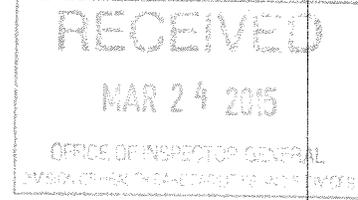


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/20/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESLEY MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5012 EAST MANSLICK RD LOUISVILLE, KY 40219</b>		
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F 000	INITIAL COMMENTS  A Recertification Survey was initiated on 02/17/15 and concluded on 02/20/15 and found the facility not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of a "G".	F 000			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure needed repairs were completed to the resident's environment for nine (9) of thirty-three (33) resident rooms, (rooms S2, S5, S6, N1, N5, W1, W2, W3, and W6), one (1) of two (2) resident living rooms, (shared by the North and South Unit) and one (1) of two (2) resident dining rooms (rear dining room). The resident living room and resident rooms had gouged walls and scraped paint. The resident dining room had peeling paint on the walls.  The findings include:  Review of the facility's policy regarding Maintenance Repair Requests, dated 02/25/12, revealed staff wrote any maintenance concerns, except emergency maintenance issues, on a Maintenance Issue Log sheet located on a clipboard in the Health Care and Memory Care nurses' station. Any staff member who identified	F 253	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All areas identified during the survey (living room and residents rooms S2, S5, S6, N1, N5, W1, W2, W3, AND W6) will be repaired and repainted. (work began on 3-20-15). Also, the entire facility will be inspected by the administrator to identify any other areas that need repair or repainting and those areas will also be fixed. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents in the facility have the same potential to be affected by this deficient practice. Any resident rooms that utilize certain care equipment (mechanical lifts, beds, wheel-chairs, geri-chairs) have a greater potential for wear-and-tear than the rooms that do not utilize that equipment. Regular inspections will note those rooms that require use of equipment, and protective wall coverings or other options will be utilized when appropriate.	04/05/15	



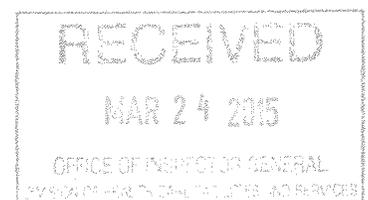
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator (X6) DATE 03-21-15

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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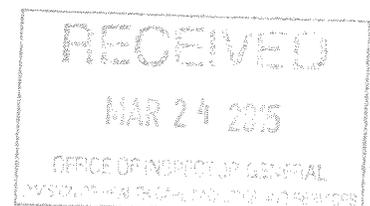
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F 253	<p>Continued From page 1</p> <p>a maintenance issue were to write on the Maintenance Issue Log sheet and Maintenance staff checked the log sheets daily.</p> <p>Review of the facility's Preventative Maintenance Plan, dated 01/01/14, revealed maintenance staff inspected the condition of the floors, walls, and ceiling's daily. It further stated maintenance staff checked the Maintenance Issue Log sheets daily. Maintenance staff would make notes on the sheet to address any delays in completing the maintenance task. Once the task was completed, the maintenance staff signed off on the sheet and sent it to the Vice President of Administration to be kept on file for six (6) months.</p> <p>Observation, on 02/18/15 at 11:40 AM, of the resident living room for the North and South halls revealed paint was missing and the drywall was exposed on three (3) of four (4) walls. The scraped area was approximately three (3) inches above the chair rail and extended most of the length of each wall affected.</p> <p>Observation, on 02/18/15 at 11:44 AM, revealed three (3) resident rooms on the South Hall, rooms S2, S5, and S6, with gouged walls and chipped and peeling paint in areas near where furniture sat.</p> <p>Observation, on 02/18/15 at 11:54 AM, revealed two (2) resident rooms on the North Hall, rooms N1 and N5, with gouged walls and chipped and peeling paint in areas near where furniture sat. Observation further revealed resident room N5 had black areas on the wall near the bed and scratches and scuffs on the wall adjacent to the door. The wall near the bed also had six (6)</p>	F 253	<p>MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <ol style="list-style-type: none"> <li>1. The administrator will make monthly inspections of the facility's physical plant utilizing the survey form (attachment F253-1) and report the results to the maintenance department. The Maintenance Department will complete repairs and report their progress to the administrator.</li> <li>2. The admissions coordinator will inspect each room before any new admission utilizing a new survey form (attachment F253-2) and report the condition of each room to the Maintenance Department. The maintenance department will perform required repairs prior to the admission of the new resident.</li> <li>3. All nursing department staff will be educated using on-the-spot inservices regarding the use of the maintenance logs located in the nursing station and the importance of reporting room condition on the maintenance log. (Attachment F253-3).</li> </ol> <p>HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE MAINTAINED:</p> <p>Monthly audits by the administrator will ensure that results are maintained. The results will also be reported to the monthly meetings of the Quality Assurance Committee for continued oversight and to make recommendations.</p>	



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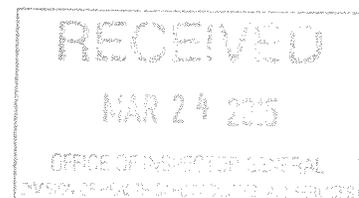
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F 253	<p>Continued From page 2</p> <p>painted over screws, six (6) wall anchors, not painted over, and several other screw holes in the wall. There were no items hanging on the wall.</p> <p>Observation, on 02/18/15 at 12:10 PM, on the West Hall revealed four (4) resident rooms, rooms W1, W2, W3, and W6, contained walls with various gouges, screw holes, and scrapes exposing drywall.</p> <p>Observation, on 02/18/15 at 2:35 PM, in the rear dining room revealed scrapes on the right side wall of the dining room. The scrapes were approximately two (2) feet off the ground, several inches wide, and traveled the length of this wall. The damaged portion of the wall appeared blackened by scuffmarks and paint was peeling away from the wall near the gouged area.</p> <p>Interview with the Director of Maintenance, on 02/18/15 at 4:02 PM, revealed the facility used a contractor to paint doors and walls. The Director of Maintenance confirmed the scrapes and holes in the walls of the resident rooms. The Maintenance Director stated he attempted to have rooms painted when residents move out of the rooms; however, the facility moved new residents into those rooms before painting could be completed. He stated the facility considered paint and wall repair a lower priority to other maintenance issues. He further indicated he had not received any work order requests to repair paint or gouged walls for the facility.</p> <p>Interview with the Director of Nursing (DON), on 02/19/15 at 4:50 PM, revealed the Director of Maintenance was responsible to ensure needed repairs to walls were completed. The DON stated the Director of Maintenance reports to the</p>	F 253	<p>STAFF MEMBER RESPONSIBLE FOR THE PLAN TO BE ACCOMPLISHED:</p> <p>Administrator</p>		



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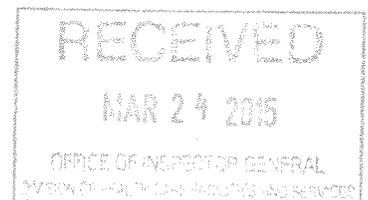
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F 253	Continued From page 3 Administrator. She further revealed any staff member might document needed repairs throughout the facility on the maintenance log, located at the nurses' station. The DON stated she tried to put an order in to get rooms painted when a resident moved out of the facility; however, many residents remained at the facility for a long time. The DON stated she did not pay much attention to the condition of the walls in the facility.  Interview with the Administrator, on 02/19/15 at 4:30 PM, revealed the facility had a preventative maintenance program that included paint. The Administrator also stated the facility staff had a maintenance log available to them to document needed repairs throughout the facility. The Administrator stated he was responsible for ensuring the maintenance staff addressed the issues and completed the work; however, he was unaware of the gouged and peeling walls. He stated he just recently started directly supervising the maintenance staff and was previously unaware of the issue.	F 253			
F 280 SS=G	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	F 280	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FROUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A comprehensive care plan was developed for resident #6 related to the hard cervical collar on 3-13-15 (see attach F280-1). A comprehensive care plan was also developed for resident #6related to the wounds as a result of the cervical collar rubbing the back of the resident's head on 3-13-15(see attach F280-2). HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	04/05/15	



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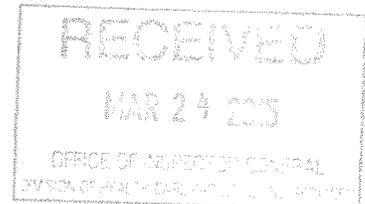
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F 280	<p>Continued From page 4</p> <p>for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure a Comprehensive Care Plan was revised related to the use of a hard cervical collar for one (1) of sixteen (16) sampled residents, (Resident #6). Resident #6 returned from the hospital with a hard cervical collar on 01/31/15; however, the facility did not revise the resident's care plan to include proper use and monitoring of the device to prevent wounds. On 02/18/15, the facility identified Resident #6 had developed two (2) wounds on the back of the head as a result of the cervical collar rubbing. (Refer to F314 and F498)</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Resident Care Plan, revised February 2013, revealed the Health Care Center (HCC) Team Manager or Nurse Team leader would update the care plan promptly as changes occurred.</p> <p>Review of Resident #6's clinical record revealed the facility admitted the resident on 09/25/13 with</p>	F 280	<p>All other residents in the facility were reviewed and it was determined that one additional resident utilized a cervical collar. A comprehensive care plan was developed for that resident as well for the cervical collar and the need for skin assessment. (see attachment F280-3).</p> <p>MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <ol style="list-style-type: none"> <li>1. Resident Plan of Care policy was revised on 3/11/15. (see attachment F280-4).</li> <li>2. The skin breakdown/pressure ulcer policy was revised on 3/11/15 (see attachment F280-5).</li> <li>3. The initial needs care plan was reviewed and revised on 3-13-15 (see attachment F280-6).</li> <li>4. Mandatory in-services will be conducted by the VP of Nursing, Assistant Director of Nursing, and Staff Development Coordinator to review all policy changes and care plan changes between March 17 and March 26, 2015. (see attachments F280-7 and F280-8).</li> <li>5. The medical director reviewed and approved the revisions for the resident plan of care policy, the skin breakdown and pressure ulcer care policy, and the initial needs care plan on 3-12-15.</li> </ol> <p>HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE MAINTAINED: The Assistant DON and the Director of RAI will perform daily audits during the morning clinical team meetings. The Assistant DON and the VP of Nursing will perform monthly care plan audits on all new admissions and re-admissions to ensure all current care needs and physician's orders have been transferred to the comprehensive care plan. All completed audits will be turned into the</p>		



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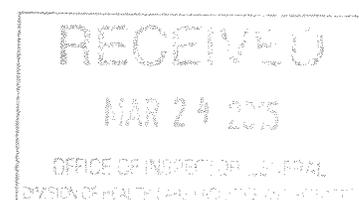
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F 280	<p>Continued From page 5</p> <p>diagnoses of Alzheimer's Dementia, Diabetes Mellitus Type 2, and Depression.</p> <p>Review of Resident #6's Quarterly Minimum Data Set (MDS) assessment, completed on 12/04/14, revealed the facility assessed the resident as rarely/never understood with short term and long term memory problems. The facility assessed the residents bed mobility as extensive assistance and total dependence for transfers, dressing and personal hygiene. The facility assessed the resident at risk for pressure ulcers with no current or history of pressure ulcers.</p> <p>Review of the Comprehensive Care Plan for Resident #6 revealed the facility developed a care plan on 09/12/14 for risk of skin breakdown related to the resident sitting quite a bit, with a goal to prevent skin breakdown through the next quarter. Interventions included: pressure reduction mattress; treatments per Physician orders; incontinent care; space boots in bed; and, monitor skin with incontinent care and bathing and report any changes to the nurse.</p> <p>Review of the hospital records for Resident #6, dated 01/31/15, revealed the resident returned to the facility after a fall with an injury with orders to wear a hard cervical collar at all times until seen for follow-up by the Physician.</p> <p>Continued review of the Comprehensive Care Plan for Resident #6 revealed the care plan had not been revised for the resident to indicate the use of the hard cervical collar or to direct staff on the assessment and care of the skin under the collar.</p> <p>Continued review of physician orders for Resident</p>	F 280	<p>Quality Assurance Committee for review and recommendations, if any.</p> <p>STAFF MEMBER(S) RESPONSIBLE FOR THE PLAN TO BE ACCOMPLISHED: VP of Nursing/Assistant Director of Nursing.</p>		



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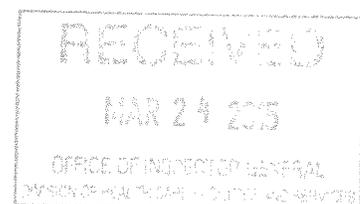
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F 280	<p>Continued From page 6</p> <p>#6 revealed on 02/08/15 an order was written to apply skin prep to the right and left ear and ear lobe as a preventive measure while the collar was in use. An order was written on 02/12/15 to assess the skin under the collar every shift. The orders were placed on the Medication Administration Record (MAR); however, they were not found on the care plan.</p> <p>Observation, on 02/17/15 at 5:00 PM, of Resident #6 revealed the resident was laying on the bed. The resident had a cervical collar on, but it was up on the face and did not appear to be in the proper position.</p> <p>Observation, on 02/18/15 at 7:42 AM, of Resident #6 revealed the resident was in bed, with the cervical collar on, but was positioned up on the face.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 02/20/15 at 12:05 PM, revealed the CNAs received report from the nurses and if they had questions about the resident's care they could ask the nurse. The CNA stated she was familiar with the care needs of the resident; however, received no training on the collar and it was not on the CNA care plan.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 02/19/15 at 2:15 PM, revealed she was not responsible to revise care plans. She stated the charge nurse or desk nurse updated the comprehensive care plan and Certified Nursing Assistant (CNA) care plans when physician orders were taken off. She stated the Resident Assessment Coordinator then followed up to ensure the care plans were correct.</p>	F 280		



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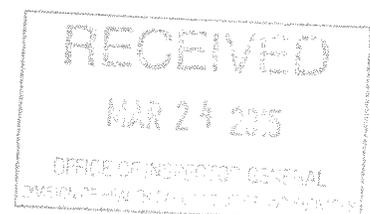
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F 280	<p>Continued From page 7</p> <p>Interview with LPN #6, on 02/19/15 at 2:35 PM, revealed she was the second shift Supervisor. She stated when a physician order was taken off, the person who took the order off, should have updated the care plan. She stated when Resident #6 returned from the hospital with a hard cervical collar, the care plan should have been revised to ensure the residents needs were identified and care needs were met. She stated the Resident Assessment Coordinator was responsible to follow up to ensure the orders received had been placed on the care plan.</p> <p>Interview with Registered Nurse (RN) #3, on 02/20/15 at 11:15 AM revealed she was the day shift Unit Manager. She stated the person who takes the orders off was responsible to update the comprehensive care plan and CNA care plan. She stated when Resident #6 returned from the hospital with the hard cervical collar, it should have been placed on the care plan. She stated the care plan coordinated the care of the resident so the resident could receive the best possible care.</p> <p>Interview with LPN #3, on 02/20/15 at 11:48 AM, revealed she never updated the care plan because the charge nurse and Resident Assessment Coordinator were responsible for updating the care plan.</p> <p>Interview with RN #2, on 02/20/15 at 10:40 AM, revealed she was the Resident Assessment Coordinator. She stated the process for care plan development or revision occurred when the nurses received a new order. They had the opportunity to develop or revise the care plan. She then followed-up on the physician order by attending the morning meeting and reviewing the</p>	F 280		



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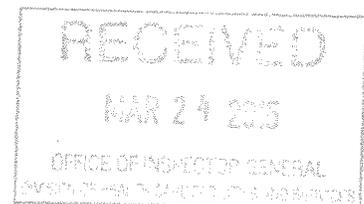
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F 280	Continued From page 8 physician orders. She stated she was aware of the fall with Resident #6 because she had seen everything on the twenty-four hour report when the resident returned from the hospital. She stated she had not added anything to the care plan, because in multiple places on the care plan, it stated treatment per physician order and medications per physician order. Per interview, she didn't think she needed to repeat what was on the medication record and treatment record for Resident #6. She stated she believed the care plan was sufficient to meet the needs of Resident #6. She did not think specific interventions needed to be added to the care plan to ensure appropriate care was provided related to the use of the collar.	F 280			
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was consistently followed to prevent accidents for one (1) of sixteen (16) sampled residents, (Resident #6). The facility assessed Resident #6 to require the use of a postural vest to maintain posture while sitting in a wheelchair. A Physician's order was written on 09/26/14 to place a postural vest on the resident when up in the wheelchair. The falls	F 282	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A comprehensive care plan was developed for resident #6 related to the postural vest on 2-22-15. (see att. F282-1). A comprehensive care plan was also updated for resident #6 related to falls on 3-12-15. (see att. F282-2). The CNA assignment sheet for resident #6 was updated on 3-12-15 to coordinate the information identified on the comprehensive care plan. The CNA assignment sheet reads, "Postural vest for trunk support and fall risk when in wheelchair at all times to never be without postural vest due to high fall risk. (This is a restraint)." HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	04/05/15	



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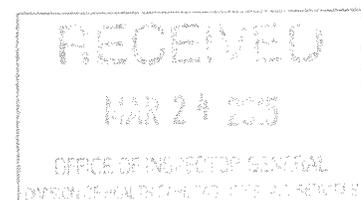
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F 282	<p>Continued From page 9</p> <p>care plan was revised on 09/26/14 to include the physician order and was placed on the Certified Nursing Assistant's (CNA) care plan. However, on 01/30/15, CNA #2 failed to apply the postural vest on Resident #6 while up in the wheelchair and left the resident unattended in the resident's room. The resident fell from the wheelchair and sustained a concussion, a contusion to the face, and laceration to the forehead requiring a hospital transfer and sutures. (Refer to F323 and F498)</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Resident Care Plans, revised April 2013, revealed Care Plans would include the date initiated; problem area; goals; interventions; the department responsible for each intervention; and, the goal review date. Changes to the care plan may occur due to changes in the resident's behavior; a new onset of falls; an addition of a new medication; and, a new onset of skin changes.</p> <p>Review of the facility's policy regarding CNA Assignment sheets/Resident Plan of Care, revised January 2014, revealed each CNA would be provided a CNA assignment sheet/Plan of Care that followed the resident's comprehensive care plan, and directed the CNA on the care to provide based on physician orders and interventions, and to ensure the best quality care.</p> <p>Review of Resident #6's clinical record revealed the facility admitted the resident on 09/25/13 with diagnoses of Alzheimer's Dementia, Diabetes Mellitus Type 2, and Depression.</p> <p>Review of Resident #6's Quarterly Minimum Data Set (MDS) assessment, completed on 12/04/14,</p>	F 282	<p>All other residents in the facility were reviewed by the Director of RAI on 3-11-15 and it was determined that one additional resident utilized a postural vest. A comprehensive care plan was developed for that resident as well for the postural vest and the risk for falls. (see attach F282-3 and F282-4).</p> <p>MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <ol style="list-style-type: none"> <li>1. The CNA assignment sheet/Resident Plan of Care policy was revised on 3/11/15. (see attachment F282-5).</li> <li>2. The Falls Prevention Program policy was revised on 3/11/15 (see attachment F282-6).</li> <li>3. Mandatory in-services will be conducted by the VP of Nursing, Assistant Director of Nursing, and Staff Development Coordinator to review all policy changes and care plan changes between March 17 and March 26, 2015. (see attachments F282-7 and F282-8).</li> <li>4. The medical director reviewed and approved the revisions for the CNA assignment sheet/resident plan of care policy and the Falls Prevention Program policy on 3-12-15.</li> </ol> <p>HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE MAINTAINED:</p> <p>The Assistant DON and the Director of RAI will perform daily audits during the morning clinical team meetings to ensure the CNA assignment sheet and the comprehensive care plan information coordinate and provide clear direction to the CNA for care. The Assistant DON and the VP of Nursing will perform 5 random monthly audits on each hall comparing the CNA assignment sheets with the comprehensive care plan to ensure that information and care coordinate and provide clear direction to the CNA for care.</p>		



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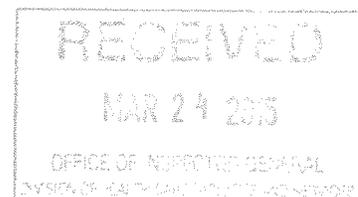
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F 282	<p>Continued From page 10</p> <p>revealed the facility assessed the resident as rarely/never understood with short term and long term memory problems. The facility assessed the resident's bed mobility as extensive assistance and total dependence for transfers, dressing and personal hygiene.</p> <p>Review of the Comprehensive Care Plan for Resident #6, revealed the facility developed a care plan on 09/12/14 for risk of falls related to progression of Alzheimer's and Dementia, with a goal to be free from preventable falls while remaining restraint free, in order to decrease the risk of injury from falls, through the next quarter. Interventions included to assist with balance during care giving; toilet and transfer per the CNA sheet; therapy to screen quarterly; monitor for unsafe behavior; clip alarm at all times; bed sensor pad in bed and in wheelchair; and, bed wedges when in bed. On 09/26/14 the falls care plan was revised with a new intervention for a postural vest on the resident when up in the wheelchair.</p> <p>Review of the incident investigation, dated 01/30/15 at 7:45 PM, revealed CNA #2 reported she had put a gown on Resident #6 for bed, placed the tab alarm back on the resident, then left the room to get the mechanical lift. When she came back, less than a minute later, the resident was laying on the floor, on the left side, in a pool of blood, with the tab alarm sounding. The resident was sent to the hospital for an evaluation.</p> <p>Continued review of the incident investigation, dated 01/30/15, revealed the Director of Nursing (DON) interviewed CNA #2 on 01/31/15 regarding the fall. The CNA stated she had not put the</p>	F 282	<p>If 100% compliance is achieved during the first 6 months of the audits, then the frequency of audits will be decreased. All completed audits will be turned into the Quality Assurance Committee for review and recommendations, if any.</p> <p>STAFF MEMBERS RESPONSIBLE FOR THE PLAN TO BE ACCOMPLISHED: VP of Nursing/Assistant Director of Nursing.</p>		



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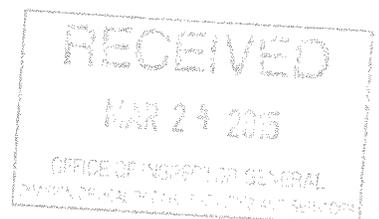
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F 282	<p>Continued From page 11</p> <p>postural vest on the resident when she left the room to get the lift because the order for the vest said for the resident to have it on when out of bed, but it did not say the resident couldn't be without it at any time, when out of bed. She didn't feel like she needed to put the postural vest on the resident just to go down the hallway to get the lift.</p> <p>Review of the hospital transfer records, dated 01/30/15- 01/31/15, revealed Resident #6 sustained a concussion, scalp laceration, and contusion to the face, from a fall at the nursing home. Discharge instructions included use of a hard cervical collar.</p> <p>Interview with CNA #2, on 02/19/15 at 1:15 PM, revealed she had worked with Resident #6 and was familiar with the resident's care needs. She stated she got her information about resident care needs from the CNA care plan and reports from the previous shift. She stated Resident #6 had a tab alarm, sensor pad when in bed and wheelchair, and a postural vest when up in the wheelchair. She stated she did not know the resident was a falls risk prior to the fall on 01/30/15 and was not aware of any previous falls. She stated she believed the postural vest was used when Resident #6 was up in the wheelchair for posture and not to prevent falls. She stated she had never left the resident unattended, without the postural vest in place while up in the wheelchair, prior to this incident.</p> <p>Review of the CNA care plan for Resident #6, not dated, and used by staff prior to the fall on 01/30/15, under the section mobility devices, positioning and safety, the interventions included a postural vest when up in the wheelchair; a clip</p>	F 282	



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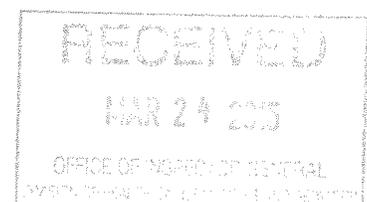
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F 282	<p>Continued From page 12 alarm at all times; a sensor pad to the wheelchair; and a bed sensor.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 02/19/15 at 2:35 PM, revealed she was the second shift Supervisor and her responsibility was to oversee floor staff to ensure they were providing appropriate care for the residents. She stated the CNAs received a daily care plan that included the care needs of the residents and any new orders were given to staff in daily report. She ensured residents were getting proper care by observing the residents, and looking at the CNA books to ensure they documented care provided. She stated Resident #6 should not have been left without the postural vest in place as it was ordered for safety. She stated the order was on the comprehensive care plan and the CNA care plan; however, CNA #2 failed to follow the care plan as required.</p> <p>Interview with LPN #2, on 02/19/15 at 2:15 PM, revealed she had provided care for Resident #6 on a regular basis and was familiar with the resident's care needs. She stated she received report every morning and generally gave report to CNAs daily on what was going on with the residents on the unit. She ensured the CNAs were providing the proper care by supervising them, and going behind them. She looked at the residents everyday to make sure they were clean and had everything they needed. She stated the resident used the postural vest for safety because he/she would slump over. She stated she believed CNA #2 knew the resident required the postural vest for safety; however, made a mistake by failing to follow the care plan.</p> <p>Interview with Registered Nurse (RN) #3, on</p>	F 282			



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F 282	Continued From page 13 2/20/15 at 11:15 AM, revealed she was the charge nurse on day shift. Her responsibility was to help the nurses as needed, answer questions staff may have, and ensure residents received care as ordered. She stated Resident #6 had the intervention to wear the postural vest when up in the wheelchair that was on the comprehensive care plan and the CNA care plan. She stated if a staff member was assigned to a resident and there was something they were not familiar with, they were told to ask questions. She stated CNA #2 was probably in a hurry and wasn't thinking about the safety of the resident when she failed to apply the postural vest for Resident #6.  Interview with the DON, on 02/20/15 at 2:52 PM, revealed the care plan stated for the resident to wear the postural vest when up in the wheelchair and the resident was up in the chair when he/she fell. She acknowledged the CNA failed to follow the care plan by not applying the postural vest on the resident when the resident was up in the chair.	F 282			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced	F 314	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A comprehensive care plan was developed for resident #6 related to skin breakdown due to hard cervical collar on 2-22-15 and updated on 3-12-15 (see att. F314-1). HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All other residents in the facility were reviewed and it was determined that one additional resident utilized a cervical collar. A comprehensive care plan was developed for that resident as well for the cervical collar and the	04/05/15	



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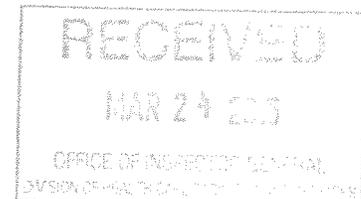
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F 314	<p>Continued From page 14</p> <p>by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to ensure residents admitted without pressure sores did not develop pressure sores, for one (1) of sixteen (16) sampled residents (Resident #6). The hospital returned Resident #6 on 01/31/15 with a hard cervical collar in place with orders for a hard cervical collar to be worn at all times. The facility failed to assess and monitor the skin under the collar appropriately, failed to train staff on the assessment of the skin under the collar, use of the collar, and proper application of the collar, and failed to develop a Comprehensive Care Plan for use of the hard cervical collar, resulting in the resident developing two (2) wounds on the back of the residents head. (Refer to F280 and F498)</p> <p>The findings include:</p> <p>Review of the facility's policy regarding skin breakdown/pressure ulcer, revised October 2014, revealed an avoidable pressure ulcer was the development of a pressure ulcer in which the facility failed to do one or more of the following: evaluate the residents clinical condition and pressure ulcer risk factors; define and implement interventions that were consistent with resident needs, goals, and standards of practice; monitoring and evaluating the interventions; and, revision of approaches as appropriate. Friction was defined as a mechanical force exerted on skin that was dragged across any surface. The policy did not include any information on assessment and prevention regarding residents with splints or devices that may cause pressure.</p> <p>Review of Resident #6's clinical record revealed</p>	F 314	<p>need for skin assessment. (see attachment F314-2).</p> <p>MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <ol style="list-style-type: none"> <li>1. The skin breakdown/pressure ulcer policy was revised on 3/11/15. Specific changes on page 8 to address splints, braces, assistive devices, and restraints. (see attachment F314-3).</li> <li>2. Mandatory inservicing held on 3/3/15 for assistive device training. This training was conducted by the Staff Development Coordinator, PT and OT. The inservicing included the purpose and process of use of all current assistive devices and restraints in the facility. (see attachments F314-4, F314-5, and F314-6).</li> <li>3. When the physician has ordered a new assistive device, the team manager will contact the therapy manager to schedule inservices before the assistive device is put into service. (see attachment F314-9).</li> <li>4. Mandatory in-services will be conducted by the VP of Nursing, Assistant Director of Nursing, and Staff Development Coordinator to review all policy changes between March 17 and March 26, 2015. (see attachments F314-7 and F314-8).</li> <li>5. The medical director reviewed and approved the revisions for the skin breakdown policy. The medical director has also reviewed and approved the assistive device training policy. He did this on 3-12-15.</li> </ol>	

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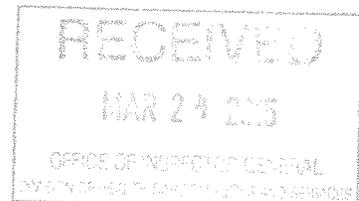
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F 314	<p>Continued From page 15</p> <p>the facility admitted the resident on 09/25/13 with diagnoses of Alzheimer's Dementia, Diabetes Mellitus Type 2, and Depression.</p> <p>Review of Resident #6's Quarterly Minimum Data Set (MDS) assessment, completed on 12/04/14, revealed the facility assessed the resident as rarely/never understood with short term and long term memory problems. The facility assessed the residents bed mobility as extensive assistance and total dependence for transfers, dressing and personal hygiene. The facility assessed the resident at risk for pressure ulcers with no current or history of pressure ulcers.</p> <p>Review of the Comprehensive Care Plan for Resident #6 revealed the facility developed a care plan on 09/12/14 for risk for skin breakdown related to the resident sits quite a bit, with a goal to prevent skin breakdown through the next quarter. Interventions included: pressure reduction mattress; treatments per Physician orders; incontinent care; space boots in bed; and, monitor skin with incontinent care and bathing and report any changes to the nurse.</p> <p>Review of the hospital records for Resident #6, dated 01/31/15, revealed the resident returned to the facility after a fall with an injury with orders to wear a hard cervical collar at all times until seen for follow-up by the Physician.</p> <p>Continued review of the Comprehensive Care Plan for Resident #6 revealed the care plan was not revised to indicate the use of the hard cervical collar for the resident.</p> <p>Continued review of physician orders for Resident #6, revealed on 02/08/15 an order was written to</p>	F 314	<p>HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE MAINTAINED.</p> <p>The Assistant DON and the Director of RAI will perform daily audits during the morning clinical team meetings to ensure that all skin care concerns have been identified and addressed appropriately on the comprehensive care plans. The Assistant DON and the VP of Nursing will perform 5 random monthly audits on each hall ensuring all skin care concerns have been identified and addressed appropriately.</p> <p>If 100% compliance is achieved during the first 6 months of the audits, then the frequency of audits will be decreased.</p> <p>All completed audits will be turned into the Quality Assurance Committee for review and recommendations, if any.</p> <p>STAFF MEMBERS RESPONSIBLE FOR THE PLAN TO BE ACCOMPLISHED: VP of Nursing/Assistant Director of Nursing.</p>		



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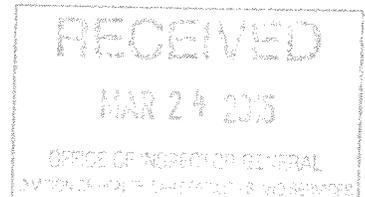
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F 314	<p>Continued From page 16</p> <p>apply skin prep to the right and left ear and ear lobe for prevention while the collar was in use. An order was written on 02/12/15 to assess the skin under the collar every shift. Review of the Medication Administration Record (MAR) revealed the skin assessments were being documented as completed.</p> <p>Observation of Resident #6, on 02/17/15 at 5:00 PM, revealed the resident laying on the bed. The resident had a cervical collar on, but it was positioned up on the face and did not appear to be in the proper position.</p> <p>Observation, on 02/18/15 at 7:42 AM, revealed the resident was in bed with the cervical collar on and was position up on the face as the previous day.</p> <p>Interview with LPN #2, on 02/19/15 at 10:45 AM, revealed staff had identified two (2) spots on the back of the residents head on 02/18/15.</p> <p>Review of the incident report for Resident #6, dated 02/18/15 at 11:15 AM, revealed two (2) area's were identified on the back of the residents head. The first area was a circular scabbed area that measured 2.5 centimeters by 1 centimeter. The second area just below the first area was a circular scabbed area that measured 1.25 centimeters by 0.75 centimeters. In the description, the Assistant Director of Nursing documented, she instructed the charge nurse to call the Physician regarding the cervical collar due to the collar rubbing the resident's head.</p> <p>Continued interview with LPN #2, on 02/19/15 at 2:15 PM, revealed Resident #6 returned from the hospital with the cervical neck collar. The</p>	F 314		



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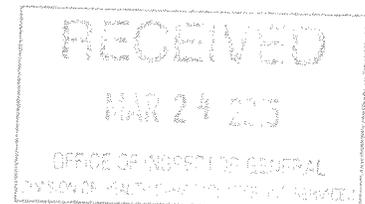
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F 314	<p>Continued From page 17</p> <p>resident was required to wear it at all times. She stated it was on the MAR to assess the resident's skin around the collar every shift and she had been doing this; however, she failed to look at the back of the resident's head. LPN #2 stated when residents come back from the hospital with splints and devices, therapy usually trained staff on the proper use; however, they had not trained staff on the use of the hard cervical collar when Resident #6 came back from the hospital. She stated they received orders for Resident #6, on 02/18/15, to pad the back of the cervical collar.</p> <p>Observation, on 02/19/15 at 12:45 PM, of the skin assessment completed by LPN #2 for Resident #6, revealed two (2) scabbed areas on the back of the resident's head. One area was smaller and just below the larger area. Observation of the removed cervical neck collar for Resident #6, due to meal time, revealed dried serosanguinous substance on the inner back side of the collar over two (2) flat white buttons that attached the Velcro piece to the collar.</p> <p>Interview with LPN #6, on 02/19/15 at 2:35 PM, revealed she was the second shift Supervisor. She stated Resident #6 was readmitted to the facility on 01/31/15 with orders for a hard cervical collar not a soft collar. She stated she had not been trained on the hard cervical neck collar when the resident returned; however, staff should have because it was a different collar and staff needed to know where the pressure points were for that collar and this resident. She stated the cervical collar should have been put on the resident's Comprehensive Care Plan because it identified the problem and ensured care needs were met.</p>	F 314	



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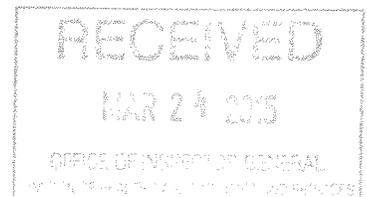
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F 314	Continued From page 18 Interview with LPN #3, on 02/20/15 at 11:48 AM, revealed when Resident #6 returned from the hospital on 01/31/15 with the hard cervical collar, she had questioned it because the collar was not on the resident in the correct position. She stated she had talked with the Nurse Practitioner, but the Physician did not want to make a change until the resident was seen during follow-up. She stated no one at the facility instructed staff on the use of the collar or where to assess the skin when the resident returned from the hospital.  Interview with the DON, on 02/20/15 at 2:52 PM, revealed staff should have been trained on assistive devices used in the facility. She stated obviously, there was a system problem related to training of staff on assistive devices used in the facility. She stated it was a risk to the residents if the staff were not trained because the care needs may not be met.	F 314			
F 323 SS=G	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 review of the facility's policy, it was determined the facility failed to ensure residents received adequate supervision and assistive	F 323	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A comprehensive care plan was developed on 2-22-15 and updated on 3-12-15 for resident #6 related to falls. (see attachment F323-1). A comprehensive care plan was developed for resident #6 for the use of the postural vest on 3-12-15 (see attach F323-2). HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: 1. Utilizing our PointClickCare database, we identified all residents who are at a high risk for falls based on the Morse Fall Scale assessment. This was completed by the Director of RAI on 3-12-15.	04/05/15	



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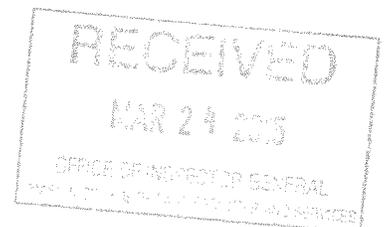
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F 323	<p>Continued From page 19</p> <p>devices to prevent accidents for one (1) of sixteen (16) sampled residents, (Resident #6). The facility assessed Resident #6 to require the use of a postural vest to maintain posture during sitting in a wheelchair. On 01/30/15, Certified Nursing Assistant (CNA) #2 failed to apply the postural vest on Resident #6 while up in the wheelchair and left the resident unattended in the resident's room. The resident fell from the wheelchair and sustained a concussion, a contusion to the face, and laceration to the forehead requiring a hospital transfer and sutures. (Refer to F282 and F498)</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Falls and Fall Risk Management, revised 05/16/13, revealed the purpose of assessing falls and their causes was to provide guidelines for assessing a resident after a fall and to assist in identifying the cause of a fall. The staff would evaluate functional and psychological factors that may increase the risk of falls including: ambulation; mobility; gait; balance; excessive motor activity; Activities of Daily Living capabilities; activity tolerance; continence; and, cognition. Under the section Continuing Successful Interventions, it stated if interventions had been successful in preventing falls, staff would continue the interventions.</p> <p>Review of the incident investigation, dated 01/30/15 at 7:45 PM, revealed CNA #2 reported she had put a gown on Resident #6 for bed, placed the tab alarm back on the resident, then left the room to get the mechanical lift. When she came back, less than a minute later, the resident was laying on the floor, on the left side, in a pool</p>	F 323	<p>2. All residents with a risk for falls have had their comprehensive care plan reviewed and modified if appropriate.</p> <p>3. All residents identified as "high risk" for falls have been identified on the CNA assignment sheet with a "star" by their name.</p> <p>4. All residents utilizing a restraint have been identified on the CNA assignment sheet with a symbol of a person in a seat belt by their name. All residents utilizing a restraint are considered "high risk" for falls.</p> <p>MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>1. The Falls Prevention Program policy was revised on 3/11/15. (see attachment F323-3). The CNA assignment sheet/resident plan of care policy was revised on 3/12/15. (see attachment F323-4). The physical restraint program policy was revised on 3/12/15. (see attachment F323-5).</p> <p>2. Mandatory inservicing was held on 3/3/15 for assistive device training. This training was conducted by the Staff Development Coordinator, PT and OT. The inservicing included the purpose and process of use of all current assistive devices and restraints in the facility. (see attachments F323-6, F323-7, and F323-8).</p> <p>3. When the physician has ordered a new assistive device, the team manager will contact the therapy manager to schedule inservices before the assistive device is put into service. (see attachment F323-9).</p> <p>4. Mandatory in-services will be conducted by the VP of Nursing, Assistant Director of Nursing, and Staff Development Coordinator to review all policy changes between March 17 and March 26, 2015. (see attachments F323-10 and F323-11).</p> <p>5. The medical director reviewed and</p>



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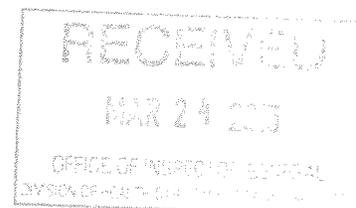
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F 323	<p>Continued From page 20 of blood, with the tab alarm sounding. The resident was sent to the hospital for an evaluation.</p> <p>Continued review of the incident investigation, dated 01/30/15, revealed the Director of Nursing (DON) interviewed CNA #2 on 01/31/15 regarding the fall. The CNA stated she had not put the postural vest on the resident when she left the room to get the lift because the order for the vest said for the resident to have it on when out of bed, but it did not say the resident couldn't be without it at any time, when out of bed. She didn't feel like she needed to put the postural vest on the resident just to go down the hallway to get the lift.</p> <p>Review of the hospital transfer records, dated 01/30/15- 01/31/15, revealed Resident #6 sustained a concussion, scalp laceration, and contusion to the face, from a fall at the nursing home. Discharge instructions included use of a hard cervical collar.</p> <p>Interview with CNA #2, on 02/19/15 at 1:15 PM, revealed she had worked with Resident #6 and was familiar with the resident's care needs. She stated she got her information about resident care needs from the CNA care plan and reports from the previous shift. She stated Resident #6 had a tab alarm, sensor pad when in bed and wheelchair, and a postural vest when up in the wheelchair. She stated she did not know the resident was a falls risk prior to the fall on 01/30/15 and was not aware of any previous falls. She stated she believed the postural vest was used when Resident #6 was up in the wheelchair for posture and not to prevent falls. She stated she had never left the resident unattended,</p>	F 323	<p>approved the revisions for the falls prevention program policy, CNA assignment sheet/ resident plan of care policy, and the physical restraint program policy on 3-12-15. The medical director also reviewed and approved the assistive device training policy on 3-12-15. HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE MAINTAINED:</p> <ol style="list-style-type: none"> <li>1. The Assistant DON and the Director of RAI will evaluate any fall that occurs on the next work day during the morning clinical team meetings to ensure that appropriate interventions have been identified and addressed on the comprehensive care plans. Any fall with significant injury will be reported to the manager on call in a timely manner and a QA committee meeting will be held by the next work day.</li> <li>2. The Nurse team leaders will complete daily a restraint assessment form to ensure that there is proper management of residents utilizing restraints. (see attachment F323-12).</li> <li>3. The Assistant DON and Director of RAI will perform a monthly review of all restraint orders. (see attachment F323-13). Once completed, a copy will be provided to the VP of Nursing for review.</li> <li>4. The completed restraint review will be turned into the Quality Assurance Committee for review and recommendations, if any.</li> </ol> <p>STAFF MEMBERS RESPONSIBLE FOR THE PLAN TO BE ACCOMPLISHED: VP of Nursing/Assistant Director of Nursing.</p>



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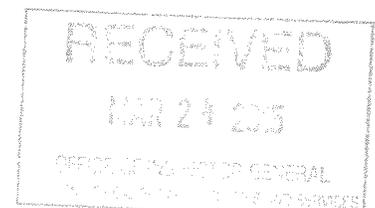
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F 323	<p>Continued From page 21</p> <p>without the postural vest when up in the wheelchair, prior to this incident. She stated she had not been trained on the use of the postural vest for this resident or for any other resident.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 02/19/15 at 2:35 PM, revealed she was working on the evening when Resident #6 sustained the fall and CNA #2 called her to the room and she found the resident on the floor, turned to the left side, with blood pooled on the floor. She stated CNA #2 told her she had turned to get the lift and the resident fell. The CNA did not tell her she had left the room to get the lift. She stated the DON did not interview her after the incident. LPN #6 stated Resident #6 should not have been left without the postural vest in place as it was ordered for safety. She stated she was very comfortable that CNA #2 was aware the resident required the postural vest on at all times when up in the wheelchair and, it was on the CNA care plan. She stated Resident #6 was weak, and had no control of his/her trunk at all and if you sat the resident up, the resident would fall forward, backward or sideways.</p> <p>Review of the CNA care plan in place prior to the 01/30/15 fall revealed under the section mobility devices, positioning and safety, the interventions included: postural vest when up in the wheelchair; a clip alarm at all times; a sensor pad to wheelchair; and a bed sensor.</p> <p>Observation, on 02/17/15 at 5:00 PM, of Resident #6 revealed the resident laying on the bed. Bed bolsters were in place to the side of the bed and a tab alarm was on the shirt by the left shoulder. The resident had on a cervical collar but it was up on the face and did not appear to be in the proper</p>	F 323		



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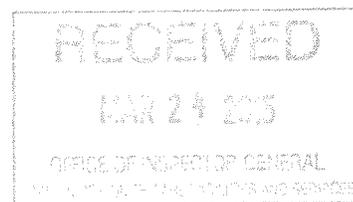
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F 323	<p>Continued From page 22</p> <p>position. A scab was noted on the residents forehead and the left eye had a light purple area over the eye lid. The resident was vocalizing with no apparent intent.</p> <p>Review of Resident #6's clinical record revealed the facility admitted the resident on 09/25/13 with diagnoses of Alzheimer's Dementia, Diabetes Mellitus Type 2, and Depression.</p> <p>Review of the Occupational Therapy (OT) notes for Resident #6, revealed Therapist #2 completed an initial evaluation on 08/15/14 for poor positioning and hyperextension of the neck, with functional goals for caregiver/nursing staff to ensure resident was positioned in a high back wheelchair to increase postural alignment and to increase safety. On 08/18/14, Therapist #1 documented the resident did not require a lap buddy any more. On 08/19/14 she documented, observation of the resident in the wheelchair, with the head and neck flexed forward and sleeping. The resident required readjustment at the hips to increase postural alignment. On 08/29/14 she documented, observation of the resident at breakfast with the resident's trunk leaning forward. On 09/03/14, 09/05/14, and 09/09/14 Therapist #1 documented the resident was exhibiting neck extension.</p> <p>Review of the Comprehensive Care Plan for Resident #6, revealed the facility developed a care plan on 09/12/14 for risk of falls related to progression of Alzheimer's and Dementia, with a goal to be free from preventable falls while remaining restraint free, in order to decrease the risk of injury from falls, through the next quarter. Interventions included assist with balance during care giving; toilet and transfer per the CNA sheet;</p>	F 323			



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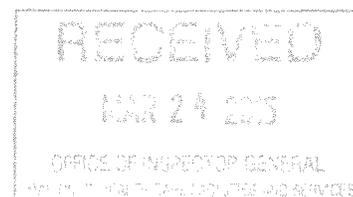
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F 323	<p>Continued From page 23</p> <p>therapy to screen quarterly; monitor for unsafe behavior; clip alarm at all times; bed sensor pad in bed and in wheelchair; and, bed wedges when in bed.</p> <p>Further review of the OT notes for Resident #6 revealed on 09/16/14 Therapist #1 documented the resident continued with neck extension and changed posture very frequently. On 09/18/14 she documented due to leaning forward from the pillow, she would plan to place a postural vest on the resident to increase the residents alignment and stability.</p> <p>Review of physician orders for Resident #6, revealed on 09/26/14 an order was written for a postural vest on the resident when up in the wheelchair for safety and positioning.</p> <p>Continued review of the resident's care plan revealed on 09/26/14 the care plan was revised with a new intervention for postural vest on resident when up in the wheelchair.</p> <p>Further review of the OT notes for Resident #6 revealed, on 09/30/14, Therapist #2 documented the resident remained leaning forward and was very rigid when repositioned.</p> <p>Review of the Falls Risk Assessment, dated 12/02/14, revealed the facility assessed Resident #6 on 12/02/14 as a high falls risk with a score of 55.0 on the Morse fall scale. A score over 45 indicated a high risk. The facility indicated on the mental status assessment the resident had previous falls, was non-ambulatory, had impaired gait, and forgot limits.</p> <p>Review of the Restraint Screening for Resident</p>	F 323		



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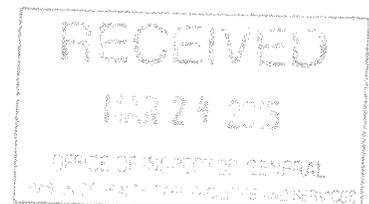
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F 323	<p>Continued From page 24</p> <p>#6, dated 12/02/14, revealed LPN #2 documented the resident had a safety vest as a restraint for safety, but did not complete the the last two (2) questions: did it limit the residents mobility, and was the resident able to remove the device. The form was then signed off by LPN #1 as the designated signature.</p> <p>Interview with LPN #2, on 02/20/15 at 12:05 PM, revealed she had completed the restraint assessment for Resident #6 on 12/02/14, but did not know why she did not answer all of the questions. She stated she called it a safety vest because it was for safety due to the resident leaning forward. She stated Registered Nurse (RN) #2, the Resident Assessment Coordinator, had left restraint assessments for staff to complete during the resident's Minimum Data Set Assessment period. She went on to say she was not sure if she had been trained on how to complete the restraint assessment. She stated an accurate assessment was important to ensure the change in a condition was reported.</p> <p>Interview with RN #2, the Resident Assessment Coordinator, on 02/20/15 at 10:40 AM, revealed nurses were assigned to complete restraint assessments for residents on admission, quarterly, and with any change in condition. The form was then returned to her department where she was usually the person who signed off as completed. She stated the restraint screening completed for Resident #6 on 12/02/14 was inaccurate because they called it a safety vest and not a postural vest and all the questions were not answered. She stated if the assessment was not completed or accurate, proper care could not be ensured. She went on to say, she was in the process of completing a Significant Change</p>	F 323			



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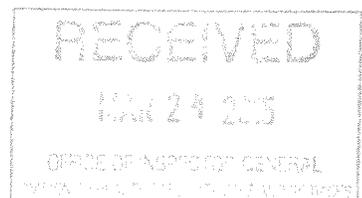
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F 323	<p>Continued From page 25</p> <p>Assessment and it would be coded as a restraint since the resident had a fall.</p> <p>Interview with RN #3, on 02/20/15 at 11:15 AM, revealed RN #2, who was the Resident Assessment Coordinator, was responsible to oversee restraint assessments. RN #3 gave restraint assessments to nurses to complete as needed. She stated she was not trained on completing the restraint assessment, but if it was not completed it would not be an accurate assessment and could result in the residents not receiving the best care possible.</p> <p>Review of Resident #6's Quarterly Minimum Data Set (MDS) assessment, completed on 12/04/14, revealed the facility assessed the resident as rarely/never understood with short term and long term memory problems. The facility assessed the resident's bed mobility as extensive assistance and total dependence for transfers, dressing and personal hygiene. Under the section Restraints, the facility assessed the resident as having no restraint.</p> <p>Interview with RN #2, the Resident Assessment Coordinator, on 02/20/15 at 9:28 AM, revealed when she completed the Quarterly Assessment for Resident #6 in December 2014, she had assessed the postural vest as a positioning devise and not a restraint because the resident was not trying to get up.</p> <p>Interview with LPN #2, on 02/19/15 at 2:15 PM, revealed she had provided care for Resident #6 on a regular basis and was familiar with the resident's care needs. She stated the postural vest was implemented for Resident #6 because the resident was leaning forward and it was</p>	F 323		



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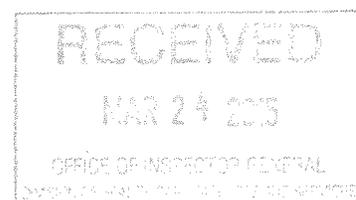
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F 323	<p>Continued From page 26</p> <p>intended for positioning and to prevent the resident from falling out of the chair. LPN #2 stated it was not safe for the resident to be up in the wheelchair without the postural vest, but she could see where it might be misleading to the CNA by it being called a postural vest.</p> <p>Interview with CNA #4, on 02/19/15 at 2:00 PM, revealed she had provided care for Resident #6 and was familiar with the resident's needs. She stated at the beginning of the shift she retrieved her CNA care plans for residents she was assigned. She then received report from the nurse before the shift and if anything had changed on her assigned residents. She was only familiar with one (1) fall with Resident #6 that occurred most recently. She stated Resident #6 used the postural vest to keep the resident sitting up straight because the resident leaned forward and moved around frequently and was at risk for falls. She stated the postural vest was required when Resident #6 was up at any time because the resident was not safe without it.</p> <p>Interview with RN #3, on 2/20/15 at 11:15 AM, revealed she was the charge nurse on day shift. Her responsibility was to help the nurses as needed, answer questions staff may have, and ensure residents received care as ordered. She stated Resident #6 was referred to therapy because the resident was leaning forward. Therapy had worked with the resident and recommended the postural vest for safety and positioning. After therapy had initiated an assistive device, they usually trained all the staff on the proper use of the device. She stated if a staff member was assigned to a resident and there was something they were not familiar with they were told to ask questions. She stated the</p>	F 323		



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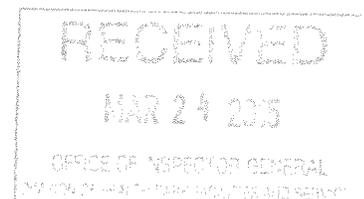
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F 323	Continued From page 27 CNAs may not have been properly trained on the use of the postural vest if the training was not facility wide because some staff could have been missed.  Interview with OT #1, on 02/19/15 at 1:45 PM, and on 02/20/15 at 8:20 AM, revealed she was the Therapy Department Director for the facility. She stated she had treated Resident #6. She stated the resident did have a lap buddy restraint previously due to falls. She stated the lap buddy was discontinued because the resident stopped trying to get up and was observed more leaning forward and side to side. She stated the resident was very difficult to work with because his/her posture changed so frequently. She stated they had tried multiple other things like pillows, and rolled blankets to improve the resident's posture, but the resident's tone changed so much they implemented the postural vest for postural stability. She stated poor posture could lead to falls and it would be in the resident's best interest if the postural vest was on at all times while up in the wheelchair. She stated the physician's order stated the resident was to have it on when up in the wheelchair. She stated it was up to nursing to assess the postural vest as a restraint. She stated when new devices were implemented for residents they trained the staff on duty that day on the use of the device and then those staff would pass it along to everyone else. Per the her OT note, dated 10/06/14, staff was educated on positioning and tightening of the postural vest for proper use. However, she did not have any evidence of who was trained on the use of the postural vest. She stated it was not her practice to keep documentation of staff trained on assistive devices from her department.	F 323			



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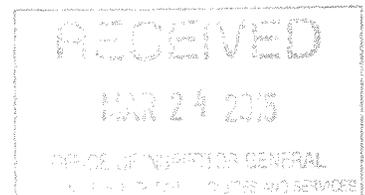
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F 323	<p>Continued From page 28</p> <p>Interview with RN #1, the Staff Development Coordinator, on 02/20/15 at 12:23 PM, revealed CNAs were trained to use their CNA sheet as a guide to provide care for the residents. If they had any questions they were to ask a nurse. She stated the last training on falls was 10/15/14 for the nurses and clips alarm training for CNAs. She stated if a resident had an incident, the DON or Nurse Manager would let her know if more education was needed; however, there was no additional training after Resident #6 had a fall. She stated all staff should be trained on equipment used in the facility and believed the therapy department was doing all the training on therapy equipment. She stated she had not completed any staff training on the use of the postural vest but it was probably needed. She stated RN #2, the Resident Assessment Coordinator, was responsible to oversee restraint assessments and she had not completed any staff training on restraint assessments or use.</p> <p>Interview with the DON, on 02/20/15 at 2:52 PM, revealed she, the Assistant Director of Nursing, the Resident Assessment Coordinator, and Staff Development met every morning regarding falls in the facility; however, the Therapy Director did not attend. She stated when a resident had a fall, they determined what new interventions needed to be added. When Resident #6 had the fall she did the investigation and determined the intervention on the CNA care plan for the postural vest said, on when up in the chair, and not at all times. She stated the care plan stated for the resident to wear when up in the wheelchair and the resident was up in the chair when he/she fell, but she could see where there was room for interpretation as CNA #2 stated. The DON stated staff should have been trained on assistive</p>	F 323			



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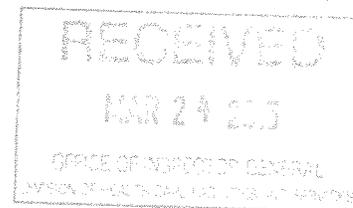
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F 323	Continued From page 29 devices used in the facility and did not know they were not trained on the use of the postural vest or that there was no documentation from the therapy department on who was trained on devices. Their system for restraint assessments needed work and obviously their training on restraints, assessments and devices had a problem. She stated the risk for the residents were their care needs may not be met.	F 323			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	CORRECTIVE ACTION TO BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Expired cream for unsampled resident A was discarded, and new cream was ordered. The blood specimen tubes that were expired were discarded on 2-18-15. These items were not replaced because the facility has a lab company that performs all lab procedures and these items do not need to be maintained in house. The 3 containers of bleach wipes that were expired were discarded on 2-18-15 and "in-date" bleach wipes were obtained from the stock room. The 2 boxes of enteral feeding tube sets that were expired were discarded on 2-18-15. The item was not replaced as it was a product no longer used on campus.	04/05/15	



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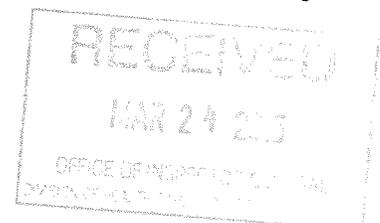
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F 431	<p>Continued From page 30</p> <p>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure one (1) of one (1) medication storage rooms and one (1) of one (1) treatment carts were free from expired supplies and medications.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Medication Storage in the Facility ID1: Storage of Medications, Dated 09/01/13, revealed outdated, contaminated, or deteriorated medications and medication-related supplies were immediately removed from stock, and disposed of according to procedures for medication disposal.</p> <p>Observation, on 02/18/15 at 3:05 PM, revealed one (1) tube of Lac-Hydrin 12% cream with an expiration date of November 2014, was stored in the facility's one (1) treatment cart, and was ready for use for Unsampled Resident A. In addition, the following supplies were found in the medication storage/supply room with expired dates: six (6) Vacutainer (purple top) blood specimen tubes with expiration dates of November 2014, one (1) purple top tube with an expiration date of January</p>	F 431	<p>HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident who uses an expired supply item has the same potential to be affected by this deficient practice.</p> <p>MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:</p> <ol style="list-style-type: none"> <li>1. Our pharmacy has in place a policy regarding the removal of expired medications and supplies from service. (see attachment F431-1).</li> <li>2. The VP of Nursing, the Assistant DON, and the Staff Development Coordinator will provide mandatory inservicing from March 17 through March 26, 2015, regarding the removal of expired medications and supplies from service. (see attachments F431-2 and F431-3).</li> </ol> <p>HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE MAINTAINED:</p> <ol style="list-style-type: none"> <li>1. The medication and treatment carts will be audited every two weeks by the Night Shift CMT. (see attachments F431-4 and F431-5).</li> <li>2. A Medication room audit will be performed by the night shift CMT every two weeks opposite the medication and treatment carts audit. (see attachment F431-6).</li> <li>3. The contract pharmacy performs monthly audits of the medication carts.</li> <li>4. The supply room will be audited monthly by the unit secretary. (see attachment F431-7).</li> <li>5. All audit information will be reported to the QA Committee at its regular meetings for review and recommendations, if any.</li> </ol> <p>STAFF MEMBER(S) RESPONSIBLE FOR PLAN TO BE ACCOMPLISHED: Assistant Director of Nursing.</p>	



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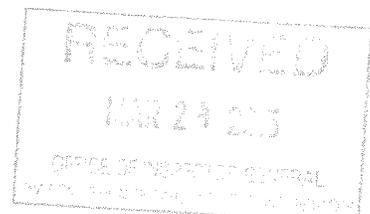
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F 431	<p>Continued From page 31</p> <p>2015, and one (1) blue top tube with an expiration date of January 2015; three (3) containers of bleach wipes with expiration dates of August 2014, 09/10/14, and 01/04/15; one (1) 30 count box of enteral feeding tube sets with expiration dates of December 2013, and one (1) 30 count box of enteral feeding tube sets with expiration dates of June 2014.</p> <p>Review, on 02/18/15 of Unsampled Resident A's current physician's orders revealed Lac-Hydrin 12% cream was ordered for application to the resident's feet twice daily. Review of the Medication Administration Record (MAR) revealed staff had been applying the cream to Unsampled Resident A's feet on the 7-3 and the 3-11 shifts.</p> <p>Interview, on 02/18/15 at 3:05 PM, with the facility's Second Shift Supervisor revealed the facility's Unit Secretary audited the medication room for expired supplies. She stated she thought the expired Vacutainers were placed in the storage room by contracted personnel that provided phlebotomy services. The Second Shift Supervisor stated she had not used the Vacutainer tubes and had not witnessed other nurses using them. She further stated the facility kept bleach wipes on hand so staff could wipe down the exterior of the medication and treatment carts at the end of each shift and as needed. The Second Supervisor stated the facility did not currently have residents that required feeding via a gastrostomy tube. The Second Shift Supervisor stated the bleach wipes were used to rid surfaces of germs and bacteria, and expired bleach wipes may not be effective for decontaminating those surfaces.</p>	F 431			



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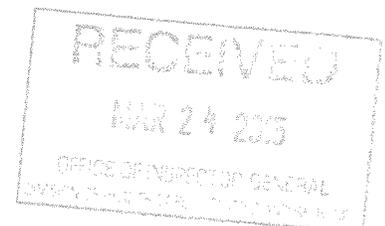
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F 431	<p>Continued From page 32</p> <p>Interview, on 02/19/15 at 2:32 PM with Licensed Practical Nurse (LPN) # 3, revealed she had been instructed by the facility that she might have to perform a stat collection of a blood specimen and that she would obtain the necessary Vacutainer tubes and needles from the medication storage room. LPN #3 stated she thought the use of a blood collection tube that was not in date (expired) might cause a false result when the specimen was analyzed. She stated if an expired tube had been used, the specimen would have to be discarded and the nurse would need to obtain another blood specimen from the resident.</p> <p>Interview, on 02/19/15 at 1:23 PM, with LPN #1 revealed medications should not be used after the listed date of expiration on the container because the medications may not be effective in treating the resident's diagnosed condition.</p> <p>Interview, on 02/18/15 at 5:05 PM, with the Director of Nursing (DON), revealed nursing staff on the third (3rd) shift was responsible for removing any expired medications and/or supplies from the medication storage areas. The DON stated the staff from the pharmacy also conducted periodic audits of the facility's medication storage areas.</p> <p>Review of the audit tools provided by the facility revealed the pharmacy conducted a drug storage inspection on 12/18/14 and had not identified any expired medications or supplies.</p> <p>Review of the Medication Cart Audits provided by the facility (dated 02/02/15, 02/04/15, 02/06/15, 02/14/15, and 02/15/15), revealed the contents of the facility's medication carts were audited, but the documents did not indicate the treatment cart</p>	F 431		



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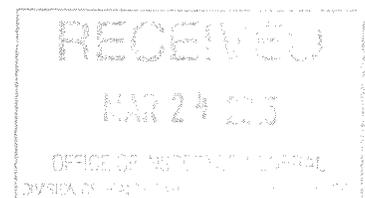
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F 431	Continued From page 33 or the medication storage room had been audited.  Continued interview, on 02/19/15 at 3:30 PM, with the DON revealed the pharmacy reviewed all supplies in the facility's medication storage areas and then shared their findings with the facility's Assistant Director of Nursing (ADON). Pharmacy would pull any expired items they originally supplied and replenish with in-date stock. Pharmacy would make the facility aware of any other expired supplies that belonged to the facility, and the facility would be responsible for removing those items from the storage areas. The DON stated a Certified Medication Technician (CMT) employed by the facility also conducted routine audits of the medication carts, but that upon her own review of the completed audits, she noted they did not indicate the CMT had audited the facility's treatment cart or the medication storage room. The DON stated the facility's current system of auditing the medication storage areas needed to be repaired because staff was not routinely auditing all medication/supply storage areas. She stated medication carts, treatment carts and the medication storage room should be audited weekly to ensure expired items had been removed. The DON stated licensed nurses should examine all medications and treatment supplies before use to ensure the item(s) were in date. The potential problem was expired medications/treatments could have lost their efficacy.	F 431		
F 498 SS=G	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS  The facility must ensure that nurse aides are able	F 498	ADDRESS WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	04/05/15



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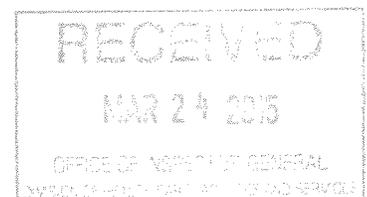
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F 498	<p>Continued From page 34</p> <p>to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of staff training and education, it was determined the facility failed to ensure nurse aides were trained on the use of assistive devices to prevent accidents for one (1) of sixteen (16) sampled residents, (Resident #6). Interview and record review revealed nursing assistants had not been trained on the use a postural vest for Resident #6. Certified Nursing Assistant (CNA) #2 failed to apply the device to Resident #6 on 01/30/15, resulting in a fall from the wheelchair that caused a concussion, contusion to the face, and laceration to the forehead requiring a hospital transfer and sutures. In addition, nursing assistants had not been trained on the proper use of a cervical collar for Resident #6 when the resident returned from the hospital on 01/31/15. The facility failed to train staff on the assessment of the skin under the collar, use of the collar, and proper application of the collar resulting in the resident developing two (2) wounds on the back of the residents head. (Refer to F314 and F323)</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding staff training and education.</p> <p>Review of the incident investigation, dated 01/30/15 at 7:45 PM, revealed CNA #2 reported she put a gown on Resident #6 for bed, placed</p>	F 498	<p>Mandatory in-servicing regarding the postural vest used by resident #6 began on March 3, 2015 for all nursing staff. This was a formal class provided to all nursing staff members to review all current assistive devices. Therapy demonstrated the use of most assistive devices by bring them to the class. Several items could not be demonstrated by using the device because it was a singular device and was in use by the resident all or most of the time. For those items, the therapy staff reviewed the written material with the nursing staff. Staff was encouraged to ask questions during or after the meeting to obtain assistance at any time there were questions with a device. None of the devices in current use are new to the staff, and staff has been applying the devices correctly, however staff did not report knowing the reason for the device use, and this was discussed for each device in the formal class. Information is also provided in the demonstration log regarding why each device may be used. The final make-up when all staff must be compliant for this training is March 18, 2015. (see attachment F498-1 and F498-2).</p> <p>HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:</p> <p>All residents have equal potential for being at risk for injury related to staff training on assistive devices.</p>		



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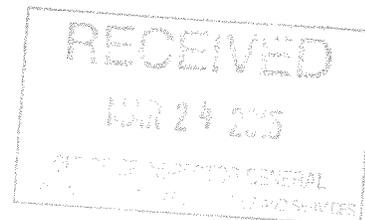
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F 498	<p>Continued From page 35</p> <p>the tab alarm back on the resident, then left the room to get the mechanical lift. When she came back, less than a minute later, the resident was laying on the floor, on the left side, in a pool of blood, with the tab alarm sounding. The resident was sent to the hospital for an evaluation.</p> <p>Continued review of the incident investigation, dated 01/30/15, revealed the Director of Nursing (DON) interviewed CNA #2 on 01/31/15 regarding the fall. The CNA stated she had not put the postural vest on the resident when she left the room to get the lift because the order for the vest said for the resident to have it on when out of bed, but it did not say the resident couldn't be without it at any time, when out of bed. She didn't feel like she needed to put the postural vest on the resident just to go down the hallway to get the lift.</p> <p>Review of the hospital discharge instruction for Resident #6, revealed on 01/31/15, the resident was transferred back to the facility with an order for the resident to wear a hard cervical collar at all times until seen on follow-up by the Physician.</p> <p>Interview with CNA #2, on 02/19/15 at 1:15 PM, revealed she had not been trained on the use of the postural vest for this resident and thought it was used for posture, but not to prevent falls. CNA #2 stated the resident came back from the hospital with the collar; however, she had not been educated on the reason for its use or proper positioning of the collar for the resident.</p> <p>Interview with CNA #4, on 02/19/15 at 2:00 PM, revealed she could not remember if she had been trained on the postural vest used for Resident #6, but it was common sense. In regards to the hard</p>	F 498	<p>MEASURES TO BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT SOLUTIONS ARE MAINTAINED:</p> <ol style="list-style-type: none"> <li>1. A new policy has been developed entitled "Staff Development Programs" on 3/12/15. (see attachment F498-3).</li> <li>2. A new policy has been developed entitled "Inservice Training Program, Nursing" on 3/12/15. Annual competency evaluation clinics for CNAs will be provided by the Staff Development Coordinator and other team managers to ensure basic CNA competency. (see attachment F498-4).</li> <li>3. Job description and Performance Appraisal for CNAs were revised on 3/13/15. (see attachment F498-5).</li> <li>4. Mandatory inservice will occur on March 17 through March 26, 2015.</li> </ol> <p>For current devices, their application is and has been correct for current staff. The chief concern from staff was that the facility was not providing communication regarding the purpose and need for the device. Between 3-315 and 3-18-15, Therapy and the Staff Development Coordinator provided 7 formal classes on all shifts. During each class, therapy demonstrated devices used in the facility. A select number of items could not be brought to class because those devices are being used by residents all or most of the time. Written materials for those devices were reviewed. Therapy reviewed with the staff the purpose and reason devices are used. The facility did not require staff to complete competency testing for the following reasons:</p> <ol style="list-style-type: none"> <li>1. Unable to provide competency testing on single, specialty items that are utilized by the resident all or most of the time. Doing so would create discomfort for the resident.</li> <li>2. Devices were not new to the facility and were not used incorrectly. therapy did demonstrate</li> </ol>



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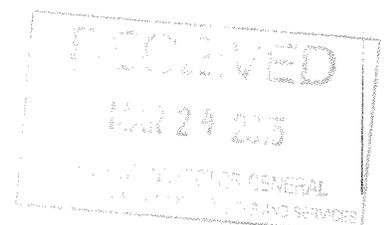
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F 498	<p>Continued From page 36</p> <p>cervical collar on Resident #6, she stated she had been trained previously on the neck collars; however, not for Resident #6. She was unsure who did the training previously on the use of neck collars.</p> <p>Interview with Registered Nurse (RN) #3, on 02/20/15 at 11:15 AM, revealed she was the Unit Manager for the Health Care Unit. She stated she thought the Therapy Department conducted the training on assistive devices implemented by the Therapy Department. She stated Resident #6 was evaluated and treated by the Therapy Department because the resident was leaning forward and at risk for falls. She stated if training was not facility wide someone might not receive the training; therefore, the CNAs were probably not adequately trained on the use of the postural vest. In regards to the hard cervical collar, she was not aware of any training completed when Resident #6 returned from the hospital with the cervical collar by the Therapy Department or Staff Development.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 02/19/15 at 2:15 PM, revealed she had been trained on the use of the postural vest for Resident #6 by the Therapy Department, but was unaware of who trained the other staff on it's use. She believed therapy did the training since they recommended the assistive device. LPN #2 stated when residents come back from the hospital with splints and devices, therapy usually trained staff on the proper use. However, they had not trained staff on the use of the hard cervical collar when Resident #6 came back from the hospital.</p> <p>Interview with Occupational Therapist #1, on</p>	F 498	<p>all devices and allowed time for staff to ask questions and to spend time afterwards with the devices, working with them, trying them on, etc.</p> <p>3. A key focus during the formal class was the purpose and use of each device. As the facility moves forward and a new device comes into the facility, the following will happen:</p> <ol style="list-style-type: none"> <li>1. The assistive device will not be used by the resident until Therapy trains the current staff for the correct application. therapy must ensure that managers are involved in the training.</li> <li>2. Therapy will provide training for 3 days and, along with the Staff Development Coordinator, they will ensure managers are trained, and they will then train the other care-givers.</li> <li>3. All staff will understand that care will not be provided to the resident until training occurs with the new devices and staff both understand the devices' use and purpose.</li> </ol> <p>After the meetings were completed on 3-18-15, the Staff Development Coordinator began sessions, with all staff to ensure they have completed the information on attach F498-6 to assist management in identifying knowledge and understanding. Also, this will assist management in recognizing the areas that trainers need to focus on and where staff will require follow-up training.</p> <p>5. The facility medical director reviewed and approved the "Staff Development Program" and "Inservice Training Program, Nursing" policies on 3-12-15.</p> <p>6. When the physician has ordered a new assistive device, the team manager will contact the therapy manager to schedule inservices before the assistive device is put into service. (see attachment F498-6).</p> <p>HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE MAINTAINED:</p> <ol style="list-style-type: none"> <li>1. The annual competency evaluation clinics will ensure that solutions are maintained.</li> <li>2. The results of the competency evaluation clinics will be reported to the regular meetings of the QA committee for review and recommendations, when required.</li> </ol> <p>STAFF MEMBER(S) RESPONSIBLE FOR THE PLAN TO BE ACCOMPLISHED: Staff Development Coordinator.</p>		



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F 498	<p>Continued From page 37</p> <p>02/19/15 at 1:45 PM, and on 02/20/15 at 8:20 AM, revealed when new assistive devices were implemented for residents they trained the staff on duty that day on the use of the device and then those staff would pass it along to everyone else. She stated she did not have any evidence of who was trained on the use of the postural vest. She stated it was not her practice to keep documentation of staff trained on assistive devices from her department. In regards to the hard cervical collar for Resident #6, she stated therapy had not picked up the resident when he/she returned from the hospital because they were unsure of the Physician follow-up; therefore, she did not train the staff on the use of the cervical collar.</p> <p>Interview with RN #1, the Staff Development Coordinator, on 02/20/15 at 12:23 PM, revealed the most recent staff training was falls on 10/15/14 for the nurses and clip alarm training for CNAs. She stated if a resident had an incident, the DON or Nurse Manager would let her know if more education was needed; however, there was no additional training after Resident #6 had the fall on 01/30/15. She stated all staff should be trained on equipment used in the facility and believed the Therapy Department was doing all the training on therapy equipment. She stated she had not completed any staff training on the use of the postural vest but it was probably needed. She stated in regards to the hard cervical collar, Resident #6 was readmitted with on 01/31/15, and staff had not brought it to her attention that training was needed. However, she acknowledged she had seen the resident wearing the cervical collar.</p> <p>Interview with the DON, on 02/20/15 at 2:52 PM,</p>	F 498		



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F 498	Continued From page 38 revealed staff should have been trained on assistive devices used in the facility and was unaware all staff was not trained on the use of the postural vest or that there was no documentation from the Therapy Department on who was trained on devices. She stated obviously there was a system problem related to training of staff on assistive devices used in the facility. She stated it was a risk to the residents if staff was not trained because the resident care needs may not be met.	F 498			

