

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 07/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/06/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER TRS- EDWARDSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 751 BLAKE ST. EDWARDSVILLE, KS 66111		
(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 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS77541 and #KS74757.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This Requirement is not met as evidenced by: The facility reported a census of 95 residents. The sample included 16 residents. Based on observation, interview, and record review the facility failed to honor the resident right to choose when to bathe for 2 (#80, #90) of 3 residents reviewed for choices. Findings included: - Review of the signed physician order sheet for resident #80 dated 6/5/2015 recorded diagnoses of paranoid schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and candidiasis (yeast infection). Review of the annual MDS (Minimum Data Set) dated 6/20/2014 documented a BIMS (Brief Interview for Mental Status) score of 9, which indicated moderate cognitive impairment. He/she required extensive assistance of one staff with bathing and did not reject cares. The	F 242		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 242	<p>Continued From page 1</p> <p>resident reported it was very important for him/her to choose his/her method of bathing.</p> <p>Review of the quarterly MDS dated 3/18/2015 recorded a BIMS score of 8, which indicated moderate cognitive impairment. The resident was dependent on 2 or more staff with bathing and did not reject cares.</p> <p>Review of the Cognitive Loss Care Area Assessment (CAA) dated 7/3/2014 recorded the resident's cognitive loss could lead to poor decision making and decreased independence.</p> <p>Review of the Activities of Daily Living (ADL) CAA dated 7/3/2014 recorded the resident had left sided weakness and required extensive assistance with most of his/her ADL.</p> <p>Review of the Psychosocial CAA dated 7/3/2014 recorded the resident yelled at staff during ADL cares due to his/her frustration regarding the assistance he/she needed from staff, however staff were able to redirect.</p> <p>Review of the resident's care plan dated 6/11/2015 documented the resident preferred to receive a shower in the evening.</p> <p>The care plan lacked the number of times the resident preferred to shower in a week.</p> <p>Review of the direct care staff care sheet dated 6/24/2015 documented the resident was incontinent of bladder at times.</p> <p>Review of an undated evening shift shower schedule recorded the resident was scheduled for showers on Wednesday and Saturday evenings based on the resident's Hallway, room, and bed</p>	F 242		

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F 242	<p>Continued From page 2 number.</p> <p>An observation on 6/30/15 at 4:45 P.M. the resident stated to direct care staff R he/she wanted a shower, who replied, "when did I give you one last? " The staff did not respond to the resident's request for a shower.</p> <p>On 6/24/15 at 3:41 P.M. an interview with the resident stated he/she received 2 showers a week and would like 3 showers a week due to his/her incontinence.</p> <p>On 6/30/15 at 8:41 A.M. an interview with direct care staff T stated the nurses asked the resident on admission the resident's preference for a bath or shower, and when, such as morning, afternoon, evenings. The policy was for resident's to receive 2 baths a week. If the resident was soiled or sweaty, staff would ask the resident if he/she would like a shower or bath. The facility scheduled bathing based on hallway, room and bed number. The resident's showers were scheduled for Wednesdays and Saturdays evenings.</p> <p>On 6/30/15 at 10:25 A.M. an interview with the resident stated he/she received 2 showers a week on Wednesdays and Fridays, but would like a shower every other day and had told staff he/she wanted one every 2 days.</p> <p>On 6/30/15 at 3:26 P.M. an interview with direct care staff R stated the nurses completed assessments when the resident was admitted to include the resident's preference for time of day, how often, and method of bathing. The resident required total assistance with bathing. The care sheet did not indicate the resident's preferences for showers. A shower sheet that specified the</p>	F 242		

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F 242	<p>Continued From page 3</p> <p>resident's scheduled shower days. The resident was scheduled to shower 2 times a week, but the resident could ask to shower more often.</p> <p>On 7/1/15 at 9:10 A.M. an interview with direct care staff O stated the resident's shower days were usually on Monday and Thursday evenings and was unsure if the resident received a shower last night (6/30/15) as requested. He/she stated the care sheets document what shift the resident preferred a shower and the shower sheets listed the days and shift the resident was scheduled.</p> <p>On 7/1/15 at 10:32 A.M. an interview with licensed staff H stated when a resident was admitted, a check-off sheet specified the resident's preference for a bath or shower and time of day. He/she acknowledged the check-off list did not indicate the number of baths or showers per week the resident preferred and the resident did not receive a shower as requested on 6/30/15. Resident baths were scheduled 2 times a week and the date and time were based on the hallway and room number. Staff scheduled this resident for showers in the evenings on Wednesdays and Saturdays. If the resident asked for an additional shower yesterday there would be no reason why he/she would not receive a shower.</p> <p>On 7/1/15 at 2:33 P.M. an interview with administrative nursing staff D stated the social worker completed a preference sheet on admission and at quarterly care plan review for the days a resident wanted a shower or bath. He/she would expect the direct care staff to shower the resident as requested on 6/30/15.</p> <p>On 7/1/15 at 4:01 P.M. an interview with administrative nursing staff G stated the facility</p>	F 242		

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F 242	<p>Continued From page 4</p> <p>lacked documentation the resident was asked how many times a week they preferred to shower.</p> <p>Review of the Resident's rights policy provided by the facility revised 10/09 revealed the facility was to gather information to assist residents to make individual choices regarding schedules and health care reflected their preferences including bath schedules.</p> <p>The facility failed to honor this dependent resident's choice for bathing.</p> <p>- Review of the signed physician order sheet for resident #90 dated 6/5/2015 documented diagnoses of schizoaffective disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and urinary incontinence (involuntary release of urine).</p> <p>Review of the quarterly MDS (Minimum Data Set) dated 1/22/2015 recorded a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The resident was independent with bathing and did not reject cares.</p> <p>Review of significant change MDS dated 4/16/2015 a BIMS score of 15, which indicated intact cognition. The resident required extensive assistance of 2 or more staff with transfers and assistance of one staff with bathing, functional impairment to one side of lower body, and rejected cares for 1 to 3 days during the 7 day observation period. The resident reported it was very important for him/her to choose his/her method of bathing.</p>	F 242		

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F 242	<p>Continued From page 5</p> <p>Review of the Cognitive Loss Care Area Assessment (CAA) dated 4/30/2015 recorded the resident had one episode of refusing care during the 7 day observation period. The resident needed assistance with decisions and was able to understand others and make him/herself understood.</p> <p>Review of the activities of daily living CAA dated 4/30/2015 recorded a fracture of the right ankle, urinary incontinence (involuntary release of urine) and a cerebral vascular accident (loss of blood flow to brain tissue) with right sided hemiparesis (weakness). The resident required many cues throughout completing his/her ADLs to ensure he/she had proper stance/set up. The resident's decline in ADL function could lead to physical changes, infection, skin issues, falls, loss of independence, weight changes, mood/behavior changes, cardiac and respiratory changes.</p> <p>Review of the resident's care plan revised 5/5/15 revealed staff were to encourage the resident with choices with care. The resident preferred afternoon baths and felt he/she did not need set up assistance at this time.</p> <p>Review of an undated shower schedule documented the facility scheduled the resident for a shower on Monday and Thursday evenings based on Hallway, room, and bed number.</p> <p>On 6/30/15 at 7:36 A.M. the resident sat at the dining room table with a clean face and clean hands.</p> <p>On 6/25/15 at 9:11 A.M. an interview with the resident stated he/she would like to bath on Monday, Wednesday and Friday, currently received bathing on Monday and Thursday.</p>	F 242			

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F 242	<p>Continued From page 6</p> <p>On 6/30/15 at 8:41 A.M. an interview with direct care staff T stated this resident's showers were scheduled for Monday and Thursday evenings based on room, bed, and hallway. The nurses asked the resident on admission the resident's preference for a bath or shower, and when, such as morning, afternoon, evenings. The policy was for the resident to receive 2 baths a week. If the resident was soiled or sweaty, staff would ask the resident if he/she would like a shower or bath. Bathing was scheduled based on hallway, room and bed number.</p> <p>On 6/30/15 at 3:09 P.M. an interview with the resident stated he/she received showers on Mondays and Thursdays, but would like at least on Monday, Wednesdays, and Fridays and had received daily showers prior to admission. Staff did not ask him/her how many showers a week he/she preferred.</p> <p>On 6/30/15 at 3:26 P.M. an interview with direct care staff R stated the nurses completed assessments when the resident was admitted to include the resident's preference for time of day, how often, and method of bathing. The resident required total assistance with bathing. The care sheet did not indicate the resident's preferences for showers. A shower sheet that specified the resident's scheduled shower days. The resident was scheduled to shower 2 times a week, but the resident could ask to shower more often.</p> <p>On 7/1/15 at 10:32 A.M. an interview with licensed staff H stated when a resident was admitted, a check-off sheet specified the resident's preference for a bath or shower and time of day. He/she acknowledged the check-off list did not indicate the number of baths or</p>	F 242			

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F 242	<p>Continued From page 7</p> <p>showers per week the resident preferred. Resident baths were scheduled 2 times a week and the date and time were based on the hallway and room number. The staff scheduled this resident for showers in the evenings on Monday and Thursday. If the resident asked for an additional shower there would be no reason why he/she would not receive a shower.</p> <p>On 7/1/15 at 2:33 P.M. an interview with administrative nursing staff D stated the social worker completed a preference sheet on admission and at quarterly care plan review for the days a resident wanted a shower or bath. He/she would expect the direct care staff to shower the resident as requested.</p> <p>On 7/1/15 at 4:01 P.M. an interview with administrative nursing staff G stated the facility lacked documentation the resident was asked how many times a week they preferred to shower.</p> <p>Review of the Resident's rights policy provided by the facility revised 10/09 revealed the facility was to gather information to assist residents to make individual choices regarding schedules and health care reflected their preferences including bath schedules.</p> <p>The facility failed to honor this dependent resident's choice for bathing.</p>	F 242			
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p>	F 280			

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F 280	<p>Continued From page 8</p> <p>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.</p> <p>This Requirement is not met as evidenced by: The facility identified a census of 95 residents. The sample included 16 residents. Based on observation, interview, and record review, the facility failed to revise comprehensive care plans for 2 of three sample residents for falls (#30, #73) and 1 of 1 residents sampled for a facility acquired pressure sore (#80).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #30 admitted to the facility on 5/25/15 had diagnoses that included: schizophrenia (a severe brain disorder in which people interpret reality abnormally), movement disorder (a neurological conditions that affects the speed, fluency, quality, and ease of movement), and epilepsy (a neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain). <p>The resident's admission Minimum Data Set</p>	F 280		

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F 280	<p>Continued From page 9</p> <p>(MDS) assessment dated 6/9/15 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident's cognition was intact. The MDS recorded the resident required extensive assistance of one to two persons with bed mobility, transfers, dressing and toilet use. The MDS documented the resident was continent, used a wheel chair for mobility, had no recent history of falls, and received anti-psychotic (medication used to treat mental disorders), anti-anxiety (medications used to relieve symptoms of anxiousness/restlessness), and diuretic (medication used to relieve excess fluid from the body).</p> <p>The 6/9/15 care area assessment (CAA) (a narrative description of resident characteristics) for activities of daily living (ADLs) recorded staff developed a care plan to minimize the resident's risk of fall and/or injury due to his/her decreased mobility.</p> <p>The initial fall risk assessment dated 5/25/15 recorded a score of 13 which placed the resident at risk for falls (a score greater than 10 equals at risk status).</p> <p>The June 2015 electronic physician's order sheet (POS) lacked documentation of any physician orders related to the residents mobility problems.</p> <p>Review of the electronic and paper clinical record revealed the resident experienced a fall on 6/12/15 and the investigation directed staff not to leave the resident unattended in his/her room, and maintenance tried get auto-lock brakes for his/her wheelchair.</p> <p>The resident had a second fall on 6/21/15 at 4:45 A.M. and the investigation documented the facility</p>	F 280			

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F 280	<p>Continued From page 10</p> <p>placed the resident on a toileting plan and directed staff to toilet the resident before bed.</p> <p>The resident's care plan revised last on 5/29/15 directed staff to assess his/her wheelchair for appropriate size and/or the need for locking wheels, keep his/her call light in reach, and keep his/her room well lit and uncluttered.</p> <p>The care plan lacked documentation of the resident's falls on 6/12/15 and 6/22/15 and/or interventions developed to prevent future occurrences, such as auto-lock wheelchair brakes, companionship while in his/her room, or any toileting plan.</p> <p>Observation on 6/25/15 at 3:32 P.M. revealed the resident was unattended seated upright in his/her wheelchair in his/her bathroom and washing his/her hands. The resident's wheelchair did not have auto-lock brakes.</p> <p>Interview on 7/1/15 at 10:45 A.M. administrative staff nurse D stated maintenance ordered auto-lock brakes for the resident's wheel chair but they did not yet receive them. Nurse G stated staff were educated regarding the residents fall status but acknowledged staff failed to add new interventions to the residents care plan.</p> <p>The facility indicated they utilized the Resident Assessment instrument (RAI Manual) for the development and revision of resident care plans.</p> <p>The facility's undated Falls Management Guideline policy recorded: following a resident's fall the care plan was updated to reflect his/her current status.</p> <p>The facility failed to revise the resident's</p>	F 280		

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F 280	<p>Continued From page 11</p> <p>comprehensive care plan to reflect falls, and/or any new interventions designed to prevent future falls for this mobility impaired resident.</p> <p>- Review of the resident # 80's physician order sheet dated 6/5/2015 included the following diagnoses: history of ulcer to other part of the foot, edema, generalized pain, diabetes type II (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), not stated as uncontrolled, hemiplegia affecting unspecified side (paralysis of one side of the body).</p> <p>Review of resident # 80's annual MDS (Minimum Data Set) dated 6/20/2014 documented a BIMS (Brief Interview for Mental Status) score of 9, which indicated moderate cognitive impairment. The resident required extensive assistance of one staff with bed mobility and did not reject cares during the 7 day observation period. The resident had no pressure ulcers or other wounds and was at risk for developing pressure ulcers. He/she had a pressure reducing device for his/her chair and bed.</p> <p>Review of the ADL (Activities of Daily Living) CAA dated 7/3/2014 recorded the resident had left sided weakness and required extensive assistance with most of his/her ADLs.</p> <p>Review of the quarterly MDS (Minimum Data Set) dated 3/18/2015 recorded a BIMS score of 8, which indicated moderate cognitive impairment. The resident required extensive assistance of 2 or more staff with bed mobility and did not reject cares during the 7 day observation period. The resident had no pressure ulcers or other wounds and was at risk for developing pressure ulcers. He/she had a pressure reducing device for</p>	F 280			

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F 280	<p>Continued From page 12 his/her chair and bed.</p> <p>Review of the resident's revised care plan dated 4/8/2015 recorded the resident was at risk for non pressure and pressure related skin impairment. The care plan directed staff to provide supervision with bed mobility, inspect the resident's skin with cares, weekly skin inspections, keep the feet elevated when lying down, provide pressure reducing wheelchair cushion and pressure reduction/relieving mattress. The care plan was revised on 7/1/2015 and identified the resident had an unstageable pressure ulcer to the right heel due to required assistance with bed mobility assistance, skin desensitized, peripheral vascular disease (an abnormal condition of the blood vessels), diabetes, Braden Score of 18 or greater, obesity, absence of pedal pulse, and presence of edema. The care plan directed the staff to apply skin prep to the right heel twice a day.</p> <p>Review of physician's orders included the following: Skin prep to both heels twice daily to prevent skin from opening, effective 5/16/2015 and discontinued on 6/30/2015.</p> <p>During an observation on 07/01/2015 at 8:47 A.M. direct care staff O and S used the sit to stand mechanical lift to transfer the resident from the wheelchair to his/her bed. The resident was dependent on staff with getting upper and lower body into the bed.</p> <p>During an interview on 6/30/15 at 10:16 A.M. the resident reported his/her right heel hurt when staff touched the area. He/she rated the pain a 4 on a scale of 0-10, with zero being no pain and 10 being the worst pain imagined. The resident</p>	F 280		

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F 280	<p>Continued From page 13</p> <p>reported his/her heel hurt for more than a month.</p> <p>During an interview on 06/30/2015 11:04 A.M. direct care staff O reported the resident's right heel was healing for at least a month. Staff O said the resident complained of pain to the right foot, especially when transferring into the bed and taking off his/her socks. Staff O stated he/she notified the charge nurse about 2 weeks ago of redness surrounding the wound on the resident's right heel.</p> <p>During an interview on 07/01/2015 at 10:55 A.M. licensed nursing staff H reported the resident currently had no skin issues and no staff reported any skin issues to him/her. Staff H reported a current interventions to protect the resident's skin was to ensure the feet were elevated and positioned with pillows when in bed. Staff H reported and he/she noticed the resident wore pressure boots this morning and was not sure of the reason.</p> <p>During an interview on 07/01/2015 at 2:02 P.M. administrative nursing staff E stated he/she expected staff O to pass the information regarding the resident's right heel wound to the oncoming direct care staff and he/she did not inform the charge nurse of the resident's wound, order for skin prep, or of the pressure relieving boots. Staff E stated he/she did not update the care plan or inform the charge nurse of the resident's wound or new intervention for boots until this morning.</p> <p>During an interview on 07/01/2015 at 2:39 P.M. administrative nursing staff D stated he/she expected administrative nursing staff E or the charge nurses the care plan to update the care plan when changes occur.</p>	F 280			

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F 280	Continued From page 14 The facility reported use of the 3.0 RAI (Resident Assessment Instrument) Manual as guidance for care plan revisions. Facility staff should review and revise the care plan at least quarterly and when changes in the resident's condition occurred. The facility failed to ensure resident # 80's care plan was reviewed and revised in a timely manner to include his/her need for extensive assistance with bed mobility, presence of red and soft heels on 5/12/2015, unstageable pressure ulcer to right heel, and the use of boots to both feet. - The signed Physician Order Sheet (POS) for resident #73 dated 06/ 04/15 revealed diagnoses of schizoaffective disorder unspecified (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), dementia unspecified with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), other forms of epilepsy (brain disorder characterized by repeated seizures) and recurrent seizures, (brain disorder characterized by repeated seizures) diabetes, (impaired insulin utilization coupled with the body's inability to compensate with increased insulin production). The Admission Minimum Data Set (MDS) dated 09/03/2014 revealed the resident was not assessed for Brief Interview of Mental Health (BIMS). The resident's mood score was a 0 which indicated no depression. The resident was independent with bed mobility, transfers, walking in room and corridor, locomotion on and off the unit, and toilet use with no setup or physical help from staff. He/She required supervision for	F 280			

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F 280	<p>Continued From page 15</p> <p>dressing, eating, and personal hygiene with no setup or physical help from staff, and was always continent of bowel and bladder. He/She did not have a history of falls in the past 6-months prior to admission. The resident received antipsychotic and antidepressant medication 7 out of 7 days; and antianxiety medication 2 out of 7 days of the look back period.</p> <p>The Medicare 5-day (MDS) dated 06/09/2015 revealed a Brief Interview for Mental Health (BIMS) of 4 which indicated severe cognitive impairment. The Mood score of 3 indicated minimal depression. The resident required limited assistance with one staff for bed mobility and transfers. He/She walked on unit with supervision and set up assistance, but walked in the corridor with supervision and assistance of one staff, resident was not steady, and only able to stabilize with assistance. The resident had one non-injury fall and one major fall since admission or reentry. He/She received 268 minutes of physical therapy 5 out of 7 days of the look back period, resident received antipsychotic, antidepressant and diuretic medications.</p> <p>The Fall Care Area Assessment (CAA) dated 09/03/14 documented no ROM (Range of Motion) limitations noted, steady gait, independent with ambulation, and denied any pain, and had no recent falls. The nursing progress notes reflected no falls prior to admission. The nursing progress note dated 8/27/2014 revealed the resident had anxiety, and was hyper-verbal and paced. Nursing staff to monitor and report as indicated; as well as treat as ordered. Physical therapy to evaluate as ordered and treat as indicated and as approved by the resident, psychiatrist and physician to review as indicated.</p>	F 280			

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F 280	<p>Continued From page 16</p> <p>Care Plan for falls dated 03/24/2015 revealed resident was at risk for falls related to use of antidepressant medication and a new environment. Assess as needed to move the resident closer to nurse's station and report as indicated, assess for pain every shift and PRN (as needed). Staff kept the bed in low position as indicated per facility policy. Call light or personal items available and within easy reach. Educate, encourage, and assist resident as needed to keep environment well lit and free of clutter. Observe for side effects of medications and report when indicated. Orient resident to his/her new room and roommate.</p> <p>Record review revealed the resident had four falls from 03/30/2015 through 06/09/2015.</p> <p>The fall investigation dated 03/03/2015 at 6:40 P.M. reported the resident fell in the backyard while walking around during a supervised smoke break. The resident stated he/she "tripped over my feet and lost my balance". This was a non-injury fall. Staff assessed the resident and vital signs were within normal limits and neurological exam was completed. Recommendation was to ask the resident to sit on the bench or picnic table while smoking.</p> <p>The fall investigation dated 06/04/2015 at 8:10 P.M. reported the resident fell when going outside using a walker. This was an injury fall. The resident fractured their left arm. Resident stated he/she "was going outside". Recommendation was for the staff to provide a wheelchair for resident 's use.</p> <p>Per observation 06/30/2015 at 11:57 A.M. resident lying in bed, fall mat next to bed, call light with reach, bed in low position and wheelchair</p>	F 280		

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F 280	Continued From page 17 next to bed. During an interview on 07/01/2015 at 3:26 P.M. direct care staff Q stated I take this resident out to smoke in his/her wheelchair on my shift. The wheelchair was not on the direct care staff's jot sheets (a pocket size care plan of resident information). During an interview on 07/01/2015 at 1:05 P.M. administrative nurse GG reported the care plan was started based on the CAAs which he/she completed. As the care plan progressed the charge nurses and administrative staff E were responsible for updating fall and wound interventions. During an interview on 07/01/2015 2:02 P.M. Administrative nurse E stated he/she forgot to update CNA care sheet. The facility failed to update the care plan concerning falls for this cognitively impaired resident who had a history of falls.	F 280		
F 314 SS=G	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: The facility reported a census of 95 residents with	F 314		

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F 314	<p>Continued From page 18</p> <p>16 residents in the sample. Based on observation, interview and record review the facility failed to ensure a resident who entered the facility without a pressure ulcer did not develop a pressure ulcer and failed to ensure a resident received the necessary care and treatment to promote wound healing for one of one sampled residents reviewed for pressure ulcers. (#80)</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - Review of the resident # 80's physician order sheet dated 6/5/2015 included the following diagnoses: history of ulcer to other part of the foot, edema, generalized pain, diabetes type II (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), not stated as uncontrolled, and hemiplegia affecting unspecified side (paralysis of one side of the body). <p>Review of resident # 80's annual MDS (Minimum Data Set) dated 6/20/2014 documented a BIMS (Brief Interview for Mental Status) score of 9, which indicated moderate cognitive impairment. The resident required extensive assistance of one staff with bed mobility and did not reject cares during the 7 day observation period. The resident had no pressure ulcers or other wounds and was at risk for developing pressure ulcers. He/she had a pressure reducing device for his/her chair and bed.</p> <p>Review of the ADL (Activities of Daily Living) CAA dated 7/3/2014 recorded the resident had left sided weakness and required extensive assistance with most of his/her ADLS.</p> <p>Review of the Pressure Ulcer CAA dated 7/3/2014 recorded the resident's skin was dry</p>	F 314			

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F 314	<p>Continued From page 19 and intact with no opened areas.</p> <p>Review of the quarterly MDS (Minimum Data Set) dated 3/18/2015 recorded a BIMS score of 8, which indicated moderate cognitive impairment. The resident required extensive assistance of 2 or more staff with bed mobility and did not reject cares during the 7 day observation period. The resident had no pressure ulcers or other wounds and was at risk for developing pressure ulcers. He/she had a pressure reducing device for his/her chair and bed.</p> <p>The Braden Skin Risk Assessments dated 1/1/2014, 12/7/2014, and 3/18/2015 recorded the resident scored 13, which indicated he/she was a moderate risk for development of pressure ulcers.</p> <p>Review of the resident's revised care plan dated 4/8/2015 recorded the resident was at risk for non pressure and pressure related skin impairment. The care plan directed staff to provide supervision with bed mobility, inspect the resident's skin with cares, weekly skin inspections, keep the feet elevated when lying down, provide pressure reducing wheelchair cushion and pressure reduction/relieving mattress. The care plan was revised on 7/1/2015 and identified the resident had an unstageable pressure ulcer to the right heel due to required assistance with bed mobility assistance, skin desensitized, peripheral vascular disease (an abnormal condition of the blood vessels), diabetes, Braden Score of 18 or greater, obesity, absence of pedal pulse, and presence of edema. The care plan directed the staff to apply skin prep to the right heel twice a day.</p> <p>Review of an annual nutritional assessment dated 6/29/2015 at 10:04 A.M. recorded the resident's</p>	F 314		

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F 314	<p>Continued From page 20 skin was intact and without pressure ulcers.</p> <p>Review of a nursing progress note dated 6/30/15 at 12:14 P.M. recorded the resident had a unstageable area with eschar to the right heel, which was tender and measured 0.5 cm (centimeters) x 0.5 cm. Appropriate treatment at this time was pressure relieving boots and skin prep to the right heel twice daily to prevent the area from opening. The practitioner would assess the resident during rounds on 7/2/2015.</p> <p>Review of physician's orders documented the following: Elevate heels with pillows and reposition both feet while in bed to prevent skin breakdown, effective 4/16/15 Skin prep to both heels twice daily to prevent skin from opening, effective 5/16/2015 and discontinued on 6/30/2015. Skin prep to the right heel every day and evening shift twice daily to prevent the area from opening. Pressure relieving boots when in bed, effective 6/30/15.</p> <p>Review of May 16, 2015 TAR (Treatment Administration Record) to June 30, 2015 lacked documentation of skin prep to both heels on the evening shifts of 5/13/15, 6/16/15, 6/22/15 and on the day shifts of 6/26/15 and 6/27/15.</p> <p>During an observation on 06/30/2015 at 9:57 A.M. direct care staff O and P assisted the resident to his/her bed using a mechanical sit to stand lift. When staff attempted to remove the resident's right sock the resident shouted loudly "it hurts". Observation revealed a pencil eraser sized circular dark area towards the right side of the resident's heel. Staff O placed one pillow under the resident's legs leaving the heels to still touch</p>	F 314			

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F 314	<p>Continued From page 21 the mattress.</p> <p>During an observation on 06/30/2015 at 2:00:51 P.M. the resident was lying flat in his/her bed on a regular mattress with soft open heel boots on both feet. The resident's heels were not positioned in the opened area of the soft boots and the lower legs were elevated on one pillow, which was not sufficient to relieve pressure of the heels off the regular mattress.</p> <p>During an observation on 06/30/2015 from 2:53 P.M. to 4:52 P.M. the resident was lying on his/her back, flat in the bed on a regular mattress with soft open heel boots on both feet. The resident's heels were not positioned in the open area of the boots and laid flat against the regular mattress, despite one pillow under the resident's legs. At 4:42 P.M. direct care staff R and Q entered the resident's room to assist the resident out of bed for his/her evening meal.</p> <p>During an observation on 07/01/2015 at 8:47 A.M. direct care staff O and S used the sit to stand mechanical lift to transfer the resident from the wheelchair to his/her bed. The resident was dependent on staff with getting upper and lower body into the bed. Staff positioned the resident on his/her back with the head of bed at 10-15 degrees. The resident had soft open heeled boots on both feet and staff O placed one pillow under the resident's legs positioned above his/her heels. The resident then requested staff remove the boots. Staff O removed both boots and placed in his/her wheelchair. Staff failed to ask the resident why he/she did not want to wear the boots and did not provide education regarding the purpose of the boots to the resident.</p> <p>During an interview on 6/30/15 at 10:16 A.M. the</p>	F 314			

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F 314	<p>Continued From page 22</p> <p>resident reported his/her right heel hurt when staff touched the area. He/she rated the pain a 4 on a scale of 0-10, with zero being no pain and 10 being the worst pain imagined. The resident reported his/her heel hurt for more than a month.</p> <p>During an interview on 06/30/2015 11:04 A.M. direct care staff O reported the resident's right heel was healing for at least a month. Staff O said the resident complained of pain to the right foot, especially when transferring into the bed and taking off his/her socks. Staff O reported interventions to prevent skin breakdown included not wearing shoes. He/she was unaware of any other interventions to help with wound healing. Staff O stated he/she would let the charge nurse know if a resident complained of pain or had skin issues. Staff O stated he/she notified the charge nurse about 2 weeks ago of redness surrounding the wound on the resident's right heel.</p> <p>During an interview on 06/30/2015 3:34:18 .P.M. direct care staff R reported the resident has no skin breakdown or history of skin breakdown. Staff R reported interventions to prevent skin breakdown for this resident was to provide incontinence care. Staff R said if a resident had new skin issues the off going nurse would let him/her know during rounds and if the resident was independent the independent resident would let the staff know. Staff R reported he/she received an off going report from staff O on 6/30/2015 and he/she did not report any skin issues for this resident.</p> <p>During an interview on 07/01/2015 at 9:19 A.M. direct care staff O reported he/she did not received any instructions on how to apply the resident's soft boots or how often the resident should wear the soft boots.</p>	F 314			

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F 314	<p>Continued From page 23</p> <p>During an interview on 06/30/2015 at 11:27 A.M. administrative nursing staff E reported the resident had a history of a diabetic ulcer on his/her right lateral foot, which healed. Staff E reported the CNAs or nurses informed him/her if there was a wound that e/she needed to measure. He/she was unaware of any skin issues to the resident's feet at this time. Staff E assessed the resident's right foot at the surveyor's request. The resident yelled loudly that the wound hurt when the wound nurse palpated the resident's right heel. Staff E stated the wound was unstageable and believed the wound was pressure related. One pillow remained under the resident's legs, which did not prevent the heels from touching the mattress. Staff E described the wound to the resident and asked if he/she would wear soft boots. The resident was agreeable.</p> <p>During an interview on 07/01/2015 at 10:55 A.M. licensed nursing staff H reported the resident currently had no skin issues and no staff reported any skin issues to him/her. Staff H reported a current interventions to protect the resident's skin was to ensure the feet were elevated and positioned with pillows when in bed. Staff H reported and he/she noticed the resident wore pressure boots this morning and was not sure of the reason.</p> <p>During an interview on 07/01/2015 at 2:02 P.M. administrative nursing staff E reported practitioner H was phoned on 6/30/2015 and was told the resident had pain to his/her right heel and an area of eschar, believed to be caused from pressure, was discovered on the right heel. Staff E told practitioner H staff provided the resident pressure relieving boots and his/ her feet were floated and</p>	F 314			

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F 314	<p>Continued From page 24</p> <p>elevated. Staff E reported nursing informed him/her the resident had red and soft heels on 5/16/15. Staff E stated he/she did not assess the heels, took the nurses word and told them to elevate the heels and get an order for skin prep. Staff E reported he/she was "spread thin" and believed if his/her duties did not include working the floor he/she would have time to assess the wound, educate the staff, and follow up on other interventions that could prevent the unstageable pressure ulcer, such as a low air loss mattress. Staff E reported he/she gave direct care staff O the pressure relieving boot without instructing him/her how to apply the boots correctly. Staff E stated he/she expected staff O to pass the information regarding the resident's right heel wound to the oncoming direct care staff and he/she did not inform the charge nurse of the resident's wound, order for skin prep, or of the pressure relieving boots. Staff E stated he/she did not assess the soft boots on the resident and was not aware of the fit or placement.</p> <p>During an interview on 07/01/2015 at 2:39 P.M. administrative nursing staff D reported he/she was made aware of the resident's wound to his/her heel/ankle area on 6/30/2015. Staff D was unaware the resident experienced redness and softness to the right heel on 5/16/2015 and was not aware staff obtained an order for skin prep at that time. He/she expected staff would inform him/her of the skin issue on 5/16/2015 when the redness and softness was first recognized. DON expected the wound nurse to educate staff on the wound and pressure relieving boots and felt staff should have assessed the resident for a low air loss mattress.</p> <p>During an interview on 7/2/2015 at 10:44 A.M. dietary consultant DD reported he/she was</p>	F 314			

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F 314	<p>Continued From page 25</p> <p>unaware of the resident having red and soft heels on 5/16/2015 and was not aware of an unstageable pressure wound on the resident's right heel. He/she visited the facility once weekly and would expect nursing or the dietary manager would inform him/her given the history of diabetic ulcers and amputation history. Consultant DD reported he/she would make recommendations for a resident who experienced wounds.</p> <p>During a phone interview on 7/2/2015 at 12:53 P.M. physician F reported he/she was aware the resident had a history of ulcers, but was unaware of the resident's current unstageable ulcer to his/her right heel. Staff F expected the resident's heels were elevated off the mattress as the most important intervention for healing and if heels were unable to remain elevated a low air loss mattress would be the next consideration. Staff F reported practitioner H saw residents for him/her in the facility and they would meet once or twice a month to discuss residents status. Staff F reported practitioner H had not informed him/her of the resident's skin issues.</p> <p>Review of the facility's Prevention of Pressure Ulcer Policy dated 1/26/2015 documented residents were assessed to prevent the development of pressure ulcers. Assessment guidelines and equipment included; assessment of mobility status to include bed mobility, assessment of range of motion and limitations, appropriate bed support, heel protectors, and a turning and repositioning schedule to meet the resident's needs.</p> <p>The facility failed to ensure physician ordered interventions to elevate and reposition resident # 80's heels with pillows while in bed and apply skin prep twice daily were followed. The resident</p>	F 314		

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F 314	Continued From page 26 developed an unstageable pressure ulcer to his right heel.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: The facility identified a census of 95 residents. The sample included 16 residents. Based on observation, record review, and interview the facility failed to follow an individual toileting plan for 1 of 3 residents sampled with urinary incontinence (#80). Findings included: - Resident #80's electronic record documented the resident had diagnoses that included: urinary tract infection (an infection in any part of your urinary system - your kidneys, ureters, bladder and urethra) and candidiasis of other urogenital sites (a fungal/yeast infection which can affect several areas of the body). The 3/18/15 quarterly Minimum Data Set (MDS) 3.0 assessment recorded the resident had a Brief interview for Mental Status (BIMS) score of 8 which indicated moderately impaired cognition.	F 315		

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F 315	<p>Continued From page 27</p> <p>The MDS documented the resident had functional limitations on one side of his/her body, required extensive assistance of two staff with bed mobility, transfers, dressing and toileting, was frequently incontinent of bowel and bladder and was not on a scheduled toileting plan.</p> <p>The urinary incontinence Care Area Assessment (CAA) dated 7/30/2014 recorded the resident wore adult sized briefs to manage his/her incontinence but lacked any detailed information related to the resident's incontinence.</p> <p>Review of the bladder assessment form dated 3/18/15 recorded the resident experienced stress and urge incontinence (mixed incontinence). The assessment lacked documentation of a treatment program or interventions.</p> <p>Review of the bowel and bladder record data collection tool dated 6/7/15 through 6/10/15 recorded the resident experienced episodic incontinence with saturation of his/her brief from slightly wet to most of the pad saturated.</p> <p>The resident's revised care plan dated 6/11/15 recorded the resident forgot where the bathroom was located and used a wheelchair. The care plan directed staff to evaluate the frequency and timing of incontinent episodes, report any changes in ability to toilet and/or continence, and schedule toileting before and after meals, at bedtime, and as the resident requested.</p> <p>Observation on 6/30/15 between 7:55 A.M. and 9:37 A.M. revealed the resident finished his/her breakfast, was assisted in his/her wheelchair to the social services office and back to the television room. The resident sat in the television room and at 9:07 A.M. had his/her eyes open and</p>	F 315			

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F 315	<p>Continued From page 28</p> <p>looking toward the television and at 9:19 A.M. the resident's eyes were closed with his/her head on his/her chest.</p> <p>Observation on 6/30/14 a 9:40 A.M. direct care staff O approached the resident but did not offer to assist him/her with toileting.</p> <p>Observation on 6/30/15 at 9:57 A.M. (2 hours and 2 minutes after breakfast) revealed direct care staff O and P toileted the resident where-in the resident's brief was soaked with urine and smelled foul.</p> <p>Interview on 6/30/15 at 10:16 A.M. the resident reported he/she sometimes knows when he/she needed to void, stated he/she would like to toilet on the commode, he/she did not use the toilet after breakfast, and staff would take him/her in the afternoon, if he/she asked.</p> <p>Interview on 6/30/15 at 3:43 P.M. direct care staff R stated the resident required total assistance with all care including toileting, he/she was always incontinent and not on a toileting schedule.</p> <p>Interview on 7/1/15 at 9:39 A.M. direct care staff O stated the resident was always incontinent and was toileted every two hours per the care plan.</p> <p>Interview on 7/1/15 at 11:07 A.M. licensed nursing staff H stated the resident received scheduled toileting but was also incontinent at times.</p> <p>Interview on 7/1/15 at 1:37 P.M. licensed nurse GG stated staff did a 3 day voiding diaries were done annually and/or with any significant change and the charge nurse determined if a resident's plan of care needed changed.</p>	F 315			

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F 315	Continued From page 29 Interview on 7/1/15 at 1:40 P.M. administrative licensed nurse E acknowledged staff could have missed things on the revised bladder data assessment. Interview on 7/1/15 at 2:54 P.M. administrative nurse D acknowledged staff needed education to follow the care plan related to the resident's toileting schedule. The undated facility policy Incontinence Management/Bladder Function documented: Develop a schedule of toileting times specific to the resident; Observe and record the residents voiding pattern and revise the toileting schedule to meet the resident's toileting needs; and If the resident displays a pattern of incontinence due to urge or mixed incontinence establish toileting times prior to an accident. The facility failed to follow the toileting schedule to prevent decline and/or restore normal bladder function for this cognitively impaired dependent resident.	F 315		
F 323 SS=D	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: The facility identified a census of 95 residents. The sample included 16 residents. Based on	F 323		

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F 323	<p>Continued From page 30</p> <p>observation, record review and interview the facility failed to adequately assess, care plan, prevent, and investigate a fall with injury for 3 of 3 residents (#30, #73, #90)reviewed for falls.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The electronic record dated June 2015 for resident #30 posted the resident had diagnosis that included: schizophrenia (a severe brain disorder in which people interpret reality abnormally), movement disorder (a neurological conditions that affect the speed, fluency, quality, and ease of movement), and epilepsy (a neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain). <p>The 6/9/15 admission Minimum Data Set (MDS) 3.0 assessment recorded the resident with a Brief interview for Mental Status score of 14 indicating the resident's cognition was intact. The MDS recorded the resident required extensive assistance of one to two persons with bed mobility, transfers, dressing and toilet use. The MDS documented the resident was continent, used a wheel chair for mobility, had no recent history of falls, and received anti-psychotic (medication used to treat mental disorders), anti-anxiety (medications used to relieve symptoms of anxiousness/restlessness), and diuretic (medication used to relieve excess fluid from the body).</p> <p>The 6/9/15 care area assessment (CAA) (a narrative description of resident characteristics) for activities of daily living (ADLs) recorded staff developed a care plan to minimize the resident's risk a fall and/or injury from falls due to his/her</p>	F 323			

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F 323	<p>Continued From page 31 decreased mobility.</p> <p>The initial fall risk assessment dated 5/25/15 recorded a score of 13 which placed the resident at risk for falls (a score greater than 10 indicated at risk status).</p> <p>The June 2015 electronic physician's order sheet (POS) lacked documentation of orders related to the residents mobility problems.</p> <p>Review of the electronic and paper clinical record revealed the resident experienced a fall on 6/12/15 at 12:00 P.M. A staff member found the resident on the floor in his/her bathroom and wet with urine. The investigation recorded prior to the fall a staff member attempted to toilet the resident but he/she became aggressive and fought staff. Staff exited to allow the resident to calm down.</p> <p>The investigation directed staff not to leave the resident unattended in his/her room and maintenance ordered auto-lock brakes for the resident's wheelchair.</p> <p>Review of the nurses progress notes (NN) documented the resident experienced intermittent agitation and restlessness and the NN dated 6/20/15 at 5:27 P.M. revealed the facility tested the resident for a urinary tract infection and the physician ordered antibiotic therapy (8 days after the resident's fall).</p> <p>A second fall investigation recorded on 6/21/15 at 4:45 A.M. staff found the resident in his room, on his/her back on the floor and soiled with urine. The resident initially complained of back pain but the assessment revealed no abnormality. Staff placed the resident on a toileting plan and directed staff to toilet the resident before bed.</p>	F 323			

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F 323	<p>Continued From page 32</p> <p>The resident's care plan revised last on 5/29/15 documented the resident was at risk for falls and directed staff to assess his/her wheelchair for appropriate size and or the need for locking wheels, keep his/her call light in reach, and keep his/her room well lit and uncluttered.</p> <p>The care plan lacked documentation of the resident's falls on 6/12/15 and 6/22/15 and/or interventions developed to prevent future occurrences, such as auto-lock wheelchair brakes, companionship while in his/her room, monitor for urinary tract infections and/or any toileting plan.</p> <p>Review of direct care staff Jot sheets (a pocket size care plan of resident characteristics) lacked documentation of the resident's falls or any interventions developed to prevent the reoccurrence of falls.</p> <p>Observation on 6/25/15 at 3:32 P.M. revealed the resident was unattended and seated upright in his/her wheelchair in his/her bathroom and washing his/her hands. The resident's wheelchair did not have auto-lock brakes.</p> <p>Interview on 6/25/15 at 3:32 P.M. the resident stated he/she remembered he/she fell in the facility at 5:20 in the evening (the NN indicated the fall occurred at 4:20 in the morning) and I was in bed, and, pushed the button (call light), the wheelchair was not near me and I could not reach it.</p> <p>Interview on 7/1/15 at 7:47 A.M. night shift licensed nursing staff I stated the resident usually slept through the night, sometimes would awaken but rarely wanted to get up in the night; he/she</p>	F 323		

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F 323	<p>Continued From page 33 called if he/she wanted something.</p> <p>Interview on 7/1/15 at 7:49 A.M. day shift licensed nursing staff J stated the resident only fell one time that he/she knew of. The resident missed the toilet when he/she tried to self transfer.</p> <p>Interview on 7/1/15 at 7:57 A.M. direct care staff U stated he/she remembered there was a time when the resident was more agitated than usual and the nurses obtained a urine test, but he/she was not aware of the results. He/she said since then however, the resident was better and did not attempt to transfer him/her.</p> <p>Interview on 7/1/15 at 9:20 A.M. administrative licensed nursing staff D stated staff should document all information related to fall prevention, intervention's and actual falls on the residents care plan and communicate to staff.</p> <p>Interview on 7/1/5 at 10:45 A.M. administrative staff nurse D stated fall follow-up was conducted by reviewing the DQI (fall investigations) in daily start up meeting and the interdisciplinary team added new information/interventions to the resident's care plan and the nursing assistant Jot sheets.</p> <p>The facility's undated Fall Management Guideline Policy recorded: The Interdisciplinary Team reviewed the Change of Condition Report -Post Fall/Trauma and made additional recommendations within 72 hours of the fall.</p> <p>The policy further recorded the following element were in place to demonstrate satisfactory compliance with the guide: Residents at risk for falls were Care planned with individualized interventions.</p>	F 323		

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F 323	<p>Continued From page 34</p> <p>The facility failed to document on the resident's care plan and direct care staff Jot Sheets the occurrence of two falls, new interventions developed to prevent future falls, and the facility failed to communicate falls and interventions to direct care staff caring for this resident with impaired mobility.</p> <p>- Review of the resident # 90's signed physician order sheet dated 6/5/2015 included the following diagnoses: ankle fracture (broken bone), generalized pain, diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) without complications type II not stated as uncontrolled, hypertension, urinary incontinence, and insomnia (inability to sleep).</p> <p>Review of the resident's annual MDS (Minimum Data Set) dated 6/6/2014 recorded a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The resident was independent with bed mobility, transfers walking, and toileting. He/she was not steady when turning around and facing the opposite direction while walking. The resident had no history of falls and did not reject cares during the 7 day observation period.</p> <p>Review of the significant change in status MDS (Minimum Data Set) dated 8/27/2014 recorded a BIMS score of 15, which indicated intact cognition. The resident required extensive assistance of 2 or more staff with bed mobility and transfers; supervision and set up with toileting; and walking occurred once or twice during the 7 day observation period. The resident experienced one major injury fall since his/her prior assessment and rejected care 1-3 days during the observation period.</p>	F 323			

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F 323	Continued From page 35 Review of the Cognitive Loss CAA (Care Area Assessment) dated 6/20/2014 recorded the resident experienced fluctuating inattention and disorganized thinking. The resident's impaired cognition could lead to poor decision making, injury, decreased independence, and complications with communication. Review of the ADL (Activities of Daily Living) CAA dated 6/20/2014 recorded the resident required supervised assistance with dressing and personal hygiene, was incontinent at times and required cueing to finish tasks. Review of the Falls CAA dated 6/20/2015 recorded the resident was not at risk for falls and had no fall history. The resident had a steady gait with a limp. Review of the Cognition CAA dated 9/30/2014 recorded the resident was able to communicate his/her needs and wants, was usually able to make reasonable daily decisions, although he/she had poor safety awareness. The resident did resist assistance with his/her ADL cares at times. Review of the ADL CAA dated 9/30/2014 recorded the resident required extensive assistance with all ADLs except for eating and personal hygiene. The resident experienced a right ankle fracture with a repair and now required a wheelchair for locomotion. Review of the Fall CAA dated 9/30/2014 recorded the resident was at risk for falls and had a history of falls with a fracture. Review of the resident's fall risk assessment prior	F 323		

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F 323	<p>Continued From page 36</p> <p>to his/her fall on 6/17/2014 recorded a score of 4, which indicated the resident was not at risk for falls. The assessment failed to accurately score medications, urinary incontinence, and unsteady balance when walking, which would result in a higher score, indicating the resident was a fall risk.</p> <p>Review of the resident's fall risk assessment following his/her fall on 8/13/14 recorded a score of 9, which indicated the resident was not at risk for falls. The assessment failed to accurately score medications, which would result in a higher score, indicating the resident was a fall risk.</p> <p>Review of the resident's care plan dated 3/4/2014 recorded the resident was at risk for falls due to use of psychotropic medications. The care plan directed the staff to keep the bed in a low position, keep the call light and personal items within easy reach, encourage, educate, and assist the resident as needed to keep his/her environment free from clutter, encourage, educate, and assist the resident to wear footwear to prevent slipping, observe for side effects of medications, and assist with toileting every 2 hours and as needed while sleeping during the night, therapy referral as needed. The facility staff revised the care plan on 6/17/2015 to assist with all transfers.</p> <p>Review of a fall investigation dated 6/17/2014 at 5:25 A.M. recorded an aide witnessed the resident getting out of bed with an unsteady gait due to inappropriate footwear. The aide attempted to redirect and educate the resident. The resident stated "I'm just using the toilet." The aide then left the resident's room, walked up the hallway, heard a loud noise and a call for help. As the aide was leaving the room the resident</p>	F 323			

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F 323	<p>Continued From page 37</p> <p>was walking back toward his/her bed. The aide and nurse discovered the resident lying on his/her left side with his/her right foot facing outward.</p> <p>During an observation on 06/30/2015 at 8:12 A.M. the resident propelled him/herself down the hallway where his/her room was located. At 8:15 A.M. direct care staff O propelled the resident into his/her room to the bathroom. The resident required extensive assistance with toileting transfer and clothing management as the resident used the grab bar to assist with transfer from the wheelchair to the toilet. A transfer pole was at the bedside, which the resident used to transfer from the wheelchair to the bed in addition to extensive assistance from staff. The resident wore tennis shoes. Staff O positioned the call light within reach and placed the wheelchair in the hallway.</p> <p>During an observation on 06/30/2015 at 3:01 P.M. the resident activated his/her call light and requested assistance getting out of bed. Direct care staff R provided extensive assistance to help the resident to a standing position while the resident used a transfer pole at the bedside to transfer from the bed to the wheelchair. The resident's antilock brakes on his/her wheelchair did not keep the wheelchair from moving backwards when the resident attempted to scoot him/herself back in the wheelchair.</p> <p>During an interview on 06/30/2015 at 3:04 P.M. the resident reported he/she fell since admission and did not recall the details of when he/she fell and broke his/her ankle</p> <p>During an interview on 06/30/2015 at 8:34 A.M. direct care staff O reported the resident required extensive assistance in the past and currently</p>	F 323		

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F 323	<p>Continued From page 38</p> <p>required limited assistance with toileting and transfers. He/she reported the resident had a fall history and did not experience a serious injury related to falls. Staff O reported current interventions to prevent falls included; placing the call light within reach, keeping the wheelchair out of the resident's room when he/she was in bed, and use of a transfer pole for transfers.</p> <p>During an interview on 06/30/2015 at 3:46 P.M. direct care staff R reported the resident was a fall risk. Staff R reported current interventions to prevent falls included the removal of the resident's wheelchair from his/her room when in bed, use of antilock brakes, transfer pole, bed in low position, and ensuring the call light was within reach. Staff R confirmed the resident's bed was not in a low position and reported the anti lock brakes did not function properly. He/she was unsure whether maintenance was aware.</p> <p>During an interview on 07/01/2015 at 10:30 A.M. direct care staff O reported if the resident displayed behavior, which placed the resident at risk for falling, such as unsteady walking, he/she would remain with the resident until the resident was safe.</p> <p>During an interview on 07/01/2015 at 11:12 A.M. licensed nursing staff H reported the resident was a fall risk due to altered safety awareness and attempts to get out of bed unassisted. Staff H reported interventions to prevent falls included; education provided to use the call light, assess for pain, restorative program, bed in low position to the floor, call light and personal items within reach, environment free of clutter, proper foot wear, observing for medication side effects, blood sugar monitoring, supervision with showers/shower chair, and therapy referrals as</p>	F 323		

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F 323	<p>Continued From page 39</p> <p>needed. Staff H stated he/she expected the direct care staff to remain with any resident who displayed an unsteady gait until the resident was in a safe position.</p> <p>During an interview on 07/01/2015 at 3:04 P.M. administrative nursing staff D reported he/she was aware the antilock brakes on the resident's wheelchair did not function properly and maintenance ordered new antilock brakes. Staff D was unaware of the date staff notified him/her of the brakes or the date of the order. Staff D recalled the resident's fall on 6/17/2014 and expected the aide involved to remain with the resident until the resident was safe. Staff D reported the aide involved received education on the need to remain with the resident until the resident was safe.</p> <p>Review of the facility's Fall Management Guidelines dated 1/22/2015 documented residents were assessed to determine fall history and gait and appropriate interventions were implemented prior to the resident's admission.</p> <p>The facility failed to ensure resident # 90 received adequate supervision to prevent a fall on 6/17/2014, which resulted in a right ankle fracture.</p> <p>- The signed Physician Order Sheet (POS) for resident #73 dated 06/ 04/15 revealed diagnoses of schizoaffective disorder unspecified (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), dementia unspecified with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), epilepsy (brain disorder characterized by repeated seizures) and</p>	F 323			

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F 323	<p>Continued From page 40</p> <p>recurrent seizures, (brain disorder characterized by repeated seizures) diabetes, (impaired insulin utilization coupled with the body's inability to compensate with increased insulin production).</p> <p>The Admission Minimum Data Set (MDS) dated 09/03/2014 revealed the resident was not assessed for Brief Interview of Mental Health (BIMS). The resident's mood score was a 0 which indicated no depression. The resident was independent with bed mobility, transfers, walking in room and corridor, locomotion on and off the unit, and toilet use with no setup or physical help from staff. He/She required supervision for dressing, eating, and personal hygiene with no setup or physical help from staff, and was always continent of bowel and bladder. The resident did not have any falls in the 6-months prior to entry into the facility. He/She received antipsychotic and antidepressant medication 7 out of 7 days; and antianxiety medication 2 out of 7 days of the look back period.</p> <p>The Medicare 5-day (MDS) dated 06/09/2015 revealed a Brief Interview for Mental Health (BIMS) of 4 which indicated severe cognitive impairment. The Mood score of 3 indicated minimal depression. The resident required limited assistance with one staff for bed mobility and transfers. He/She walked on unit with supervision and set up assistance, but walked in the corridor with supervision and assistance of one staff, resident was not steady, and only able to stabilize with assistance. The resident had one non-injury and one major fall since admission or reentry. He/She received 268 minutes of physical therapy 5 out of 7 days of the look back period, resident received antipsychotic, antidepressant and diuretic medications.</p>	F 323			

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F 323	<p>Continued From page 41</p> <p>The Fall Care Area Assessment (CAA) dated 09/03/14 documented no ROM (Range of Motion) limitations, steady gait, independent with ambulation, and denied any pain, and had no recent falls. The nursing progress notes reflected no falls prior to admission. The nursing progress note dated 8/27/2014 revealed the resident had anxiety, and was hyper-verbal and paced. Nursing staff to monitor and report as indicated; as well as treat as ordered. Physical therapy to evaluate as ordered and treat as indicated and as approved by the resident, psychiatrist and physician to review as indicated.</p> <p>Care Plan for falls dated 03/24/2015 revealed resident was at risk for falls related to use of antidepressant medication and a new environment. Assess as needed to move the resident closer to nurse's station and report as indicated, assess for pain every shift and PRN (as needed). Staff to keep the bed in low position as indicated per facility policy, call light or personal items available and within easy reach. Educate, encourage, and assist resident as needed to keep environment well lit and free of clutter. Observe for side effects of medications and report when indicated. Orient the resident to his/her new room and roommate.</p> <p>Record review revealed the resident had four falls from 03/30/2015 through 06/09/2015.</p> <p>The fall investigation dated 03/03/2015 at 6:40 P.M. reported the resident fell in the backyard while walking around during a supervised smoke break. The resident stated he/she " tripped over my feet and lost my balance". This was a non-injury fall. Staff assessed the resident and vital signs were within normal limits and neurological exam was completed.</p>	F 323			

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F 323	<p>Continued From page 42</p> <p>Recommendation was to ask the resident to sit on the bench or picnic table while smoking.</p> <p>The fall investigation dated 05/27/2015 at 7:40 A.M. reported the resident fell to the floor in the front foyer and landed on his/her back and buttocks. The resident was agitated about being in the facility and wanted to leave. This was a non-injury fall witnessed by staff. Recommendation was for the psychiatrist to evaluate resident X-ray was obtained.</p> <p>The fall investigation dated 06/04/2015 at 8:10 P.M. reported the resident fell when going outside using a walker. This was an injury fall. The resident fractured his/her left arm. The resident stated he/she "was going outside" Recommendation was for the staff to provide a wheelchair for the resident's use.</p> <p>The fall investigation dated 06/09/2015 at 3:45 A.M. reported the resident yelling from his/her room. Direct care staff and a nurse found the resident in the bathroom. The resident attempted to ambulate to the rest room without his/her wheelchair. This was an unwitnessed fall without injury. Recommendation was for a change in his/his pain medication.</p> <p>Per observation 06/30/2015 at 11:57 A.M. resident lying in bed, fall mat next to bed, call light with reach, bed in low position and wheelchair next to bed.</p> <p>During an interview on 07/01/2015 at 3:26 P.M. direct care staff Q stated he/she took this resident out to smoke in his/her wheelchair when he/she worked. The use of the wheelchair was not on the direct care staff's jot sheets (a pocket size care plan of resident information).</p>	F 323		

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F 323	<p>Continued From page 43</p> <p>During an interview on 07/01/2015 at 1:05 P.M. administrative nurse GG reported the care plan was started based on the CAAs which he/she completed. As the care plan progressed the charge nurses and administrative staff E were responsible for updating fall and wound interventions.</p> <p>During an interview on 07/01/2015 2:02 P.M. Administrative nurse E stated he/she forgot to update direct care staff's sheet.</p> <p>The facility failed to update the care plan to ensure this cognitively impaired resident who had a history of falls remained free of accident hazards.</p>	F 323			