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

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FORM APPROVED
OMB NO. 0938-0391

RECEIVED NOV 24 2015 Division of Health Care Southern Enforcement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 07/30/2015
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	

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F 000	INITIAL COMMENTS AMENDED An abbreviated/standard/extended survey (complaint #KY23569) was initiated on 07/22/15 and concluded on 07/30/15. The complaint was substantiated and Immediate Jeopardy was identified on 07/23/15 and was determined to exist on 04/12/15 at 42 CFR 483.20 Resident Assessment (F280 - "J") and 42 CFR 483.25 Quality of Care (F323 - "J"), with Substandard Quality of Care at 42 CFR 483.25 Quality of Care (F323). The facility was notified of the Immediate Jeopardy on 07/23/15. The facility failed to assess Resident #8's risk factors for falls and failed to evaluate fall interventions to determine if further interventions/actions were needed when the resident sustained a fall from the wheelchair on 03/05/15. Resident #8 sustained another fall from the wheelchair on 04/12/15, which resulted in a brain injury. The resident passed away on 04/23/15. A standard health survey was conducted on 07/28-30/15 in conjunction with the abbreviated survey. An acceptable Allegation of Compliance was received on 07/30/15, which alleged removal of the Immediate Jeopardy on 07/30/15. An extended survey was conducted on 07/30/15, and the State Survey Agency determined the Immediate Jeopardy was removed on 07/30/15, which lowered the scope and severity to "D" at 42 CFR 483.20 Resident Assessment (F280) and 42 CFR 483.25 Quality of Care (F323) while the facility monitors the effectiveness of systemic	F 000	Prestonsburg Health Care Center does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should considered as a wavier of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response , credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn Watts
TITLE: LNHA
(X6) DATE: 11-24-15

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 000	Continued From page 1 changes and quality assurance activities. Additional deficient practice was identified at 42 CFR 483.20 Resident Assessment (F278 - "E" and F279 - "D") and 42 CFR 483.64 Infection Control (F441 - "D").	F 000		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	**F278 483.20(g)-(j)ASSESSMENT ACCURACY COORDINATION/CERTIFIED** **Corrective action for resident(s) affected:** DON, ADON, ADM, Regional MDS nurse or wound nurse reviewed #17, #18, #22, and #23 MDS for accuracy on 9-11-15. Inaccuracy MDS were modified on 9-11-15 by DON or regional nurse.	

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F 278	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure residents received an accurate assessment by staff regarding relevant care areas about the residents' status, needs, strengths, and areas of decline for four (4) of twenty-six (26) sampled residents (Residents #17, #18, #22, and #23). Residents #17, #18, #22, and #23 were assessed by facility staff on the most recent Minimum Data Set (MDS) Assessments to require extensive assistance from staff for various areas of activities of daily living (ADLs). However, observations and interviews with facility staff and residents, conducted on 07/30/15, revealed the assessments were not accurate and the residents did not require the amount of assistance that was coded by the facility on the MDS. The findings include: Interview with the Minimum Data Set (MDS) Assessment Coordinator on 07/30/15 at 2:17 PM revealed the facility had no policy related to MDS assessments; however, she stated she utilized the MDS manual in completing assessments for facility residents. A review of the MDS 3.0 manual revealed when completing the ADL section of the MDS, staff should review the documentation in the medical record for the last seven days; talk with direct care staff from each shift that has cared for the resident to learn what the resident does for himself during each episode of each ADL activity during the seven day look-back period; and when reviewing records, interviewing staff, and	F 278	**How the Facility will act to protect residents in similar situations:** DON, ADON, and ADM or Wound Nurse will reassess all other residents MDS for accuracy by 9-13-15. All MDS that are found to be inaccurate will be modified by DON or Regional MDS Nurse by 9-14-15. **Measures to prevent reoccurrence:** Regional MDS nurse will train our new MDS nurse on accuracy of MDS within 1 week of hire date. **Monitoring of correction action:** The DON, ADON, and or regional nurse will audit 5 different residents MDS for accuracy weekly for 4 weeks then monthly for 3 months then every 3 months for 6 months. Findings will be discussed in QAPI and issues identified will be addressed immediately. **Completion Date:** 10-1-15	

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F 278	Continued From page 3 observing the resident, be specific in evaluating each component as listed in the ADL activity definition. 1. Review of Resident #17's medical record revealed facility staff admitted the resident on 04/02/15 with diagnoses that included Lack of Coordination and Dementia. Review of a significant change MDS assessment for the resident, dated 07/03/15, revealed the resident required extensive assistance of two (2) staff members with bed mobility and transferring. Staff had also assessed Resident #17 to require extensive assistance of one (1) staff member for walking in his/her room and for locomotion on and off the unit. However, review of Resident #17's physician's orders dated 07/01/15 revealed the resident had orders that he/she "May Transfer Independently." Further review revealed the order for the resident to transfer independently was initiated on 05/25/15. Observations conducted of Resident #17 on 07/30/15 at 9:00 AM revealed the resident transferred from bed to a standing position and ambulated in the room and to the facility dining room with no assistance required from staff. Interview with State Registered Nurse Aide (SRNA) #6 on 07/30/15 at 11:00 AM revealed she had provided care to Resident #17 within the past 30 days. The SRNA stated she had never had to provide assistance to the resident with transferring out of bed, and stated the resident turned and repositioned independently when in bed. The SRNA stated Resident #17 ambulated in and out of his/her room independently, and	F 278		

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F 278	Continued From page 4 required no assistance with ambulation. 2. Review of Resident #22's medical record revealed facility staff admitted the resident on 07/01/15 with diagnoses that included Diabetes and Weakness. Review of the admission MDS assessment dated 07/08/15, revealed staff assessed the resident to require extensive assistance of two (2) staff members with bed mobility, transferring, and walking in his/her room. Staff had also assessed that the resident required extensive assistance of one (1) staff member for locomotion on and off the unit. Observations of Resident #22 on 07/30/15 at 12:00 PM revealed the resident rose from the bed and ambulated to his/her sink with no assistance required. Continued observations revealed the resident ambulated in the facility hallway and to the dining room, with no assistance required from staff. Interview with SRNA #6 on 07/30/15 at 11:00 AM revealed she had provided care to Resident #22 often within the past 30 days. The SRNA stated she had never had to provide assistance to Resident #22 with transferring out of bed, and the resident was able to turn and reposition independently when in bed. The SRNA stated the resident ambulated in and out of the room independently, and required no assistance with ambulation. 3. Review of Resident #18's medical record revealed the facility admitted the resident on 07/06/15 with diagnoses that include Cerebral Vascular Accident (CVA), Degenerative Disc Disease (DDD), Spinal Stenosis, and Dementia.	F 278		

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F 278	Continued From page 5 Review of the admission MDS assessment dated 07/13/15 revealed staff assessed the resident to require extensive assistance of two (2) staff members with transfers and ambulation. Resident #18's Brief Interview for Mental Status (BIMS) score was 15, which revealed the resident was interviewable. However, review of Resident #18's physician's orders, dated 07/07/15, revealed an order that the resident may transfer with one (1) assist and a gait belt. Observations of Resident #18 on 07/30/15 at 9:45 AM revealed the resident up in the facility hall ambulating with the assistance of one (1) staff member and the use of a walker and a gait belt. Interview on 07/30/15 at 9:45 AM with Resident #18 revealed the resident required the assistance of one (1) staff member and the use of a walker and a gait belt for transfers and ambulation. Interview on 07/30/15 at 10:05 AM with SRNA #6 revealed Resident #18 required assistance of one (1) staff member and the use of a gait belt for ambulation and transfers. The interview further revealed the SRNA had worked with Resident #18 often since his/her admission to the facility and the resident had always ambulated with the assistance of one (1) staff member and the use of a gait belt and a walker. 4. Review of Resident #23's medical record revealed the facility readmitted the resident on 07/13/15 with diagnoses that include Peripheral Vascular Disease (PVD), Difficulty Walking, Muscle Weakness, and Neuropathy. Review of the admission MDS assessment dated 07/20/15	F 278		

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F 278	Continued From page 6 revealed staff assessed the resident to require extensive assistance of two (2) staff members for transfers and toileting. Resident #23's BIMS score was 13, which revealed the resident was interviewable. Observation on 07/30/15 at 10:05 AM of Resident #23 revealed the resident transferred independently from the resident's wheelchair to the toilet. Interview on 07/30/15 at 10:15 AM with Resident #23 revealed the resident was independent for all activities of daily living except the resident required assistance with showers. Interview on 07/30/15 at 2:25 PM with SRNA #8 revealed Resident #23 was independent for activities of daily living except the resident required assistance with showers. The interview further revealed the SRNA had worked with Resident #23 multiple times since the resident's admission to the facility and the resident had always been able to transfer and toilet independently. Interview with the MDS Coordinator on 07/30/15 at 2:17 PM revealed she was responsible to code the Functional Status portion of MDS assessments for facility residents. The MDS Coordinator stated she coded the MDS from information obtained from the tracking forms completed by the facility SRNAs, and she also reviewed physician's orders and therapy documentation. The MDS Coordinator stated even if she had observed a resident's functional status that contraindicated the information added into the ADL tracking system by the SRNAs, she "still coded the highest level of assistance	F 278		

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F 278	Continued From page 7 documented by the" SRNAs. The MDS Coordinator stated when she had identified discrepancies in the ADL tracking information related to a resident's functional status, she should have "clarified" the SRNA's "fluctuations" in documentation related to the assistance the resident was documented to require, prior to coding information on the resident's MDS assessment. The MDS Coordinator acknowledged Residents #17 and #22 ambulated independently in the facility daily, Resident #18 transferred independently and ambulated with one (1) staff member's assistance and the use of a gait belt, and Resident #23 was independent with transfers and toileting. However, she had not identified that the MDS information she had coded was inaccurate related to the residents' functional status. Interview with the facility Clinical Resource Specialist on 07/30/15 at 2:26 PM revealed she conducted quarterly audits in the facility to ensure MDS assessment information had been coded accurately. She stated she had conducted an audit "a few months ago" at the facility and had not identified any "major concerns."	F 278		
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. 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	F 279	**F 279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** **Corrective action for resident(s) affected:** DON, ADON, MDS Coordinator and or nurse reassessed resident #3, #11, #20, and #21 for assistance needed with Adls on 10-1-15. The care plans and CNA care plans were update to appropriately reflect the findings by DON, ADON, and/or nurse on 10-1-15.	

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F 279	Continued From page 8 assessment. 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). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility policy it was determined the facility failed to use the results of the assessment to develop the residents' comprehensive plans of care for three (3) of twenty-six (26) sampled residents (Residents #11, #20, and #21). Review of the Minimum Data Set (MDS) Assessments for Residents #11, #20, and #21 revealed the residents were assessed using the MDS for the level of assistance required to be provided by staff. However, review of the Comprehensive Care Plans for the residents revealed the information in the plan of care was not consistent with the assessment. Interview with the MDS Coordinator revealed she had not utilized information from the residents' MDS assessments to develop, review, and/or revise the residents' comprehensive plans of care. The findings include: Review of the facility policy titled "Care Plans,"	F 279	**How the facility will act to protect residents in similar situations:** All other residents will be reassessed by the DON, ADON, and/or nurse for assistance needed for adls by 10-1-15. All other resident's care plans and CNA care plans will be updated to reflect these needs by 10-1-15 by DON,ADON, and/or nurse. **Measures to prevent reoccurrence:** SDC will inservice all nursing staff on appropriately identifying and documenting resident ADL care needs along with updating resident care plans and CNA care plans by 8-21-15. Will train new MDS Coordinator in all aspects of adl coding for MDS and care plan by MDS Regional nurse within one week of hire date. **Monitoring of correction action:** The DON, ADON, and or nurse will audit 10 different residents care plans for correct adl assistance needed weekly for 4 weeks then monthly for 3 months then every 3 months for 6 months. All findings will be discussed in QAPI. Concerns will be addressed immediately.	

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F 279	Continued From page 9 last revised October 2010, revealed the residents' comprehensive care plans were based on a thorough assessment which included, but was not limited to, the MDS Assessment. 1. Review of Resident #21's medical record revealed the facility admitted the resident on 07/09/15 with diagnoses that included Difficulty Walking and Dementia. Review of an Admission MDS assessment dated 07/16/15 revealed staff assessed the resident to require extensive assistance of two (2) staff members with transferring and ambulation in his/her room. The resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident was not interviewable. Review of Resident #21's comprehensive care plan dated 07/16/15, revealed the resident required assistance of one (1) staff person and use of a gait belt, instead of two (2) person assist per the MDS assessment when he/she was transferred. Further review of the care plan revealed the care plan failed to direct staff on what level of assistance was required to assist the resident with ambulation. The "Certified Nurse Aide" (CNA) care plan directed staff to provide assistance with mobility to the resident; however, the number of staff required to safely assist the resident was not included on the resident's plan of care. Interview with State Registered Nurse Aide (SRNA) #6 on 07/28/15 at 10:05 AM, revealed she had provided care to Resident #21 a "couple" of times since the resident's admission to the facility. She stated the resident required assistance of one (1) staff member for transfers and ambulation, and had never required	F 279	**Completion date:** 10-1-15	

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F 279	Continued From page 10 assistance of two (2). 2. Review of the medical record revealed the facility admitted Resident #20 on 10/29/09 with diagnoses that included Mood Disorder, Anxiety, Depression, Psychotic Disorder, Schizophrenia, Difficulty Walking, Lack of Coordination, Generalized Weakness, Urinary Retention, and Gastroesophageal Reflux. Review of an Annual Minimum Data Set (MDS) assessment completed on 02/06/15 revealed the facility assessed Resident #20 to require extensive physical assistance of two (2) or more persons with transfers. Review of the Fall Risk assessment for Resident #20 dated 02/13/15 revealed Resident #20 was assessed to be at high risk for falls. Further review of the medical record revealed the comprehensive care plan for Resident #20 dated 02/06/15 did not address Resident #20's need for two (2) persons to assist with transfers as assessed on the MDS. Review of the facility's fall investigation for Resident #20 revealed the resident sustained a fall on 04/16/15 at 11:30 AM, when one (1) CNA assisted the resident from the bed to the wheelchair. The nursing fall intervention that was implemented on 04/16/15 was to refer Resident #20 to Therapy to evaluate for transfer with the assistance of two (2) persons instead of one (1) person. However, the resident had already been assessed on the annual MDS assessment dated 02/06/15 to require the assistance of two (2) persons with transfers but the information was not on the plan of care. 3. Review of the medical record for Resident #11	F 279		

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F 279	Continued From page 11 revealed the facility admitted the resident on 02/22/10 with diagnoses that include Muscle Weakness, Difficulty Walking, Lack of Coordination, Mild Cognitive Impairment, Mood Disorder, Osteoarthritis, Osteoporosis, and Senile Dementia. Review of Resident #11's Annual MDS dated 11/17/14 and Quarterly MDS assessment dated 04/16/15 revealed the facility assessed Resident #11 to require the extensive assistance of two persons to transfer. The MDS also revealed Resident #11 had been assessed to have a Brief Interview for Mental Status (BIMS) score of 4, which indicated severe cognitive impairment. Review of the comprehensive plan of care for Resident #11 dated 11/17/14 with a revision date of 04/16/15 revealed the facility developed a care plan that stated the resident required the assistance of one person with a gait belt for transfers. Review of the CNA care plan dated July 2015 revealed the facility developed a CNA care plan that stated the resident required the assistance of one person with a gait belt. Interview with the MDS Coordinator on 07/30/15 at 2:17 PM revealed she had not utilized information from the resident's MDS to develop, review, or revise the resident's comprehensive plan of care. The MDS Coordinator stated she had not been trained to develop, review, or revise a resident's comprehensive plan of care from information contained in the MDS. Interview with the Director of Nursing (DON) on 07/30/15 at 11:45 AM revealed she did not	F 279		

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F 279	Continued From page 12 compare the MDS to the comprehensive care plan to make sure they coincide. The DON further stated she reviewed care plans, but not MDS assessments. Interview with the Administrator on 07/30/15 at 2:35 PM revealed she was not aware that the interventions on the resident's care plan did not address the resident's assessed needs as identified in the comprehensive assessment. She also stated she was not aware that the MDS Coordinator did not follow the MDS to formulate the resident's care plans. The Administrator further stated that the previous MDS Coordinator trained the current MDS Coordinator, but she did not think the current MDS Coordinator "gets it" related to developing the care plan according to the assessment.	F 279		
F 280 SS=J	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	**280 483.20 (d) (3), 483.10 (k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** **Corrective action for resident(s) affected:** Resident #8 no longer a resident at facility. DON, ADON, regional nurse, and /or nurse reviewed all incident and accident reports in last 90 days to make sure appropriate intervention were in place by 7-25-15.	

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F 280	Continued From page 13 each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility policy and investigations/incident reports, it was determined the facility failed to have an effective system in place to ensure residents' comprehensive care plans were reviewed and revised after falls occurred for one (1) of twenty-six (26) sampled residents (Resident #8). (Refer to F323.) Resident #8 sustained a fall on 03/05/15 when the resident leaned forward in his/her wheelchair and fell through the breakaway lap buddy onto the floor, hitting his/her head on the floor sustaining an injury. Facility staff determined the resident was trying to pick up a cup from the floor when the resident fell from the wheelchair. The facility educated staff on 03/05/15 to "not leave cups (stuff from hydration) with the resident" to prevent further falls from occurring. However, review of the comprehensive plan of care for Resident #8 provided no evidence that facility staff reviewed/revised the resident's plan of care to prevent further falls from occurring. Resident #8 sustained another fall on 04/12/15 when the resident leaned forward in his/her wheelchair and fell through the breakaway lap buddy onto the floor. As a result of the fall, the resident was diagnosed with a closed head injury on 04/13/15 and expired at the facility on 04/23/15. The facility's failure to ensure residents'	F 280	**How the Facility will act to protect residents in similar situations:** DON, ADON, regional nurse, and /or nurse reviewed all incident and accident reports in last 90 days to make sure appropriate intervention were in place by 7-25-15 **Measures to prevent reoccurrence:** SDC will inservice all nursing staff on appropriate measures to do on accident and incident reports along with updating care plan appropriately to address residents current needs by 9-1-15. **Monitoring of correction action:** The DON, ADON, and or nurse will audit 5 accident/incident reports for appropriate intervention along with resident care plan weekly for 4 weeks then monthly for 3 months then every 3 months for 6 months. All findings will be discussed in QAPI and findings will be addressed immediately. **Completion Date:** 10-1-15	

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F 280	Continued From page 14 comprehensive plans of care were reviewed and revised to prevent accidents has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/23/15, and was determined to exist on 04/12/15. An acceptable Allegation of Compliance was received on 07/30/15, which alleged removal of the Immediate Jeopardy on 07/30/15. The State Survey Agency determined the Immediate Jeopardy was removed on 07/30/15, which lowered the scope and severity to "D" while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled "Care Plans," last revised October 2010, revealed the resident's comprehensive plan of care was designed to identify problem areas and incorporate risk factors associated with the problems identified by facility staff. Review of the closed medical record for Resident #8 revealed the facility admitted Resident #8 on 01/09/09, with diagnoses of Alzheimer's Disease, Osteoporosis, and Psychosis. Review of the resident's quarterly Minimum Data Set (MDS) Assessment dated 02/24/15 revealed Resident #8 required extensive assistance from staff with locomotion on and off the unit and the resident utilized a wheelchair as a mobility device. Review of Resident #8's comprehensive plan of care, dated 12/09/14 revealed staff had identified that the resident was at risk for fall related injury	F 280		

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F 280	Continued From page 15	F 280		

and required the use of a "breakaway" lap buddy (a cushion that fits on a wheelchair at the resident's lap. The middle of a "breakaway" cushion is held together with Velcro).

A review of a fall investigation revealed Resident #8 sustained a fall on 03/05/15 when the resident leaned forward in a wheelchair and fell through the lap buddy onto the floor, hitting his/her head on the floor. Review of the resident's care plan revealed staff revised the resident's plan of care after the resident experienced the fall on 03/05/15 to include an intervention to "not leave cups (stuff from hydration) with the resident." The care plan further revealed staff was in-serviced related to the intervention. However, review of the comprehensive plan of care provided no evidence that staff assessed the resident or the breakaway lap buddy to ensure the interventions that were implemented were effective to prevent further falls from occurring for the resident.

Further review of fall investigations for Resident #8 revealed on 04/12/15, the resident sustained another fall when the resident leaned forward and fell through the breakaway lap buddy a second time. Resident #8 was transferred to the hospital and was diagnosed with a closed head injury on 04/13/15 and expired on 04/23/15.

Interview with the Director of Nursing (DON) on 07/23/15 at 6:25 PM revealed Resident #8's fall, including the care plan, was reviewed on 03/05/15. The DON stated staff was in-serviced to not leave cups/hydration items with the resident. However, the DON acknowledged staff had not assessed the resident to ensure the breakaway lap buddy was effective to prevent further falls from occurring for the resident.

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F 280	Continued From page 16 Interview with the MDS Coordinator on 07/30/15 at 2:17 PM revealed residents' care plans were reviewed and revised during daily clinical meetings. The MDS Coordinator stated care plans were a "group effort" and they had not identified any concerns with the revision of Resident #8's care plan on 03/05/15. **The facility provided an acceptable Allegation of Compliance (AOC) on 07/30/15. The facility implemented the following actions to remove the Immediate Jeopardy: 1) Resident #8 no longer resides at the facility. Resident #8's chart was audited and reviewed by the Regional Nurse Consultant on 07/23/15. 2) The facility has a current system to ensure residents' fall safety care needs are being met: -Floor staff process: a. Nurse notified of resident fall by State Registered Nurse Aide (SRNA), housekeeper, visitors, etc. b. Nurse to assess resident including neurological checks, pain, Range of Motion (ROM), skin, joints, extremities, vital signs. c. Nurse to provide immediate care as indicated by the assessment. d. Notify physician and Power of Attorney (POA) of the fall. e. Document assessment and pertinent facts related to the fall.	F 280		

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

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F 280	Continued From page 17 f. Begin investigation of the fall. g. Complete Incident/Accident in event manager system. h. Determine root cause of fall if possible. 1. Nurse utilizes root cause questionnaire to assist with root cause. 2. SRNAs draw out a picture of the scene. i. Update care plan with appropriate intervention. j. Enter resident's name on Nursing communication log for 72 hour follow-up charting. k. Notify the Director of Nursing (DON) if the resident is sent out; otherwise, the Administrator and the DON are notified by event manager system. -Clinical administration/IDT team process: The facility Administrator, DON, Assistant Director of Nursing (ADON), Minimum Data Set (MDS) Coordinator, Staff Development Coordinator (SDC), Social Services Director (SSD), Therapy Services Manager, Central Supply, and Quality of Life (QOL) Director review event data, which includes falls, weight loss, skin integrity, etc. in the event manager system daily during morning clinical meeting. a. Daily clinical/PI meeting conducted and all Accident/Incidents, care plans, SRNA care plans, and pertinent resident data is reviewed.	F 280		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 280	Continued From page 18 b. Resident is logged on the fall tracker log and resident tracker log for tracking and trending. c. Root cause is completed utilizing the five(5) why template. d. The resident chart is reviewed during the meeting. e. Tracking/trending, root cause, and info from resident chart review are all taken into consideration for appropriate intervention. f. Care plan and SRNA care plan is updated with new interventions. g. Follow up for 72 hours to assess resident's status and intervention appropriateness. 3) All facility residents were assessed by completing a falls risk assessment on each resident and then comparing falls risk identified to current care plan interventions by the DON, ADON, SDC, Nursing Supervisor, or Regional Nurse Consultant on 07/24/15 and then all resident care plans were re-audited, by comparing current resident care plans with current resident ADLs assist level with latest MDS, starting on 07/28/15 and completed on 07/29/15 to determine if safety needs were being met as outlined by resident's care plan, to include wheelchair (w/c) safety devices. Noted concerns from re-audit on 07/28 - 07/29 were five (5) residents whose ADL care plan did not reflect the residents' current level of ADL assistance required. 4) All accident/incident reports, for the past 90 days, have been reviewed, to include not just the	F 280		

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F 280	Continued From page 19 individual incident/accident but a more global approach by reviewing the tracking/trending of individual resident falls to include day, shift, time, location on 07/24/15 by the DON, ADON, SDC, Nursing Supervisor, or Signature Care Consultant to identify any safety concerns, ensure thorough investigation of all Accidents/Incidents was completed, and implemented interventions on care plan that address root cause. No concerns identified by the facility. 5) Once resident assessments and accident/incident reviews along with tracking/trending reviews were completed by 07/24/15, then all resident care plans and SRNA care plans were audited, utilizing a census board audit tool, by 07/24/15, reviewed and updated as needed, to include wheelchair safety devices, by the DON, ADON, Nursing Supervisor, MDS Coordinator, or Regional Nurse Consultant to ensure that each resident's care plan/SRNA care plan reflects current resident safety care needs. The DON, ADONs, Nursing supervisor, or MDS Coordinator will audit all residents, with any changes noted, care plan/SRNA care plan for any updates, revisions, and/or new interventions, during the morning clinical meeting with IDT present, daily starting on 07/24/15, and continuing until immediacy is lifted, then 10 different resident care plans/SRNA care plans will be audited weekly for 4 weeks to ensure resident safety care needs are being met. Results will be reviewed in weekly (Quality Assurance Performance Improvement) QAPI meeting. QAPI committee will determine ongoing frequency of resident care plan audit at that time 6) The DON, ADONs, SDC, MDS or Nursing Supervisor will review all A/I daily to ensure	F 280		

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F 280	Continued From page 20 thorough (individual incident along with tracking/trending for that specific resident) investigation initiated, root cause analysis conducted and appropriate intervention, to meet root cause, implemented, along with care plan updated to reflect new intervention starting on 07/24/15. Compliance will be reviewed in weekly QAPI meeting. 7) The DON, ADONs, Nursing Supervisor, or MDS Coordinator will audit all residents, with any changes noted, care plan/SRNA care plan for any updates, revisions, and/or new interventions, during the morning clinical meeting with IDT present, daily starting on 07/24/15, and continuing until immediacy is lifted, then 10 different resident care plans/SRNA care plans will be audited weekly for 4 weeks to ensure resident safety care needs are being met. Results will be reviewed in weekly QAPI meeting. QAPI committee will determine ongoing frequency of resident care plan audit at that time 8) The facility Administrator, DON, ADON, SDC, RN Supervisor, MDS Coordinator, Business Office Manager (BOM), Rehabilitation Service Manager (RSM), Dietary Manager, QOL Director, Human Resources (HR) Director, Environmental Services Director, SSD, Admissions Director, Medical Records, and Chaplain were educated on 07/23/15 by the Signature Care Consultant on the fall program process/system noted in #2, care plan policy, to include revising and updating the care plan along with interventions that meet not only the individual accident/incident but also patterns identified from tracking and trending, accident/incident policy, and falls policy and procedure, to include tracking and trending procedure. This training was performed	F 280		

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F 280	Continued From page 21 face-to-face in order to facilitate discussion and question. Department Administrative Managers could not return to work until the above education was provided, post-test administered, and 100% score obtained; if Manager did not score 100% on post-test, then Manager was immediately re-educated and post-test re-administered. This process continued until all Managers obtained a 100% score on post-test. All post-tests were reviewed for compliance by the Signature Care Consultant. 9) Once facility Administrator, DON, ADON, SDC, RN Supervisor, MDS, BOM, RSM, Dietary Manager, QOL Director, HR, Environmental Services Director, SSD, Admissions Director, Medical Records, and Chaplain were re-educated on the process in #2, care plan policy, to include revising and updating the care plan along with interventions that meet not only the individual accident/incident but also patterns identified from tracking and trending, accidents/incidents policy, and falls policy and procedure, to include tracking and trending procedure, they were then assigned to assist the SDC in providing education to the staff on the above policies and procedures, which started on 07/23/15. No employee will be allowed to work until education is provided. The facility has 88 employees. Seventy employees received the education by 07/24/15, six employees were scheduled to receive education by 07/26/15, and twelve employees had certified letter sent out on 07/24/15. Employees could not return to work until the above education was provided, post-test administered and 100% score obtained; if employee did not score 100% on post-test, then employee was immediately re-educated and post-test re-administered. This process	F 280		

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F 280	Continued From page 22 continued until all employees obtained a 100% score on post-test. All post-tests were reviewed for compliance by the Signature Care Consultant. This education will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until education is provided, post-test administered and 100% score obtained; if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test. No agency staff is utilized by the facility. 10) A nurse from the Regional Team or Corporate Office has been onsite since 07/23/15 and will remain in the facility daily until jeopardy has been lifted. The nurses from the Regional Team or home office will be validating compliance with all audits and reviews completed daily until immediacy is lifted, then will validate compliance weekly for 4 weeks. The Regional Nurse Consultants will also be assisting with completion of investigations, root cause analysis, updating and/or revising care plans, performing chart audits, and providing oversight and consultation. The Vice-President of Operations, Special Projects Administrator, or Director of Clinical Programs will be in daily contact with the Signature Care Consultant and will review compliance daily until immediacy is lifted, then weekly for 4 weeks. 11) Administrative oversight of the facility will be completed by the Vice President of Operations, Signature Care Consultant, or Special Projects Administrator daily until the removal of immediacy beginning 07/23/15, then weekly for 4 weeks, then monthly.	F 280		

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F 280	Continued From page 23 12) Results of all audit and reviews will be discussed daily for compliance and action plan implemented immediately to address any identified concerns. Any identified concerns will be discussed during weekly QAPI meeting. A Quality Assurance meeting will be held weekly for 4 weeks beginning 07/23/15, then monthly for recommendations and further follow-up regarding the above stated plan. At that time based upon evaluation the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. ***The State Survey Agency validated the Immediate Jeopardy was removed as follows: 1) Record review revealed the Regional Nurse Consultant audited Resident #8's chart on 07/23/15. 2) Interviews on 07/30/15 with Housekeeping Staff #1 at 10:58 AM, Dietary Staff #1 at 1:50 PM, SRNA #8 at 9:57 AM, SRNA #9 at 10:08 AM, SRNA #10 at 10:14 AM, SRNA #3 at 10:22 AM, SRNA #6 at 10:30 AM, Licensed Practical Nurse (LPN) #4 at 10:38 AM, and Registered Nurse (RN) #4 at 10:50 AM revealed the staff had been trained and were familiar with the facility's fall protocol. Interviews on 07/30/15 with the Administrator at 2:37 PM, DON at 11:21 AM, ADON at 2:08 PM, MDS Coordinator at 2:17 PM, SDC at 12:15 PM, SSD at 12:01 PM, Central Supply at 12:07 PM, and QOL at 11:03 AM revealed the staff was familiar with the review	F 280		

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F 280	Continued From page 24 process for falls and accidents/incidents. 3) Record review of fall assessment and audits of care plans and CNA care plans revealed any issues identified were corrected by facility staff beginning on 07/24/15 and completed on 07/29/15. Interviews on 07/30/15 with the DON at 11:21 AM, ADON at 2:08 PM, SDC at 12:15 PM, and the Regional Nurse Consultant at 1:57 PM revealed there were some issues identified with ADL assistance requirements with the care plans, MDS assessments, and the CNA care plans but the issues were corrected. 4) Review of facility audits and tracking logs revealed facility administrative staff had reviewed all accident/incident reports related to falls for the past 90 days and did not identify any concerns. Interviews on 07/30/15 with the DON at 11:21 AM, ADON at 2:08 PM, SDC at 12:01 PM, and Signature Care Consultant at 1:57 PM revealed all falls for the past 90 days had been reviewed and no concerns were identified. 5) Review of audits completed by administrative staff on 07/24/15 revealed no issues were identified related to safety devices on care plans and CNA care plans and no safety concerns were identified with residents. The reviews continued in the daily morning clinical meeting. Interviews on 07/30/15 with the DON at 11:21 AM, ADON at 2:08 PM, and MDS Coordinator at 2:17 PM revealed the audits were done for all residents and continued in the daily morning clinical meeting. 6) Interviews on 07/30/15 with the DON at 11:21 AM, ADON at 2:08 PM, SDC at 12:15 PM, and MDS Coordinator at 2:17 PM revealed all	F 280		

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F 280	Continued From page 25 accident and incident reports were reviewed daily and any concerns identified would be corrected immediately. The interviews revealed no concerns had been identified. 7) Review of audits conducted of all resident charts, care plans, and CNA care plans for changes noted revealed the reviews were done daily during the morning clinical meeting. Interviews on 07/30/15 with the DON at 11:21 AM, ADON at 2:08 PM, and MDS Coordinator at 2:17 PM revealed resident charts were audited daily for changes to ensure care plans and CNA care plans were updated with changes. 8) Review of education provided on 07/23/15 to the facility Administrator, DON, ADON, SDC, RN Supervisor, MDS Coordinator, BOM, RSM, Dietary Manager, QOL Director, HR, Environmental Services Director, SSD, Admissions Director, Medical Records, and Chaplain included information on the fall process/program, care plan policy including revising and updating care plans, appropriate interventions implemented, tracking and trending of falls, the fall policy and procedure, and environmental hazards. A review of the post-test revealed no issues were identified. Interviews on 07/30/15 with the Administrator at 2:37 PM, DON at 11:21 AM, ADON at 2:08 PM, SDC at 12:15 PM, MDS Coordinator at 2:17 PM, RSM at 2:26 PM, Dietary Manager at 1:15 PM, QOL Director at 11:03 AM, Environmental Services Director at 9:45 AM, SSD at 12:01 PM, Admissions Director at 12:01 PM, and Medical Records at 12:07 PM revealed they were educated face to face on the fall policy and procedures, tracking and trending of falls, care plan revision and updating, ensuring appropriate interventions are implemented after	F 280		

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F 280	Continued From page 26 falls and environmental hazards. 9) Review of education provided to direct care staff revealed the staff was educated on the fall policy and procedure, care plan revision and updates, ensuring appropriate interventions are implemented after a fall and environmental hazards. Interviews on 07/30/15 with Housekeeping Staff #1 at 10:58 AM, Dietary Staff #1 at 1:50 PM, SRNA #8 at 9:57 AM, SRNA #9 at 10:08 AM, SRNA #10 at 10:14 AM, SRNA #3 at 10:22 AM, SRNA #6 at 10:30 AM, Licensed Practical Nurse (LPN) #4 at 10:38 AM, and Registered Nurse (RN) #4 at 10:50 AM revealed the staff was knowledgeable about the fall policy/procedures, environmental hazards, care plan revision and updates, and ensuring interventions implemented after a fall were appropriate and related to the root cause of the fall. 10) Interview on 07/30/15 at 1:57 PM with the Regional Nurse Consultant revealed he had been in the facility daily since the Immediate Jeopardy was identified and had been conducting audits to validate compliance daily. The Regional Nurse Consultant further revealed he had assisted with fall investigations, chart audits, and care plan audits. 11) Interview on 07/30/15 at 1:57 PM with the Regional Nurse Consultant revealed administrative oversight had been provided by the VP of Operations, Special Projects Administrator, and the Signature Care Consultant daily since the beginning of the immediate jeopardy and would continue weekly for 4 weeks and then monthly. 12) Interviews on 07/30/15 with the DON at 11:21	F 280		

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F 280	Continued From page 27 AM, Administrator at 2:37 PM, and the Regional Nurse Consultant at 1:57 PM revealed all audits and reviews were discussed daily and any identified concerns were corrected immediately. The interview further revealed all identified concerns were discussed weekly in the QAPI meeting and the weekly QAPI meetings would be weekly for 4 weeks, then monthly, and then the frequency would be evaluated and determined for meeting and audits.	F 280		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility's policy and investigations/incident reports, it was determined the facility failed to have an effective system in place to assess residents' falls to determine if other risk factors for falls were present or if interventions were implemented and/or revised to prevent falls for two (2) of twenty-six (26) sampled residents (Residents #8 and #20). On 03/05/15, Resident #8 leaned forward in the wheelchair and fell through a breakaway lap buddy onto the floor, hitting his/her head on the floor. The facility determined the resident was	F 323	**F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **Corrective action for resident(s) affected:** #8 resident is no longer in the facility. #20 was observed to address appropriate assistance for transfers on 7-24-15. DON, ADON, SDC, and/or nurse did a new fall risk assessment on resident #3, #8, #13, and #20 on 7-23-15. DON, ADON, SDC, nurse, and/or regional nurse audited incident and accident reports for the last 90 days to insure interventions were in place for each incident on 7-24-15. Maintenance Director performed immediate safety rounds on all resident's rooms on 7-23-15. The floor nurses also did a safety round on resident #3, #13, and #20 on 7-24-15.	

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F 323	Continued From page 28 trying to pick up a cup from the floor, but failed to assess the resident to determine if other risk factors for falls were present or if interventions that were in place to prevent falls were effective. Facility staff continued to utilize the breakaway lap buddy as a fall prevention for the resident. On 04/12/15, Resident #8 leaned forward again and fell through the lap buddy onto the floor. The resident sustained a head/brain injury and passed away on 04/23/15 at the facility. Resident #20 required the assistance of two (2) staff persons with transfers; however, on 04/16/15, one (1) staff person assisted the resident and the resident fell. The facility failed to identify that the assessed level of assistance was not being provided when the resident fell. The failure of the facility to assess residents' falls to determine if other risk factors for falls were present or if interventions were implemented and/or revised to prevent falls has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/23/15, and was determined to exist on 04/12/15. An acceptable Allegation of Compliance was received on 07/30/15, which alleged removal of the Immediate Jeopardy on 07/30/15. An extended survey was conducted on 07/30/15. The State Survey Agency determined the Immediate Jeopardy was removed on 07/30/15, which lowered the scope and severity to "D" while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include:	F 323	**How the Facility will act to protect residents in similar situations:** DON, ADON, SDC, and/or nurse did a new fall risk assessment on all residents on 7-23-15. DON, ADON, SDC and/or nurse assessed all residents to validate current need for adl assistance with transfers by 10-1-15. DON, ADON, SDC, nurse, and/or regional nurse audited incident and accident reports for the last 90 days to insure interventions were in place for each incident on all residents on 7-24-15. Maintenance Director performed immediate safety rounds throughout the facility 7-23-15. The floor nurses also did a safety round on all residents on 7-24-15. **Measures to prevent reoccurrence:** All incident reports will be reviewed in morning clinical meeting held Monday thru Friday by DON, ADON, SDC, and wound nurse. SDC will inservice on use of incident and accident report, "10 question", root cause analysis utilizing "5 Whys" and picture drawing to all nursing staff by 8-28-15. SDC will inservice nurse aides on adl documentation and process of changes to a resident by 7-25-15.	

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F 323	Continued From page 29 Review of the facility policy titled "Falls Policy," dated April 2012, revealed staff was to initiate an investigation and determine the root cause of the fall if possible. Staff was to update the resident's care plan, and the resident's falls and care plans were to be reviewed during the daily clinical meeting for a minimum of three (3) days. The policy further stated staff was required to continue root cause analysis during the daily clinical meeting and take appropriate action as indicated. 1. Review of the closed medical record for Resident #8 revealed the facility admitted Resident #8 on 01/09/09, with diagnoses of Alzheimer's Disease, Osteoporosis, and Psychosis. Review of the resident's quarterly Minimum Data Set (MDS) Assessment dated 02/24/15 revealed Resident #8 required extensive assistance from staff with locomotion on and off the unit and the resident utilized a wheelchair as a mobility device. The resident had no Brief Interview for Mental Status (BIMS) score coded on the MDS, therefore was not interviewable. Review of Resident #8's care plan dated 12/09/14 revealed the facility identified the resident was at risk for a fall related injury and required the use of a "breakaway" lap buddy (a cushion that fits on a wheelchair at the resident's lap with the middle held together with Velcro). Review of an incident report dated 03/05/15 revealed Resident #8 leaned forward in his/her wheelchair and fell through the lap buddy onto the floor, hitting his/her head on the floor. As a result of the fall, Resident #8 was assessed to have a 3-centimeter (cm) laceration to the left side of his/her forehead and was transferred to a local hospital, where the resident required eight (8)	F 323	**Monitoring of correction action:** DON/designee will review incident reports daily Monday thru Friday to ensure that root case analysis completed, appropriate interventions are in place and care plans have been appropriately updated. SDC or designee will monitor for appropriate transfers for 5 residents a week x 4 then 5 residents a month x 3 months. Finding will be reported in QAPI meeting weekly and for 2 weeks then monthly. **Completion date:** 10-1-15	

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F 323	Continued From page 30 sutures for the laceration. A Computerized Tomography (CT) scan of the resident's head was also obtained and no brain injury was noted. Facility staff determined the resident was trying to pick up a cup from the floor when the resident fell from the wheelchair, but failed to assess the resident to determine if other risk factors for falls were present or if interventions to prevent falls that were in place were effective. Facility staff continued to utilize the breakaway lap buddy as a fall prevention for the resident. Review of an incident report dated 04/12/15, revealed Resident #8 sustained another fall from the wheelchair when the resident leaned forward and fell through the breakaway lap buddy a second time. Record review revealed Resident #8's "lap buddy came undone" and the resident sustained a fall to the floor. Facility staff assessed the resident to have a 2 cm long laceration, with a large amount of blood observed to the left side of the resident's forehead. The resident was also assessed to have an abrasion to his/her left knee that was 2 cm long. The resident was transferred to a local hospital. Review of the resident's hospital record revealed the resident was diagnosed with a closed head injury on 04/13/15. Review of Resident #8's CT scan results, documented 04/13/15, revealed the resident had a brain contusion, a 6.4 by 4.4 millimeter (mm) area in the brain that was either a small hematoma (a collection of blood that has leaked into tissue where it does not belong) or an aneurysm (an enlargement of an artery caused by a weakening of the artery wall). The CT further revealed blood was observed in the resident's right lateral ventricle of the brain. Interview with State Registered Nurse Aide	F 323		

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F 323	Continued From page 31 (SRNA) #1 on 07/23/15 at 6:00 PM revealed that on 04/12/15 she was assigned to care for Resident #8. The SRNA stated the resident appeared weaker and was leaning forward in the wheelchair more than usual. The SRNA stated she had to "readjust" the resident "a few times" on 04/12/15. The SRNA stated she did not notify the nurse that Resident #8 appeared weaker and was leaning forward in his/her wheelchair and further stated no action was taken to assess the resident to determine if interventions continued to be appropriate for the resident. Interview with Resident #8's physician on 07/23/15 at 3:15 PM revealed the resident was observed to always be leaning forward when he evaluated the resident in the facility. The physician stated the resident had Dementia, had a history of terminal events, and "was close to dying." He stated the injuries the resident sustained from the fall probably hurried the resident's death along and the resident's death was "probably" related to the injuries sustained from the fall in the facility on 04/12/15. Interview with the Director of Nursing (DON) on 07/23/15 at 6:25 PM revealed when a resident sustained a fall, the nurse who was working at the time of the fall implemented an intervention to prevent further falls, completed an incident report, and initiated an investigation. The DON stated the interdisciplinary team met each morning Monday through Friday to review incident reports and fall investigations. She stated the team also reviewed the interventions that the nurse had put in place and implemented other interventions as they saw fit. The DON stated Resident #8's fall that occurred on 03/05/15 had been reviewed in the daily clinical meetings as required. The DON	F 323		

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F 323	Continued From page 32 stated an intervention was implemented to ensure staff kept hydration items away from the resident to prevent cups from being on the floor. However, the DON acknowledged staff had not assessed the resident or the breakaway lap buddy to determine if further interventions were required to prevent the resident from falling. 2. Observation of Resident #20 on 07/29/15 at 4:15 PM revealed the resident was propelling him/herself in a wheelchair. Observation of the resident's room revealed the resident utilized a low bed. Review of the medical record revealed the facility admitted Resident #20 on 10/29/09 with diagnoses that included Mood Disorder, Anxiety, Depression, Psychotic Disorder, Schizophrenia, Difficulty Walking, Lack of Coordination, Generalized Weakness, Urinary Retention, and Gastroesophageal Reflux. Review of an Annual Minimum Data Set (MDS) assessment completed on 02/06/15 revealed the facility assessed Resident #20 to require extensive physical assistance of two (2) or more persons with bed mobility, transfers, and locomotion on and off the unit. The resident utilized a wheelchair as a mobility device. Further review of the MDS revealed the resident's BIMS score was 12. Review of a Fall Risk Evaluation dated 02/13/15 revealed the facility assessed Resident #20 to be at high risk for falls, and the resident utilized a low bed for a fall intervention. Review of the comprehensive care plan dated 02/06/15 revealed the resident had an ADL	F 323		

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F 323	Continued From page 33 (activities of daily living) self-care deficit and was at risk for complications related to difficulty walking and lack of coordination. The approach to address the problem was to transfer the resident with the assistance of one (1) staff member and the use of a gait belt. The care plan did not address Resident #20's need for two (2) persons to assist with transfers as assessed by the MDS. Review of the "Certified Nursing Assistant" (CNA) care plan for April 2015 revealed that prior to 04/20/15, the care plan stated Resident #20 required the assistance of one (1) person for transfer with a gait belt. Review of the facility's fall investigation for Resident #20 revealed the resident sustained a fall on 04/16/15 at 11:30 AM, when one (1) "CNA" assisted the resident from bed to a wheelchair. According to the fall investigation, the resident's knee gave out, and the resident went down to the floor on both knees. The investigation revealed the resident's bed was in a low position and the resident did not sustain injury from the fall. According to the facility's investigation, the SRNA who assisted the resident reported she was helping the resident out of bed and the resident was unable to support his/her own weight. The resident became very weak and fell to the floor. Review of the Fall Investigation revealed the facility identified the factors contributing to the fall were the resident's poor balance, difficulty maintaining sitting balance, impaired balance during transitions, unsteady gait, and "change or increase in ADL assistance." There was no evidence the facility identified that staff failed to provide the assessed level of assistance required to transfer Resident #20 as a factor that	F 323		

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F 323	Continued From page 34 contributed to the resident's fall. Further review of the facility's investigation of Resident #20's fall revealed the facility referred the resident to Therapy to evaluate the need for the assistance of two (2) staff persons instead of one (1), even though the facility had already assessed Resident #20 to require extensive physical assistance of two (2) or more persons with transfers. The SRNA involved in the incident no longer worked at the facility and was not available for interview. Interview with the DON at 11:00 AM on 07/30/15 revealed the clinical team which included the DON reviewed Resident #20's fall during the morning clinical meeting and did not identify that Resident #20 was already assessed to need two (2) persons to assist with transfers when the fall occurred on 04/16/15. The DON stated if the resident had two (2) persons assisting with the transfer on 04/16/15 as assessed on the MDS, the fall probably would have been prevented. **The facility provided an acceptable Allegation of Compliance (AOC) on 07/30/15. The facility implemented the following actions to remove the Immediate Jeopardy: 1) Resident #8 no longer resides at the facility. Resident #8's chart was audited and reviewed by the Regional Nurse Consultant on 07/23/15. 2) The facility has a current system to ensure residents' fall safety care needs are being met: -Floor staff process:	F 323		

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F 323	Continued From page 35 a. Nurse notified of resident fall by State Registered Nurse Aide (SRNA), housekeeper, visitors, etc. b. Nurse to assess resident including neurological checks, pain, Range of Motion (ROM), skin, joints, extremities, vital signs. c. Nurse to provide immediate care as indicated by the assessment. d. Notify physician and Power of Attorney (POA) of the fall. e. Document assessment and pertinent facts related to the fall. f. Begin investigation of the fall. g. Complete Incident/Accident in event manager system. h. Determine root cause of fall if possible. 1. Nurse utilizes root cause questionnaire to assist with root cause. 2. SRNAs draw out a picture of the scene. i. Update care plan with appropriate intervention. j. Enter resident's name on Nursing communication log for 72 hour follow-up charting. k. Notify the Director of Nursing (DON) if the resident is sent out; otherwise, the Administrator and the DON are notified by event manager system.	F 323		

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F 323	Continued From page 36 -Clinical administration/IDT team process: The facility Administrator, DON, Assistant Director of Nursing (ADON), Minimum Data Set (MDS) Coordinator, Staff Development Coordinator (SDC), Social Services Director (SSD), Therapy Services Manager, Central Supply, and Quality of Life (QOL) Director review event data, which includes falls, weight loss, skin integrity, etc. in the event manager system daily during morning clinical meeting. a. Daily clinical/PI meeting conducted and all Accident/Incidents, care plans, SRNA care plans, and pertinent resident data is reviewed. b. Resident is logged on the fall tracker log and resident tracker log for tracking and trending. c. Root cause is completed utilizing the five (5) why template. d. The resident chart is reviewed during the meeting. e. Tracking/trending, root cause, and info from resident chart review are all taken into consideration for appropriate intervention. f. Care plan and SRNA care plan is updated with new interventions. g. Follow up for 72 hours to assess resident's status and intervention appropriateness. 3) All facility residents were assessed by completing a falls risk assessment on each resident and then comparing falls risk identified to	F 323		

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F 323	Continued From page 37 current care plan interventions by the DON, ADON, SDC, Nursing Supervisor, or Regional Nurse Consultant on 07/24/15 and then all resident care plans were re-audited, by comparing current resident care plans with current resident ADLs assist level with latest MDS, starting on 07/28/15 and completed on 07/29/15 to determine if safety needs were being met as outlined by resident's care plan, to include wheelchair (w/c) safety devices. Noted concerns from re-audit on 07/28 - 07/29 were five (5) residents whose ADL care plan did not reflect the residents' current level of ADL assistance required. 4) All accident/incident reports, for the past 90 days, have been reviewed, to include not just the individual incident/accident but a more global approach by reviewing the tracking/trending of individual resident falls to include day, shift, time, location on 07/24/15 by the DON, ADON, SDC, Nursing Supervisor, or Signature Care Consultant to identify any safety concerns, ensure thorough investigation of all Accidents/Incidents was completed, and implemented interventions on care plan that address root cause. No concerns identified by the facility. 5) Once resident assessments and accident/incident reviews along with tracking/trending reviews were completed by 07/24/15, then all resident care plans and SRNA care plans were audited, utilizing a census board audit tool, by 07/24/15, reviewed and updated as needed, to include wheelchair safety devices, by the DON, ADON, Nursing Supervisor, MDS Coordinator, or Regional Nurse Consultant to ensure that each resident's care plan/SRNA care plan reflects current resident safety care needs.	F 323		

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F 323	Continued From page 38 The DON, ADONs, Nursing supervisor, or MDS Coordinator will audit all residents, with any changes noted, care plan/SRNA care plan for any updates, revisions, and/or new interventions, during the morning clinical meeting with IDT present, daily starting on 07/24/15, and continuing until immediacy is lifted, then 10 different resident care plans/SRNA care plans will be audited weekly for 4 weeks to ensure resident safety care needs are being met. Results will be reviewed in weekly (Quality Assurance Performance Improvement) QAPI meeting. QAPI committee will determine ongoing frequency of resident care plan audit at that time 6) The DON, ADONs, SDC, MDS or Nursing Supervisor will review all A/I daily to ensure thorough (individual incident along with tracking/trending for that specific resident) investigation initiated, root cause analysis conducted and appropriate intervention, to meet root cause, implemented, along with care plan updated to reflect new intervention starting on 07/24/15. Compliance will be reviewed in weekly QAPI meeting. 7) The DON, ADONs, Nursing Supervisor, or MDS Coordinator will audit all residents, with any changes noted, care plan/SRNA care plan for any updates, revisions, and/or new interventions, during the morning clinical meeting with IDT present, daily starting on 07/24/15, and continuing until immediacy is lifted, then 10 different resident care plans/SRNA care plans will be audited weekly for 4 weeks to ensure resident safety care needs are being met. Results will be reviewed in weekly QAPI meeting. QAPI committee will determine ongoing frequency of resident care plan audit at that time	F 323		

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F 323	Continued From page 39 8) The facility Administrator, DON, ADON, SDC, RN Supervisor, MDS Coordinator, Business Office Manager (BOM), Rehabilitation Service Manager (RSM), Dietary Manager, QOL Director, Human Resources (HR) Director, Environmental Services Director, SSD, Admissions Director, Medical Records, and Chaplain were educated on 07/23/15 by the Signature Care Consultant on the fall program process/system noted in #2, care plan policy, to include revising and updating the care plan along with interventions that meet not only the individual accident/incident but also patterns identified from tracking and trending, accident/incident policy, and falls policy and procedure, to include tracking and trending procedure. This training was performed face-to-face in order to facilitate discussion and question. Department Administrative Managers could not return to work until the above education was provided, post-test administered, and 100% score obtained; if Manager did not score 100% on post-test, then Manager was immediately re-educated and post-test re-administered. This process continued until all Managers obtained a 100% score on post-test. All post-tests were reviewed for compliance by the Signature Care Consultant. 9) Once facility Administrator, DON, ADON, SDC, RN Supervisor, MDS, BOM, RSM, Dietary Manager, QOL Director, HR, Environmental Services Director, SSD, Admissions Director, Medical Records, and Chaplain were re-educated on the process in #2, care plan policy, to include revising and updating the care plan along with interventions that meet not only the individual accident/incident but also patterns identified from tracking and trending,	F 323		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 40 accidents/incidents policy, and falls policy and procedure, to include tracking and trending procedure, they were then assigned to assist the SDC in providing education to the staff on the above policies and procedures, which started on 07/23/15. No employee will be allowed to work until education is provided. The facility has 88 employees. Seventy employees received the education by 07/24/15, six employees were scheduled to receive education by 07/26/15, and twelve employees had certified letter sent out on 07/24/15. Employees could not return to work until the above education was provided, post-test administered and 100% score obtained; if employee did not score 100% on post-test, then employee was immediately re-educated and post-test re-administered. This process continued until all employees obtained a 100% score on post-test. All post-tests were reviewed for compliance by the Signature Care Consultant. This education will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until education is provided, post-test administered and 100% score obtained; if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test. No agency staff is utilized by the facility. 10) A nurse from the Regional Team or Corporate Office has been onsite since 07/23/15 and will remain in the facility daily until jeopardy has been lifted. The nurses from the Regional Team or home office will be validating compliance with all audits and reviews completed daily until immediacy is lifted, then will validate compliance weekly for 4 weeks. The Regional Nurse	F 323		

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F 323	Continued From page 41 Consultants will also be assisting with completion of investigations, root cause analysis, updating and/or revising care plans, performing chart audits, and providing oversight and consultation. The Vice-President of Operations, Special Projects Administrator, or Director of Clinical Programs will be in daily contact with the Signature Care Consultant and will review compliance daily until immediacy is lifted, then weekly for 4 weeks. 11) Administrative oversight of the facility will be completed by the Vice President of Operations, Signature Care Consultant, or Special Projects Administrator daily until the removal of immediacy beginning 07/23/15, then weekly for 4 weeks, then monthly. 12) Results of all audit and reviews will be discussed daily for compliance and action plan implemented immediately to address any identified concerns. Any identified concerns will be discussed during weekly QAPI meeting. A Quality Assurance meeting will be held weekly for 4 weeks beginning 07/23/15, then monthly for recommendations and further follow-up regarding the above stated plan. At that time based upon evaluation the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. ***The State Survey Agency validated the Immediate Jeopardy was removed as follows: 1) Record review revealed the Regional Nurse	F 323		

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F 323	Continued From page 42 Consultant audited Resident #8's chart on 07/23/15. 2) Interviews on 07/30/15 with Housekeeping Staff #1 at 10:58 AM, Dietary Staff #1 at 1:50 PM, SRNA #8 at 9:57 AM, SRNA #9 at 10:08 AM, SRNA #10 at 10:14 AM, SRNA #3 at 10:22 AM, SRNA #6 at 10:30 AM, Licensed Practical Nurse (LPN) #4 at 10:38 AM, and Registered Nurse (RN) #4 at 10:50 AM revealed the staff had been trained and were familiar with the facility's fall protocol. Interviews on 07/30/15 with the Administrator at 2:37 PM, DON at 11:21 AM, ADON at 2:08 PM, MDS Coordinator at 2:17 PM, SDC at 12:15 PM, SSD at 12:01 PM, Central Supply at 12:07 PM, and QOL at 11:03 AM revealed the staff was familiar with the review process for falls and accidents/incidents. 3) Record review of fall assessment and audits of care plans and CNA care plans revealed any issues identified were corrected by facility staff beginning on 07/24/15 and completed on 07/29/15. Interviews on 07/30/15 with the DON at 11:21 AM, ADON at 2:08 PM, SDC at 12:15 PM, and the Regional Nurse Consultant at 1:57 PM revealed there were some issues identified with ADL assistance requirements with the care plans, MDS assessments, and the CNA care plans but the issues were corrected. 4) Review of facility audits and tracking logs revealed facility administrative staff had reviewed all accident/incident reports related to falls for the past 90 days and did not identify any concerns. Interviews on 07/30/15 with the DON at 11:21 AM, ADON at 2:08 PM, SDC at 12:01 PM, and Signature Care Consultant at 1:57 PM revealed all falls for the past 90 days had been reviewed	F 323		

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F 323	Continued From page 43 and no concerns were identified. 5) Review of audits completed by administrative staff on 07/24/15 revealed no issues were identified related to safety devices on care plans and CNA care plans and no safety concerns were identified with residents. The reviews continued in the daily morning clinical meeting. Interviews on 07/30/15 with the DON at 11:21 AM, ADON at 2:08 PM, and MDS Coordinator at 2:17 PM revealed the audits were done for all residents and continued in the daily morning clinical meeting. 6) Interviews on 07/30/15 with the DON at 11:21 AM, ADON at 2:08 PM, SDC at 12:15 PM, and MDS Coordinator at 2:17 PM revealed all accident and incident reports were reviewed daily and any concerns identified would be corrected immediately. The interviews revealed no concerns had been identified. 7) Review of audits conducted of all resident charts, care plans, and CNA care plans for changes noted revealed the reviews were done daily during the morning clinical meeting. Interviews on 07/30/15 with the DON at 11:21 AM, ADON at 2:08 PM, and MDS Coordinator at 2:17 PM revealed resident charts were audited daily for changes to ensure care plans and CNA care plans were updated with changes. 8) Review of education provided on 07/23/15 to the facility Administrator, DON, ADON, SDC, RN Supervisor, MDS Coordinator, BOM, RSM, Dietary Manager, QOL Director, HR, Environmental Services Director, SSD, Admissions Director, Medical Records, and Chaplain included information on the fall	F 323		

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F 323	Continued From page 44 process/program, care plan policy including revising and updating care plans, appropriate interventions implemented, tracking and trending of falls, the fall policy and procedure, and environmental hazards. A review of the post-test revealed no issues were identified. Interviews on 07/30/15 with theAdministrator at 2:37 PM, DON at 11:21 AM, ADON at 2:08 PM, SDC at 12:15 PM, MDS Coordinator at 2:17 PM, RSM at 2:26 PM, Dietary Manager at 1:15 PM, QOL Director at 11:03 AM, Environmental Services Director at 9:45 AM, SSD at 12:01 PM, Admissions Director at 12:01 PM, and Medical Records at 12:07 PM revealed they were educated face to face on the fall policy and procedures, tracking and trending of falls, care plan revision and updating, ensuring appropriate interventions are implemented after falls andenvironmental hazards. 9) Review of education provided to direct care staff revealed the staff was educated on the fall policy and procedure, care plan revision and updates, ensuring appropriate interventions are implemented after a fall and environmental hazards. Interviews on 07/30/15 with Housekeeping Staff #1 at 10:58 AM, Dietary Staff #1 at 1:50 PM, SRNA #8 at 9:57 AM, SRNA #9 at 10:08 AM, SRNA #10 at 10:14 AM, SRNA #3 at 10:22 AM, SRNA #6 at 10:30 AM, Licensed Practical Nurse (LPN) #4 at 10:38 AM, and Registered Nurse (RN) #4 at 10:50 AM revealed the staff was knowledgeable about the fall policy/procedures, environmental hazards, care plan revision and updates, and ensuring interventions implemented after a fall were appropriate and related to the root cause of the fall. 10) Interview on 07/30/15 at 1:57 PM with the	F 323		

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F 323	Continued From page 45 Regional Nurse Consultant revealed he had been in the facility daily since the Immediate Jeopardy was identified and had been conducting audits to validate compliance daily. The Regional Nurse Consultant further revealed he had assisted with fall investigations, chart audits, and care plan audits. 11) Interview on 07/30/15 at 1:57 PM with the Regional Nurse Consultant revealed administrative oversight had been provided by the VP of Operations, Special Projects Administrator, and the Signature Care Consultant daily since the beginning of the immediate jeopardy and would continue weekly for 4 weeks and then monthly. 12) Interviews on 07/30/15 with the DON at 11:21 AM, Administrator at 2:37 PM, and the Regional Nurse Consultant at 1:57 PM revealed all audits and reviews were discussed daily and any identified concerns were corrected immediately. The interview further revealed all identified concerns were discussed weekly in the QAPI meeting and the weekly QAPI meetings would be weekly for 4 weeks, then monthly, and then the frequency would be evaluated and determined for meeting and audits.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441	**F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **Corrective action for Resident(s) affected:** Resident was monitored by nursing staff every shift for 72 hours, starting on 7/22/15 and completed on 7/25/15, for any sign of infection.	

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F 441	Continued From page 46 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This STANDARD is not met as evidenced by: Based on observation, interview, record review, and a review of the facility's policy it was determined the facility failed to establish and maintain an effective infection control program related to incontinence care provided to facility residents for one (1) unsampled resident	F 441	**How the facility will act to protect Residents in similar situation:** All residents were assessed for any S/S of UTI by DON, ADON, SDC or wound nurse on 7/23/15. Residents noted with UTI symptoms were all previously identified and being treated appropriately. Nursing staff will monitor all residents for signs and symptoms of UTI every shift. SDC will inservice all nursing staff on appropriate pericare and on infection control policy by 8-28-15. SDC, DON, ADON, and/or nurse will observe and perform a compentency check on all nursing staff in regards to pericare/ glove changing routines by 8-28-15. **Measures to prevent reoccurrence:** SDC will inservice all nursing staff on appropriate pericare and glove changing techniques by 8-28-15. **Monitoring of corrective action:** DON, ADON, SDC and/or nurse will monitor pericare performed by 5 nurse aids a week x 4 weeks. Then the DON, ADON, SDC and/or nurse will monitor 5 nurse aides every month x 3 months for compentancy in pericare and glove changing. All findings will be discussed in QAPI and issues addressed immediately.	

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F 441	Continued From page 47 (Resident A). Observations revealed staff failed to change their gloves when the gloves became contaminated, while providing incontinence care to Resident A. The findings include: Review of the facility policy titled "Perineal Care," dated December 2010, revealed staff was to cleanse the resident's perineum to prevent infections and odors. The policy directed staff to wear disposable gloves. The policy did not address staff changing or discarding gloves if they became contaminated with urine or stool. Review of Resident A's medical record revealed the facility admitted the resident on 08/08/14 with diagnoses that included Senile Dementia and Muscle Weakness. Review of the resident's quarterly Minimum Data Set (MDS) Assessment dated 06/30/15 revealed the resident was incontinent of bowel and bladder and required extensive assistance of two (2) staff members for toileting needs. Observations conducted of incontinence care for Resident A on 07/22/15 at 1:20 PM revealed staff provided perineal care, cleaned urine and stool from the resident, and discarded the resident's soiled brief. Staff was observed to apply a clean brief and touch the resident's clothing, linen, and bed railing without discarding the contaminated gloves. Interview with State Registered Nurse Aide (SRNA) #2 on 07/22/15 at 4:20 PM revealed she had provided incontinence care to Resident A. The SRNA acknowledged she had failed to change her gloves after they became	F 441	**Completion date:** 10-1-15	

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F 441	Continued From page 48 contaminated with urine and stool. SRNA #2 stated she had been trained to change her gloves after they were contaminated, but forgot to do so. Interview with the Director of Nursing on 07/23/15 at 6:25 PM confirmed staff had been trained to change their gloves when they became contaminated with urine or stool, when incontinence care was provided to facility residents. The DON acknowledged the failure of staff to change their gloves after they became contaminated was an infection control concern for facility residents.	F 441		