AMENDED

During a complaint investigation at Summit View of Farragut, LLC on July 21, 2013, no deficiencies were cited for complaints #31301, #310905, #31566, #31574, or #31716.

F225 was cited related to C/O: #31267. F323 was cited related to C/O: #30916.

483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the

Resident #5 care plan reviewed and updated by MDS Coordinator. Resident #4 and all other residents who have allegations of abuse will be properly reported to the required agencies.

All residents with injuries of unknown origin or allegations of abuse have the potential to be affected. All residents with allegations of abuse have the potential to be affected.

Unit Managers will bring all incident reports to weekly high risk meeting and DON will review for completeness and accuracy. Administrator will sign all incident reports as complete after review. Administrator is responsible for investigating and delegating investigations of unknown origin. A flow sheet will be used to investigate injuries of unknown origin including all nursing procedures and notification process. The Administrator will submit investigations of unknown origin as outlined in the abuse and investigation protocol.

[Signature]

FLOW SHEET

[Date: 7/10/13]
### F 225 Continued From page 1

Investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

Based on review of medical record review, review of facility policy, review of facility investigation documentation, and interview, the facility failed to report an allegation of abuse for one resident (#4) and failed to thoroughly investigate an injury of unknown origin for one resident (#5) of twelve sampled residents.

The findings include:

- Resident #4 was admitted to the facility on August 3, 2011, with diagnoses including Altered Mental Status and Acute Renal Failure.

- Review of an Incident/Occurrence Report dated February 22, 2013, revealed, "...alleged staff handled resident roughly...APS (Adult Protective Services) reports unsure of who staff member is...Investigation started..."

- Review of a facility investigation document signed by the Director of Nursing and dated February 22, 2013, revealed, "...Social Services conducted interviews of other resident family members that..."
SUMMIT VIEW OF FARRAGUT, LLC

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<tr>
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<tbody>
<tr>
<td>F 225</td>
<td>Continued From page 2 are here quite often and also interviewed residents in the unit. An extensive skin assessment was done as well, showing no signs related to an episode of anyone being rough with (resident)...unable to verify the story that was received by APS.</td>
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</table>

Medical record review of nurse's notes dated February 13, 2013, through February 26, 2013, revealed no documentation regarding the allegation of abuse.

Medical record review of a nurse's note dated February 27, 2013, revealed, "informed family that APS had been by because of an abuse had been reported that a staff member had been wrong with him. Staff member had been suspended pending investigation. Family thanked us for investigation."

Review of facility policy titled "Guidelines for Reporting Abuse most recently revised in January 2007, revealed, "...When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following...The State licensing/certification agency..."

Interview with the Administrator on June 28, 2013, at 10:00 a.m., in the Medical Director's office, confirmed the facility failed to report the allegation of abuse as required.

Resident (#5) was admitted to the facility on November 14, 2012, with diagnoses including
Continued From page 3

Alzheimer's Disease.

Medical record review of a nurse’s note dated February 11, 2013, revealed, "...called to (secured unit) by CNA (Certified Nursing Assistant) due to pt (patient) noted with fresh blood on (resident's) shirt, sitting on bed in torn brief with blood smeared on back, face, arms and hands...Mood coming from apparent laceration on back of head...Pressure applied...assessed for further injury. Noted nickel sized black/purple contusion at base of R (right) buttock...Roommate stated pt (patient) had fallen on mat at bedside, but did not hit (resident's) head. Inspection of room revealed no clue as to source of injury..."

Review of facility policy titled "Guidelines for Reporting/Investigation Resident Accidents/Incidents dated August 2007, revealed, "...Management will thoroughly investigate all accidents/incidents involving residents and will document the findings of such investigation on 'Investigation Form..."

Review of facility policy dated June 2006, revealed, "...injury of unknown source is defined as an injury that meet both the following conditions: the injury was not observed by any person or the source of the injury could not be explained by the resident...and...injury is suspicious because of the extent of the injury...or the location of the injury...The following information should be reported...The name(s) of any witnesses to the incident..." Continued review revealed no documentation regarding the identity of the Certified Nursing Assistant (CNA) responsible for reporting the injury or statements from staff on duty at the time the
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| F225 |            | **Continued From page 4**  
Injury was identified or witness statement from the CNA.  
Interview with the Administrator on June 19, 2013, at 11:00 a.m., in the Medical Director's office, confirmed the facility failed to thoroughly investigate an injury of unknown origin for Resident #5. | F225 |            |                                                                                                   |                 |
| C/O: #31267 | 483.20(d)(3), 483.10(k)(2) | RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  
The resident has the right, unless adjudged 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 medical record review, review of facility | F280 |            |                                                                                                   | 7/16/13 |
| F280 |            |                                                                                                   |            |            |                                                                                                   |                 |

All residents with positioning devices were audited for accurate documentation on the care plan and physician orders in place.  
Completed by Unit Managers and reviewed by Director of Nursing.  
In-service Therapy, LPNS and RNs to include MDS Coordinators to ensure orders were written and that care plan was updated with accurate information for all new positioning devices.  MDS Coordinators will review and revise as necessary the care plan quarterly and as the RAI guidelines mandate.
F 280 Continued from page 5

Investigation documentation, and interview, the facility failed to revise the care plan to address the
use of safety devices and positioning of wheelchair seat one resident (#7) of twelve
sampled residents, resulting in a fractured right
hip for Resident #7.

The findings included:

Resident #7 was admitted to the facility on
October 25, 2012, with diagnoses including
Pneumonia, Respiratory Failure, Dementia, and
Atrial Fibrillation.

Medical record review of a Fall Risk Evaluation
dated October 25, 2012, revealed a score of 18
and a score of 10 or higher represented at risk for
falls, and included, "...if resident scored a 10 or
above, interventions should be initiated.
Document interventions below...Bed alarm 72 hrs
(hours) 1/2 SR x 2 (siderails on each side)
non-skid socks Velcro seat belt with alarm when
up in w/c (wheelchair)..." 

Medical record review of a physician's order
dated October 25, 2012, revealed, "1/2 SR x 2 for
mobility Velcro seat belt alarm to w/c (able to
undo on command) with alarm..."

Medical record review of a History and Physical
dated October 26, 2012, revealed, "...CHF
(Congestive Heart Failure)...Depression,
Anxiety...pacemaker placement...Review of
Systems: Unobtainable due to pt (patient) does
not speak English/Dementia..."

Medical record review of an Occupational
Therapy Plan of Treatment For Rehabilitation

Director of Nursing will conduct audits monthly
For 3 months to ensure orders in place and care
plan updated for all new positioning devices and
bring results to Quality Assurance meeting for
review by QA team. Decision on frequency of
checks after 3 months will be determined by QA
after results reviewed.
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<tr>
<td>F 280</td>
<td>Continued From page 8 dated October 28, 2012, revealed, &quot;...unable to follow commands, does not speak English...positioning straps added to prevent pt (patient) from leaning forward and falling from w/c...leaning forward to the floor...leaning to left mainly but frequently moving around in w/c...&quot; Medical record review of a nurse's note dated October 29, 2012, at 9:29 a.m., revealed, &quot;...up in wheel chair with shoulder straps and alarming velcro seatbelt for safety...&quot; Medical record review of an Occupational Therapy End of Week Summary dated October 29 – November 2, 2012, revealed, &quot;...positioned in lowered w/c...in anterior pelvic tilt position, front and rear anti lippers, and seat belt. Seat belt adjusted in back...to decrease slack as pt (patient) was able to stand up with seat belt as tight as possible before adjustment...&quot; Medical record review of a nurse's note dated November 4, 2012, at 2:31 a.m., revealed, &quot;...ambulates with two assist, needs encouragement to straighten up...&quot; Medical record review of a nurse's note dated November 5, 2012, at 7:46 a.m., revealed, &quot;...up most of night. Will not stay in bed...has seat belt when up in chair.&quot; Medical record review of a care plan dated November 5, 2012, revealed, &quot;...has signs and symptoms of memory loss, impulsiveness...At risk for falls related to weakness, poor safety awareness, and dementia...Will receive extensive assistance with transfers...locomotion...Ensure resident wears appropriate, well fitting footwear to minimize the risk of slipping...Mobility...&quot;</td>
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| F 280       | Continued From page 7 devices/equipment: wheelchair and rolling walker Velcro seat belt to wheelchair...Safety training and education as needed Prompt to ask for assistance... Medical record review revealed no documentation regarding Occupational Therapy's recommendations for safe positioning and/or safety devices to prevent falls. Medical record review of a Minimum Data Set (MDS) dated November 8, 2012, revealed the resident "rarely/never" understood others, was severely impaired with decision-making skills and "rarely/never" able to express ideas and wants verbally or non-verbally. Continued review revealed the resident had difficulty concentrating nearly every day. Continued review revealed the resident required extensive assistance with transfers, dressing, and hygiene, did not walk within the resident's room, and required limited assistance to walk in the corridor. Continued review revealed the resident was dependent on staff for locomotion while in a wheelchair and unable to balance without staff assistance when moving from a seated to standing position and walking and had no falls since admission. Medical record review of a Therapy Services Quarterly Screening Form dated November 14, 2014, revealed, "Notes...Therapy recommends merriwalker (wheeled walker/seat combination) to be attempted but continue direct supervision. Resident has been observed to range from ambulating independently requiring min/mod A (minimum/moderate assistance) on same day. Resident requires supervision." Medical record review of a nurse's note dated November 14, 2012, at 2:28 p.m., revealed, "...up
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<td>F 280</td>
<td>Continued From page 8</td>
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<td>In merry walker...crawled out under the strap... Medical record review of a nurse's note dated November 14, 2012, at 2:48 p.m., revealed, &quot;...was up in w/o (wheelchair), self released seat belt alarm and slid to floor, no injuries noted...&quot;</td>
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<td>Review of a Fall Investigation Worksheet dated November 14, 2012, revealed, &quot;...Position of Resident Prior to the Fall Wheelchair...What was resident doing at the time of the fall? Unassisted Transfer...Equipment at Time of Fall Socks Wheelchair...&quot; Review of facility investigation documentation dated November 14, 2012, revealed, &quot;...Location of Incident: Dining Room...Full Description of Occurrence: slid out of w/o onto the floor without injury...Interventions: place resident in recliner when starts releasing seat belt...&quot;</td>
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<td>Medical record review of a care plan dated November 14, 2012, revealed, &quot;Resident fell after self releasing seat belt in w/o...Assist to transfer...Non-skid socks Velcro seat belt alarm Place resident in recliner with pad alarm as needed...&quot; Continued review revealed no documentation regarding Occupational Therapy's recommendations for safety positioning and/or safety devices.</td>
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<td>Medical record review of a nurse's note dated November 22, 2012, at 2:42 a.m., revealed, &quot;...W/C primary mode of transport...gait very unsteady...monitor.&quot; Medical record review of a Skilled Nurse Note dated November 24, 2012, revealed, &quot;...Gait unsteady Weakness Balance Problems...&quot;</td>
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| | Medical record review of an Occupational
### F 280

Continued From page 9

Therapy Plan of Treatment for service dates 10-26-12 through 11-28-12, revealed,
"...Assessment Notes from 10/26/12...unable to follow commands, does not speak English...In
standard wc seat belt, rear anti-lipper, positioning straps added to prevent pt (patient)
from leaning forward and falling from
wc,...leaning forward to the floor and is at high
risk of falling out of wc (positioning straps added
to prevent this)....frequently moving around in
wc...seat belt in place to prevent
standing...Effective 10/26/12 Nursing to
Incorporate adaptive equipment/strategies into
pt's daily routine...Reason(s) for Discharge: Pt
has met max (maximum) potential with
positioning program. Pt tolerates w/o tilt
position to prevent sliding from wc. Positioning
straps used to prevent leaning forward and
falling...seat belt in place to prevent standing,..."

Interview with the MDS/Care Plan Coordinator on
June 21, 2013, at 1:23 p.m., in the Medical
Director's office, confirmed the care plan had not
been revised to address the positioning and/or
safety devices required to prevent falls for
Resident #7.

Refer to F323.

C/O: #30916

### F 323

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.
SUMMIT VIEW OF FARRAGUT, LLC

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of facility investigation documentation, and interview, the facility failed to ensure the use of an effective safety device to prevent falls for one resident (#7) of twelve sampled residents, resulting in a fractured right hip for Resident #7.

The findings included:

Resident #7 was admitted to the facility on October 25, 2012, with diagnoses including Pneumonia, Respiratory Failure, Dementia, and Atrial Fibrillation.

Medical record review of a Fall Risk Evaluation dated October 25, 2012, revealed a score of 18 and a score of 10 or higher represented at risk for falls, and included, "...If resident scored a 10 or above, interventions should be initiated, Document Interventions below...Bad alarm 72 hrs (hours) 1/2 SR x 2 ( siderails on each side) non-skid socks Velcro seat belt with alarm when up in w/c (wheelchair)..."

Medical record review of a physician's order dated October 25, 2012, revealed, "1/2 SR x 2 for mobility Velcro seat belt alarm to w/c (able to undo on command) with alarm..."

Medical record review of a History and Physical dated October 26, 2012, revealed, "...CHF (Congestive Heart Failure)...Depression,

Audit completed by 7/10/13 on all residents with safety devices in place to ensure they were an appropriate, functioning intervention by Physical and Occupational Therapists.

Adjustments made as necessary to update care plan to safest possible device. Newly Created Safety and Positioning List 7/10/13 brought to IDT team to include Physician/NP, MDS coordinator, Therapy Manager, Administrator, DON, nurse managers and Social Services Director. List was approved by IDT team and this list will be brought weekly to the IDT meeting for review and correction as necessary.

All staff in-serviced on 7/8/2013 regarding safety device use and they will immediately notify the charge nurse of any non-functioning intervention. Any
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</table>
| F 323      | Continued From page 11 Anxiously...pacemaker placement...Review of Systems: Unobtainable due to: pt (patient) does not speak English/Dementia...  
Medical record review of an Occupational Therapy Plan of Treatment For Rehabilitation dated October 26, 2012, revealed, "...unable to follow commands, does not speak English...positioning straps added to prevent pt (patient) from leaning forward and falling from w/c...leaning forward to the floor...leaning to left mainly but frequently moving around in w/c..."  
Medical record review of a nurse's note dated October 29, 2012, at 9:29 a.m., revealed, "...up in wheel chair with shoulder straps and alarming velcro seatbelt for safety..." Medical record review of a nurse's note dated October 31, 2012, at 11:13 p.m., revealed, "...with increased agitation and attempts to undress self...refused to take po (oral) meds (medication) for agitation..."  
Medical record review of an Occupational Therapy End of Week Summary dated October 29 - November 2, 2012, revealed, "...positioned in lowered w/c...in anterior pelvic tilt position, front and rear anti tippers, and seat belt. Seat belt adjusted in back...to decrease slack as pt (patient) was able to stand up with seat belt as tight as possible before adjustment."  
Medical record review of a nurse's note dated November 4, 2014, at 2:31 a.m., revealed, "...ambulates with two assist, needs encouragement to straighten up..." Medical record review of a nurse's note dated November 5, 2012, at 7:48 a.m., revealed, "...up most of night. Will not stay in bed...has seat belt when up..." employees not present for in-services will be educated prior to return to work by Staff Development. The Charge nurse will seek intervention through the Physician or Nurse Practitioner after thorough assessment of the safety device. Changes will be reflected on care plan. Therapy Manager will be responsible for updating Safety and Positioning device list. Nurse Aides will use Cardex system inserted into ADL books and sign off each shift that devices were in place. They will also be checked PRN throughout the shift. The Cardex is the care plan listed so all staff have access to updated care plans as needed. These are updated monthly and as changes occur. | F 323 | Weekly IDT Team (Therapy Manager, DON, Administrator, MD/NP, MDS Coordinator, Unit Managers and Social Worker) will review. Safety and Positioning Device List and therapy manager will update list to reflect the changes that have been made. This device list will be taken to the QA meeting and analyzed to ensure process is functioning as intended for following 3 QA meetings. (QA consists of same members as IDT Team) |
F 323 Continued from page 12

in chair."

Medical record review of a care plan dated November 5, 2012, revealed, "...has signs and symptoms of memory loss, impulsiveness...At risk for falls related to weakness, poor safety awareness, and dementia...Will receive extensive assistance with transfers...locomotion...Ensure resident wears appropriate, well-fitting footwear to minimize the risk of slipping...Mobility devices/equipment: wheelchair and rolling walker Velcro seat belt to wheelchair...Safety training and education as needed. Prompt to ask for assistance..."

Medical record review of a Minimum Data Set (MDS) dated November 8, 2012, revealed the resident "rarely/never" understood others, was severely impaired with decision-making skills and "rarely/never" able to express ideas and wants verbally or non-verbally. Continued review revealed the resident had difficulty concentrating nearly every day. Continued review revealed the resident required extensive assistance with transfers, dressing, and hygiene, did not walk within the resident's room, and required limited assistance to walk in the corridor. Continued review revealed the resident was dependent on staff for locomotion while in a wheelchair and unable to balance without staff assistance when moving from a seated to standing position and walking and had no falls since admission.

Medical record review of a physician's order dated November 14, 2012, at 12:00 p.m. revealed, "Cleared for dis (discharge) home today with son."
Continued From page 13

Medical record review of a Therapy Services Quarterly Screening Form dated November 14, 2014, revealed, "Notes...Therapy recommends memnwalker (wheelied walker/seat combination) to be attempted but continue direct supervision. Resident has been observed to range from ambulating independently to requiring min/mod A (minimum/moderate assistance) on same day. Resident requires supervision."

Medical record review of a nurse's note dated November 14, 2012, at 2:28 p.m., revealed, "...up in merry walker...crawled out under the strap..."

Medical record review of a nurse's note dated November 14, 2012, at 2:48 p.m., revealed, "...was up in w/c (wheelchair), self released seat belt alarm and slid to floor, no injuries noted..."

Medical record review of a physician's order dated November 14, 2012, revealed, "Disregard...previous orders regarding a discharge today."

Review of a Fall Investigation Worksheet dated November 14, 2012, revealed, "...Position of Resident Prior to the Fall Wheelchair...What was resident doing at the time of the fall? Unassisted Transfer...Equipment at Time of Fall Socks Wheelchair..." Review of facility investigation documentation dated November 14, 2012, revealed, "...Location of Incident: Dining Room...Full Description of Occurrence: slid out of w/c onto the floor without injury...Interventions: place resident in recliner when starts releasing seat belt..."

Medical record review of a care plan dated November 14, 2012, revealed, "Resident fell after..."
**SUMMARY STATEMENT OF DEFICIENCIES**

**ID** PREF IX **TAG**

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<td>Continued From page 14 self releasing seat belt in w/c...Assist to transfer...Non-skid socks Velcro seat belt alarm Place resident in recliner with pad alarm as needed...&quot;</td>
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<td>Medical record review of an Occupational Therapy Plan of Treatment for service dates 10-26-12 through 11-26-12, revealed, &quot;...Assessment Notes from 10/26/12...unable to follow commands, does not speak English (resident spoke Farsi)...In standard w/c seat belt, rear anti-tippers, positioning straps added to prevent pt (patient) from leaning forward and falling from w/c...leaning forward to the floor and is at high risk of falling out of w/c (positioning straps added to prevent this)...frequently moving around in w/c...seat belt in place to prevent standing...Effective 10/26/12 Nursing to Incorporate adaptive equipment/strategies into pt's daily routine...Reason(s) for Discharge: Pt has met max (maximum) potential with positioning program, Pt tolerates w/c in tilt position to prevent sliding from w/c. Positioning straps used to prevent leaning forward and falling...seat belt in place to prevent standing...&quot;</td>
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<td>Medical record review of a physician's order dated November 26, 2012, revealed, &quot;PT to eval &amp; Tx (evaluate and treat).&quot;</td>
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F 323 Continued From page 15

Medical record review of an Initial Physical Therapy Evaluation dated November 26, 2012, revealed the resident had poor balance while moving, required minimum assistance with transfers, and included, "...Discharge Plan: Long Term Care..."

Medical record review of a nurse’s note dated November 28, 2012, at 10:21 p.m., revealed, "...had a witness (witnessed) fall without injury at (5:20 p.m.), pt (patient) took off seatbelt and got up quickly out of w/c fall on buttock..." Continued review revealed no documentation regarding positioning shoulder straps.

Review of a Fall Investigation Worksheet dated November 28, 2012, revealed, "...Position of Resident Prior to Fall Wheelchair...What was resident doing at time of fall? Unassisted Ambulation...Mental Status Prior to Fall Confused...Footwear/Equipment at Time of Fall Slippers Wheelchair..." Continued review revealed no documentation regarding positioning straps. Review of facility investigation documentation dated November 28, 2012, revealed, "...Time of Fall: 5:20 (p.m.) Location of Incident: Dining Room...Full Description of Occurrence: pt took seat belt off. Stood up quickly and chair roll (rolled) from under pt. Landed on buttock New intervention pad alarm in recliner, encourage (resident) to sit in the recliner...Bruise," Continued review revealed no documentation regarding positioning straps.

Interview with the Administrator on June 21, 2013, at 10:38 a.m., in the Medical Director's office, revealed a secured unit activity employee clocked out at 5:15 p.m., the facility was unable to
F 323 Continued From page 16
verify the positioning straps were in place at the
time the resident removed the seat belt, fell and
fractured the resident's right hip on November 28,
2012.

Medical record review of a physician's order
dated December 2, 2012, revealed, "Obtain x-ray
of Rt (right) hip due to pain in that area."

Medical record review of an x-ray report dated
December 2, 2012, revealed, "...No definite
radiographic evidence of acute fracture or
dislocation. If symptoms persist, consider
follow-up radiographs in order to evaluate for
initial radiographically occult fracture..."

Medical record review of a nurse's note dated
December 3, 2012, at 3:35 a.m., revealed, "While
putting resident into bed, CNA (Certified Nursing
Assistant) reports finding large greenish-colored
bruise on resident's right hip. When resident was
examined...appeared to have pain on any
movement or touching of...right hip..."

Medical record review of a physician's progress
note dated December 3, 2012, revealed, "...seen
for reports of difficulty walking since yesterday.
This is accompanied by some bruising. She has a
history of gait disturbance...son is present and
assists with translation. He reports that (resident)
has pain in (resident's) right hip..."

Medical record review of a physician's order
dated December 3, 2012, revealed, "...CT
(computed tomography) Scan R (right) hip no
contrast..."

Medical record review of a CT Scan report dated
December 5, 2012, revealed, "...Nondisplaced fracture is present through the greater trochanter, with fracture line extending into the posterior base of the femoral neck superiorly...Suspect this is an acute to subacute fracture...Impression: Acute, subacute fracture of the right greater trochanter..."

Medical record review of a physician's order dated December 5, 2012, revealed, "Sent to (hospital) for evaluation CT + (positive) for hip fx (fracture)."

Interview with CNA #1 on June 19, 2013, at 1:58 p.m., in the Medical Director's office, revealed the CNA provided restorative ambulation for the resident and included "...could tell (resident) needed things by body language,...(resident) could undo seat belt when told...positioning straps were used to prevent leaning. (Resident) would take them off..."(Resident) could roll seat belt around on (resident's) own..."

Interview with the Activities Director (AD) on June 21, 2013, at 10:17 a.m., in the Medical Director's office, revealed the AD worked as a Restorative CNA prior to the resident's hip fracture. Continued interview revealed, "...(resident) so fast (and) fidgety...one (employee) would push wheelchair and other hold on to (resident)...in (resident's) wheelchair (resident) so fidgety would bend down a lot and play with (resident's) shoes...short wheelchair...a belt self releasing alarm, shoulder straps...was so tiny (resident) would fidget and straps would fall to side. (It) was a constant thing with (resident's) straps. (Resident) would always 'dust the floor' (sweeping gestures)...Was always trying to do something,
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stand whatever... was just so fidgety."

Interview with the Director of the Rehabilitation Department on June 21, 2013, at 11:38 a.m., in the Medical Director's office, revealed numerous safety interventions had been attempted for the resident. He stated, "When the plan is to go home we try to keep them as mobile as possible... sometimes return to device attempted before..."

Interview with the Medical Director on June 21, 2013, at 12:30 p.m., in his office, revealed adequacy of a safety device was determined by the reason for use of a device and if the device was appropriate for the resident. Continued interview confirmed the facility failed to provide an effective safety device to prevent falls from a wheelchair after the resident unfastened the self-release seat belt. The facility's failure resulted in a fractured hip for Resident #7, who was known to remove the seat belt, removed the seat belt and fell from the wheelchair. The facility also failed to ensure shoulder straps were in place to prevent the resident's fall.

C/O: #30916