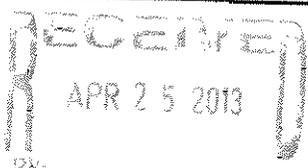


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/04/2013
NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated survey to investigate KY00019928 was initiated on 04/01/13 and concluded on 04/04/13. KY00019928 was substantiated with deficiencies cited.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		04/26/2013
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>		TITLE <i>Administrator</i>		DATE 04/25/13

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

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy it was determined the facility failed to immediately consult with the resident's physician when there was an accident involving the resident which resulted in an injury and had the potential for requiring physician interventions for one (1) of three (3) sampled residents. The facility failed to notify Resident #1's Physician when on 02/22/13 Resident #1's left foot dropped and went underneath the wheelchair as State Registered Nurse Aide (SRNA) #1 pushed Resident #1 in his/her wheel chair. On 02/25/13, three (3) days later, Resident #1's left lower leg was noted to be more red/purple and the resident complained of increased pain, an x-ray was ordered and Resident #1 was sent to the emergency room for further evaluation and treatment.</p> <p>The findings include:</p> <p>Review of the facility's policy, titled "Incident/Accident Follow-up Policy and Procedure", dated November 11, 2009, revealed an incident/accident report should be completed after an incident or accident to include notifying the Physician of the accident.</p> <p>Review of the medical record revealed Resident #1 was admitted to the facility, on 06/11/07, with diagnoses which included Osteoporosis, Diabetes, Renal Artery Stenosis, Malaise and Fatigue. Review of an Annual Minimum Data Set</p>	F 157	<p>If not 100% compliant, the DON/ADON or QA nurse (Individual doing audit) will ensure the MD/APRN (or on-call) is notified immediately and the nurse involved is educated immediately; in addition to the continuation of monthly audits until compliance is achieved.</p>	

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F 157	<p>Continued From page 2</p> <p>(MDS) Assessment, dated 02/01/13, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating Resident #1 was cognitively intact. Further review of Resident #1's MDS Assessment, dated 02/01/13, revealed Resident #1 was assessed to utilize a wheel chair with one person staff assist for locomotion.</p> <p>Review of Resident #1's Nurse's Notes (NN) signed by Licensed Practical Nurse (LPN) #1, dated 02/22/13 at 10:00 AM, revealed SRNA #1 told LPN #1 while she was transferring Resident #1, the resident moved his/her legs and was not hurt. Further review of NN revealed LPN #1 assessed Resident #1 and the resident did not have any redness, denied pain and Resident #1 had stated she was "fine". Further record review revealed, no documented evidence the Physician was notified of the accident which had occurred on 02/22/13.</p> <p>Review of the NN, dated 02/22/13 at at midnight and 02/23/13 at 10:00 PM, revealed Resident #1 complained of foot pain with documentation of reddened areas to his/her feet and ankles. Further review of NN, dated 02/23/13 at 11:00 PM revealed the Nurse Practitioner was notified of the pain to both feet (chronic issue with history of bilateral fractures); however there was no documented evidence of notification to the Physician of the accident which had occurred the day before.</p> <p>Review of NN, dated 02/25/13 at 1:30 PM, revealed Resident #1 had waxing and worsening of redness and purple color to the resident's Bilateral Lower Extremities. Review of a Portable</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>Radiology evaluation (completed three (3) days after the accident) on 02/25/13, revealed Resident #1 had potentially sustained a fracture to the left ankle.</p> <p>Review of the Physician's orders, on 02/25/13 at 5:30 PM, revealed an order for Resident #1 to be transferred to an acute care hospital for further evaluation. Review of the final Radiology report from the acute care hospital, 02/25/13, revealed no fracture and no acute abnormality of the ankle. Additional review of the hospital records revealed since the preliminary x-ray revealed a possible fracture, and a posterior splint would be placed on the resident's left leg.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1, on 04/03/13 at 2:35 PM, revealed she was the aide caring for Resident #1 on 02/22/13 when the incident occurred. SRNA #1 stated she pushed Resident #1's wheel chair out of the shower room when the resident's foot went under the wheel chair and became entrapped and stopped pushing the wheel chair when the resident yelled out. SRNA #1 further stated she reported the accident to LPN #1.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 04/03/13 at 2:45 PM, revealed she was the LPN caring for Resident #1 on 02/22/13 when SRNA #1 reported an accident had occurred involving Resident #1 and the resident's left foot. LPN #1 indicated she assessed Resident #1, did not notice any injury and the resident denied having any pain. Further interview revealed LPN #1 documented the accident on the twenty-four (24) hour report; however, did not complete a change in condition or an incident/accident report.</p>	F 157		
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F 157	Continued From page 4 Additionally, LPN #1 stated it was her responsibility to investigate the accident further and she should have completed a change in condition and an incident/accident report as well as notified the Physician. Interview with the Director of Nursing, on 04/04/13 at 8:50 AM, revealed the facility's policy for incidents and accidents was to notify the Physician in a timely manner and LPN #1 did not completed the appropriate change in condition or incident/accident documentation nor did LPN #1 notify the Physician in a timely manner.	F 157		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	1) The facility utilizes a 3-part form which includes the nurses note, care plan and MD order (attachment #2 and #5). The care plan section of the form serves as the care plan update until the comprehensive care plan is reviewed and revised. 2) The DON/ADON, QA nurse and MDS nurses completed an audit of all current in house resident care plans and any care plans that required revisions were revised. 3) The MDS nurse will utilize their copy of the 3-part order form and the MD orders to ensure all new orders are care planned (attachment #2). The MDS nurse will complete an audit on each completed comprehensive care plan and will submit a copy of the audit to the DON/ADON, RN MDS Coordinator and QA nurse; in addition to their MDS schedule. 4) The DON/ADON, RN MDS Coordinator and QA nurse will use the audits received	04/26/2013

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F 280

Continued From page 5

This REQUIREMENT is not met as evidenced by:
Based on interview and record review it was determined the facility failed to ensure a comprehensive care plan was revised for one (1) of three (3) sampled residents (Resident #1). The facility failed to revise Resident #1's Comprehensive Care Plan to reflect a Physician's order for a wheel chair with bilateral leg rests. (refer to F-323)

The findings include:

Review of the medical record revealed, Resident #1 was admitted to the facility, on 06/11/07, with diagnoses which included Osteoporosis, Diabetes, Renal Artery Stenosis, Malaise and Fatigue. Review of the Annual Minimum Data Set (MDS) Assessment, dated 02/01/13, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating Resident #1 was cognitively intact. Further review of Resident #1's MDS Assessment, dated 02/01/13, revealed Resident #1 was assessed to utilize a wheel chair with one person staff assist for locomotion.

Review of a Physician's order, dated 02/01/13, revealed an order for Resident #1 to use a twenty-two (22) inch wheel chair with bilateral leg rests and a right foot trough.

Review of Resident #1's Comprehensive Care Plan, 02/06/13, revealed Resident #1 was not care planned for a leg rest until 02/27/13.

F 280

from the MDS nurses as a tool to complete audits on 10 resident care plans each month for 6 months.
If 100% compliant, we will audit every other month for 6 months (for a total of 1 year) then discontinue audits.
If not compliant, we will educate the MDS nurses immediately and continue to audit 10 resident care plans every month until compliance is achieved.

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F 280	Continued From page 6 Review of Resident #1's Nurse's Notes (NN) signed by Licensed Practical Nurse (LPN) #1, dated 02/22/13 at 10:00 AM, revealed SRNA #1 told LPN #1 while she was transferring Resident #1, the resident moved his/her legs and was not hurt. Further review of NN revealed LPN #1 assessed Resident #1 and the resident did not have any redness, denied pain and Resident #1 had stated she was "fine". Review of the NN, dated 02/22/13 at at midnight and 02/23/13 at 10:00 PM, revealed Resident #1 complained of foot pain with documentation of reddened areas to his/her feet and ankles. Further review of NN, dated 02/23/13 at 11:00 PM revealed the Nurse Practitioner was notified of the pain to both feet (chronic issue with history of bilateral fractures); however there was no documented evidence of notification to the Physician of the accident which had occurred the day before. Review of NN, dated 02/25/13 at 1:30 PM, revealed Resident #1 had waxing and worsening of redness and purple color to the resident's Bilateral Lower Extremities. Review of a Portable Radiology evaluation (completed three (3) days after the accident) on 02/25/13, revealed Resident #1 had potentially sustained a fracture to the left ankle. Review of the Physician's orders, on 02/25/13 at 5:30 PM, revealed an order for Resident #1 to be transferred to an acute care hospital for further evaluation. Review of the final Radiology report from the acute care hospital, 02/25/13, revealed no fracture and no acute abnormality of the ankle. Additional review of the hospital records revealed since the preliminary x-ray revealed a possible fracture, and a posterior splint would be placed on the resident's left leg.	F 280			

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F 280 Continued From page 7
Interview with State Registered Nursing Aide (SRNA) #1, on 04/03/13 at 2:35 PM, revealed Resident #1's wheel chair did not have the bilateral leg rests or foot cradle attached to the wheel chair and in use on 02/22/13 at which time the resident was injured when the left foot turned and went under the wheel chair. SRNA #1 stated she did not put the leg rests on the wheel chair because the resident had refused them in the past.

Interview with Licensed Practical Nurse (LPN) #1, on 04/03/13 at 2:45 PM, revealed Resident #1 had a physician's order for bilateral leg rests; however, the care plan was not revised to include the leg rest until 02/27/13, after Resident #1 had an accident where the leg rests were not attached. Continued interview revealed she did not know if the resident had signed a waiver to not use the leg rests.

Interview with the Director of Nursing (DON), on 04/04/13 at 8:50 AM, revealed Resident #1 did have a Physician's order for bilateral foot rests attached to the wheel chair. Further interview revealed, there was no documented evidence there was a waiver signed by the resident or the responsible party to not have the bilateral foot rests. Additionally, the DON stated the foot rests should have been utilized by the staff per the Physician's order and it should have been documented on the care plan.

F 281 483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS
SS=D
The services provided or arranged by the facility must meet professional standards of quality.

F 280

F 281 Resident #1 told SRNA #1 she did not want her foot rests put on.
1) No other residents were affected.
2) April 13-April 25 nursing staff were re in-serviced by the social workers and DON on resident rights to refuse. They were educated on what form

04/26/2013

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F 281	Continued From page 8 This REQUIREMENT Is not met as evidenced by: Based on interview and record review it was determined the facility failed to follow Physician's orders for one (1) of three (3) sampled residents (Resident #1). The facility failed to follow the Physician's order for Resident #1 to use a standard wheel chair with bilateral leg rests with a foot trough. The findings include: Review of the medical record revealed Resident #1 was admitted to the facility, on 08/11/07, with diagnoses which included Osteoporosis, Diabetes, Renal Artery Stenosis, Malaise and Fatigue. Review of the Annual Minimum Data Set (MDS) Assessment, dated 02/01/13, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating Resident #1 was cognitively intact. Further review of Resident #1's MDS Assessment, dated 02/01/13, revealed Resident #1 was assessed to utilize a wheel chair with one person staff assist for locomotion. Review of a Physician's order, dated 02/01/13, revealed an order for Resident #1 to use a twenty-two (22) inch wheel chair with bilateral leg rests and a foot trough. Review of Resident #1's Nurse's Notes (NN) signed by Licensed Practical Nurse (LPN) #1, dated 02/22/13 at 10:00 AM, revealed SRNA #1 told LPN #1 while she was transferring Resident	F 281	must be completed when a resident chooses not to follow an MD order (attachment #3). The form is then submitted to the social worker and the form is discussed in the daily morning meeting with the interdisciplinary team. The right to refuse form is utilized as a tool to make revisions to a resident's plan of care accordingly. 3) April 11-April 25 an in-service went out to all departments regarding leg rests (see attachment #4). Leg rests are being discontinued for those residents who choose not to utilize leg rests or clarified when necessary. 4) The QA nurse will audit 10 residents with wheelchair orders (that have foot rest/adaptive equipment) each month for 3 months to ensure their leg rests/adaptive equipment are being utilized per MD order. If compliant, the audit will be discontinued. If not compliant, the QA nurse will conduct the audit every month until compliance is achieved and audits will then be discontinued.		

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F 281	<p>Continued From page 9</p> <p>#1, the resident moved his/her legs and was not hurt. Further review of NN revealed LPN #1 assessed Resident #1 and the resident did not have any redness, denied pain and Resident #1 had stated she was "fine". Review of the NN, dated 02/22/13 at midnight and 02/23/13 at 10:00 PM, revealed Resident #1 complained of foot pain with documentation of reddened areas to his/her feet and ankles. Further review of NN, dated 02/23/13 at 11:00 PM revealed the Nurse Practitioner was notified of the pain to both feet (chronic issue with history of bilateral fractures); however there was no documented evidence of notification to the Physician of the accident which had occurred the day before. Review of NN, dated 02/25/13 at 1:30 PM, revealed Resident #1 had waxing and worsening of redness and purple color to the resident's Bilateral Lower Extremities. Review of a Portable Radiology evaluation (completed three (3) days after the accident) on 02/25/13, revealed Resident #1 had potentially sustained a fracture to the left ankle.</p> <p>Review of the Physician's orders, on 02/25/13 at 5:30 PM, revealed an order for Resident #1 to be transferred to an acute care hospital for further evaluation. Review of the final Radiology report from the acute care hospital, 02/25/13, revealed no fracture and no acute abnormality of the ankle. Additional review of the hospital records revealed since the preliminary x-ray revealed a possible fracture, and a posterior splint would be placed on the resident's left leg.</p> <p>Interview with State Registered Nursing Aide (SRNA) #1, on 04/03/13 at 2:35 PM, revealed Resident #1's wheel chair did not have the bilateral leg rests or foot trough attached to the</p>	F 281		

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F 281	Continued From page 10 wheel chair and in use on 02/22/13 at which time the resident was injured when the left foot turned and went under the wheel chair becoming entrapped. SRNA #1 stated she did not put the leg rests on the wheel chair because the resident had refused them in the past. Interview with Licensed Practical Nurse (LPN) #1, on 04/03/13 at 2:45 PM, revealed she did not know if Resident #1 had signed a waiver to not use the leg rests. Additionally, LPN #1 stated that if the resident did not have a signed waiver to not utilize the leg rest, then the staff should have been using the leg rests per the Physician's order. Interview with the Director of Nursing (DON), on 04/04/13 at 8:50 AM, revealed Resident #1 had a Physician's order for bilateral foot rests attached to the wheel chair and there was no documented evidence there was a waiver signed by the resident to not have the bilateral foot rests applied to the resident's wheelchair. Additionally, the DON stated the foot rests should have been utilized by the staff per the Physician's order.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	1) No other residents were affected. 2) April 12-April 25 nursing staff were re in-serviced by the social workers and the DON on resident rights to refuse and what form must be completed when a resident chooses not to follow an MD order (see attachment #3). The form is then submitted to the social worker and the form is discussed in the daily morning meetings with the interdisciplinary team. The right to refuse form is utilized as a tool to make revisions to a resident's plan of	04/26/2013

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/04/2013
NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504		
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F 323	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review it was determined the facility failed to ensure the residents received adequate supervision and assistance devices to prevent accidents for one (1) of three (3) sampled residents (Resident #1). Resident #1 sustained an injury to his/her left foot during while being propelled by staff in a wheel chair without bilateral leg rests per Physician's order.</p> <p>The findings include:</p> <p>Review of the medical record revealed Resident #1 was admitted to the facility, on 06/11/07, with diagnoses which included Osteoporosis, Diabetes, Renal Artery Stenosis, Malaise and Fatigue. Review of the Annual Minimum Data Set (MDS) Assessment, dated 02/01/13, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating Resident #1 was cognitively intact. Further review of Resident #1's MDS Assessment, dated 02/01/13, revealed Resident #1 was assessed to utilize a wheel chair with one person staff assist for locomotion.</p> <p>Review of a Physician's order, dated 02/01/13, revealed an order for Resident #1 to use a twenty-two (22) inch wheel chair with bilateral leg rests and a foot trough.</p> <p>Review of Resident #1's Nurse's Notes (NN) signed by Licensed Practical Nurse (LPN) #1, dated 02/22/13 at 10:00 AM, revealed SRNA #1 told LPN #1 while she was transferring Resident #1, the resident moved his/her legs and was not</p>	F 323	<p>care accordingly.</p> <p>3) April 11- April 25 an In-service went out to all departments regarding leg rests (attachment #4). Leg rests are being discontinued for those residents who choose not to utilize leg rests or clarified when necessary. Waivers will be obtained when necessary.</p> <p>4) The QA nurse will audit 10 residents with wheelchair orders (that have foot rest/adaptive equipment) each month for 3 months to ensure their leg rests/adaptive equipment are being utilized per the MD order. If compliant, the audit will be discontinued. If not compliant, the QA nurse will conduct the audit every month until compliant and audits will then be discontinued.</p>		

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F 323	Continued From page 12 hurt. Further review of NN revealed LPN #1 assessed Resident #1 and the resident did not have any redness, denied pain and Resident #1 had stated she was "fine". Review of the NN, dated 02/22/13 at at midnight and 02/23/13 at 10:00 PM, revealed Resident #1 complained of foot pain with documentation of reddened areas to his/her feet and ankles. Further review of NN, dated 02/23/13 at 11:00 PM revealed the Nurse Practitioner was notified of the pain to both feet (chronic issue with history of bilateral fractures); however there was no documented evidence of notification to the Physician of the accident which had occurred the day before. Review of NN, dated 02/25/13 at 1:30 PM, revealed Resident #1 had waxing and worsening of redness and purple color to the resident's Bilateral Lower Extremities. Review of a Portable Radiology evaluation (completed three (3) days after the accident) on 02/25/13, revealed Resident #1 had potentially sustained a fracture to the left ankle. Review of the Physician's orders, on 02/25/13 at 5:30 PM, revealed an order for Resident #1 to be transferred to an acute care hospital for further evaluation. Review of the final Radiology report from the acute care hospital, 02/25/13, revealed no fracture and no acute abnormality of the ankle. Additional review of the hospital records revealed since the preliminary x-ray revealed a possible fracture, and a posterior splint would be placed on the resident's left leg. Review of Resident #1's Comprehensive Care Plan, dated 02/06/13, revealed no documented evidence Resident #1 was Care Planned to utilize a twenty-two (22) inch wheel chair with bilateral	F 323		

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F 323	Continued From page 13 leg rests until 02/27/13, five (5) days after the accident. Interview with State Registered Nursing Aide (SRNA) #1, on 04/03/13 at 2:35 PM, revealed Resident #1's wheel chair did not have the bilateral leg rests or foot cradle attached to the wheel chair and in use on 02/22/13 at which time the resident was injured when the left foot turned and went under the wheel chair becoming entrapped. SRNA #1 stated she did not put the leg rests on the wheel chair because the resident had refused them in the past. Interview with Licensed Practical Nurse (LPN) #1, on 04/03/13 at 2:45 PM, revealed if Resident #1 had a Physician's order to utilize bilateral leg rests and a foot trough and did not have a signed waiver to not use the leg rests, then the staff should have been using the leg rests per Physician's order. Interview with the Director of Nursing (DON), on 04/04/13 at 8:50 AM, revealed since Resident #1 had a Physician's order for bilateral foot rests attached to the wheel chair and there was no documented evidence there was a waiver signed by the resident to not have the bilateral foot rests then the foot rests should have been utilized by the staff per the Physician's order.	F 323			