The facility will 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 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 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 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 to 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.
The facility will have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations will be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident.

and if the alleged violation is verified appropriate corrective action will be taken. The facility will thoroughly investigate falls and other incidents/accidents affecting residents of the facility. Policy updated 9-15-11 to include form that will be completed for every unusual happening or incident involving a resident. Incident may be defined as an accident, injury noted, complete incident report...Leave no blanks...State only what was witnessed. Do not make assumptions...

Resident #1 was admitted to the facility on July 28, 2011, with diagnoses including Hypothyroidism, Degenerative Joint Disease, and Schizoaffective Disorder. Medical record review of the Minimum Data Set (MDS) dated August 15, 2011, revealed a Brief Interview for Mental Status (BIMS) score of 14 and a score of 13-15 indicated cognition was
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continued from page 2

Intact. Medical record review of a nurse's note dated August 6, 2011, at 12:30 p.m. revealed, "noted to be sitting on floor. No visible injury."

Review of facility investigation documentation dated August 6, 2011, revealed the person to whom the fall was reported and medications that could have contributed were not identified, and included "...Witnessed by (Name) (section was blank) ...facts observed at scene of incident. Resident found sitting on floor ...Ask the Resident what precipitated the fall ... (section was blank) ...Causative Factor: Resident was sitting in wc (wheelchair) stood up wc moved resident lost balance ..." Continued review revealed no additional investigational documentation.

Interview with the Director of Nursing on September 12, 2011, at 2:55 p.m., in a conference room, confirmed the facility failed to thoroughly investigate the resident's fall on August 6, 2011. Resident #2 was admitted to the facility on October 22, 2011, with diagnoses including Macular Degeneration and Dementia.

Medical record review of the MDS dated June 23, 2011, revealed the resident was severely impaired with decision-making skills, non-ambulatory, and had no history of falls.

Medical record review of a nurse's note dated August 21, 2011, at 6:30 p.m., revealed, "...flip out of chair and hit head on floor ...

Review of facility investigation documentation dated August 21, 2011, revealed the form was completed by licensed practical nurse (LPN #1) and included, "Accident ...Report ...facts observed at scene ...Resident lying in floor on R (right) side ...Causative factors: CNA (certified nursing assistant) #1 was pushing the WC the resident was sitting on."
F 225 Continued from page 3
Interview with CNA #1 on September 12, 2011, at 10:48 a.m., revealed CNA #1 left the resident seated in a wheelchair unattended to obtain linen from a linen cart, in the hallway and saw the resident fall from the wheelchair as CNA #1 re-entered the resident’s room.

Interview with LPN #1 on September 12, 2011, at 11:14 a.m., in a conference room, revealed LPN #1 completed the report regarding the resident’s fall on August 21, 2011, the form was completed before an investigation was completed, and LPN #1 stated, “…The talk in the room (at the time of the fall) was that the CNA was pushing the resident (in wheelchair). I don’t know that’s what happened. The fall investigation was filled out in error…it contains hearsay…”

Interview with the DON on September 12, 2011, at 2:50 p.m., in a conference room, confirmed the facility failed to thoroughly investigate the resident’s fall on August 21, 2011.

Resident #4 was admitted to the facility on January 20, 2010, with diagnoses including Dementia and Recurrent Hip Fractures with Falls. Medical record review of the MDS dated August 25, 2011, revealed the resident was impaired with decision making skills, needed limited assistance with ambulation, and had a history of falls. Medical record review of a nurse’s note dated August 27, 2011, revealed, “…lying on L side…”

Review of facility investigation documentation dated August 27, 2011, revealed, “…Incident Date: 8/27/11…Type: Unattended Fall Witnessed by (name deleted)…Medications that could have contributed to incident (space was blank)…Causative factor: Resident had not slept much that night…” Review of a Fall Investigation, Evaluation, and Interventions Form dated August 27, 2011, revealed, “…NEW Interventions: (Note
F 225 Continued From page 4
Immediate interventions implemented: (space was blank)." Interview with the DON on September 12, 2011, at 1:35 p.m., in a conference room, confirmed the facility failed to thoroughly investigate the resident’s fall on August 27, 2011.

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.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of facility investigation documentation, observation, and interview, the facility failed to provide adaptive devices and/or adequate supervision to prevent falls for one resident (2#) of five sampled residents, resulting in a subdural hematoma and fractured cervical spine, actual harm for Resident #2.
The findings included:
Resident #2 was admitted to the facility on October 22, 2001, with diagnoses including Hypertension, Macular Degeneration, and Dementia.
Medical record review of the Minimum Data Set (MDS) dated June 23, 2011, revealed the resident was severely impaired with decision-making skills, moderately visually impaired, non-ambulatory, and dependent on

The ADON will review incident reports during Morning Meetings Monday thru Friday and report to the DON.
The DON will monitor fall/incident reports through record review and report to the QA committee.
The committee consists of the Medical Director, Administrator, DON, ADON, MDS Coordinator, Staff Development, Medical Records Director, Activity Director and Social Service Director.
QA will review falls on a monthly basis and make any further recommendations and/or interventions to be implemented if applicable.
Resident #1 was referred to Psych services on 8-8-11;
Resident ambulates with cane and does not use wheelchair. Therefore wheelchair was removed from room on 8-6-11; PT educated resident on safety with transfers and instructed to use call light and ask for assistance will all out of bed activities on 8-8-11. Resident’s care plan was updated on 8-6-11 to reflect event of fall with the following interventions:
Psych. Services prn; continue P.T., remove w/c from room.
Pharmacy reviewed resident’s medications 9-25-11.
Continued From page 5

staff for mobility. Continued review revealed the resident had no history of falls, had not moved from a seated to standing position, transfer was coded 2 (2 = Not steady, but only able to stabilize with hand assistance).

Medical record review of a Fall Risk Assessment dated June 23, 2011, revealed a score of 10 and included, "...Total score of 10 or above represents HIGH RISK."

Medical record review of a care plan in effect on August 21, 2011, and effective through September 20, 2011, revealed, "...08/12/2010 ...Potential for injury R/T (related to) falls secondary to psychotropic medications therapy, unsteady with transfers, non-ambulatory, visual dysfunction and mental error of senile dementia which may prevent resident from recognizing safety hazards...remain free from injury secondary to falls...Provide adaptive devices as needed...uses w/c (wheelchair) Remind resident and reinforce safety awareness...PT/OT (physical therapy/occupational therapy) consults as needed..."

Medical record review of a recapitulation (brief summary) of physician orders dated August, 2011, revealed no documentation regarding a wheelchair and included, "..."Safety & Devices"** May be up in G/C (geri-chair) in reclining position for comfort..."

Medical record review of a nurse's note dated August 21, 2011, at 6:20 p.m., "CNA (certified nursing assistant) pushing resident in WC (wheelchair) stated that resident put (resident's) feet down causing (resident) to flip out of chair and hit head on floor resident noted to have open area to forehead CNA called nurse to room (resident's)...Resident noted (to) be lying in floor on Rt (right) side in floor..."
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Medical record review of a physician’s order dated August 21, 2011, revealed, "May send to ER (emergency room) to evaluate and treat."
Medical record review of a nurse’s note dated August 21, 2011, at 6:30 p.m., revealed, "Ambulance service arrived and called for Lifestar (airborne medical transportation) to transport resident to (hospital) D/F (due to) head injury..."
Medical record review of an Emergency Provider Record dated August 21, 2011, revealed, "...chief complaint: Fall injury to: forehead...nursing home...context: fell from wheelchair...
...Impression: Subdural Hematoma/Cervical Dens Fx (fracture)."
Medical record review of an Emergency Department nurse’s note dated August 21, 2011, at 7:45 p.m., revealed, "...fall from...w/c (wheelchair), pt struck head on floor...star shaped lac (laceration) to R (right) forehead...
Medical record review of a CT (computed tomography) C-Spine (cervical spine) dated August 21, 2011, revealed, "Reason for Exam fell from chair onto forehead...
...Impression: Non-displaced type II dens fracture with slight posterior angulation." Medical record review of a CT head dated August 21, 2011, revealed, "...Findings: A small right posterior temporal/occipital subdural hematoma measures 7 mm (millimeters) in thickness ...
...moderate sized right frontal soft tissue laceration is noted...
Review of facility investigation documentation provided by the facility on September 9, 2011, revealed, "Accident...Report...Incident Date 8/21/11...State facts observed at scene of incident: Resident lying in floor on R (right) side...
...Part of body Affected: Skull or scalp Type of on 9-25-11.
Resident #4 had PT screening due to fall on 08-27-11. PT screening obtained on 8-31-11.
U/A on 8-27 determined resident had UTI; X-Ray on 8-27 revealed resident had dx pneumonia, treated with antibiotic tx.
P.T. screening performed 8-31-11.
Pharmacy reviewed resident’s medications on 9-25-11.
Care Plan was updated on 8-27-11.
F323

The facility will 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.

The facility will provide adaptive devices and/or adequate supervision to prevent falls for residents in the facility.
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<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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Injury: Fracture, Resident activity when....occurred: sitting in W/C (wheelchair)...Causative factors: CNA was pushing the W/C, the resident was sitting on, when resident went into floor."

Review of facility investigation documentation provided by the facility on September 12, 2011, revealed an undated handwritten statement (CNA #1), and included, "...went into resident's room to get...bed ready....did not notice the resident moving...feet back and forth but...did that sometimes...I walked out of the room to the linen cart...When I was about to enter the room, I saw (resident) falling...I tried to get to (resident) but (resident) had already fallen face first. I immediately took the wash clothes and applied pressure to (resident's) forehead. I yelled for the nurse. I noticed (resident's) foot was between the small wheel and the big wheel on...wheelchair..."

Review of facility investigation documentation (handwritten statement (licensed practical nurse - LPN #1) provided by the facility on September 9, 2011, revealed the statement was undated and included, "...Resident...was lying in floor on...side blood was present on forehead and in the floor...made preparations for the resident to go to emergency room."

Review of facility investigation documentation (handwritten statement, LPN #2) provided by the facility on September 9, 2011, revealed the statement was undated and included, "...Resident was lying face down on floor and was noted to be bleeding. Resident also was noted to be trying to move (resident's) head...noticed the foot pegs (wheelchair foot rests) were not on wheelchair one was lying beside...chest of drawers and one was by...closet..."

Review of facility investigation documentation

Resident #2 was admitted to hospital 8-21-11 and returned 9-1-11. Foot props were attached to wheelchair by ADON and care plan was updated to reflect the foot props on 9-2-11. Foot props are to be in place on wheelchair when resident is in w/c.

On 9-2-11 fall risk assessment was performed by MDS Coordinator.

On 9-6-11 a Significant Change MDS was performed. On 9-12-11 a side rail assessment was performed by MDS Coordinator. Orders for Side rails on 9-12-11 and placed on resident bed with monitoring every 30 minutes with repositioning q 2 hours and prn. Pharmacy reviewed resident's medications 9-25-11.

All residents charts were reviewed by ADON, Care Plan Coordinator and MDS Coordinator along with observation, to determine if any residents had orders for assistive devices that were not being utilized or had been discontinued without physician orders. Completed on 9-19-11.
The charge nurses will observe every shift for use of assistive devices with residents with orders.

Utilizing record review and observation, the ADON will review orders for assistive devices and determine resident application daily M-F and report to the DON. The weekend RN Supervisor will review orders for assistance devices to determine resident application daily on weekends. The DON will monitor utilizing observation and record review to monitor assistive devices and resident applications and report to the QA committee consisting of Medical Director, Administrator DON, ADON, Social Services MDS Coordinator, Rehab Manager, Medical Records, Dietary Manager Staff Development Coordinator, Activity Director, Maintenance Supervisor and Housekeeping Supervisor.

QA will review assistive devices on a monthly basis and make any further recommendations and/or interventions to be implemented if applicable.
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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| F 323 | Continued From page 9 | History: Medical record review of an Occupational Therapy (OT) Evaluation dated April 12, 2010, revealed, "...Fall Precautions ...reason for referral ...address W/C (wheelchair) positioning needs (sitting needs) ...Safety Awareness poor ...Balance: ...Sitting poor ..." Medical record review of an OT progress report dated May 17, 2010, revealed," ...D/C (discharge) ...with W/C with L (left) side supports to decrease L lateral (side) lean, anti-thrust cushion to prevent sliding forward and B (bilateral) leg protectors ...and prevent LE (lower extremities) from sliding off." Medical record review of a physician's order dated May 26, 2010, revealed, " ...OT ...D/C (discharged) with side support on L side, anti-thrust cushion and swing away foot rest for W/C sitting for (upright) positioning and (increased) safety ..." Interview with LPN #1 on September 12, 2011, at 11:14 a.m., in a conference room, revealed LPN #1 was familiar with the resident, and LPN #1 stated, " ...No safety devices were used ...no postural or balance problems I know of." Telephone interview with LPN #2 on September 12, 2011, at 11:50 a.m., revealed LPN #2 was familiar with the resident, and LPN #2 stated, "... (resident) usually up in a wheelchair. (Resident) previously had been in a geri-chair and one of the therapists decided (resident) would be better off in a wheelchair. I did not realize (resident) had order for geri-chair ...think a while back (therapist) made a recommendation for a wheelchair." Interview with Assistant Director of Nursing #1 on September 12, 2011, at 11:58 a.m., in a conference room, revealed the wheelchair in the resident's room was the same wheelchair the resident fell from on August 12, 2011. Observation with the Director of Nursing and COTA (certified occupational therapy assistant)
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#1 on September 12, 2011, at 12:00 p.m., revealed the resident's wheelchair had no left lateral side support and swing away footrests were in the seat of the wheelchair.

Interview with COTA #1 on September 12, 2011, at 12:45 p.m., in the 300 hall, revealed the resident had used a left lateral side support on the wheelchair at one time and no explanation for the support not being used.

Interview with Assistant Director of Nursing #1 on September 12, 2011, at approximately 2:30 p.m., in a conference room, revealed the facility had no documentation the ordered adaptive equipment had been discontinued.

Telephone interview with M.D. #1 on September 12, 2011, at 3:22 p.m., revealed M.D. #1 had observed the resident attempt to stand at times and he stated, "...Sometimes (resident) would rock forward like a rocking chair...Mistakes were made for sure..." Continued interview confirmed the facility had failed to provide adaptive equipment and/or adequate supervision to prevent falls for Resident #1, resulting in a Subdural Hematoma and Fractured Cervical Spine.

C/O: #28659