| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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paged Z3 and Z3 did not call back so she paged Z4. E28 said that Z4 also did not call back and she endorsed this to the night shift. There is no indication in R3 ' s record that Z3 or Z4 was made aware of R3 ' s incident of being kissed and fondled.

As there was no immediate reporting of the 6/1/12 sexual abuse observation to the supervisors E2 and E24 or E1, the facility did not conduct an immediate investigation of the allegation. The investigation started when E24 observed R3 being fondled by Z1 in the hallway on 6/1/12.

On 9/13/12 at 3 PM, E1 said that staff is expected to stop Z1 if he was seen kissing R3 or fondling her breast or genital area in the dayroom. E1 continued that staff is also expected to call the supervisor or the nurse and report what the staff saw, and wait for help, then the alleged perpetrator should be separated from the resident. The resident should not be left alone and unsupervised with the alleged perpetrator per E1 after there is an allegation of sexual abuse. E1 said during this interview that there was no kissing with tongue or fondling of R3 that occurred on 6/1/12. E1 then added that if he had knowledge of kissing with tongue or fondling of breast and genital area of R3 in AM, he would have made Z1 leave the building immediately to protect the resident. (A)

300.610a)
300.1210b)2)
300.1210c)

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| F9999 | Continued From page 59<br>300.1210d)3)6)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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:<br>2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion | F9999 | | |

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is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
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:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
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 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidence by:

Based on interview, and record review, the facility failed to ensure proper positioning during care of

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| F9999 | Continued From page 61<br>1 (R4) of 3 residents reviewed for injuries/fractures. This failure led to R4 sustaining a fracture to his right arm.<br><br>Findings include:<br><br>R4 was admitted to the facility with the following diagnoses: quadriplegia, depression, gastric ulcer, and diabetes mellitus. The facility ' s investigation report dated 3/15/12 documents that R4 complained of pain in his right arm while receiving ADL (activities of daily living) care. The report documents that R4 is totally dependent with bed mobility, transfers, bathing, and dressing. The report adds that R4 stated " when I was turned on my right side, I heard my arm pop. " The report goes on to read that the facility obtained an x-ray of R4 ' s arm, and it revealed a fracture.<br><br>R4 ' s care plan documents that R4 is totally dependent with bed mobility and requires staff assistance.<br><br>The facility ' s fall investigation summary dated 3/15/12, signed by E20 (nurse) documents that R4 informed E20 that on 3/14/12 at 6:00 a.m., when the staff turned him to his side, he heard a " crack " and when he was turned back to his original position, he heard the same sound.<br><br>On 9/11/12 at 10:45am (location-resident room), R4 stated that the incident occurred on 3/14/12 at approximately 6:00 a.m. R4 added that his arm is paralyzed, but in certain locations, he has feeling. R4 stated that the CNAs (Certified Nursing Assistants) providing care were not properly positioning him. R4 added that he was trying to | F9999 | | |

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instruct the staff on the proper way to turn him. R4 then stated that when the staff turned him, his right arm became " stuck " and he heard a snap. R4 stated the arm snapped 2 times and he felt severe pain. R4 acknowledged that he requires staff assistance to move his extremities.

On 9/11/12 at 1:20 p.m., E24 (Registered Nurse, Falls Coordinator) stated that she and E2 (Director of Nursing) investigated the incident involving R4 ' s arm. E24 stated that R4 indicated that while being turned by staff, he heard a popping noise. E24 stated that through talking with the staff, she was informed that R4 had complained of pain in the arm. E24 stated that the facility obtained an x-ray which revealed a fracture. According to E24, R4 did not have a fracture to his right arm prior to 3/14/12.

On 9/11/12 at 2:45pm, E37 (C.N.A) stated that when she came to work the morning of 3/14/12, R4 complained that he had experienced arm pain during care. E37 stated that she worked with R4 on 3/13/12 and there were no complaints. E37 added that R4 had not complained of arm pain prior to 3/14/12.

On 9/12/12 at 9:17am, E36 (C.N.A) stated that he, E35 and E36 (C.N.As) were providing care for R4 on 3/14/12. E36 added that R4 was " heavy. " E36 stated that upon being turned, R4 complained of shoulder pain. E36 stated he placed R4 ' s right arm on his chest prior to turning him. When asked what position R4 was turned to, E36 stated " the left " . E36 then stated " the right " . E36 stated " He ' s a big guy. He ' s the type of resident that would have you in his room all night. " E36 added that R4 has never

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complained of arm pain prior to this occurrence.

On 9/12/12 at 9:38am, E35 stated that she was assisting with ADL care for R4 on 3/14/12. E35 stated that when the staff turned R4 onto his side, he complained of pain, so they turned him onto his back. E35 stated that R4 ' s arms were at his sides while being turned. E35 added " he has no control over that arm. " E35 stated that R4 has not complained of pain in the arm prior to that occurrence.

On 9/12/12 at 12:25pm, E34 (C.N.A) stated that she was assisting with ADL care for R4 on the morning of 3/14/12. E34 stated that when the staff turned R4, he complained that his arm was hurting. E34 stated that R4 ' s arms were positioned at his sides. E34 also stated that R4 had not complained of arm pain prior 3/14/12.

There were no documented nursing assessment, notification of physician/family, or interventions located in R4's medical record for 6:00 a.m. on 3/14/12. There was a nurse ' s note documented on 3/14/12 at 10:00 p.m. (approximately 16 hours later). The nurse ' s note documents that R4 had complained of severe pain in his right arm, and the arm was swollen. The note further documents that R4 complained of arm pain with any movement and an x-ray was ordered.
Subsequent nurse ' s notes documents:
12:30am on 3/15/12- x-ray was obtained.
2:30am on 3/15/12-redness to right upper arm, warm; lower arm cool to touch.
5:00am on 3/15/12- medicated with Dilaudid (Opioid analgesic) for the pain.
8:35am on 3/15/12-x-ray results received, send to hospital.

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The radiology report for R4 dated 3/15/12 documents: Significant findings-right humerus. Impression- fracture of the mid humeral diaphysis.

The facility provided documentation on a separate nurse ' s note dated 3/16/12 (2 days post incident and after hospital transfer), which read: " addendum, 3/14/12, approx 6:50 a.m." The nurse ' s note goes on to explain that R4 had complained of arm pain during care on 3/14/12. The nurse ' s note was completed by E48 (nurse).

On 9/12/12 at 12:47 p.m., E2 stated that there was no documentation by the nurse on duty (E25) on 3/14/12 at 6:00 a.m. because E25 did not document. E2 stated she disciplined E25 for not following facility policies. E2 stated that E48 documented the events on 3/16/12 (2 days later). E2 added that E25 and E48 are no longer employed at the facility. According to E2, R4 is incapable of actively moving his arms. E2 stated that R4 suffered a fracture as a result of the incident. E2 further stated that R4 did not have a fracture prior 3/14/12. E2 added that R4 has occasional pain, but the pain he endured on 3/14/12 is beyond his baseline. There was no documentation located in R4 ' s chart documenting a fracture of the right arm prior to 3/14/12.

The facility ' s change in resident ' s condition policy documents:
-It is the policy of the facility except in a medical emergency, to alert the resident ' s physician of a change in condition.
-Nursing will notify the resident ' s physician or

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| F9999 | Continued From page 65<br>nurse practitioner when:<br>a. The resident is involved in an accident or incident.<br>b. There is a significant change in the resident ' s physical, mental or emotional status<br>(B) | F9999 | | |