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F 323	Continued From page 4 interventions for fall prevention and to minimize injuries for residents who experience a fall. Each intervention is specific to each resident's needs and individual risk factor. The post fall follow-up assessment states any changes to the resident's plan of care as a result of the fall will be documented. When a resident is found on the floor, the facility is obligated to investigate and try to determine how he/she got there, and to put into a place this from happening again." This was not done or followed.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.680a)c) 300.696c)2) 300.1210d)6) 300.1220b)3) 300.3240a) 300.7040e) Section 300.680 Restraints a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff	F9999		

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that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part. These policies shall be developed by the medical advisory committee or the advisory physician with participation by nursing and administrative personnel.
c) Physical restraints shall not be used on a resident for the purpose of discipline or convenience.

This regulation was not met as evidenced by the following:

Based on observation and record review, the facility failed to follow their restraint policy and did not assess the restraint as being the least restrictive for 1 of 1 (R11) in the sample of 8 reviewed for restraints.

Findings Include:

5/21/2012, R11 was observed having lunch in the 2nd floor dining room at approximately 12:10pm. The resident was sitting in an arm chair. The back of her chair was placed next to the wall and the table was positioned so that the arms of the chair were under the table making it impossible for the resident to rise. R11 was wearing a gait belt around her waist. R11's husband was sitting at the table at the time of the observation, cueing the resident to eat her lunch. Every time the resident tried to rise up, the chair and the table held her back.

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F9999	Continued From page 6 On 5/24/2012, at approximately 10:50am, during an activity in the dining room, R11 was in the same position, wearing a gait belt. The resident tried twice to rise and could not. The facility's restraint policy was reviewed. The facility's restraint policy state's that a resident will receive an assessment before the use of a restraint. A physician's order will be obtained for the restraint. A consent for the restraint will be obtained. R11's clinical record was reviewed. No Physician order for a restraint was found. 5/24/2012, R11's restraint was discussed with E1 (Administrator) and E2 (DON). They were asked for an assessment, physician order, consent and reason for the restraint. Nothing was presented. AW Section 300.696 Infection Control c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340): 2) Guideline for Hand Hygiene in Health-Care Settings This regulation was not met as evidenced by the following: Based on observation, interview and record review the facility failed to follow current standards of infection control practices as well as their own policy and procedures for hand	F9999		

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washing, nail hygiene and changing and storage of oxygen accessories for 2 residents, R7 and R9 in the sample of 8 and 8 residents(R14 , R15 , R16, R17, R18, R19, R20 and R21) in the supplemental sample reviewed for infection control.

Findings include:

On 5/21/12 at 9:15 am during the initial tour on 5th floor, R9's nebulizer mask and reservoir chamber were not covered or in a plastic bag. and exposed
At 9:30am R20's nasal cannula was not in a bag or covered. The portable oxygen tubing was dated 2/15/12.
Facility's changing of oxygen and nebulization accessories policy dated 5/1/2009 documents under #3-3 and 4.
"Put oxygen/nebulization accessories in a plastic bag in between use; make sure that is dated and initialed.
Oxygen supply tubings, nasal cannula/mask, humidifier, nebulizer mouthpiece,mask and other related accessories must be discarded and replaced every week."

On 5/22/12 at 8:15am E4 (CNA) Certified Nurse Assistant was providing care to R17, E4 took off the gloves and left R17's room without washing hands. E4's nails were long.
At 8:45am E5(CNA) left R17's room and washed her hands for less than 10 seconds and at 9:00am E5, washed her hands again for less than 5 seconds. E5's nails were long..

At 9:10am E5 was feeding R14, R15 and R16. E5 held a sweet roll with her bare hands and gave it

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F9999	Continued From page 8 to R16. At 9:10 am E4 stated "I sing happy birthday while I wash my hands before care, after care, before and after you feed." At 9:20am E5 stated "I sing happy birthday every time. I wash them when you touch a resident, before and after you touch anything." At 9:20 am E3 (Dietary Manager) was on the second floor kitchen checking the refrigerator and coaching E6. E3's hair net did not cover her hair entirely, E3's bangs were not covered. At 9:30am E3 washed her hands in the kitchen sink, for 5 to 8 seconds and closed the faucet with her bare hands. At 11:55am E7(Dietary) was checking food temperatures and pouring soup for residents. E7 was wearing a hair net that did not cover her hair entirely, her bangs were not covered. At 1:50pm E4, finished feeding R7, E4 washed her hand for less than 10 seconds and close the faucet with her bare hands, then grabbed the paper towel to dry her hands. At 2:00pm E4 (CNA) nails were long. Hand washing/Hand Hygiene facility policy last reviewed with 8/2009 date documents under general guidelines #1, a and d, 5 and 6. "Appropriate ten (10) to fifteen (15) second hand washing with antimicrobial or non antimicrobial soap and water must be performed under the following conditions: "Before and after direct contact with residents. After removing gloves. Do not wear artificial nails or extender tips when	F9999		

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working with immunocompromised or severely ill residents.
Keep natural nail tips less than 1/4 inch long."
Under Steps in the Procedure-Washing Hands #3 "Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel".

At 8:45 am on second floor dinning room E10 (RN) Registered Nurse was feeding R18. E10 got up and went to encourage R19 to eat, she rubbed R19's back. E10 did not wash hands in between residents contact between R18 and R19.

At 9:00am on second floor dinning room E6 was observed serving breakfast to R17 without gloves. E6 was wearing a hair net that did not cover her hair entirely. Her bangs were uncovered.
E6 put on her gloves to pour coffee to R17, took off the gloves and proceeded to pour a glass of milk to R15. E6 did not wash her hands after taking off her gloves and prior to serving the glass of milk to R15.

At 9:05am E3 walked to 2nd floor dining room wearing a hair net that was not covering her hair entirely, her bangs were uncovered.

At 11:00am on 5th floor E11's (CNA) nails were long.

At 12:00pm on 2nd floor Z1 (Private Duty) arrived to floor to feed R21. Z1 did not perform hand hygiene before she started feeding R21. Z1 went in the kitchen without wearing a hair net.

At 1:30pm E12 (Dietary Supervisor) was walking back to the kitchen. E12 was wearing a hair net

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F9999	Continued From page 10 that was not covering all her hair. Her bangs were not covered. On 5/24/12 E2 at 3:55pm (DON) Director of Nursing stated "Some of them started removing their long nails and dietary inservices have started regarding their hair nets." AW Section 300.7040 Activities e) Activities shall be adapted, as needed, to provide for maximum participation by individual residents. If a particular resident does not participate in at least an average of 4 activities per day over a one-week period, the unit director shall evaluate the resident's participation and have the available activities modified and/or consult with the interdisciplinary team. This requirement was not met as evidenced by: Based on observation and record review, the facility failed to created a modified activity program for 1 (R12) of 5 residents in the sample with dementia residing on the Alzheimer designated unit. R12 refuses to attend activities. The facility did not create a modified activity schedule based on the resident's abilities and behaviors. Finding Include: 5/21/2012, at approximately 3pm, R12 was observed in bed, eyes open. A 2nd floor staff member was asked if there were any activities scheduled for the 2nd floor? "No, residents who	F9999		

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F9999	Continued From page 11 want to participate in activities go to another floor." R12's clinical record under activities states that the resident refuses to go to activities. R12's Activity care plan is dated 11/30/11 states the resident has problems with activities due to her diagnosis of dementia and Scoliosis. One of the approaches is asking R12 is she wants to play ball. Due to her physical ailment, playing ball would be an inappropriate activity but is listed as her only activity. In an activity note dated 3/1/2012, it is acknowledged that the resident is bent over from the waist, permanently and is unable to understand or discuss due to cognitive impairment. Yet the resident is asked if she wants to participate in a activity that requires mobility. AW Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.	F9999		

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F9999	Continued From page 12 Section 300.1210 General Requirements for Nursing and Personal Care 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 that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	F9999		

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agent of a facility shall not abuse or neglect a resident.

These regulations were not met as evidenced by the following:

Based on closed record review and interview, the facility failed to ensure that one of five residents (R5) reviewed for falls from a total sample of 10, who was identified as a fall risk had adequate supervision to prevent multiple falls. The facility failed to revise/review the care plan for effectiveness of the interventions and failed to supervise and update the plan of care. These failures resulted in multiple fractures and surgical repairs for R5 due to falls.

Findings include:

R5 was a 79 year old who was admitted to the facility on 01/18/12 with diagnoses of Right Hip Fracture, Wound Care, Alzheimer's, History of Bilateral Hip Fracture, Urinary Tract Infection, Pneumonia, Senile, Parkinson, Osteoporosis, Syncope/Collapse, Depression, Difficulty in Walking,Macrocytic Anemia, Femoral Neck fracture and Status Post Left hip pinning on 02/28/12.

The incident reports stated," 01/23/12 at 7:30pm, Unsteady altered balance when bending and or stooping. Witnessed by Certified Nurse Aide (CNA) on duty.

02/16/12 at 3:20pm, found resident sitting on the floor in her room at the foot post of her bed.

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02/27/12 at around 3:00pm CNA noted resident in bed, holding her left hip with facial grimacing. Resident's husband said that R5's back hurts which R5 validated. When CNA asked her if she has pain on her left leg, she said" yes, a little." Charge nurse made aware of CNA observation and resident complaint. Body assessment done by charge nurse. Noted with pain on her left leg upon movement, no swelling or bruise. Resident admitted to hospital with impacted fracture of the left femoral neck.

03/18/12 at 9:50pm, Found lying on her right side on the floor mattress. Resident is confused.

03/30/12 3:40pm Noted in kneeling position at bathroom doorway. resident unable to related what happen. No visible injury.

On 03/31/12 at around 8:00am, resident complained of severe pain on the left hip. The assessment findings of the nurses and the current complaint of left hip pain, with order to send resident to hospital emergency room treatment. Resident refused to go to the hospital and claimed that she felt much better. Resident complained of intermittent pain on her left hip which was relieved by pain medication.

04/02/12, daughter (Power of Attorney) called and was updated R5's continued pain and advised to take resident to hospital. Resident sent to the hospital emergency room for further evaluation and was admitted with diagnosis of fever and fall. X-Ray and a CT scan done to rule out fracture. 04/3/12 a diagnosis of right femoral head fracture was made.
At 8:50am on 04/13/12, R5 was observed by staff

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nurse to be sitting on the floor next to her bed in room 425, mobility alarm sounding. R5 reported right hip pain on scale of 4-5/10 upon physical assessment. Resident sent to the emergency room for evaluation. R5 was evaluated and diagnosed with a right pubic ramus fracture.

Status Post fall pelvic fracture. 04/16/12 at 8:20pm, found resident on the floor in her room in a squatting position in front of her wheelchair. Found resident's shirt off with the alarm attached to it. No apparent injury with slight red marks on upper back and right shoulder blade.

5/10/12 at 7:40am, R5 was observed on the bathroom floor seated on her buttocks by her assigned CNA. Status Post Left hip pinning. 05/10/12 at 4:40pm, Resident sitting in wheelchair in front of nurses station along with other residents. Residents leaning forward and slowly sliding off the from chair."

Review of documentation identifies R5 as needing supervision as evidenced by The Minimum Data Sets (MDS) date 03/12/12 stated," Section C: C1000 -Cognitive Skills for Decision Making score is 2(Moderately impaired - decisions poor; cues/supervision required.)

The MDS dated 03/12/12 denoted in section G0110 Functional Status: (B). Transfer was score 3/2 (Extensive assistance- staff provide weight bearing support/ one person assist). (C and D). Walk in room and corridor score is 8/8 (Activity did not occur).

A review of nurses notes from 01/27/12 to 05/10/12 denote there is no consistent

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documentation related to frequently monitoring or increased supervision that was given to R5 in view of frequent falls and resulting injury from the falls. The care plan date from 03/06/12 through 05/10/12 fails to identify an effective intervention and monitoring program for the frequent falls R5 sustained.

E13 (Unit Manager) on 05/22/12 at 3:00pm stated," R5 was on the 4th floor for rehabilitation because of the hip fracture due to fall on the 5th floor. When she came to the floor April 13, 2012 at 8:30am, she fell and was noted on the floor. She was sent out to the hospital. She was far away from the nurse station. We were not able to monitor or supervise her in this room. She was never ambulatory. She was wheelchair bound. She could never walk alone. She needed assistance with 1 -2 person. The care plan was not updated or revised after the fall for effectiveness. We would update or revise the care plan on quarterly basis only."

The Fall Prevention Program policy and procedure stated," To develop resident specific interventions for fall prevention and to minimize injuries for residents who experience a fall. Each intervention is specific to each resident's needs and individual risk factor. The post fall follow-up assessment states any changes to the resident's plan of care as a result of the fall will be documented. When a resident is found on the floor, the facility is obligated to investigate and try to determine how he/she got there, and to put into a place this from happening again." This was not done or followed.

B

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