STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFIGATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	1315 S UNIVERSITY DR FARGO, ND 58103

(X4) ID 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 For the complaint investigation, conducted September 16-17, 2014, the sample included (5) five current residents for review.	F 000	Fargo Plan of Correction for complaint survey conducted on 9/16/14. The statements on this plan of correction are not admittances to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take action as set forth in the following plan of correction. The plan of correction constitutes the center's assertion of compliance. All alleged deficiencies cited have been or will be corrected by dates indicated.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Ellerine	Administrator	11-5-14

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to report 1 of 1 alleged incident of neglect (involving Resident #5) immediately to the state survey and certification agency and also failed to report the results of the investigation within five working days. Failure to report and thoroughly investigate all alleged violations involving neglect has the potential to place all residents at risk of possible neglect. Findings include: Review of the facility policy titled "Abuse" occurred on 09/16/14. This policy, dated 2011, stated, "'Abuse' means the willful infliction of injury . . . with resulting physical harm, pain . . . . 'Neglect' means failure to provide goods and services necessary to avoid physical harm . . . The center must ensure that all alleged violations involving mistreatment, neglect or abuse . . . are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures (including to the state survey and certification agency). . . . The results of all investigations must be reported to the administrator or his/her designated respresentative and to other officials in acccordance with state law (including the state survey and certification agency) within 5 working days of the incident. . . ."	F 225	F225 ManorCare Fargo strives to report cases of neglect in accordance with State law. The CNA that failed to follow Resident # 5's plan of care is no longer employed by the center. Residents residing at ManorCare have potential to be effected by this practice. Education to interdisciplinary staff members on identifying and reporting neglect was initiated on 10/02/2014 and will be completed with staff by 10/30/14. ADNS or designee will conduct random audits weekly times six weeks, then monthly times two months, then quarterly times two quarters to ensure cases of neglect are reported and investigated in accordance with State law. Quality Assurance was initiated on 9/30/14, revisited on 10/24/2014, and will be ongoing as per center routine and as outlined above.	

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F 225	Continued From page 2 - Review of Resident #5's medical record occurred on September 16-17, 2014. Diagnoses included Alzheimer's disease, Meniere's disease, muscle weakness, difficulty walking, and history of falls. The annual Minimum Data Set (MDS), dated 12/03/13, identified severely impaired cognitive skills, extensive assistance of two or more people required for transfers, and two falls with injury. The incident report, dated 01/20/14, identified, ". . . Brief description of incident: CNA [certified nurse assistant] approached nurse stating pt [patient] was on the floor in the shower room. CNA states her and one other CNA were transferring him to his w/c [wheelchair] after his shower and pt would not hold himself up and they had to lower him to the floor. . . . .Type of injuries: Cut to LLE [left lower extremity] . . . Immediate action taken by center: Checked CP [care plan] . . . on transfer status of pt. Pt to be a Hoyer lift for shower chair transfers . . . CNA involved [with] lift to have education and a written warning. [The report failed to address actions taken with the second CNA involved in the incident.] Staff education to be provided [with] other CNA's on reviewing the kardex/task lists [considered part of the care plan] of each pt [at] the beginning of their shift. . . . Disposition: 2nd written warning for CNA for not following task list for transfers. Investigation done [and] CNA terminated. It is unclear why the facility terminated the CNA if they did not consider her actions neglectful." During an interview on 09/16/14 at 4:00 p.m., two administrative staff members (#1 and #2) reported the two CNAs providing cares failed to follow Resident #5's care plan (using a Hoyer lift	F 225	Audits will be forwarded to the QAPI committee for further recommendations and actions based on findings. ADNS or designee responsible for compliance by 10/30/14.	

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F 225	Continued From page 3 to transfer Resident #5 from the shower chair). Instead, they attempted to stand-pivot Resident #5 into his wheelchair. The two administrative staff members (#1 and #2) confirmed they expect CNAs to read the care plan prior to providing cares to a resident. When asked why the 01/20/14 incident had not been reported to the State, they replied, "It wasn't neglect. There was no intent to harm the resident." When asked if the CNAs' failure to follow the resident's care plan (which resulted in the resident being lowered to the ground and obtaining a cut to his left leg) met the definition of neglect, the two administrative staff members (#1 and #2) replied, "Yes," and agreed it should have been reported to the State. Failure to report the incident (involving two CNAs who failed to follow the resident's care plan and resulted in him being lowered to the ground and obtaining a cut to his left leg) limited the facility's ability to ensure the safety of Resident #5 and placed all residents at risk of possible neglect and/or physical injury.	F 225		
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	F 280		

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F 280	Continued From page 4 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. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 1 of 5 sampled residents (Resident #1). Failure to revise the care plan limited staff's ability to communicate care needs and ensure continuity of care. Findings include: Review of the facility policy titled "Interdisciplinary Care Planning" occurred on 09/16/14. This policy, dated 2011, stated, ". . . The interdisciplinary team designs the patient's care plan to focus on all of the patient's issues including those associated with fall prevention and fall risk management. . . . Caregivers are also asked for suggestions about interventions they have successfully used in managing a patient's fall risk. . . ." - Review of Resident #1's medical record occurred on September 16-17, 2014. Diagnoses included cerebrovascular accident (CVA), dementia, muscle weakness, and history of falls. The admission Minimum Data Set (MDS), dated 07/21/14, identified moderately impaired cognitive	F 280	F280 ManorCare Fargo strives to ensure that all residents using specialty chairs are indicated as such in their plan of care. Resident #1's care plan was assessed and updated to reflect her specialty chair as appropriate. Residents who use specialty chairs have potential to be effected by this practice. Care plans were reviewed and revised when indicated for these residents. ADNS or designee to educate Nurse Supervisors on revising the care plan to communicate care needs and ensure continuity of care. Education was initiated on 10/02/14 and will be completed by 10/30/14. Nurse supervisors on PRN or leave status will complete education prior to working in the facility.	

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F 280	Continued From page 5 skills, extensive assistance of two or more people required for bed mobility and transfers (due to being unsteady, only able to stabilize with staff assistance when transferring surface-to-surface). The "Fall" Care Area Assessment (CAA), dated 07/22/14, identified, ". . . Physical Performance Limitations: difficulty maintaining sitting balance . . . impaired balance during transitions. . . ." The care plan identified the following: * 07/15/14, "Focus: ADL Self care deficit as evidenced by weakness related to physical limitations . . . Interventions: . . . Assist to bathe/shower as needed, Assist with . . . eating as needed . . . Encourage and/or assist to reposition frequently, Transfer with mechanical lift with 2 assist." The progress note identified the following: * 07/18/14 at 4:42 p.m., ". . . Pt [patient] . . . sitting in broda chair. . . ." * 08/06/14 at 11:36 a.m., ". . . Staff notified me that pt just fell out of her w/c [wheelchair]. I went to see the pt right away and see pt lying on the floor facing down. She has a golf ball size hematoma in the middle of her forehead. She also has mild swelling and bleeding in the upper lip, and 1 cm [centimeter] long superficial cut in the nose, between her eyebrows. . . . Pt reports having pain in the forehead at this time. She is alert, oriented to self and family members. She doesn't remember the incident and why she fell. Staff states pt was placed in a different w/c today and not her usual one, and the new one is easy for her to get out as she doesn't want to sit in the w/c. . . ." The fall incident report, dated 08/06/14, identified, ". . . Patient was placed in her own personal	F 280	ADNS or designee will conduct random audits weekly times six weeks, then monthly times two months, then quarterly times two quarters to ensure appropriate care plans for those using specialty chairs. Quality Assurance was initiated on 09/30/14, reviewed 10/24/14 and will be ongoing as per center routine and as outlined above. Audits will be forwarded to the QAPI committee for further recommendations and actions based on findings. ADNS or designee responsible for compliance by 10/30/14.	

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F 280	Continued From page 6 wheelchair and not the Broda chair assigned to her. . . . A note was placed on the wheelchair not to use it and to use the Broda chair." During an interview on 09/16/14 at 4:00 p.m., three administrative staff members (#1, #2, and #3) reported the facility failed to care plan for the Broda chair prior to Resident #1's fall on 08/06/14, and placed the wheelchair "in storage" after the fall. They stated, "They [therapy staff] tried a wheelchair, but she wouldn't/couldn't hold herself up, too weak, so she used a Broda. She was in a Broda chair on admit [admission to the facility]. She was always in a Broda chair." The administrative staff member (#1) added, "I thought everyone knew. I don't remember a time she didn't have a Broda chair. From the first day of therapy, they knew it wasn't feasible for her not to be in a Broda [chair]." The administrative staff member (#1) provided additional information to the state survey and certification agency. She stated, ". . . The Broda chair was being used as an alternative place for [Resident #1] to sit in order to help encourage her to get out of bed after she was witnessed slumped forward in her regular wheelchair . . . Nursing staff members stated that she appeared more comfortable in the Broda chair and was more willing to sit up if it was being used." Resident #1's care plan failed to reflect her use of the Broda chair secondary to her lack of muscle strength and inability to maintain sitting balance, and per her personal preference.	F 280		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interviews, the facility failed to provide adequate supervision and assistive devices for 2 of 5 sampled residents (Resident #1 and #5) who experienced falls in the facility. Failure to utilize the Broda chair resulted in Resident #1's having an avoidable fall, and resulted in her hematoma, mild swelling, bleeding, superficial cut, and bruising to her face. Failure to ensure staff utilized a Hoyer (full body) lift placed Resident #5 at risk of falling and resulted in the cut to his leg. Findings include: Review of the facility policy titled "Falls Practice Guide Flowchart" occurred on 09/16/14. This policy, dated 2011, stated, ". . . Assess . . . Develop/revise initial or interdisciplinary care plan as applicable . . . initiate/update patient information worksheet, kardex, task list . . . Staff education . . ." - Review of Resident #1's medical record occurred on September 16-17, 2014. Diagnoses included cerebrovascular accident (CVA), dementia, muscle weakness, and history of falls. The admission Minimum Data Set (MDS), dated	F 323	F323 ManorCare Fargo strives to provide adequate supervision and assistance devices to prevent accidents. The CNA that failed to follow resident #5's plan of care is no longer employed by the center. Resident #1's care plan was assessed and updated to reflect her specialty chair as appropriate. Residents residing at ManorCare have potential to be effected by this practice. Care plans were reviewed and revised when indicated for these residents. Direct care staff education was initiated 10/02/14 regarding following care plans and updating resident's plan of care if suitable due to a change in condition to ensure staff utilizes assistance devices as appropriate. Education will be completed by 10-30-14. Direct care staff on PRN or leave status will be educated prior to providing care and services.	

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F 323	Continued From page 8 07/21/14, identified moderately impaired cognitive skills, extensive assistance of two or more people required for bed mobility and transfers (due to being unsteady, only able to stabilize with staff assistance when transferring surface-to-surface). The "Fall" Care Area Assessment (CAA), dated 07/22/14, identified, ". . . Physical Performance Limitations: difficulty maintaining sitting balance . . . impaired balance during transitions. . . . Risk Factors: . . . cognitive impairment . . . dementia . . . loss of arm or leg movement (following CVA) . . ." The care plan, dated 07/15/14, identified, "Focus: ADL Self care deficit as evidenced by weakness related to physical limitations . . . Interventions: . . . Assist to bathe/shower as needed, Assist with . . . eating as needed . . . Encourage and/or assist to reposition frequently, Transfer with mechanical lift with 2 assist." The progress note identified the following: * 07/18/14 at 4:42 p.m., ". . . Pt [patient] . . . sitting in broda chair. . . ." * 08/06/14 at 11:36 a.m., ". . . Staff notified me that pt just fell out of her w/c [wheelchair]. I went to see the pt right away and see pt lying on the floor facing down. She has a golf ball size hematoma in the middle of her forehead. She also has mild swelling and bleeding in the upper lip, and 1 cm [centimeter] long superficial cut in the nose, between her eyebrows. . . . Pt reports having pain in the forehead at this time. She is alert, oriented to self and family members. She doesn't remember the incident and why she fell. Staff states pt was placed in a different w/c today and not her usual one, and the new one is easy for her to get out as she doesn't want to sit in the w/c. . . ."	F 323	Random audits weekly times six weeks, then monthly times two months, then quarterly times two quarters will be conducted by the ADNS or designee to ensure care is provided in accordance with the plan of care and that all specialty chairs are care planned. Quality Assurance was initiated on 9/30/14, reviewed on 10/24/14, and will be ongoing as per center routine and as outlined above. Audits will be forwarded to the QAPI committee for further recommendations and actions based on findings. ADNS or designee responsible for compliance by 10/30/14.	

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F 323	Continued From page 9 * 08/06/14 at 4:16 p.m. (Nursing staff documented additional information regarding Resident #1's earlier fall.), "Patient was assisted in to her wheelchair by Nursing Assistant. Nursing Assistant locked the breaks on the wheelchair. . . . Approximately 20 minutes later, at 11 a.m. patient was found on the floor. She was laying on her stomach, face down in front of her wheelchair. Blood was observed by Patient's head near her face. . . . . NP [nurse practioner] notified and assessed the patient. Blood determined to be coming from the Patient's upper lip on the inside. Resident was assisted in to bed with a mechanical lift and 2 staff. ROM [range of motion] done to upper and lower extremities in bed without difficulty. Patient observed to have a hematoma in the middle of her forehead. Hematoma the size of a small egg (approximately). Due to fall being unwitnessed Neuro checks started. . . . Patient was cleaned up and Ice pack applied to Hematoma. . . ." * 08/06/14 at 11:13 p.m., ". . . bruises on face from falls. . . c/o [complained of] pain in mouth due to falls. . . ." The physician's orders identified the following: * 08/06/14, "Ice Pack to forehead area for swelling hematoma secondary to fall. Applied Q 2 [hours] while awake - 20 min [minutes] every time." * 08/06/14, "Hold Coumadin due to bruises on face." The fall incident report, dated 08/06/14, identified, ". . . Patient was placed in her own personal wheelchair and not the Broda chair assigned to her. Personal wheelchair placed in patient's bathroom. In the bath tub in her room. A note was placed on the wheelchair not to use it and to use	F 323		

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F 323	Continued From page 10 the Broda chair." The progress notes identified the following: * 08/07/14 at 12:31 p.m., ". . . Pt fell yesterday from sitting in the w/c. . . . Pt has new bruises in her face, under and upper eye orbital area. Bruises showed up today from fall yesterday. . . . pain secondary to hematoma forehead . . . swelling has reduced significantly. cont. with ice pack to the area q [every] 2 hr [hours] while awake to the area as well as face/ye [sic] area if pt allows. start Tylenol 650 mg [milligrams] BID [twice daily] for 3 days . . . We also talked about the fact the pt is on Coumadin . . ." * 08/07/14 at 11:35 p.m., ". . . Neuro-checks wnl [within normal limits] and patient when asked about pain pointed to areas around eyes. Site a little swollen. Ice pack used every 2 hours on fore head as ordered and prn [as needed]. Tylenol given x 1 with some relief noted. . . ." The care plan, dated 08/07/14, identified, "Focus: ADL Self care deficit as evidenced by weakness related to physical limitations . . . Interventions: . . . BRODA chair for locomotion." The facility failed to care plan for the Broda chair prior to Resident #1's fall. The progress notes identified the following: * 08/08/14 at 8:27 a.m., ". . . Pt fell 2 days ago from sitting in the w/c. Her hematoma in the forehead stays stable, smaller in size and less swelling. . . . When assessing today pt states she has pain a little pain in the right shoulders but able to move arms and shoulder at her base line with no problems. Her bruises in her face, under and upper eye orbital are [sic] present and slightly edematous under the eyes. . . ." * 08/12/14 at 8:48 a.m., ". . . Pt fell last week	F 323		

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F 323	Continued From page 11 while sitting in the w/c. . . . Her hematoma in the forehead is getting smaller. She cont to have bruises present in facial area. some of it is fading. . . . pain secondary to hematoma forehead . . . swelling in forehead cont to reduce significantly. . . . cont [continues] Tylenol 650 mg BID and q 6 hrs prn for now . . ." * 08/13/14 at 1:13 p.m., "pt is an assist of two with transferring and bed mobility. pt is dependent on staff for eating. . . . ice applied x 3 to head. . . ." The physician's order, dated 09/02/14, identified, "DC ice pack to forehead." During the initial tour on 09/16/14 at 11:30 a.m., Resident #1 was observed from the doorway to her room as she lay in the dark in bed. The resident showed bruising to her forehead/face. During an interview on 09/16/14 at 4:00 p.m., three administrative staff members (#1, #2, and #3) reported "Resident #1's family brought her personal wheelchair [even though she utilized a Broda chair at the facility]. [Resident #1's] Broda [chair] was in the hallway outside her room. The CNA monitoring her hall [walked past the Broda chair, entered her room, and] put her into the wheelchair." The three administrative staff members (#1, #2, and #3) further reported the facility failed to care plan for the Broda chair prior to Resident #1's fall, and placed the wheelchair "in storage [the bathroom]" after the fall. They stated, "[Resident #1] was so weak, [she was] not able to hold herself up. They [therapy staff] tried a wheelchair, but she wouldn't/couldn't hold herself up, too weak, so she used a Broda. She was in a Broda chair on admit [admission to the facility]. She was always in a Broda chair. She had no muscle strength, very, very weak." The	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 12	F 323		

administrative staff member (#1) added, "I thought everyone knew. I don't remember a time she didn't have a Broda chair. From the first day of therapy, they knew it wasn't feasible for her not to be in a Broda."

The daily work assignment sheets, dated 07/17/14 - 08/06/14, identified the CNA who transferred Resident #1 into the wheelchair (versus Broda chair) worked on the South Unit (where Resident #1's room was located) on 11 of the 21 days prior to the fall.

The administrative staff member (#1) provided additional information to the state survey and certification agency. She stated, ". . . We were being asked by [Resident #1's] family to strongly encourage her to sit up in a chair instead of lying in bed all day. According to [Resident #1's son], the Broda chair was in her room shortly after [Resident #1] was admitted to the facility. The Broda chair was being used as an alternative place for [Resident #1] to sit in order to help encourage her to get out of bed after she was witnessed slumped forward in her regular wheelchair . . . Nursing staff members stated that she appeared more comfortable in the Broda chair and was more willing to sit up if it was being used."

The facility failed to ensure staff utilized the Broda chair with Resident #1, thereby reducing her risk of falls. The medical record contained documentation to indicate Resident #1 was unsteady and had difficulty maintaining sitting balance. Information provided on 09/23/14, indicated the Broda chair was utilized after staff witnessed Resident #1 slumped forward in the regular wheelchair, and described Resident #1 as

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F 323	Continued From page 13 "appearing more comfortable in the Broda chair and more willing to sit up if it was being used." Staff interviews confirmed Resident #1 utilized a Broda chair since admission due to her having "no muscle strength" and being "unable to hold herself up." Documentation further showed the CNA who transferred Resident #1 into the wheelchair had worked on the unit 11 of 21 days prior to the fall and therefore would have seen Resident #1 in the Broda chair on previous occasions. It is unclear why the facility removed the regular wheelchair if they felt the it's continued use was safe for Resident #1. - Review of Resident #5's medical record occurred on September 16-17, 2014. Diagnoses included Alzheimer's disease, Meniere's disease, muscle weakness, difficulty walking, and history of falls. The annual Minimum Data Set (MDS), dated 12/03/13, identified severely impaired cognitive skills, extensive assistance of two or more people required for transfers (due to being unsteady, only able to stabilize with staff assistance when transferring surface-to-surface), and two falls with injury. Resident #5's care plan stated, "Focus: At risk for falls . . . history of falls. . . Interventions: . . . Utilize hoyer lift for transfers to and from shower chair . . ." The progress note identified the following: * 01/20/14, "CNA [certified nurse assistant] approached nurse stating pt [patient] was on the floor in the shower room. CNA states her and one other CNA were transferring him to his w/c [wheelchair] after his shower and pt would not hold himself up and they had to lower him to the floor. Pt was wearing his shoes. A 1 in [inch] cut	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 09/17/2014

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F 323	Continued From page 14 is noted on his lower left leg. . . . Pt did not hit his head. ROM [range of motion] WNL [within normal limits]. Pt assisted in to w/c via hoyer lift. . . . Will continue to monitor." * 01/21/14 at 11:07 p.m., "New order . . . Steristrips and tegaderm to LLE [left lower extremity] skin tear change Q [every] 7 days and PRN [as needed] until resolved." * 02/07/14 at 1:15 a.m., "skin check done no skin issues noted . . ." The incident report, dated 01/20/14, identified, ". . . Brief description of incident: CNA approached nurse stating pt was on the floor in the shower room. CNA states her and one other CNA were transferring him to his w/c after his shower and pt would not hold himself up and they had to lower him to the floor. . . . Type of injuries: Cut to LLE . . . Immediate action taken by center: Checked CP [care plan] [and] task list/kardex on transfer status of pt. Pt to be a hoyer lift for shower chair transfers [and] a standing lift for all other transfers. . . . Will obtain treatment orders for pt's LLE cut. CP updated on presence of cut/open area. . . ." During an interview on 09/16/14 at 4:00 p.m., two administrative staff members (#1 and #2) reported the two CNAs providing cares failed to follow Resident #5's care plan (using a Hoyer lift for transfer from the shower chair). Instead, they attempted to stand-pivot Resident #5 into his wheelchair. The two administrative staff members (#1 and #2) confirmed they expect CNAs to read the care plan prior to providing cares to a resident. The facility failed to utilize the Hoyer lift to transfer Resident #5 to/from the shower chair resulted in	F 323		

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F 323	Continued From page 15 an injury to his leg.	F 323		