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	146077	A. BUILDING _____ B. WING _____	01/13/2012

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F 441	Continued From page 26 Review of the infection control logs also showed the logs were not accurate. The facility's Isolation List showed R19 was placed in contact isolation for MRSA of the nares and for C-Diff on 12/8/11. The infection control log for Dec. 2011 did not show that R19 was in contact isolation for MRSA of the nares.	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see	F9999		

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F9999	Continued From page 27 that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met, as evidenced by the following: Based on observation, record review and interview the facility failed to: - Develop and implement specific and individualized interventions to monitor R16 from falling. - Conduct a comprehensive assessment for the use of assistive devices including total mechanical lift and chair and bed alarm for R16. - Ensure the staff was proficient when transferring R16 with a total mechanical lift. R16 is confused and disoriented, incontinent, unsteady to ambulate independently, has a history of multiple falls and dependent on staff for her activities of daily living. As a result: - R16 had fallen 13 times between 8/3/11 and 11/4/11. On 8/23/11 when R16 fell for the 5th time she sustained right ankle fracture. R16 also fell seven times after she sustained the right ankle fracture. - R7 sustained left hip fracture on 11/24/11 when she had fallen in dining room. On 1/3/12 R7 sustained left orbital contusion when she was	F9999		

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F9999	Continued From page 28 transported in wheel chair by a transporter. This is for three of six residents (R16, R7 and R17) in the sample of 22 residents who are risk for falls. Findings include: 1. R16's admission record documented she is an 88 year old female admitted to the facility on 10/6/10 with multiple diagnoses including Alzheimer's Disease and Dementia. R16's 10/14/11 Minimum Data Set (MDS) indicated she is incontinent of bowel and bladder, dependent on staff for her activities of daily living, unstable in balance to ambulate and has a history of multiple falls. R16's 7/5/11 fall risk assessment scored 14 and it was indicated a score greater than '10' is high risk for falls. The facility did not analyze the risk factors or if the risk factors could be modified. The plan of care interventions for falls is not individualized for the use of bed and chair alarm. The facility documented between 8/3/11 and 11/4/11 13 accidents and incidents showing R16 had fallen: 8/3/11 10:05 am resident sitting on floor, removed bed alarm, got out of bed. The interventions added were to add a tamper poof alarm and educate resident to call for help. R16 is confused and has unstable balance. It is not clear as to how these interventions will prevent R16 from falling again. 8/5/11 1:00 am alarm sounded, found resident on floor in front of bathroom, resident stated she slid out of her wheel chair and intervention added was to have non-skid pad in wheel chair in place. The	F9999		

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investigation did not comment as to why R16 was in her wheel chair at 1:00 am un-attended.
8/7/11 2:54 am resident sitting next to bed, resident stated she reached for call light. The intervention was to clip call light to blanket. R16 has short term memory impairment, it is not clear how the facility will ensure R16 will follow the education.
8/8/11 2:50 pm found resident on floor with sheet under her. The intervention was to keep R16 in wheel chair at the foot of the bed. No intervention noted who will monitor R16 to ensure she is safe in her room unattended.
8/23/11 12:40 pm resident (R16) was found on the floor out side the bathroom in her room by a visitor; she stated she tripped over a rug, but there was no rug. R16 toileted self independently and attempted to ambulate back to wheel chair and fell. R16 is unsteady in balance to ambulate self. The facility failed to monitor R16 in her wheel chair, even though the facility was aware of R16 got up from wheel chair, ambulated and fell multiple times prior to this incident. As a result R16 fell and on the floor and sustained right ankle fracture.
After R16 returned from the hospital on 8/26/11 10:45 pm she was found on floor next to her bed.
On 9/10/11 at 9:35 am staff heard alarm sounding in R16's room and found her on floor in a sitting position on the floor in front of wheel chair by her bed.

The facility evaluated and implemented; (i) 9/10/11 to use a bed enclosure (bed enclosed with a tarpaulin and net) when she is in bed and (ii) to use a seat belt when she is in wheel chair. Even after these interventions were in place the facility continued to monitor R16 is safe when she

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was in bed and when she was in her chair. The examples of unsafe situations are:
(i) on 9/17/11 5:35 am R16 sustained a cut on her great toe from wedging into webbing of the bed enclosure;
(ii) on 9/27/11 12:50 pm alarm sounded, staff found R16 sitting on floor in front of wheel chair in room, R16 took shoe off of left foot and slid out of wheel chair.
(iii) 10/1/11 10:50 am R16 was found on floor at room mate side of room with her back against the wall, R16 was in her wheel chair.
(iv) 11/4/11 12:30 pm R16 was found on floor in her room with wheel chair beside her, resident stated she tried to get off from wheel chair to toilet.
It is unclear to explain these instances of R16 landing on the floor from her wheel chair if a seat belt was applied while she was in the wheel chair. R16 also had an incident of falling to the floor in the bath room with two staff being present on 10/5/11 at 8:15 am. The incident report noted two staff took R16 to the toilet. When the staff got R16 of the toilet her knees gave out and fell on the floor on her buttocks. The investigation report indicated the facility discipline the staff for their failure to use a total mechanical lift to transfer R16.

2) Incident report of 11/24/11 indicates that R7, a 84 year old female, was in the D-wing dining room at 6:00 pm when she was found on the floor sitting next to her wheel chair. Resident stated she was trying to get up and fell on her let and hit her head as well. R7 said she had a shooting pain to left leg from knee to thigh. The injury listed is

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redness to the left side of her head and cannot move left leg with normal range of motion. R7's physician ordered an Xray that was done in the facility that evening. R7 was sent to the hospital with diagnosis of a left hip fracture. The report indicates this fall was not witnessed and no staff was in the dining room. The last time R7 was seen was 10 minutes prior to this fall.

R7's last full annual assessment prior to this fall dated 11/7/11. The cognitive status section of this assessment indicates that R7 is severely impaired. The care area assessment indicates that R7 is alert and oriented to person only. She is confused and forgetful. She needs cues and reminders from staff. diagnosis included alzheimer's dementia. R7 is at risk for falls related to gait, balance and weakness. R7's care plan of 11/11/2011 indicates R7 has the potential for trauma-falls and injury. The approach includes to observe and report all unsafe conditions and situations, encourage to ask for assistance, anticipate fall times, monitor closely. The interventions listed on the incident report are to re-educate staff on having staff present in the dining room for supervision until all residents are done.

R7 was readmitted from the hospital at 11/29/11 according to nursing notes. R7 has surgical wound 19 1/2 cm with 25 staples intact. On 1/9/12 R7 was observed seated in the the D wing dining room at the breakfast meal at 7:45am. R7 had ecchymosis around both eyes and a scrape on her face. R7 said she did not remember how this happened. E1 administrator said at 1:45 pm on 1/9/12 that R7 was involved in an incident on 1/3/12 when she was being transported to an

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appointment.

3. Review of R 17's admission face sheet showed R17 was admitted to the facility on 7/10/10 with diagnoses including Hypertension, Macular Degeneration, and Senile Dementia. R17's CAA (care area assessment) for cognition dated 6/2/11 showed R17 had poor short term memory and poor decision making and safety sense. The CAA also showed R17 had difficulty focusing attention and had disorganized thinking. R17's CAA addressing functional status showed R17 was hard of hearing and had macular degeneration.

R17's fall assessment showed R17 was assessed at high risk for falls. Review of the facility's incidents from 8/2011 to 12/2011 showed R17 had 11 incidents. Of the 11 incidents 8 were incidents of falls. Of the 8 falls, five occurred on the night shift (11:00 p.m. - 7:00 a.m.). With these incidents R17 was usually found on the floor. Review of the eight fall incidents showed with five of the incidents R17 was found on the bathroom floor or found on the bedside floor mat with with wet linens.

R17's physician's orders showed R17 had an order for Lasix 20 mg. (diuretic) every morning. On 8/19/11 a bladder diary was initiated for R17 for 10 days (8/19 to 8/29/11). Review of the bladder diary documentation showed the documentation was very sparse. Two days (8/20 and 8/26/11) had no documentation. On the remaining days (8/19, 8/21, 8/22, 8/23, 8/24, 8/25, 8/27, and 8/29/11) there was sparse documentation with no documentation on all shifts. Review of documentation on the night shift

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F9999	Continued From page 33 showed only 1 day of documentation (8/27/11). Review of all incident documentation showed no analysis of trends and patterns of R17's falls in an attempt to determine why R17 was having falls. There was also no noted evaluation or follow up review of the sparsely documented/incomplete bladder diary. Further review of R17's incidents noted on 8/22/11 R17 was found with a bruise to her left arm and elbow and a skin tear to the left posterior hand. On 12/1/11 at 5:40 a.m. R17 fell out of her wheel chair hitting her head on the floor and was noted with a bruise to the right forehead measuring 4 x 4 cm. Interviews with E2 (Director of Nurses) and E3 (Assistant Director of Nurses) on 1/11/11 at 11:55 a.m. noted both to admit no analysis for trends, patterns, etc. had been initiated to identify why R17 was having falls. (B)	F9999		