RECEIVED NOV 30 2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355102	A. BUILDING _____ B. WING _____	11/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPOLEON CARE CENTER	311 E 4TH ST NAPOLEON, ND 58561

(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 11/08/10 and completed on 11/10/10 the sample included two residents for complete review, eight residents for focused review, and one closed record. The sample included one additional resident to verify specific concerns during the survey.	F 000		
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	Napoleon Care Center (NCC) will complete accurate assessments reflecting the resident's status on the Minimum Data Set (MDS). 1. Accurate assessments re: residents #1,8,9 & 3 will be completed with subsequent scheduled assessments. Residents #1,3, &9 have all had recent MDS assessments from 10-21-10 to 11-11-10 with correct coding for assistance provided. Resident #8 is due for a quarterly MDS on 12-14-10. 2. All NCC residents will have accurate assessments reflecting the residents status on the MDS. 3. Education was provided to Aide's on 11-16-10 by Jeanne Schumacher RN MDS Coordinator re: coding of ADL's. Education was provided to nurses on 11-17-10 also on coding of ADL's and on their role of supervision of aide coding to assure accuracy. 4. NCC will monitor res# 1,3, 8 & 9 in addition to a random sample of NCC residents that their MDS assessments are completed accurately monthly x 3 then quarterly by the QA Coordinator. QA will be monitored by the QA Coordinator Completion Date December 16, 2010 K Beechie F-278 Per telephone call on 12/8/10 @ 11:30am c Melissa Glatt DON	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richard Regner — TITLE: Administrator — (X6) DATE: 11-24-10

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 278	Continued From page 1	F 278		

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the residents' status for 4 of 10 sampled residents (Resident #1, #3, #8, and #9). Failure to accurately assess and code the MDS to reflect the resident's current status may affect the level of care provided by staff, and prevent the resident from attaining their highest level of physical, mental, and psychosocial functioning.

Findings include:

- Review of Resident #1's medical record occurred on all days of survey. Medical diagnoses included osteoarthritis. Review of Resident #1's most current care plan stated, "Problem/Need: Dressing . . . assist of 1 with dressing and undressing . . . Problem/Need: Mobility . . . Transfer [with] ez stand [a mechanical lift] and 1 A [assist] . . . Problem/Need: Toileting . . . 1 assist with toileting . . ."

Review of Resident #1's quarterly MDS, dated 10/21/10, identified the resident required total assistance of one staff member for transfers, dressing, and toilet use.

Observation on 11/08/10 at 2:55 p.m. showed two certified nursing assistants(CNAs) (#2 and #3) asked Resident #1 to place his feet on the ez stand and hold onto the handle bars. The CNAs removed the resident's wet brief and noted his trousers wet. They sat the resident down on the edge of the bed and removed his wet trousers and applied dry trousers. Observation showed

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F 278	Continued From page 2 Resident #1 lifted his legs to assist in the dressing process when cued by the CNAs. Observation on 11/09/10 at 8:45 a.m. showed two CNAs (#4 and #6) utilized the ez stand, transferred Resident #1 to the toilet, and left the room. At 9:00 a.m., the resident's bathroom call-light rang and the CNA (#4) entered the bathroom and Resident #1 had toilet paper in his hand, and stated "I'm done." The observations made on November 8-9, 2010 and Resident #1's care plan indicate a contradiction between the resident's status (limited or extensive assist) and the status coded on the MDS (total assistance required). During an interview on 11/10/10 at 1:20 p.m., an administrative nurse (#1) confirmed Resident #1 is not totally dependent on staff for activities of daily living (dressing, transfers, and toileting). - Review of Resident #8's medical record occurred on November 09-10, 2010. Review of resident's current care plan, dated 09/20/10, indicated one assist with transfers, bed mobility, toileting, dressing and personal hygiene. An entry on the current care plan, dated 09/23/10, stated, ". . . Res [resident] may perform room dist. [distance] amb [ambulation] [with] A [assist] of 2, GB [gait belt] + [and] FWW [front wheeled walker] as tol [tolerated]." Resident #8's most current MDS, dated 09/14/10, indicated resident required total assistance for bed mobility, transfer, dressing, toilet use, personal hygiene and locomotion in room. During an observation on 11/10/10 at 10:50 a.m.,	F 278		

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F 278	Continued From page 3 two CNA's (#4 and #7) wheeled Resident #8 into the bathroom. They positioned the resident's wheel chair next to the toilet with the grab bars and, without the use of a gait belt, instructed Resident #8 to "grab on to the bars and stand up." The resident held onto the bars and pulled herself up without the physical assist of the CNA's. The CNA (#7) pulled down the resident's pants and helped her turn and sit on the toilet. When she finished, the CNA's instructed Resident #8 to again grab the bar and stand up. The CNAs then helped the resident turn and sit back in her wheelchair. During the survey, observations and review of Resident #8's care plan identified the resident did not require total assistance during ADL performance as indicated on the MDS. - Review of Resident #9's medical record occurred on November 9-10, 2010. The resident's current MDS, dated 08/11/10, indicated total assistance of one person for transferring, toilet use, and dressing. Resident #9's current care plan (as well as previous care plans) stated, ". . . Problem/Need . . . TOILETING . . . Approaches . . . Transfer per 1-2 assist to toilet with gait belt. . . ." Observation on 11/10/10 at 10:04 a.m. showed two CNAs (#4 and #7) helped Resident #9 to the bathroom. The CNAs assisted Resident #9 to stand using a gait belt, and then ambulated with her to the bathroom. Observation showed Resident #9 attempted to pull down her own pants and brief, and the CNA (#4) stated, "I'll do that, [Resident name]." The above observation indicates a contradiction	F 278		

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F 278	Continued From page 4 between the resident's actual status (transferring, toileting, and dressing with assistance) and the status coded on the MDS (total assistance required). - Review of Resident #3's medical record occurred on all days of survey. The resident's current MDS, dated 08/09/10, indicated total assistance of one person for in-room ambulation and total assistance of two or more people for toilet use. Resident #3's current (revised 08/26/10) care plan, as well as previous care plans, stated, ". . . Problem/Need . . . TOILETING . . . Approaches . . . Assist of 1-2 with toileting with use of GB [gait belt] . . . Problem/Need . . . MOBILITY . . . Uses a W/C [wheelchair]. Ambulatory with FWW & assist. . . ." Observation on 11/08/10 at 3:37 p.m. showed two CNAs (#8 and #9) assisted Resident #3 out of bed using a gait belt. They ambulated with the resident to a recliner positioned near her bed and assisted her to pivot and sit. During an interview on 11/09/10 at 9:50 a.m., Resident #3 (identified by the facility as interviewable) stated she walks with two staff members to the bathroom. The above observation indicates a contradiction between the resident's actual status (walking with assistance) and the status coded on the MDS (total assistance required).	F 278		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	Napoleon Care Center will provide services that meet professional standards of quality.	

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F 281	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, professional reference, and staff interview, the facility failed to ensure the services provided met professional standards of quality following a fall for 4 of 8 sampled residents (Resident #2, #4, #5, and #9) who experienced an unwitnessed fall or who reported hitting their head during a fall. Failure to complete a thorough exam and develop a protocol for neurological assessments after a fall has the potential for injuries to go undetected. Findings include: Lippincott Manual of Nursing Practice (6th edition, 1991): The standard of nursing practice dictates that following a head injury, the resident should be monitored for signs of increased intracranial pressure-altered level of consciousness, observed for cerebrospinal fluid leakage, assess for contusions about the eyes and ears and assessed for neurological changes - pupils, reflexes, and motor ability. A thorough assessment including neurological status checks will be done and documented for 72 hours following the incident. The recommended nursing standard for neurological assessments are: every fifteen minutes for the first hour, then every thirty minutes for the second hour, then every hour for the next four hours, then every two hours for the first 24 hours, and then every shift for the second and third day. These assessments should be continued if the person is not stable or is showing evidence of a change in status. - Review of Resident #4's medical record occurred during all days of survey. The resident's	F 281	1. Neurological checks will be provider per NCC policy for resident # 2, 4, 5 &9 when they have a fall and it involves head injury or if they have an unwitnessed fall and are unable to report head involvement. 2. All NCC residents will receive professional standards of quality by having neuro checks completed per NCC policy with falls involving head injury or unwitnessed falls with residents who are unable to report head involvement. 3. Education was provided to nurses at meeting held 11-17-10 re: neuro checks. A NCC policy has been developed with consultation from our medical director Dr. Kosiak and Kay Rau PA-C, the policy will be educated on at our December 8th nurses meeting. 4. NCC will monitor resident #2, 4, 5 & 9 in addition to a random sample of NCC residents that neuro checks are completed with falls involving head injury or unwitnessed falls that the resident can not report head involvement. F281 Completion Date 12-16-10 Per telephone conversation w Melissa Colatt, DON on 12/8/10 @ 11:30 am, the QA Coordinator will complete QA monthly for 3 months and quarterly thereafter. K Beecher	

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F 281	Continued From page 6 diagnoses included in part, Alzheimer's Disease, osteoarthritis, and convulsions. Resident #4's nurses notes stated the following: * 10/19/10 2:34 p.m., ". . . Resident sustained fall in bathroom. Resident's head was laying against wall . . . after assisting resident to wheelchair then denied head discofort [sic] " * 10/02/10 11:38 a.m., ". . . Residsent [sic] sustained fall in BR [bathroom] . . . nurse entered BR resident was laying on floor with head and right shoulder leaning against door and west wall . . . Back of head, hips, and shoulder assessed without noted injury . . . " * 08/06/10 8:55 p.m., ". . . had fallen down to his knees. Stated he may have hit the rt [right] front side of his head on the recliner but it didn't hurt at all . . . Hand grasps strong and equal. PERLA [pupils equal and reactive to light and accommodation] . . . " * 05/09/10 6:21 p.m., " . . . Resident's wife . . . stating that resident fell onto floor. Entering room resident found laying on floor next to bed. Resident admits hitting head and knees are sore . . . " The record lacked further information that the facility performed neurological assessments following the unwitnessed falls or the falls in which Resident #4 reported hitting his head. - Review of Resident #9's medical record occurred on November 9-10, 2010. Diagnoses included circulatory system disease, cerebrovascular disease, and Alzheimer's disease. Nurses' notes stated the following: * 10/22/2010 at 10:27 a.m.: ". . . Late entry: 0910AM, Res. [resident] fell this AM during transfer from w/c [wheelchair] with CNA [certified	F 281		

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F 281	Continued From page 7	F 281		

nursing assistant] present. . . . sustained a hematoma (goose egg) to the back of her head. Approximate size of a quarter. . . . Res. c/o [complains of] pain to head. . . . PERLA. . . . Ice applied to head. . . ."
* 10/22/10 at 11:23 a.m.: ". . . Hematoma remains to back of head. PERLA. . . ."
* 10/22/10 at 12:35 p.m.: ". . . Goose egg to back of head has decreased in size. PERLA. . . ." The record lacked documentation that facility staff performed any type of neurological status checks after this point.

- Review of Resident #2's medical record occurred November 08-10, 2010. The record identified the resident's diagnoses as dementia, syncope, cardiac dysrhymthmias, hypertension, and Type II diabetes.

Review of Resident #2's nurses' notes identified five unwitnessed falls with potential for a head injury. The nurses' notes lacked evidence facility staff performed neurological status checks or neurological assessments following these falls. The falls included:
*11/01/10 at 10:16 a.m., ". . . Resident found on fall [sic] in her room by CNA. Resident was trying to self transfer from recliner to wheelchair. Resident assessed with no apparent injuries. Resident assisted up off the floor and into wheelchair. When asked if she hurt anywhere she stated 'yeah, a little' while rubbing the back of her head. . . ."
*10/15/10 at 3:16 p.m., " . . . aide . . . notified nurse of resident sitting on floor. Nurse assessed resident no apparent injury, asked what resident was doing she said, 'I just slipped out of my recliner.' Denied pain . . . "
*08/06/10 at 6:19 p.m., ". . . Res stood up from

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F 281	Continued From page 8 wheelchair and was standing in front of her dresser "looking for something" and legs gave out res sat on floor, no injuries, 'just my pride'. . ." *07/15/10 at 2:25 p.m., " . . . Res found sitting on the floor in her room by the night stand she was talking on the phone to her brother had gotten up from the bed to answer the phone and sat on the floor, no injuries noted. . ." *04/16/10 at 2:15 p.m., " . . . Resident had fall in room doing self transfer into wheelchair and sat on floor, no injuries . . ." - Review of Resident #5's medical record occurred on all days of survey. The record lacked documentation that facility staff performed any type of initial neurological assessment after these unwitnessed falls, as noted in the above staff interview. Nurses' notes stated the following: * 11/03/10: ". . . Resident found sitting on floor in middle of her room. No injury noted on assessment. . . ." * 08/20/10: ". . . Res. had fall to floor in room, wanted to go to bathroom and noticed someone was in there and turned around to go back to chair and lost balance and fell to floor. Found lying on rt [right] hip and down on right elbow. . . ." During an interview on 11/10/10 at 2:00 p.m., an administrative nursing staff member (#5 confirmed the identified falls were unwitnessed and nursing staff should have completed a neurological assessment following each fall.	F 281		
F 323	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	F 323	Napoleon Care Center will ensure our resident's environment is free of accident hazards, and that each resident receives adequate supervision and assistance devices to prevent accidents.	

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F 323	Continued From page 9 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to implement safety measures and provide necessary supervision to prevent falls for 4 of 8 sampled residents (Resident #3, #5, #7, and #9) who experienced falls at the facility. Failure to provide supervision and implement fall prevention measures resulted in Resident #7 sustaining a fall and fracture and may have resulted in Resident #3, #5, and #9 experiencing avoidable falls and injuries. Findings include: - Review of Resident #7's medical record occurred on all days of survey. Medical diagnoses included a fracture of the lumbar vertebrae, macular degeneration, muscle spasms, and alcohol dementia. Resident #7's quarterly Minimum Data Set (MDS), dated 03/18/10, identified both long and short term memory problems, moderately impaired daily decision making skills, extensive assistance of one person for transfers, limited assistance of one person for toilet use, and a fall in the past 30 days. Resident #7's care plan at the time of the fall on 05/15/10, stated, "Problem/Need . . . At Risk for Falls: . . . Approaches: Call light within reach. Remind to ask for help . . . Alarmed tabs unit to w/c . . ." Review of Resident #7's nurses' notes identified the following: * 05/16/10 at 12:00 a.m. - "Late entry for today at	F 323	1. Safety measures and necessary supervision to prevent falls will be provided for resident # 3,5, 7 &9. Resident #3 was provided with a longer call light and is pinned to the resident per her request so it is always within reach. Resident #5 has been provided with chair and bed alarms to alert staff to her trying to self transfer. Resident was provided with a longer call light so it is within reach when she is sitting in her recliner. Resident will be offered to transfer from her w/c to her recliner or bed when she is in her room. Resident's w/c will have the brakes locked to prevent it from moving if resident does self transfer and the foot pedals will be out of the way to prevent any tripping. Resident #7 will not be left alone in the bathroom d/t his dementia and he doesn't remember to use the call light. Resident #9 will have the calf strap removed from her w/c prior any transfers to prevent tripping and any potential falls.	

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F 323	Continued From page 10 1830 [for previous day, 05/15/10 at 6:30 p.m.] . . . Staff went to check on [resident name] in shower room and found him sitting on floor next to the toilet, in front of his wheel chair. He had not put the call light on though it had been in reach and had tried to transfer himself from the toilet to the wheelchair. He had just fallen. Stated he did not hit his head, but complained of tenderness coccys [sic] area . . ." * 05/16/10 - "At 2:30 a.m. [resident name] awake . . . Complained of increased pain coccyx area, lower back and left buttock when trying to sit at the side of the bed. He wasn't unable to rate it [sic] but said 'It takes my breath away.' . . . At 3:15 a.m. received orders to . . . transfer him in the morning via ambulance for xrays." * 05/16/10 - "[7:30 a.m.] . . . transfer as ordered . . ." * 05/16/10 - "[10:00 a.m.] Res returned . . . [provider name] called with update on condition CT [Computerized Tomography] scan of LS [lumbosacral] spine and sacrum area negative, contusion . . . increased pain in lower back with sitting and standing . . . [1:00 p.m.] . . . c/o [complaints of] increased tenderness above pubic bone . . . [5:00 p.m.] . . . c/o pain . . ." * 05/17/10 - "3:23 a.m. Res repositioned from w/c [wheelchair] to bed, in extreme pain, clenching his teeth, heavy breathing and moaning . . . Res resting without pain at [12:30 a.m.]. Res encouraged to reposition to prevent sores now in extreme pain. Res again medicated . . . continues to moan out . . . [6:30 a.m.] Res lying in bed CNA [certified nursing assistant] repositioned to get pants up and res had extruciating [sic] pain in left lower back area . . . Medicated . . . [8:40 a.m.] . . . res using the trapeze and with little lifting of his buttocks again writhing [sic] in pain and screaming . . . MS 4 mg SQ [morphine 4	F 323	2. All NCC residents will receive safety measures and necessary supervision by NCC staff to prevent falls. Call lights were assessed and longer cords were ordered and will be provided where needed. 3. Education will be provided to all staff inservice on 11-24-10 re: fall prevention. Specific fall prevention education for nursing department will be provided to aides on 12-7-10 and nurses on 12-8-10. 4. NCC will monitor resident #3,5, 7 &9 in addition to a random sample of NCC residents that they are provided safety measures and necessary supervision to prevent falls. F-323 Completion date 12-16-10 Per telephone conversation w Melissa Glatt, DON on 12-8-10 @ 11:30 am: QA Coordinator will complete QA for 3 months & quarterly thereafter. K Beetle	

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	355102	A. BUILDING _____ B. WING _____	11/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPOLEON CARE CENTER	311 E 4TH ST NAPOLEON, ND 58561

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F 323	Continued From page 11 milligrams subcutaneous] given for pain . . . [2:30 p.m.] [name of provider] in to examine res for increased spastic pain in lower back . . . res very uncomfortable with any slight movement, lower back muscles very tight . . . Phone call placed to [name of provider] regarding better pain control . . . orders received . . ." * 05/18/10 - "11:28 a.m. [name of provider] here this am and examined resident. Resident is still having a lot of pain to pelvis with any type of movement . . . Orders to start Oxycontin 20 mg bid [twice a day] . . . " * 05/19/10 - ". . . At 11:50 a.m. spoke to [provider name] updated on resident having pain . . . At 12:15 [p.m.] [provider name] returned call with instructions to have resident transferred to [name of hospital] ER [emergency room] for evaluation . . . " * 05/22/10 - "[3:00 p.m.] Res returned to [name of facility] . . . x-ray LS spine showed compression fracture at the L1 [first lumbar vertebrae] level . . ." During an interview the afternoon of 11/10/10, an administrative nurse (#5) stated staff members should not have left Resident #7 alone in the bathroom. Failure of facility staff to provide supervision for Resident #7 while he was in the bathroom resulted in the resident sustaining a fall which resulted in a compression fracture, excruciating pain, and hospitalization. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included abnormal gait and cerebrovascular disease. Resident #3's current MDS, dated 08/09/10, indicated extensive assistance of two or	F 323		

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F 323	Continued From page 12 more people for transfers and total assistance of one person for in-room ambulation. Resident #3's current care plan, revised 08/26/10, stated, ". . . Problem/Need . . . Problem Onset 06/15/2009 . . . FALLS: HISTORY OF FALLS: Has had some incidents of sliding down and out of chair. . . . Approaches . . . Call light within reach at all times . . ." A nurses' note, dated 06/27/10, stated the following: ". . . [Resident name] had been sitting in her recliner chair in her room. Her roommate saw her reaching for her call light and slide out of her recliner chair and notified staff immediately. She was found on the floor in front of her recliner chair lying on her right side. . . ." During an interview on the morning of 11/10/10, a nursing staff member (#5) stated "the call light cord was too short" to reach the resident, and "it was clipped to the edge of the bed." After the fall, facility staff moved Resident #3's recliner closer to the bed. Placing the call light cord closer to the resident could have prevented this fall. - Review of Resident #9's medical record occurred on November 9-10, 2010. Diagnoses included hemiplegia and cerebrovascular disease. Resident #9's current MDS indicated total assistance of one person with transfers. A note written by an occupational therapist (OT) on 10/13/10 stated the following, ". . . I did have admin. [administration] order a soft calf strap to be placed on the W/C [wheelchair] . . . The purpose of the calf strap is to position the L/E's [lower extremities] with calf support with feet on	F 323		

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F 323	Continued From page 13 the foot rests. . . ." Resident #9's care plan, updated 10/13/10, stated, ". . . Per OT consult, calf strap ordered [and] added . . ." A nurses' note, dated 10/22/10, stated the following: ". . . Res. [Resident] fell this AM during transfer from w/c with CNA [certified nursing assistant] present. Calf strap velcroed to res. legs during transfer & res. fell to floor & sustained a hematoma (goose egg) to the back of her head. . . ." During an interview on the morning of 11/10/10, a nursing staff member (#5) stated the CNA forgot to remove the calf strap from Resident #9's wheelchair and the resident tripped. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included mental disorder not otherwise specified, macular degeneration, and osteoarthrosis. Resident #5's current MDS, dated 10/27/10, identified severely impaired cognition and extensive assistance from one person for transfers, in-room ambulation, and toilet use. Resident #5's current care plan, revised 11/04/10, stated, ". . . Problem/Need . . . FALLS; AT RISK FOR FALLS . . . Approaches . . . Call light within reach. Remind to ask for help. Keep all walkways and floors clear and free of clutter. Monitor with fall assessment per policy. Assist as needed. Keep frequently used items within reach and in the same place. Remind and assist res. to use FWW [front-wheeled walker] or w/c to prevent falls. The care plan also stated, ". . . Problem/Need . . . MOBILITY . . . Requires w/c as of 10/29/10 with increased weakness and start of Celexa . . . Approaches . . . Assist of 1 with	F 323		

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F 323	Continued From page 14 mobility and transfers. . . ." Review of Resident #5's nurses' notes revealed the following: * 11/06/10: ". . . Resident found walking to the BR [bathroom] without walker. This nurse then assisted her to BR and presented her the walker. Resident upset and stating that the walker is not hers and she doesn't need it. Reminder given that she fell a couple days because she wasn't using her walker. . . ." * 11/03/10: ". . . Resident found sitting on floor in middle of her room. . . ." During an interview on the morning of 11/10/10, a nursing staff member (#5) stated the resident did not have her walker at the time and the fall was unwitnessed. * 10/21/10: ". . . Resident up out in hall without assisstve [sic] device, resident redirected to use walker and assisted with same. . . ." * 09/20/10: ". . . CNA reports that resident had near miss. When resident was up ambulating in her room her right knee gave out and resident caught herself on the bed. . . ." During an interview on the morning of 11/10/10, a nursing staff member (#5) stated the CNA walked by Resident #5's room and saw the incident. * 08/20/10: ". . . Res. had fall to floor in room, wanted to go to bathroom and noticed someone was in there and turned around to go back to chair and lost balance and fell to floor. Found lying on rt [right] hip and down on right elbow. . . ." During an interview on the morning of 11/10/10, a nursing staff member (#5) stated the resident stood from the recliner and was ambulating without her walker when she fell. * 05/13/10: ". . . Res. found sitting on floor beside bed by staff walking by. Resident relates that she slipped off bed as she was trying to get to recliner. . . ."	F 323		

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F 323	Continued From page 15 Observations of Resident #5 on 11/09/10 revealed the following: * 2:30 p.m.: Seated in a recliner in her room, call light pinned to bedspread and located approximately 3 feet from the resident (not in reach of the resident) * 4:00 p.m.: Asleep in bed, wheelchair positioned near the bed with left brake locked and right brake unlocked, both foot pedals still in place, and the call light, pinned to its cord, located behind the resident's headboard (not in reach of the resident) Observations of Resident #5 on 11/10/10 revealed the following: * 8:15 a.m.: A CNA (#4) pushed Resident #5 in her wheelchair into her room. The CNA positioned the wheelchair in front of the resident's recliner, locked the brakes, and left the room. Observation showed Resident #5 then transferred herself to the recliner by bracing one hand on the arm of the wheelchair and one hand on a nearby table. * 1:15 p.m.: Seated in a recliner in her room, call light pinned to bedspread and located approximately 3 feet from the resident (not in reach of the resident) Facility staff failed to implement any additional fall prevention measures after Resident #5 experienced falls related to self-transferring and ambulating without a walker or supervision. During an interview on the morning of 11/10/10, a nursing staff member (#5) stated, "That shouldn't have happened [referring to Resident #5's self-transfer earlier that morning]." She also stated Resident #5 needs to be transferred with the assistance of one person, and "Maybe we	F 323		

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F 323	Continued From page 16 should have had one on her [referring to a chair alarm]."	F 323		