

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

PRINTED: 07/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/23/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>ATTICA LONG TERM CARE FACILITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 N BOTKIN</b> <b>ATTICA, KS 67009</b>		
(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	{F 000}			
F 225 SS=D	<p>The following citations represent the findings of the Non-Compliance Revisit and Complaint investigations #66094, #65725 and #67316.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</p> <p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and</p>	F 225			

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 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.  This REQUIREMENT is not met as evidenced by: The facility census totaled 49. The sample included 3 residents were reviewed for neglect. Based on interview and record review the facility failed to immediately report potential neglect, for one of three residents (#2), to the State Hotline.  Findings included:  - Review of nursing notes for Resident #2 identified staff found the resident lying partially on the bed and partially off of the bed on the evening of 5-3-13. Staff documented the resident's head was between the help rail and the mattress of the bed at the time the staff checked the resident.  The facility failed to report the potential neglect to the State Hotline until 5-6-13.  The facility failed to immediately report the potential neglect to the State Hotline. The incident occurred on 5-3-13 and the facility reported it to the State Hotline 3 days later on 5-6-13.	F 225			
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	{F 279}		6/5/13	

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{F 279}	<p>Continued From page 2</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: The facility census totaled 49. The sample included 12 residents reviewed for care plans. Based on interview and record review the facility failed to develop a comprehensive care plan, including use of a "help rail" for 1 of 12 sampled residents (#2).</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Review of resident #2's annual Minimum Data Set (MDS) dated 3-11-13 revealed the resident scored a 0 on the Basic Interview for Mental Status (BIMS) which indicated the resident displayed severe cognitive impairment. The MDS further identified the resident required extensive assistance of two for bed mobility. The MDS also identified the resident required extensive assistance of one for transfers, walking in room</li> </ul>	{F 279}			

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{F 279}	<p>Continued From page 3</p> <p>and corridor, dressing, toileting and personal hygiene. The MDS showed no use of side rails for this resident.</p> <p>Review of the significant change MDS dated 6-3-13 revealed the resident had a BIMS of 0. The resident required extensive assistance of one person for dressing and eating. The resident required extensive assistance of 2 persons for bed mobility. The MDS showed the resident was dependent on two staff for transfers and toileting and one staff for personal hygiene. The MDS identified no use of side rails for this resident.</p> <p>Review of the care plan with an initial date of 9-6-11 revealed the resident had a monitor and bed pad alarm to alert staff if the resident tried to walk or transfer self. The care plan updated on 6-11-13 included the resident received hospice care. The care plan identified staff needed to perform personal hygiene for the resident, and he/she received a bed bath by staff. The care plan included staff transfer of the resident using a sling lift. The care plan identified the resident stayed in his/her room in his/her bed or his/her recliner for comfort. The care plan identified the resident as non-ambulatory and did not stand. The care plan also identified the resident demonstrated independence to extensive assistance needs for bed mobility, which varied moment by moment. On 11-28-11 staff noted the addition of a mat to the floor next to the resident's bed because he/she had a habit of getting him/herself out of bed and lowering him/herself down onto the mat. The staff noted since the resident had this habit they would not intervene. The care plan also identified the resident had an alarm to alert staff to him/her getting up</p>	{F 279}			

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{F 279}	<p>Continued From page 4</p> <p>unassisted, and a bed sensor while in bed. Staff revised the care plan again on 5-3-13 with a note that the staff found the resident "on floor mat, head against bed rail- New low bed being attempted. Mats will be on floor and he/she routinely scoots off the bed onto mats." Interview on 7-23-13 at 3:00 p.m. with Administrative Nursing Staff D revealed the resident used the help rail when he/she wanted to use it. Staff D said the staff still had to assist the resident up for Activities of daily living (ADL's) to get done what needed done, but the resident could get him/herself up without staff assist, but didn't follow directions of the staff. The staff failed to develop a care plan that included the need, how and when to use the "help rails" on the resident's bed until 5/3/13. The facility also failed to develop care plan interventions to prevent potential safety risks related to the "help rail".</p> <p>Review of the physical restraint elimination assessment dated 3-11-13 revealed the resident leaned and scooted while in the wheelchair or recliners, had a history of frequent falls in past prior to use of merry walker, alert and oriented only to self. Normal for resident to be confused and anxious usually cannot follow simple directions, easily agitated. Frequently anxious, depending on activity, may participate with assist. Merry Walker (an assistive device with a seat to allow an unstable resident to walk safely and sit down when needed) used for safety.</p> <p>A nurses note dated 5-3-13 at 11:30 p.m. revealed at 7:30 p.m. staff found the resident on a floor mat with his/her head against mattress and bed rail. Staff assisted the resident back to</p>	{F 279}			

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{F 279}	<p>Continued From page 5</p> <p>bed, and then lowered the rail for safety of the resident. Licensed Nursing Staff G notified, the nurse on call, Licensed Staff D of the incident. Staff G also noted in the nurse note that he/she obtained a new low bed for the resident, and put the resident in the new bed for safety. Staff G also noted staff would continue with the use of floor mats for the resident. Staff G noted the plan to continue to monitor the resident closely. The note also showed the resident ate broth for supper. Staff noted the resident displayed fatigue. The staff documented the resident demonstrated restlessness until an hour after the staff administered the resident's evening medications.</p> <p>Review of the most recent side rail quarterly assessment dated 3-14-13 identified the resident did not ambulate, demonstrated an alteration in safety awareness due to cognitive decline, demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed, had difficulty with balance or poor trunk control, did not use side rails while in bed, did not express the desire to have side rails raised while in bed, did not indicate a need for side rails and did not use the rails as an enabler to promote independence and no further evaluation required to determine appropriateness of side rails. An undated handwritten note under the comment section identified the resident used help rails. Interview on 7-22-13 at 1:07 p.m. with Administrative Nursing Staff B revealed the facility used the side rail quarterly assessment for both side rails and help rails. After discussion Staff B said he/she could see the need for separate assessments for the two different types of rails, and he/she would get one in place within the day.</p>	{F 279}			

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{F 279}	Continued From page 6  Interview on 7-17-13 at 7:51 p.m. with Licensed Nursing Staff G revealed the resident always had a lot of restless movement and often got on the floor on the fall mat to sleep. Staff G said family reported the resident also often laid on the floor at home, prior to admission to the facility. Staff G said the staff had always let the resident have the option of lying on the floor because it made him/her more comfortable. On the night of the incident, 5-3-13, Staff G said Direct Care Staff F made rounds on residents and found the resident with his/her head between the mattress and the rail of the bed. Staff G said Staff F came and requested help of Staff G to get the resident repositioned. Staff G said the two staff lifted the resident's head and then rolled his/her body back on the bed. Staff G documented in the nurse notes that the resident's blood pressure was 158/74 pulse 99, respirations 18 and oxygen saturations was 96% on room air. The nursing notes contained no indication of injury.  The facility failed to develop a care plan related to the use of a help rail with a resident who displayed frequent episodes of constant motion and the potential for the constant motion to move the bed mattress leaving a potentially dangerous gap between the help rail and the mattress for resident	{F 279}			
{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.	{F 323}		6/6/13	

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{F 323}	Continued From page 7  This REQUIREMENT is not met as evidenced by: The facility census totaled 49. The sample included 4 residents reviewed for accidents. Based on interview and record review the facility failed to ensure adequate supervision to provide a safe environment for one sampled resident (#2) with "help rails".  Findings included:  - Review of resident #2's annual Minimum Data Set (MDS) dated 3-11-13 revealed the resident scored a 0 on the Basic Interview for Mental Status (BIMS) which indicated the resident displayed severe cognitive impairment. The MDS further identified the resident required extensive assistance of two for bed mobility. The MDS also identified the resident required extensive assistance of one for transfers, walking in room and corridor, dressing, toileting and personal hygiene. The MDS showed no use of side rails for this resident.  Review of the significant change MDS dated 6-3-13 revealed the resident had a BIMS of 0. The resident required extensive assistance of one person for dressing and eating. The resident required extensive assistance of 2 persons for bed mobility. The MDS showed the resident was dependent on two staff for transfers and toileting and one staff for personal hygiene. The MDS identified no use of side rails for this resident.	{F 323}			

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{F 323}	Continued From page 8  Interview with Administrative Nursing Staff D on 7-23-13 at 3:00 p.m. in regard to the assessment and care plan indicating the resident required extensive assistance for bed mobility, revealed the resident used the help rail and moved about in bed and got up if he/she wanted. Staff D said the staff still had to assist the resident up for ADL's to get done what needed done, but the resident could get him/herself up without staff assist.  Review of the care plan with an initial date of 9-6-11 revealed the resident had a monitor and bed pad alarm to alert staff if the resident tried to walk or transfer self. The care plan updated on 6-11-13 included the resident received hospice care. The care plan identified staff needed to perform personal hygiene for the resident, and he/she received a bed bath by staff. The care plan included staff transfer of the resident using a sling lift. The care plan identified the resident stayed in his/her room in his/her bed or his/her recliner for comfort. The care plan identified the resident as non-ambulatory and did not stand. The care plan also identified the resident demonstrated independence to extensive assistance needs for bed mobility, which varied moment by moment. On 11-28-11 staff noted the addition of a mat to the floor next to the resident's bed because he/she had a habit of getting him/herself out of bed and lowering him/herself down onto the mat. The staff noted since the resident had this habit they would not intervene. The care plan also identified the resident had an alarm to alert staff to him/her getting up unassisted, and a bed sensor while in bed. Staff revised the care plan again on 5-3-13 with a note that the staff found the resident "on floor mat,	{F 323}			

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{F 323}	<p>Continued From page 9</p> <p>head against bed rail- New low bed being attempted. Mats will be on floor and he/she routinely scoots off the bed onto mats." Interview on 7-23-13 at 3:00 p.m. with Administrative Nursing Staff D revealed the resident used the help rail when he/she wanted to use it. Staff D said the staff still had to assist the resident up for ADL's to get done what needed done, but the resident could get him/herself up without staff assist, but didn't follow directions of the staff. The staff failed to develop a care plan that included the need, how and when to use the "help rails" on the resident's bed until 5/3/13. The facility also failed to develop care plan interventions to prevent potential safety risks related to the "help rail".</p> <p>Review of the physical restraint elimination assessment dated 3-11-13 revealed the resident leaned and scooted while in the wheelchair or recliners, had a history of frequent falls in past prior to use of merry walker, alert and oriented only to self. Normal for resident to be confused and anxious usually cannot follow simple directions, easily agitated. Frequently anxious, depending on activity, may participate with assist. Merry Walker used for safety.</p> <p>Nurses notes dated 5-1-13 at 10:00 a.m. noted the resident returned to the facility from the hospital. Staff identified the resident as lethargic, opened eyes a little, did not move much.</p> <p>On 5-2-13 at 1:20 p.m. staff noted the resident displayed extreme anxiousness and agitation. The staff noted the resident attempted to crawl out of both, the bed and the merry walker. Staff</p>	{F 323}			

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{F 323}	<p>Continued From page 10 identified the resident remained in constant motion.</p> <p>Nurses notes dated 5-2-13 at 1:45 p.m. noted the resident attempted to stand up with staff assist but did not bear much weight. The nursing notes showed staff laid the resident in bed but he/she would not stay in the bed; the resident moved him/herself to the mat. Staff attempted to sit the resident in a Geri chair and the resident kept scooting all the way out of the chair. Staff then tried the merry walker and the resident could not stand but continuously tried; kept scooting self to sit on strap. At the time staff wrote this note the resident laid on the floor on mats for "safety". The CNA's (certified Nurse Aides) did frequent visual checks on the resident.</p> <p>Nursing notes dated 5-2-13 at 10:20 p.m. identified the resident displayed restlessness. At 5:30 p.m. staff had assisted the resident to the Geri chair (a reclining chair on wheels) and fed the resident. The note further identified when staff fed the resident and during the meal the resident patted his/her thighs, spoke through clenched teeth, scooted down in the Geri Chair and drew up his/her knees. The nurse identified staff assisted the resident to the mats on the floor. The staff monitored the resident frequently and observed him/her for safety. Staff noted the resident kicked the mats lightly, scooted around on the mats patting his/her thighs and motioned with his/her hand while he/she said "come here, come here." Staff went into the room to try and help relieve the resident's anxiety. The staff could only relieve the anxiety momentarily. Nursing staff noted on 5-2-13 at 10:45 p.m. the resident remained very restless and continued</p>	{F 323}			

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{F 323}	<p>Continued From page 11</p> <p>scooting mats. Staff addressed the resident's needs and ADL 's (Activities of Daily Living) carefully. Nursing staff also noted CNA's and Nurses performed frequent visual checks of the resident for safety and needs. The residents vital signs remained within normal limits.</p> <p>The next note dated 5-3-13 at 2:05 a.m. identified the resident remained "very restless". The same note identified the resident still laid on the mat on the floor, and staff continued frequent visual checks for safety and assisted the resident with ADL's.</p> <p>On 5-3-13 at 3:30 p.m. the nurse noted the resident required extensive assist with ADL's toileting and transfers. The nurse also noted the resident had multiple incontinent loose stools. At 3:00 p.m. the resident received Imodium 2 milligram (mg) for loose stools. Staff documented the Imodium provided some relief for the diarrhea, however the resident had red and sore rectum and buttocks.</p> <p>A nurses note dated 5-3-13 at 11:30 p.m. revealed at 7:30 p.m. staff found the resident on a floor mat with his/her head against mattress and bed rail. Staff assisted the resident back to bed, then lowered the rail for safety of the resident. Licensed Nursing Staff G notified, the nurse on call, Licensed Staff D, of the incident. Staff G also noted in the nurse note that he/she obtained a new low bed for the resident, and put the resident in the new bed for safety. Staff G also noted staff would continue with the use of floor mats for the resident. Staff G noted the plan to continue to monitor the resident closely. The note also showed the resident ate broth for supper. Staff noted the resident displayed fatigue. The staff documented the resident demonstrated</p>	{F 323}			

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{F 323}	<p>Continued From page 12</p> <p>restlessness until an hour after the staff administered the resident's evening meds.</p> <p>Review of the facility investigation completed on 5-13-13 showed the incident happened on a Friday, 5-3-13 at 7:30 p.m. The report information statement noted Administrative Nursing Staff B visited with Administrative Staff A on the 6th of May. Administrative Staff A reported the incident that occurred on 5-3-13 to Staff B. Staff B e-mailed the hotline to alert them the facility had a reportable incident. The summary of the investigation noted Administrative Staff A went into the facility and Licensed Nurse G reported that the resident got caught in between the mattress and the side rail. Staff A then told Staff G to change out the bed for the resident, and not to leave him/her in the same bed. The report also noted direct care staff F found the resident on the floor mat and on the bed with his/her head caught in between the mattress and the help rail. The investigation also noted staff replaced the bed of the resident with a PVC bed, then placed the resident in it.</p> <p>Review of a physical exam completed by Medical Staff C on 5-10-13 revealed the resident returned to the facility after a hospital stay. Staff C noted the resident displayed much less activity since the hospital stay (4-20-13 to 5-1-13) and needed mostly comfort care. Facility staff reported to Staff C that the resident got more alert and sometimes agitated after the hospital stay.</p> <p>Staff C identified the resident had a diagnoses of dementia with behavior first diagnosed on 9-16-11, Diabetes Mellitus without complications, first identified on 9-6-11 and a gastrointestinal</p>	{F 323}			

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{F 323}	<p>Continued From page 13 bleed first identified in the record on 5-10-13.</p> <p>Staff C performed a physical exam, and noted the resident displayed agitation, movement in the Geri chair and slapping his/her hands to his/her own thighs constantly, did not open his/her eyes. Staff C noted the resident sometimes followed simple commands but did not talk or respond well to touch or voice.</p> <p>Review of the most recent physical restraint elimination assessment date 3-11-13 revealed the resident leaned and scooted while in the wheelchair or recliners, had a history of frequent falls in past prior to use of merry walker, and was alert and oriented only to self. The staff identified this as normal for the resident to display confusion and anxiousness and lack of ability to follow simple directions; easily agitated.</p> <p>Review of the most recent side rail quarterly assessment dated 3-14-13 identified the resident did not ambulate, demonstrated an alteration in safety awareness due to cognitive decline, demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed, had difficulty with balance or poor trunk control, did not use side rails while in bed, did not express the desire to have side rails raised while in bed, did not indicate a need for side rails and did not use the rails as an enabler to promote independence and no further evaluation required to determine appropriateness of side rails. An undated handwritten note under the comment section identified the resident used help rails. Interview on 7-22-13 at 1:07 p.m. with Administrative Nursing Staff B revealed the facility used the side rail quarterly assessment for both side rails and help rails. After discussion</p>	{F 323}			

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{F 323}	<p>Continued From page 14</p> <p>Staff B said he/she could see the need for separate assessments for the two different types of rails, and he/she would get one in place within the day.</p> <p>Review of the facility investigation of the incident showed the incident happened on a Friday, 5-3-13 at 7:30 p.m., and no one contacted the hotline until 5-6-13 when Administrative Nursing Staff B returned from vacation and Administrative staff A reported the incident to Staff B.</p> <p>The statement written by Administrative Staff A noted when he/she went by the resident's room and saw mats on the floor he/she asked the staff about the mats and staff said the resident displayed restlessness and staff put the mats down for the resident to lay on because staff had concerns about the resident's safety. Staff A then asked Licensed Nurse G what else he/she did about the incident. According to the statement written by Staff A, Staff G reported Administrative Licensed Nursing Staff E knew about the incident. Staff A then asked Staff G what he/she did about the resident's bed. Staff G said he/she did nothing but did say Administrative Nursing Staff D and E both knew about the incident. Staff A called Staff E to ask about the situation and Staff E said he/she and Licensed Staff D did not know what else to do other than put mats out to protect the resident. Staff A asked about the call light and how staff monitored the resident and was told staff checked the resident when they walked by the resident's room. Staff D reported he/she contacted the resident's responsible party, and that person agreed to try and keep the resident safe by using the floor mats. Staff A then investigated the location of a PVC bed and helped other staff get the bed into the resident's</p>	{F 323}			

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{F 323}	<p>Continued From page 15 room.</p> <p>Administrative Nursing Staff D wrote a statement that he/she received a phone call from Staff A sometime after 8:00 p.m. on 5-3-13. Staff A said he/she thought changing the bed for the resident might help. Staff D agreed if someone located a PVC bed. Staff A also asked Staff D what to put on the careplan, so he/she could pass it on to the charge nurse.</p> <p>A statement from Direct Care Staff F revealed on 5-3-13 he/she made rounds, and made sure everyone was okay when he/she checked in on the resident and found him/her with his/her head stuck between the mattress and bed rail on the left side of the bed. Staff F said he/she and a contracted help, staff put the resident in a chair while they switched the beds out. Staff F noted the resident "was on the ground" multiple times during the shift.</p> <p>A statement from Licensed Nursing Staff G revealed the resident 's bed mattress scooted back against the wall. Staff G noted the resident's head lay on the bed rail between the mattress and the help rail. Staff G and Direct Care Staff F then assisted the resident into a sitting position and helped the resident with positioning in bed with the resident's head on a pillow at the head of the bed. Staff lowered the resident's help rail for safety. Staff G notified Staff D. Staff G noted staff obtained a new low bed for the resident and continued to use the floor mats.</p> <p>Interview on 7-17-13 at 7:51p.m.with Licensed Nursing Staff G revealed the resident always had a lot of restless movement and often got on the floor on the fall mat to sleep. Staff G said family reported the resident also often laid on the floor at home, prior to admission to the facility. Staff G</p>	{F 323}			

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{F 323}	<p>Continued From page 16</p> <p>said the staff had always let the resident have the option of lying on the floor because it made him/her more comfortable. On the night of the incident, 5-3-13, Staff G said Direct Care Staff F made rounds on residents and found the resident with his/her head between the mattress and the rail of the bed. Staff G said Staff F came and requested help of Staff G to get the resident repositioned. Staff G said the two staff lifted the resident's head and repositioned the resident on the bed. Staff G documented in the nurse notes that the resident's blood pressure was 158/74, pulse 99, respirations 18 and oxygen saturations was 96% on room air. The nursing notes contained no indication of injury.</p> <p>Interview of Direct Care Staff F on 7-17-13 at 7:55 p.m. revealed Staff F found the resident on the night of 5-3-13 with his/her head resting between the mattress and rail. Staff F said the resident always displayed restlessness even before the last hospitalization (4/20/13 through 5/1/13); however he/she used to smile prior to the hospitalization, but now he/she doesn't smile or act like he/she is happy.</p> <p>Administrative Nursing Staff B said on 7-18-13 at 10:51 a.m., the resident never stopped moving after the return from the hospital. Staff B said even when staff fed the resident, he/she remained in constant motion. Staff B said the resident had not felt good for a while. Staff B said the resident received the services of a hospice and at the time this incident occurred the resident was on comfort care measures. Staff B said even when the resident first came to the facility a couple of years back, the resident clapped his/her hands and patted his/her legs frequently. Staff B</p>	{F 323}			

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{F 323}	Continued From page 17 said the doctor diagnosed the resident with scabies and as soon as that condition got under control the resident's movements lessened considerably. Interview with Staff B on 7-22-13 at 5:30 p.m. revealed the facility had a variety of mattress keepers on different types of beds. Some had plastic corners on the bed foundation to keep the mattress from sliding off the bed, some had open guides on each end of the bed and some had metal guides on all four sides of the bed. Staff B was not sure how the resident ' s mattress got partially off of the bed with mattress guides on the unless somehow in the resident ' s restlessness he/she kicked one of the guides down.  The facility identified the resident displayed "constant motion" frequently, however the facility failed to identify the potential for the residents constant motion to cause the mattress to slide out of place on the bed, even with mattress keepers (plastic or metal strips designed to hold the mattress in place on the bed) leaving a potentially dangerous gap between the rail of the bed and the mattress.	{F 323}			
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify	{F 520}			5/11/13

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{F 520}	<p>Continued From page 18</p> <p>issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: The facility census totaled 49 residents with 12 residents sampled. Based on deficiencies cited on the Health Survey completed on 5-20-13 and re-cited on the Noncompliance Revisit completed on 7-23-13 the facility failed to developed implement an effective quality assurance plan. This had the potential to affect all 49 residents in the facility.</p> <p>Findings included:</p> <p>- Interview with Administrative Staff B on 7-23-13 at 4:20 p.m. revealed the members of the facility's Quality Assurance Committee Program had talked about identifying and reporting all incidents of alleged abuse, neglect or exploitation to the State in a timely manner. Staff B said the daily "stand up meeting" was utilized to identify and address the incidents. The facility failed to report an allegation of neglect regarding one resident, in</p>	{F 520}			

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{F 520}	<p>Continued From page 19</p> <p>a timely manner. Please see F 225 for additional information.</p> <p>- Interview with Administrative Staff B on 7-23-13 at 4:20 p.m. revealed the members of the facility's Quality Assurance Committee Program had talked about development of care plans to include all needs of the individual residents, and the staff responsible for care plans had a plan to review and revise all care plans in the facility. The plan included review and revision of each care plan at least quarterly, and the care plan staff pulled some care plans prior to the quarterly date. The facility failed to develop a comprehensive care plan for one resident reviewed. Please see F 279 for additional information.</p> <p>- Interview with Administrative Staff B on 7-23-13 at 4:20 p.m. revealed the members of the facility's Quality Assurance Committee Program had talked about and developed a plan of trending accidents and determining what action to take to prevent further accidents. The facility failed to identify one residents constant movement as a possible accident hazard due to the movement of the resident's bed mattress. Please see F 323 for additional information.</p> <p>The facility failed to develop and implement an effective Quality Assurance Program to address all quality deficiencies identified on the Health Resurvey dated 5-20-13.</p>	{F 520}			