STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345562	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEAR CREEK NURSING & REHABILITATION CENTER	**10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227**

(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 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to care plan a resident ' s increased risk of skin tears that included goals and interventions for skin tear prevention for 1 of 3 residents (Resident #3) reviewed for skin impairment. Findings included: Resident #3 was admitted on 3/31/15 with diagnoses of difficulty walking, generalized muscle weakness, chronic hypotension, congestive heart failure and hypertension. Progress notes for 3/31/15 3:47 PM indicated Resident #3 had been admitted with skin tears to	F 279	Clear Creek Nursing and Rehabilitation Center acknowledges receipt of the statement of Deficiencies and proposes this Plan of Correction to the ectent that the summay of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Clear Creek Nursing and Rehabilitation Center□s response to this Statement of	7/27/15

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

Electronically Signed | 07/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 1 top of his left wrist, right hand and right wrist. Review of the 4/7/15 Admission Minimum Data Set (MDS) indicated Resident # 3 was severely cognitively impaired with no behaviors or rejection of care. The MDS revealed the resident required extensive assistance for transfer, dressing, toilet use, and personal hygiene. Progress notes for 4/10/15 at 9:32 AM indicated Resident #3 had sustained a skin tear to his right elbow during a transfer from bed to the wheelchair. The nurse documented Resident #3 was resistive to care during activities of daily living and transfers. There were no interventions or plan initiated to prevent Resident #3 from sustaining skin tears. On 4/10/15 at 11:59 AM progress notes indicated the treatment nurse noticed skin tears to Resident #3 ' s right forearm while assessing Resident #3 ' s other areas. The nurse documented Resident #3 had very fragile skin. The intervention documented was observation to see if the resident ' s medications needed adjustment. There was no documentation that indicated the nurse had reviewed the resident ' s medication. Review of a nursing progress note for 4/18/15 at 11:24 AM indicated the RP brought to the nurse ' s attention an open area to the resident's left shin area. The nurse documented she assessed the area, cleansed the area with normal saline and applied a hydrocolloid dressing. No measures were put into place to prevent further skin tears. Review of the care plan did not reveal any identification that Resident #3 had a problem with skin tears and included no interventions for prevention of skin tears. NA #2 was interviewed on 6/30/15 at 1:21 PM. The NA stated she cared for Resident #3 each day she worked which was usually 5 times per	F 279	Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Clear Creek Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F279 Develop Comprehensive Care Plans Criteria 1 Resident #3 discharged on 7/9/2015 Criteria 2 100% Audit was completed on 7/22/15 of all residents with skin tears by MDS nurses, Assistant Director of Nursing, Staff Facilitator and Director of Nursing. Care Plan and Care Guide updated based on findings. 100% of all residents will have a preventative assessment completed by licensed nurses by 7/22/15. On 7/16/15, the Staff Facilitator initiated a 100% in-servicing of licensed nursing staff on how to complete preventative assessments on admission and quarterly, interventions initiated based on the findings. All incidents will have immediate interventions by a license Nurse. On 7/16/15, MDS nurses in-serviced by Director of Nursing on updating Care plan for actual and at risk for skin tears. Criteria 3 The Director of Nursing, Assistant	

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F 279	Continued From page 2 week and added it was not unusual for the resident to get skin tears. NA #2 when she transferred Resident #3 she tried to make sure the path was clear to avoid having any object hit his skin. The NA stated instructions for caring for residents were found on the care guides located at the nurse ' s station. NA #2 reviewed Resident #3 ' s care guide and acknowledged the care guide did not include information about residents who are at risk for skin tears During an interview with Nurse #1 on 6/30/15 at 2:30 PM, she stated the facility ' s wound care protocols covered the treatment of skin tears. She added it was the responsibility of the MDS nurse to care plan skin tears. An interview was held with the Director of Nursing (DON) and MDS Nurse #1 on 7/1/15 at 1:30 PM. The DON stated she expected Resident #3 ' s skin tears to be addressed on the care plan. The DON reviewed the care plan and stated she did not see a care plan identifying skin tears as a problem for Resident #3, did not identify interventions for skin tear prevention and did not identify the resident ' s current wound identified as caused by a skin tear. The DON reviewed the care guide, identified to be used by the NAs for caring for residents and stated the resident's risk of skin tears and interventions for skin tear prevention was not identified on the care guides for Resident 3. The MDS nurse stated she had no explanation why the skin tear on the left shin or interventions to prevent skin tears had not been addressed or Resident #3 ' s care plan or care guide.	F 279	Director of Nursing, Staff Facilitator, and MDS Nurses will monitor all new admissions, and any incidents to ensure care plans and care guides are updated with interventions. This will be completed during clinical meeting Monday-Friday for one week, then weekly for one month, then monthly for two months. Incident audits will be reviewed in the daily meeting M-F. Criteria 4 The Director of Nursing or Quality Improvement nurse will report the audit results to the Executive Quality Improvement Committee. The Committee will review the results of the audits monthly and make recommendations as needed for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		7/27/15

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F 280	Continued From page 3 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interviews with staff and record review the facility failed to revise the care plans for 2 of 3 residents (Resident #3 and Resident #4) reviewed for falls. Findings included: 1. Resident #4 was admitted on 2/6/15 with diagnoses that included personal history of fall, generalized muscle weakness, diabetes, osteoarthritis, rheumatoid arthritis, lack of coordination and hypertension. The fall care plan for Resident #4, with a created date of 2/09/15, indicated the goal was she would be free from falls. Interventions added in February and March 2015 included anti-roll back tippers on her wheelchair, assist during transfer and mobility, bed in low position, fall risk protocol	F 280	F280 Right To Participate Planning Care-Revise CP Criteria 1 Care plan and care guide updated by MDS Nurse to include fall interventions for Resident #4 on 7/21/15. Resident #3 discharged on 7/9/2015 Criteria 2 100% Audit of all residents will have a fall risk evaluation completed by licensed nurse, and care plan and care guide updated by MDS Nurses based on findings by 7/22/15 On 7/16/15, the Staff Facilitator initiated a 100% in servicing of	

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F 280	Continued From page 4 (no explanation for what the protocol entailed), have commonly used articles within easy reach, keep call light within easy reach, monitor and intervene for factors causing falls and educate resident to wear proper and non-slip footwear during transfers. The Admission Minimum Data Set (MDS), dated 2/13/15, revealed Resident #4 was cognitively intact. She was coded as requiring limited assistance with transfers, extensive assistance for ambulation in her room and locomotion on the unit. The MDS also indicated Resident #4 was only able to stabilize with human assistance during transition and walking. Resident #4 was identified as having falls since her admission. Review of nurse ' s progress notes, dated 4/14/15 at 4:37 AM, revealed Resident #4 was found on her knees between wheelchair and the bed. Education for the resident and family on preventative interventions, such as lying down to sleep and locking wheelchair when using the chair for support, were added to the care plan. Nurse ' s progress notes dated 4/21/15 at 7:53 PM indicated Resident #4 had 2 falls that shift with no injuries. The care plan revealed interventions were added to include frequent reminders to call for assistance and to empty the urine collection system after each meal. Review of the facility ' s fall log indicated Resident #4 had fallen on 4/23/15. On 4/23/15, the care plan was revised and staff were instructed to monitor for routine needs. The resident ' s care guide, with a print date of 4/23/15, indicated the resident was to walk with supervision only. Under Special Precautions, the resident was identified with the word " FALLS " . Included for the nursing assistant ' s use were the instructions to empty the ostomy bag after each meal, encourage the resident to call for	F 280	licensed nursing staff on how to complete falls assessments on admission and quarterly and as needed , with interventions based on the findings. All incidents will have immediate interventions by a License Nurse. On 7/16/15, MDS nurses in-serviced by Director of Nursing on updating Care Plans and Care Guides to include new interventions Criteria 3 The Director of Nursing, Assistant Director of Nursing, Staff Facilitator, and MDS Nurses will monitor all new admissions, and any incidents to ensure care plans and care guides are updated with interventions. This will be completed during clinical meeting Monday-Friday for one week, then weekly for one month, then monthly for two months. Incident audits will be reviewed in the daily meeting M-F. Criteria 4 The Director of Nursing or Quality Improvement nurse will report the audit results to the Executive Quality Improvement Committee. The Committee will review the results of the audits monthly and make recommendations as needed for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring.	

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F 280	Continued From page 5 assistance (based on cognition), keep personal items in reach, non-skid footwear and supervised ambulation. Resident #4 ' s Quarterly Minimum Data Set (MDS), dated 5/15/15, indicated the resident was severely cognitively impaired. Extensive assistance was required for transfer, bed mobility, limited assistance was required when walking in the room, supervision was needed for walking in the corridor and limited assistance with locomotion was required with locomotion on and off the unit. The MDS identified Resident #4 as requiring extensive assistance with toilet use and personal hygiene. The resident was also identified with falls since admission or the prior assessment that numbered 2 or more with no injury. Review of nurse ' s notes for 5/29/15 at 9:28 AM, revealed during change of shift, the nurses were notified Resident #4 was on the floor. No interventions were added on the care plan to prevent further falls. Nurse ' s notes dated 5/30/15 at 5:05 AM indicated staff reported Resident #4 was on the floor. Review of progress notes and the care plan revealed no new interventions were initiated. On 6/1/15 at 1:28 PM, nurse ' s notes revealed therapy had notified nursing staff that Resident #4 was found sitting on the bathroom floor. The nurse documented she spoke to resident about the importance of pulling the emergency bell when she needed to go to the bathroom. On 6/2/15, the care plan was revised and included an intervention to educate Resident #4 to use a urinal to empty the urinary collection system. Nurse ' s notes for 6/12/15 at 7:22 PM indicated the nurse was called to Resident #4 ' s room by the nursing assistant (NA). No interventions were	F 280		

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F 280	Continued From page 6 added to the care plan On 6/18/15 at 11:14 PM, nurse ' s notes indicated at 7:50 PM the nurse heard Resident #4 calling for help. The nurse documented she found the resident holding to the side rail with her buttocks half way off the bed with feet on the floor Resident #4 was encouraged to use the call light. No interventions were added to the care plan. On 7/1/15 at 2:16 PM, MDS Nurse #1 and the Director of Nursing (DON) were interviewed. The MDS nurse stated information about resident falls was relayed during the morning department head meetings. She added she was unaware Resident #4 had fallen on 6/18/15. Review of the falls with the DON and the MDS nurse revealed there was no incident reports or investigations for the 5/29/15 fall. She stated without an incident report, an investigation would not be completed and interventions would not be placed to prevent further falls. A telephone interview was held with Nurse #5 on 7/2/15 at 3:03 PM. She stated she did not remember the specifics about the resident's 6/12/15 fall. She added Resident #4 tried to go to the bathroom by herself and has been educated many times to ask for assistance. The nurse stated most of the time the resident was alert and oriented, but had frequent urinary tract infections which increased her confusion and her falls. Nurse #5 stated multiple intervention were used for Resident #4 including 1 to 1 observation or to place the resident in a common area for increased observations. Review of the nurse ' s notes failed to reveal documentation of 1 to 1 observations. 2. Resident #3 was admitted on 3/31/15 with diagnoses of difficulty walking, atrial fibrillation, generalized muscle weakness, chronic	F 280		

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F 280	Continued From page 7	F 280		

hypotension, hypertension and congestive heart failure.
Nurse ' s notes dated 4/15/15 at 4:00 PM, revealed Resident #3 yelled out for help. The nurse noted upon entering the room, Resident #3 was found to be sitting on the floor in front of his wheelchair. She noted she assisted him from the floor back to his bed.
Review of nurse ' s notes for 4/16/15 at 6:13 PM revealed the resident ' s bed was in low position and his call light was in place.
Nurse ' s notes for 4/17/15 at 8:39 PM indicated the nurse had been notified by the nursing assistant (NA) that Resident #3 was found sitting in the floor in front of his wheelchair. The intervention was to monitor.
The care plan for Resident #3, last reviewed on 4/28/15 indicated the resident was at risk for falls. The goal of not sustaining serious injury through the next review was to be attained by assisting during transfer and mobility (4/2/215), bed in low position (4/2/15), rehabilitation therapy referral (4/18/15), fall risk protocol (4/2/15), call light in reach and answer timely (4/2/15) and provide frequent reminders to resident to call for assistance before getting up (4/15/15).
On 5/20/15 at 9:22 PM the nurse documented in nurse ' s notes that Resident #3 was observed sitting on the floor in front of his wheelchair. There were no interventions added to the care plan.
An interview was held with the Director of Nursing (DON) and the MDS #1 on 7/.1/15 at 1:30 PM. The MDS nurse reviewed Resident #3 ' s care plan and care guide and stated the phrase " encourage to use call bell based on cognition " was based on the days Resident #3 understood instruction and was able to use the call bell. The MDS nurse reviewed Resident #3 ' s MDS and

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F 280	Continued From page 8 acknowledged he had been assessed as severely cognitively impaired. The DON and MDS Nurse #1 stated education was not an appropriate intervention for Resident #3 based on his cognitive status. The DON stated the care plan should be revised within 24 hours after a fall. Review of the care plan revealed the 5/20/15 fall had been added to the care plan. MDS nurse #1 had no explanation why the care plan had not been revised.	F 280		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, interviews with a family member and record review, the facility failed to place interventions for prevention of skin tears for 1 of 1 resident (Resident #3) reviewed for skin tears, whose skin tear resulted in an unstageable wound. Findings included: Resident #3 was admitted on 3/31/15 with diagnoses of difficulty walking, generalized muscle weakness, chronic hypotension, congestive heart failure and hypertension. Progress notes for 3/31/15 3:47 PM indicated Resident #3 had been admitted with skin tears to top of his left wrist, right hand and right wrist.	F 309	F309 Provide Care/Services For Highest Well Being Criteria 1 Resident #3 discharged on 7/9/2015 Criteria 2 On 7/22/15 100% Audit was conducted of all residents with skin tears by MDS nurses, Assistant Director of Nursing, Staff Facilitator and Director of Nursing. Care Plan and Care Guide updated based on findings. 100% of all residents will have a preventative assessment completed by	7/27/15

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F 309	Continued From page 9 Review of the 4/7/15 Admission Minimum Data Set (MDS) indicated Resident # 3 was severely cognitively impaired with no behaviors or rejection of care. The MDS revealed the resident required extensive assistance for transfer, dressing, toilet use, and personal hygiene. Progress notes for 4/10/15 at 9:32 AM indicated Resident #3 had sustained a skin tear to his right elbow during a transfer from bed to the wheelchair. The nurse documented Resident #3 was resistive to care during activities of daily living and transfers. There were no interventions or plan initiated to prevent Resident #3 from sustaining skin tears. On 4/10/15 at 11:59 AM progress notes indicated the treatment nurse noticed skin tears to Resident #3 ' s right forearm while assessing Resident #3 ' s other areas. The nurse documented Resident #3 had very fragile skin. The intervention documented was observation to see if the resident ' s medications needed adjustment. There was no documentation that indicated the nurse had reviewed the resident ' s medication. Review of a nursing progress note for 4/18/15 at 11:24 AM indicated the RP brought to the nurse ' s attention an open area to the resident's left shin area. The nurse documented she assessed the area, cleansed the area with normal saline and applied a hydrocolloid dressing. No measures were put into place to prevent further skin tears. On 5/5/15, a Flow-sheet of Non-Ulcer Skin Conditions indicated Resident #3 had a left shin, lower leg, medium skin tear with no skin flap. The skin tear was described as red and yellow discoloration with defined edges. The treatment documented indicated the skin tear should be cleaned with wound cleanser and hydrogel (a treatment that provides moisture to the wound	F 309	licensed nurses by 7/22/15. On 7/16/15, the Staff Facilitator initiated a 100% in-servicing of licensed nursing staff on preventative assessments on admission, quarterly, and as needed with interventions based on the findings for at risk residents. All incidents will have immediate interventions by a License Nurse. On 7/16/15, MDS nurses in-serviced by Director of Nursing on updating Care plan for actual and at risk for skin tears. Criteria 3 The Director of Nursing, Assistant Director of Nursing, Staff Facilitator, and MDS Nurses will monitor all new admissions, and any incidents to ensure care plans and care guides are updated with interventions. This will be completed during clinical meeting Monday-Friday for one week, then weekly for one month, then monthly for two months. Incident audits will be reviewed in the daily meeting M-F. Criteria 4 The Director of Nursing or Quality Improvement nurse will report the audit results to the Executive Quality Improvement Committee. The Committee will review the results of the audits monthly and make recommendations as needed for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring.	

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bed and aides in healing) applied. The dressing was documented as changed every 3 days and as needed.
On 6/3/15, the Flow-sheet of Non-Ulcer Skin Conditions indicated Resident #3 had a left shin skin tear with no flap, yellow discoloration, with defined wound edges. The nurse noted the resident was seen by the wound care specialist (WCS) weekly. Noted was a new physician ' s order to discontinue the Santyl (a wound product used to remove dead tissue) and use medihoney (a wound product used to promote healing) daily.
Wound/Skin/Treatment notes for 6/11/15 at 6:57 PM were reviewed and indicated Resident #3 was evaluated by the WCS on 6/10/15 and found the wound to the left anterior mid shin as improved. The wound measured 1.6 centimeters (cm) x 0.7 cm with 100% necrotic (dead) tissue. Debridement was performed. Medihoney was continued as the treatment.
On 6/16/15, the Flow-sheet of Non-Ulcer Skin Conditions noted a left lower leg skin tear measuring 1.8 cm x 1.9 cm x 0.2 with no exudate. Under comments, the nurse had written the area would be cleansed with wound cleanser, patted dry, Santyl applied and cover with dry protective dressing daily and as needed until healed.
On 6/19/15 at 11:27 AM, the nurse noted Resident #3 was seen by the WCS for skin tear on left anterior mid shin measuring 1.8 cm x 0.9 cm x 0.2 cm. The skin tear was described as having yellow necrotic tissue present.
Review of the care plan did not reveal any identification that Resident #3 had a problem with skin tears and included no interventions for prevention of skin tears.
A wound care observation was completed on 6/30/15 at 9:24 AM. Nurse #1 and Nursing Assistant (NA) #1 worked with Resident #3 to

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complete the treatment. Resident #3 was observed with an open wound on his left lower leg that was approximately 2.54 cms. The wound bed appeared to be 50% to 75% yellow tissue. Nurse #1 stated the resident ' s family member discovered the wound, but the facility had been " on it " since discovery. She stated she was unaware of the origin of the wound. Nurse #1 added the WCS saw Resident #3 every Wednesday.

The family member was interviewed on 6/30/15 at 9:40 AM. She stated another family member was the one that discovered the wound. She added the open wound was seen on Resident #3 ' s lower leg as he sat in the wheelchair. His pants rose above the wound and that ' s when it was observed. The family member had no idea how the wound had occurred.

NA #2 was interviewed on 6/30/15 at 1:21 PM. The NA stated she cared for Resident #3 each day she worked which was usually 5 times per week. NA #2 stated she was unaware how Resident #3 received the skin tear on his lower leg, but added it was not unusual for the resident to get skin tears. She added when she transferred Resident #3 she tried to make sure the path was clear to avoid having any object hit his skin. NA #2 stated she was off duty when the lower leg skin tear was found. She added the day before discovery, when she worked, she was sure the resident had no skin tear on his leg.

The NA stated instructions for caring for residents were found on the care guides located at the nurse ' s station. The care guide, the NA stated, did not include information about residents who are at risk for skin tears

During an interview with Nurse #1 on 6/30/15 at 2:30 PM, she stated the facility ' s wound care protocols covered the treatment of skin tears.

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She added it was the responsibility of the MDS nurse to care plan skin tears. The nurse was unaware how the skin tear on Resident #3 ' s skin had occurred.
NA #3 was interviewed on 7/1/15 at 10:03 AM. She was unaware how the left lower leg skin tear had occurred.
An interview was held with the Director of Nursing (DON) and MDS Nurse #1 on 7/1/15 at 1:30 PM. The DON stated she expected Resident #3 ' s skin tears to be addressed on the care plan. The DON reviewed the care plan and stated she did not see a care plan identifying skin tears as a problem for Resident #3, did not identify interventions for skin tear prevention and did not identify the resident ' s current wound identified as caused by a skin tear. The DON reviewed the care guide, identified to be used by the NAs for caring for residents and stated the resident's risk of skin tears and interventions for skin tear prevention was not identified on the care guides for Resident 3. The MDS nurse stated she had no explanation why the skin tear on the left shin or interventions to prevent skin tears had not been addressed or Resident #3 ' s care plan or care guide.
A telephone interview with Nurse #2 was conducted on 7/2/15 at 10:47 AM. The nurse acknowledged she had written the note dated 4/18/15 at 11:24 AM about the open area on Resident #3 ' s left shin. Nurse #2 stated she had not known about the area prior to that day. The nurse stated she had observed the resident's family member placing an antibiotic ointment on the resident's leg and asked what she was doing. Nurse #2 added she had not received reports about the skin tear to Resident 3 ' s left shin from the NA or during report. The nurse stated on first observation, the wound was a small red area that

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F 309	Continued From page 13 looked superficial. Nurse #3 added she had reported the area to the treatment nurse. Nurse #2 stated she had questioned NA #2 and the NA had told her the area was not there during the resident's bath.	F 309		
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 observations, interviews with staff and record review, the facility failed to correctly assess a pressure ulcer for 1 of 2 sampled residents (Resident #1) and failed to consistently use care planned pressure ulcer interventions for 1 of 2 sampled residents (Resident #1) reviewed with pressure ulcers. Findings included: Resident #1 was admitted on 4/29/15 with diagnoses that included Alzheimer's disease, history of fall, generalized muscle weakness and aphasia. The 4/29/15 Nursing Admission and Re-entry Assessment indicated on admission the resident had bruising on her right lower extremity, a small scab on the back of her head, old bruising on the right buttock and a red birth mark on her chin.	F 314	F314 Treatment/Services to Prevent/Heal Pressure Sores Criteria 1 Heels floated for resident #1. Treatment nurse watched Orientation Video on Wound Care. Treatment nurse in-serviced by Nurse Consultant on Assessment, Documentation and Staging of Wounds. Criteria 2 On 7/8/15 the Staff facilitator initiated a 100% in-servicing of all nursing staff on following Care Guides, how to properly float heels, and how to correctly apply bunny boots. Treatment nurses watched Wound Care Video and in-serviced by	7/27/15

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F 314	Continued From page 14 There was no documentation of blisters on the right or left heel or the ischium. A late entry nursing progress note, dated 4/29/15 at 3:50 PM, with a created date of 5/6/15 at 9:06 AM indicated Resident #1 was admitted to the facility with blisters to the right heel and left heel to which skin prep would be applied daily. There was also a fluid filled blister to the right ischium measuring 0.2 centimeters (cm) x 0.1 (cm) to which skin prep would be applied daily. A 5/3/15 at 2:37 AM, Skin/Wound Treatment Note indicated Resident #1 had blisters noted to both heels. A physician's order, dated 5/4/15, indicated Resident #1 ' s heels were to be floated while in bed. The 5/5/15 Admission Minimum Data Set (MDS) indicated Resident #1 had short and long term memory with severely impaired cognitive skills for daily decision making. Rejection of care was documented as occurring 1 to 3 days per week. The resident required extensive assistance with bed mobility, transfer, eating, toilet use and personal hygiene. Resident #1 was identified with 3-Stage II pressure ulcers that were present on admission. On 5/7/15 a Skin/Wound Treatment noted stated it was to continue the note of 4/29/15. Resident's right heel blister measured 6.1 centimeters (cms) x 4.2 cm x 0 cm and the left heel blister measured 5.9 cm x 4.0 cm x 0 cm with red and dark red/purple discoloration noted. Staff received a physician ' s telephone order on 5/11/15 that indicated a dry dressing should be applied to the resident ' s right heel to protect the skin. The Care Area Assessment (CAA) Worksheet, dated 5/14/15, indicated the resident had existing pressure ulcers. She further documented 3	F 314	Nurse Consultant on completing the skin assessments, documentation, and staging of wounds. License nurses will Ensure and monitor that interventions are in place. Criteria 3 The Director of Nursing, Assistant Director of Nursing, Staff Facilitator, and MDS Nurses will monitor all new admissions, and any incidents to ensure proper assessments, documentation, and staging of wounds are correct, also care plans and care guides are being updated and followed. This will be completed during clinical meeting Monday-Friday for one week, then weekly for one month, then monthly for two months. Director of Nursing and Assistant Director of Nursing DON will monitor 5 wounds per week for 4 weeks then 5 wounds monthly for 4 months then quarterly. any negative findings will be corrected immediately and Nurses educated. Incident audits will be reviewed and monitored in the daily meeting M-F. Criteria 4 The Director of Nursing or Quality Improvement Nurse will report the audit results to the Executive Quality Improvement Committee. The committee will review the results of the audits monthly and make recommendations as needed for continued compliance in this area and to determine the need for and or/frequency of continued QI monitoring.	

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blisters that included the right and left heel and the right ischium. A decision was made to care plan the pressure ulcers. The MDS nurse documented staff were to " ensure appropriate pressure relieving devices in place during repositioning " .
Review of a 5/14/15 Flow-sheet of Non-Ulcer Skin Condition revealed a blister was noted to the left heel measuring 1.4 cm x 1.5 cm with pink and red tissue and granulation tissue. The nurse documented a xeroform (a type of non-adhesive dressing) and dry dressing was applied. The nurse described the blister as blood filled.
Review of the resident ' s care plan, reviewed on 5/14/15, indicated the resident was at risk for skin breakdown or development of further pressure ulcers. The goal of the current wound not worsening was to be attained through assuring appropriate pressure relieving devices, inspecting the skin and notifying the nurse of abnormal changes and placing Resident #1 on pressure relieving products such as a pressure relieving mattress and chair cushion as appropriate.
On 5/20/15, the Wound Care Specialist (WCS) assessed Resident #1 and found she had a Stage II pressure wound of the left posterior heel and an unstageable (due to necrosis) pressure ulcer to the left posterior, lateral heel. The resident was also found to have a Stage II pressure ulcer of the coccyx and a Stage II pressure ulcer to the left lateral hip. The WCS noted this was the initial evaluation of the coccyx pressure ulcer and the left, lateral hip pressure ulcer.
The Non-Ulcer Skin Condition flow sheet dated 5/27/15 indicated open blister of the left heel measuring 1.4 cm x 1.9 cm. The form indicated the resident was seen weekly by the Wound Care Specialist (WCS) and new orders were received

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F 314	Continued From page 16 for Medihoney (a product for treating wounds) to be applied. The 5/27/15 WCS Evaluation of Resident #1 revealed a Stage III pressure ulcer of the left posterior heel and an unstageable pressure ulcer of the right, posterior, lateral heel. The coccyx pressure ulcer was not staged as unstageable due to necrosis and there was also a Stage II pressure ulcer of the left, lateral hip. Under Assessment and Plan, the WCS had recommended floating the resident ' s heels when she was in bed and off-loading the wound. Review of the Non-Ulcer Skin Condition flow sheet 5/27/15 open blister right heel 0.7 cm x 0.9 cm with granulation tissue (a type of tissue that indicates healing). The Non-Ulcer Skin Condition flow sheet, dated, 5/27/15 indicated Resident #1 had a left lateral hip blister measuring 1.3 cm x 1.0 cm. Review of the June 2015 Medication Administration Record (MAR) indicated an entry to float heels had been added to the MAR. Review of the 6/3/15 Non-Ulcer Skin Condition Flow-Sheet indicated Resident #1 ' s left heel had 100% granulation. The WCS Evaluation, dated 6/3/15, indicated a Stage III pressure ulcer of the left posterior heel, an unstageable pressure ulcer of the coccyx, and a Stage II pressure ulcer to the left, lateral hip that had resolved on 6/3/15. Review of a 6/3/15 at 8:42 Skin/Wound/Treatment Note indicated the blister to the right heel and left lateral hip were resolved by the WCS. The Physician's telephone order, dated 6/8/15, indicated Resident #1 ' s heels should be floated. On 6/10/15, review of the WCS Evaluation indicated a Stage III pressure ulcer to the left, posterior heel that had improved and an	F 314		

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F 314	Continued From page 17 unstageable pressure ulcer of the coccyx that had improved A Skin/Wound Treatment note, dated 6/11/15, at 9:11 PM indicated a Stage III pressure ulcer to the left posterior heel presented as improved measuring 0.2 cm x 0.5 cm x unmeasurable with 100% granulation tissue. Review of the 6/17/15 WCS Evaluation revealed a Stage III pressure ulcer of the left, posterior heel with a resolved date of 6/17/15, a Stage IV pressure wound of the coccyx and an unstageable deep tissue injury of the right ischium. The WCS noted this was his initial evaluation of the right ischial wound. Physician's telephone order for 6/17/15 indicated the right ischium wound continue to receive a foam dressing daily. The physician also ordered wound be off loaded (pressure relieved from the area). Review of a 6/19/15 Skin/Wound/Treatment note revealed the Stage III left posterior heel wound had resolved. The note indicated an unstageable deep tissue injury of right ischium measuring 10 cm x 6.5 cm. The note also identified a right ishchial wound (note indicated resident was admitted with the wound, although the WCS note of 6/17/15 indicated it was a new onset pressure wound in the facility). The Resident Care Guide (a guide to direct nursing assistants (NA) in caring for residents) with a date of 6/19/15, indicated the resident's heels should be off loaded. A wound observation was completed on 6/30/15 at 11:20 AM. The right ischial wound appeared approximately the size of a 50 cent piece. The tissue in the wound bed had yellow slough. The area was cleansed with hydrogel and a foam dressing applied. The dressings were secured with a clear adhesive bandage. Both heel	F 314		

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wounds appeared healed. The sacral wound was not observed at this time since the treatment was halted due to the resident ' s pain. The resident ' s heels were not floated off the bed. Bunny boots were on the bed, but not applied correctly leaving the resident ' s heels directly in contact with the bed.
The Treatment Nurse that initially identified the area to the ischium and the heels that assessed the wounds as non-pressure areas was unavailable for interview since she no longer was employed by the facility.
During an interview with NA #1 and Nurse #1 on 6/30/15, the nurse stated the admitting nurse was responsible for admission skin assessments. She added if an area of skin impairment was found, the facility wound protocol was followed and a referral made to the treatment nurse. The treatment nurse or the WCS was responsible for weekly measurements and documentation. The nurse added if a wound was found in house, statements are gathered from the staff and the interdisciplinary team handles the incident. NA #1 stated Resident #1 ' s ischial pressure ulcer was discovered last week. Prior to that, she stated the area was red. The NA stated she was a NA II and did provide wound care to residents and that was how she knew the area had been red on the resident ' s ischium. The NA stated she instructed the NA assigned to Resident #1 to turn her every 2 hours. The nurse stated pressure ulcer interventions in place for Resident #1 included an air mattress, limited time sitting up, foam protective dressing on the left hip and turn and position which was standard for all residents requiring assistance. The nurse stated all nursing staff was responsible to make sure residents had their bunny boots on and their feet were floated. She stated there was no order on

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the resident ' s treatment sheet to her heels.
An interview was held with Nurse #3 on 6/30/15 at 2:23 PM. She stated when she worked, she worked with Resident #1. Nurse #3 stated it was the responsibility of all staff to make sure pressure ulcer prevention interventions were placed, including floating heels. She stated NAs were responsible for replacing interventions removed during provision of care. Nurse #3 stated when heels were floated, the heels were kept from touching any surface. She added this included the pillow on which the legs rested. Interventions for pressure ulcer prevention include pillows for positioning, turn and position, not get out of bed just turn from side to side and bunny boots. The nurse stated if bunny boots were used for a resident they should be listed in the treatment book. An observation was made at this time. The nurse acknowledged the resident ' s heels were not floated, but laying on the pillow that supported her legs.
An observation was made on 7/1/15 at 9:00 AM. Resident #1 was lying in bed. One bunny boot was on and one was off. Her feet were laying on bed with no pillows observed to float her heels. NA #4, who was assigned to care for Resident #1 on 7/1/15 was interviewed on 7/1/15 at 10:48 AM. She stated that floating heels meant to keep the heels elevated and keep them from rubbing against anything. The NA stated the resident moved her feet a lot. The NA stated she had also worked with the resident yesterday and it was her fault there had been no pillow under the resident's feet. This morning, NA #4 stated she removed the pillow under Resident #1 ' s feet in order to assist the resident with eating. The NA stated she did not know why she had not placed a pillow under the resident ' s feet yesterday and had forgotten to replace the pillow after breakfast this

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F 314	Continued From page 20 morning. MDS Nurse #2 and the Director of Nursing (DON) were interviewed on 7/1/15 at 12:01 PM. The MDS nurse stated she had coded Resident #1 had pressure ulcers because the assessment indicated blisters, which would be considered Stage II pressure ulcers. She based this assessment on nurse ' s notes dated 4/29/15 and 5/3/15 and not the Non-Pressure Ulcer Wound documentation. The DON stated the expectation was for wound documentation to be completed within 24 hours and not a week later. The DON stated the nurse that documented the 4/29/15 note and had called Resident #1 ' s pressure ulcers, non-pressure ulcers, no longer worked for the facility. The DON stated the documentation of the heel wounds, starting on 5/14/15 was inaccurate. The heel wounds should have been coded under pressure. The DON stated the wound status, non-pressure versus pressure had not made a difference in the treatment received by Resident #1. An interview was held with MDS Nurse #1 on 7/1/15 at 1:10 PM. The MDS nurse stated the purpose of the care was to put something in place to maintain function or to put interventions in place to fix the problems. The care plan directed care of the resident. The MDS nurse stated the term " making sure appropriate pressure releasing devices " were in placed covered air mattresses, bunny boots and floating heels. The MDS nurse stated the nurse and the NA were responsible to make sure all interventions were in placed and applied correctly. Floating heels meant the heels should not be resting on the bed and should be elevated. Nurse #4 was interviewed on 7/1/15 at 3:48 PM. Nurse #4 reviewed the admission nursing assessment for Resident #1 and stated she had	F 314		

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F 314	Continued From page 21 completed the admission assessment for this resident. The nurse added the expectation was for all wounds present to be documented by the admitting nurse or the treatment nurse within 24 hours of admission. On admission, she added, Resident #1 had a dark area on her sacrum where she currently has a wound, bruising on her arms and legs and a scab on top of her head. Nurse #4 added if Resident #1 had a pressure ulcer on admission, she should have documented that pressure ulcer. The nurse was unable to remember if the resident had pressure ulcers on admission. The nurse stated the treatment nurse at the time assessed the resident the next day, but added she was unaware of what the treatment nurse found. Nurse #4 added that treatment nurse no longer worked for the facility.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of medical records the facility failed to implement interventions to prevent falls of severely cognitively impaired residents. The facility failed to evaluate interventions that were put in place after multiple falls of 2 of 3 sampled residents (Resident #4 and Resident #3)	F 323	F323 Free of Accident Hazards/Supervision/Devices Criteria 1 Care plan and care guide updated by MDS Nurse to include fall interventions for Resident #4 on 7/21/15.	7/27/15

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F 323	Continued From page 22 reviewed for falls. Findings included: 1. Resident #4 was admitted on 2/6/15 with diagnoses that included personal history of fall, generalized muscle weakness, diabetes, osteoarthritis, rheumatoid arthritis, lack of coordination and hypertension. The Admission Minimum Data Set (MDS), dated 2/13/15, revealed Resident #4 was cognitively intact. She was coded as requiring limited assistance with transfers, extensive assistance for ambulation in her room and locomotion on the unit. The MDS also indicated Resident #4 was only able to stabilize with human assistance during transition and walking. Resident #4 was identified as having falls since her admission. Review of nurse ' s progress notes, dated 4/14/15 at 4:37 AM, revealed Resident #4 was found on her knees between wheelchair and the bed. She sustained a small skin tear. The nurse documented Resident #4 stated she was sitting on the side of the bed because her knees were bothering her while holding on to wheelchair and added she must have fallen asleep. The nurse documented she removed the wheelchair. Education for the resident and family on preventative interventions, to include lying down for sleep and locking the wheelchair when used for support, were added to the care plan. Nurse ' s progress notes dated 4/21/15 at 7:53 PM indicated Resident #4 had 2 falls that shift with no injuries. The nurse documented the resident attempted to go to the bathroom unassisted after being reminded to ring for staff assistance. The care plan revealed interventions added included frequent reminders to call for assistance and to empty the urine collection system after each meal were added. Review of the facility ' s fall log indicated Resident	F 323	Resident #3 discharged on 7/9/2015 Criteria 2 100% Audit of all residents will have a fall risk evaluation completed on 07/22/15 by license nurses, and care plan and care guide updated based on findings by 7/22/15. On 7/16/15, the Staff Facilitator initiated a 100% in servicing of licensed nursing staff on how to complete falls assessments which are to be completed upon admission and quarterly and as needed, with interventions based on the findings. All incidents will have immediate interventions by license Nurse. On 7/16/15, MDS nurses in-serviced by Director of Nursing on updating Care Plans and Care Guides to include new interventions after each incident. Criteria 3 The Director of Nursing, Assistant Director of Nursing, Staff Facilitator, and MDS Nurses will monitor all new admissions to identify who are at risk for falls and skin impairment, and any incidents to ensure care plans and care guides are updated with new interventions. This will be completed during clinical meeting Monday-Friday for one week, then weekly for one month, then monthly for two months. Incidents audits will be reviewed in the daily meeting M-F. Criteria 4 The Director of Nursing or Quality Improvement Nurse will report the audit results to the Executive Quality	

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F 323	Continued From page 23 #4 had fallen on 4/23/15. There was no progress note that documented the fall. On 4/23/15, the care plan was revised and staff were instructed to monitor for routine needs. The resident ' s care guide, with a print date of 4/23/15, indicated the resident was to walk with supervision only. Under Special Precautions, the resident was identified with the word " FALLS " . Included for the nursing assistant ' s use was the instructions to empty the ostomy bag after each meal, encourage the resident to call for assistance (based on cognition), keep personal items in reach, non-skid footwear and supervised ambulation. The nurse ' s progress notes, written by Nurse #2 and dated 4/24/15 at 6:15 PM, indicated staff heard Resident 4 ' s call bell at 4:45 PM. Resident #4 was found sitting on her buttocks on bathroom floor. The nurse noted the resident was assisted back to her wheelchair and placed in common area. She also documented 15 minute checks were initiated. The nurse did not document a time frame for the 15 minute checks. On 5/6/15, Resident #4 was identified as a fall risk using the fall risk assessment. Resident #4 ' s Quarterly Minimum Data Set (MDS), dated 5/15/15, indicated the resident was severely cognitively impaired. Extensive assistance was required for transfer, bed mobility, limited assistance was required when walking in the room, supervision was needed for walking in the corridor and limited assistance with locomotion was required with locomotion on and off the unit. The MDS identified Resident #4 as requiring extensive assistance with toilet use and personal hygiene. The resident was also identified with falls since admission or the prior assessment that numbered 2 or more with no injury.	F 323	Improvement Committee. The committee will review the results of the audits monthly and make recommendations as needed for continued compliance in this area and to determine the need for and or/frequency of continued QI monitoring.	

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F 323	Continued From page 24 Review of nurse ' s notes for 5/29/15 at 9:28 AM, revealed during change of shift, the nurses were notified Resident #4 was on the floor. The nurse documented the resident was sitting on the left side of the bed facing the nightstand. Documentation revealed the resident rolled out of bed while trying to put her slippers on. The nurse documented Resident # 4 stated her socks were too slippery to stand up. Resident #4 was assisted to wheelchair. No interventions were added on the care plan to prevent further falls. Nurse ' s notes dated 5/30/15 at 5:05 AM indicated staff reported Resident #4 was on the floor. The nurse documented she entered the resident ' s room and found Resident #4 lying face down on the floor. The nurse documented the resident stated she was trying to changed her bottoms. Review of progress notes and the care plan revealed no new interventions were initiated. On 6/1/15 at 1:28 PM, nurse ' s notes revealed therapy had notified nursing staff that Resident #4 was found sitting on the bathroom floor. The resident stated she was trying to empty her urinary collection bag, reached for the railing, stood up and lost her balance. The nurse documented she spoke to resident about the importance of pulling the emergency bell when she needed to go to the bathroom. On 6/2/15, the care plan was revised and included an intervention to educate Resident #4 to use a urinal to empty the urinary collection system. Nurse ' s notes for 6/12/15 at 7:22 PM indicated the nurse was called to Resident #4 ' s room by the nursing assistant (NA). Resident #4 was observed sitting in the bathroom floor with her buttocks against the wall facing the toilet. The nurse documented Resident #4 told her she was going to use the bathroom. No interventions	F 323		

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F 323	Continued From page 25 were added to the care plan On 6/18/15 at 11:14 PM, nurse ' s notes indicated at 7:50 PM the nurse heard Resident #4 calling for help. The nurse documented she found the resident holding to the side rail with her buttocks half way off the bed with feet on the floor. The nurse documented she assisted the resident to the floor. Resident #4 was encouraged to use the call light. No interventions were added to the care plan. NA #2 was interviewed on 6/30/15 at 1:21 PM. She stated she worked full time with Resident #4 on the days she was scheduled to work. The NA added she had no residents assigned to her that had been identified as a high fall risk. The NA was unaware the resident had fallen in the past 30 days. NA #3 worked with Resident #4 on 7/1/15 as a medication aide. She was interviewed at 10:03 AM. She stated interventions for residents on the fall prevention program included identifying the resident as a fall risk on the resident care guide (a guide used by the NAs for provision of care). If a resident was a fall risk staff knew to check on the resident more frequently and keep the resident in common areas as much as possible. The NA stated there were no symbols or bracelets used to identify residents as a fall risk. The NA identified Resident #4 as a fall risk, but stated she was unsure if the resident had fallen in the past 30 days. The NA added if a resident fell, that information was relayed to the NAs during the change of shift report. On 7/1/15 at 2:16 PM, MDS Nurse #1 was interviewed. The MDS nurse stated information about resident falls was relayed during the morning department head meetings. She added she was unaware Resident #4 had fallen on 6/18/15.	F 323		

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F 323	Continued From page 26 Nurse #2 was interviewed via telephone on 7/2/15 at 10:50 AM. She stated she had written the note for 4/24/15 at 6:15 PM. She stated when a resident fell, she was to assess. Interventions placed depended on the resident. The nurse stated the 15 minute checks she referred to in the note was a neurological (neuro) check since the resident had an unwitnessed fall. Nurse #2 stated she had completed the neuro checks every 15 minutes for 1 hour, then every 30 minutes for 1 hour then every hour for 4 hours, then every 4 hours until the neurological check sheet was full. There were no other interventions placed and the every 15 minute check ended at the end of 1 hour. A telephone interview was held with Nurse #5 on 7/2/15 at 3:03 PM. She stated she did not remember the specifics about the resident's 6/12/15 fall. She added Resident #4 tried to go to the bathroom by herself and has been educated many times to ask for assistance. The nurse stated most of the time the resident was alert and oriented, but had frequent urinary tract infections which increased her confusion and her falls. Nurse #5 stated multiple intervention were used for Resident #4 including 1 to 1 observation or to place the resident in a common area for increased observations. Review of the nurse ' s notes failed to reveal documentation of 1 to 1 observations. 2. Resident #3 was admitted on 3/31/15 with diagnoses of difficulty walking, atrial fibrillation, generalized muscle weakness, chronic hypotension, hypertension and congestive heart failure. An Admission Minimum Data Set (MDS), dated 4/7/15, revealed the resident was severely	F 323		

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cognitively impaired. He required extensive assistance for transfer, bed mobility, toilet use and personal hygiene. The MDS indicated Resident #3 was not steady during transition from one plane to another and during walking. He was coded as having no falls since admission.
Nurse ' s notes dated 4/15/15 at 4:00 PM, revealed Resident #3 yelled out for help. The nurse noted upon entering the room, Resident #3 was found to be sitting on the floor in front of his wheelchair. She noted she assisted him from the floor back to his bed.
Review of nurse ' s notes for 4/16/15 at 6:13 PM revealed the resident ' s bed was in low position and his call light was in place.
Nurse ' s notes for 4/17/15 at 8:39 PM indicated the nurse had been notified by the nursing assistant (NA) that Resident #3 was found sitting in the floor in front of his wheelchair. The intervention was to monitor.
The care plan for Resident #3, last reviewed on 4/28/15 indicated the resident was at risk for falls. The goal of not sustaining serious injury through the next review was to be attained by assisting during transfer and mobility (4/2/215), bed in low position (4/2/15), rehabilitation therapy referral (4/18/15), fall risk protocol (4/2/15), call light in reach and answer timely (4/2/15) and provide frequent reminders to resident to call for assistance before getting up (4/15/15).
On 5/20/15 at 9:22 PM the nurse documented in nurse ' s notes that Resident #3 was observed sitting on the floor in front of his wheelchair.
A 6/28/15 Quarterly MDS identified the resident as severely cognitively impaired, requiring extensive assistance with transfer and as having no falls since the prior assessment.
NA #2 was interviewed on 6/30/15 at 1:21 PM. She stated she worked with Resident #3 every

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day she was scheduled to work. NA #2 stated she had no residents on her assignment that were identified as a high fall risk, including Resident #3.
An observation was made on 6/30/15 at 8:05 PM. Resident #3 was in bed with the half side rails raised. The call bell was hanging on the wall over the cord outlet approximately 3 to 4 feet to the right and back of the resident. NA #2 was interviewed at this time and stated she forgotten to put the call bell in reach.
NAS #3 was interviewed on 7/1/15 at 10:03 AM. The NA stated if a resident was a high fall risk it was identified on the resident care guide. This notified the NAs to make frequent rounds on the resident and to keep them in common areas when possible. NA #3 added bracelets or symbols were not used to identify residents that were identified as a fall risk. The NA stated she was not sure if Resident #3 had fallen in the past 30 days. She added if a resident fell, the information about the fall was relayed to NAs during the change of shift report.
An interview was held with the Director of Nursing (DON) and the MDS #1 on 7/.1/15 at 1:30 PM. The MDS nurse reviewed Resident #3 ' s care plan and care guide and stated the phrase " encourage to use call bell based on cognition " was based on the days Resident #3 understood instruction and was able to use the call bell. The MDS nurse reviewed Resident #3 ' s MDS and acknowledged he had been assessed as severely cognitively impaired. The DON and MDS Nurse #1 stated education was not an appropriate intervention for Resident #3 based on his cognitive status. The DON stated the care plan should be revised within 24 hours after a fall.
Review of the care plan revealed the 5/20/15 fall had been added to the care plan. MDS nurse #1

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F 323	Continued From page 29 had no explanation why the care plan had not been revised.	F 323		