STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 166 SS=B	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO 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 record review, staff and resident interviews, and responsible party interviews, the facility did not resolve concerns regarding missing laundry items for 2 of 2 residents reviewed for missing personal property, a) Resident # 16, and b) Resident #11. Findings included: 1. a) Resident #16: In an interview with Resident #16 on 06/08/2015 at 4:43 PM, he stated he was missing 8 or 9 pairs of pants after they had been laundered in the facility, and that he reported they were missing to a staff member. In addition, Resident #16 stated he had mentioned the missing articles of clothing more than once, and that he would like for the facility to find the pants or reimburse him for them. Resident #16 could not remember the exact date when he reported the missing 8-9 pairs of pants. A follow-up interview was conducted with Resident #16 on 06/09/2015 at 5:12 PM. During this interview, Resident #16 reported the name of the staff member to whom he reported the missing pairs of pants. A review of the quarterly Minimum Data Set assessment dated 03/23/2015 revealed Resident	F 166	Colony Ridge Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Colony Ridge Nursing and Rehabilitation Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings.	6/28/15

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

Electronically Signed | 06/24/2015

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F 166	Continued From page 1 #16 was fully cognitively intact and that he required extensive to total assistance with bed mobility, transfers, dressing, personal hygiene, and bathing. 1. b) Resident #11: In an interview with Resident # 11's responsible party (RP) on 06/08/2015 at 8:20 PM, she stated that there have been times when Resident #11's personal clothing items have gone missing in the facility recently, and that she reported that the personal items were missing to a staff member. The RP stated she did not remember the name of the staff member to whom she reported the missing items. In addition, the RP stated she had mentioned the missing items to a staff member more than once. The RP explained she had been told by a staff member she could look in an area of the facility where unclaimed clothing items were kept, and that she (the RP) searched through the unclaimed items and did not find the resident's missing items. The RP stated also that she did not receive any follow up about the missing laundry items. In a follow-up interview with Resident #11's RP on 6/10/15 at 12:41 PM, the RP stated she had reported the missing clothing articles within the last 2 months. A review of the Minimum Data Set assessment dated 05/15/2015 revealed Resident #11 was severely cognitively impaired and required extensive to total assistance for all her activities of daily living, including dressing, eating, toileting, and bathing.	F 166	F 168 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A Resident Concern form was written by the Administrator for resident # 16 and resident # 11 on 6/23/15 regarding missing clothing items. An investigation was initiated by the Administrator and Housekeeping/Laundry Supervisor. All missing clothing items for resident #16 had been found and returned to the resident with resolution of this concern by 6/23/15. The investigation of missing clothes items for resident #11 is ongoing to be resolved by 6/28/15. A resident interview was initiated by the Social Worker and Activity Director on 6/23/15 with a 100% of alert and oriented residents and or family member if resident unable to participate to ensure any resident concerns reported to staff in past two months have been addressed to be completed by 6/28/15. The grievance process will be followed by the facility Social Worker and Activity Director to include documenting on a Resident Concern Form. 100% inservice for all facility staff to include NA #2, NA #3, Housekeeper #1, Manager of Housekeeping and Laundry, and Activity Director was initiated on 6/23/15 by the Staff Facilitator regarding procedures for reporting a resident or family member concern to include completing a Resident Concern Form and ensuring prompt efforts are made to resolve any grievances the resident or family member may have including those involving missing personnel items such as	

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F 166	Continued From page 2 A review of the facility's monthly Resident Concern Logs for December 2014, January 2015, February 2015, March 2015, April 2015, May 2015, and June 2015 revealed there were no entries regarding Resident #16 or Resident #11 for any type of missing personal items. An interview was conducted with the facility's Activities Director (AD) and the Administrator on 06/11/2015 at 10:10 AM. During the interview, the AD stated he was the facilitator for the resident council meetings, and that concerns regarding missing personal items, particularly items that had been sent to the laundry, were sometimes brought up in the resident council meetings. The AD explained that usually the concerns were resolved by locating the missing laundry items and returning them to the resident. The AD provided all the monthly minutes from the January 2015 through May 2015, and a review of the minutes revealed there were no reports of missing clothing items for Resident #16 or Resident #11. The Administrator stated that if there were a concern for missing personal items reported to staff at other times (not at the resident council meetings) it would be entered onto the facility's Resident Concern Log and that it would be investigated. The Administrator explained there would also be a follow-up with the resident who reported the missing articles. The Administrator stated it was possible that a concern regarding missing personal items might not have been reported to her or the Social Worker by the staff member who could have received concerns from Resident #16 or Resident #11's RP. In addition, the Administrator stated that if there were multiple missing items for a resident which were never found, she would contact the facility's Regional Vice President, and	F 166	clothing. To be completed by 6/26/15. All new employees will be inserviced during orientation by the Staff Facilitator regarding procedures for reporting a resident or family member concern to include completing a Resident Concern Form and ensuring prompt efforts are made to resolve any grievances the resident or family member may have including those involving missing personnel items such as clothing. When a resident or family member reports a concern to a facility employee the employee will record the concern on a Resident Concern Form and immediately report the concern to their supervisor or department head. When the concern or incident has occurred during the visitation time or during the shift reported the supervisor will investigate and strive to resolve the concern promptly. All resident concern forms will be routed to the administrator in a timely manner. The Administrator will review all Resident Concern forms promptly, route to the appropriate department head for resolution, and fill out the Resident Concern Routing Log for tracking of concern resolution. The complainant shall be contacted promptly on completion of the investigation by the investigating department head as to the outcome. Upon completion of the investigation the administrator will review the Resident Concern Form to ensure complete and sign the form in the designated space. The Social Worker will then complete the Resident Concern Log Tool indicating that the investigation has been completed.	

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F 166	Continued From page 3 that she would determine whether the missing personal items should be replaced or if the resident could be reimbursed. In an interview with the Social Worker (SW) on 06/11/2015 at 11:05 AM, she stated that any time there was a concern reported by a resident or a responsible party for a resident, a concern report was completed by any staff member who received the concern. The SW provided a Resident Concern form and added that sometimes the staff members would report the concern to her rather than fill out a concern report themselves. In addition, the SW explained that the form would then be forwarded to the appropriate facility department designee to investigate. She stated that department designee would review the concern, take appropriate actions, and resolve the issue. She explained that the completed concern/investigation form would be signed by both the designee and the Administrator. In addition, the SW stated she did not receive a concern regarding missing laundry items for Resident #16 or Resident #11. In an interview with Housekeeper #1 on 06/11/2015 at 11:25 AM, she stated that if a resident or RP were to mention a missing personal item to her, she would immediately report it to the SW. The Manager of Housekeeping and Laundry stated in an interview on 06/11/2015 at 11:30 AM that if a family member or resident reported missing laundry items, she would go to the family member to get a description of the missing articles and remind them that the resident's clothing should be labeled with their names in order for lost items to be located. She also stated	F 166	Social Worker will conduct a 10% interview of alert and oriented residents or responsible party if resident unable to participate weekly x 8 weeks then monthly x 2 months to ensure all grievances have been addressed and resolved using a Resident Concern Audit Tool. Any concerns identified will be addressed by the Social Worker utilizing the resident concern process to include completing a Resident Concern form. The Administrator will review and initial the Resident Concern Routing Log, Resident Concern Log, and Resident Concern Audit Tool weekly x 8 weeks then monthly x 2 months to ensure timely investigation and resolution of concerns. The Social Worker will compile the results of the QI Resident Concern Auditing Tool and report to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	

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F 166	Continued From page 4	F 166		

that there had been an issue with a broken washing machine and that there had been a "backlog" of laundry recently, and that it had been difficult to locate any missing laundry items due to the large number of personal clothing items that were laundered. In addition, she stated that she would fill out a concern form if laundry items were missing that could not be found, and that she would try to address the issue on the same day. She further stated that she had invited residents and their families to look through racks of unclaimed laundry items to try to locate their missing articles.

In an interview on 06/11/2015 at 11:46 AM, NA #2 stated that she remembered Resident #11's RP saying that the resident was missing some undergarments, and that she told the RP to fill out a concern form to report it, and that she explained to her where to find the concern forms. NA #2 stated that she did not fill out the concern forms herself. She stated also that she did not recall Resident #16 reporting missing clothing to her.

In an interview with NA #3 on 06/11/2015 at 11:51 AM, she stated that Resident #16 had reported missing clothing items over the past 3 months, but she couldn't remember exactly what the missing items were. She stated that when the missing items were reported, she had told someone in the laundry department. She explained that other times when missing items were reported, she had sent the resident to the laundry to search for the missing items.

An interview was conducted with the Director of Nursing (DON) on 06/11/2015 at 12:45 PM. During the interview, she stated that she would

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F 166	Continued From page 5 expect a grievance (concern) form to be filled out by the staff member who received the report for missing laundry items so that it could be investigated and resolved. The DON also stated that if a missing article of clothing was found immediately after it was reported missing, there would be no need for the concern form to be filed.	F 166		
F 241 SS=D	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, record review and staff interviews the facility failed to cover a urinary catheter bag for 1 of 1 sampled residents (Resident #130). Findings included: Resident #130 was admitted to the facility on 05/31/15 with cumulative diagnoses of neurogenic bladder, kidney replacement, and diabetes. Resident #130's Admission Minimum Data Set (MDS) dated 06/06/15 revealed Resident #130 was cognitively aware and had an indwelling urinary catheter. Review of the Physician Telephone Orders dated 05/31/15 showed an order for an indwelling urinary catheter for Resident #130. In an observation on 06/08/15 at 3:15 PM Resident #130 was seen being propelled in a wheelchair by facility staff. The urinary catheter bag containing lemonade colored urine was visible hanging under the wheelchair seat.	F 241	F241-383.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The urinary catheter bag for resident # 130 was covered with a blue dignity bag on 6/15/15 by the licensed floor nurse. A 100% audit was conducted by the Director of Nursing (DON) on 6/15/15 to ensure all other urinary catheter bags including the urinary drainage bag for resident #130 were covered with a dignity bag. All other urinary catheter bags were found to be covered by a dignity bag. A 100% inservice was initiated on 6/23/15 for all licensed nursing staff, Certified Nursing Assistants (CNA), and therapists to include NA #1 and the Certified Occupational Therapy Assistant (COTA) by the Staff Facilitator regarding the need to ensure the use of dignity bags or fig	6/28/15

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F 241	Continued From page 6 In an observation on 06/08/15 at 4:25 PM Resident #130 was seen sitting up in a wheelchair in his room speaking with a visitor. The urinary catheter bag containing lemonade colored urine was visible from the doorway and also visible to the visitor. In an observation on 06/09/15 at 2:28 PM Resident #130 was seen being propelled in a wheelchair by facility staff. The urinary catheter bag containing lemonade colored urine was visible hanging under the wheelchair seat. In an interview on 06/10/15 at 9:55 AM Resident #130 stated that on admission he was told the facility did not have privacy bags to place urinary catheter bags in. He indicated it was his preference to have the urinary bag covered for privacy. In an observation on 06/11/15 at 10:30 AM Resident #130 was seen working with therapy in the therapy room. The catheter bag was inside a white pillowcase. In an interview on 06/11/15 at 10:34 AM Nursing Assistant (NA) #1 stated she had looked for a catheter bag cover for Resident #130 but had not been able to locate one. She indicated she left Resident #130's urinary catheter bag uncovered and connected the bag under his wheelchair. NA #1 indicated it was a dignity issue not to have the bag covered and Resident #130 had expressed a concern to her that people could see the urine. In an interview on 06/11/15 at 11:23 AM the Certified Occupational Therapy Assistant (COTA) stated Resident #130 had expressed a concern that the urinary catheter bag was not covered so she had placed it in a white pillowcase. In an interview on 06/11/15 at 12:30 PM the Director of Nursing (DON) stated she expected urinary catheter bags to be covered for privacy. The DON indicated the facility did not have	F 241	leaf drainage bags with urinary catheter bags/ urinary catheters at all times to include upon resident admission/ readmission to the facility to 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 to be completed by 6/26/15. All new licensed nursing staff, CNAs, and therapists will be inserviced during orientation by the staff facilitator regarding the need to ensure the use of dignity bags or fig leaf drainage bags with urinary catheter bags/ urinary catheters at all times to include upon resident admission/ readmission to the facility to 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. When a resident is admitted/ readmitted to the facility with a urinary catheter in place the licensed nurse will ensure that the urinary catheter bag is covered with a dignity bag or has a built in fig leaf cover to maintain or enhance the resident¿s dignity and respect in full recognition of his or her individuality. Any urinary drainage bag found without a dignity cover will have a dignity bag immediately applied. CNAs and therapists will report any uncovered urinary drainage bags to the licensed floor nurse and a dignity bag will immediately be applied. The DON and shift supervisors will conduct an audit 3 x week using the Quality Insurance (QI) Urinary Catheter Audit Tool to ensure all urinary catheter bags are covered with a	

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F 241	Continued From page 7 catheter bag covers at this time.	F 241	dignity bag or have a built in fig leaf cover x 4 weeks, weekly x 4 weeks then monthly x 2 months to include first, second and third shifts. Any urinary catheter bags found without a dignity bag or fig leaf cover will be immediately corrected and the licensed nurse caring for the resident will be retrained on the need to provide dignity covers for urinary catheter bags. The Administrator will review and initial the QI Urinary Catheter Audit tool weekly x 8 weeks then monthly x 2 months. The results of the QI Urinary Catheter Audit Tool will be compiled by the DON and presented to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to provide splinting to prevent a further decrease in Range of Motion for 1 of 1 sampled residents (Resident #27). Findings included:	F 318	F 318 483.25 (e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Soft elbow splints were applied to the resident¿s bilateral elbows by the 300 hall	6/28/15

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F 318	Continued From page 8 Resident #27 was admitted to the facility on 10/03/06 with cumulative diagnoses of non-Alzheimer's dementia, depression and anemia. Resident #27's Quarterly Minimum Data Set (MDS) dated 04/14/15 revealed Resident #27 had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. Resident #27 was dependent on one staff member for dressing, eating, and hygiene. Review of the Physician's Telephone Orders dated 02/22/15 revealed Occupational Therapy (OT) was to be discontinued and Resident #27 was to have bilateral soft splints applied with AM care (morning care) and to wear them for 8 hours. The splints were to be put on at 8:00 AM and removed at 4:00 PM. Review of the Occupational Therapy Discharge Summary dated 02/23/15 showed the floor staff Nursing Assistants (NAs) were to provide passive and active range of motion (ROM) to Resident #27's elbows during care prior to donning splints. The splints were used to reduce further progression and development of contractures. In an observation on 06/08/15 at 9:40 AM Resident #27 was lying in bed. Bilateral elbow splints were seen in the bed but were not on Resident #27's arms. In an observation on 06/10/15 at 8:44 AM Resident #27 was in a reclined chair at the bedside. Her arms were crossed over her chest. No splints were seen on her arms. The splints were seen on the bedside table. In an observation on 06/10/15 at 3:30 PM Resident #27 was lying in bed. The elbow splints were not in place. The splints were seen on the bedside table. In an interview on 06/10/15 at 4:20 PM Nursing	F 318	licensed floor nurse and assigned CNA on 6/11/15. The Care Guide and Care Plan for resident #27 was updated to show that bilateral soft elbow splints should be applied at 8AM and removed at 4PM on 6/11/15 by the Minimum Data Set (MDS) Nurse. 100% audit was initiated comparing all residents current care plans to actual observations of all residents to include resident # 27 to be completed by 6/25/15 by the DON and Minimum Data Set (MDS) Nurse to ensure services being provided regarding splint/braces were in accordance with the residents¿ plan of care. Any areas of concern regarding splints/ braces was immediately addressed by the DON and MDS Nurse with referral to therapy, updating of care plan and care guide as needed, and or immediate splint application. The Restorative Nurse and MDS Nurse were inserviced by the Facility Consultant on 6/23/15 on creation of a Resident Care Plan for residents with splints/ brace and need to ensure that the Resident Care Guide accurately reflects the current plan of care. 100% inservice to be conducted on or before June 26, 2015, by the Staff Facilitator for all CNAs and Restorative Aids (RAs) to include NA #4 and NA #5 to check Resident Care Guides for assigned residents at the beginning of the shift to identify residents requiring splint/braces to ensure splint application, splint removal, and documentation in the electronic medical record as per plan of care. 100% inservice to be conducted on or before June 26, 2015 by the Restorative Nurse	

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F 318	Continued From page 9 Assistant (NA) #4 who was caring for Resident #27 that afternoon stated if the resident was supposed to wear splints it would be on the Resident Care Guide in Resident #27's closet. He reviewed the Care Guide and stated there were no splints listed for Resident #27. In an observation on 06/11/15 at 10:40 AM Resident #27 was in a reclined chair at the bedside. Her arms were crossed over her chest and no splints were on her arms. The splints were on the bedside table behind Resident #27. In an observation on 06/11/15 at 11:14 AM Resident #27 was in a reclined chair at the bedside. Her arms were still crossed over her chest and no splints were in place. The splints were still on the bedside table behind Resident #27. In an interview on 06/11/15 at 11:23 AM the Certified Occupational Therapy Assistant (COTA) verified Resident #27 should be wearing elbow splints to keep her arms from crossing over her chest. She indicated the NAs should know which residents needed to wear splints so they could apply them as ordered. She stated it was a problem that Resident #27 was not wearing the elbow splints. The COTA stated education had been provided to the nursing staff regarding Resident #27's splints but it seemed the carryover to the NAs had not been done. In an interview on 06/11/15 at 11:36 AM NA #5 who was caring for Resident #27 that morning stated if he saw a splint he would put it on Resident #27. He indicated he did not know Resident #27 was supposed to wear elbow splints. He indicated he could look at the Resident Care Guide in Resident #27's closet to see if splints were supposed to be worn. NA #5 reviewed the Care Guide and stated it showed bilateral hand splints should be worn. When the	F 318	with all RAs and CNAs to include NA #4 and NA #5 regarding proper application/removal of splints/braces. 100% inservice initiated on 6/23/15 for all licensed nurses regarding need to check to ensure all splints are applied by CNA or RA per Resident Care Guide to be completed by 6/26/15. All new RAs and CNAs to be inserviced during orientation by the staff facilitator regarding need to check Resident Care Guides for assigned residents at the beginning of the shift to identify residents requiring splint/braces to ensure splint application, splint removal, and documentation in the electronic medical record as per plan of care. All new RAs and CNAs will be inserviced by the Restorative Nurse during orientation regarding proper application/removal of splints/braces. All new licensed nurses will be inserviced by the staff facilitator on the need check to ensure all splints are applied by CNA or RA per Resident Care Guide. When new residents are referred to nursing for splint/brace application by the rehabilitation department the Restorative Nurse will create a plan of care for the resident. The resident¿s care guide will be updated by the Restorative Nurse to accurately reflect the plan of care. The RA¿s and CNAs will check the Resident Care Guide at the beginning of the shift to identify residents requiring splint/brace application. The CNA or RA is responsible for applying and removing splint/brace as per care planned instructions with documentation of task in the electronic medical record. The Treatment Nurse and	

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F 318	Continued From page 10 elbow splints were pointed out to NA #5 he indicated they were not hand splints. In an interview on 06/11/15 at 11:42 AM the MDS nurse walked into Resident #27's room and stated an audit had been done the night before and it was seen the splints were not on the Care Guide. She indicated she had replaced the Care Guide and it now showed the hand splint information. She indicated she realized the hand splint information was incorrect as it was elbow splints that were needed so she was replacing the Care Guide one more time with the correct information for the elbow splints. In an interview on 06/11/15 at 11:59 AM the Occupational Therapist (OT) stated Resident #27 needed to wear the elbow splints as ordered to prevent further contractures of her arms. In an observation on 06/11/15 at 12:15 PM Resident #27 was seen wearing the elbow splints. Her arms were no longer crossed over her chest. In an interview on 06/11/15 at 12:35 PM the Director of Nursing (DON) stated it was her expectation that the nurses and aides know which residents should be wearing splints. If the aides had questions regarding splints they could ask the nurse or look at the Resident Care Guides. She indicated she expected the Resident Care Guides to reflect the current information and needs of the residents. She stated she saw it as a problem that the NAs did not know Resident #27 needed elbow splints.	F 318	11-7 Charge Nurse will monitor to sustain solution by completing resident rounds to include resident # 27 using the QI Splint/Brace Audit Tool five x per week x 4 weeks, then 2 x weekly x 4 weeks, then weekly x 8 weeks to ensure residents have splint/braces applied in accordance with the written plan of care. The Treatment Nurse and 11-7 Charge Nurse will address any identified areas of concern immediately by ensuring interventions are in place and retraining with the appropriate staff member. The DON will monitor to ensure solution sustained by reviewing and initialing the QI Splint/Brace Audit Tools weekly x 8 weeks then monthly x 2 months for completion and to ensure all identified areas of concern were addressed. The results of the QI Splint/Brace Audit Tool will be compiled by the QI Nurse and presented to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		6/28/15

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F 323	Continued From page 11 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to make sure a bed alarm, utilized as a fall intervention, was functional for 1 of 4 sampled residents (Resident #44) who experienced falls in the facility. Findings included: Resident #44 was admitted to the facility on 06/11/10 and readmitted on 05/03/13. Her documented diagnoses included multiple closed pelvic fractures, osteoporosis, difficulty walking, muscle weakness, and anxiety. A 02/05/15 progress note documented at approximately 4:20 AM Resident #44's bed alarm sounded, and the resident was found in her room on the floor between the beds. The resident stated she was "going out". The bed was in the lowest position, and the resident had on non-skid socks. The resident complained of hip pain, and her right leg appeared to be slightly drawn up. She was taken to the hospital where she was diagnosed with multiple pelvic fractures. The resident's 05/12/15 quarterly minimum data set (MDS) documented her cognition was severely impaired, she required extensive assistance from a staff member for bed mobility, and she had no falls since her last MDS assessment. The resident's care plan, last updated on	F 323	F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES A bed alarm system was placed on the bed of resident #44 by the maintenance assistant on 6/11/15 who also checked to ensure that it was functioning properly. A 100% audit of all fall prevention devices to include bed alarms was initiated on 6/24/15 by the Director of Nursing (DON) and MDS Nurse to ensure that devices were in place/functioning as per Resident Care Plan/ Care Guide to be completed by 6/26/15. Any identified concerns will be immediately addressed by the DON and MDS Nurse. 100% inservice was initiated for all licensed nursing staff and nursing assistants (CNAs) to include NA #6, Nurse #1, Nurse #2, NA #7, NA #8, Nurse #3, Nurse #4 on 6/23/15 by the staff facilitator regarding the need to check and ensure that all fall interventions indicated on the Resident Care Guide including bed alarms are in place and functional as per the Resident Plan of Care every shift. All new licensed nurses and CNAs will be inserviced during orientation by the staff facilitator on the need to check and ensure that all fall interventions indicated on the Resident Care Guide including bed alarms are in place and functional as per the Resident Plan of Care every shift.	

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F 323	Continued From page 12 06/04/15, identified "Risk of falls d/t (due to) impaired cognition, balance, endurance, and chronic pain in her back and legs" as a problem. Interventions to this problem included a bed alarm which was to be connected into the resident's call bell system. Review of undated electronic care guide (found in the computer) and the undated printed resident care guide (found in the resident's closet) revealed Resident #44 was to have her bed pad alarm, which was connected into her call bell system, on at all times when in bed. Review of Resident #44's June 2015 medication administration record (MAR) revealed nurses were to initial off each shift that they had checked the bed and chair alarms. There were no nurse initials for second shift on 06/02/15 and 06/04/15, first shift on 06/05/15 and 06/07/15, and second or third shift on 06/09/15 indicating Resident #44's alarms were checked. Resident #44's AM care was observed at 10:30 AM on 06/10/15 10. Following the care the resident was transferred from the bed to the chair, but no alarm sounded. Observation revealed the pad portion of a bed alarm was under the resident's sheet, but the short cord extending from the pad was not connected to an alarm box or the call bell system. At 10:50 AM on 06/10/15 nursing assistant (NA) #6, assigned to care for Resident #44, stated the resident was supposed to have a bed alarm which was connected into the call bell system so the call light would illuminate, and the call bell would sound when the resident tried to get out of bed unassisted. However, after searching the	F 323	When a new fall intervention is put in place, such as bed alarms, the Resident Care Plan and Care Guide will be updated by the MDS Coordinator or licensed nurse initiating the intervention. Licensed nursing staff and CNAs should review assigned residents¿ Care Guides each shift to ensure all indicated fall prevention devices are in place to include bed alarms and ensure functioning properly. Any identified concerns will be immediately addressed by the charge nurse on the hall. The DON and QI Nurse will conduct an audit 3 x week for 4 weeks then weekly x 4 weeks then monthly x 2 months using the QI Falls Prevention Audit Tool to ensure all fall prevention devices are in place as per the Resident Care Guide and functioning properly. Any identified concerns will be addressed immediately by the DON or QI Nurse and reeducation will be provided for staff. The Administrator will review the Falls Prevention Device Audit Tool weekly x 8 weeks then monthly x 2 months and initial. The results of the QI Falls Prevention Audit Tool will be compiled by the QI Nurse and presented to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	

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resident's room, the NA reported she was unable to find any of the connection cords or the alarm box which would make the pressure pad bed alarm system complete. If the alarm system was completely assembled, NA #6 stated it would have sounded when she transferred Resident #44 off the bed and into her chair. According to the NA, her assignment was rotated so she was unsure of how long Resident #44's bed alarm system had been non-functional.

At 2:41 PM on 06/10/15 Nurse #1, Resident #44's primary nurse on first shift, stated the bed pad alarm connected with the call bell system was still being utilized as a fall intervention for the resident. She reported the bed pad alarm was supposed to remain intact at all times, and was turned on anytime the resident was placed in bed. She commented she had been assigned to other halls recently, but she recalled Resident #44's bed alarm going off last week several times.

At 4:36 PM on 06/10/15 Nurse #2, who cared for Resident #44 on second shift, stated the last time she remembered the resident's bed alarm going off was on 06/08/15 when the resident accidentally leaned over, placed her hands on the bed, and then withdrew them. She reported in the past there were some problems with housekeeping accidentally disconnecting the bed alarm/call bell system when they were cleaning.

At 9:09 AM on 06/11/15, during a telephone interview, NA #7, who cared for Resident #44 on 06/09/15 second shift, stated the resident was already in bed when she started her shift on 06/09/15. Since the resident was already in the bed the NA commented she could not remember for sure whether she checked the placement and

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functioning of the alarm, but she reported the alarm definitely did not go off during second shift on 06/09/15. According to the NA, sometimes the nurses asked her about the placement and functionality of alarms, and other times they did not. She reported if an alarm was missing or it was not working correctly she reported it to her nurse. NA #7 stated Resident #44 was still attempting to get out of bed unassisted some, but not as frequently as she was doing a couple of months ago.

At 9:20 AM on 06/11/15 NA #8 stated Resident #44 was in bed when she left at the end of first shift on 06/09/15. She reported the resident still tried to get out of the bed unassisted. She commented she thought the resident's bed alarm was in place on 06/09/15, but could not say for sure. The NA stated the nurses rarely asked her about placement and functionality of alarms, but she told them if she saw they were missing or not working properly.

At 9:33 AM on 06/11/15, during a telephone interview with Nurse #3 who cared for Resident #44 on 06/09/15 third shift, she stated alarms were to be checked every shift to make sure they were in place and working. She reported she did not ask the NA directly about Resident #44's bed alarm on 06/09/15, but she did not remember the NA reporting any problems in conjunction with the alarm. According to Nurse #3, she did not observe the resident's bed alarm herself on 06/09/15, and there were no alarms at all that sounded on 06/09/15 third shift. She commented that to her knowledge Resident #44's bed alarm did not tie into the call bell system.

At 9:48 AM on 06/11/15, during a telephone

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interview with Nurse #4 who cared for Resident #44 on 06/09/15 second shift, she stated alarms were to be checked every shift to make sure they were in place and working. She reported she did not ask the NA directly about Resident #44's bed alarm on 06/09/15, but she did not remember the NA reporting any problems in conjunction with the alarm. According to Nurse #4, she did not observe the resident's bed alarm herself on 06/09/15. She commented that to her knowledge Resident #44's bed alarm did not tie into the call bell system.

At 10:15 AM on 06/11/15 the maintenance assistant stated he and the maintenance manager had been called to look at Resident #44's bed alarm about a half dozen times over the past month. He commented the staff reported it being non-functional, and different things were tried to fix it. He reported that maintenance finally figured out that the hole cut into the alarm box holder was too small, and was preventing the jack from plugging completely into the alarm box. However, he stated that he was not aware of the resident being without a bed alarm during the whole repair process.

At 10:22 AM on 06/11/15 the maintenance assistant provided Resident #44's new bed alarm system for inspection, and demonstrated in the resident's room that the system was functional.

At 12:32 PM on 06/11/15 the director of nursing (DON) stated the NAs were supposed to check all alarms every shift and report to their nurses that alarms were in place and functional. She reported for some residents who had alarms in place for a long time, alarm checks printed out on the MARs. According to the DON, the facility

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F 323	Continued From page 16 utilized bed alarms connected into the call bell system when residents had multiple falls or sustained a major injury from a fall, such was the case for Resident #44. She commented the bed alarm/call bell system should be in place at all times with the bed alarm activated whenever the resident was in bed. If a part of the alarm system went missing or became non-functional, she stated she expected the entire system to be replaced.	F 323		
F 520 SS=C	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 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.	F 520		6/26/15

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F 520	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on staff interviews the facility's Quality Assessment and Assurance Committee (QAA) failed to meet quarterly with the presence of a physician designated by the facility. Findings included: During an interview with the QI (Quality Improvement) Nurse on 06/11/15 at 1:00 PM, revealed that the facility had daily stand-up meetings and quarterly quality assessment and assurance (QAA) meetings. The QI nurse stated the facility staff who attended the quarterly QAA meetings were the Dietary Manager, Director of Nursing (DON), Minimum Data Set (MDS) nurse, Facility Administrator, Social Worker (SW), Pharmacist, and the Activity Director. The QI nurse stated that the previous Medical Director and their current Medical Director had never attended any of the quarterly QAA meetings, and that the previous Medical Director was too busy to attend, due to the many buildings he oversaw; however, she stated the Medical Director did receive a copy of the QAA meeting minutes and would sign-off on them that he had reviewed them. During an interview with the DON on 06/11/15 at 1:30 PM, revealed that it was her expectation that the Medical Director would be present during the facility's quarterly QAA meeting. During an interview with the Interim Administrator on 06/11/15 at 1:50 PM, revealed that it was her	F 520	F 520 483.75 (o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS The Medical Director attended the Quarterly Quality Improvement meeting on 6/23/15 as per facility policy and state regulation. The Administrator was inserviced by the Facility Consultant regarding the need for the Medical Director to be present at Quarterly Quality Improvement meetings per facility policy and state regulations on 6/23/15. The Quality Improvement Executive Committee directs and supervises the Quality Improvement Program in the facility. This committee will meet quarterly or more frequently as designated by the Administrator to review information concerning resident care, environment of the facility, medical records, dietary services, activities, social services, and general resident and family satisfaction. The committee will be composed of the Administrator, Medical Director, Quality Improvement Coordinator, Social Worker, Director of Nursing, Pharmacist, Medical Records Director, Dietary Manager, and Housekeeping Supervisor or other staff members as designated by the administrator. The Facility Consultant will review the Quality Improvement Executive Committee meeting minutes quarterly x 2 to ensure at least 3 members of the	

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F 520	Continued From page 18 expectation that the Medical Director attend the facility's quarterly QAA meeting. The Interim Administrator stated, since she had been in the facility, the Quality Assessment and Assurance (QAA) committee met quarterly without the presence of a physician designated by the facility.	F 520	facility staff and a physician had attended with appropriate signatures noted per policy and state regulation. The facility consultant will address any identified areas of concern with the Administrator. The administrator will send a quarterly Quality Improvement Executive Committee meeting schedule to the Facility Consultant. The Facility Consultant will review and initial the Quality Improvement Executive Committee meeting minutes quarterly x 2.	