STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident, staff and nurse practitioner interviews the facility failed to notify the physician after a	F 157	F157 Notify of Changes (injury/decline/room/etc.) It is the policy of this facility to notify the	10/26/15

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

Electronically Signed | 10/29/2015

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F 157	Continued From page 1 resident fall with skin tears, bleeding, swelling and bruising for 1 of 4 residents sampled for accidents. (Resident #7). The findings included: Resident #7 was readmitted to the facility on 05/07/15 with diagnoses which included heart disease, chronic kidney disease, left sided paralysis from a stroke, difficulty walking, generalized muscle weakness and lack of coordination. A review of the most recent quarterly Minimum Data Set (MDS) dated 08/21/15 indicated Resident #7 was cognitively intact for daily decision making and required extensive assistance by staff for toileting. A review of physician's orders dated 09/01/15 indicated Plavix (blood thinner) 75 milligrams (mg) by mouth daily and Aspirin 81 mg by mouth daily. A review of a nurse's note dated 09/19/15 indicated in part at 9:30 AM Resident #7 was observed in the floor in the bathroom. The note documented by Nurse #1 revealed she had assisted Nurse Aide (NA) #4 to transfer Resident #7 to the toilet then stepped out to continue working on her medication pass. The notes revealed about 2 minutes later Nurse #1 heard a loud noise and went in Resident #7's room to check on her and she was in the floor. The notes further indicated Nurse #1 assessed Resident #7 and she was alert and oriented but had a skin tear to the left elbow, a skin tear and raised area approximately 1 inch above left eye, swelling around left eye, a bruise to left shoulder with a	F 157	attending or on-call physician when there has been an accident or incident with injury that has the potential for requiring physician intervention. 1.Corrective actions taken for resident found to have been affected by alleged deficient practice Resident #7 received treatment by Nurse # 1 for her superficial injuries, per the standing orders, and the bleeding was stopped. Nurse #1 exercised her clinical judgement and initiated vital signs monitoring and neurological monitoring to observe for changes in condition and also held her scheduled dose of Plavix. Nurse # 1 listed the incident in the Physician Communication Book on 9/19/15. The Geriatric Nurse Practitioner (GNP) acknowledged the incident information placed in the book on the morning of 9/21/15. No new orders or physician interventions were required related to the incident. Nurse #1 received in-service on Physician notification procedures on 10/8/15 by the DON. 2.Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: Incident / Accident reports from 9/1/15 through 10/7/15 were reviewed by the DON to ensure that the requirements were met for 483.10(b)(11) physician notification. It was determined through	

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F 157	Continued From page 2 raised area. Nurse #1 applied a non stick antiseptic mesh gauze and dressings to Resident #7's left elbow and above her left eye. During an observation and interview on 10/06/15 at 10:02 AM Resident #7 was seated in a wheel chair next to her bed and had bruising above her left eye and on both cheeks of her face. She explained she was paralyzed on her left side and could not use her left arm because of a stroke and confirmed she recently had a fall in her bathroom when she was trying to clean herself and fell forward off the toilet and hit her face and left arm. During an interview on 10/07/15 at 8:15 AM with Nurse #1 she confirmed she was the nurse assigned to Resident #7 on 09/19/15. She explained she found the resident on the floor and Resident #7 was bleeding from her head and left elbow and the skin above her left eye was sheared off and she had bruising and swelling over the area. She explained she stopped the bleeding and checked Resident #7's vital signs and they were within normal limits. Nurse #1 stated she called Resident #7's responsible party but did not call the physician or nurse practitioner because she did not think she needed to call since Resident #7's vital signs were stable and she thought the resident was fine. During an interview on 10/07/15 at 9:31 AM the Director of Nursing (DON) stated it was her expectation for nursing staff to notify the physician or nurse practitioner when a resident had a fall. She explained she communicated with the nurse practitioner on a regular basis but was not always available so she expected for the nurses to communicate with the physician and	F 157	this review that the requirement had been met in each instance. No other residents had been affected by the alleged deficient practice. 3. Measures taken and systems changed to prevent repeat of alleged deficient practice. The facility policy for "Change in Resident Condition or Status" was reviewed by the Administrator, Assist Administrator, and DON to ensure all the requirements were met in the current policy relating to F157 regulation 483.10(b)(11) Notification of Changes. The current facility policy does meet the requirement and was used for the in-service education for the licensed nurses. In-Service training was initiated on 10/8/15 by the DON for all nurses concerning requirements for immediate physician notification when an accident with injury to the resident occurs and has the potential for requiring physician intervention. All licensed nurses were required to receive and acknowledge the Physician notification in-service training prior to beginning his/her next scheduled work shift. *This in-service training per our policy included: Immediate notification to GNP or Physician of any accident involving a resident resulting in injury that has the potential for requiring physician intervention, as listed in regulation 483.10(b)(11). This required immediate notification is to be made in person by the	

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F 157	Continued From page 3 nurse practitioner so they would be aware of the resident's fall. During an interview on 10/07/15 at 9:45 AM the nurse practitioner stated it was her expectation for nursing staff to notify the physician or herself when a resident had a fall. She further stated physician coverage was provided 24 hours a day and there were numerous ways for nursing staff to contact her or the physicians. She stated she received most of the calls during the day and there was also a non emergency call line for them to report skin tears or minor injuries and the messages were checked the following day.	F 157	nurse to the provider if the provider is in the facility at the time of the occurrence or via the telephone to the GNP or physician on call if the medical provider is not in the facility at the time of the occurrence. All nurses were reminded of the location of the numbers for the physician, GNP, and physician on call phone numbers and the need to call and report accidents as described above as well as for these reasons as well: significant change in the residents physical, mental, or psychosocial status, and a need to alter treatment significantly, or a decision to transfer or discharge a resident from the facility as specified in 483.12(a) 4. Facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing or designee will monitor all Incidents / Accidents weekly for one (1) month, then 2 per week for one (1) month, tapering to 1 per week for two or more consecutive months to ensure Physician notification has occurred when there is an accident involving a resident which results in injury and has the potential for requiring physician intervention. Results of the monitor/audits will be reported by the DON in the monthly Quality Assurance Performance Improvement monthly meetings. The results will be reviewed and discussed and the QAPI committee will assess and	

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F 157	Continued From page 4	F 157	modify the action plan as needed to ensure continued compliance.	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to assist a resident to the bathroom upon request and the resident experienced incontinence for 1 of 1 sampled resident (Resident #5). The findings included: Resident #5 was admitted to the facility on 05/02/13 with diagnoses that included behavioral disturbances, anxiety and others. Review of Resident #5's care plan updated 08/18/15 specified the resident was to be toileted during rounds and as needed. Further review of the medical record for Resident #5 revealed a nurse's entry dated 09/01/15 that read in part, "Resident was very upset and crying with staff when they did not take her to the bathroom as soon as she got done with breakfast. Resident was explained that staff would help her as soon as they could." The most recent Minimum Data Set (MDS) dated 09/08/15 specified had no impaired cognition but required extensive assistance of two persons with activities of daily living including toileting and was frequently incontinent of bladder. On 10/06/15 at 10:15 AM Resident #5 was interviewed and reported that staff did not always	F 311	F311 Treatment/Services to Improve/Maintain ADL¿s It is the policy of this facility to provide treatment and services to residents to maintain or improve abilities. 1. Corrective actions taken for resident found to have been affected by alleged deficient practice Resident # 5 was assisted to the bathroom on 10/7/15 at 7:18 a.m. by two CNAs. On 10/08/15, NA #2 received counseling and re-education, by the DON and Assistant Administrator, on the importance of timely toileting and being responsive to the needs of residents. 2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: A list of interviewable residents who require assistance to use the toilet was developed on 10/14/15. These residents were interviewed by nursing management	10/26/15

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F 311	Continued From page 5 assist her to the bathroom timely. She stated she had experienced incontinence as a result of having to wait on staff. She explained that she was scared to use her room bathroom and preferred to toilet in the hall shower room. She added that it took two people to transfer her to the toilet. Resident #5 did not provide specific incidents or staff that failed to assist her to the bathroom. During the interview, Resident #5 stated she had received assistance to the bathroom that morning. On 10/07/15 at 7:15 AM Resident #5 was in her wheelchair at the end of the 200 Hall across from the shower room crying, saying, "They won't let me go pee." During this observation, staff were noted to walk by the resident as she continued to cry, saying, "They won't let me go pee." At 7:17 AM Resident #5 was interviewed and stated that she needed to use the bathroom but the "girl" that got her up told her that she could not take her to the bathroom. On 10/07/15 at 7:18 AM two nurse aides assisted Resident #5 to the bathroom. Observations revealed her adult brief was damp and the resident urinated. On 10/07/15 at 7:20 AM nurse aide (NA) #2 was interviewed and explained that she had provided morning care for Resident #5 at 6:50 AM that same morning. She added that she provided incontinence care in bed and applied a dry adult brief to Resident #5. NA #2 stated that Resident #5 required two person assistance with activities of daily living but she was able to use the sit-to-stand (a type of mechanical lift) as the additional assistance required to transfer the resident. NA #2 reported that Resident #5 requested to go to the bathroom but the NA told her that she would have to wait because the NA was not able to take the sit-to-stand lift into the	F 311	team members from 10/15/15 thru 10/20/15 to determine if staff assisted them to the bathroom and/or other means of toileting (bed pan, bedside commode etc.) in a timely manner. The results of these interviews concluded that no other residents were identified as having been affected by the alleged deficient practice. 3. Measures taken and systems changed to prevent repeat of alleged deficient practice. In-services for A) Dignity and B) ADL care assistance for CNA staff were provided on October 8th and 9th by the Nurse Consultant. Continued in servicing for the remainder of CNA staff not in attendance on October 8th and 9th was provided by the DON. 4. Facility plans to monitor its performance to make sure that solutions are sustained. The Nursing Management team consisting of DON, ADON, Supervisor and Clinical Coordinator will perform observations of staff assistance with timely toileting for 6 residents per week for 4 weeks, then 3 residents per week for 4 weeks, and then taper to 1 resident weekly for 4 weeks. The Nursing Management team will conduct resident interviews to determine if toileting needs and ADL care needs are met in a timely manner for 6 residents weekly for 4 weeks, then 3 residents	

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F 311	Continued From page 6 resident's bathroom. NA #2 stated that she left Resident #5 and reported to her next assignment but notified NA #3 at 7:00 AM at change of shift that Resident #5 needed to go to the bathroom. On 10/07/15 at 7:25 AM NA#3 was interviewed and reported she was assigned to Resident #5 on 10/07/15 from 7 AM to 3 PM. NA #3 stated that she was not made aware at shift change that Resident #3 needed to go to the bathroom. On 10/07/15 at 9:20 AM the Director of Nursing (DON) was interviewed and stated she expected nurse aides to provide care and services to residents timely. She added that she would have expected NA #2 to assist Resident #5 to the bathroom upon request by either using the sit-to-stand lift to toilet the resident in the shower room or getting assistance from another trained staff member. The DON stated that NA #2 should not have left the hall without assisting Resident #5.	F 311	weekly for 4 weeks, and taper to 1 resident weekly for 4 weeks. Results of these observations and interviews will be reported by the DON in the monthly Quality Assurance Performance Improvement committee¿s monthly meetings. The results will be reviewed and discussed and the QAPI committee will assess and modify the action plan as needed to ensure continued compliance.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review the facility failed to safely transfer a resident and the resident fell fracturing her left tibia and fibula and failed to	F 323	F323 Free of Accident Hazards/Supervision/Devices It is the policy of this facility to ensure that the resident environment remains as free	11/4/15

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F 323	Continued From page 7 provide supervision during toileting for a resident who was at risk for falls for 2 of 4 sampled residents (Residents #9 and #7). The findings included: 1. Resident #9 was admitted to the facility on 07/01/15 with diagnoses that included difficulty walking, general muscle weakness, a right hemispheric cerebrovascular accident and others. Resident #9's care plan dated 07/01/15 for impaired physical mobility specified the resident was to be transferred with 2 persons. The admission Minimum Data Set (MDS) dated 07/08/15 specified the resident had moderately impaired cognitive skills and required extensive assistance with activities of daily living, and two person assistance with transfers. Review of Resident #9's medical record revealed a nurses' entry 09/21/14 and made by nurse #1 read in part, "Resident observed in floor of shower room screaming in pain from left knee. Nurse Aide #1 attempted to put a shower chair under the resident." A physician's order dated 09/21/15 specified to send resident to the Emergency Department for evaluation after a fall. On 09/21/15 the resident was sent to the Emergency Department for evaluation of pain after a fall and was admitted to the hospital. Hospital records were reviewed and revealed an x-ray dated 09/21/15 revealed Resident #9 fractured her left tibia and fibula. Further review revealed Resident #9 was admitted to the hospital and discharged on 09/26/15to the facility. On 10/06/15 at 2:40 PM Resident #9 was observed in her bed wearing a brace to her left leg. Resident #9 was interviewed and explained that after she had a stroke it took two people to transfer her. She added that on 09/21/15 two	F 323	of accident hazards as possible and each resident receives adequate supervision and assistance devices to prevent accidents. 1. Corrective actions taken for residents found to have been affected by alleged deficient practice A) Resident #9 was admitted to the hospital for evaluation and treatment immediately following the incident. Nurse Aide #1, who was caring for resident #9 when this incident occurred, received one-on-one counseling and re-training by the DON prior to beginning her next scheduled work shift on 9/23/15. The DON also placed NA #1 on intensified monitoring, beginning 9/23/15, to observe resident transfers to ensure she was using the correct transfer methods as is listed on the Transfer Sheets that are provided to each NA daily. B) Resident #7 was examined for injuries when the accident occurred and received treatment and monitoring in the facility by Nurse # 1. She required no further medical interventions related to this fall. Nurse Aide #4, who was assigned to care for resident #7 on the day of this incident, was provided one-on-one education by Nurse #1 on 9/19/15 on maintaining resident safety during toileting which included not leaving the room while resident was on the toilet. Nurse aide #4 was also counseled by the DON on 10/21/15.	

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F 323	Continued From page 8 nurse aides assisted her to the shower and one of the nurse aides left leaving her alone with nurse aide #1. Resident #9 stated, "I told her she better get help before trying to move me but she said she could do it." Resident #9 added that NA #1 asked the resident to stand up and hold on to the whirlpool bathtub and walked away from the resident. While standing there, the Resident reported that her legs "gave way" and she fell. On 10/06/15 at 3:00 PM NA #1 was interviewed and reported that she was new to the facility but was instructed to use a "transfer lift sheet" as a reference to know what type of transfer assistance a resident required. NA #1 added that on 09/21/15 she was assigned to give Resident #9 a shower. She explained that she and another NA transferred Resident #9 into the shower room and from her wheelchair to the shower chair and then the other NA (name not provided) left the shower room. NA #1 stated that she proceeded to bathe the resident and rather than calling for assistance, she attempted to transfer the resident from the shower chair to the wheelchair but the Resident fell. NA #1 stated that she had not referenced her "transfer lift sheet" to see what type of assistance Resident #9 needed for transfers but added that she should have known and it was her fault. On 10/07/15 at 8:10 AM nurse #1 was interviewed on the telephone and reported she was the nurse assigned to Resident #9 on 09/21/15. The nurse explained that she heard a scream and went to the shower room and observed NA #1 coming out of the shower room and Resident #9 in the floor in pain. Nurse #1 stated she asked what happened and NA #1 reported that she was attempting to put a chair (unsure if it was shower chair or wheelchair)	F 323	2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: A) The transfer status sheets were reviewed by the Therapy Director for all residents to assure the indicated level of assistance for transfers was appropriate and accurate. This review is in addition to individual updates/revisions made by therapy if and when resident condition/mobility changes occur. The "transfer sheets" are generated on a daily basis and provided to the CNA staff. As part of the Performance Improvement Project (PIP) initiated on 9/22/15, the DON initiated transfer observations of the CNA staff on 9/22/15, completed by the licensed staff nurses on each shift. The nurses were provided guidance on safe transfers and instructions from the DON and Nurse Supervisor from 9/22 - 9/24 to observe the CNAs during resident transfers to ensure the level of assistance listed on the "Transfer Sheet" was provided. An audit tool was created to record the observation findings. The audit tools are forwarded to the DON after each shift by the licensed nurses, for analysis of findings. B) A list of residents who require assistance to the bathroom for toileting needs was developed by Nursing Management team (which consisted of DON, ADON, Nurse Supervisor, and Clinical Coordinator) on 10/14/15. The transfer status for each resident was	

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F 323	Continued From page 9 under the resident and her legs gave out and she fell. Nurse #1 stated that Resident #9 required 2 persons for transfers and that NA #1 was new and apparently didn't know to use two people. On 10/07/15 at 9:15 AM the Director of Nursing (DON) was interviewed and reported that she had investigated the fall and determined that NA #1 did not get assistance to transfer Resident #9. The DON stated that NA #1 should have known that Resident #9 required 2 person assistance with transfers because two people had transferred the resident to the shower chair and NA #1 had her "transfer lift sheet" in her pocket at the time of the fall. The DON stated she expected staff to transfer residents in accordance with their plan of care. 2. Resident #7 was admitted to the facility on 05/07/15 with diagnoses which included heart disease, chronic kidney disease, left sided paralysis from a stroke, difficulty walking, generalized muscle weakness and lack of coordination. A review of the most recent quarterly Minimum Data Set (MDS) dated 08/21/15 indicated Resident #7 was cognitively intact for daily decision making and required extensive assistance by staff for toileting. The MDS also indicated Resident #7 was frequently incontinent of bladder and bowel. A review of a care plan with a problem statement for impaired mobility dated 05/08/15 revealed a goal that staff would anticipate and meet all daily care needs. The approaches indicated to assist with toileting and incontinence care with rounds and as needed and 2 person assist for transfers and assist with positioning as necessary or as requested by resident.	F 323	reviewed and revised by the Therapy Director to alert staff to not leave residents unattended in the bathroom and to instruct the resident the need to call for assistance before attempting to clean themselves as applicable. The ADON met with each of the identified residents on that list between 10/15 - 10/20 to explain the need for safety precautions and staff supervision to prevent accidents with toileting while maintaining resident dignity to the highest extent possible. 3. Measures taken and systems changed to prevent repeat of alleged deficient practice. The Therapy Department began in-servicing CNA staff on 10/15/15 for Incident / Accident Prevention. The in-service topics included heighted awareness of resident¿s safety, adherence to the established transfer status for each resident, and safety precautions applicable to safe toileting of residents. The directed in-service training, addressing supervision to prevent accidents, was initiated on 10/26/15 for the licensed nurses and CNA staff. The DHSR approved curriculum "Mobility and Safe Movement of the Elderly, Improving Your Skills to Prevent Injuries and Reduce Falls" by Teepa Snow, MS, OTR,/L, FOTA, Dementia Care Specialist, is being utilized for this directed in-service. This entire training will be completed by 11/4/15.	

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F 323	Continued From page 10 A review of physician's orders dated 09/01/15 indicated Plavix (blood thinner) 75 milligrams (mg) by mouth daily and Aspirin 81 mg by mouth daily. A review of a nurse's note dated 09/19/15 indicated in part at 9:30 AM Resident #7 was observed in the floor in the bathroom. The note documented by Nurse #1 revealed she had assisted Nurse Aide (NA) #4 to transfer Resident #7 to the toilet then stepped out to continue working on her medication pass. The notes further revealed about 2 minutes later Nurse #1 heard a loud noise and went in Resident #7's room to check on her and she was in the floor. The notes indicated Resident #7 stated she was trying to clean herself and lost her balance. The notes further indicated Nurse #1 assessed Resident #7 and she was alert and oriented but she had a skin tear to the left elbow, a skin tear and raised area approximately 1 inch above left eye, swelling around left eye, a bruise to left shoulder with a raised area and she applied a non stick antiseptic mesh gauze and dressings to Resident #7's left elbow and above her left eye. A review of a facility document titled Resident Incident Reports dated 09/19/15 at 9:31 AM revealed Resident #7 had a non-witnessed fall in the bathroom with a skin tear, abrasion, hematoma and bruise. The report indicated Nurse #1 assisted NA #4 and placed Resident #7 on the toilet and left the room to continue with a medication pass. The report further indicated Nurse #1 heard a crash and went into Resident #7's bathroom and saw the resident on the floor in front of the toilet. The report revealed Resident #7 stated she was trying to clean herself and lost	F 323	The above described accident prevention and supervision curriculum will also be included in the orientation process for newly hired direct care staff. New staff will also be educated on the need to utilize the "Transfer Sheets" to assure the appropriate level of assistance is provided during all transfers and safety precautions are provided when toileting residents. The DON immediately initiated a PIP (performance improvement project) on 9/22/1 . The PIP was developed to ensure that resident safety is maintained during transfers and that nurse aides are performing resident transfers according to the indicated transfer status as a result of evaluations conducted by the Therapy Department for each resident. The nurses were instructed to observe for, and immediately correct, any potential safety concerns identified in the observations and to determine if a therapy referral/evaluation was needed. The nurse will document on the transfer monitoring tool any negative findings or need for further intervention. The monitoring tools are then returned to the DON or designee who will then analyze the data for any root causes and trending and implement corrective action/interventions as needed. 4. Facility plans to monitor its performance to make sure that solutions are sustained. The Nurse observation of resident transfer technique as described above in Item # 3 was initiated on 9/22/15.	

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F 323	Continued From page 11 her balance. The report further revealed Resident #7 had swelling above her left eye, a skin tear to her left elbow and a bruise on her left shoulder. The report indicated Nurse #1 applied a non stick antiseptic mesh gauze and dressings above Resident #7's left eye and to her left elbow. A review of a therapy note dated 09/19/15 at 11:01 AM indicated Resident #7 was seated in wheel chair in room with bump and blood on left side of face above eye and left elbow due to falling off toilet while trying to complete hygiene with no assistance. During an observation and interview on 10/06/15 at 10:02 AM Resident #7 was seated in a wheelchair next to her bed and had bruising above her left eye and on both cheeks of her face. She explained she was paralyzed on her left side and could not use her left arm because of a stroke and confirmed she recently had a fall in her bathroom when she was trying to clean herself and fell forward off the toilet and hit her face and left arm. She stated 2 staff had assisted her to the toilet and they left her in the bathroom with the door almost closed except for a narrow opening. She further stated she thought 2 staff were waiting outside the door until she finished so she attempted to clean herself and when she did she fell forward off the toilet and hit her face and left arm on the wall in front of the toilet. She stated she did not ring the call bell because it happened so quickly and after she fell in the floor she could not reach the call bell. She explained she then realized there were no staff outside the door because it took several minutes before staff came into the bathroom and helped her up into her wheelchair.	F 323	Observations of 12 to 15 staff assisted resident transfers were conducted daily by the licensed nursing staff from 9/22/15 until 10/23/15 for the PIP. The observations will continue at 2 transfers per shift each week for one week, then 1 transfer per shift every week for two months for continued QAPI monitoring. A member of the Administrative Nursing team consisting of DON, ADON, Nurse Supervisor and Clinical Coordinator will observe CNA and/or licensed nurses when providing assistance to residents who use the bathroom or bedside commode for toileting as follows: 4 resident observations for 1 week, then 2 each week for one month, then 1 each week for 1 month. Results of the observations will be reported by the DON in the monthly Quality Assurance Performance Improvement committee monthly meetings. The results will be reviewed and discussed and the QAPI committee will assess and modify the action plan as needed to ensure continued compliance.	

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During an interview on 10/06/15 at 3:02 PM with Nurse #2 she verified Resident #7 required 2 staff assist for transfers and they tried not to leave Resident #7 in the bathroom unattended but if there was only 1 NA on the hall and another resident rang a call bell they left her to go attend to the other resident. She stated during breaks and lunch sometimes there was only 1 NA on hall and she was usually passing medications to residents and if she was in a resident room she couldn't hear if a resident called.

During an interview on 10/06/15 at 2:38 PM with NA #4 she verified she was the NA assigned to Resident #7 on 09/19/15 when she fell in the bathroom. She stated staff were aware Resident #7 was at risk for falls because she had fallen since she had been in the facility. NA #4 explained Nurse #1 helped her transfer Resident #7 onto the raised toilet seat that was positioned over the toilet in her bathroom and they told the resident to ring the call bell when she finished and she left the bathroom door barely open to give the resident privacy. She further explained Nurse #1 went back to her medication cart and then a call bell rang in the central bath on the hall so she left Resident #7's room and went to the central bath. She confirmed when she left Resident #7's room there were no other staff in the room with Resident #7. She stated while she was still in the central bath another NA came in and told her Resident #7 had fallen in her bathroom. She explained she went to Resident #7's room and saw her lying in the floor in front of the toilet with her head against the wall and was bleeding from above her left eye and left elbow. She further explained she left Resident #7's room to answer the call light in the central bath because she thought another NA who was also assigned to

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work on the hall would respond if Resident #7 rang her call bell but later found out the other NA had left the hall and had not told her.

During an interview on 10/07/15 at 8:15 AM with Nurse #1 she confirmed she was the nurse assigned to Resident #7 on 09/19/15. She stated she was giving medications to residents when Resident #7 rang her call bell and said she needed to go to the toilet right away. She explained she stopped giving medications when NA #4 asked for her help and they transferred Resident #7 onto a raised toilet seat in her bathroom because she required 2 staff assist for transfers. She stated Resident #7 was incontinent before they could get her transferred to the toilet so she told NA #4 to clean her and she went back to passing medications to residents. She stated she thought NA #4 had stayed with Resident #7 but a few minutes later she heard a loud noise and went to Resident #7's bathroom to check on her and she was in the floor. She explained Resident #7 was bleeding so after she determined she did not have any broken bones she and other staff who had come to the room moved her and got her into a wheelchair. She stated Resident #7 was bleeding from her head and left elbow and the skin above her left eye was sheared off and she had bruising and swelling over the area. She explained she got the bleeding stopped and checked her vital signs and they were within normal limits. She further explained Resident #7 wanted to be independent and care for herself but she was not physically capable of being independent.

During an interview on 10/07/15 at 9:31 AM the Director of Nursing confirmed Resident #7 had a fall in her bathroom on 09/19/15. She explained

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F 323	Continued From page 14 Resident #7 needed staff assistance with transfers and toileting because she was paralyzed on her left side. She further explained Resident #7 wanted to be independent with her care but was not capable of taking care or herself and was modest with personal care. She stated it was her expectation for staff to respect her privacy but not leave her unattended during toileting.	F 323		
F 520 SS=D	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		10/26/15

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F 520	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in July of 2015. This was for one recited deficiency which was originally cited in July of 2015 on a recertification survey and on the current complaint survey. The deficiency was in the area to provide supervision to prevent accidents. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: Resident #7 was admitted to the facility on 05/07/15 with diagnoses which included heart disease, chronic kidney disease, left sided paralysis from a stroke, difficulty walking, generalized muscle weakness and lack of coordination. A review of the most recent quarterly Minimum Data Set (MDS) dated 08/21/15 indicated Resident #7 was cognitively intact for daily decision making and required extensive assistance by staff for toileting. The MDS also indicated Resident #7 was frequently incontinent of bladder and bowel. A review of a care plan with a problem statement for impaired mobility dated 05/08/15 revealed a goal that staff would anticipate and meet all daily care needs. The approaches indicated to assist with toileting and incontinence care with rounds and as needed and 2 person assist for transfers and assist with positioning as necessary or as requested by resident.	F 520	F520 Quality Assurance It is the policy and practice of the facility to maintain a quality assessment and assurance committee (QAA) consisting of the outlined members that meet monthly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action designed to correct identified quality deficiencies. The facility has policies and procedures designed to maintain these goals. Quality assurance monitoring, physician reviews, consultant reviews, and staff training are examples of the many components utilized. Our Quality Assurance Performance Improvement monitoring for the cited deficiency in the last federal survey involved a resident with wandering and exit seeking behavior that went outside on the grounds unattended. The QAPI monitoring indicated 100% compliance with the actions taken to prevent another occurrence. We are now adding these steps in response to the current citation involving two residents who experienced falls. 1. Corrective actions taken for residents found to have been affected by alleged deficient practice and (2.)for other residents having the potential to be affected by alleged deficient practice: A) A list of residents who require	

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F 520	Continued From page 16 A review of physician's orders dated 09/01/15 indicated Plavix (blood thinner) 75 milligrams (mg) by mouth daily and Aspirin 81 mg by mouth daily. A review of a nurse's note dated 09/19/15 indicated in part at 9:30 AM Resident #7 was observed in the floor in the bathroom. The note documented by Nurse #1 revealed she had assisted Nurse Aide (NA) #4 to transfer Resident #7 to the toilet then stepped out to continue working on her medication pass. The notes further revealed about 2 minutes later Nurse #1 heard a loud noise and went in Resident #7's room to check on her and she was in the floor. The notes indicated Resident #7 stated she was trying to clean herself and lost her balance. The notes further indicated Nurse #1 assessed Resident #7 and she was alert and oriented but she had a skin tear to the left elbow, a skin tear and raised area approximately 1 inch above left eye, swelling around left eye, a bruise to left shoulder with a raised area and she applied a non stick antiseptic mesh gauze and dressings to Resident #7's left elbow and above her left eye. A review of a facility document titled Resident Incident Reports dated 09/19/15 at 9:31 AM revealed Resident #7 had a non-witnessed fall in the bathroom with a skin tear, abrasion, hematoma and bruise. The report indicated Nurse #1 assisted NA #4 and placed Resident #7 on the toilet and left the room to continue with a medication pass. The report further indicated Nurse #1 heard a crash and went into Resident #7's bathroom and saw the resident on the floor in front of the toilet. The report revealed Resident #7 stated she was trying to clean herself and lost	F 520	assistance to the bathroom for toileting needs was developed by nurse management team on 10/14/15. The care guide sheets that include meal and transfer information for each resident was then reviewed and revised to alert staff to not leave residents unattended in the bathroom and to instruct the resident to call for assistance before attempting to clean themselves as applicable. The ADON then met with each of the interviewable residents on this list from 10/15/15 thru 10/20/15 to explain the need for safety precautions and staff supervision to prevent accidents with toileting while maintaining resident dignity to the highest extent possible. B) The DON immediately initiated a safe transfer PIP (performance improvement project) on 9/22/15. The PIP was developed to ensure that resident safety is maintained during transfers and that nurse aides are performing resident transfers according to the indicated transfer status as a result of evaluations conducted by the Therapy Department for each resident. The nurses were given monitoring tools and instructed to observe for, and immediately correct, any potential safety concerns identified in the transfer observations and to determine if a therapy referral/evaluation was needed. The nurse will document on the transfer monitoring tool any negative findings or need for further intervention. The monitoring tools will then be returned to the DON or designee who will then analyze the data for any root causes and	

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F 520	Continued From page 17 her balance. The report further revealed Resident #7 had swelling above her left eye, a skin tear to her left elbow and a bruise on her left shoulder. The report indicated Nurse #1 applied a non stick antiseptic mesh gauze and dressings above Resident #7's left eye and to her left elbow. A review of a therapy note dated 09/19/15 at 11:01 AM indicated Resident #7 was seated in wheel chair in room with bump and blood on left side of face above eye and left elbow due to falling off toilet while trying to complete hygiene with no assistance. During an observation and interview on 10/06/15 at 10:02 AM Resident #7 was seated in a wheelchair next to her bed and had bruising above her left eye and on both cheeks of her face. She explained she was paralyzed on her left side and could not use her left arm because of a stroke and confirmed she recently had a fall in her bathroom when she was trying to clean herself and fell forward off the toilet and hit her face and left arm. She stated 2 staff had assisted her to the toilet and they left her in the bathroom with the door almost closed except for a narrow opening. She further stated she thought 2 staff were waiting outside the door until she finished so she attempted to clean herself and when she did she fell forward off the toilet and hit her face and left arm on the wall in front of the toilet. She stated she did not ring the call bell because it happened so quickly and after she fell in the floor she could not reach the call bell. She explained she then realized there were no staff outside the door because it took several minutes before staff came into the bathroom and helped her up into her wheelchair.	F 520	trending and implement corrective action/interventions as needed. The PIP observations were conducted on 12 to 15 residents daily from 9/22/15 to 10/23/15. 3. The facility Quality Assessment and Assurance Program (QAA), referred to as Quality Assurance Performance Improvement (QAPI), was re-assessed by the Administrator, Assistant Administrator, and Director of Nursing on 10/12/15. The current process of accident reporting/monitoring will remain in place: ¿ Accident/incidents are reported and discussed in morning stand up meeting. Possible causal factors are identified and interventions are implemented as needed. The care plan is updated to reflect any new interventions. ¿ The Therapy Director collects data for any falls that occur each month, analyzes the data to look for trends, root cause analysis etc. She then reports the data and analysis to the facility QAPI Committee monthly for further discussion. The following revisions to the QAPI program were made and approved by the Medical Director and QAPI committee members: New QAPI sub-committee focused on Fall Prevention was implemented where fall risk data and any falls that occur each week are reviewed and discussed to assure appropriate interventions are put into place and that those interventions are effective in preventing reoccurrence. 4. Facility plans to monitor its	

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F 520	Continued From page 18 During an interview on 10/06/15 at 3:02 PM with Nurse #2 she verified Resident #7 required 2 staff assist for transfers and they tried not to leave Resident #7 in the bathroom unattended but if there was only 1 NA on the hall and another resident rang a call bell they left her to go attend to the other resident. She stated during breaks and lunch sometimes there was only 1 NA on hall and she was usually passing medications to residents and if she was in a resident room she couldn't hear if a resident called. During an interview on 10/06/15 at 2:38 PM with NA #4 she verified she was the NA assigned to Resident #7 on 09/19/15 when she fell in the bathroom. She stated staff were aware Resident #7 was at risk for falls because she had fallen since she had been in the facility. NA #4 explained Nurse #1 helped her transfer Resident #7 onto the raised toilet seat that was positioned over the toilet in her bathroom and they told the resident to ring the call bell when she finished and she left the bathroom door barely open to give the resident privacy. She further explained Nurse #1 went back to her medication cart and then a call bell rang in the central bath on the hall so she left Resident #7's room and went to the central bath. She confirmed when she left Resident #7's room there were no other staff in the room with Resident #7. She stated while she was still in the central bath another NA came in and told her Resident #7 had fallen in her bathroom. She explained she went to Resident #7's room and saw her lying in the floor in front of the toilet with her head against the wall and was bleeding from above her left eye and left elbow. She further explained she left Resident #7's room to answer the call light in the central bath because she thought another NA who was also assigned to	F 520	performance to make sure that solutions are sustained. The PIP requiring nurse observations of transfer technique, as described above in Item # 3, was initiated on 9/22/15. Transfer observations were conducted on 12 to 15 residents daily, by the licensed nursing staff, from 9/22/15 until 10/23/15. After this intensified monitoring period was completed, the monitoring continues as follows: 2 resident transfers per shift each week for one week beginning 10/26/15, then 1 resident transfer per shift every week for two months thereafter. The Administrative Nursing team consisting of DON, ADON, Nurse Supervisor and Clinical Coordinator will observe CNAs and/or licensed nurses when providing assistance to residents who use the bathroom or bedside commode for toileting beginning 10/26/15 as follows: 4 resident observations for one week, then 2 residents each week for one month, then 1 monthly for 2 months. Results of the observations stated above will be reported by the DON in the monthly Quality Assurance Performance Improvement committee monthly meetings. The Therapy Director will also report fall data derived from her own monthly review as well as the data reported by the Fall Prevention sub-committee in the monthly meetings. The results will be reviewed and discussed and the QAPI committee will	

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F 520	Continued From page 19 work on the hall would respond if Resident #7 rang her call bell but later found out the other NA had left the hall and had not told her. During an interview on 10/07/15 at 8:15 AM with Nurse #1 she confirmed she was the nurse assigned to Resident #7 on 09/19/15. She stated she was giving medications to residents when Resident #7 rang her call bell and said she needed to go to the toilet right away. She explained she stopped giving medications when NA #4 asked for her help and they transferred Resident #7 onto a raised toilet seat in her bathroom because she required 2 staff assist for transfers. She stated Resident #7 was incontinent before they could get her transferred to the toilet so she told NA #4 to clean her and she went back to passing medications to residents. She stated she thought NA #4 had stayed with Resident #7 but a few minutes later she heard a loud noise and went to Resident #7's bathroom to check on her and she was in the floor. She explained Resident #7 was bleeding so after she determined she did not have any broken bones she and other staff who had come to the room moved her and got her into a wheelchair. She stated Resident #7 was bleeding from her head and left elbow and the skin above her left eye was sheared off and she had bruising and swelling over the area. She explained she got the bleeding stopped and checked her vital signs and they were within normal limits. She further explained Resident #7 wanted to be independent and care for herself but she was not physically capable of being independent. During an interview on 10/07/15 at 9:31 AM the Director of Nursing confirmed Resident #7 had a fall in her bathroom on 09/19/15. She explained	F 520	assess and modify the action plan as needed to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/07/2015

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F 520	Continued From page 20	F 520		

Resident #7 needed staff assistance with transfers and toileting because she was paralyzed on her left side. She further explained Resident #7 wanted to be independent with her care but was not capable of taking care or herself and was modest with personal care. She stated it was her expectation for staff to respect her privacy but not leave her unattended during toileting.

During the recertification survey of 07/24/15 the facility was cited for failure to have interventions in place to prevent 1 of 3 cognitively impaired residents with wandering behavior from exiting, unsupervised from the facility. On 5/12/2015 Resident #191 was seen attempting to leave the facility through a non-alarmed door and 5/21/2015 the resident was found outside by a staff member, approximately 300 feet from the same, non-alarmed exit door. On the current complaint survey F 323 was again recited for failing to provide supervision during toileting for a resident who was at risk for falls.

During an interview on 10/07/15 at 10:30 AM the Assistant Administrator explained Quality Assessment and Assurance Committee meetings were held monthly on the third Tuesday of the month and the last meeting was conducted on 09/15/15. She added during the Quality Assessment and Assurance Committee meeting each citation was reviewed from the recertification and sub-committees were developed as a result of the citations to specifically analyze a citation and implement corrective actions and audit monitoring tools. She stated as a result of the F 323 citation the facility had changed its investigation process to be more thorough. She explained fall

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F 520	Continued From page 21 investigations were reviewed by a fall subcommittee to determine if a Performance Improvement Plan (PIP) was needed. She stated that a PIP was determined on a case by case basis however, the facility was unable to provide documentation related to a Performance Improvement Plan (PIP) related to the fall for Resident #7.	F 520		