INITIAL COMMENTS

Complaint investigations were conducted from 12/20/13 to 1/31/14 for Intakes: TN00031918, TN00032055, TN00032084, TN00032347, TN00032470, TN00033027 and TN00033048. The following complaints had a deficiencies cited: F 159 was cited for Intake: TN00031918; F 281 was cited for Intake: TN00033027; F 309 was cited for Intake: TN00032084; F 314 was cited for Intake: TN00033027 and F 323 was cited for Intakes: TN00032084 and TN00033027

No regulatory violation was found for Intakes: TN00032055, TN00032347, TN00032470 and TN00033048.

F 159

483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system

1) Resident #5 no longer resides in the facility.

2) Current residents have the potential to be affected by this alleged deficiency. Current resident trust funds have been audited. No other Residents were found to be affected.

2/25/14
F 159 Continued From page 1

that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:

Intake: TN00031918

Based on review of the resident's trust fund, it was determined the facility failed to retain a copy of receipts for all transactions for 1 of 3 (Resident #5) sampled residents with an account in the resident trust fund.

The findings included:

Review of Resident #5's trust fund account documented "Insurance Premiums" were paid on

3) Resident Trust Funds will be maintained according to facility policy. The Business Office Manager will retain a copy of any transaction for a Resident's Trust Fund. The Administrator/designee will do random audits of the Trust Fund account book to ensure accurate accounts.

4) Results of the audits will be presented by the Administrator monthly to the Quality Assurance Committee for three months and randomly thereafter.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER:

445440

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

C

01/31/2014

NAME OF PROVIDER OR SUPPLIER

GALLAWAY HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE

435 OLD BROWNVILLE RD

GALLAWAY, TN 38036

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 159 Continued From page 2

11/9/11 for the amount of $23.06; 11/28/11 for the amount of 145.65 and 2/21/12 for the amount of 364.09. There was no documentation of payments for insurance premiums after 2/21/12. The facility was unable to provide documentation why the insurance premiums were not paid after 2/21/12.

Review of Resident #5's trust fund account documented the purchases of "Personal Needs Items" on 8/2/12 for the amount of $200.00; 8/27/12 for the amount of $29.13; 10/26/12 for the amount of $150.00; 11/6/12 for the amount of $27.8; and 2/19/13 for the amount of $99.23. The facility was unable to provide receipts for the purchases of these personal needs items.

F 281

SS=D

483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Intake: TN00033027

Based on policy review, medical record review and observation, it was determined the facility failed to ensure staff maintained professional standards of practice by not cleaning an injection site prior to administering an injection for 1 of 1 (Resident #15) sampled resident observed receiving an intramuscular injection.

The findings included:

Review of the facility's "Intramuscular Injections"

ID PREFIX TAG

F 159

F 281

1) Resident #15 has received ordered injections per policy. Resident #15's skin was assessed by the DON to determine if any infection was present at the injection site. Results of the assessment were negative.

2) Current residents whom receive injections have the potential to be affected by this alleged deficiency. Residents who receive injections were audited and are receiving injections as ordered by physician and per facility policy.

2/25/14
### F 281
Continued From page 3

policy documented, "...6. Clean the site with an alcohol swab using a circular motion from the proposed site of injection outward...

Medical record review for Resident #15 documented an admission date of 1/15/09 with diagnoses of Diabetes Mellitus, Peripheral Neuropathy, Anemia, Seizure Disorder, Apoplexy, Arthritis, Hypertension, Gastroesophageal Reflux Disease, Benign Prostate Hypertrophy, Depression, Anxiety, Constipation, Inguinal Hernia, History of Stroke, and Chronic Pain. Review of the physician's order signed 1/11/14, documented "...CYANOCOBALAMIN [Vitamin B12] 1000MCG/1ML [micrograms per milliliter]...INJECT 1ML [milliliter] EVERY MONTH (15TH)..."

Observations in Resident #15's room on 1/15/14 at 11:45 AM, Nurse #3 told Resident #15 she was going to give him his B12 injection. Nurse #3 washed her hands, donned gloves, raised the sleeve of his shirt on his left arm, and injected the medication into his deltoid muscle. Nurse #3 did not clean the site with an alcohol swab prior to the injection.

### F 309
483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced

---

3) The following steps will be taken to ensure that injection sites are properly prepared prior to injections: 1) Licensed Nurses will be re-educated on the proper technique of cleaning the skin prior to an injection 2) the Director of Nurses will conduct random observations of Licensed Nurses as they prepare injection sites for Residents receiving injections.

4) Results from the DON's random observations of Licensed Nurses preparing injection sites will be presented at the monthly Quality Assurance Meeting by the DON.
Continued From page 4 by:
Intake: TN00032084

Based on medical record review and interview, it was determined the facility failed to follow physician's orders for a podiatry consult, when the podiatrist visited on 11/15/13 for 1 of 3 (Resident #1) sampled residents with physician's orders for a podiatry consult.

The findings included:

Medical record review for Resident #1 documented an admission date of 5/1/08 with diagnoses of Diabetes Mellitus, Dementia, Congestive Heart Failure, Hypertension and Peripheral Artery Disease. Review of the physician's orders dated 11/1/13 documented, "Podiatry Consult." The Podiatrist visited the facility on 11/15/13. The facility was unable to provide documentation that Resident #1 received a podiatry consult during the podiatrist's visit to the facility on 11/15/13.

During an interview in the Director of Nursing's (DON) office on 12/23/13 at 11:05 AM, the DON stated, "If he [Resident #1] had a podiatry consult and his insurance doesn't pay, the facility will pay for the podiatry care."

During an interview in the conference room on 12/23/13 at 11:45 AM, the social service director (SSD) stated that Resident #1 was on the list to be seen on 11/15/13 by the podiatrist. The staff member did not know to go ahead and have the resident seen by the podiatrist even though his insurance did not cover the cost. The facility picked up the cost. He is a diabetic. He is on the list to be seen by the podiatrist on 1/17/14.

1) Resident #1 had a podiatry appointment on January 17, 2014. His next appointment will be March 21, 2014. He has been placed on a routine rotation list.

2) Current residents have the potential to be affected by this alleged deficiency.

3) Residents will be provided with podiatry services as needed. Social Services will maintain a rotation list for the podiatrist. Podiatry appointments are reviewed daily in Stand Up Meeting. Social Services or designee will audit the podiatry documentation sheet after each podiatry visit to ensure Resident was treated. The treatment sheet will be maintained in the Medical record.

4) Results of audits will be presented to the Quality Assurance Committee monthly by the Director of Social Services for three months and randomly thereafter.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLAIRE IDENTIFICATION NUMBER: 445440

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED 01/31/2014

NAME OF PROVIDER OR SUPPLIER
GALLAWAY HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE
438 OLD BROWNSVILLE RD
GALLAWAY, TN 38036

(X4) ID PREFIX TAG
F 314

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Intake: TN00033027

Based on medical record review and observation, it was determined the facility failed to ensure the treatments for pressure ulcers were completed as ordered for 2 of 5 (Residents #8 and 13) sampled residents reviewed with pressure ulcers.

The findings included:

1. Medical record review for Resident #8 documented the resident was original admission date to the facility was 6/20/13 and readmission 10/9/13 with diagnoses of End Stage Renal Disease, Dialysis, Diabetes Mellitus, Chronic Pain, Morbid Obesity, Anemia, Osteomyelitis, Muscle Spasms, Constipation, Anxiety, Depression, Diabetic Neuropathy, Hypothyroidism and Pressure Ulcer. Review of the recertification orders signed 1/14/14 documented, "...12/06/13: USE HEEL PROTECTORS DAILY WHILE RESIDENT IN BED AS RESIDENT WILL COMPLY... 12/20/13: CLEAN (R [right]) HEEL WOUND WITH WOUND SPRAY - APPLY

F 314

1) Resident #13 was discharged.

Resident #8’s skin and dressings were assessed by nursing. Results of the assessment were negative. Treatments for Resident #8 are being completed per physician orders. The Resident Care Plan has been updated to reflect current condition.

2) Current residents with orders for skin treatments have the potential to be affected by this alleged deficiency. An audit of current Residents’ treatment records was conducted and Residents are receiving treatments per physician orders and facility policy.
<table>
<thead>
<tr>
<th>ID Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>Provider's Plan of Correction (Each Corrective Action Should be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 314</td>
<td>Continued From page 6 WOUND GEL AND DRY DRSG [dressing] - CHECK EVERY DAY - CHANGE EVERY 3- [to] 5 DAYS AND AS NEEDED. ... Review of a telephone order dated 1/7/14 documented, &quot;...D/C [discontinue] tx [treatment] to (R) heel... Clean (R) heel Wound [with] Wound Spray, apply Calcium alginate and hydrocolloid dsq [dressing] [check] QD [every day] [change] q [every] 3 days &amp; [and] PRN [as needed]...&quot;</td>
<td>F 314</td>
<td>2/5/14</td>
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3) Licensed nurses will be re-educated on the proper documentation of treatments in the treatment record after the treatment has been applied. Unit Managers/Weekend Supervisors will monitor treatment books daily M-F x 4 weeks to ensure that documentation is complete. The DON will conduct random audits weekly x 4 of treatment records. Missing treatment documentation will be discussed in morning meeting M-F, ongoing.

4) The results of the audits by Unit Supervisors, Weekend Managers and the DON will be presented by the DON at the monthly Quality Assurance Meeting for three months and randomly thereafter.
Continued From page 7
resident non-compliant [with] heel boots...

F 314

Review of the Wound Treatment and Progress Record for the the Right heel wound, documented the following (There were no records provided prior to 11/5/13.):

a. 11/5/13 - "...DTI [Deep Tissue Injury]. Size... 2.0 cm [centimeters] x [by] 2.0 cm... (R) heel DTI, black in color, refuses to wear heel protector, Non-complaint [with] dialysis..."

b. 11/12/13 - "...Stg [stage] III [three]. Size... 2.0cm x 2.5cm... resident refuses hell protectors... poor p.o. [by mouth] intake..."

c. 11/19/13 - "...Stg III - Size... 2.0cm x 2.0cm x 0.2cm...debridement per [named doctor]..."

d. 11/27/13 - Size - 2.0cm x 2.0cm x 0.2cm.

e. 12/9/13 - Size - 2.0cm x 2.3cm x 0.5cm - "...Wound bed 75% [percent] slough, return from Hospital 12-6-13..."

f. 12/17/13 - Size - 2.0cm x 2.3cm x 0.5cm.

g. 12/23/13 - Size - 1.8cm x 1.6cm x 0.5 cm - "...refuses heel boots..."

h. 12/31/13 - Size - 1.8cm x 1.6cm x 0.2cm.
F 314 Continued From page 8

Observations in Resident #8's room on 1/16/14 at 10:20 AM, Nurse #2 performed a dressing change on Resident's #8's right heel wound. The wound bed was pink, with no slough observed, and there was no drainage observed. The dressing change was performed appropriately and according to the physician's orders. The resident was not wearing heel protectors. Attempted to interview Resident #8 at the time of the dressing change, and he preferred not to speak with the surveyor.

2. Closed medical record review for Resident #13 documented an admission date of 4/16/13 with diagnoses of Diabetes Mellitus, Cerebral Vascular Accident, Bipolar Disease, Reflux Disease, Hypertension, Morbid Obesity, Pressure Ulcer, Psychosis, Dementia with Behaviors, Depression, Hypothyroidism and a Urinary Tract Infection.

Review of the nurses' notes documented the following:

a. 4/16/13 - Admission assessment - "...Open area Rt glutal [gluteal] fold, about 3-4 cm [centimeters], wound bed covered in yellow slough (R) buttocks 5cm x [by] 4.5 cm..."

b. 5/29/13 at 4:10 PM - "...ADMITTING DIAGNOSIS... Sepsis, UTI [Urinary Tract Infection], sacral gluteal ulcer infection... Resident has very large wound to gluteal fold area that has been surgically [surgically] debrided [debrided], wound bed beefy red...

c. 10/16/13 at 12:55 PM - "...skin warm & clammy very shaky * [increased] confusion noted... Temp [temperature] 102.5 [degrees]... sent to the hospital..." Left the facility at 3:00 PM.

d. 11/1/13 at 5:00 PM - Nursing readmission evaluation - "...R [right] gluteal 2.5cm..."
<table>
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<tr>
<th>F314</th>
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<tr>
<td>e. 11/1/13 at 6:00 PM - &quot;...Resident very confused and CNA [certified nursing assistant] observed resident getting out of bed and sit on floor. Resident scratch [scratched] old sore and put hand in mouth...&quot;</td>
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<tr>
<td>f. 11/2/13 at 10:00 AM - &quot;...alert [with] confusion very agitated... combative... T [temperature] 103.5 [degrees]... NP [Nurse Practitioner] notified T.O. [telephone order] Rocephin IM [intramuscular] 1gm [gram] NOW Rocephin 1g [gram] IM X [times] 10 days...&quot;</td>
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<td>g. 11/2/13 at 10:20 AM - &quot;...Rocephin 1g [gram] administered... Tylenol 650 mg [milligrams] PO administered... At 12:00 PM - &quot;...Resident laying in bed skin cool, clammy, sweating and very agitated...&quot; At 3:20 PM - &quot;...very confused, skin cool clammy, sweating, combative. Resident T 104.6 [degrees]... NP notified, RP [Responsible Party] notified concerning resident status RP agreed to send resident to ER [Emergency Room]...&quot; At 5:00 PM - &quot;...transport resident [to ER]...&quot;</td>
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<td>h. 11/12/13 (no time) - &quot;...Resident arrive to facility via stretcher by ambulance... alert [with] some confusion... Dx [diagnosis] acute encephalopathy, bipolar, depression, sepsis...&quot;</td>
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<tr>
<td>i. 11/13/13 at 7:30 AM - &quot;...Head to toe skin assessment performed... (R) gluteal stage 4 wound 5.5 cm x 7.0 cm x 6.0 cm macerated wound bed pink edges white... (L) posterior ankle Stage II wound, yellow slough noted 3.5cm x 1.3 cm...&quot; At 4:50 PM - inserted a Foley catheter. At 7:00 PM - NP notified of &quot; [elevated] temp [temperature] N.O. [new order] noted for Levaquin 500mg [milligrams] po daily X [times] 10 days &amp; Probiotic po bid [twice a day] X 10 days...&quot;</td>
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| j. 11/16/13 on night shift SNF note - "...Continues Abl [antibiotic] bx [treatment] MRSA [meticillin..."
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
</table>
| F 314 | | Continued From page 10 resistant staphylococcal aureus]...
| | | k. 11/19/13 at 8:00 AM - "... (R) gluteal wound bed c [with] gray black matter, foul odor. dsg [dressing] changed tx changed..."
| | | l. 11/19/13 at 4:30 PM - "...Resident seen by [named doctor], debridement of (R) gluteal wound, tx orders changed..."
| | | m. 11/27/13 at 11:30 AM - Weekly PAR note - "...Continues with stage IV wound to (R) gluteal... decrease in size..."
| | | n. 12/4/13 at 1:45 PM - Weekly PAR note - "...decrease in wound size, tx changed..."
| | | o. 12/14/13 at 4:00 PM - "...Resident sweating profusely and skin warm..." [increased] confusion noted. Temp 101.6 NP notified T.O. Rocephin 1gm IM OD [every day] X 7 days... CN [charge nurse] administered Rocephin... Tylenol 650mg po given..."
| | | p. 12/18/13 at 2:00 PM - Weekly PAR note - "... (R) gluteal stage VI [IV] wound... decrease in size of wounds, alternating pressure wheelchair cushion ordered..."

Review of the Wound Treatment & Progress Record for November and December 2013 of the gluteal wound documented the following:

a. 11/13/13 - Treatment order - "...Clean (R) gluteal wound c [with] wound spray, apply wound gel pack [with] dry 4x4's [4 inch by 4 inch gauze] cover [with] dry dsg [change] daily & PRN [as needed]..." Documented the wound was identified on admission on 11/13/13. The measurement was documented as 5.5cm x 7.0cm x 6.0 cm Stage IV. Additional Documentation: "...Resident admitted from hospital wound bed red skin macerated, tx orders in progress..."

b. 11/19/13 - Treatment order changed - "...Clean (R) gluteal Wound [with] Wound Spray, apply Medihoney & Daykins soaked 4x4's apply dry dsg
F 314 | Continued from page 11
[change] QD & PRN..." Documented the wound measured 4.6cm x 5.9cm x 7.5cm. Additional Documentation - "...Wound bed gray, serosanguinous drainage noted... debridement per [named doctor] Abt ordered..."

b. 11/26/13 - Documented the wound measured 4.0cm x 5.9cm x 6.0cm.

c. 11/29/13 - Treatment order changed - "...Clean (R) gluteal Wound [with] wound spray apply wound gel pack [with] 4x4's apply dry dsg [change] QD & PRN..."

d. 12/3/13 - Documented the wound measured 4.0cm x 6.0cm x 6.0cm. Additional Documentation - "...Increase in Wound size. Wound bed pink, decrease drainage...

e. 12/10/13 - Treatment order changed - "...Clean (R) gluteal [with] wound spray apply Medihoney and pack [with] Alginate apply dry dsg [change] daily & PRN..." Documented the wound measured 5.5cm x 5.5cm x 6.7cm. Additional Documentation - "...Treatment changed, assessed per [named doctor]."

f. 12/17/13 - Documented the wound measured 4.0cm x 5.5cm x 6.7.

g. 12/24/13 - Documented the wound measured 6.2cm x 8.0cm x 7.0. Additional Documentation - "...Increase to wound size assessed per [named doctor] will cont. current tx. resident non-compliant [with] positioning and w/c cushion at times..."

Review of the daily wound assessment record for November and December 2013 documented blanks on 11/17/13, 11/28/13 and 12/7/13. There was a note on the November 2013 wound progress record dated 11/17/13 which documented, "...agitated & Refused care to gluteal wound..." The dressings were ordered to be changed every day. The dressings were not changed as ordered on 11/28/13 and 12/7/13,
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**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) | **COMPLETION DATE**
---|---|---|---|---
F 314 | Continued From page 12 and there was no documentation to determine why the dressing changes were not completed. | F 314 | 1) | 
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. | F 323 | 2) | 

This REQUIREMENT is not met as evidenced by:
Intakes: TN00032084 and TN00033027

Based on policy review, medical record review and interview, it was determined the facility failed to ensure new appropriate interventions were put into place after falls for 4 of 5 (Residents #1, 13, 14 and 20) sampled residents with falls.

The findings included:
1. Review of the facility's "Falls and Fall Risk, Managing - Revised September 2012" policy documented, "...4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant."

2. Medical record review for Resident #1 documented an admission date of 5/1/08 with diagnoses of Diabetes Mellitus, Dementia, Congestive Heart Failure, Hypertension and Peripheral Artery Disease. Review of the progress
Continued From page 13

notes dated 11/6/13 at 8:55 PM documented, "Resident observed lying on floor beside bed. Stated he was looking for call light and fell out of bed. Call light observed in bed attached to linens. ROM [range of motion] to all extremities without difficulty and no complaints of pain. Scratch noted to LLE [left lower extremity]."

Review of Resident #1's care plan for risk for falls revealed an intervention of "11/6/13 Instructed staff to keep call light in resident's reach at all times while in room" was handwritten on the care plan. "Keep call light within reach" was an intervention in place prior to this fall. No new interventions were documented on the care plan for this fall.

3. Closed medical record review for Resident #13 documented an admission date of 4/16/13 with diagnoses of Diabetes Mellitus, Cerebral Vascular Accident, Bipolar Disease, Reflux, Hypertension, Morbid Obesity, Pressure Ulcer, Psychosis, Dementia with Behaviors, Depression, Hypothyroidism and a Urinary Tract Infection. Review of the nurses' notes documented the following:
   a. 11/1/13 at 8:00 PM - "...Resident very confused and CNA [Certified Nursing Assistant] observed resident getting out of bed and sit on floor..."
   b. 11/13/13 at 10:30 AM - "...CNA reported that resident was lowered to floor p [after] his leg gave out while transferring him to the w/c [wheelchair] c [with] assist of 2 [two]..."
   c. 11/14/13 at 12:45 AM - "...resident sitting on floor beside bed..."
   d. 11/14/13 at 6:30 AM - "...heard resident yell "chnh" by time nurse got to doorway, he was already headed toward floor... landed on buttocks... stated he was trying to get up... [no]"
**F 323 Continued From page 14**

- **a.** 11/14/13 at 9:45 PM - "...CNA informed nurse resident was in floor... resident sitting beside bed..."
- **b.** 11/17/13 on night shift skilled (SNF) note - "...Resident found on floor by staff. Resident assists to bed via hoist lift staff X [times] 4 four... @ [at] 230am Resident on floor in bathroom stated he felt the need to empty catheter..."
- **c.** 11/19/13 at 6:20 PM - "...Heard alarm going off resident noted in upright position scooting across floor in another resident room..."
- **d.** 11/19/13 at 7:30 PM - "...resident was on the floor... scooting across the floor..."
- **e.** 11/25/13 on night shift SNF note - "...gets self out of bed. Lowers side rails and removes own pad alarm. Resident sets on mat on side of bed..."
- **f.** 11/27/13 on day shift SNF note - "...Continues to get out of wheel chair and bed on to floor..."
- **g.** 12/27/13 at 6:15 AM - "...Resident observed sitting on side of the bed then lowered himself into sitting position on the floor & [and] then crossed his legs..."

Review of the Accident/Incident Reports documented the following:

- **a.** 9/22/13 at 2:15 PM - "...observed resident on floor in front of wheelchair in kneeling position... No injury."
- **b.** 11/13/13 at 10:20 AM - "...resident was lowered to the floor [after] his leg gave out while transferring... Staff inserviceed to use lift."
- **c.** 11/14/13 at 12:45 AM - "...CNA reported to nurse resident was on floor... No injury. Bed alarm applied at night."
- **d.** 11/14/13 at 6:30 AM - "...heard resident yell "ohh" ran toward room and saw resident land on
F 323

Continued From page 15

floor on his buttocks... No injury. Resident encouraged to call for assistance for transfers."

e. 11/14/13 at 9:30 PM - "...observed resident on floor beside bed sitting... No injury. Every hour safety checks throughout the night."

f. 11/17/13 at 8:00 PM - "...heard resident's alarm going off... Upon entering [Resident #13’s] room... observed him on the floor... No injury. Educated on use of call light."

g. 11/19/13 at 2:30 AM - "...found resident on floor in bathroom stating he had to empty his catheter bag... No injury. Staff to empty catheter bag every shift."

h. 11/20/13 at 9:15 PM - "...resident was sitting ^ [up] next to w/c attempted to lie down on floor when staff arrived... No injury. Walking rounds every 30 minutes while awake, and every hour while asleep."

Review of Resident #13’s care plan dated 11/14/13 documented "...at risk for falls r/t [related to] Unaware of safety needs... Anticipate and meet needs..." No new interventions for the falls on 9/22/13 and on 11/17/13 were documented on the care plan, or on the incident reports.

During an interview in the conference room on 1/16/14 at 1:30 PM, the Director of Nurses (DON) was asked about interventions for the falls on 9/22/13 and 11/17/13. The DON stated, "...I don’t know what to say... that was the other DON... it should be on the care plan..." The DON further stated that it is the charge nurse’s responsibility to initiate a new intervention after a fall. The interventions are put on the care plan during the morning meeting, when the falls are discussed.

4. Closed medical record review for Resident #14 documented an admission date of 6/28/12
F 323: Continued From page 16

with diagnoses of Traumatic Brain Injury from a motor vehicle wreck, Reflux Disease, Depression, Pain, Insomnia, Psychosis, Seizure Disorder, Hypertension, Agitation, Anxiety, Mood Disorder and Personality Disorder. Review of a telephone order dated 12/2/13, documented "...[decrease] Clonazepam to 0.5 mg [milligrams] po [by mouth] bid [twice a day]...sedation..." An order dated 12/5/13, documented "...Levaquin 500mg po QD [every day] x [times] 10 days..." A telephone order dated 12/6/13 at 7:00 AM, documented "...Rocephin 1 gm [gram] one time dose..."

Another order dated 12/6/13 at 8:00 AM, documented "...Send to ER [emergency room] for eval [evaluation] et [and] tx [treatment] R/T [related to] change in status, ^ [increased] temp [temperature]..."

Review of the nurses’ notes, incident reports and care plan, documented the following falls:

a. 9/14/13 - Found on floor, no injury. No new intervention was documented.

b. 10/9/13 - Found on floor, no injury. Intervention to re-educate to use the call light.

c. 10/11/13 - Found on floor, no injury. Intervention to put to bed after dinner.

d. 10/20/13 - Found on floor, no injury. Intervention to place a mat in the floor beside the bed.

e. 10/21/13 - Found on floor, no injury. Intervention to redirect, and to consult psychiatric services for a medication review.

f. 11/17/13 - Found on floor, no injury. Intervention to encourage to work on airplane activity when agitation is noticed.

g. 11/19/13 - Found on floor, no injury. Intervention to apply a pillow clip to the bed. Resident had dropped his pillow on the floor.

h. 11/19/13 - Found on floor, no injury.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
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<td>F 323</td>
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<td>Continued From page 17</td>
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<td>Intervention to assist to wheelchair for meals, and the bed alarm was replaced.</td>
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<td>There was no documentation of a new intervention put into place after the fall on 9/14/13.</td>
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<td>5.</td>
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<td>Closed medical record review for Resident #20 documented an admission date of 12/9/13 with diagnoses of Depression, Hypertension, Dementia with Behavior disturbance, Diabetes Mellitus and Schizoaffective Disorder. Review of the progress notes dated 1/8/14 at 2:00 PM documented, &quot;...discussed resident c [with] fall on 1/2/14, [no] injury rolled out of bed CNA educated on proper use of bed alarm...&quot; Review of Resident #20's care plan for risk for falls revealed an intervention of &quot;1/2/14 Fall [no] injury Alarm in place at all times and check proper functioning per shift and PRN [as needed]&quot; was handwritten on the care plan. A bed and chair alarm was in place prior to this fall. No new interventions were documented on the care plan for this fall.</td>
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