STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PH10	A. BUILDING: _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE	11 PECAN DRIVE COLUMBIA, MS 39429

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M 000	Initial Comments The State Agency (SA) conducted a licensure survey from 8/12/19 to 8/15/19. During the survey the SA determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statutes M500, M620, and M640. The census at the time of the survey entrance was 81, and the facility was certified for 86 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to	M 500		9/12/19

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M 500	Continued From page 1 participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this	M 500		

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M 500	Continued From page 2 responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as	M 500		

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M 500	Continued From page 3 documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on resident interviews, staff interviews, record reviews, and facility policy review, the facility failed to ensure the resident's right to be free from misappropriation of funds, for one (1) of four (4) Resident Trust Funds reviewed.	M 500	1. The following corrective actions were put into place for the resident found to have been affected by this deficient practice: A) A grievance form was initiated on Resident #61 and completed by Social Worker on 8/15/19 outlining the alleged	

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M 500	Continued From page 4 Resident #61. Findings include: A review of the facility's Abuse and Neglect-Consumer Information Sheet, undated, revealed, according to the Nursing Home Reform Act of 1987, all residents in nursing homes are entitled to receive quality care and live in an environment that improves or maintains the quality of their physical and mental health. This entitlement includes freedom from abuse and misappropriation of funds. Review of the facility's policy titled, "Abuse, Neglect, or Exploitation Policy, no date, revealed: Definition: Misappropriation of Resident Property- The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of resident's belongings or money without the resident's consent. Reporting: The complaint must be reported as soon as possible to the Administrator, Director of Nurses, and Facility Contact Person. Investigation: Any report of abuse, neglect or exploitation will be investigated by the Administrator, Director of Nurses, Social Services, Quality Assurance Committee, and Facility Security. Action: Any employee suspected of abuse, neglect or exploitation will be investigated and actions taken will at the discretion of administration. On 8/15/19 at 11:00 AM, an interview with Administrator #1, revealed nothing had been reported to him. On 8/15/19 at 11:01 AM, an interview with Administrator #2, revealed nothing had been reported to her.	M 500	money that was missing. B) An investigation into the missing money was completed by the Quality Assurance/Infection Prevention Nurse on 8/19/19 and was faxed to the Mississippi State Department of Health & the Attorney General's Office. C) The Administrator provided Resident #61 with a lock box and key. Lock box was installed in resident's night stand and we suggested she use lockbox to keep her cash in to prevent any further mishaps. D) The Facility has suggested all current residents who keep money in their rooms or on their persons purchase a small lock box. E) The Administrator interviewed Resident #61 s roommate on 8/15/19. During the interview the Administrator asked the roommate if she had ever had any money to come up missing and she replied No. 2. All residents who keep money in their rooms or on their persons have the potential to be affected by this deficient practice. 3. The following measures and systemic changes were put into place to ensure the deficient practice will not recur: A) An in-service was held by the Administrator on 9/6/19 for all employees that covered a resident's right to be free from abuse (including misappropriation), the facility policy on reporting abuse, and the facility's policy on investigating incidents. B) The Assistant Administrator was counseled by the Administrator on 8/19/19 about the importance of reporting potential	

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M 500	Continued From page 5 On 8/15/19 at 11:05 AM, an interview with the Assistant Administrator (AA), revealed she was not aware of anyone handling the resident roughly, but rather it was Certified Nursing Assistant (CNA) #5 (CNA #5 was also Resident #61's relative) taking the resident to the bathroom. The AA stated the resident had stated CNA #5 had not been talking to her. The AA also stated she asked CNA #5 to take someone with her when she went in to care for Resident #61. The AA stated Resident #61 reported to her that CNA #5 did not want to work with her (Resident #61) and that CNA #5 was acting like her daddy. The AA stated Resident #61 and CNA #5 just did not get along. The AA stated CNA #5 had started swapping out when she had to care for Resident #61. She also stated she had talked with the Resident #61's Resident Representative (RR) and the RR stated she gets along with her cousin, CNA #5. The AA stated Resident #61 thinks transferring on the sit to stand lift is handling her rough because she is unable to hold onto one side of the lift, and she thinks the staff is doing something to her. She stated Resident #61 feels she can do more than what she is able to do for herself. She also stated she does know it was the sit to stand lift that Resident #61 was referring to. The AA stated Resident #61 never reported to her that CNA #5 was handling her roughly. She stated she did not do an investigation because she did not feel there was anything to investigate because this happened before the last survey. She also stated Resident #61 stated she had some money missing but Resident #61 had found her money. The AA stated, Resident #61 had $105.00 or $106.00. She stated she was off from work the next day. She also stated, Resident #61 had given the Licensed Social Worker (LSW) $100.00 and had gotten $50.00 of it the other day from the LSW. She stated Resident #61 signed	M 500	allegations of misappropriation of resident funds to the proper departments so facility can begin investigation. C) Our admission agreement was amended by the Administrator on 9/5/19 to include language that suggests that if a resident wants to keep cash, checkbook and/or credit debit cards in their rooms, they may want to consider purchasing a lock box to keep their money in. 4. The facility plans to monitor the effectiveness of our plan by doing the following: A) The Social Worker, Administration and the Quality Assurance/Infection Prevention Nurse will communicate daily with each other during our morning stand-up meetings to ensure there have been no allegations of misappropriation of resident property. If we find that there has been an allegation, we will investigate immediately. B) The Social Worker, Administration and the Quality Assurance/Infection Prevention Nurse will be able to monitor the effectiveness of the plan immediately by reviewing our grievance logs weekly to ensure we have investigated any/all allegations of missing property that were reported through our grievance form. If any negative findings occur Quality Assurance will investigate those immediately. C) During our weekly Q/A meetings, we will discuss any potential investigations into missing resident property. 5. These corrective actions were completed on 9/12/19	

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M 500	Continued From page 6 off on it in her (AA) office and she (AA) had the money in a little locked box. The AA stated that was the day Resident #61's son had come to the facility. She also stated Resident #61 has $50.00 left. The AA stated she usually does not hold money. She stated the resident had money missing last month and had brought some money to the office to the LSW and Front Office Worker #1 which was $100.00. She stated "Wednesday" morning when she returned to work, the LSW gave her $100.00 for Resident #61 and this was last week, but her days are kind of running together. The AA also stated when the resident's son was at the facility, Resident #61 had gotten $50.00 of her money. She stated she rolled the camera back, and she did not see anyone go in or out of Resident #61's room. She also stated the next day Resident #61 brought the money to her office because she did not want to hold that amount of money. She stated she does not know the policy on when a resident has missing money. She also stated she generally handles it by telling the residents if they have any problems to let her know about it and she will roll the camera back. She stated she did not tell Administrator #1. She also stated she told the Director of Nursing (DON), but at that time, the money came back. She stated to her, the situation was over with because she (Resident #61) brought money to the office. She also stated, she asked the resident when she has that kind of large sums of money, she needs to have it locked up. She stated Resident #61 had not had that type of money before. The AA also stated she did not write anything down regarding the CNA situation or the money situation. She stated it is the facility's policy to investigate the resident's concerns, but she did not investigate because it was an issue that was resolved. She also stated other than the nurse that was standing in the	M 500		

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M 500	Continued From page 7	M 500		

hallway, no one knew about the situation. She stated she does not remember who that nurse was. She stated she should have gone to the Director of Nurses (DON) and the DON should take the next step, but she kind of handled it herself. She stated she thought everything was okay. She stated Resident #61 wants to go home tonight if she could. She also stated the resident was here previously, had gone to a facility in another town, and eventually returned to this facility. She stated the resident was wanting to go home before all of this occurred. She also stated if she failed to do something it was because of the relationship that she and Resident #61 has. This interview was conducted by speaker phone in the presence of another surveyor.

On 8/15/19 at 11:35 AM, an interview with the Licensed Social Worker (LSW) revealed, Resident #61 had not reported anything to her about being unhappy with a CNA. She also stated the resident had not personally reported to her that she had some money missing. The LSW stated she had witnessed the AA giving the resident some money ($50.00) this week out of $100.00. She stated the rest of the $50.00 is in the AA's office. The LSW stated Resident #61 always goes to the AA and does not open up to her (LSW). She stated the resident had not mentioned anything to her. She stated if a resident came to her with a concern regarding how a CNA for example, is caring for them, she would go through the chain of command. She stated she would go to Licensed Practical Nurse (LPN) #5.

On 8/15/19 at 11:50 AM, an interview with the DON, revealed the resident had not mentioned anything to her regarding any CNA. She also

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M 500	Continued From page 8 stated the resident had not told her about any missing money. On 8/15/19 at 12:00 PM, an interview with Resident #61, revealed she had gone to the AA because CNA #5 had stopped speaking to her. She stated she had not had a chance to talk to the AA about CNA #5 handling her roughly. She stated she had not told anyone about that. She also stated the AA came to her and gave her $50.00, and she had $50.00 left in the office. Resident #61 stated she wanted to draw half of the $100.00 out. She stated the $100.00 she had missing was about one month ago. She also stated a staff member brought her $50.00 of the $100.00 that was missing a month ago. Resident #61 also stated she told the AA and the AA said she would roll the camera back. Resident #61 stated she had another $100.00 after the first $100.00 went missing. She stated she had $100.00 twice, but not at the same time. She stated she had the first $100.00 about a month ago. Resident #61 stated the whole $100.00 came up missing. She stated she had nine $10.00 bills and two $5.00 bills. She stated she had another $5.00 and $1.00 bill. She stated she did not tell anyone until one of the workers came into her room. Resident #61 told this worker that $100.00 was taken out of her purse and her purse was taken from underneath her pillow. Resident #61 does not want to state the worker's name. She stated the first person she told was Resident #23, and then she told the AA and the AA told her (Resident #61) she was going to roll the camera back. She stated the AA told her that a woman was coming to talk to her and would want to know where the money came from. She stated the woman never came. She stated the AA stated she would have to get someone else to come. She stated that same worker (the worker	M 500		

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M 500	Continued From page 9 that Resident did not want to give her name) came into her room that night and put $50.00 in the envelope. She stated the worker was going through her things and she saw the worker lift her hand and handed the envelope to her which had the $50.00 in it. She stated the worker told her it was not $100.00 but it was $50.00. The resident stated she asked the worker where was her other $50.00 at. She stated she never heard anymore from the AA. On 8/15/19 at 12:30 PM, an interview with Administrator #1 revealed, he would expect the Assistant Administrator to handle issues and does not expect her to bring everything to him. He stated the policy on misappropriation is to go through the proper chain of command. He stated anyone in the facility can go to Quality Assurance (QA). He also stated he would expect the staff to report abuse to the administrator. He stated if someone reported to him that a resident had money missing, he would conduct an investigation. A review of the facility's Face Sheet revealed, the facility admitted Resident #61, on 7/20/18, with diagnoses including Myoneural Disorder and Gastroesophageal Reflux Disease (GERD). A review of the most recent Yearly comprehensive Minimum Data Set (MDS) reveaintact.led, Resident #61 had a Brief Mental Status (BIMS) score of 15, which indicated she was cognitively intact.	M 500		
M 620 SS=D	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling	M 620		9/12/19

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M 620	Continued From page 10 catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. Level II Based on observation, staff interviews, record reviews, and facility policy review, the facility failed to provide catheter care in a manner to prevent possible cross contamination for one (1) four (4) resident catheter care observations. Resident #33. Findings include: A review of the facility's policy titled, "Incontinent care Policy", undated, revealed: Wipe area only once with same cloth, change cloth or fold cloth to clean side and clean from front to back. A review of the facility's policy titled, "Catheter Care Policy", undated, revealed it is the policy of this facility that catheter care will be done as follows: Wiping buttock from the anal area upward and cleanse the catheter from the body to the end of the catheter, never from the end of the catheter toward the body. On 8/14/19 at 9:35 AM, an observation revealed CNA #6 assisted by CNA #7 performed Resident #33's catheter care. CNA #6 had already set up her barrier and supplies. Both CNA #6 and CNA #7 washed their hands and applied clean gloves. CNA #6 set up two (2) basins, one was to wash Resident #33, and one was to rinse the resident. When CNA #6 was cleaning Resident #33's penis she wiped the resident's penis three times (x3) without rotating her washcloth, then placed that	M 620	1. The following corrective actions were put into place for the resident found to have been affected by this deficient practice. A) Certified Nursing Assistant #6 was counseled and retrained on the importance of following the plan of care with regard to catheter/perineal care by the Director of Nursing on 9/5/19. B) On 9/5/19, Certified Nursing Assistant #6 also had to demonstrate proper catheter care while the Certified Nursing Assistant Coordinator observed. C) Resident #33 was monitored for signs/symptoms of any possible infection due to improper catheter care; no infection was noted. 2. The 6 residents who have a foley catheter and require catheter care to be provided have the potential to be affected by this deficient practice. 3. The following measures and systemic changes were put into place to ensure the deficient practice will not recur: A) An in-service was held for all Nursing Staff on 9/6/19 by the Certified Nursing Assistant Coordinator about the importance of following the plan of care regarding catheter/perineal care. A demonstration of proper catheter care was also performed. B) The Certified Nursing Assistant Coordinator performs pop-in visits while	

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M 620	Continued From page 11 washcloth in the soiled linen bag. CNA #6 retrieved another washcloth and wiped the resident's penis again twice (x2). When CNA #6 rinsed the resident's penis area she wiped two times (x2) without rotating the washcloth and placed that washcloth in the soiled linen bag. CNA #6 retrieved another washcloth and wiped the resident's penis area three time (x3) without rotating the washcloth. CNA #6 then dried the resident's penis area, and while drying the area she used a patting motion times five (x5) without rotating the towel, then patted the area dry again three times (x3) and again four times (x4) without rotating the towel. On 8/14/19 at 3:00 PM, an interview with CNA #6 revealed she stated she, "wiped too many times." CNA #6 stated she should have wiped one time and folded her washcloth before she wiped again. She also stated wiping too many times causes germs to spread. An interview, on 8/14/19 at 3:17 PM, with Registered Nurse (RN) #1, revealed when CNA #6 wiped more than once without rotating her washcloth that caused cross contamination and infection control issues. Review of the Physician's Orders revealed an order, dated 4/29/19, to change the Foley catheter (18 French (FR) with a 10 cubic centimeter (cc) bulb every 30 days and as needed) for the diagnosis of Neurogenic Bladder. A record review of the most recent Quarterly Minimum Data set (MDS) assessment, with an Assessment Reference Date (ARD) of 6/3/19, revealed Resident #33 was coded for an indwelling catheter.	M 620	Certified Nursing Assistants are about to perform peri/catheter care in order to observe and ensure the care plan is being followed as it pertains to peri/catheter care. 4. The facility will continue to monitor and ensure the quality of catheter care remains high through the following: A) During orientation, Certified Nursing Assistants must watch a video on the proper method for performing catheter care. They also spend at least two weeks with an experienced Certified Nursing Assistant to get hands-on training and can be corrected if any improper care is observed. Finally, the Certified Nursing Assistant must pass a skills test which is given by the Certified Nursing Assistant Coordinator, which includes catheter care. The Certified Nursing Assistant is not allowed to take care of a resident by herself until she can pass this skills check-off. B) Nursing Staff attend a mandatory in-service on catheter/ perineal care at least every 6 months. The Certified Nursing Assistant Coordinator conducts these in services. C) In addition, Certified Nursing Assistants are tested annually on their skills. They must demonstrate competency in all areas of resident care, including catheter care. The Certified Nursing Assistant Coordinator conducts these skills checks. D) Quality Assurance and Performance Improvement meetings are held quarterly to discuss the effectiveness of our interventions that we put into place. We will examine the progress of our corrective	

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	PH10	A. BUILDING: _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 620	Continued From page 12	M 620	actions through monitoring data such as the number of Urinary Tract Infections we have. If the Quality Assurance and Performance Improvement Council notices our infection rates are increasing, they will make adjustments to our approach during these meetings. 5. These corrective actions were completed on 9/12/19.	
M 640 SS=D	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Based on resident interview, staff interview, record review, and facility policy review, the facility failed to prevent falls for one (1) of three (3) residents reviewed for falls. Resident #15. Findings include: A review of the facility's policy titled, "Fall Protocol Policy", without a date, revealed the facility would evaluate possible alternative interventions to help prevent falls. A review of the Resident #15's Comprehensive Care Plan revealed staff was to stay in the bathroom with the resident while being toileted related to her fall risk.	M 640	1. The following corrective actions were put into place for Resident #15, who was affected by the deficient practice: A) Since last fall on 6/11/19, a new intervention was implemented on 6/12/19 to "allow staff to assist with pulling down brief and pants during toileting" and there have been no falls since that new intervention. B) Director of Nursing provided an in service to all nursing staff held on 9/6/19 that addressed the importance of following the plan of care for Resident #15, with an emphasis on remaining in the bathroom with the Resident while she is in there.	9/12/19

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M 640	Continued From page 13 Review of Resident #15's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/22/19, revealed in section J1900B the resident fell two or more times since the prior assessment with injury (not major). A review of Resident 15's, "Resident Incident Report", dated 6/11/19, revealed Resident #15 was assisted by Certified Nursing Assistant (CNA) #1 to the bathroom. CNA #1 removed the resident's walker from the bathroom. While Resident #15 was standing in front of the commode pulling her down pants and brief, Resident #15 started to fall, but CNA #1 was not able to break the fall. Resident #15 fell to the floor hitting her face and forehead and knee. The incident report noted an abrasion to the forehead and right side of neck and lip. Resident #15 was sent to Emergency Room (ER) for evaluation without any orders on return for treatment on her medical record. Review of a handwritten statement, dated 6/11/19, by CNA #1, on the facility's Written Statement on Accident/incident was attached to Resident #15's incident report. CNA #1 stated, she turned her back to Resident #15 to move the walker out of the way of the resident, and when she turned around the resident was falling. A review of Resident 15's "Resident Incident Report", dated 4/11/19, revealed the resident was found in front of bathroom door by Licensed Practical Nurse (LPN) #1 with a laceration to the right brow, and was sent to to the ER for evaluation. The documentation noted on the incident report revealed the fall was not witnessed. A review of Resident 15's "Resident Incident	M 640	2. All residents are at risk for falls and have the potential to be affected by this deficient practice. Residents are assessed by interdisciplinary team at least quarterly for fall risk using fall assessment tool. 3. The following measures and systemic changes were put into place to ensure the deficient practice will not recur: A) The Social Worker will interview Resident #15 weekly beginning on 9/12/19 to ensure staff is staying with her while she is in the restroom. B) The findings from the Social Worker's interview will be presented to the Quality Assurance nurse each week beginning on 9/13/19. C) If needed, the Quality Assurance nurse will review video recordings to ensure staff did/did not remain in the restroom with Resident #15. 4. The facility plans to monitor the effectiveness of our plan by doing the following: A) The Quality Assurance nurse will bring the findings of the Social Worker interviews to our weekly Quality Assurance meetings. The Quality Assurance committee will make recommendations and/or changes as needed. B) If findings result in staff not staying with the resident while she is toileting, the Administrator will counsel, in-service and	

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M 640	Continued From page 14 Report", dated 2/11/19, revealed the resident was in the bathroom and stood up by herself, and lost her balance, leaned against the wall and then slid to the floor. LPN #4 documented the CNAs were reminded that Resident #15 cannot be left alone in the bathroom and discussed with the Director of Nursing (DON). No injuries were reported on the incident report. The incident was documented as non-witnessed. An interview, on 8/14/19 at 2:43 PM, with LPN #1 revealed Resident #15 had a history of not calling for help when she would go to the bathroom, but that had improved now. LPN #1 said she did help when Resident #15 fell, on 4/11/19, but was not her nurse and couldn't recall who the aide was that day. An interview, on 8/14/19 at 3:28 PM, with LPN #4, revealed she was present when Resident #15 fell on 2/11/19. She said she completed the incident report and said CNA #2 assisted Resident #15 to the bathroom, but left Resident #15 in the bathroom to answer another call light. LPN #4 said when CNA #2 came back to the bathroom, the resident was on the floor. LPN #4 said Resident #15 had no injuries. LPN #4 also said she was aware the resident's care plan said to stay with the resident while in the bathroom. LPN #4 said the expectation for nurses and aides was to follow the care plan. An interview, on 8/14/19 at 2.51 PM, with CNA #2, revealed she said she was Resident #15's CNA when she fell on 2/11/19. CNA #2 said she helped Resident #15 to the toilet in the bathroom and had heard a call light that had been "going off for about 5 minutes" and went to answer it. CNA #2 said she asked Resident # 15 to not get up and that she would return. CNA #2 said when	M 640	discipline staff when necessary. C) Other residents that have falls will continue to be assessed by the Quality Assurance Nurse and the Interdisciplinary Team and new interventions will be put into place to prevent future falls. The Staff will be educated on new interventions and resident care plan amended to reflect the new intervention. 5. These corrective actions were completed on 9/12/19.	

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M 640	Continued From page 15 she got back, Resident #15, was leaning on the wall by the hand rail on the floor. CNA #2 said she was aware Resident #15's care plan said the resident needed to have someone to stay with her in the bathroom, but she knew the other staff members were busy with other residents and wanted to answer the light. CNA #2 said she had received education and had not left the resident by herself anymore. A review of a facility's "In-Service Meeting", dated 2/6/19, revealed CNA #2 attended the education related to fall prevention safety. An interview, on 8/15/19 at 8:36 AM, with Resident #15, revealed she stated she was helped and that no one has left her alone in the bathroom. Resident #15 said this place was a good home. She also said she was getting in her recliner this morning from her wheelchair, and a nurse walked by and reminded her not to get up without calling for help. An interview, on 8/15/19 at 9:31 AM, revealed the DON said CNA #2 was instructed and educated after the fact with a write up in her file for not following the care plan resulting in a fall. Review of the Face Sheet revealed Resident #15 was admitted by the facility, on 10/23/12, with diagnoses that included Parkinson's Disease and Tremors. Review of Resident #15's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/4/19, revealed a Basic Interview for Mental Status (BIMS) was coded a 15, which indicated no cognitive impairment.	M 640		