DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	03/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58701

(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 standard Medicare/Medicaid recertification survey started on March 14, 2011 and completed on March 17, 2011, the sample included five (5) residents for complete review, 22 residents for focused review, and three (3) closed records for review. The sample included five (5) additional residents to verify specific concerns during the survey.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to provide an environment that promotes resident's dignity on 4 of 4 days of survey (March 14, 15, 16, and 17, 2011). The facility failed to provide an environment that respects each residents need for individual dignity, when providing cares such as; meal assistance, privacy during personal cares, and transporting a resident to their room after a shower Findings included: - An observation on 03/14/11 at 1:30 p.m., showed an unidentified staff member enter Resident #36's room without knocking or announcing themselves. A few minutes later, a second unidentified staff member entered the same room, also failing to knock or announce	F 241	Education and inservices provided to all staff regarding the importance of knocking on resident doors before entering, and announcing to resident that they are entering the room; feeding techniques, appropriate behavior and treating residents with respect and dignity. Employees involved in the inappropriate behavior with transporting a resident back to her room received written education and counseling. All residents have potential to be affected. Staff has been inserviced on knocking & waiting for reply, or announcing to resident that they are coming in to the resident room. Education also provided to staff in how to appropriately feed a resident, e.g. not "scraping" food from the residents face, and not using the clothing protector the resident is wearing to wipe away excess food, and resident dignity. Random observations on each of these areas will be made to insure staff is complying with these areas. Observations will be done weekly and reported monthly to the QA Committee until compliance is obtained. Once compliance is obtained, monthly observations with quarterly reporting will be done. The Director of Nursing will be responsible for this process. Date of Correction: April 8, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rhonda Lanberg	RN Administrator	4/08/2011

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

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F 241	Continued From page 1 themselves. - During an observation of Resident #14's personal cares, on 03/15/11 at 10:20 a.m., a certified nursing assistant (CNA) (#9) failed to knock or announce herself before entering the resident's room. The CNA (#9) opened the door, walked in and looked around the curtain and then left. - Observations during the noon meal on 03/15/11 from 12:15 to 12:30 p.m., showed a CNA (#7) assisting Resident #34 with the meal. Several times the staff member fed the resident a pureed meal with a spoon, scraped food from around the resident's mouth, returned it to the bowl, and continued to feed the resident from the bowl. - Observation during the noon meal on 03/15/11 from 12:15 to 12:30 p.m., showed a CNA (#9) assisting Resident #35 with the meal. Several times the staff member fed the resident a pureed meal with a spoon, scraped food from around the resident's mouth, returned it to the bowl, and continued to feed the resident from the bowl. - During observations on 03/16/11 at 7:50 a.m., while standing at the end of the hall, the surveyor heard a noise in the joining hall, similar to someone running. The observation revealed two CNAs (#7 and #8) holding on to the shower chair and pushing Resident #33 quickly down the hall. One of the CNAs stated "vroom hold on (resident's name)," and quickly took the resident into her room and shut the door. During an interview on 03/17/11 at 10:40 p.m., after being informed of the observation on 03/16/11 at 7:50 a.m., an administrative staff	F 241		

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F 241	Continued From page 2 member (#1) stated, "that behavior is not acceptable." - A random observation, at 9:15 a.m. on 03/17/11, showed a nursing staff member feeding a resident in the 4-East dining room. Observation showed the nurse lifting the resident's clothing protector up to the resident's face several times to wipe food from the sides of the resident's mouth.	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to assess specific resident behaviors for precipitating factors and develop and implement/revise appropriate interventions, as necessary for 1 of 2 residents (Resident #19) identified as repetitively asking questions and wandering on/off unit. Failure to address and monitor Resident #19's behaviors has resulted in her agitating/angering other residents, intruding on their privacy, and wandering off the unit, and placed her at risk for injury due to falls or retaliation by another resident. Findings include: - Random observations made March 14-17, 2011, showed Resident #19 wandering up and down the	F 250	Resident # 19 is now residing on the Alzheimer's Unit. The Wandering Risk Assessment has been updated to include a definition of wandering and a comment box to document actions and interventions. Any resident that develops wandering behaviors are at risk for harm from other residents and/or at risk of harming themselves. All residents have the potential to be affected. The wandering assessment in the electronic record has been modified to insure that this assessment will be completed and give the information needed to all staff. Nursing, Social Services, and family will meet to discuss an appropriate plan of action for the resident, which will include appropriate interventions and relocation of residents who fall into this category. All residents who have had a wandering assessment completed will have this information brought to the weekly falls meeting for discussion and planning on the appropriate steps to be taken. Education on this change in practice provided to Nursing and Social Services.	

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F 250	Continued From page 3 2 East hallways, looking into/entering other residents rooms and/or the nurses station, and requesting "help" from staff, other residents, and visitors. - On 03/15/11 at 4:00 p.m., two unidentified nursing staff members sat in the nurses station discussing Resident #19. They stated, "We looked all over for [Resident #19's] foot-rest. She wandered into [another 2 East Resident's] room and hung it on the register in her room and left. Isn't that cute. We've been looking all over for it [the foot-rest]." Review of Resident #19's medical record occurred on March 14-17, 2011. Diagnoses included dementia, depression, anxiety and insomnia. The Minimum Data Set (MDS), dated 09/11/10, identified long-term and short-term memory problems and severely impaired daily decision making skills, and the MDS, dated 02/06/11, identified continuous inattention and disorganized thinking, behaviors that significantly intrude on the privacy or activity of others and significantly disrupt care or the living environment, total assist of 1 person with locomotion on/off unit, and a fall within the last 2-6 months. Review of the MDS: Care Area Assessment (CAA) for Resident #19, dated 02/08/11, stated, "Falls: . . . She will propel herself short distances but staff propels her long distances. She has poor safety awareness due to dx [diagnosis] of Dementia and uses a bed and chair alarm for safety. Staff will cont. [continue] to monitor her safety and assist her per her request and as needed with transferring and mobility. . . ." Review of Resident #19's current care plan, dated	F 250	Weekly QA audits will be completed by Social worker and results will be shared with DON and Nurse Managers. Inservices given to all employees. The Social Service Department Manager will be responsible for this process. Date of correction: April 8, 2011	

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F 250	Continued From page 4 03/17/11, stated, "Problem: . . . Behavior - anxiety/repetitive questioning, wandering, . . . disruptive to others, sleep issues . . ." The care guide, dated 03/17/11, also stated, "Behavior Approaches . . . Redirect from inappropriate behavior. Provide re-orientation . . . Monitor agitation/restlessness . . . Monitor anxiety . . . Document . . . behaviors." Review of Resident #19's "Nursing Progress Notes" showed the following: 08/31/10 to 12/05/10 - 3rd Floor * 09/01/10 at 2:02 p.m. - ". . . Uses wheelchair for primary mobility -- propels self. Resident wanders around unit, going in and out of other resident's rooms. Unable to redirect due to poor memory and cognition . . ." * 10/03/10 at 5:00 p.m. - "Resident has been going up and down the halls all afternoon repeatedly saying help, help. . . . is not redirectable. Other resident's [sic] are getting angry and agitated with her. When other resident's [sic] move to get away from her, she will tend to follow them. Ativan and Tramadol have no effect on behaviors. . . ." * At 10:19 p.m. - "CNA reports resident wandering in another unit on same floor this evening. resident was retrieved and re oriented to floor. resident continued to wander the corridor on the floor seeking help. . . ." * 10/14/10 at 4:30 a.m. - ". . . resident did calm down after a while but went into another residents [sic] room and was yelled at by her for coming into her room in the middle of the night. . . ." * 12/05/10 at 9:21 p.m. - "Resident found on floor in back hallway. . . ." 02/12/11 to 02/28/11 - 2nd Floor * 02/12/11 at 12:54 p.m. - "Resident wandered off unit x 2 thus far this shift. . . ." * At 1:26 p.m. - "Wandered to 2 South again; 2S	F 250		

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F 250	Continued From page 5 nurse transported her back to 2E. . . . difficult to redirect." * At 6:39 p.m. - "wandered to 2W x 1, 2W nurse wheeled her back . . . then she wandered some here on floor . . ." * 02/13/11 at 11:35 a.m. - "Wandered off unit x 1 thus far this shift. . . ." * At 5:36 p.m. and at 7:53 p.m. - "Wandered off unit x 1 this shift. . . ." * 02/14/11 at 11:00 a.m. - ". . . difficult to redirect today." * 02/28/11 at 7:13 p.m. - "Continues to propel self about on unit with w/c. Does occasionally wander to anther [sic] unit [and] brought back by personal [sic]. . . ." Review of Resident #19's "Falls Documentation", dated 10/27/10, identified the ". . . Fall was not witnessed, resident of room 336 came to desk to report a woman was in her room . . ." Review of Resident #19's "Summary of Responses to Wandering Risk Assessment" identified the following: 10/01/10 to 12/20/10 - 3rd Floor * 10/01/10 - "Wandering up and down the halls and into other residents rooms." * 10/03/10 - "around unit and into aother [sic] residents room. . . . asks every passing person repeatedly 'can you help me again and again.'" * 10/06/10 - "around unit and trying to get into other resident's rooms. . . . Resident wandering in and out of other resident's rooms, found on 3 west." * 10/07/10 - "Resident wonder [sic] in and out of other residents roon [sic] and was brought back from 3 West by CNA. . . . wandering around unit, redirected out of other resident's rooms several times."	F 250		

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F 250	Continued From page 6 * 10/12/10 - "Resident wandering up and down halls and in and out of other resident's rooms. . . . wandering up and down halls, but stayed on unit for this shift." * 10/14/10 - "Resident continues to go in and out of other residents room at night, had to close door due to her trying to go off the unit." * 10/15/10 - "in and out of others room [sic]." * 10/16/10 - "Resident over to 3 south." * 10/19/10 - ". . . Resident shows signs of agitation . . . many attempts to reorient to floor but wandering continues." * 10/20/10 - "in and out of other room . . ." * 10/22/10 - "wandering down hallways, found in dining room late in the evening." * 10/28/10 - "around unit and into other resident's room" * 10/30/10 - ". . . in and out of rooms." * 11/02/10 - "wandering in and out of other residents rooms . . ." * 11/09/10 - "CNA brought her back from the south unit." * 11/10/10 - "found her over on the west unit." * 11/14/10 - "around unit and into other resident rooms" * 11/16/10 - "Wandering up and down the halls, trying to go into other resident's [sic] rooms." * 11/22/10 - "In and out of other resident's rooms. Was found once on 3 west." * 11/26/10 - "Up at 0400, wandering in and out of other resident rooms." * 12/01/10 - "staff found her on the west side asking about the elevator and how to get out of here. . . . found on 3 west per staff." * 12/06/10 and 12/09/10 - "around unit and into other resident rooms." * 12/12/10 - ". . . into other resident rooms and onto other units." * 12/19/10 - "Resident tried to get into elevator . .	F 250		

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F 250	Continued From page 7 " 02/12/11 to 03/17/11 - 2nd Floor * 02/12/10 - "x 2 off unit to south side . . . was on 2 w [and] wheeled back by 2 w nurse x 1 this shift." * 02/13/10 - "Resident wandered off to 2 W on wheelchair. Brought back to facility per nurse. . . . wandered off unit x 1 this shift." Review of Resident #19's "Summary of Responses to Behavior Tracking Intervention Assessment" identified the following: 09/19/10 to 12/20/10 - 3rd Floor * 09/19/10 - "Resident was anxious at lunch time. wandering around dining room, repetitively asking for help and multiple questions." * 09/27/10 - "resident was found in the chapel area around 2030." * 10/03/10 - ". . . Resident asks anyone (staff, other residents, guests) to 'help me again' . . . Targets people and follows them around . . ." * 10/26/10 - ". . . Her constant cry for help would disturb other residents around her." 02/15/11 to 03/17/11 - 2nd Floor * 02/15/11 - ". . . very anxious today . . . when she would get up she would wander into other residents rooms I took her out of the rooms and explained to her that she couldn't go into another residents room. While I was doing cares on a resident [Resident #19] opened the door and didn't want to get out of the room. she almost knocked the residents TV of [sic] his stand . . ." * 02/16/11 - "resident was going into other residents rooms which made them upset and also went off the floor to 2 south." During two interviews on 03/17/11 at 2:00 p.m. and 3:25 p.m., three nursing staff members (#4, #14 and #15) and one social services staff	F 250		

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F 250	Continued From page 8 member (#16) stated they were "unaware of what was going on, and of any other residents complaining about Resident #19 entering their rooms." One nursing staff member (#4) stated, "A couple of the other residents have asked that their doors be closed to prevent her from entering their rooms." Failure of the facility to assess the precipitating factors leading up to, or resulting in Resident #19's behaviors and wandering, develop and implement effective interventions, as well as revise them as necessary; resulted in the resident agitating/angering other residents, intruding on their privacy, and wandering off the unit, and placed the resident at risk for injury due to falls or retaliation by another resident.	F 250		
F 280 SS=E	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 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.	F 280	Care plans for residents #4, #5, #6, #17, and #23 have been re-done. All care plans and care guides have been reviewed and updated to reflect current plan of care. Care guides and care plans contain the same information needed to provide consistent care to the residents. Resident care plans are developed based on information obtained from current resident assessment and needs of the resident to provide optimum level of care. Care guides will follow care plans. All residents have the potential to be affected.	

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F 280	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise the residents' plan of care for 5 of 30 sampled residents (Resident #4, #5, #6, #17, and #23). Failure to revise the care plan/care guide has the potential for residents to receive inconsistent care and/or fail to receive ordered cares. Findings include: - On March 15-16, 2011, observations of Resident #4 included staff assisting the resident to complete her meal, a blackened ulcer to top of the third right toe, and a foot cradle on her bed. Review of Resident #4's medical record occurred on March 15-17, 2011. Diagnoses included left below-the-knee amputation, peripheral artery disease with ulceration to right lower extremity, peripheral vascular disease (PVD), convulsions, and history of brain cancer. Resident #4's careplan, dated 03/11/11, identified "Problem: Nutrition/Feeding - triggers for weight loss [at] 1, 3, 6 months . . . occasionally leaves 25% or more at meals, starts to feed self, staff finish feeding . . ." The current Care Guide listed, "Eating: Encourage independent food choices, Deliver & setup tray, Feeds self." The Care Guide failed to include the intervention for staff to finish feeding the resident. Resident #4's careplan, dated 12/21/10, identified "Problem: Convulsions. Goal: Seizures will be	F 280	Professional nursing staff and Care Plan Coordinator will review all resident care plans to insure all potential risks are addressed and interventions are in place to prevent potential risks. Education provided to nursing staff to follow plan of care and care guides for all residents. This education included communication to appropriate staff on follow through and communication on interventions in the plan of care, equipment changes, being specific and not giving "ranges" e.g. "transfer per one" OR "transfer per two", and identifying non-compliance by residents with appropriate interventions and documentation. Weekly observations and random review of care plans and care guides will be done to insure residents' needs are identified on the care plan and interventions are being communicated and followed by all staff. The DON, ADON. Nurse Managers and Care Plan Coordinator will be responsible to monitor all results. The Care Plan Coordinator will submit a report of the monitoring results to the QA Committee monthly. Date Completed: April 8, 2011	

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controlled with current medication. Approach: No Code [do not resuscitate]." The current careplan and/or Care Guide failed to include any monitoring/safety precautions related to seizures.

Resident #4's careplan, dated 01/04/11, identified,"Problem: Skin Integrity - potential for skin impairment related to diagnosis [PVD], occasional bladder incontinence, & needing help with mobility. Approach: . . . Monitor scab - 2nd toe Rt [right] foot till resolved daily . . . Keep foot dry et [and] clean - R [right] foot." The current careplan and Care Guide failed to address the ulcer on Resident #4's third right toe and lacked the intervention of a foot cradle on the bed.

A progress note from the Podiatrist, dated 02/23/11, noted severe PVD and an ulcer to Resident #4's third right toe.

During an interview on 03/17/11 at 10:30 a.m., an administrative nurse (#4) agreed the Care Guide should be updated with the current information such as the foot cradle and assisting the resident to eat, as the certified nurse aides (CNAs) follow the Care Guides to provide cares.

- Observations of Resident #5 on March 15-16, 2011 included an electric wheelchair in her room, isolation cart by the door, staff gowning and gloving as needed, snack crackers, candy, and regular soda pop in the resident's room, breakfast uneaten, and use of heel protector foam boots.

Review of Resident #5's medical record occurred on March 15-17, 2011. Diagnoses included diabetes, paraplegia, and pressure ulcer. The resident's blood sugars from March 8-15, 2011 ranged from 199 to 498.

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F 280	Continued From page 11 Resident #5's Care Guide, dated 03/15/11, identified the area, "Ambulation: Non-ambulatory, Uses manual wheelchair, Self-propels wheelchair . . ." The current careplan and Care Guide failed to identify Resident #5's use of an electric wheelchair. Resident #5's careplan, dated 03/14/11, identified, "Problem: Infection Precautions - VRE [Vancomycin resistant enterococcus] . . ." The current Care Guide failed to indicate isolation precautions in place for Resident #5. Resident #5's careplan, dated 03/14/11, identified "Problem: Behavior - . . . exhibited verbal and physical abuse towards another resident." The current careplan and Care Guide failed to include interventions to prevent further abuse. Resident #5's careplan, dated 03/03/11, identified, "Problem: Nutrition/Feeding. Approach: . . . Diet - ADA [American Diabetic Association]." The current Care Guide listed, "Eating: Encourage independent food choices, Deliver & setup tray, Encourage intake of fluids." The current careplan and Care Guide failed to address interventions to increase compliance with a diabetic diet. Resident #5's careplan, dated 03/03/11, identified, "Problem: Skin Integrity. Approach: . . . Monitor Skin - right outer foot and ball of foot . . . Monitor Skin - left heel 5x [by] 4cm [centimeter] healing open area where blister was . . ." The current careplan and Care Guide failed to include the intervention of heel protector foam boots. During an interview on 03/17/11 at 9:40 a.m., an	F 280		

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	355074	A. BUILDING _____ B. WING _____	03/17/2011

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F 280	Continued From page 12	F 280		

administrative nurse (#4) stated Resident #5 mainly uses the electric wheelchair and is noncompliant with a diabetic diet, and agreed Resident #5's careplan/Care Guide had not been updated with all interventions.

- On 03/15/11 at 10:00 a.m., observation showed a CNA student (#10) assisted Resident #6 to stand and pivot from the bed to the wheelchair, with a second CNA (#11) in the room. At 11:02 a.m., a CNA (#12) assisted the resident to stand and pivot from the wheelchair into his bed. At 3:23 p.m., a CNA (#13) assisted Resident #6 to stand from the bed and pivot into the wheelchair.

Review of Resident #6's medical record occurred on March 15-17, 2011. Diagnoses included PVD and right below-the-knee amputation.

Resident #6's careplan, dated 01/10/11, identified, "Problem: Transferring - self care deficit - requires extensive assistance. Goal: Resident will transfer safely with 1 or 2 staff assist." The current Care Guide identified two conflicting interventions for transfers: assist of "2" and assist of "1-2."

- Observation of Resident #17 on March 14-17, 2011 included an isolation cart by the door and isolation signage on the outside of the resident's door.

Review of Resident #17's medical record occurred on all days of survey. Diagnoses included dementia, hemiplegia, and diabetes.

Resident #17's current care plan, dated 03/15/11, stated "Problem: Infection Precautions - . . . identify positive for MRSA [methicillin-resistant

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F 280	Continued From page 13 Staphylococcus aureus] and VRE. The care plan failed to address any goals, interventions or indicate isolation precautions in place for Resident #17 regarding the infection precautions. The care guide failed to indicate isolation precautions. - Review of Resident #23's medical record occurred on 03/17/11: Diagnoses included dementia and history of hip fracture. The resident's fall documentation records showed three falls in the last four weeks. Resident #23's current care plan, dated 03/17/11, stated, "Problem: Safety - fell on 10-18-09 & [and] fractured left hip; potential for further injury from falls. Goal: Resident will remain free from any further fall-related injury. Approach: ADL [activities of daily living] Safety . . . every month PRN [as needed], Falls Doc. [documentation] PRN, and Chair Alarm: Two times daily." The care plan failed to address specific interventions to maintain safety and prevent falls.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 and staff interview, the facility failed to ensure safety and	F 323	Staff involved in this incident have been counseled and educated on the process of work orders, and the importance of replacing defective equipment. All residents who have adaptive equipment in place, and are at risk for falls, have the potential to be affected.	

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F 323	Continued From page 14 supervision for 1 of 1 resident (#16) who experienced a fall. Findings include: Observation on 03/15/11 at 10:30 a.m., showed a Certified Nursing Assistant (CNA) (#17) attempting to coax Resident #16 to his room to check for incontinence. The resident refused. Observation showed no chair alarm attached to the back of the wheelchair. Observation on 03/15/11 at 2:52 p.m., showed two CNAs (#17 and #18) assisted the resident from his wheelchair into bed to check for incontinence. Observation showed no chair alarm attached to the back of the wheelchair. Review of Resident #16's medical record occurred on all days of survey. The diagnoses included dementia with behaviors and wandering. The resident's most recent Minimum Data Set (MDS), dated 03/07/11, stated sometimes makes self understood and understands others, short and long term memory problems, severe cognitive impairment, and requires extensive to total assistance by staff for all activities of daily living. Resident #16's care plan, dated 12/15/10, stated "PROBLEM: Safety - at risk for falls r/t [related to] confusion, at risk for falls r/t impaired decision making skills. GOAL: Resident will remain free from fall-related injury. APPROACH: . . . high low bed q [every] shift, bed alarm - staff to ensure bed alarm has correct placement and in working order q shift." Resident #16's Care Guide, dated 03/15/11, stated ". . . Safety: Requires 1/2 siderails, hoyer PRN, Call light within reach, Bed	F 323	Work orders will be filled out in accordance with facility procedure, and all work orders will be completed on a priority-level, with resident safety being top priority. Staff has been educated that any piece of equipment used for patient safety is to be replaced immediately upon removal of the defective equipment. Plant Operations Manager will do weekly QA audits for 2 months, and then monthly QA audits to assure that all work orders for resident safety are completed in a timely manner. Random audits by nursing will be done weekly by nursing staff, and these reports will be given to Quality Assurance and be reported quarterly. The Director of Nursing will be responsible for this process. Date of Correction: April 5, 2011	

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F 323	Continued From page 15 alarm, Chair alarm, Hi-Lo Bed, monitor closely for wandering/leaving floor." The resident's Care Guide, dated 03/17/11, added, ". . . encouraged res [resident] to stay close to nursing station." Review of Falls Documentation records included the following: * 09/22/10 at 8:30 p.m. "Resident attempted to get into bed from his wheelchair" * 11/21/10 at 8:10 p.m. "Resident was in wheelchair and may have tried to get on the toilet . . . resident stated hit head. No injuries found." * 12/03/10 at 5:20 p.m. ". . . [resident] trying to get into bed from his wheelchair on his own and lost his balance . . . [found] on floor in front of his bed . . . chair alarm didn't go off . . ." * 12/15/10 at 2:45 p.m. "Found on the floor beside his wheelchair . . . resident says he was trying to take a nap." * 01/05/11 at 4:40 p.m. "Resident found on floor . . . resident tried standing up and lost his balance, resident had been in his wheelchair . . ." * 03/15/11 at 8:15 p.m. "Res found on the floor in his room . . . Res confused, probably wanted to get up, . . . Abrasion to forehead . . . indentation from r/t [related to] laying on foot pedal to L [left] middle side of chest . . . staff educated about safety precautions with res, will try to encourage res to stay close to nursing station for safety measures." Review of a Falls Committee progress note, dated 09/28/10, stated, "Continue hourly rounds and ask [Resident #16] if he needs help & sensor pad for W/C [wheelchair] was added." Review of Resident #16's nursing progress notes, dated 03/16/11, stated, ". . . fall quest [question] accident happened at 8:15 p.m." [on 03/15/11].	F 323		

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F 323	Continued From page 16 An interview with staff members (#3 and #5) occurred on 03/16/11 at 7:45 a.m. The staff members stated Resident #16 had fallen in his room and staff found him on the floor last evening. The facility transferred Resident #16 to the hospital by ambulance, where he was admitted for evaluation/treatment. When asked if the chair alarm sounded, the staff member (#3) stated the chair alarm had been disconnected from the wheelchair due to a malfunction and beeping and had been stored at the nursing station. The staff member (#5) stated the sensor pad remained on the seat of Resident #16's wheelchair without an alarm. The staff member (#3) stated the yellow copy of the repair order was taken to maintenance at approximately 3:00 a.m. the morning of 03/15/11. Observation showed the work order request, undated, not signed, stated the chair alarm located at the nurses station required repair. The staff member (#3) stated the staff did not apply a replacement alarm to Resident #16's wheelchair. An interview with a maintenance staff member (#6) occurred on 03/16/11 at 8:35 a.m. The staff member stated he came to repair the wheelchair alarm on 03/15/11 at approximately 8:00 a.m., but could not locate the wheelchair and alarm and did not know which resident the malfunctioning alarm belonged to. The staff member stated he did not ask a nursing staff member regarding the whereabouts of the alarm requiring repair and left the unit. An interview with administrative staff members (#1 and #2) occurred on the afternoon of 03/17/11. The staff members agreed multiple staff from the night and day shifts should have	F 323		

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F 323	Continued From page 17 replaced the missing wheelchair alarm which may have prevented Resident #16's fall. The facility's failure to replace and/or repair the wheelchair alarm placed Resident #16 at high risk for additional falls. Resident #16 sustained a fall, injury, and required hospitalization, which may have been prevented if staff had ensured the fall measures were implemented.	F 323		