurse aides (NAs) told her they did not have a lift sling that was large enough to lift her from her bed into her recliner chair. She further explained Resident #17 required an extra large lift sling but they only had a limited number of extra large slings because NAs usually left lift slings under residents until they transferred them back to bed because that was easier for them. She stated she did not request for a sling to be ordered for Resident #17 because she had been told the Maintenance Director was auditing lift slings and she thought he had ordered new slings.

During an interview on 07/08/14 at 9:37 AM with NA #3 she confirmed she assisted with the transfer of Resident #17 when the sling ripped on 06/23/14 and Resident #17 fell into the recliner chair. She stated she transferred Resident #17 back to bed after the fall but they could not lift Resident #17 out of bed the next day because they did not have a sling that was large enough to lift her and she thought the nurses were aware. She further stated Resident #17 was in bed for 8 days before an extra-large sling was available to get her out of bed.

During an interview on 07/11/14 at 3:06 PM the DON stated lift slings were not assigned to residents and they were stored in the linen closet

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F 246	Continued From page 63 for resident use after they were laundered. She stated it was her expectation for different sizes of lift slings to be kept available in the facility and NAs should report to their nurse when they did not have a sling large enough to transfer a resident. She further stated she expected nurses to notify the Maintenance Director so he could order lift slings so residents did not have to stay in bed. During an interview on 07/11/14 at 5:23 PM the Maintenance Director stated he was not told that staff could not get Resident #17 out of bed after her fall on 06/23/14 because they did not have a sling large enough to lift her. He confirmed he ordered 4 extra-large lift slings when he placed his routine monthly order on 06/30/14 and those slings were delivered to the facility earlier today.	F 246		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record review, the facility failed to clarify a reordered eye medication with the pharmacy in order to avoid missed medications for 1 of 6 sampled residents. (Resident #13). The findings included: Resident #13 was admitted to the facility on 10/17/13 with diagnoses of diabetes mellitus and glaucoma.	F 281	Resident # 13 is currently receiving eye drops per physicians order. Any resident requiring medications can be affected by this practice. Therefore, the DON, SDC and RN Supervisor did a audit comparing the Medication Administration Cart to the Medication Administration Record on all units for all residents on 7/15/14 to ensure all physician prescribed medications were	8/10/14

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F 281	Continued From page 64 A record review of the Minimum Data Set (MDS) quarterly assessment dated 04/22/14 revealed that Resident #13 had been identified as cognitively intact. A care plan dated 04/30/14 revealed an identified problem for Resident #13 of impaired vision secondary to glaucoma. An intervention included: Medication as ordered. During an interview with Resident #13 on 06/30/14 at 11:35 AM Resident #13 stated that her eye drops for glaucoma had not been administered over the weekend. A record review of the Medication Administration Record (MAR) for Resident #13, for the month of June, 2014 revealed that Latanoprost solution 0.005 % was to be instilled in each eye every night for glaucoma. Further review revealed that it had been signed and circled for the dates of 06/28/14 thru 06/30/14 and no explanation of why it was circled on the MAR. An interview with Nurse #13 on 07/01/14 at 3:35 PM revealed that on 06/28/14 and 06/29/2014 she was the nurse who initialed the MAR on those nights for Resident #13. She revealed she circled the Latanoprost eye drops on the MAR, and it meant the medication was not given because, the medication was not available. An interview with Nurse #14 on 07/01/14 at 3:40 PM revealed that she worked on 06/30/14 evening shift, and she was the nurse who initialed and circled the Latanoprost on the MAR for Resident #13 as not given because it was not available. She also revealed that she ordered the	F 281	available. All medications were available. The DON and SDC re-educated all licensed nursing staff between 7/17/14 and 8/9/14 regarding the process for obtaining medications when ordered and for using the back-up pharmacy located locally. Nursing staff were educated between 7/17/14 and 8/9/14 regarding notifying the physician and DON when a medication is unavailable. The QA Nurse and RN Supervisor will do daily MAR audits for issues regarding missing documentation on the medication record. The audits will be done daily x 8 weeks and brought to the monthly QAPI meeting by the DON for review and recommendations.	

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F 281	Continued From page 65 medication from pharmacy on 06/30/14. An interview with the Physician on 07/02/14 at 12:30 PM revealed he did not feel missing the Latanoprost eye drops for 3 days would be significant enough to impact Resident #13, and would not raise the pressure in Resident #13's eyes. He did state that if Resident #13 missed 30 days of the eye drops he would worry about the pressure. An interview with the Director of Nursing (DON) on 07/03/14 at 8:50 AM revealed that the nurse who was passing medications at the time the medication was due, but finds it was not available, was responsible for communicating and clarifying any orders for the medication with the pharmacy. She further stated if the nurse does not receive the medication right away she should report it to the pharmacy and the DON. She revealed it is her expectation that the medication should have been ordered by the nurse responsible for that medication during her med pass, and there should have been communication about the specific need for the medication to the pharmacy. She stated the nurse was expected to follow up with pharmacy if the medication had not arrived at the facility that same day.	F 281		
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.	F 309		8/10/14

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F 309	Continued From page 66 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, physician and staff interviews, the facility failed to identify and assess the need for a Magnetic Resonance Imaging (MRI) x-ray for 12 days after initial x-rays were negative for a resident who continued to complain of left knee pain after she fell from a lift for 1 of 2 residents who had falls from lifts (Resident #17). The facility failed to reassess for the use of a drinking straw for 1 of 3 sampled residents (Resident #12). The findings included: 1. Resident #17 was admitted to the facility on 01/30/14 with diagnoses which included generalized weakness, arthritis, high blood pressure, diabetes, thyroid disease and depression. The most recent quarterly Minimum Data Set (MDS) dated 04/26/14 indicated Resident #17 had no short or long term memory problems, was cognitively intact for daily decision making and was totally dependent on staff for transfers. A review of a care plan with a revised date of 04/30/14 indicated a problem statement that Resident #17 required assistance with activities of daily living and included a handwritten note to use a full body lift to transfer with 2 people. A review of a nurse's note dated 06/23/14 at 2:59 PM indicated a change of status which revealed Resident #17 was being lifted out of a recliner	F 309	The physician was notified by the Director of Nursing (DON) regarding resident # 17 change in condition related to pain and the results of the x-ray and MRI 5-8-14 and 5-19-14. Resident # 17 continued to receive pain medications per physicians order and no further x-rays or tests had been ordered. Resident #17 was discharged home on 7/28/14. Resident # 12 was reassessed by the Speech Therapist on 7/18/14 and was deemed safe to use a straw to assist with drinking fluids. The care plan was updated by the MDS Coordinator on 7-30-14 and staff was re-educated from 7-18-14 to 8-9-14. The no straw alert was removed from the MAR, tray card and Physician telephone order All residents may be affected by this issue. A Numerical Pain Scale form requiring a numerical score and licensed nurses initials every shift was added to each resident's medication administration record and will be completed for all residents every shift to better assess and document a change in pain. Any resident requiring special needs at meals or change in condition related to pain can be affected.	

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F 309	Continued From page 67 chair with a mechanical lift and the lift pad ripped at the left front corner. The notes indicated Resident #17 fell back into chair approximately 6 inches and there was no apparent injury noted. A review of a nurse's note dated 06/24/14 at 7:46 AM indicated a late entry note for 6:00 AM that Resident #17 was complaining of left knee pain and was given as needed (PRN) pain medication. A review of a nurse's note dated 06/24/14 at 1:25 PM indicated Resident #17 was interviewed by the Director of Nursing (DON) to follow up on the resident ' s status related to her fall from a lift. The notes revealed Resident #17 stated to the DON that her left knee hurt and the DON requested for Nurse #2 to get a physician's order for a left knee x-ray. The notes indicated a physician's order was obtained and continue to monitor for increased pain and requests for PRN pain medication. A review of a physician's order dated 06/24/14 at 1:30 PM indicated x-ray of left knee due to pain. A review of a radiology report dated 06/24/14 at 5:44 PM indicated left knee x-ray indicated no fractures but moderate osteoarthritis in the left knee. A review of a nurse's note dated 06/24/14 at 6:44 PM indicated x-ray results revealed no fracture or joint effusion of the left knee and mild osteoarthritis was present. The notes further indicated Resident #17 and the DON and Administrator were notified of x-ray results and continue to observe for changes. A review of a nurse's note dated 06/25/14 at 1:35	F 309	The RD and the MDS Team reviewed and audited all residents with adaptive equipment or specialty needs for accuracy on 7/18/14. Re-education was done by the DON and SDC between 7/18/14 and 8/9/14 for all licensed nursing staff members concerning resident□s special needs for meals. Physician orders were reviewed for follow-up and care plans were updated as needed. A Pain Scale requiring a numerical score is being completed for all residents every shift utilizing the Numerical Pain Scale to better assess and document a change in pain. Any resident exhibiting symptoms of pain will have a pain assessment completed. The physician will be notified of change in condition related to pain as clinically appropriate. Re-education was done by the DON and SDC between 7/18/14 and 8/9/14 for all licensed nurses and medications aides concerning the new pain scale. The nurse will place the issue on the 24-hour report for follow-up during the next morning meeting. Residents will be reviewed for special needs or change of condition related to pain in the clinical morning meeting for follow-up and recommendations. A referral to the RD and Speech Therapist will be made as needed to determine if special needs for meals are needed or will continue to be appropriate. Any resident admitted requiring adaptive equipment or special needs will have a	

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F 309	Continued From page 68 AM indicated at 1:00 AM Resident #17 continued to verbalize that her left knee was painful or sore especially with activity and the area was guarded. The notes further indicated Resident #17's left knee had no redness, no bruising and no swelling. A review of a physician's progress note dated 06/25/14 indicated the physician who was also the facility medical director documented he was asked to see Resident #17 because of the onset of severe left knee pain. The notes revealed Resident #17 fell into her recliner while staff was using a lift and the fall was from about 6 inches above the level of the recliner. The notes further revealed Resident #17 stated her left leg hit the floor first and she suddenly developed left knee pain and today at the time of the examination she had significant tenderness in the distal thigh, knee region and proximal (central point) of her foreleg on her left leg but there was no deformity, no significant swelling or redness of the skin but she had markedly reduced range of motion. The notes indicated Resident #17 had been receiving oxycodone by mouth twice a day and every six hours on a PRN basis for pain. The progress notes also indicated Resident #17 was in distress due to severe pain on left knee. A section titled diagnosis, assessment and plan indicated Resident #17 had a history of severe degenerative joint disease, and had been followed by orthopedic surgery because of chronic right knee pain. The notes further indicated the physician had requested a complete bone survey of the left lower leg to assess for possible fractures and would await x-ray evaluation before deciding further intervention if needed.	F 309	physician□s telephone order written. A communication form will be completed by the nurse receiving the physicians order and will be forwarded to the RD, DON and the MDS Team. The physician□s order and communication form will be brought to the morning meeting to ensure that the appropriate departments have been notified. The audit of the adaptive equipment will be completed weekly x 4 weeks and then monthly x 3 months by the RD and MDS Team. The pain scale will be audited daily x 2 weeks and then weekly x 12 weeks and will be taken to the monthly QAPI meeting by the DON x 3 months for review. The Director of Nursing (DON) will review all residents identified as having a change in condition related to pain on a daily basis to ensure that assessment and the plan of care are being implemented as well as physician notification. The QAPI Committee will review a summary of the findings of the observations related to pain assessments and adaptive equipment. Recommendations for additional changes will be made as needed by the committee.	

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A review of a physician's order dated 06/25/14 at 2:00 PM indicated x-ray full left hip and whole left leg due to pain and change oxycodone to 5 milligrams (mg) by mouth twice a day and 5 mg by mouth every 6 hours PRN for pain.

A review of a physician's order dated 06/25/14 with no time indicated an order clarification to obtain left leg x-rays of the hip, tibia (shin bone) /fibula (calf bone) and femur (thigh bone) with 2 views on each.

A review of a nurse's note dated 06/25/14 at 2:52 PM indicated Resident #17 was assessed by the physician and continued to complain of left knee pain. The notes further indicated physician orders were received for scheduled pain medication and x-ray of full leg and hip.

A review of a radiology report dated 06/25/14 indicated moderate osteoarthritis of the left hip and no acute fracture, dislocation or destructive lesions in the left femur.

A review of a nurse's note dated 06/26/14 at 10:25 AM indicated Resident #17 had a fall into a recliner from a lift and x-ray results of her left hip, femur, and tibia/fibula were negative. The notes further indicated Resident #17 continued to complain of left leg pain and medication scheduled for pain was given.

A review of a nurse's note dated 06/27/14 at 3:25 PM indicated Resident #17 continued to complain of left knee pain and moderate relief was obtained from pain medication. There was no documentation in the notes that the physician was notified.

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A review of a physician's order dated 07/07/14 indicated a Magnetic Resonance Imaging (MRI) x-ray of left knee status post injury due to severely decreased range of motion and normal x-rays.

A review of a physician's order dated 07/07/14 indicated a clarification order for MRI of left knee without contrast due to injury with severely decreased range of motion and normal x-rays.

A review of a nurse's note dated 07/08/14 at 1:17 PM indicated Resident #17 was out of the facility for a MRI of left knee due to severely decreased range of motion.

A review of an x-ray report titled MRI left knee without contrast dated 07/08/14 at 2:30 PM had a facsimile (faxed) date of 07/11/14 and time stamped at 12:46 PM in the top left corner of the report. The report indicated the following impression:
1. Moderate to severe osteoarthritis of the medial (middle) compartment associated with contusions.
2. The medial meniscus (a semicircular cartilage that provides structural integrity to the knee) is extruded (pushed out) and there is a probable tear of the extruded body.
3. Findings suggest a grade 1 sprain of the medial collateral ligament (MCL) on the inner part of the knee.
4. Moderate intramuscular swelling within the vastus medialis (large muscle located on the front of the thigh).

A further review of MRI report with the faxed date of 07/11/14 at 12:46 PM revealed a hand written note that was not signed which indicated reported

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to physician. Orthopedic referral to bone and joint specialist on Monday 07/21/14 at 2:00 PM.

A review of a physician's order dated 07/11/14 at 3:15 PM indicated to refer Resident #17 to a bone and joint specialist on 07/21/14.

During an interview on 07/02/14 at 11:30 AM Resident #17 explained on 06/23/14 she was sitting in a recliner chair in her room and called for staff to transfer her back to bed and Nurse Aide (NA) #3 and NA #15 went to go find a lift. She stated Nurse Aide (NA) #3 and NA#15 came back into her room with the lift and connected the hooks located on each corner of the sling to the lift arms and started to raise her up out of her chair. She explained when they raised her up off the chair the entire front left corner of the sling toward her feet ripped apart and she fell from the lift back into the recliner chair. She further explained when she started to fall NA #15 was standing next to her on her left side and pushed her back toward the chair so she would fall into the chair instead of falling on the floor. She stated her left leg hit the floor and she was in so much pain and was crying and NA #3 and NA #15 called for Nurse #2 to come to the room and they got another sling and lifted Resident #17 from the recliner chair back into bed. She explained the physician ordered x-rays of her left knee on Tuesday 06/24/14 and they were negative. She stated the physician saw her on Wednesday 06/25/14 because she was having so much pain in her left knee and since the previous x-rays were negative he ordered x-rays of her left hip and leg and they were also negative. Resident #17 further stated she felt something was wrong with her left knee and thought she should have a MRI because she had not had pain in that knee

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before she fell from the lift and now had to take pain medication daily on a regular basis.

During an interview on 07/08/14 at 9:34 AM with Nurse #2 she stated on 06/23/14 during the afternoon she was at the nurse's desk and heard screaming coming from Resident #17's room. She explained she ran into the room and Resident #17 was in her recliner chair screaming that her left foot was stuck between her recliner and the mechanical lift. She stated she pulled the lift back and Resident #17 stopped screaming. She explained she assessed Resident #17 but she could not find any redness or swelling or bruising. She stated she asked Resident #17 what what had happened and she said the sling had ripped at the left front corner and she dropped approximately 6 inches back down in the recliner. She further stated Resident #17 was sitting in the recliner with the sling still hooked to the mechanical lift and Nurse #2 verified the left front corner of the sling had totally ripped off the sling. She explained Resident #17 had a left knee x-ray done on 06/24/14 and the results were negative and then she had x-rays of her left hip and left leg on 06/25/14 and the results were negative. She stated Resident #17 was supposed to have been discharged to go home on 06/26/14 but her discharge was put on hold because of her left knee pain. She explained she had not talked with the physician about x-ray results until the DON told her to call him to request a MRI on 07/07/14 since Resident #17 was still complaining of pain in her left knee. She stated she called the physician and he gave a verbal order to schedule Resident #17 for an MRI and Resident #17's appointment was scheduled for this afternoon because that was the next available appointment date and time.

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During an interview on 07/08/14 at 5:16 PM the DON explained she talked with Resident #17 on 06/24/14 as part of her investigation regarding her fall from a lift and the resident complained that her left knee was hurting. The DON stated she told Nurse #2 to call the physician to get an order for a left knee x-ray. She explained the x-ray results were negative but Resident #17 was still complaining of pain in her left knee on 06/25/14 and the physician examined her and ordered full xrays of her left leg but they were also negative. She stated on 07/07/14 she was made aware that Resident #17 was still complaining of left knee pain and she told Nurse #2 to call the physician because she thought the physician should order an MRI. She confirmed Resident #17 went to get the MRI done this afternoon but she did not know what the results were.

During an interview on 07/09/14 at 12:47 PM Resident #17's physician who was also the facility Medical Director verified he was asked to see Resident #17 after she had a fall from a lift and complained of severe pain in her left knee. He confirmed Resident #17 had a history of pain in her right knee due to severe osteoarthritis but he was not aware Resident #17 had any problems with her left knee or had complained of pain in her left knee before she fell from the lift. He explained he was asked by nursing staff while making rounds in the facility to see Resident #17 on Wednesday 06/25/15 and she was complaining of severe pain and tenderness and had decreased range of motion in her left knee. He stated he first ordered x-rays of her left knee and those results were negative and then he ordered x-rays of her left hip and leg and was waiting on the results so he could determine the

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appropriate treatment. He stated he was next called by nursing staff but did not remember the exact date because they wanted orders for a MRI because the left leg and hip x-rays were negative. He stated that he had not been called about the results of the MRI and was waiting for the results so he could determine appropriate treatment for Resident #17. The physician stated it was his expectation for the nurses in the facility to be his eyes and ears when he was not there. He further stated he expected for nurses to communicate with him when x-ray results came back or if the resident continued to complain of pain or had a change in their condition and he thought the communication could be improved.

During a follow up interview on 07/11/14 at 3:06 PM the DON stated she had not seen the results of Resident #17's MRI but she thought nursing staff had called earlier that day for the results. The DON obtained a copy of the MRI results and after she read the impression of the report out loud she stated the report indicated Resident #17 had a torn meniscus of her left knee and the physician needed to be notified.

2. Resident #12 was admitted to the facility on 09/23/08 with diagnoses which include kidney failure, altered mental status with intellect disability, dysphagia (difficulty in swallowing), epilepsy, and cerebral palsy.

A review of Resident #12's medical record indicated a speech therapy evaluation dated 12/20/13 indicated Resident #12 had weight loss secondary to a decline in her ability to swallow, a decline in her cognition, and communication skills. The clinical summary of the speech therapy evaluation indicated Resident #12 was changed to a mechanical soft diet, supervision/total

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assistance with eating of small bites, and no drinking straws.

The quarterly Minimum Data Set (MDS) dated 05/13/14 indicated Resident #12 was severely impaired in cognition for daily decision making and was totally dependent on staff for activities of daily living (ADLs).

A review of the physician's orders dated from 12/01/13 through 06/30/14 revealed an order for "mechanical soft diet with full range of liquids, a snack at bedtime, and no straw."

A review of the nurse's Medication Administration Record (MAR) dated 12/01/13 through 06/30/14 indicated "No Straw" for Resident #12.

A review of a care plan with a revised date of 06/04/14 indicated a problem statement that Resident #12 required assistance with ADLs and listed approaches in part for a mechanical soft diet, no drinking straws, and swallowing precautions which consisted of the following: supervision with meals, encourage small bites, head of the bed elevated with meals and at least for 30 minutes after meals.

Resident #12 was observed on 07/01/14 at 8:08 AM sitting up in her bed; her head and neck titled to the left side, without use of her left arm/hand due to the cerebral palsy, her breakfast tray was set up by the Nursing Assistant (NA) #13, which consisted of scrambled eggs, grits, a muffin, orange juice, and a carton of milk with a straw. Resident #12, with no staff in the room, drank the milk through the straw and was observed to have 3 episodes of a cough.

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Nurse #3 was observed on 07/01/14 at 8:34 AM go into Resident #12's room with an 8 ounce cup of a thickened shake and a straw. Nurse #3 was observed to put the straw in the cup of shake and held the cup for Resident #12 to drink half of the thickened shake through the straw.

Resident #12 was observed on 07/01/14 at 12:36 PM, her lunch tray was set up by NA #13 with a straw placed into the resident's carton of milk at which time she left the resident's room. Resident #12 was observed to have 1 episode of a cough while sucking the milk through the straw.

NA #13 was interviewed on 07/01/14 at 12:44 PM. She stated she was unaware that Resident #12 was not supposed to be drinking through a straw.

Nurse #3 was interviewed on 07/01/14 at 12:50 PM. She stated she was unaware that Resident #12 was not supposed to be drinking through a straw. She further stated she had never noticed the "no straw" printed on the MAR until it was brought to her attention during the interview.

Speech Therapist (ST) #1 was interviewed on 07/01/14 at 2:37 PM. She stated the ST that completed the evaluation on Resident #12 on 12/20/13 was no longer with the facility because the ST's were under a different contractor as of 04/01/14. She indicated she had no orders, information, and/or evaluations regarding Resident #12 and had not worked with her since she had been with the facility.

The Director of Nursing (DON) was interviewed on 07/01/14 at 3:09 PM. She stated she would have expected the nurses to be aware that

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F 309	Continued From page 77 Resident #12 was not supposed to have a straw when it was printed on the MAR.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide assistance with eating meals for 1 or 3 sampled residents dependent on staff for activities of daily living (Resident #12). The findings included: Resident #12 was admitted to the facility on 09/23/08 with diagnoses which include kidney failure, altered mental status with intellect disability, dysphagia (difficulty in swallowing), epilepsy, and cerebral palsy. The quarterly Minimum Data Set (MDS) dated 05/13/14 indicated Resident #12 was severely impaired in cognition for daily decision making and was totally dependent on staff for activities of daily living (ADLs). The MDS further revealed Resident #12 had impaired range of motion of her head and neck, left arm, and both legs. The MDS noted rejection of care was not exhibited and she had a poor appetite "every day."	F 312	Resident #12 is assisted with all meals at bedside. The RN Supervisor is monitoring residents that require assistance with eating to ensure they are receiving needed assistance. Any resident requiring assistance with meals can be affected. Therefore, The RD and the MDS Team reviewed the current assistive needs for all residents for accuracy on 7/14/14. The Care Plan was reviewed and updated as needed. All Dietary Staff were re-educated by the RD for the Dietary Department between 7/14/14 and by the DON and SDC for the all licensed and certified nursing staff between 7/17/14 and 8/9/14 regarding provision of assistance with meals. The MDS Team, RN Supervisor and Weekend RN Supervisor will do audits in the Assisted Dining Room 5	8/10/14

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F 312	Continued From page 78 A review of Resident #12's medical record indicated a speech therapy evaluation dated 12/20/13 indicated Resident #12 had weight loss secondary to a decline in her ability to swallow, a decline in her cognition, and communication skills. The clinical summary of the speech therapy evaluation indicated Resident #12 was changed to a mechanical soft diet and supervision to total assistance with eating consisting of small bites. A review of a care plan with a revised date of 06/04/14 indicated a problem statement that Resident #12 required assistance with ADLs and listed approaches in part for a mechanical soft diet and swallowing precautions which consisted of the following: requires supervision with meals, encourage small bites, head of the bed elevated with meals and at least for 30 minutes after meals. The care plan noted Resident #12 had a communication deficit, speech was unclear and garbled, and staff would anticipate her needs. Nursing Assistant (NA) #13 was observed on 07/01/14 at 8:08 AM to set Resident #12 up in her bed, set up her breakfast tray, and leave the room. Resident #12 was observed to drink her carton of milk with spillage down her face, neck, gown, and onto the bed. Further observations revealed Resident #12 to pick up her spoon with her right hand in an attempt to feed herself with approximately 35% of her breakfast meal in her bed and approximately 15% consumed. Nurse #3 was observed on 07/01/14 at 8:34 AM go into Resident #12's room to give her an 8 ounce cup of a thickened shake. Nurse #3 held the cup for Resident #12 to drink half of the thickened shake and had no observation of Nurse #3 attempt to assist Resident #12 with eating her	F 312	x a week x 8 weeks to observe that residents needing assistance are receiving the needed assistance. The audit will be taken to the monthly QAPI meeting by the DON x 3 months for review and recommendations	

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breakfast meal.

NA #13 was observed on 07/01/14 at 12:36 PM to set up Resident #12's lunch tray and leave the room. Resident #12 was observed to drink her milk with spillage down her face, neck, shirt, and onto her bed. Further observations revealed Resident #12 drank her milk and ate 0% of her lunch meal.

The Director of Nursing (DON) was observed on 07/01/14 at 12:43 PM to stop at Resident #12's room at the doorway and ask "are you done eating?" Resident #12 was observed to mumble an incomprehensible response to the DON.

NA #13 was observed on 07/01/14 at 12:44 PM to pick up Resident #12's lunch tray and take it out of the room.

NA #13 was interviewed on 07/01/14 at 12:44 PM, she stated Resident #12 would drink her milk but almost never ate her food and usually would eat only 15% to 25% of her meals. She indicated she had always set up her meal trays but had not assisted her with eating. She further indicated she would have to change Resident #12's clothes and bed linens after her meals because she would spill her milk and food. She further stated she was unaware that Resident #12 needed assistance with eating.

Nurse #3 was interviewed on 07/01/14 at 12:50 PM, she stated she was aware that speech therapy had worked with Resident #12 to assist her to independently eat her meals but was unaware Resident #12 actually needed assistance.

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F 312	Continued From page 80 Speech Therapist (ST) #1 was interviewed on 07/01/14 at 2:37 PM. She stated the ST that completed the evaluation on Resident #12 on 12/20/13 was no longer with the facility because the ST's were under a different contractor as of 04/01/14. She indicated she had no orders, information, and/or evaluations regarding Resident #12 and had not worked with her since she had been with the facility. The Director of Nursing (DON) was interviewed on 07/01/14 at 3:09 PM. She stated she was unaware Resident #12 needed assistance and/or supervision with her meals. She verified that Resident #12's care plan indicated she was required supervision with meals. She further stated she would have expected the NAs to supervise and/or assist Resident #12 with all of her meals.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to clarify a physician orders to treat a newly developed pressure ulcer and implement	F 314	Resident #16 no longer has a pressure ulcer. Resident #12 is receiving treatments per	8/10/14

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F 314	Continued From page 81 new treatment orders for 2 of 8 sampled residents reviewed with pressure ulcers (Resident #16 and #12). The findings included: 1. Resident #16 was admitted to the facility on 05/01/14 with diagnoses of peripheral vascular disease. There were no standing orders for a stage II pressure area located in the medical record. The admission Minimum Data Set (MDS) dated 05/08/14 coded her with intact cognition, requiring extensive assistance with bed mobility, dressing, toilet use and hygiene. She was coded as having no pressure ulcers but being at risk for the development a pressure ulcer. The Care area assessment dated 05/13/14 for pressure ulcers assessed her as being at risk for developing pressure ulcers due to poor mobility due to being a bilateral amputee, requiring assistance with transfers and bed mobility, being noncompliant with activities of daily living skills and resisting care. Review of the May 2014 Treatment Record revealed she was receiving an in house barrier cream to her excoriated coccyx and peri-area as needed. This area was noted as healed on 05/19/14. A care plan was developed on 05/21/14 for Resident #16 being at risk for developing a pressure ulcer. The goal was for her to remain free of skin breakdown. Interventions included pressure reduction devices in the bed and chair, encourage her to weight shift when sitting up in a	F 314	physician□s orders. Resident #12 is on hospice and the IDT met on 7/30/14 to determine that the current treatment plan remains appropriate. The wounds were assessed and documented and the Care Plan was reviewed and updated. The physician is currently aware of the resident□s condition. The treatment order is correct on the treatment records. The family is aware of the resident□s condition. Any resident with recommended treatments can be affected; therefore, the Regional Clinical Nurse reviewed the current treatment records and compared them to the physician□s orders between 7/23/14 and 7/24/14 for accuracy of content of the treatment orders. The Regional Clinical Nurse met with the new treatment nurse on 7-17-14 to educate her on writing a correct treatment order and re-educated her on the process of writing, noting and transcribing a physician order including adding it to the 24-hour report. The DON will review new orders for follow-up in the clinical morning meeting process. A Qualified Clinical Education Manager was been obtained to provide directed in-service training in all aspects of wound care, including physician□s orders, provision of care technique, wound care	

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F 314	Continued From page 82 chair, and having 2 persons to assist with repositioning to avoid shearing. On 06/26/14 a physician's progress note written by the nurse practitioner (NP) revealed Resident #16 developed a 2 centimeter (cm) by 2 cm stage II (open) pressure ulcer on her lower back sacrum. The note stated the NP requested wound care to follow. Review of physician orders dated 06/26/14 (no time) revealed an order for "wound care for stage II pressure ulcer buttocks." This order was signed as received by Nurse #9. Review of the Wound/Skin Healing Record revealed one entry dated 06/26/14 on the right buttocks noted as a stage II measuring 2.0 centimeters (cm) by 2.0 cm by 0.2 cm deep with a small amount of serous exudate and peripheral tissue edema. This note was signed by the wound nurse, Nurse #7. Under comments was one word "Hydrocolloid" a type of wound dressing. Review of the June 2014 treatment record there were no noted orders or documented treatments on until 06/29/14. The first nursing notes to identify the new pressure area was noted on 06/29/14 which stated the nurse practitioner noted a stage II wound on Resident #16's coccyx and an order was written for wound care eval and hydrocolloid to the affected coccyx to be changed every 3 days. On 06/29/14 an order was written for hydrocolloid to open area on coccyx change every 3 days and	F 314	products and accurate documentation to all licensed nurses and medication aides. These in-service were conducted from 8-01-14 to 8-9-14. The DON will audit new orders daily for wound treatments. The Regional Clinical Nurse will review new orders for wound treatments monthly x 4 months to determine if the orders are written correctly. Results will be presented by the DON and reviewed by the Regional Nurse Consultant at the monthly QAPI x 4 months.	

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as needed. This treatment order was noted as placed on the Treatment Record on 06/29/14. The June 2014 treatment record had no other orders written or initialed as being completed before this entry indicating that no treatment was provided until 06/29/14.

Interview with the wound care consultant on 07/01/14 at 1:52 PM revealed she was not seeing Resident #16.

Interview with the Nurse #7 on 07/07/14 at 3:18 PM revealed the measurements listed on the Wound/Skin Healing Record were directly taken from the wound care nurse practitioner's (NP) measurements. She stated that she did not do measurements only transferred what the wound NP measured.

Interview on 07/11/14 at 1:59 PM with the Assistant Director of Nursing revealed that if there was missing documentation in the treatment records, the treatment was not completed. She stated Nurse #7 was auditing the treatment sheets to ensure treatments were being completed as ordered.

Interview with the Director of Nursing on 07/11/14 at 3:08 PM revealed she did not know what the 06/26/14 wound care order was actually for and expected that Nurse #9 who took the order or Nurse #7 the facility's wound nurse would have clarified the order with specific instructions on 06/26/14 when the order was taken. She further revealed she expected the treatment records to be filled out when the dressing was completed. If there were no initials on the treatment record then the treatment was not completed as ordered. The DON stated on 07/07/14 at 3:35 PM that if

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there was a telephone order that was not written on the treatment record then she expected the wound nurse to ensure what the wound treatment should be and know what the orders were when doing the treatments.

Interview with the Nurse #9 via phone on 07/11/14 at 4:33 PM revealed it would be up to the wound nurse to clarify the physician's order as she would have started the treatment. Nurse #7 was no longer in the facility and could not be reached for comment.

2. Resident #12 was admitted to the facility on 09/23/08 with diagnoses which include kidney failure, altered mental status with intellect disability, dysphagia (difficulty in swallowing), epilepsy, and cerebral palsy.

The quarterly Minimum Data Set (MDS) dated 05/13/14 indicated Resident #12 was severely impaired in cognition for daily decision making and was totally dependent on staff for activities of daily living (ADLs). The MDS coded Resident #12 with having 1 stage 3 pressure ulcer and 1 stage 4 pressure ulcer.

A care plan was developed with a revised date of 06/04/14 which included the goal for the pressure ulcers to reduce in size. Interventions included reposition frequently, use pressure relieving mattress, perineal care as needed, provide incontinence protection: adult briefs, diet as ordered, treatments as ordered, wound care physician to see weekly, and weekly skin assessments.

Record reviews of the Treatment Administration Record (TAR) and Physician (MD) orders are as

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follows:

On 06/26/14 a Physician's (MD) order was received to cleanse sacrum with normal saline, apply Dakins (antiseptic solution) ½ strength to lightly moisten 4x4 gauze, and pack inside wound twice daily, and cover with 4x4 gauze and tape.

The MD's order was transcribed on the June 2014 TAR correctly. The TAR revealed the treatment for Resident #12 was initialed by the Wound Treatment Nurse #1 to indicate wound treatment was done on the following dates: 06/26/14, 06/27/14, 06/28/14, 06/29/14, and 06/30/14. Further review of the TAR had no initials for the treatment being completed twice daily on 06/26/14, 06/27/14, 06/28/14, 06/29/14, or 06/30/14.

Nurse #7 was observed on 07/01/14 at 1:31 PM perform Resident #12's pressure sore treatment of the sacral area. The sacral wound was clean, moist, with granulated tissue surrounding the open wound.

An interview was conducted with Nurse #7 on 07/02/14 at 3:12 PM. She verified her initials on the June 2014 TAR as having completed Resident #12's sacral wound treatment once a day from 06/26/14 to 06/30/14. She stated she would complete the resident's first wound treatment late in the afternoons and she would not complete a second daily treatment unless the dressings were soiled.

An interview was conducted with Nurse #9 on 07/02/14 at 3:46 PM. She verified her hand writing and initials on the June 2014 TAR as to writing the order on 06/26/14. She stated she was

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F 314	Continued From page 86 responsible for the treatment and dressing changes for Resident #12 on her shift from 3 PM to 11 PM on the dates of 06/26/14, 06/27/14, 06/28/14, 06/29/14, and 06/30/14. She further stated she did not perform Resident #12's sacrum wound treatments on these days. An interview was conducted with the wound consultant Physician's Assistant (PA) on 07/03/14 at 1:15 PM. She stated she thought Resident #12's wound care was being preformed in the facility twice daily as ordered. She indicated when she visits the facility on Thursdays, the treatments observed are the ones she has ordered for the residents. In relation to Resident #12, she stated she was unaware the treatments were not being done twice a day as ordered. She further stated she would have expected the facility's wound treatment nurse to do Resident #12's first daily wound treatment in the morning and that the evening nurses would perform the resident's second daily wound treatment. An interview was conducted with the Director of Nursing (DON) on 07/03/14 at 2:52 PM. She stated if the TARs were not initialed then she had to say the treatment was not completed as ordered. She further stated there had not been a good monitoring of skin areas and she expected the wound nurse to be responsible for wound orders and making sure they were correctly transcribed and followed.	F 314		
F 323 SS=J	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	F 323		8/10/14

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F 323	Continued From page 87 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, policy review, record review, staff and resident interviews, the facility failed to transfer 2 of 3 sampled residents using mechanical lift slings which were in safe operating condition and correct size resulting in the slings ripping and the residents falling (Residents #17 and #18); failed to follow the manufacturer's recommendation to use a specific brand lift with the same brand slings (Residents #12, #14, #23, #29, #30 and #32); and failed to monitor that air conditioning units did not have hazardous parts extending from them (Resident #5). Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E.	F 323	Resident #18 continues to be transferred by mechanical lift and is using a new sling that is appropriate for the resident's needs. The resident's care plan was updated as needed and all nursing staff and the support staff that assist with lifts which includes, the Maintenance Director, Housekeeping/Laundry Services Director, Physical Therapist and the Floor Technicians were educated. Resident #17 continues to be transferred by mechanical lift and is using a new sling that is appropriate for her needs. The resident's care plan was updated as needed and all nursing staff and the support staff that assist with lifts which includes, the Maintenance Director, Housekeeping/Laundry Services Director, Physical Therapist and the Floor Technicians were educated. Resident Room #119 has had the decorative flap removed from the base of the air conditioning unit by the Maintenance Director on 6/30/14. Resident #5 no longer resides in the facility. Residents who require an	

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F 323	Continued From page 88 The findings included: A review of the facilities undated Hydraulic Lift Policy included the procedures: "7. Check hooks and sling holes for fraying and security. DO NOT use frayed lift pads." A review of the Owner's Operator and Maintenance Manual, revised October 2008, included the warning "After each laundering (in accordance with instruction on the sling), inspect slings(s) for wear, tears, and loose stitching. Bleached, torn, cut, frayed, or broken slings are unsafe and could result in injury. Discard immediately." A review of the manufacturer's undated guide to sling sizes provided by the maintenance supervisor revealed slings with the following colored binding with maximum weight limitations for each sling: *Green binding indicated a large sling with maximum weight capacity of 300 pounds. *Blue binding indicated an extra large sling with maximum weight capacity of 450 pounds. *Black binding indicated an extra/extra large sling with maximum weight capacity of 600 pounds. An attached warning included "Use the sling that is recommended by the individual's doctor, nurse or medical attendant. Before lifting, check all sling straps for secure points of attachment on the lift device. Do not exceed weight limitation posted on lift. Use only with (brand name) patient lifts. Bleached, torn, cut, frayed or broken slings are unsafe and could result in injury. Discard immediately. Do not alter slings. Use only on (brand name) lifts." 1. Resident #17 was admitted to the facility on	F 323	incident/accident report and investigation and residents who are assessed to require a mechanical lift transfer are likely to be affected by this issue. Residents that have a potential to be affected were identified by the Director of Nursing, the RN Supervisor/ADON and one C.N.A. as resident requiring the use of mechanical lift and sling for transfers on 6/16/2014. All Care Plans have been reviewed and updated as needed. All nursing staff was educated on any updates. All mechanical lift slings were evaluated and per manufacturers recommendations. No replacements were required. Any resident that resides in the facility can be affected by the decorative flap on the Air-Conditioning units. Therefore, The Maintenance Director removed all decorative flaps from the units on 7/16/14. The Director of Nursing, RN Supervisor/ ADON and Staff Development Coordinator read and reviewed manufacture recommendation for mechanical lift and slings. All licensed nursing staff, certified nursing assistants, therapy, housekeeping and maintenance staff that assist with transfers and spotting have been in serviced and provided instructions based on manufacture recommendations and provided written instruction by Staff Development coordinator or RN Supervisor/ADON on 07/09/2014. The	

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F 323	Continued From page 89 01/30/14 with diagnoses which included generalized weakness, arthritis, high blood pressure, diabetes, thyroid disease and depression. The most recent quarterly Minimum Data Set (MDS) dated 04/26/14 indicated Resident #17 had no short or long term memory problems, was cognitively intact for daily decision making and was totally dependent on staff for transfers. A review of a care plan with a revised date of 02/19/14 indicated a problem statement that Resident #17 was at risk for pressure ulcers and listed approaches in part to use a mechanical lift to avoid skin friction and shearing. A review of a care plan with a revised date of 04/30/14 indicated a problem statement that Resident #17 required assistance with activities of daily living and included a handwritten note to use a full body lift to transfer with 2 people. A review of a nurse's note dated 06/23/14 at 2:59 PM indicated a change of status which revealed Resident #17 was being lifted out of a recliner chair with a mechanical lift and the lift pad ripped at the left front corner. The notes indicated Resident #17 fell approximately 6 inches back into chair and there was no apparent injury noted. The notes further indicated the Physician, Administrator and Assistant Director of Nursing (ADON) were made aware immediately. A review of a nurse's note dated 06/24/14 at 7:46 AM indicated a late entry note for 6:00 AM that Resident #17 was complaining of left knee pain and was given as needed (PRN) pain medication. A review of a nurse's note dated 06/24/14 at 1:25	F 323	education included determining the appropriate Size of sling for the resident, care and inspection of sling per manufacturer□s instructions, lift batteries/ chargers/ plug in, care/ inspection of lifts per manufacturer□s instructions and troubleshooting lifts. All the above employees completed a return demonstration using a mechanical lifts with slings on: 1. Seated transfer 2. Repositioning up in bed 3. Scale operation 4. Inspection for holes, tears, frays or unraveling on sling 5. Sling in-service: 6. Safe use of sling with two staff members always 7. Identifying defects in the sling (if defect is found do not use it, give sling to the charge nurse) The Director of Nursing will monitor the daily schedule to ensure that anyone that had not had the above in service will not be scheduled to work until in the in service is completed. An in-service was conducted with laundry and one housekeeper staff that is crossed trained for laundry on 7/10/2014 for inspection of slings to include: 1. Holes, tears, frays or unraveling 2. Identifying defects in the slings, the housekeeping/ laundry employee will lock the defective sling in the housekeeping / laundry	

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F 323	Continued From page 90 PM indicated Resident #17 was interviewed by the Director of Nursing (DON) this afternoon to follow up on the resident's status related to her fall from a lift. The notes revealed Resident #17 stated to the DON that her left knee hurt and the DON requested for Nurse #2 to get a physician's order for a left knee x-ray. The notes indicated a physician's order was obtained and would continue to monitor for increased pain and requests for PRN pain medication. A review of a physician's order dated 06/24/14 at 1:30 PM indicated x-ray of left knee due to pain. A review of a radiology report dated 06/24/14 at 5:44 PM indicated left knee x-ray indicated no fractures but moderate osteoarthritis in the left knee. A review of a nurse's note dated 06/24/14 at 6:44 PM indicated x-ray results revealed no fracture or joint effusion (a build-up of fluid) of the left knee and mild osteoarthritis was present. The notes further indicated Resident #17, the DON and Administrator were notified of x-ray results and would continue to observe for changes. A review of a nurse's note dated 06/25/14 at 1:35 AM indicated at 1:00 AM Resident #17 continued to verbalize that her left knee was painful or sore especially with activity and the area was guarded. The notes further indicated Resident #17's left knee had no redness, no bruising and no swelling. A review of a physician's progress note dated 06/25/14 indicated the physician who was also the facility medical director documented he was asked to see Resident #17 because of the onset	F 323	supervisor office. Fill out work order for maintenance director to replace sling and dispose of the defective sling. 3. Maintenance director is to reorder the size sling that was taken out of service This in service was completed by 3: 00 PM on 7/10/14 by the Staff Development coordinator or RN Supervisor and Housekeeping/ Laundry supervisor. Any employee that has not attended the above named in service after 3:00 PM on 7/10/14 will not be allowed to work until in serviced. All new employees will be in serviced during orientation. An audit on all slings in the facility was completed 7/09/2014 at 8:00 PM by the Maintenance Director, Director of Nursing and Housekeeping/ Laundry Supervisor. The Audit of the slings included the following: 1. All slings were identified, numbered # 1 to #42 and size noted 2. The Condition of the slings were inspected for holes, tears, frays and defects 3. During this audit no sling were removed due to defects All new air-conditioning units will be inspected for any sharp edges by the Maintenance Director before	

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F 323	Continued From page 91 of severe left knee pain. The notes revealed Resident #17 fell into her recliner while staff was using a lift and the fall was from about 6 inches above the level of the recliner. The notes further revealed Resident #17 stated her left leg hit the floor first and she suddenly developed left knee pain and today at the time of the examination she had significant tenderness in the distal thigh, knee region and proximal (central point) of her foreleg on her left leg but there was no deformity, no significant swelling or redness of the skin but she had markedly reduced range of motion. The notes indicated Resident #17 had been receiving Oxycodone by mouth twice a day and every six hours on a PRN basis for pain. The progress notes also indicated Resident #17's weight exceeded 300 pounds and she was in distress due to severe pain on left knee. A section titled diagnosis, assessment and plan indicated Resident #17 had a history of severe degenerative joint disease, and had been seen by an orthopedic surgeon because of chronic right knee pain. The notes further indicated the physician had requested a complete bone x-rays of the left lower leg to assess for possible fractures and would await x-ray evaluation before deciding further intervention if needed. A review of a physician's order dated 06/25/14 at 2:00 PM indicated x-ray full left hip and whole left leg due to pain and change Oxycodone to 5 milligrams (mg) by mouth twice a day and 5 mg by mouth every 6 hours PRN for pain. A review of a physician's order dated 06/25/14 with no time documented indicated an order clarification to obtain left leg x-rays of the hip, tibia (shin bone), fibula (calf bone) and femur (thigh bone) with 2 views on each.	F 323	being placed into service. On 7/16/14, the Maintenance Director was re-educated on preventing accidents in a resident□s room by the Administrator. The Maintenance Director performs weekly room audits to ensure that all equipment is safe from sharp edges. All mechanical lift policies and audits will be reviewed as directed by the QAPI committee to ensure the effectiveness of the program. All new employees will be in serviced on mechanical lift policies during orientation. All mechanical lift policies and audits will be reviewed as directed by the QAPI committee to ensure the effectiveness of the program. An audit of all mechanical lifts and slings will be done weekly x 3 months and will be submitted to the QAPI committee for review and recommendations by the maintenance director. After three months, the QAPI Committee will recommend a schedule of continuing audits. The Quality Assurance Committee will oversee the implementation of all aspects of the above plan and meet within one week to review the plan,	

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F 323	Continued From page 92 A review of a nurse's note dated 06/25/14 at 2:52 PM indicated Resident #17 was assessed by the physician and continued to complain of left knee pain. The notes further indicated physician orders were received for scheduled pain medication and x-rays of full leg and hip. A review of a radiology report dated 06/25/14 at 6:15 PM indicated moderate osteoarthritis of the left hip and no acute fracture, dislocation or destructive lesions in the left femur. A review of a nurse's note dated 06/26/14 at 10:25 AM indicated Resident #17 had a fall into a recliner from a lift and x-ray results of her left hip, femur, and tibia/fibula were negative. The noted further indicated Resident #17 continued to complain of left leg pain and medication scheduled for pain was given. A review of a nurse's note dated 06/27/14 at 3:25 PM indicated Resident #17 continued to complain of left knee pain and moderate relief was obtained from pain medication. A review of a physician's order dated 07/07/14 with no time documented indicated a Magnetic Resonance Imaging (MRI) x-ray of left knee status post injury due to severely decreased range of motion and normal x-rays. A review of a physician's order dated 07/07/14 with no time documented indicated a clarification order for MRI of left knee without contrast due to injury with severely decreased range of motion and normal x-rays. A review of an x-ray report titled MRI left knee	F 323	reassess for effectiveness, and modify the plan as necessary. The Quality Assurance Committee will address mechanical lift and sling safety at each Quality Assurance meeting for one year. The Regional Nurse Consultant will attend the Quality Assurance Committee meetings for six months as an advisor to ensure the committee is accessing all relevant data at their disposal, fully addressing all current issues, reassessing the effectiveness of their plans of action, revising their plans of action as needed, and keeping issues on the agenda of the committee until the issue has been fully resolved. Individual committee members will be designated as the responsible party to follow up with action plans, give progress reports and provide a target completion date. The Administrator will ensure that, prior to Quality Assurance meetings, all supervisors and Administrative staff are polled for any issues that need to be discussed at the meeting. The Administrator will review any accident/incident reports in the daily stand-up meeting and request staff to report any new issues that need immediate attention. Remedial actions will be determined and current plans assessed for effectiveness	

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F 323	Continued From page 93 without contrast dated 07/08/14 at 2:30 PM indicated the following impression: 1. Moderate to severe osteoarthritis of the medial (middle) compartment associated with contusions. 2. The medial meniscus (a semicircular cartilage that provides structural integrity to the knee) is extruded (pushed out) and there is a probable tear of the extruded body. 3. Findings suggest a grade 1 sprain of the medial collateral ligament (MCL) on the inner part of the knee. 4. Moderate intramuscular swelling within the vastus medialis (large muscle located on the front of the thigh). A review of a physician's order dated 07/11/14 at 3:15 PM indicated to refer Resident #17 to a bone and joint specialist and the appointment was scheduled for Monday 07/21/14 at 2:00 PM. During an interview on 07/02/14 at 11:30 AM Resident #17 explained on 06/23/14 she was sitting in a recliner in her room with a lift sling under her that had been used earlier that day when staff transferred her from her bed to the recliner chair. She stated she called for staff to transfer her back to bed and Nurse Aide (NA) #3 and NA #15 went to go find a lift. She explained Nurse Aide (NA) #3 and NA#15 came back into her room with the lift and connected the hooks located on each corner of the sling to the lift arms and raised her up out of her chair. She stated as she was suspended by the lift, the entire left front corner of the sling toward her feet ripped apart and she fell from the lift back into the recliner chair and her left foot hit the floor. She further stated when she started to fall NA #15 was standing next to her on her left side and pushed	F 323	in the daily stand-up meeting. If necessary, the Administrator will also convene a meeting of relevant members of the Quality Assurance Committee after the daily stand-up meeting to address problems needing immediate attention. One indication would be any issue that has the capacity to cause harm or has caused harm be addressed immediately and then be addressed in the next monthly Quality Assurance Meeting. Any issue requiring immediate in-servicing of staff will be supervised by the Administrator to ensure 100% of all relevant staff are re-educated prior to returning to work. Any issue requiring immediate audits of equipment will be supervised by the Administrator to ensure 100% of all relevant equipment is included in the audit and any defective equipment is immediately removed from access by staff. On weekends and holidays, the Administrator will be informed by the manager on duty of any incident/accident report involving resident safety to determine if an immediate plan of action is required to protect residents.	

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her back toward the chair so she would fall into the chair instead of falling on the floor. She explained when her left foot hit the floor she was in so much pain and was crying. She stated NA #3 and NA #15 called for Nurse #2 to come to the room and they got another sling and lifted Resident #17 from the recliner chair back into bed. Resident #17 stated she saw the sling after she was put back into bed and the sling was a faded light blue color and the left front corner had totally ripped off and the edges of the sling and all of the remaining corners were torn and frayed. She explained the physician ordered x-rays of her left knee on Tuesday 06/24/14 and they were negative. She stated the physician saw her on Wednesday 06/25/14 because she was having so much pain in her left knee and since the previous x-rays were negative he ordered x-rays of her left hip and leg. Resident #17 stated she felt something was wrong with her left knee because she had not had pain in her left knee before she fell from the lift and had not had to take pain medication routinely but now had to take pain medication each day on a regular basis and it made her feel bad.

During an interview on 07/08/14 at 9:34 AM with Nurse #2 she stated on 06/23/14 during the afternoon she was at the nurse's desk and heard screaming coming from Resident #17's room. She explained she ran into the room and Resident #17 was in her recliner chair screaming that her left foot was stuck between her recliner chair and the mechanical lift. She stated she pulled lift back and Resident #17 stopped screaming. She explained she assessed Resident #17 but she could not find any redness or swelling or bruising. She stated she asked Resident #17 what what had happened and she

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said the sling had ripped at the left front corner and she dropped approximately 6 inches back down in the recliner chair. She further stated Resident #17 was sitting in the recliner with the sling still hooked to the mechanical lift and verified the left front corner of the sling had totally ripped off the sling. She stated she ran to get the Administrator because she knew it was a serious problem and NA # 3 and NA #15 transferred Resident #17 back to bed with a different sling that the Maintenance Director had brought into the room. She stated she later looked at the sling after Resident #17 was put back in bed and the sling was a light blue color and looked stained and thin and looked much older than the newer dark blue slings that were currently stored in the linen closet. She also stated she realized the sling was a large sling with a maximum weight capacity of 300 pounds but Resident #17 weighed more than 300 pounds. She explained Resident #17 was supposed to have been discharged to go home on 06/26/14 but her discharge was put on hold because of her left knee pain and she was scheduled for a MRI of her left knee later today because of the continued pain in her left knee.

During an interview on 07/08/14 at 9:37 AM with NA #3 she stated nurse aides (NAs) were expected to determine the proper size of lift slings for residents by visually looking at the sling when they placed it under a resident to determine if it was the correct size for the resident. She explained they were supposed to be able to see the sides of the sling sticking out from under the resident's body and if you couldn't see the sides of the sling it was not big enough and then they were supposed to pick a larger size to use. She confirmed she assisted with the transfer of Resident #17 when the sling ripped on 06/23/14

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and Resident #17 fell into the recliner chair. She also confirmed NA #15 assisted her with the transfer and as they lifted Resident #17 up from a recliner chair in her room she was suspended up above the chair when the sling tore completely across the left front corner and Resident #17 fell back into the chair. She stated when Resident #17 fell she hurt her left leg and caused her to have pain and they called for Nurse #2 to come to the room. She explained they got the sling out from her and replaced it with another one the Maintenance Director brought into the room and then they put Resident #17 back to bed. She stated she should have inspected the sling before she used it to lift Resident #17 and confirmed it was the same sling they had used earlier in the day to transfer her from bed to recliner chair. She further stated Resident #17 could not be gotten out of bed after her fall from the lift because they did not have a sling that was large enough to lift her and she was in bed for 8 days before the new sling arrived for them to get her out of bed.

During an interview on 07/08/14 at 2:46 PM with NA #15 she explained NA #3 had asked her to assist with transferring Resident #17 from her recliner chair to bed on 06/23/14 because the resident had requested to go back to bed and was leaning to one side in her recliner chair. She explained she placed the loops of the sling on her side onto the arm of the lift and she did not notice worn or frayed areas. She explained Resident #17 was raised up with a mechanical lift approximately 12 inches above her chair and they were just getting ready to turn the lift to put her in the bed when she heard a noise. She stated she realized the noise she heard was the sling ripping at the foot on the left side. She further stated once she saw the sling was ripping apart she

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pushed the resident back over her chair so she would fall back in the chair and not on the floor. She explained as she pushed Resident #17 back toward her chair the left front corner of the sling totally ripped off and Resident #17 fell into the recliner chair. She stated Resident #17 was shaken up by the fall and NA #3 went to get Nurse #2. She explained Nurse #2 came into the room and Resident #17 was complaining of left knee pain. She stated Nurse #2 then went and got the Administrator and he came into the room and the room then quickly filled with staff. She explained someone went and got another sling and they put it under Resident #17 while she was seated in the recliner chair and they lifted her back to bed.

During an interview on 07/08/14 at 5:16 PM the Director of Nursing (DON) explained she was not called on 06/23/14 when the sling ripped and Resident #17 fell from the lift but she saw the incident report the following morning on 06/24/14. She stated NA #15 had told her she heard a ripping sound when Resident #17 was suspended in the sling above her recliner chair and NA #15 put her knee up under the resident and pushed her back toward the recliner chair. She stated she talked with Resident #17 because she complained that her left knee was hurting and called the physician who ordered full xrays of her left leg but they were negative. She stated she was concerned that Resident #17 continued to complain of left knee pain and requested the physician to order a MRI. She explained she had no idea why the sling was available for staff use since the Maintenance Director and Housekeeping Supervisor had audited slings on Tuesdays of each week and all slings that were worn or frayed were supposed to have been

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discarded.

During an interview on 07/08/14 at 6:03 PM the Maintenance Director explained he saw the sling after Resident #17 fell from the lift on 06/23/14 after they got it out from under her and described it as light blue on one side and darker blue on the other side with a green reinforcement band. He further explained one whole corner had ripped off and the sling was frayed on the edges. He stated he was not sure why the sling was available for staff use since it had frayed edges and it should have been caught when they did the weekly audits to check for damaged or worn slings but it must have been missed somehow.

During a follow up interview on 07/09/14 at 9:45 AM with NA #3 she confirmed she did not inspect the condition of the sling when she first placed it under Resident #17 on 06/23/14 and could not describe what it looked like before it ripped and Resident #17 fell from the lift into a recliner chair.

During an observation and interview on 07/09/14 at 10:57 AM the Housekeeping Supervisor brought a sling to a conference room and verified it was the sling that had ripped when Resident #17 fell from the lift. He demonstrated and verified a corner of the sling had ripped completely off and the piece that had ripped off had the hooks still attached that would have been hooked onto the arm of the lift. He further verified the sling had frayed edges along the top left side and on the right side at the top and bottom near the remaining hooks on the green reinforcement binding. He confirmed it was an old lift sling and should have been discarded before it was used to transfer Resident #17 on 06/23/14. He stated it must have slipped through the cracks when the

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weekly audits of slings were done.

During a follow up interview with the Maintenance Director on 07/09/14 at 11:33 AM he confirmed the size of the sling used to transfer a resident with a mechanical lift was determined by the colored reinforcement binding around the edges of the sling. He also confirmed slings with green reinforcement bindings were large slings with a maximum weight capacity of 300 pounds.

During an interview on 07/09/14 at 12:47 PM Resident #17's physician who was also the facility Medical Director verified he was asked to see Resident #17 after she had a fall from a lift and was complaining of severe pain in her left knee. He confirmed Resident #17 had a history of pain in her right knee due to severe osteoarthritis but he was not aware Resident #17 had any problems with her left knee or had complained of pain in her left knee before she fell from the lift. He confirmed when he saw Resident #17 on Wednesday 06/25/15 she was complaining of severe pain and tenderness and had decreased range of motion in her left knee. He stated he first ordered x-rays of her left knee and those results were negative and then he ordered x-rays of her left hip and left leg and those results were negative. He further stated since Resident #17 still complained of left knee pain and had limited range of motion he ordered a MRI and was waiting on the results so that he could determine appropriate treatment for Resident #17.

During an interview on 07/11/14 at 1:59 PM the Assistant Director of Nursing (ADON)/Day Shift Supervisor explained the size of lift sling for a resident transfer was supposed to be based on the resident's height and weight. She stated NAs

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should get the resident's height and weight first and then select the appropriate size sling based on the color coded reinforcement band that indicated the weight capacity to transfer the resident. She stated she was working on 06/23/14 when Resident #17 fell from the lift but did not go into her room until after she fell. She explained Resident #17 was already in bed and she asked Resident #17 what had happened. She stated Resident #17 told her the sling had ripped when she was being transferred back to bed and her she had fallen back into the recliner and had pain in her left knee. The ADON stated she did not know what size sling staff had used to transfer Resident #17 but thought she would have required an extra large or extra/extra large because her weight was greater than 300 pounds.

During an interview on 07/11/14 at 3:06 PM the DON explained during her investigation of the fall, she was told the wrong size sling had been used to transfer Resident #17. She further explained she found out staff had used a blue sling with a green reinforcement band and that indicated it was a large sling with a maximum weight capacity of 300 pounds. She confirmed staff should have used an x-large sling for Resident #17's transfer because her weight was greater than 300 pounds and also confirmed the sling that had been used to transfer Resident #17 was worn with frayed edges and should not have been used for her transfer. She stated it was her expectation that worn or frayed slings should be discarded immediately and not available for resident use.

During another follow up interview on 07/11/14 at 5:23 PM the Maintenance Director verified the sling that was used to transfer Resident #17 had

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a green reinforcement binding which indicated a maximum weight capacity of 300 pounds. He stated since Resident #17's weight exceeded 300 pounds the large sling should not have been used during the transfer and a larger sling should have been used.
2. Resident #18 was admitted to the facility on 12/18/13 with diagnoses which included left sided paralysis, traumatic brain injury, bilateral leg paralysis, high blood pressure, and depression. The most recent quarterly Minimum Data Set (MDS) dated 03/24/14 indicated Resident #18 had no short or long term memory problems, was cognitively intact for daily decision making and was totally dependent on staff for transfers.

A review of a care plan with a revised date of 04/16/14 indicated a problem statement that Resident #18 was at risk for pressure ulcers and listed approaches in part to use a mechanical lift to avoid skin friction and shearing.

A review of a care plan with a revised date of 06/15/14 indicated a problem statement that Resident #18 was risk for a fall and included a hand written note to use a mechanical lift.

A review of a nurse's note dated 06/16/14 at 12:54 AM indicated a late entry note for 9:30 PM that Resident #18 was being lifted out of his wheelchair with a mechanical lift and the "lift pad ripped at the bottom left corner and frayed and ripping apart at top left corner." The notes indicated Resident #18 fell approximately "a foot or less" to the floor and landed on the left side of his back and left buttock. The notes indicated Resident #18 complained of left sided back pain with redness noted to the left sided middle back area and pain medication was administered.

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A review of a nurse's note dated 06/16/14 at 1:15 AM indicated a late entry note for 11:00 PM that the responsible party for Resident #18, the Physician, and the Administrator were notified of the incident.

During an interview on 07/02/14 at 5:13 PM Resident #18 explained on 06/15/14 he was sitting in a his wheelchair in the hallway outside his room with a lift sling under him that had been used earlier that day when staff transferred him from his bed to the wheelchair. He stated he informed staff to transfer him to bed for the night and Nurse Aid (NA) #4 went to find a lift. He explained NA #4 and NA #10 came back to the hallway with the lift and connected the hooks located on each corner of the sling to the lift arms and raised him up out of his wheelchair. He stated as he was suspended by the lift, the entire top part of the sling ripped and immediately the bottom left corner ripped apart and he fell from the lift to the floor hitting his back. He stated NA #4 called for Nurse #5 and they got another sling and lifted Resident #18 from the floor in the hallway into his bed. Resident #18 stated he saw the sling after he was put into bed and the sling was a faded blue color and both top and bottom corners were ripped and the other corners were frayed and torn. He further explained he had pain immediately in his back and Nurse #5 gave him medication scheduled for back pain after the fall.

During an interview on 07/08/14 at 2:55 PM with NA #4 she stated the nurse aides (NAs) were expected to inspect the slings for any rips, tears, or frays and if the slings had any they were not supposed to use that sling. They were to give the sling to the charge nurse and get another sling to

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use with the resident. She confirmed she assisted with the transfer of Resident #18 when the sling ripped on 06/15/14 and Resident #18 fell to the floor in the hallway. She also confirmed NA #10 assisted with the transfer and as they lifted Resident #18 up from his wheelchair he was suspended up above the floor and they had just turned him away from the wheelchair when the sling ripped completely across the left top corner and then simultaneously before they could do anything the left bottom corner of the sling ripped completely across leaving the loop part of the sling hooked to the lift arm when Resident #18 fell to the floor.

During an interview on 07/08/14 at 4:22 PM with NA #10 he stated NA #4 had asked him to assist with transferring Resident #18 from his wheelchair to his bed on 06/15/14 because the resident had requested to go to bed. He explained the sling was under Resident #18 and he placed the loops of the sling on his side onto the arm of the lift and he did not notice the worn or frayed areas. He explained Resident #18 was raised up with the mechanical lift above his wheelchair and he had turned Resident #18 away from the wheelchair so NA #4 could push Resident #18 into his room. He stated the top left corner of the sling tore completely across and immediately the bottom left corner of the sling tore and the loop part of the sling was remained hooked to the lift arm. He further stated after Resident #18 was assessed by Nurse #5 he got another sling and they lifted Resident #18 out of the floor and put him into his bed.

During an interview on 07/08/14 at 5:16 PM with the Director of Nursing (DON), she explained she was called the night the sling ripped and Resident

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#18 fell from the lift and there was a discussion about the incident the next morning. She stated she expected the NA's to inspect the slings before using them for tears and frayed areas. She further stated if any of the slings were frayed or torn she expected the NA's not to use those and give the worn sling to the Maintenance Director, Housekeeping Supervisor, or the Charge Nurse. She explained she had no idea why the sling was available for staff use since the Maintenance Director and Housekeeping Supervisor had gone around and collected all the slings and checked them and all slings that were worn or frayed were supposed to have been discarded.

During an interview on 07/08/14 at 6:03 PM the Maintenance Director explained he saw the sling on 06/16/14 after Resident #18 fell from the lift on 06/15/14. He described it as light blue on one side and white on the other side. He further described the sling was ripped at the seam area of the top corner and had completely ripped off at the bottom left corner. He stated he was not sure why the sling was available for staff use since it had frayed edges and it should have been caught when they did the weekly audits to check for damaged or worn slings but it must have been missed somehow.

During an interview on 07/08/14 at 6:22 PM with Nurse #5 she stated on 06/15/14 during the evening shift she was at the nurse's desk and she was called to the hallway outside of Resident #18's room. She explained she assessed Resident #18 and found redness to his left middle back area where he was complaining of pain. She further explained she gave Resident #18 his pain medication scheduled for chronic back pain after

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the fall. She further explained the lower left corner of the sling had completely ripped apart and the top corner of the sling had completely frayed up to the loop area. She indicated she inspected the sling and in the center back part of the sling was frayed, with a white spot "bleached out" area on the back, was a light blue in color, and appeared to her to have been "compromised for some time."

During an observation and interview on 07/09/14 at 10:57 AM the Housekeeping Supervisor brought a sling to a conference room and verified it was the sling that had ripped when Resident #18 fell from the lift. He demonstrated and verified a corner of the sling had ripped completely at the top left corner and the bottom left corner had frayed edges and ripped edges. He confirmed it was an old lift sling and should have been discarded before it was used to transfer Resident #18 on 06/15/14.

During an interview on 07/09/14 at 11:42 AM with NA #2 she confirmed she placed the lift sling under Resident #18 the morning of 06/15/14 before lifting him from his bed to his wheelchair. She further indicated she noticed the frayed edges around the material on the outside edges of the sling but there were no frayed edges around the loops that hook to the lift arms. She stated she did not remember reporting the frayed sling to anyone that she used the morning of 06/15/14 to lift Resident #18.

During a follow up interview with the DON on 07/11/14 at 3:06 PM she confirmed the sling that had been used to transfer Resident #18 was worn with frayed edges and should not have been used for his transfer. She stated it was her expectation

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that worn and frayed slings should be discarded immediately and not available for resident use

The facility's Administrator and Director of Nursing were notified of Immediate Jeopardy on 07/09/14 at 1:42 PM for Resident #17 and #18. The facility provided a credible allegation of compliance on 07/11/14 at 7:00 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy.

Credible Allegation of Compliance:

On 06/15/2014 at 9:30 PM Resident #18 was being assisted by two NA's with a mechanical lift to transfer from the chair to the bed. During the transfer the sling ripped and the resident fell onto the floor. After the nurse assessed the resident, he was lifted onto the bed using another mechanical lift and sling that was inspected and had no defects. The ripped sling was removed from service by the charge nurse and locked in the medication room. The ripped sling was given to the maintenance director the next morning for disposal. The Resident #18 continues to be transferred by mechanical lift and sling with no defects. Staff involved was educated by the charge nurse on sling inspection.
On 06/16/2014 all slings were inspected by the maintenance director following the manufactures recommendation.
On 06/23/2014 at 2:59 PM Resident #17 was lifted from the recliner to the bed via a mechanical lift and two NA's. Upon lifting the resident up the sling ripped and the resident fell back into the chair. After the resident was assessed by the nurse, she was lifted into the bed using another sling that was inspected and had no defect. The ripped sling was given to

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Nursing Home Administrator; the ripped sling was locked in the Nursing home administrator office. The NA was given one on one in service by maintenance director and the nursing home administrator on sling inspection. The next day the NA was in service by the RN Supervisor/ ADON and the therapy department. The NA that was spotting the transfer was in serviced in the general in service regarding inspecting slings provided on 06/23/2014.

Any other resident that have a potential to be affected were identified by Director of Nursing, the RN Supervisor/ADON and one NA as resident requiring the use of mechanical lift and sling for transfers on 06/16/14.

The Director of Nursing, RN Supervisor/ ADON and Staff Development Coordinator read and reviewed manufacture recommendation for mechanical lift and slings. All licensed nursing staff, certified nursing assistants, therapy, housekeeping and maintenance staff that assist with transfers and spotting have been in serviced and provided instructions based on manufacture recommendations and provided written instruction by Staff Development coordinator or RN Supervisor/ADON on: 07/09/2014

* Determining the appropriate Size of sling for the resident
* Care and inspection of sling per manufacturer's instructions
* Lift batteries/ chargers/ plug in
* Care/ inspection of lifts per manufacturer's instructions
* Troubleshooting lifts

All the above employees completed a return demonstration using a mechanical lifts with slings on:

* Seated transfer
* Floor transfer

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F 323	Continued From page 108 * Repositioning up in bed * Scale operation * Inspection for holes, tears, frays or unraveling on sling Sling in-service: * Safe use of sling with two staff members always * Identifying defects in the sling (if defect is found do not use it, give sling to the charge nurse) * The nurse is to remove the defective sling from service and place in the locked medication room for maintenance to pick up for disposal. * The nurse is to fill out a work order for maintenance to replace the defective sling. * The Maintenance director is to reorder the same size sling that was taken out of service This in service was started at 2:45 PM on 07/9/2014 and will be completed by 3:00 PM on 07/10/2014. Any employee that has not attended the above named in service after 3:00 PM on 07/10/14 will not be allowed to work until the in service is completed by Staff Development Coordinator, Day shift RN Supervisor/ADON or 3 to 11 RN Supervisor. All new employees will be in serviced during orientation. At 3:00 PM on 07/10/2014 a list of employees that did not receive the above in-service will be given to the Director of Nursing. The Director of Nursing will monitor the daily schedule to ensure that anyone that had not had the above in service will not be scheduled to work until in the in service is completed. An in service will be conducted with laundry and one housekeeper staff that is crossed trained for laundry on 07/10/2014 for inspection of slings to include: * Holes, tears, frays or unraveling	F 323		

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* Identifying defects in the slings, the housekeeping/ laundry employee will lock the defective sling in the housekeeping / laundry supervisor office. Fill out work order for maintenance director to replace sling and dispose of the defective sling.
* Maintenance director is to reorder the size sling that was taken out of service

This in service will be completed by 3:00 PM on 07/10/14 by the Staff Development coordinator or RN Supervisor and Housekeeping/ Laundry supervisor.

Any employee that has not attended the above named in service after 3:00 PM on 07/10/14 will not be allowed to work until in serviced. All new employees will be in serviced during orientation.

An audit on all slings in the facility was completed 07/09/2014 at 8:00 PM by the Maintenance Director, Director of Nursing and Housekeeping/ Laundry Supervisor. The Audit of the slings included the following:

* All slings were identified, numbered #1 to #42 and size noted
* The Condition of the slings were inspected for holes, tears, frays and defects
* During this audit no sling were removed due to defects

Immediate Jeopardy was removed on 07/11/14 at 7:00 PM when interviews with nurses, nurse aides, and therapy staff revealed awareness of expectations to check lift slings to make sure they were not frayed or torn and how to correctly position them under the resident. They verified they had received in-service training and they were aware of the color coded binding on the lifts which indicated the correct sling to use according to the resident's weight. They stated if they found a lift sling that was frayed or torn they were

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expected to give it to the Maintenance Director so that he could dispose of it. Interviews with nurses further revealed they were expected to place slings that were frayed or worn in the locked medication rooms and fill out a work order for maintenance to dispose and replace the sling. Interviews with housekeeping staff revealed they had attended in-service training and were expected to look for holes, tears and fraying of lift slings and were expected to lock them in the housekeeping/laundry supervisors office and fill out a work order for maintenance to dispose of the sling and reorder a new replacement. Interviews with maintenance staff revealed awareness of staff to lock torn or frayed slings in medication rooms or in the laundry/housekeeping supervisors office and complete a work order for disposal and replacement of the sling. A review of lift slings in the facility revealed each sling had a number marked on it with a black permanent marker and each sling was listed by their corresponding number on the audit sheets. There was also documentation on the audit sheets with the date of the audit and the condition of each sling. There was no documentation of holes, tears, trays or defective slings on the audit sheets.

3. Review of the Owner's Operator and Maintenance Manual, revised 10/2008, included the instruction: One piece fabric easy fit sling can only be used with (brand name A) lifts and (number A) lifts.
The facility provided the survey team a list dated 06/16/14 of 31 residents who required the use of a mechanical lift in order to transfer.
On 07/08/14 at 4:21 PM, the Maintenance Supervisor and the surveyor observed the 4 mechanical total lifts located in the facility. There

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were 2 (brand name B) lifts which had a maximum weight limit of 450 pounds and 2 (brand name C) lifts which had a maximum weight limit of 600 pounds. The Maintenance Supervisor stated that the specific slings had to go with the specific lift.

On 07/08/14 at 6:34 PM, the Maintenance Supervisor stated he only purchased the one piece fabric easy fit sling from the owner's manual as noted above. He stated the lift (brand C) was the same manufacturer of the easy fit slings just a generic version.

A phone interview was held on 07/09/14 at 9:31 AM with a customer service representative from the manufacturer of the slings used in the facility. The customer service representative stated that the slings were to be used only with the recommended lifts (brand A) unless there was documentation of a risk assessment that showed staff knew how to use the slings and the lifts. The documentation would have to include the risks and a statement that they are safe to use together. The customer service representative confirmed that the lifts (brands B and C) were not the manufacturer's recommended lifts to use with the slings currently used by the facility.

Follow up interview with the Maintenance Supervisor on 07/09/14 at 11:33 AM revealed that he had a standing order monthly for slings. He stated that the facility had always ordered the same brand of slings currently in use. He stated that when a new mechanical lift was needed, he received bids and the administrator made the decision for all purchases over $500.00. He stated the slings had always worked safely in the lifts the facility had and that he had checked the

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slings and the lifts himself. When asked if he had documentation that he tested the slings with the different brand lifts, he stated that was 7 years ago and he had no documentation.

Residents were transferred via easy fit slings using the facility total lifts (Brands B and C) together against the manufacturer's recommendation as follows:

Resident #29 was observed on 06/30/14 at 11:01 AM being transferred using a mechanical lift (Brand C) and an easy fit sling from his bed out to the hall into his chair by 2 NAs.

Resident #14 was observed on 06/30/14 at 2:32 PM lifted via the facility sling and total mechanical lift (brand C with scale) in order to obtain her weight. The resident was then unhooked from the lift and hooked to another mechanical lift (brand C without scale) while in the same facility sling. While raised in the mechanical lift, staff rolled her into the hallway where a staff member was holding the wheelchair secure. Resident #14 was then lowered into her wheelchair. A total of 5 nurse aides, 2 therapy staff and the maintenance supervisor assisted during this transfer using a sling which did not meet the manufacturer's recommendation for use with the coordinating lift.

On 07/01/14 at 9:59 AM, Resident #12 was observed being transferred by NA #13 and Nurse #3 from a shower chair into bed using an easy fit sling and a mechanical lift (Brand C).

On 07/11/14 at 6:50 AM NA #18 was observed leaving Resident #23's room with a total mechanical lift (Brand B) and the resident was in the wheelchair sitting in a sling. On 07/11/14 at

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7:10 AM NA #18 stated during interview she had used the facility lift and the easy fit sling during the transfer.

Resident #30 was observed being transferred on 07/08/14 at 10:02 AM using an easy fit sling and mechanical lift (Brand C). NA #7 and Nurse #3 lifted him from a shower table in the hall into his bed in his room.

Resident #32 was observed on 07/08/14 at 10:11 AM being transferred by NAs #6 and #5 and Nurse #4 using a total mechanical lift (Brand B) and easy fit sling. The resident was moved from her bed into a gerichair.

The Director of Nursing reviewed the owner's operators manual for the easy fit slings on 07/11/14 at 3:06 PM with the surveyor. She stated that based on the manufacturer's recommendation the easy fit slings should not be used with the mechanical lifts (Brands B and C).

4. Resident #5 had been admitted to the facility 01/17/14 with diagnosis including hypertension, fracture aftercare, and depression. The admission Minimum Data Set (MDS) assessment dated 01/22/14 revealed Resident #5 was cognitively intact, able to understand and able to be understood. Records revealed Resident #5 had resided in room 119 during her stay at the facility.

Review of resident incident report dated 01/28/14 revealed Resident #5 had fallen that morning at 6:30 AM due to tripping on a piece of the heating unit sticking out of the lower section of the heater in room 119. Resident #5 had fallen and hit against the window, injuring her left arm. The

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incident report further revealed part of the post incident action had been a new heater had been put in place and the room had been cleared of any debris.

Observation on 06/30/14 at 10:41 AM of heating unit in room 119 revealed a strip of metal protruding from the bottom, under the unit. The metal was attached under the heating unit on the left end of the unit but was not attached to the right end and protruded out several inches beyond the unit.

Observation on 06/30/14 at 1:39 PM of heating unit in room 119 revealed a protruding strip of metal on the bottom right of the unit. The strip was protruding several inches beyond the heating unit.

Observation on 06/30/14 at 4:01 PM of heating unit in room 119 revealed a metal strip protruding from the bottom, under the unit. The metal flap was observed protruding several inches beyond the unit on the right side of the unit.

Interview with maintenance supervisor on 07/01/14 at 9:18 AM revealed because he had discovered the access door on the bottom of the in-room heating units had not been staying attached and kept popping loose. The maintenance supervisor said he had begun routinely removing all of them during the past 2 weeks. The maintenance supervisor stated he could not recall a report of any resident being injured by the door hanging off the heating unit. The maintenance supervisor said if staff noticed an access door hanging off the unit before he had been able to get to that room to remove it, they were supposed to complete and submit a work

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F 323	Continued From page 115 order to the administrator so he would know to remove the door immediately in order to prevent any injuries or accidents. Follow up interview with maintenance supervisor on 07/01/14 at 2:45 PM revealed he had toured the facility, checked the access doors on the in-room heating units on all bedrooms in the facility and had discovered about 4 more doors that were hanging off the units and needed immediate attention. The maintenance supervisor said he had removed the doors from the heating units that had been hanging out. Observation on 07/01/14 at 3:30 PM of the heating unit in room 119 revealed the access door from the heating unit had been removed and was no longer hanging off the unit.	F 323		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide an adaptive drinking cup for 1 of 3 sampled residents reviewed for the need of an assistive eating device (Resident #12). The findings included: Resident #12 was admitted to the facility on 09/23/08 with diagnoses which include kidney failure, altered mental status with intellect	F 369	Resident #12 was reassessed by the Registered Dietician (RD), Speech Therapist, and the MDS Team on 7/21/14 for the continued need of the adaptive cup. Resident will not continue to use the adaptive cup per the team decision. Anyone requiring adaptive equipment can be affected. Therefore; the Speech Therapist, RD and MDS	8/10/14

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F 369	Continued From page 116 disability, dysphagia (difficulty in swallowing), epilepsy, and cerebral palsy. A review of Resident #12's medical record revealed a speech therapy evaluation dated 12/20/13 which indicated Resident #12 had weight loss secondary to a decline in her ability to swallow, a decline in her cognition, and communication skills. The clinical summary of the speech therapy evaluation indicated Resident #12 was to use a nosey cup (an 8 ounce cup with a cutout for the nose as to use for drinking without tipping the head back or extending the neck), receive a mechanical soft diet, and be supervised with total assistance when eating. The quarterly Minimum Data Set (MDS) dated 05/13/14 indicated Resident #12 was severely impaired with cognition for daily decision making and was totally dependent on staff for activities of daily living (ADLs). The MDS further revealed Resident #12 had impaired range of motion of her head and neck, left arm, and both legs. The MDS noted rejection of care was not exhibited. A review of Resident #12's care plan with a revised date of 06/04/14 revealed a problem statement that specified the resident required assistance with ADLs and listed approaches in part for a mechanical soft diet and swallowing precautions which consisted of the following: head of the bed (HOB) elevated with meals and leave HOB elevated for at least 30 minutes after meals, requires supervision with meals, and use of adaptive equipment-nosey cup with all meals. The care plan noted Resident #12 had a communication deficit, speech was unclear and grabbled, and staff would anticipate her needs.	F 369	Team reviewed current residents with adaptive equipment for continued need on 7/18/14. Food Tray Cards and Resident Care Plans were audited to ensure need for adaptive equipment was addressed. All Dietary Staff and Nursing Staff were re-educated on adaptive equipment by the DON, SDC and RD between 7/17/14 and 8/9/14. The residents requiring adaptive equipment will be audited by the RD 3 x week x 12 weeks. The RN Supervisor and the MDS Team will audit equipment needs 5 x week x 4 weeks. The RD will take the audits to the monthly QAPI meeting x 2 months.	

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Nursing Assistant (NA) #13 was observed on 07/01/14 at 8:08 AM to set Resident #12 up in her bed, set up her breakfast tray, open the carton of milk, and leave the room. Resident #12 was observed to drink her carton of milk with spillage down her face, neck, gown, and onto the bed. Resident #12's meal tray card revealed her likes and dislikes in food but no indication for a nosey cup noted.

NA #13 was observed on 07/01/14 at 12:36 PM to set up Resident #12's lunch tray and leave the room. Resident #12 was observed to drink her milk from the carton with spillage down her face, neck, shirt, and onto her bed. Further observations revealed milk was the only beverage served on the resident's meal tray and there were no drinking glasses, cups or nosey cup on her tray.

NA #13 was interviewed on 07/01/14 at 12:44 PM, she indicated she would have to change Resident #12's clothes and bed linens after her meals because she would spill her milk and food. She further indicated she was unaware that Resident #12 was to have a nosey cup with all of her meals.

Nurse #3 was interviewed on 07/01/14 at 12:50 PM, she stated she was aware that speech therapy had worked with Resident #12 to assist her in independently eat and drink but was unaware Resident #12 was to have a nosey cup with all of her meals. She verified the care plan indicated Resident #12 was supposed to have a nosey cup with all meals.

The Dietary Manager/Registered Dietician was interviewed on 07/01/14 at 2:27 PM. He stated he

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F 369	Continued From page 118 completed a dietary update for Resident #12 in May 2014 and was unaware that a nosey cup was needed for her. Speech Therapist (ST) #1 was interviewed on 07/01/14 at 2:37 PM. She stated the ST that completed the evaluation on Resident #12 on 12/20/13 was no longer with the facility because the ST's were under a different contractor as of 04/01/14. She indicated she had no orders, information, and/or evaluations regarding Resident #12 and had not worked with her since she had been with the facility. The Director of Nursing (DON) was interviewed on 07/01/14 at 3:09 PM. She stated she was unaware Resident #12 needed a nosey cup. She verified that Resident #12's care plan indicated she was supposed to have a nosey cup with all meals. She further stated she would have expected the NAs, the nurses, and/or the dietary staff to ensure Resident #12 had the indicated adaptive eating equipment.	F 369		
F 406 SS=E	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.	F 406		8/10/14

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F 406	Continued From page 119 This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and facility documentation, the facility failed to provide ongoing therapy services for 1 of 2 sampled residents when the facility did not provide Resident #14 a chair to accommodate her accessing the therapy gym for close to 4 months. The findings included: Resident #14 was admitted to the facility on 12/05/13 with pressure ulcers, diabetes, and chronic obstructive pulmonary disease. Review of the FL2 form with a faxed date of 12/03/13 revealed she required skilled nursing care, was nonambulatory, required personal care assistance for bathing and dressing, was to receive physical therapy daily and had specialized needs related to weight. The physician orders revealed physical therapy (PT) was ordered 5 times per week times 4 weeks on 12/06/13 for gait training, therapeutic exercises and activities, manual therapy, neuromuscular re-education, and home visit as needed. The evaluation completed on 12/06/13 included a short term goal to increase time out of bed to 4 hours and a long term goal to complete gait training with rolling walker. The physician orders revealed occupational therapy (OT) was ordered 5 to 7 times per week for 8 weeks on 12/06/13 for therapeutic activity, activities of daily living/self care, therapeutic exercises, neuro re-education, thermal modalities as needed, wheelchair management, manual treatment, nurse/caregiver education, and nursing	F 406	Resident # 14 was provided with a Bariatric Wheelchair on May 22, 2014. Any resident requiring specialized equipment can be affected by this practice; Therefore, an audit of specialized mobility equipment was done by the PT, Occupational Therapy Assistant and the Speech Therapist on 7/21/14. All equipment audited was found to be appropriate for the resident it is assigned to. An in-service was done for all facility staff between 7/29/14 to 8-9-14 by the DON and Administrator concerning the approved method of communication to report equipment malfunction. Staff will notify the maintenance department for follow-up using a maintenance request form and remove or replace any defective equipment that is unsafe as needed. The maintenance director will repair the problem and communicate the fix with the Administrator to be logged as completed. The maintenance director will report to the administrator weekly x 16 weeks regarding any unrepaired items. The maintenance director will take the results to the monthly QAPI meeting x 4 months.	

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education. The evaluation dated 12/07/13 included a short term goal to complete wheelchair transfers with maximum assistance of one with appropriate device and safety.

The admission Minimum Data Set (MDS) dated 12/12/13 coded her with intact cognition, total assistance needed for bed mobility, dressing, and toileting. Walking and transfers did not occur during this assessment period. She was coded as receiving PT and OT. The MDS noted there was a discharge plan for Resident #14 to return to the community.

PT notes dated 12/17/13 revealed Resident #14's family brought in a wheelchair from home which appeared too small for her and could cause pressure areas on lateral hips. PT notes dated 12/18/13 stated the resident was transferred to a bariatric gerichair that was also too small for her. PT notes dated 12/19/13 stated that the small gerichair was discussed with the rehab manager who reported that management was working on ordering a wider gerichair for the resident. PT notes dated 01/01/14 revealed that the therapist communicated with the rehab manager regarding the status of a wheelchair or gerichair for Resident #14. The rehab manager reported he had price quotes but ordering a chair was under review of the facility management. PT notes dated 01/02/14 revealed there was no wider wheelchair in the facility for Resident #14 to use and that she was very eager to get out of bed and work on standing in the parallel bars.

On 01/06/14, the physician ordered skilled PT to continue 5 times per week times 4 weeks for therapeutic exercises, therapeutic activities, neuromuscular re-education, wheelchair

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management, manual therapy, gait training, home visit as needed.

The PT discharge summary dated 01/27/14 stated the resident had not achieved her goals "due to lack of appropriate equipment to allow pt (patient) to get oob (out of bed)" and that the facility was in the process of obtaining appropriate seating. The note continued stated that therapy will reassess if indicated for further skill. Discharge instructions was for a home exercise program.

On 01/27/14 the OT discharge summary stated Resident #14 was limited to in bed activity and she was unable to access the therapy gym at this time. The note stated the facility was awaiting approval for a bariatric wheelchair and the resident was currently unable to sit at the edge of the bed secondary to the air mattress required for multiple skin ulcers. OT would re-evaluate when the wheelchair arrives.

The quarterly MDS dated 05/09/14 revealed Resident #14 was cognitively intact and did not transfer, walk, or did any locomotion during the 7 day assessment period. The mobility device normally used was noted as a wheelchair.

Physician orders dated 05/22/14 included OT to evaluate and treat Resident #14. OT physician orders dated 05/22/14 included OT to treat 3 times per week for 30 days for therapeutic exercises, therapeutic activities, neuromuscular re-education, self care/ADLs, wheelchair management and modalities as needed.

On 06/30/14 at 10:41 AM, Resident #14 stated that for awhile they did not get her out of bed and

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therapy stopped when she had no wheelchair. She stated she has a wheelchair now from another facility that fits her. She stated she generally got up around 2:45 PM and returned to bed around 4:15 PM.

On 07/01/14 at 3:01 PM Resident #14 was observed propelling herself in a wheelchair using her feet down the hall. On 07/01/14 at 3:20 PM Resident #14 was observed in the therapy gym doing arm exercises.

On 07/02/14 at 12:03 the social worker stated that initially Resident #14 did not come in with a wheelchair. The resident's family or a friend later brought one from home however therapy determined it did not fit the resident properly.

Resident #14 stated on 07/02/14 at 2:57 PM that she started in therapy when she first arrived. She stated therapy had asked her if she had a wheelchair at home and she had a friend bring her wheelchair form home to the facility. She reported that therapy determined that wheelchair was too small.

On 07/03/14 at 9:54 AM, the Administrator was interviewed and stated that the facility had been looking for months to find a wheelchair to accommodate Resident #14. He stated the current wheelchair she was using was loaned by another facility. He further stated that when the new therapy company came in (beginning in April) the new rehab manager stated there was a larger bariatric wheelchair at another facility he had been at previously, so the facility obtained that wheelchair for Resident #14 to use.

Interview on 07/03/14 at 4:15 PM with the rehab

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F 406	Continued From page 123 manager revealed a new therapy company began in the facility on 04/01/14. He became the rehab manager on 05/12/14. At that time he became involved in the morning management meetings. During the morning management meeting, there had been a discussion of a resident who needed an extra wide wheelchair. The rehab manager stated he was aware of one at another facility and suggested they try to borrow that wheelchair for her. The rehab manager stated they obtained the extra wide wheelchair the next day and Resident #14 began therapy again. An interview was conducted with OT and PT on 07/10/14 at 10:08 AM. Both OT and PT stated they had worked with Resident #14 prior to the therapy company change in April 2014 and continued on with the new therapy company since April. OT stated that Resident #14 was unable to walk and she could not access the therapy gym due no wheelchair available to fit her properly. She further stated that she was unable to do therapy and exercises at bedside due to her using an air mattress and sitting on the edge of the air mattress was a fall risk. Both OT and PT stated therapy services ended due to the facility not having the correct wheelchair for her to access the therapy gym.	F 406		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425		8/10/14

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F 425	Continued From page 124 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews the facility failed to acquire and receive the Glaucoma Medication necessary for 1 of 1 sampled resident (Resident # 13). Findings include: Resident # 13 was admitted to the facility on 10/17/13 with diagnoses of diabetes mellitus and glaucoma. A record review of the Minimum Data Set (MDS) quarterly assessment dated 04/22/14 revealed that Resident # 13 had been identified as cognitively intact. A care plan dated 04/30/14 revealed an identified problem for Resident # 13 of impaired vision secondary to glaucoma. An intervention included: Medication as ordered. A record review of the facility policy for ordering	F 425	Resident # 13 is currently receiving eye drops per physicians order. Any resident requiring medications can be affected by this practice. Therefore, the DON, SDC and RN Supervisor did a Medication Administration Cart to Medication Administration Record for every resident on every unit audit to ensure all physician ordered medications are available on 7/15/14. All physician ordered were available. The DON and SDC re-educated the licensed nursing staff between 7/17/14 to 8/9/14 regarding the process for obtaining medications when ordered and for using the back-up pharmacy located locally. All nursing staff were educated between	

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F 425	Continued From page 125 and receiving medications from the pharmacy revealed that repeat medications (refills) were written on a medication order form provided by the pharmacy for that purpose, and ordered as followed: "Reorder medications three to four days in advance of need to assure an adequate supply is on hand. The refill order is called in, faxed, or otherwise transmitted to the pharmacy". A record review of a physician's order dated 06/01/14 revealed Lantoprost Sol 0.005 % Instill one drop in each eye every night at bedtime for Glaucoma. A record review of the Medication Administration Record (MAR) for Resident # 13, for the month of June, 2014 revealed that Latanoprost solution 0.005 % was to be instilled in each eye every night for glaucoma. Further review revealed that it had been signed and circled for the dates of 06/28/14 thru 06/30/14 and no explanation of why it was circled on the MAR. During an interview with Resident # 13 on 06/30/14 at 11:35 AM Resident # 13 stated that her eye drops for glaucoma had not been administered over the weekend. An interview with Nurse # 13 on 07/01/14 at 3:35 PM revealed that on 06/28/2014 and 06/29/2014 she was the nurse who initialed the MAR on those nights for Resident # 13. She revealed she circled the Latanoprost eye drops on the MAR, and it meant the medication was not given because the medication was not available. An interview with Nurse # 14 on 07/01/14 at 3:40 PM revealed that she worked on 06/30/14 evening shift, and she was the nurse who initialed	F 425	7/17/14 to 8/9/14 notifying the physician and DON when a medication is unavailable. The QA Nurse and RN Supervisor will do daily Medication Administration Record audits for issues regarding missing documentation on the medication record. The audits will be done daily x 8 weeks and brought to the monthly QAPI meeting by the DON for review and recommendations	

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F 425	Continued From page 126 and circled the Latanoprost on the MAR for Resident # 13 as not given because it was not available. She also revealed that she ordered the medication from pharmacy on 06/30/14 and it had not arrived from the pharmacy on her shift. An observation of a medication cart on 07/01/14 at 11:45 AM revealed an unopened bottle of Lantoprost for Resident # 13. The label read: Date filled 06/30/14. An interview with the Director of Nursing (DON) on 07/03/14 at 8:50 AM revealed that the nurse who was passing medications at the time the medication was due, but finds it was not available, was responsible for communicating and clarifying any orders for the medication with the pharmacy. She further revealed if the nurse does not receive the medication right away, she should report it to the pharmacy and the DON. She revealed it is her expectation that the medication should have been ordered by the nurse responsible for that medication during her med pass, and there should have been communication about the specific need for the medication to the pharmacy. She stated the nurse was expected to follow up with pharmacy if the medication had not arrived at the facility that same day.	F 425		
F 499 SS=D	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State	F 499		8/10/14

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F 499	Continued From page 127 laws. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to prevent 1 of 1 nurse (Nurse #7) who was employed by the facility from performing nursing duties without a license. The findings included: A review of a facility time sheet dated 03/15/14 through 04/15/14 indicated Nurse #7 was clocked in at the facility on 03/28/14, 03/31/14, 04/01/14, 04/02/14, 04/03/14 04/04/14, 04/07/14, 04/08/14 and 04/09/14. During an interview on 07/07/14 at 11:40 AM Nurse #2 verified she had observed Nurse #7 at the nurse's stations between 03/28/14 and 04/09/14. She further stated she had been told Nurse #7 did not have a nursing license but she was not told what her duties were supposed to be. During an interview on 07/07/14 at 3:18 PM with Nurse #7 she verified she was made aware that her nursing license was suspended on 03/28/14 by the North Carolina Board of Nursing and her license was reinstated on 04/10/14. She stated during that time she was aware she did not have a license to practice nursing in North Carolina and was told by the former Director of Nursing (DON) who no longer worked at the facility to do office work. She explained the former DON did not give her any written guidance as to what she could or could not do. Nurse #7 confirmed the time sheet was correct and she had worked in the	F 499	No resident was named in the citation. Nurse #7 is no longer employed at Asheville Nursing & Rehabilitation. The DON has been in-serviced by the Regional Nurse Consultant on 7/29/14 on communicating any issues that affect the nursing staff at Asheville Nursing & Rehabilitation regarding expired/lost or penalty that has been applied to a nurse□s license. The Human Resources Director and Staff Development Coordinator were in-serviced by the DON and RN Supervisor between 7/17/14 and 8/9/14 concerning the communication of issues that could affect the employee□s licensure and ability to practice nursing. A current license/certifications have been audited by the Human Resources Director and the Staff Development Coordinator with the North Carolina Board of Nursing and the North Carolina Nurse Aide Registry on 7/28/14 and all other employee license/certifications are current. This audit will be done monthly by the Human Resources Director and any licensed employee's license/certification that will expire within 30 days will be given notice in writing and	

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(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 499	Continued From page 128 facility between 03/28/14 and 04/09/14. During an interview on 07/11/14 at 1:59 PM the Assistant Director of Nursing (ADON)/Day shift Supervisor stated she was told by the former DON who no longer worked at the facility that Nurse #7 did not have a nursing license between 03/28/14 and 04/10/14 and was supposed to be assigned to do administrative duties. She stated the former DON did not tell her what the administrative duties included. The ADON/Day shift supervisor confirmed Nurse #7 had signed verbal orders from a physician and physician's assistant on 03/31/14 but she did not have a valid nursing license during that time and should not have been practicing as a licensed nurse. During an interview on 07/11/14 at 3:06 PM the DON who had had only worked at the facility for a couple of weeks stated the former DON had informed her Nurse #7 did not have a nursing license from 03/28/14 until her license was reinstated on 04/10/14 and was she was only supposed to be doing administrative paperwork. She stated Nurse #7 should not have taken verbal orders from the physician and physician assistant on 03/31/14 because she was not a licensed nurse during that time.	F 499	the Administrator and DON will be notified of upcoming renewal dates. If the employee has not provided a license renewal by the date their license expires, they will not be allowed to work at Asheville Nursing & Rehabilitation until their license is current. The Human Resources Director will complete a monthly review of credentials on all licensed and certified staff. The DON will communicate with the Regional Clinical Nurse, Administrator and Human Resources Department at the Corporate Office if a nurse has any violations against their license. A summary of the issues leading to the removal of the license will be done by the DON. The nurse will not work during the period of the license suspension. Reinstatement of the nurse will be discussed by the above employees to determine return to work status. The Human Resources Director will complete a monthly review of credentials on all licensed and certified staff. Results on the monthly audit will be taken to the QAPI Committee monthly for review and recommendations.	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514		8/10/14

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F 514	Continued From page 129 accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to maintain complete and accurate medical records to include pain assessment scale results, treatment administration records and physician orders for 5 of 28 sampled residents (Resident #14, #16, #11, #2, and #8). The findings included: 1. Resident #14 was admitted to the facility on 12/05/13 with pressure ulcers, diabetes, chronic obstructive pulmonary disease and had specialized needs related to weight. The admission Minimum Data Set (MDS) dated 12/12/13 coded her with intact cognition, total assistance needed for bed mobility, dressing, and toileting. She was coded with having 2 stage 3 pressure ulcers. A care plan was developed on 12/18/13 which included the goal for the pressure ulcers to reduce in size. Interventions included diet as ordered, therapeutic mattress, turn every 2 hours or less, prevent sheet friction by using a pull pad to move resident in bed, support with pillows,	F 514	The current treatments records and physician orders were clarified for accuracy by the physician for resident #14, #2, and #8. Care plans were reviewed and updated as needed and staff was educated regarding the current orders. Resident #14, #16, and #11 had a pain assessment completed and are monitored for changes through use of the numeric pain scale in the medication records. Any resident could be affected by this practice, therefore, the RCD, DON, SDC and Unit Manager have audited and cross referenced the physician□s orders and audited the Treatment Records for accuracy on 7/17/14 and 7/18/14. All Licensed Nursing staff have been re-educated on accuracy of treatment orders, physicians orders and documentation of treatments by the DON between 7-17-14 to 8-9-14. Daily audits of the treatment record are being done by	

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F 514	Continued From page 130 treatments as ordered, measure weekly, wound care physician to see weekly and observe the effectiveness of the current treatment. Review of the medical record revealed physician orders and treatment administration records (TARs) did not match and the TARs included evidence of missed treatments as follows: *On 12/06/13 a physician's telephone order stated the left upper thigh was to be cleaned with wound cleanser, patted dry, place Maxorb Alginate in wound, cover with Optiform AG and change daily. The TAR had no initials for the treatment being completed on 12/06/13. Interview with the Nurse #7 on 07/07/14 at 2:32 PM revealed she did the treatment just signed on 12/05/13 instead of 12/06/13. *On 12/12/13 a physician's telephone order changed the treatment to the left thigh to clean the wound with normal saline and apply silvadene alginate with foam daily. The TAR revealed the treatment was not initialed as being provided on 12/12/13, 12/14/13, 12/15/13, 12/20/13, 12/21/13, 12/22/13, 12/28/13, and 12/29/13. *On 01/16/14 physician telephone orders noted to add bactroban to left thigh wound at dressing change. The facility was unable to produce the TARs for the entire month of January 2014. The TAR for February 2014 revealed the addition for Bactroban but it was noted as a "prn" (as needed) order and the TAR for February revealed it was never initialed as being administered. Interview with the Nurse #7 on 07/07/14 at 2:32 PM revealed she did the bactroban with the dressing change but it was not listed together on the TAR. She further stated lots of treatment sheets were	F 514	the RN Supervisor and QA Nurse 7 days a week to ensure accuracy of treatments and treatment orders. A Pain Scale requiring a numerical score will be completed for all residents every shift to better assess and document a change in pain. All resident's have a pain assessment completed every shift utilizing a numerical pain scale form that requires a numerical score and licensed nurses initials. This form was added to each resident's medication administration record to better assess and document a change in pain. All licensed nursing staff were educated by the DON using a visual of the numerical pain scale form between 7/17/14 and 8/9/14. The physician will be notified of change in condition related to pain as clinically appropriate. The nurse will place the issue on the 24-hour report for follow-up during the next morning meeting. Residents will be reviewed for special needs or change of condition related to pain in the clinical morning meeting for follow-up and recommendations. The MARS are audited daily by the QA Nurse or RN Supervisor for absence of documentation and follow-up as needed. The pain scale audit, treatment record audit, medication record audit will be taken to the monthly QAPI meeting by the DON x 6 months for further review and recommendations .	

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missing. In addition February 2014's TAR revealed the treatment for silvadene alginate with foam was not listed on the TAR. There was an entry for alginate with 4 x 4 to the left groin daily. The treatment record noted that the left groin treatment that was not initialed as administered on 02/15/14, 02/16/14, 02/17/14, 02/18/14 and 02/23/14. Interview with the Nurse #7 on 07/07/14 at 2:32 PM revealed the groin area was the same as the thigh area.

*Review of the March 2014 TAR revealed the left thigh wound was cleaned with wound cleanser and maxsorb alginate was applied and covered with a 4 x 4. The TAR did not include the bactroban. The TAR revealed no treatment was initialed as being given on 03/01/14, 03/04/14 or 03/05/14. A physician's telephone order discontinued the treatment on 03/06/14 with instructions to leave the thigh open. The physician assistant's (PA) wound consultant note dated 03/06/14 noted the thigh wound was resolved. Interview with Nurse #7 on 07/07/14 at 2:32 PM revealed she could not explain this difference.

*The wound PA's note dated 03/13/14 stated the left thigh had sudden breakdown a week after closure. Physician orders dated 03/13/14 stated cleanse left upper thigh with normal saline, apply thin layer of bactroban and alginate with silver to wound 3 times per week and as needed and cover with tape. This was documented as being provided on the March 2014 TAR until 03/24/14. The TAR reflected the treatment changed from 3 times a week to daily, which was initialed as being done daily beginning 03/24/14 through the end of March 2014. The facility was unable to provide the physician's order for this change to

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daily treatments. Interview with Nurse #7 on 07/07/14 at 2:32 PM revealed she could not explain this and the Director of Nursing (DON) present at this time stated there should be physician orders to match each treatment located on the TAR.

*The facility was unable to provide TARs for the beginning of April 2014 to reveal what treatment was provided 04/01/14 through 04/03/14. Resident #14 was hospitalized from 04/03/14 and readmitted to the facility on 04/09/14.

*Review of the discharge summary, dated 04/09/14, revealed treatment orders to the left thigh of apply Silvadine twice a day to open areas. This was initialed as being completed on 04/09/14 during second shift per the TAR.

*On 04/10/14 physician orders changed the order to cleanse with normal saline, apply a small piece of silver alginate to fit wound, cover with 4 x 4 to be done twice per week and as needed. This was initialed as completed as ordered on the TAR.

*On 04/24/14 physician telephone orders discontinued the treatment and changed it to apply a sheet of silver alginate to open area and cover with 4 x 4 and medfix twice per week and as needed. The TAR reflected this treatment was completed as ordered in April 2014.

*The TAR for May 2014 had the handwritten entry to cleanse wound with normal saline, apply silver alginate, cover with Optiform, secure with medfix tape and change every other day and as needed. There was no physician order in the medical record to support this change of treatment. In addition, the TAR reflected the treatment was

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administered daily with no explanation as to why it needed to be changed daily. The May 2014 TAR included no initials for 05/27/14, 05/28/14, 05/29/14, 05/30/14 and 05/31/14 indicating no treatment was provided to the thigh wound on those days.

*The TAR for June 2014 included the treatment of apply sheet of silver alginate to open area cover with 4 x 4 and medfix BIW (sic for BID) and as needed. Hand written under this computer generated treatment were the words for left upper leg/under folds and "Tue Thur Sat." The medical record had no physician's order to correspond to this treatment change. Initials reflected the treatments were not provided as ordered as indicated with the handwritten notation or per the most recent physician's order in the record (04/24/14 2 x week). Interview with Nurse #7 on 07/07/14 at 2:32 PM revealed she could not explain the missing physician order or clarify the TAR.

Review of the measurements taken by the PA since 05/29/14 revealed the thigh wound has been improving. Measurements on 05/29/14 were 3.2 cm x 2.2 cm x 0.1 and on 06/27/14 the wound measured 1.5 cm x 1.3 cm x 0.1 cm.

On 06/30/14 at 10:41 AM, Resident #14 was observed in bed on an air mattress. She stated that she has had the open area on her upper thigh since being admitted to the facility. She stated the wound consultant saw her every Thursday.

On 06/30/14 at 2:32 PM, wound Nurse #7 was observed applying a nonstick dressing on top of the opened area on the left thigh wound after

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cleaning it with normal saline and covered it with an adhesive dressing.

Interview with the wound consultant PA on 07/03/14 at 1:15 PM revealed she thought the wound care being provided in the facility was as ordered. She stated that when she visited on Thursdays, the treatments that were observed in place were the ones she had ordered. In relation to Resident #14, she has had that area since admission. It would heal and then open again. The PA stated the thigh area was due to pressure caused by a large skin fold and she believed the sheet got pushed up into the skin fold which had not helped with the healing process.

On 07/07/14 at 2:32 PM, Nurse #7 and the DON were interviewed. The DON stated at this time that if the TAR's were not initialed, then she had to say that the treatment was not completed. Related to the missing treatment records and physician orders, Nurse #7 stated papers from the medical record were missing.

During follow up interview on 07/07/14 at 4:44 PM, the DON stated there had not been good monitoring of skin areas when first found. She stated she expected Nurse #7 to be responsible for wound orders and making sure they were correctly transcribed and followed.

2. Resident #16 was admitted to the facility on 05/01/14 with diagnoses including chronic pain.

Physician admission orders dated 05/01/14 included the pain medications of Fentanyl patch to be applied every 72 hours, Gabapentin 800 milligrams (mg) three times a day, a lidoderm patch applied to her right shoulder 12 hours daily,

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and Norco 325 mg three times a day routinely and every 6 hours as needed. Orders also included to assess pain every shift and a pain scale included to note 0 = no pain, 1-3 = mild pain, 4-7 = moderate pain, 8 - 10 = worst pain possible.

The Minimum Data Set dated 05/08/14 coded her with intact cognition and as receiving routinely scheduled and as needed pain medication but having no pain at the time of the assessment.

On 05/21/14 a care plan was developed for Resident #16 being at risk for alteration in comfort. The goal was for her to verbalize a decrease in pain level or show signs and symptoms of decrease in pain level 30 minutes to 1 hour following interventions. Interventions included to monitor for complaints of pain, provide alternative measures , administer pain medications per orders, and work with resident and physician to obtain optimal level of pain control for the resident.

Review of the Medication Administration Record (MAR) for May 2014 revealed that first shift initialed that a pain assessment was completed but only documented a scale rating on 05/06/14 and 05/28/14. On second shift the pain assessment was also initialed as being completed but only documented a scale rating on 05/02/14, 05/07/14, 05/24/14 and 05/25/14. Third shift initialed and documented via pain scale on all but 6 days in May. Per the MAR pain was documented 9 times and the as needed Norco was administered 32 times over 24 days.

Review of the June 2014 MAR revealed first shift entered initials for the pain assessment being

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complete but no scale. Second shift documented 13 days initials only and only one entry with a pain scale rating, 11 days with only a number indicating she had no pain and 5 blanks. Third shift included initials daily that a pain assessment was completed but only noted a scale rating 9 days. During this month the as needed Norco was administered 9 times when a pain scale indicated 4 times she had pain.

The 60 day MDS dated 06/27/14 coded her as receiving routinely scheduled and as needed pain medication. At the time of this assessment she stated she had frequent pain and scaled it on a level of 4 (from a scale of 1 - 10 with 10 being worst).

On 06/26/14 the physician increased the as needed Norco to 2 tablets every six hours.

Interview with Nurse #4 on 07/03/14 at 11:40 AM revealed that when assessing pain, she asked the resident about their pain, or if the resident was not able to answer about their pain, she observed signs and symptoms of a resident's pain. She stated she initialed the MAR that she did the assessment and if the resident had pain and could take a prn (as needed) pain medication, she would document the administration and effectiveness of the medication on the back of the MAR. She further stated there was not enough space on the MAR to put both her initials and a number of the pain assessment scale since the pharmacy changed about a year ago. When the facility changed pharmacies and the spacing on the MAR changed, she stated there had been no training as to how to document the pain scale assessment.

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Nurse #10 stated on 07/07/14 at 10:27 AM that she assessed a resident for pain verbally or looked for nonverbal signs and symptoms of pain. She stated she would document the MAR with the number correlating with the pain scale. She stated that forms were reviewed in orientation, however, she could not recall if the expectation as to how to complete the pain assessment and MAR was reviewed in orientation.

Nurse #11 stated on 07/07/14 at 10:33 AM that she should put the number based on the pain scale on the MAR when she did her pain assessment on a resident. Any prn medication given based on the pain scale would be documented on the back of the MAR.

An interview was conducted with the Director of Nursing on 07/07/14 at 5:01 PM. She stated that the pain assessments scheduled to be done every shift should include the nurse asking the resident or observing signs and symptoms of pain for non verbal/cognitively impaired residents based on a scale of 1 - 10. She expected nurses to write the numerical result of the assessment on the MAR.

3. Resident #14 was admitted to the facility on 12/05/13 with pressure ulcers, diabetes, chronic obstructive pulmonary disease and had specialized needs related to weight.

The significant change Minimum Data Set (MDS) dated 05/09/14 coded her with intact cognition, total assistance needed for bed mobility, dressing, and toileting. Walking and transfers did not occur during this assessment period. The MDS coded her as receiving routinely scheduled

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and as needed pain medication, having frequent pain at a level of 4 (out of 10) which she believed limited her day to day activity.

Physician orders included the following pain medication: Tylenol 325 milligrams (mg) three times a day, oxycontin 10 mg twice a day routine until on 05/05/14 it was changed to 10 mg once a day at night, then discontinued on 05/21/14, ultram 50 mg 2 tabs three times a day and oxycodone 10 mg every 6 hours as needed for pain. Orders also included to assess pain every shift and a pain scale included to note 0 = no pain, 1-3 = mild pain, 4-7 = moderate pain, 8 - 10 = worst pain possible.

Review of the Medication Administration Record (MAR) for May 2014 revealed that a pain assessment was completed every day on all three shifts. Only 3 times was there a numeric number indicating there was pain and the intensity. According to the MAR, Resident #14 received the as needed oxycodone 102 times during the month.

Review of the MAR for June 2014 revealed initials each day each shift indicating a pain assessment was completed as ordered. Only third shift coded a numeric pain scale each night, indicating she had pain nightly. She received the as needed oxycodone 90 times during the month.

Interview with Nurse #4 on 07/03/14 at 11:40 AM revealed that when assessing pain, she asked the resident about their pain, or if the resident was not able to answer about their pain, she observed signs and symptoms of a resident's pain. She stated she initialed the MAR that she did the assessment and if the resident had pain

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and could take a prn (as needed) pain medication, she would document the administration and effectiveness of the medication on the back of the MAR. She further stated there was not enough space on the MAR to put both her initials and a number of the pain assessment scale since the pharmacy changed about a year ago. When the facility changed pharmacies and the spacing on the MAR changed, she stated there had been no training as to how to document the pain scale assessment.

Nurse #10 stated on 07/07/14 at 10:27 AM that she assessed a resident for pain verbally or looked for nonverbal signs and symptoms of pain. She stated she would document the MAR with the number correlating with the pain scale. She stated that forms are reviewed in orientation, however, she could not recall if the expectation as to how to complete the pain assessment and MAR was reviewed in orientation.

Nurse #11 stated on 07/07/14 at 10:33 AM that she should put the number based on the pain scale on the MAR when she did her pain assessment on a resident. Any prn medication given based on the pain scale would be documented on the back of the MAR.

An interview with the Director of Nursing on 07/07/14 at 5:01 PM. She stated that the pain assessments scheduled to be done every shift should include the nurse asking the resident or observing signs and symptoms of pain for non verbal/cognitively impaired residents based on a scale of 1 - 10. She expected nurses to write the numerical result of the assessment on the MAR.

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4. Resident #11 was admitted to the facility on 08/01/07 with diagnoses which included Alzheimer's disease, heart disease, diabetes and a stroke. The most recent quarterly Minimum Data Set (MDS) indicated Resident #11 had short term and long term memory problems and was severely impaired in cognition for daily decision making.

A review of monthly physician's orders dated May 2014 and June 2014 indicated to assess for pain every shift with a pain scale as follows: 0 no pain; 1-3 mild pain; 4-7 moderate pain; 8-10 worst pain possible. The orders further indicated to document non-pharmalogical pain interventions as follows: repositioning = 1; massage = 2; deep breathing = 3 and distraction = 4 and if any of 1- 4 was initiated document and initial.

A review of a physician's order dated 06/05/14 indicated Tylenol 650 milligrams by mouth or under the tongue every 6 hours while awake.

A review of a Medication Administration Record (MAR) dated 05/01/14 through 05/31/14 revealed the following documentation regarding pain assessments:
7:00 AM - 3:00 PM shift documented their initials but no numeric pain scale. 3:00 - 11:00 PM shift documented a numeric pain scale on 23 days but no initials.
11:00 PM - 7:00 AM shift documented their initials but no numeric pain scale.
There was no documentation of pain assessments on the 7:00 AM - 3:00 PM shift on 05/28/14 and 05/29/14 or on the 11:00 PM - 7:00 AM shift on 05/31/14.

A review of a MAR dated 05/01/14 through

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05/31/14 revealed the following documentation regarding non-pharmalogical pain interventions:
7:00 AM - 3:00 PM shift only documented their initials but not the numeric intervention except on 05/30/14 where the intervention was documented but no initials.
3:00 PM - 11:00 PM shift documented the interventions but no initials.
11:00 PM - 7:00 AM shift documented initials but no numeric interventions. There was no documentation for non-pharmalogical pain interventions on the 7:00 AM - 3:00 PM shift on 05/28/14 and 05/29/14 or on the 11:00 PM - 7:00 AM shift on 05/31/14.

A review of a MAR dated 06/01/14 through 06/30/14 revealed the following documentation regarding pain assessments:
7:00 AM - 3:00 PM shift only documented their initials and no numeric pain scale.
3:00 PM - 11:00 PM shift documented a numeric pain scale but no initials.
11:00 PM - 7:00 AM shift documented a numeric pain scale and their initials on 5 days but only documented their initials and no numeric pain scale on the remainder of the days.
There was no documentation of pain assessments on the 7:00 AM - 3:00 PM shift on 06/27/14 or on 06/30/14. Pain assessments were also not documented on the 3:00 PM - 11:00 PM shift on 06/28/14 or on the 11:00 PM - 7:00 AM shift on 06/29/14 or on 06/30/14.

A review of a MAR dated 06/01/14 through 06/30/14 revealed the following documentation regarding non-pharmalogical pain interventions:
7:00 AM - 3:00 PM shift documented their initials but not the numeric intervention.
3:00 PM - 11:00 PM shift documented the

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numeric interventions but no initials. 11:00 PM - 7:00 AM shift documented numeric interventions and initials on 5 days but only their initials on the remaining days.
There was no documentation for non-pharmalogical pain interventions on the 7:00 AM - 3:00 PM shift on 06/27/14 or on the 3:00 PM - 11:00 PM shift on 06/28/14 or on the 11:00 PM - 7:00 AM shift on 06/29/14 or 06/30/14.

During an interview on 07/03/14 at 11:40 AM Nurse #4 explained when she assessed a resident's pain, she asked the resident about their pain, or if the resident was not able to answer about their pain, she observed for signs and symptoms of pain. She stated she initialed the MAR that she did the assessment but there was not enough space on the MAR to put both her initials and a number of the pain assessment scale since the pharmacy changed the forms about a year ago. She explained when the facility changed pharmacies the spacing on the MAR changed and there had been no training as to how to document the pain scale assessment.

During an interview on 07/07/14 at 11:03 AM Nurse #2 stated she assessed her residents for pain by asking them if they had pain and she used the pain scale to document the severity of their pain. She confirmed there was not enough space on the MAR to document her initials and the number related to the severity of the resident's pain. She stated she documented the non-pharmalogical pain interventions the same way but they needed bigger spaces on the MAR so they could document correctly.

During an interview on 07/07/14 at 5:01 PM the Director of Nursing stated blank spaces on the

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MAR for pain assessments and non-pharmalogical pain interventions indicated to her they weren't done by nursing staff. She stated it was her expectation that pain assessments that were ordered to be done every shift should include documentation by the nurse of the severity of the resident's pain according to the pain scale and the nurse's initials. She further stated the non-pharmalogical pain interventions should also have the numerical number corresponding to the intervention and the nurse's initials documented.

5. Resident #2 was readmitted on 06/11/14 with diagnoses which included diabetes, small bowel obstruction, colostomy, history of recurrent diverticular (a sac in the walls of the intestine) abscess (a localized inflammation or displacement of tissue) and enterocutaneous (eruption of the intestine with the outer layer of the skin) fistulas (a tube like passage from an area to the surface of another), debility, and generalized muscle weakness.

Record reviews of the Treatment Administration Record (TAR), Medication Administration Record (MAR) and physician (MD) orders revealed the following inaccurate records:

On 02/20/14 a physician's (MD) order was received to apply Bactroban (antibiotic) ointment daily for 5 days to the left big toe and cover with a Band-Aid for 5 days. The order was not transcribed on the TAR. The order was transcribed on the MAR and was documented as completed for Bactroban for 10 days to the left big toe instead of 5 days.

On 04/02/14 an MD order was received to soak

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the infected left big toe in clean warm salt water for 20-30 minutes twice daily, apply Bactroban ointment after soaking and cover with gauze. The treatment was transcribed on the TAR as discontinued on 04/19/14 but no MD order was received to discontinue the treatment.

On 04/09/14 an MD order was received to cleanse fistula area with warm soapy water, dry the area, apply ABD (a gauze surgical pad) and secure with medfix (a kind of medical dressing tape) tape, change twice daily, and may use pouchkins (an ostomy supply) for excess drainage. The treatments were initialed as completed as ordered daily from 04/09/14 to 04/14/14 and noted as changed on 04/14/14. No MD order was received to change this treatment dated on 04/14/14.

On 04/11/14 a treatment was transcribed on the TAR to apply zinc cream to excoriated area around fistulas as needed. This treatment was initialed as completed for 17 days but there was no MD order for this treatment.

On 04/14/14 a treatment was transcribed on the TAR to cleanse fistula area with warm soapy water and apply viscopaste over excoriated area, cover with ABD and secure with tape every shift. There was no MD order to change the frequency of the dressing changes from twice daily to every shift.

On 04/16/14 an MD order was received to apply viscopaste (a type of skin protective ointment) to inner thighs bilaterally due to redness and blistering until healed and there was no frequency specified on the MD order. The order was transcribed on the TAR for treatment 3 times daily

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and was initialed as completed 3 times daily. No MD clarification orders were received for the frequency of this treatment.

The May MAR revealed the 04/16/14 MD order to apply viscopaste to inner thighs bilaterally due to redness and blistering until healed with frequency specified of PRN (as needed) and a note "frequency needs clarification". There were no initials on the MAR for providing this treatment, it was not transcribed to the TAR and there were no MD Orders to clarify the treatment frequency was PRN or 3 times daily.

The May TAR listed a treatment for cleansing the fistula area with warm soapy water apply z-guard to excoriation, apply ABD and secure with tape every shift and PRN. The TAR was documented as providing the care every shift, but there was no MD order for this treatment. The last MD treatment order dated 04/09/14 received was for dressing changes twice daily.

The June TAR recorded a treatment for cleansing the fistula sites with cleanser, apply barrier cream, and apply an ABD secured with tape every shift and PRN. The TAR was not documented as care provided as ordered: 15 shifts were missing documentation. No MD order was received in May or June to clarify the change in frequency of the treatment ordered. The last MD treatment order dated 04/09/14 received was for dressing changes twice daily.

An interview with the physician's assitant (PA) wound care consultant on 07/01/14 at 1:52 PM revealed she was not seeing Resident #2. Interview with Nurse #7 on 07/07/14 at 3:18 PM revealed the wound care orders were received

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from the PA. She stated she provided the daily dressing changes and other nurses provided wound care on the other shifts for any dressing changes that were ordered twice or three times daily. Nurse #7 further stated any changes in the wound condition were reported to the facility doctor for order changes. Nurse #7 reviewed the MD orders and the TAR from February 2014 through June 2014 for Resident #2, confirmed there were discrepancies in the transcribing of orders onto the TAR, and they were not recorded as the MD orders were received.

Interview on 07/11/14 at 1:59 PM with the Assistant Director of Nursing revealed that if there was missing documentation in the treatment records, the treatment was not completed. She stated Nurse #7 was auditing the treatment sheets to ensure treatments were being completed as ordered.

An interview with the Director of Nursing (DON) on 07/07/14 at 3:18 PM revealed she expected the treatment records to be filled out when the dressing was completed. The DON stated if there were no initials on the treatment record then the treatment was not completed as ordered. The DON further stated on 07/07/14 at 3:35 PM that if a telephone order was not written on the TAR then she expected the wound nurse to ensure what the appropriate wound treatment was and know when the treatment was to be completed. The DON reviewed the MD orders and the TAR from January 2014 through July 2014 for Resident #2. The DON verified there were discrepancies in order transcription to the TAR. The DON further confirmed there were missing initials which indicated treatment was not provided, and the treatments were not recorded

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as the MD orders were received.

6. Resident #8 was readmitted to the facility on 01/10/13 with diagnoses which included pressure ulcer, chronic skin ulcers, diabetes, chronic kidney disorder, depression, psychosis, and generalized muscle weakness.

The following records were noted to be incomplete or inaccurate.

Reviews of Resident #8's medical record from 04/05/14 through 05/31/14 revealed skin assessments were completed weekly and indicated a wound to the left hip buttock area. The skin assessments but were not completed every week in the month of June.

A review of the hospital discharge instructions dated 06/17/14 had a surgical repair of the left buttock ulcer with a skin flap and drainage tube placement. The record further indicated Resident #8 received daily dressing changes to the surgical site with a follow up appointment in 2 weeks.

Record reviews of the Treatment Administration Record (TAR), Medication Administration Record (MAR) and physician (MD) orders revealed the following inaccurate records:

On 01/02/14 a physician's (MD) order was received to add flagyl (an antibiotic skin cream) gel to the dressing change of the left ishium (buttock area). This MD order for flagyl ointment was not added to the dressing change order on the January 2014 TAR.

On 02/06/14 an MD order was received to cleanse the left buttock area wound with normal

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saline. Apply packing covered with santyl (an enzyme skin debridement gel) and gentamicin (antibiotic ointment) into the wound daily. Use ½" gauze packing and cover with a 4x4 gauze and secure with medfix (a kind of medical dressing tape) twice daily. The TAR indicated the treatments were transcribed for a daily dressing change. The TAR was initialed twice daily but was missing initials of care provided for 5 shifts.

On 03/28/14 an MD order was received to irrigate the wound with Dakin's (an antiseptic solution) ¼ strength then rinse with normal saline, place a packing wick of gauze into the tract every Monday, Wednesday and Friday (M-W-F). Apply antibiotic powder to the skin around the wound, apply gauze dressing and secure with tape. The order was transcribed to the TAR on 03/28/14. On the April 2014 TAR the 03/28/14 wound care order was transcribed for (M-W-F) dressing changes. On 04/16/14 an MD order was received to continue the dressing changes as ordered on (M-W-F). The TAR was transcribed starting 04/16/14 for dressing changes every other day and PRN (as needed), but there was no order received to change the frequency to every other day and no wound care was initialed as completed after 04/26/14.

On the May 2014 TAR there was a treatment transcribed for wound care dressing changes to be completed 2 times daily starting on 04/02/14. There was no MD order to change the frequency of the dressing changes from (M-W-F) to 2 times daily. The last MD order received was on 04/16/14 for (M-W-F). On 05/29/14 an MD order was received to apply barrier cream to outer wound, cleanse wound with Dakin's ¼ strength, apply gauze, secure with tape, and change

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dressing 2 times daily. This order was transcribed on the May TAR starting 05/30/14.

On 06/04/14 an MD order was received to continue dressing changes as previously ordered. On the June 2014 TAR wound care treatments were transcribed as previously ordered, but multiple shifts were missing initialed documentation up to 06/17/14. The MD orders revealed a surgical repair of the wound was scheduled for 06/17/14. An MD order was received dated 06/17/14 indicated daily dressing changes to the surgical site to start on 06/19/14 with Xenflo (a type of non adhering surgical dressing) and gauze dressings. A review of the July 2014 TAR revealed Resident #8 received daily dressing changes to her surgical site as ordered.

An interview with Nurse #7 on 07/07/14 at 3:18 PM revealed the wound care orders were received from the wound care physician and care was provided by the facility. She stated she provided the daily dressing changes and other nurses provided wound care on the other shifts for any dressing changes that were ordered twice or three times daily. Nurse #7 further stated any changes in the wound condition were reported to the wound clinic for order changes. Nurse #7 reviewed the MD orders and the TAR from January 2014 through July 2014 for Resident #8, confirmed there were discrepancies in order transcription onto the TAR, and the orders were not recorded as received by the MD.

An interview on 07/11/14 at 1:59 PM with the Assistant Director of Nursing revealed that if there were missing documentation in the treatment records, the treatment was not completed. She

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F 514	Continued From page 150 stated Nurse #7 was auditing the treatment sheets to ensure treatments were being completed as ordered. An interview with the Director of Nursing (DON) on 07/07/14 at 3:18 PM revealed she expected the treatment records to be filled out when the dressing was completed. The DON stated if there were no initials on the treatment record then the treatment was not completed as ordered. The DON further stated on 07/07/14 at 3:35 PM that if a telephone order that was not written on the TAR then she expected the wound nurse to ensure what the appropriate wound treatment was and know when the treatment was to be completed. The DON reviewed the MD orders and the TAR from January 2014 through July 2014 for Resident #8. The DON verified there were discrepancies in order transcription to the TAR. The DON further confirmed there were missing initials which indicated treatment was not provided, and the treatments were not recorded as the MD orders were received.	F 514		
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520		8/10/14

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F 520	Continued From page 151 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, manufacturer's recommendations, and staff interviews, the facility failed to develop and implement plans of action to prevent staff from using slings that were worn and torn and to ensure staff used the correct size sling as part of the Quality Assurance review process. The facility administration continued to have staff transfer residents via the mechanical lifts and slings without proper training on the inspection of the slings for safety after Resident #18's sling ripped causing him to fall to the floor. Before all staff were inserviced and all slings were identified and audited for wear and tear, Resident #17's sling ripped and she fell into a chair during a transfer. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 on	F 520	July 11, 2014 On 6/15/2014 at 9:30 PM Resident #18 was being assisted by two CNA□s with a mechanical lift to transfer from the chair to the bed. During the transfer the sling ripped and the resident fell onto the floor. After the nurse assessed the resident, he was lifted onto the bed using another mechanical lift and sling that was inspected and had no defects. The ripped sling was removed from service by the charge nurse and locked in the medication room. The ripped sling was given to the maintenance director the next morning for disposal. Resident #18 continues to be transferred by mechanical lift and sling with no defects. Staff involved was educated by the charge nurse on sling inspection. On 06/16/2014 all slings were inspected by the maintenance director following the manufactures recommendation.	

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F 520	Continued From page 152 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. The findings included: 1. A review of the facilities undated Hydraulic Lift Policy included the procedures: "7. Check hooks and sling holes for fraying and security. DO NOT use frayed lift pads." A review of the Owner's Operator and Maintenance Manual, revised October 2008, included the warning "After each laundering (in accordance with instruction on the sling), inspect slings(s) for wear, tears, and loose stitching. Bleached, torn, cut, frayed, or broken slings are unsafe and could result in injury. Discard immediately." A review of the manufacturer's undated guide to sling sizes provided by the maintenance supervisor revealed slings with the following colored binding with maximum weight limitations for each sling: *Green binding indicated a large sling with maximum weight capacity of 300 pounds. *Blue binding indicated an extra large sling with maximum weight capacity of 450 pounds. *Black binding indicated an extra/extra large sling with maximum weight capacity of 600 pounds.	F 520	On 6/23/2014 at 2:59 PM Resident #17 was lifted from the recliner to the bed via a mechanical lift and two CNA□S. Upon lifting the resident up the sling ripped and the resident fell back into the chair. After the resident was assessed by the nurse, she was lifted into the bed using another sling that was inspected and had no defect. The ripped sling was given to Nursing Home Administrator; the ripped sling was locked in the Nursing home administrator office. The C.NA was given one on one in service by maintenance director and the nursing home administrator on sling inspection. The next day the C.NA was in service by the RN Supervisor/ ADON and the therapy department. The C.NA that was spotting the transfer was in serviced in the general in service regarding inspecting slings provided on 6/23/2014. Any other resident that have a potential to be affected were identified by Director of Nursing, the RN Supervisor/ ADON and one C.NA as resident requiring the use of mechanical lift and sling for transfers on 6/16/2014. The Director of Nursing, RN Supervisor/ ADON and Staff Development Coordinator read and reviewed manufacture recommendation for mechanical lift and slings. All licensed nursing staff, certified nursing assistants, therapy, housekeeping and maintenance staff that assist with	

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F 520	Continued From page 153 An attached warning included "Use the sling that is recommended by the individual's doctor, nurse or medical attendant. Before lifting, check all sling straps for secure points of attachment on the lift device. Do not exceed weight limitation posted on lift. Use only with (brand name) patient lifts. Bleached, torn, cut, frayed or broken slings are unsafe and could result in injury. Discard immediately. Do not alter slings. Use only on (brand name) lifts." A review of a nurse's note dated 06/16/14 at 12:54 AM indicated a late entry note for 9:30 PM that Resident #18 was being lifted out of his wheelchair with a mechanical lift and the "lift pad ripped at the bottom left corner and frayed and ripping apart at top left corner." The notes indicated Resident #18 fell approximately "a foot or less" to the floor and landed on the left side of his back and left buttock. The notes indicated Resident #18 complained of left sided back pain with redness noted to the left sided middle back area and pain medication was administered. During an interview on 07/08/14 at 5:16 PM with the Director of Nursing (DON), she explained she was called the night the sling ripped and Resident #18 fell from the lift and there was a discussion about the incident the next morning. She stated she expected the NA's to inspect the slings before using them for tears and frayed areas. She further stated if any of the slings were frayed or torn she expected the NA's not to use those and give the worn sling to the Maintenance Director, Housekeeping Supervisor, or the Charge Nurse. She explained she had no idea why the sling was available for staff use since the Maintenance Director and Housekeeping	F 520	transfers and spotting have been in serviced and provided instructions based on manufacture recommendations and provided written instruction by Staff Development coordinator or RN Supervisor/ADON on: 07/09/2014 * Determining the appropriate Size of sling for the resident * Care and inspection of sling per manufacturer□s instructions * Lift batteries/ chargers/ plug in * Care/ inspection of lifts per manufacturer□s instructions * Troubleshooting lifts All the above employees completed a return demonstration using a mechanical lifts with slings on: * Seated transfer * Floor transfer * Repositioning up in bed * Scale operation * Inspection for holes, tears, frays or unraveling on sling Sling in-service: * Safe use of sling with two staff members always * Identifying defects in the sling (if defect is found do not use it, give sling to the charge nurse) * The nurse is to remove the defective sling from service and place in the locked medication room for maintenance to pickup for disposal. * The nurse is to fill out a work order for maintenance to replace the defective sling. * The Maintenance director is to reorder the same size sling that was taken	

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F 520	Continued From page 154 Supervisor had gone around and collected all the slings and checked them and all slings that were worn or frayed were supposed to have been discarded. During an interview on 07/08/14 at 6:03 PM the Maintenance Director explained he saw the sling on 06/16/14 after Resident #18 fell from the lift on 06/15/14. He described it as light blue on one side and white on the other side. He further described the sling was ripped at the seam area of the top corner and had completely ripped off at the bottom left corner. He stated he was not sure why the sling was available for staff use since it had frayed edges and it should have been caught when they did the weekly audits to check for damaged or worn slings but it must have been missed somehow. During an observation and interview on 07/09/14 at 10:57 AM the Housekeeping Supervisor brought a sling to a conference room and verified it was the sling that had ripped when Resident #18 fell from the lift. He demonstrated and verified a corner of the sling had ripped completely at the top left corner and the bottom left corner had frayed edges and ripped edges. He confirmed it was an old lift sling and should have been discarded before it was used to transfer Resident #18 on 06/15/14. During a follow up interview with the DON on 07/11/14 at 3:06 PM she confirmed the sling that had been used to transfer Resident #18 was worn with frayed edges and should not have been used for his transfer. She stated it was her expectation that worn and frayed slings should be discarded immediately and not available for resident use	F 520	out of service This in service was started at 2:45 PM on 7/9/2014 and will be completed by 3:00 PM on 7/10/2014. Any employee that has not attended the above named in service after 3:00 PM on 7/10/14 will not be allowed to work until the in service is completed by Staff Development Coordinator, Day shift RN Supervisor/ADON or 3 to 11 RN Supervisor. All new employees will be in serviced during orientation. At 3:00 PM on 7/10/2014 a list of employees that did not receive the above in-service will be given to the Director of Nursing. The Director of Nursing will monitor the daily schedule to ensure that anyone that had not had the above in service will not be scheduled to work until in the in service is completed. An in service will be conducted with laundry and one housekeeper staff that is crossed trained for laundry on 7/10/2014 for inspection of slings to include: * Holes, tears, frays or unraveling * Identifying defects in the slings, the housekeeping/ laundry employee will lock the defective sling in the housekeeping / laundry supervisor office. Fill out work order for maintenance director to replace sling and dispose of the defective sling. * Maintenance director is to reorder the size sling that was taken out of service This in service will be completed by 3: 00	

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F 520	Continued From page 155 Review of record review and interviews revealed the actions taken related to Resident #18's fall because the sling ripped were as follows: a. On 06/16/14 an inservice education sign in sheet for the subject of Proper use of Lift slings and not using if unsafe was signed by 37 staff members (22 nurse aides, 1 med aide, 12 nurses, 1 housekeeper and 1 laundry staff). The agenda included using 2 staff for all mechanical lift transfers, identifying defects in lift slings, communication if lift sling is found defective, removing the sling before use if not safe, writing a work order to report a bad lift sling and reordering new slings to replace defective ones. On 07/08/14 at 6:03 PM the maintenance supervisor stated he provided the first inservice on 06/16/14 and has completed no additional inservices with staff related to sling usage. b. An audit of the slings in the facility revealed that on 06/16/14 the maintenance supervisor and housekeeping supervisor counted, numbered, and audited 28 slings. 4 slings were pulled due to condition. An additional audit sheet dated 06/17/14 included 2 more slings for a total of 30 slings in the facility. On 07/08/14 at 6:03 PM the maintenance supervisor stated he completed the same audit every Tuesday. He also stated he numbered each sling to make auditing easier and make sure each sling was being observed weekly. The maintenance supervisor stated that he and the housekeeping supervisor found more slings that were not caught on the first audit, numbered them and added them to the audit sheet. A review of a nurse's note dated 06/23/14 at 2:59 PM indicated a change of status which revealed Resident #17 was being lifted out of a recliner chair with a mechanical lift and the lift pad ripped	F 520	PM on 7/10/14 by the Staff Development coordinator or RN Supervisor and Housekeeping/ Laundry supervisor. Any employee who has not attended this in-service will not be allowed to work until they have attended the in-service. All new employees will be in serviced during orientation. An audit on all slings in the facility was completed 7/09/2014 at 8:00 PM by the Maintenance Director, Director of Nursing and Housekeeping/ Laundry Supervisor. The Audit of the slings included the following: * All slings were identified, numbered # 1 to #42 and size noted * The Condition of the slings were inspected for holes, tears, frays and defects * During this audit no sling were removed due to defects The following interventions and systemic changes will ensure effective operation of the Quality Assurance Committee. All Quality Assurance Committee members will be in-serviced on 07/11/14 or prior to returning to work by the corporate Nurse Consultant and/or the Regional Director concerning the following procedures. All weekend managers will be in-serviced on 07/11/14 or prior to returning to work by the Administrator regarding reporting incident/accident reports to the Administrator on the weekends.	

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F 520	Continued From page 156 at the left front corner. The notes indicated Resident #17 fell approximately 6 inches back into chair and there was no apparent injury noted. The notes further indicated the Physician, Administrator and Assistant Director of Nursing (ADON) were made aware immediately. A review of an x-ray report titled MRI left knee without contrast dated 07/08/14 at 2:30 PM indicated the following impression: 1. Moderate to severe osteoarthritis of the medial (middle) compartment associated with contusions. 2. The medial meniscus (a semicircular cartilage that provides structural integrity to the knee) is extruded (pushed out) and there is a probable tear of the extruded body. 3. Findings suggest a grade 1 sprain of the medial collateral ligament (MCL) on the inner part of the knee. 4. Moderate intramuscular swelling within the vastus medialis (large muscle located on the front of the thigh). A review of a physician's order dated 07/11/14 at 3:15 PM indicated to refer Resident #17 to a bone and joint specialist and the appointment was scheduled for Monday 07/21/14 at 2:00 PM. During an interview on 07/08/14 at 5:16 PM the DON explained she was not called on 06/23/14 when the sling ripped and Resident #17 fell from the lift but she saw the incident report the following morning on 06/24/14. She stated NA #15 had told her she heard a ripping sound when Resident #17 was suspended in the sling above her recliner chair and NA #15 put her knee up under the resident and pushed her back toward the recliner chair. She explained she had no idea	F 520	* The Quality Assurance Committee will oversee the implementation of all aspects of the above plan and meet within one week to review the plan, reassess for effectiveness, and modify the plan as necessary. The Quality Assurance Committee will address mechanical lift and sling safety at each Quality Assurance meeting for one year. * The corporate Nurse Consultant will attend the Quality Assurance Committee meetings for six months as an advisor to ensure the committee is accessing all relevant data at their disposal, fully addressing all current issues, reassessing the effectiveness of their plans of action, revising their plans of action as needed, and keeping issues on the agenda of the committee until the issue has been fully resolved. Individual committee members will be designated as the responsible party to follow up with action plans, give progress reports and provide a target completion date. * The Administrator will ensure that, prior to Quality Assurance meetings, all supervisors and Administrative staff are polled for any issues that need to be discussed at the meeting.	

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F 520	Continued From page 157 why the sling was available for staff use since the Maintenance Director and Housekeeping Supervisor had audited slings on Tuesdays of each week and all slings that were worn or frayed were supposed to have been discarded. During an interview on 07/08/14 at 6:03 PM the Maintenance Director explained he saw the sling after Resident #17 fell from the lift on 06/23/14 after they got it out from under her and described it as light blue on one side and darker blue on the other side with a green reinforcement band. He further explained one whole corner had ripped off and the sling was frayed on the edges. He stated he was not sure why the sling was available for staff use since it had frayed edges and it should have been caught when they did the weekly audits to check for damaged or worn slings but it must have been missed somehow. During an observation and interview on 07/09/14 at 10:57 AM the Housekeeping Supervisor brought a sling to a conference room and verified it was the sling that had ripped when Resident #17 fell from the lift. He demonstrated and verified a corner of the sling had ripped completely off and the piece that had ripped off had the hooks still attached that would have been hooked onto the arm of the lift. He further verified the sling had frayed edges along the top left side and on the right side at the top and bottom near the remaining hooks on the green reinforcement binding. He confirmed it was an old lift sling and should have been discarded before it was used to transfer Resident #17 on 06/23/14. He stated it must have slipped through the cracks when the weekly audits of slings were done. During an interview on 07/11/14 at 3:06 PM the	F 520	* The Administrator will review any accident/incident reports in the daily stand-up meeting and request staff to report any new issues that need immediate attention. Remedial actions will be determined and current plans assessed for effectiveness in the daily stand-up meeting. If necessary, the Administrator will also convene a meeting of relevant members of the Quality Assurance Committee after the daily stand-up meeting to address problems needing immediate attention. If indicated, issues will be scheduled for follow-up immediately and then taken to the monthly Quality Assurance Committee meeting. One indication would be any issue that has the capacity to cause harm or has caused harm. * Any issue requiring immediate in-servicing of staff will be supervised by the Administrator to ensure 100% of all relevant staff are in-serviced prior to returning to work. * Any issue requiring immediate audits of equipment will be supervised by the Administrator to ensure 100% of all relevant equipment is included in the audit and any defective equipment is immediately removed from access by staff.	

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F 520	Continued From page 158 DON explained during her investigation of the fall, she was told the wrong size sling had been used to transfer Resident #17. She further explained she found out staff had used a blue sling with a green reinforcement band and that indicated it was a large sling with a maximum weight capacity of 300 pounds. She confirmed staff should have used an x-large sling for Resident #17's transfer because her weight was greater than 300 pounds and also confirmed the sling that had been used to transfer Resident #17 was worn with frayed edges and should not have been used for her transfer. She stated it was her expectation that worn or frayed slings should be discarded immediately and not available for resident use. Review of records and interviews revealed the additional actions taken related to Resident #17's fall from a sling when it ripped were as follows: a. Another inservice was conducted on 06/23/14 for the subject of Lift slings and transfers using safe equipment. 27 staff (17 nurse aides, 8 nurses, the housekeeping supervisor and 1 housekeeper) signed off as attending this inservice. Some of these staff had also attended the first inservice. On 07/09/14 at 1:42 PM the Administrator stated he provided this inservice. b. An audit of the slings completed on 06/24/14 revealed 30 slings were in use at that time and the sling that ripped on 06/23/14 was not on the audit sheet as having been inspected. Interview with the maintenance supervisor on 07/08/14 revealed that he and the housekeeping supervisor audited the slings every Tuesday and will continue the weekly audits until 07/16/14 at which point the audits will be done monthly. On 07/09/14 at 1:42 PM the Administrator stated	F 520	* On the weekends and holidays, the Administrator will be informed by the manager on duty of any incident/accident report involving resident safety to determine if an immediate plan of action is required to protect residents.	

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that after the first sling ripped on 06/15/14, the maintenance supervisor provided an inservice to staff on checking slings for wear and tear. An audit of the slings was also completed. He stated it was just an accident that there was a worn sling not identified in the audit that was used on 06/23/14 resulting in another fall. After this incident the Administrator stated he and the maintenance supervisor completed another inservice. He stated that he was unaware of exactly how many staff had received any inservicing on the slings and checking for wear and tear as of this date. He stated it was the responsibility of maintenance supervisor, DON, the staff coordinator and himself to make sure all staff were eventually inserviced. He further stated the inservicing would continue until staff were comfortable using the lifts and slings. He did not know who or how many staff still had not been inserviced on what to look for when using the slings.

On 07/10/14 at 5:56 PM the Administrator stated the Quality Assurance (QA) committee met the third Wednesday of each month. He stated that issues that were to be followed by the QA committee were trends and problems identified during the morning staff meetings. Morning staff meetings were held Monday through Friday with all department heads. The morning staff meetings discussed things including all incident reports, nursing issues from the 24 hour reports, old and new grievances, any resident behaviors, any environmental concerns. Per the Administrator, the team decided on what was taken to the QA committee based on the frequency and/or severity of the issue. He further stated if the same issue occurred twice that issue always went to QA. In relation to the 2 incidents

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where the slings ripped, the Administrator stated that the team decided on a mini QA. He stated they started inservicing and the auditing of the slings and then the ordering of new slings. The Administrator stated he had no written plan of action for the QA addressing the sling incidents. He also stated that the weekly audits were to continue for 3 months and he couldn't say why the maintenance director thought the audits went monthly on 07/16/14. The Administrator further stated that the results of the inservices and audits were not discussed in the June QA meeting as the June QA meeting discusses the May issues and the July QA would address the June issues. The facility's Administrator and Director of Nursing were notified of Immediate Jeopardy on 07/10/14 at 6:08 PM for the lack of a quality assurance plan of action for the facility's failure to address the falls of Resident #17 and #18. The facility provided a credible allegation of compliance on 07/11/14 at 7:00 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy.

Credible Allegation of Compliance:

On 6/15/2014 at 9:30 PM Resident #18 was being assisted by two CNA ' s with a mechanical lift to transfer from the chair to the bed. During the transfer the sling ripped and the resident fell onto the floor. After the nurse assessed the resident, he was lifted onto the bed using another mechanical lift and sling that was inspected and had no defects. The ripped sling was removed from service by the charge nurse and locked in the medication room. The ripped sling was given to the maintenance director the next morning for disposal. The Resident #18 continues to be

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transferred by mechanical lift and sling with no defects. Staff involved was educated by the charge nurse on sling inspection.
On 06/16/2014 all slings were inspected by the maintenance director following the manufactures recommendation.
On 6/23/2014 at 2:59 PM Resident #17 was lifted from the recliner to the bed via a mechanical lift and two CNA ' S. Upon lifting the resident up the sling ripped and the resident fell back into the chair. After the resident was assessed by the nurse, she was lifted into the bed using another sling that was inspected and had no defect. The ripped sling was given to Nursing Home Administrator; the ripped sling was locked in the Nursing home administrator office. The CNA was given one on one in service by maintenance director and the nursing home administrator on sling inspection. The next day the CNA was in service by the RN Supervisor/ ADON and the therapy department. The CNA that was spotting the transfer was in serviced in the general in service regarding inspecting slings provided on 6/23/2014.
Any other resident that have a potential to be affected were identified by Director of Nursing, the RN Supervisor/ ADON and one CNA as resident requiring the use of mechanical lift and sling for transfers on 6/16/2014.
The Director of Nursing, RN Supervisor/ ADON and Staff Development Coordinator read and reviewed manufacture recommendation for mechanical lift and slings. All licensed nursing staff, certified nursing assistants, therapy, housekeeping and maintenance staff that assist with transfers and spotting have been in serviced and provided instructions based on manufacture recommendations and provided written instruction by Staff Development coordinator or

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F 520	Continued From page 162 RN Supervisor/ADON on: 07/09/2014 · Determining the appropriate Size of sling for the resident · Care and inspection of sling per manufacturer ' s instructions · Lift batteries/ chargers/ plug in · Care/ inspection of lifts per manufacturer ' s instructions · Troubleshooting lifts All the above employees completed a return demonstration using a mechanical lifts with slings on: · Seated transfer · Floor transfer · Repositioning up in bed · Scale operation · Inspection for holes, tears, frays or unraveling on sling Sling in-service: · Safe use of sling with two staff members always · Identifying defects in the sling (if defect is found do not use it, give sling to the charge nurse) · The nurse is to remove the defective sling from service and place in the locked medication room for maintenance to pickup for disposal. · The nurse is to fill out a work order for maintenance to replace the defective sling. · The Maintenance director is to reorder the same size sling that was taken out of service This in service was started at 2:45 PM on 7/9/2014 and will be completed by 3:00 PM on 7/10/2014. Any employee that has not attended the above named in service after 3:00 PM on 7/10/14 will not be allowed to work until the in service is completed by Staff Development Coordinator, Day shift RN Supervisor/ADON or 3 to 11 RN	F 520		

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	345174	A. BUILDING _____ B. WING _____	C 07/11/2014

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F 520	Continued From page 163	F 520		

Supervisor. All new employees will be in serviced during orientation.
At 3:00 PM on 7/10/2014 a list of employees that did not receive the above in-service will be given to the Director of Nursing. The Director of Nursing will monitor the daily schedule to ensure that anyone that had not had the above in service will not be scheduled to work until in the in service is completed.
An in service will be conducted with laundry and one housekeeper staff that is crossed trained for laundry on 7/10/2014 for inspection of slings to include:

- Holes, tears, frays or unraveling
- Identifying defects in the slings, the housekeeping/ laundry employee will lock the defective sling in the housekeeping / laundry supervisor office. Fill out work order for maintenance director to replace sling and dispose of the defective sling.
- Maintenance director is to reorder the size sling that was taken out of service

This in service will be completed by 3: 00 PM on 7/10/14 by the Staff Development coordinator or RN Supervisor and Housekeeping/ Laundry supervisor.
Any employee that has not attended the above named in service after 3:00 PM on 7/10/14 will not be allowed to work until in serviced. All new employees will be in serviced during orientation.
An audit on all slings in the facility was completed 7/09/2014 at 8:00 PM by the Maintenance Director, Director of Nursing and Housekeeping/ Laundry Supervisor. The Audit of the slings included the following:

- All slings were identified, numbered # 1 to #42 and size noted
- The Condition of the slings were inspected for holes, tears, frays and defects

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F 520	Continued From page 164 · During this audit no sling were removed due to defects The following interventions and systemic changes will ensure effective operation of the Quality Assurance Committee. All Quality Assurance Committee members will be in-serviced on 07/11/14 or prior to returning to work by the corporate Nurse Consultant and/or the Regional Director concerning the following procedures. All weekend managers will be in-serviced on 07/11/14 or prior to returning to work by the Administrator regarding reporting incident/accident reports to the Administrator on the weekends. · The Quality Assurance Committee will oversee the implementation of all aspects of the above plan and meet within one week to review the plan, reassess for effectiveness, and modify the plan as necessary. The Quality Assurance Committee will address mechanical lift and sling safety at each Quality Assurance meeting for one year. · The corporate Nurse Consultant will attend the Quality Assurance Committee meetings for six months as an advisor to ensure the committee is accessing all relevant data at their disposal, fully addressing all current issues, reassessing the effectiveness of their plans of action, revising their plans of action as needed, and keeping issues on the agenda of the committee until the issue has been fully resolved. Individual committee members will be designated as the responsible party to follow up with action plans, give progress reports and provide a target completion date. · The Administrator will ensure that, prior to	F 520		

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F 520	Continued From page 165 Quality Assurance meetings, all supervisors and Administrative staff are polled for any issues that need to be discussed at the meeting. · The Administrator will review any accident/incident reports in the daily stand-up meeting and request staff to report any new issues that need immediate attention. Remedial actions will be determined and current plans assessed for effectiveness in the daily stand-up meeting. If necessary, the Administrator will also convene a meeting of relevant members of the Quality Assurance Committee after the daily stand-up meeting to address problems needing immediate attention. If indicated, issues will be scheduled for follow-up at the next scheduled Quality Assurance Committee meeting. One indication would be any issue that has the capacity to cause harm or has caused harm. · Any issue requiring immediate in-servicing of staff will be supervised by the Administrator to ensure 100% of all relevant staff are in-serviced prior to returning to work. · Any issue requiring immediate audits of equipment will be supervised by the Administrator to ensure 100% of all relevant equipment is included in the audit and any defective equipment is immediately removed from access by staff. · On the weekends, the Administrator will be informed by the manager on duty of any incident/accident report involving resident safety to determine if an immediate plan of action is required to protect residents. Immediate Jeopardy was removed on 07/11/14 at 7:00 PM when interviews with nurses, nurse	F 520		

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F 520	Continued From page 166	F 520		

aides, and therapy staff revealed awareness of expectations to check lift slings to make sure they were not frayed or torn and how to correctly position them under the resident. They verified they had received in-service training and they were aware of the color coded binding on the lifts which indicated the correct sling to use according to the resident's weight. They stated if they found a lift sling that was frayed or torn they were expected to give it to the Maintenance Director so that he could dispose of it. Interviews with nurses further revealed they were expected to place slings that were frayed or worn in the locked medication rooms and fill out a work order for maintenance to dispose of and replace the sling. Interviews with housekeeping staff revealed they had attended in-service training and were expected to look for holes, tears and fraying of lift slings and were expected to lock them in the housekeeping/laundry supervisors office and fill out a work order for maintenance to dispose of the sling and reorder a new replacement. Interviews with maintenance staff revealed awareness of staff to lock torn or frayed slings in medication rooms or in the laundry/housekeeping supervisors office and complete a work order for disposal and replacement of the sling. A review of lift slings in the facility revealed each sling had a number marked on it with a black permanent marker and each sling was listed by their corresponding number on the audit sheets. There was also documentation on the audit sheets with the date of the audit and the condition of each sling. There was no documentation of holes, tears, frays or defective slings on the audit sheets. Interviews with members of the QA committee revealed they understood the way the QA committee was to function, how issues would be brought to QA and their individual roles in

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F 520	Continued From page 167 developing and implementing a plan of action, specifically regarding lifts and slings.	F 520		