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	145447	A. BUILDING _____ B. WING _____	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 248 SS=E	Annual Certification Survey. 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 248		

The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, the facility failed to consistently provide evening activities and weekend activities based upon residents stated activity preferences.

This failure affects two of 18 residents (R5 and R15) in the sample and 15 residents (R19, R21, and R25-R37) from the supplemental sample reviewed for who expressed interest in weekend / evening activities.

Findings include:

On 11/19/14 at 10:00 am at the group meeting, four residents stated that there were no evening activities and very little activities on the weekends. R19 stated that there was not much to do on the weekends. He also stated that there were no activity staff in the building in the evenings or the weekends. R12 stated there could be more weekend activities. R21 stated there was not much to do on the weekends. R5 stated there was nothing except church services on the weekends, and she would enjoy Bingo

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/08/2014

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F 248	Continued From page 1	F 248		

game on Sundays. The residents in this group meeting were identified by the facility staff as being alert and cognitively able to attend a meeting and verbalize their thoughts.

On 11/20/14 at 1:30 pm, R5 again stated she would enjoy Bingo on the weekends. On 11/20/14 at 12:30 pm R12 stated there are not many activities in the evenings except for a movie on Fridays. R12 also stated there weren't many weekend activities. She stated she would enjoy Bingo or bowling at these times.

Activity calendars for May 2014 through November 2014 showed no scheduled activities after 4:00 pm on most weekdays with the following exceptions: On May and June calendar, Bible study scheduled on Tuesdays at 6:45 pm. Additionally, on 5/5/14, a Chino de Mayo party was scheduled. Other than these dates, there were no scheduled activities after 4:00 pm, and in some instances, after 3:00 pm (July, August).

The entire 5 months of activity calendars lists only "tabletop games" in the main dining room at 10:00 am and "movie" to be determined at 2:00 pm on Saturdays. Sunday activity calendar consistently lists tabletop games at 10:00 am and church at 2:00 pm.

On 11/19/14 at 12:30 pm, E 18 (former Activity Director) stated that they have no evening activity staff in the building, and no dedicated activity staff working on the weekends. E 18 stated that E 20 (Bookkeeper) works on the weekends as a weekend supervisor, and she also assists with activities as well as performing other duties. E 18 stated that weekend activities are primarily independent, and CNAs (certified nursing

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F 248	Continued From page 2 assistants) are expected to assist as needed on evenings and weekends. On 11/20/14 at 3:00 pm, E 18 stated that the current activity staffing consists of 1 full-time staff who works Monday through Friday, and 2 part time people. Of the part time staff, one works Monday, Wednesday and Friday, and one works Tuesday through Friday. E 18 stated that all of their hours are essentially the same, from about 9:00 am to 5:00 pm. E 18 stated she was the Activity Director until the end of October, and the activity staffing was the same when she was the Director as it is now. This information was presented to the facility during the daily status meeting at 3:00 pm on 11/19/14. On 11/20/14 at 10:00 am during meeting with facility staff (E 1-Administrator) and E 2 (DON), E 2 stated that they did a facility wide interview of residents to determine interest in weekend activities. E2 presented a facility census sheet with resident responses on it. The following residents indicated possible interest in weekend / evening activities: R25-R32, R36 and R37; several mentioned they might enjoy Bingo. Five residents stated that they would enjoy Bingo at these times, specifically R5, R21, R15, R34 and R35. One resident, R33, stated she would enjoy group activities at these times. The facility documented that R19 was not interested in activities at this time, but during the group meeting, R19 did state that there was not any activities in the evenings and little to do on the weekends.	F 248		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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F 309	Continued From page 3	F 309		

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

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to develop and implement individualized wound care interventions in a timely manner; failed to properly measure wounds; failed to notify the family and physician of deterioration in facility acquired wounds (other than pressure ulcer) for R1; and failed to implement hospice care plan interventions for R2.
This applies for two residents (R1, R2) in the sample of 18 residents.
Findings include:
1. R1 is an 81 year old male admitted to the facility on 6/24/14. R1 ' s medical record documents the following diagnoses: Diabetes Mellitus, Chronic ischemic heart disease, hypertension, peripheral neuropathy, dementia, esophageal reflux, anemia, osteoporosis, cellulitis and abscess, and pressure ulcer.
R1 ' s Treatment record documented that he had a new open blisters to his left shin as of 10/7/14. The wound bed was documented as pink with scant drainage. R1 ' s treatment records were reviewed and as of 11/12/14, the record documented that the wounds were pinkish in color with very scant amount of drainage.
R1 ' s Physician ' s Order Sheet (POS) documented an order for Bacitracin ointment to the wounds.

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F 309	Continued From page 4 On 11/19/14 at 8:30 am informed E8 (Wound Care Registered Nurse / RN) to allow visualization of R1 ' s wound care. E8 then completed dressing changes to R1 ' s shin prior to contacting the surveyor. The dressings were dated 11/19/14. E8 stated that R1 had superficial wounds to his leg from blisters that had opened. R1 ' s nursing note completed by E8 on 11/19/14 read that the wounds had no change in characteristics from the previous week, was pink in color and contained scant amount of drainage. R1 agreed to allow visualization of his shin. Upon removal of the dressings, the upper wound was noted open with depth greater than 0.1 cm. The lower wound was also open with depth and its bed contained 80% yellow slough. When asked how long the wound had slough, E8 stated " I noticed it yesterday. " E8 was asked to measure R1 ' s wounds. She then placed a cotton swab into the wound bed with her right hand, then held a ruler at eye level with her left hand and stated it ' s less than 0.1 cm. When asked how she marked the measurement, E8 stated she looked at the swab and placed a visual picture in her mind. E8 redressed R1 ' s wounds applying Bacitracin ointment. There was no documentation about the deterioration located in R1 ' s medical record. E8 stated she did not document it. E8 also stated she did not notify the physician or R1 ' s family, but she will do it today. R1 ' s nursing notes dated 11/19/14 at 14:00 reads: Placed call to Medical Doctor and updated on left leg shin area wound bed with 80% thin yellow slough. New treatment order received and carried out. R1 ' s medical record documents the following order: 11/19/14, Cleanse wound to left lower shin area with normal saline and apply Carasyn Gel daily in the morning.	F 309		

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F 309	Continued From page 5 The facility ' s Ulcer Policy & Procedure documents: When a resident is found to have a skin tear or wound, either on admission or during their stay, the nurse is responsible for assessing the skin tear or wound and documenting appropriately. Documentation should be factual, comprehensive and timely. The following documentation shall be initiated: -The physician is notified and orders for treatment are received and initiated. -The resident ' s family or Power of Attorney for Healthcare is notified of change in resident ' s condition and new physician orders. -Orders are documented in the clinical record. -Orders are transcribed to the Treatment Administration Record. 2. R2 is a 76 year-old female admitted to the facility 8/12/14 with medical diagnoses including hypertension, diabetes mellitus, asthma, breast cancer with metastasis to the brain and bone, esophageal reflux. She was admitted under Hospice care. R2's care plan with an initiation date of 11/18 14 for falls, mentions under the focus section that R2 is on Hospice care. That is the only focus area that discusses the fact that R2 is on Hospice. R2's care plan with an initiation date of 11/18/14 which has a goal of keeping R2 comfortable due	F 309		

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F 309	Continued From page 6 to her cancer diagnosis indicates that Hospice and Nursing staff are responsible for keeping R2 comfortable. There is no other delineation of care between Hospice and facility staff and no further integration of R2's plan of care between Hospice and the facility.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent worsening of R5's pressure ulcer and to prevent from developing new pressure sore by failing to educate the resident on the importance of relieving pressure off of her wound. Failed to develop and implement individualized interventions for the resident's reluctance to change position. The facility also failed to ensure R5's treatment was changed after a month with no improvement and even after a worsening of the wound. This applies to one of three residents (R5) reviewed for pressure sores out of a sample of 18.	F 314		

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Findings include:

R5 is an 86 year old female re-admitted to the facility on 5/7/13, with multiple diagnoses including paraplegia of the lower limbs secondary to polio, post-polio syndrome, hypertension and history of decubitus ulcer. R5 has an indwelling catheter secondary to a Stage 3 decubitus ulcer on her left lower buttock.

On 11/18/14 at 1:30 pm, E8 (treatment nurse) was questioned as to when wound care for R5 could be observed on 11/19/14. E8 stated to observe R5's wound around 1:00 pm, when R5 goes back to bed, as she gets up in her wheel chair during the day. On 11/19/14 at 9:29 am, R5 was observed seat in her wheel chair in her room, with her wheel chair cushion in place. R5 was also observed to be up in her wheel chair when she attended the group meeting held with several residents from 10:00 am to 11:00 am on 11/19/14.

At 1:40 pm, E8 performed wound care and measured R5's wound. According to R5's TAR (treatment administration record) dated 11/12/14, R5 had 1 stage 3 pressure sore on the left gluteal / ischial area, measuring 0.8 cm x 1.5 cm x 1.5 cm, with no change in wound size documented. TAR also reflects treatment to consist of Critic Aid AF to periwound and cover with dry gauze after normal saline cleanse. Upon observance of R5's wound, R5 had 1 Stage 3 wound in the previously-described location. However, upon E8 measuring the wound, she determined the wound measurements on 11/19/14 to be as follows: 0.8 cm x 2 cm x 2 cm, which E8 stated was an increase in size, indicating a worsening of the

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wound. E8 also observed a new wound proximal to the original wound, which E8 describes as being at the 5 o"clock location. this wound measured 0.5 cm x 2 cm x 0.1 cm and E8 classified the sore as a Stage 2. E8 confirmed this as a new wound, and stated she would notify R5's wound care physician, whom she sees every few weeks. When asked what she attributed the worsening of R5's wound to, E8 stated that it could be due to the fact that R5 likes to stay up in her wheel chair once she gets up in the morning, and doesn't usually go back to bed until after lunch. E8 stated that this has been a long-standing issue with R5 and that she is reluctant to relieve the pressure off her wound.

On 11/20/14 at 3:00 pm, E8 stated she had spoken to wound care clinic personnel and had relayed the worsening of R5's wound size along with the new wound. E8 stated that there was no change made to R5's treatment at the time, and R5 was to be seen again for her regularly scheduled wound clinic appointment at 11/25/14. E8 stated that R5's wound treatment had been the same for a long time.

R5's POS (physician order sheet) dated 8/28/14 contains an order which indicates to continue the same treatment to R5's wound on the left ischial area, which was to apply Critic aid AF and cover with a dry gauze. According to E8, there had been no change in R5's treatment since then.

R5's care plan for skin breakdown with an initiation date of 9/24/14 indicates that her Stage 3 wound measurements on 10/1/14 were 1 cm x 1.5 cm x 1.5 cm. Wound measurements on 10/8/14 were the same, and on 10/15/14 the measurements changed to 0.8 cm x 1.5 cm x 1.5

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cm. There was no further improvement in the wound size on any of the other dates measured (10/22/14, 10/29/14, 11/5/14 or 11/12/14). Then, there was an increase in measurement on 11/19/14 with also a new wound discovered, with no change in treatment during the prior month when there was a lack of progress or with the discovery of the new wound.

On 11/19/14, R5 stated she had not gone back to bed after she had gotten up that morning, nor had her position in the chair been changed. R5 stated she could not stand because her legs were paralyzed.. On that date at 1:55 pm, E 16 (CNA) stated that he was caring for R5 that day and that she had gotten up around 5: 30 am. When asked if R5 had gone back to bed prior to lunch or had her position changed, E16 was very vague, initially saying he could not remember. When told that R5 denied having her position changed or being returned to bed, E16 stated that he had not repositioned R5 or returned her to bed. However, at 2:15 pm (20 minutes after first interview), E16 then returned and stated that he had forgotten that he had offered to put R5 to bed after breakfast, and she had declined. R5 did not indicate that he had encouraged R5 to change her position or to off-load the pressure from her wound. E16 did not state that he informed any nursing staff of her refusal to go to bed or that he enlisted any help to persuade R5 to change her position.

R5's care plan for skin breakdown identifies that R5 is at high risk for skin breakdown. The care plan lists various interventions for R5's skin breakdown, including tissue off-loading by repositioning and encouraging shifting of buttocks while up in her wheel chair, and to turn and

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F 314	Continued From page 10 reposition R5 every two hours and as needed. This care plan also states that R5 needs assistance with ADLs (activities of daily living) and is incontinent of bowel. R5's care plan has no interventions developed for how the facility will address R5's reluctance to relieve the pressure off her wound, other than encouragement. There was no documented education given to R5 as to the importance of off-loading for wound healing and no evidence of any other plan, such as family involvement, or getting a staff person who has a good rapport with R5 to try to convince her to off load or to change her position. This information was presented to the facility on 11/19/14 during the daily status meeting at 3:00 pm. On 11/20/14 during the morning meeting with the facility at 10:00 am, E2 stated that R5 had been educated on the need to off-load pressure from her wound. At 10:45 am, R5 confirmed that staff had spoken to her that morning about the importance of returning to bed to relieve pressure from her wound. R5's care plan was updated on 11/19/14 that the risks and benefits of off-loading pressure from R5's wound had been explained to R5; there was still no further development of a plan on how the facility could attempt to get R5 to cooperate more fully with this goal. R5's September 24, 2014 MDS (Minimum Date Set identifies R5's BIMS score (brief interview for mental status) as a 14, which indicates she has no cognitive impairment. It also scores R5 as a 4/3 for transfers, indicating that R5 is totally dependent for transfers and requires two-person physical assistance for this. R5 is scored 4/3 for bed mobility.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to comprehensively assess and evaluate the cause of R10 and R8's urinary incontinence. Failed to analyze the result of R10 and R8's voiding pattern in order to implement an individualized Bowel and Bladder program. Failed to provide thorough incontinence care to R8, R9 and R10.

This applies to three of residents reviewed for incontinence in the sample of 18 residents.

The findings include:

On 11-18-14 at 10:50 AM, R 10 stated, " I ' ve been here for few weeks now (10-08-14 admission), when I got here they put diaper on me, it is not what I want but they (staff) said I have to. I never wear a diaper at home. I can feel the urge to use the bathroom but waiting for somebody to help is another story. Yes, I pee on my bed especially at night because nobody comes and answer the light at night and at

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daytime, it just depends on how fast they come and take you. I am old (78 years old) I cannot hold it for too long you know! The toilet here is too low for me, at home I have a special toilet. I am scared of falling with this toilet and I told them (staff) several times. They don ' t come in a regular schedule to toilet me. "

On 11-18-14 at 11:00 AM R 10 requested to be toileted and R 10 was able to pull self-up with one staff physical assist, able to hold the bathroom bar and assist in pulling pants back up. R 10 expressed, " I can stand up by myself but I do not want to transfer myself, because I do not want to fall. I can clean up my self too but here they do it for me. "

E5 (Certified Nursing Assistant) who assisted R 10 to the washroom stated, " She is alert and oriented with periods of confusion. She can verbalize her needs, yes she can stand with one assistance and able to help out. "

E 5 was noted to wipe R 10 ' s buttocks three times with toilet paper. E 5 did not provide a complete and thorough perineal care to R 10. The facility incontinence care policy and procedure showed the following #7. Cleanse area with soap and water (or perineal cleanser) on washcloth. (a) Using clean part of the washcloth, cleanse downward from front to back or top to bottom. #8. Rinse area well. These (#7 and # 8) steps were not implemented.

On 11-20-14 at 2:00 PM, R 10 and her family came back from out on pass, R 10 requested to be toileted. E 17 and E 16 (Certified Nursing Assistants) were observed to toilet R 10 and at

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2:08 PM, R 10 was brought out from the washroom to her room. The family was standing about two feet away from R 10, the family stated, " Can you smell that? She was just in the bathroom with the staff and she smells like that (very strong urine odor)? I think they need to clean her better, maybe check her pants or something. She (R 10) can tell if she needs to use the washroom. It's true she never use a diaper at home. She used a liner at home. She was telling us that sometimes she could not find her call light (it is not with in her reach) and several times we found that her call light is not even working, as right now it is not working again. That is the reason she said the diaper helps. There is no way she can call for help when the call light is not working and that is when she wet her bed and her diaper. "

E17 (Certified Nursing Assistant) was notified that R 10 remains with a strong urine odor after being toileted. E 7 stated, " We changed her diaper. Maybe we need to clean her more toward the front "

R 10 ' s Minimum Data Set dated 10-15-14 showed that R 10 is always incontinent (no episode of continent voiding). On 11-19-14 at 11:35 AM, E 7 (Restorative/Bowel and Bladder Nurse) presented R 10 ' s 3 days voiding diary from 11-11-14 through 11-13-14. These continence tracking was not evaluated or analyzed, or the type of incontinence was identified and no program was implemented. When E 7 was asked R 10 ' s type of incontinence, E 7 stated " totally incontinent. "

On 11-20-14, E 7 presented a form and said, " This is her (R10) bladder continence assessment

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dated 10-10-14. " This form showed that R 10 is able to feel sensation or urge to void. Uses diaper, needs moderate assist with toileting. Make toilet needs known, unable to hold bladder long. R 10 ' s plan of care showed an intervention to use diaper, check, and change every 3 hours and PRN (as needed). Scheduled toileting according to resident ' s pattern/ wishes. The facility has not identified the voiding pattern of R10.

On 11/18/14 at 10:15 am E5 (CNA) when asked when was the last time R8 was taken to toilet, E5 stated night staff got R8 up from bed to wheel chair before 6:00 am. E5 said (E5) is going to change him as soon as she is done with the resident with one other resident. At 11:10 am E5 and E6 (CNAs) transferred with a sit to stand mechanical lift from his wheel chair to toilet. R8's diaper was saturated with urine and strong urine odor emanated as E5 removed his diaper. E5 wiped R8's back with an incontinent wipe twice, with another wipe she wiped between his thighs and with the same wipe she wiped his abdomen. E5 then applied a clean diaper on R8. Neither E5 nor E6 provided perineal care.
The facility 8/27/12 incontinent care policy and procedure read: #7 cleanse area well with soap and water (or perineal cleanser) on wash cloth. (for male residents retract the foreskin if the resident is uncircumcised and after cleansing return the foreskin to its normal position). On 11/18/14 at 11:10 am neither E5 nor E6 followed this procedure when providing incontinence care for R8.
R8's incontinence care plan (dated 11/16/14 page

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6) intervention noted to use diaper / pads, check and change every three hours and as needed. There is no assessment to show how the facility determined to check and change every three hours. The facility did a three day voiding diary (10/18/14 to 10/20/14). R8's voiding pattern was not analyzed to determine check and change. On 11/19/14 at 1:30 pm E7 stated CNAs did the voiding diary, but it was looked into to develop plan of care.

R9 is a 92 year old female admitted to the facility on 12/31/14. R9 ' s medical record documents the following medical diagnoses: Urinary Tract Infection, dementia, hypertension, osteoporosis, spinal stenosis, mitral insufficiency, Lumbar and thoracic compression fractures prior to admission, and anemia.

R9 ' s Minimum Data Set (MDS) dated 10/16/14 documents that she is always incontinent of bladder. The MDS documents that she requires extensive assistance with toileting. R9 ' s care plan documents: May use diaper and check and change every 3 hours and as needed. On 11/18/14 between 10:00 am and 1:30 pm at different intervals, R9 was noted sitting in her wheel chair. At 1:30 pm, E11 and E13 (Certified Nurse Aides) performed incontinence care for R9. R9 ' s incontinence brief contained a large amount of urine with strong odor. Upon completion of care, E11 was asked when was the last time she checked R9 for incontinence. E11 stated that she checked her at 9:30 am, and not since because her family showed up to visit. About 20 minutes after exiting R9 ' s room, E11 approached the surveyor and stated that she wanted to retract her statement. E11 stated that she actually provided incontinent care at 11:30 am while R9 ' s family was in the room. Z1 (Family Member) was asked if staff checked R9

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F 315	Continued From page 16 for incontinence since arriving. Z1 stated that R9 has not received incontinence care since the family arrived. The facility ' s visitor log showed that R9 ' s family signed in at 10:25 am. The facility Census and Condition Report for the survey showed 79 of 87 residents are occasionally or frequently incontinent of bladder; 47 of 87 residents are occasionally or frequently incontinent of bladder. The facility identified one resident to be on urinary toileting program.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure the staff supervised and implemented appropriate fall prevention measures for R9; failed to ensure the staff transferred R8 in a safe manner; and failed to use appropriate sling when transferring R7. This applies for three of six residents (R9, R7 and R8) reviewed for falls in a sample of 18. Findings include: 1. R9 is a 92 year old female admitted to the facility on 12/31/13. R9 ' s medical record documents the following: Urinary Tract Infection, dementia, hypertension, osteoporosis, spinal stenosis, mitral insufficiency, Lumbar and	F 323		

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thoracic compression fractures prior to admission, and anemia. R9 Minimum Data Set (MDS) dated 10/6/14 documents: Cognition- Brief Interview for Mental Status; score 2/15 indicating cognitive impairment. Transfers - extensive assistance, one person physical assist; Ambulation- extensive assistance, one person physical assist; Balance during transfers and walking- Not steady, only able to stabilize with staff assistance.
R9 ' s fall risk assessment documents a score of 15 indicating high risk for falls.
R9 ' s fall care plan dated 10/16/14 documents that she has a mobility alarm for her bed and chair. The care plan documents the alarms as being discontinued on 10/27/14. R9 ' s Restorative Care Plan documents that she gets confused, forgetful, and disoriented, with a diagnosis of Dementia. There are no interventions to address as how the staff would monitor R9 when her bed and chair alarm was discontinued.
R9 ' s Wandering Assessment dated 6/30/14 documents that she does not have a history of wandering. There were no further reviews located in R9 ' s medical record. There was no assessment in R9 ' s medical record to determine the safety of her propelling unsupervised throughout the facility.
R9 ' s restorative assessment dated 1/1/14 documents that she has decreased endurance; decreased stamina; decreased muscle coordination, decreased balance, decreased strength, and requires cues.
The facility ' s incident report for R9 dated 11/13/14 at 1:15 pm, documents that R9 tried to transfer herself from the wheel chair to bed, and sustained a fall. R9 complained of left hip pain and was sent to the local hospital.

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On 11/19/14 at 8:55 am, E7 (Restorative Registered Nurse / RN) stated that R9 was able to transfer with 1 person contact assistance. E7 stated that R9 is confused and roams the facility alone in her wheel chair. E7 confirmed, by providing the Restorative assessment that R9 has decreased strength and balance with limitation to both shoulders. E7 also stated that R9 was admitted to the facility with compression fractures to her spine and was high fall risk. E7 said R9 was given a bed and chair alarm when she was initially admitted to the facility. E7 added that the purpose of the alarm is so that if R9 tries to get up, staff may intervene right away. However, according to E7, the bed and chair alarm was discontinued on 10/27/14.

On 11/19/14 at 1:04 pm, E10 (Certified Nursing Assistance / CNA) stated that R9 is a wanderer and she wheeled herself from the South unit onto the North. E10 stated she provided care for R9 the day she fell. E10 stated that R9 entered R39 ' s room attempting to get into R39 ' s bed. E10 was asked when was the last time she had seen R9 was. E10 did not give a time, only stating that she tried to lay R9 down earlier and she refused. E10 stated that R9 has a history of trying transfer herself to bed. According to E10 staff reminds R9 not to transfer herself but she tries anyway. E10 stated " she is confused because she ' s always looking for a way out. "

On 11/19/14 at 1:15 pm, E9 (CNA) stated that she was working on the North unit when R9 sustained the fall. E9 stated that she did not see R9, but she heard screaming from R39 ' s room. Upon entering the room, E9 noted R9 on the floor by the bed. E9 also added that R9 is confused. E9 stated that R39 ' s room is in the back hall on the North unit.

On 11/19/14, E14 (Registered Nurse) stated that

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she did not see R9, but was summoned to R39 ' s room where she observed R9 on the floor, and that R9 ' s room is on the South unit.
R9 ' s nursing notes dated 11/13/14 by E14 documents that she was summoned to R9 ' s room where she noticed her on the floor on her left side. The note also documents that R9 tried to transfer from the wheel chair to the bed and lost her balance. R9 was complaining of severe pain to the left hip according to the documentation and was transferred to the local hospital.
The location of R9 where she was found is contradicting from R9's documentation (11/13/14 incident report and and 11/13/14 nurses notes) and staff interviews (E9 and E14).
On 11/19/14 the surveyor walked the distance from R9 ' s room to R39 ' s room. At the time of the fall, R9 ' s room was located at the back end of the hall on the South unit, approximately 10-11 doors down from the nursing station. When leaving the nursing station on the South the traveler went down a hall with resident rooms and offices. The traveler would also pass by the doorway leading to the main entrance of the facility, two dining rooms, and the North nursing station. Upon reaching the nursing station, the traveler would take a right and travel to back hall. The very last room on the right was R39 ' s room (approximate 14 doors down from the nursing station). The travel from R9 ' s room to R39 ' s room was in a " U " shape, as noted on the facility ' s floor plan. Staff interviewed were unable to state where R9 ' s route began. However, R9 made her way inside R39 ' s room unnoticed by staff.
R9 ' s radiology report from the hospital dated 11/13/14 documents: Impression- There is a comminuted left femoral neck fracture with

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displaced greater trochanteric fragment. R9 ' s medical records documents that R9 was admitted to the hospital where she received left hip ORIF (Open Reduction Internal Fixation) surgery.
The facility ' s Fall Management policy documents: The potential for injury will be care planned when appropriate, based on the results of the Fall Assessment. The interdisciplinary care plan will be individualized to reflect the specific needs and risk factors of the resident.

2. On 11-18-14 at 10:05 AM, E5 and E 6 were observed to transfer R 7 using a full mechanical lift (Hoyer) from chair to bed. When R7 was lifted, R 7 was observed like in a cocoon, R 7 ' s head and legs were enclosed in the sling. E 5 explained, " We are supposed to use a small size sling for her because she is so tiny (96 pounds). "

When E 5 was asked if the sling they used for R 7 is small, E 5 was unable to answer and said this other one here (that was not use) is the small size. "

On 11-18-14 at 1:25 PM, E 7 (Restorative Nurse) explained, " We do not have an assessment for appropriate sling size for the residents. " R 7 was unable to show any documentation regarding the sling size to be used for R 7.

On 11-20-14 at 11:10 AM, E 4 (Restorative Aide) explained, " The patient head is supposed to be exposed, the canvas is position to the neck of the resident and the lower part of the canvas should be by the resident ' s coccyx. No! The patient should not be enclosed like a cocoon. "
3. On 11/18/14 at 11:10 am E5 and E6 (Certified

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F 323	Continued From page 21 Nurse Aides - CNAs) transferred R8 using a sit to stand mechanical from wheel chair to toilet in the bath room. During the process of the transfer the strap (Velcro) that held R8's legs in place to the immovable board on the machine came off two times. There was thick layer of lint build up on the straps made the straps to come off. No staff stood behind R8 to prevent him from accidental falling from the mechanical lift. When the surveyor brought to the attention of E5 about the loose straps, she attempted reinforce, but did not stick together to contain R8's legs fastened to the immovable part of mechanical lift. E5 stated one staff should have had R8's back when moving him from wheel chair to the toilet, but E6 had to leave R8's room to access R8 to position him on the toilet from the adjacent room entrance to the bath room.	F 323		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain emergency call lights in good working order. This applies to four residents (R3, R7, R8, R10) in the sample of 18 and 11 residents in the supplemental sample (R23, R27, R32, R40, R42, R43, R62, R74, R76, R89, R93).	F 463		

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F 463	Continued From page 22 Findings include: On 11/20/14 tested the emergency call lights in the South Wing. The emergency call lights did not work properly in R3, R7, R8, R10, R23, R27, R32, R40, R42, R43, R62, R74, R76, R89 and R93's rooms. These residents call lights switches either got stuck after its initiated making it to prevent from initiating again or did not light or sounded when initiated. Maintenance logs indicate the call light system has been repaired several times this year. E1 (Administrator) said, "We have approval to install a new call light system in the next few months."	F 463		
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the Certified Nurse Aides were proficient when providing incontinence care and transferring resident with a mechanical lift. This applies to two of three residents (R8 and R10) observed for incontinence care and one of two residents (R8) observed for transfer in the sample of 18 residents. Findings include:	F 498		

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1. On 11/18/14 at 10:15 am E5 (CNA) at 11:10 am E5 and E6 (CNAs) transferred with a sit to stand mechanical lift from his wheel chair to toilet. R8's diaper was saturated with urine and strong urine odor emanated as E5 removed his diaper. E5 wiped R8's back with an incontinent wipe twice, with another wipe she wiped between his thighs and with the same wipe she wiped his abdomen. E5 then applied a clean diaper on R8. Neither E5 nor E6 provided perineal care.
The facility 8/27/12 incontinent care policy and procedure read: #7 cleanse area well with soap and water (or perineal cleanser) on wash cloth. (for male residents retract the foreskin if the resident is uncircumcised and after cleansing return the foreskin to its normal position). On 11/18/14 at 11:10 am neither E5 nor E6 followed this procedure when providing incontinence care for R8.

2. On 11-18-14 at 11:00 AM R10 requested to be toileted. E5 who assisted R10 to the washroom stated, " She is alert and oriented with periods of confusion. She can verbalize her needs, yes she can stand with one assistance and able to help out. " R10 expressed, " I can stand up by myself but I do not want to transfer myself, because I do not want to fall. I can clean up my self too but here they do it for me. "

E5 removed R10's diaper and she (E5) placed R10 on the toilet. After R10 voided E 5 was noted to wipe R 10 ' s buttocks three times with toilet paper. E5 did not provide a complete and thorough perineal care to R10. The facility incontinence care policy and procedure showed the following #7. Cleanse area with soap and water (or perineal cleanser) on washcloth. (a)

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F 498	Continued From page 24 Using clean part of the washcloth, cleanse downward from front to back or top to bottom. #8. Rinse area well. These (#7 and # 8) steps were not implemented. 3. On 11/18/14 at 11:10 am E5 and E6 (Certified Nurse Aides - CNAs) transferred R8 using a sit to stand mechanical from wheel chair to toilet in the bath room. During the process of the transfer the strap (Velcro) that held R8's legs in place to the immovable board on the machine came off two times. There was thick layer of lint build up on the straps made the straps to come off. No staff stood behind R8 to prevent him from accidental falling from the mechanical lift. When the surveyor brought to the attention of E5 about the loose straps, she attempted reinforce, but did not stick together to contain R8's legs fastened to the immovable part of mechanical lift. E5 stated one staff should have had R8's back when moving him from wheel chair to the toilet, but E6 had to leave R8's room to access R8 to position him on the toilet from the adjacent room entrance to the bath room.	F 498		