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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355044	A. BUILDING _____ B. WING _____	C 04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	615 6TH ST SE STANLEY, ND 58784

(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 April 8-9, 2014, the sample included (6) six current residents for review.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) Nursing staff were instructed on 5/20/14 on the new face sheets and communication notes. Staff is to call the first contact person for all appointments, changes in resident condition, etc. The instruction was for resident #2 and resident #5 as well as all other residents who have any changes. 2) Any resident having an appointment could potentially be affected. Nursing staff were instructed on new face sheet and communication note. Policy & Procedure titled "Contacting Family of Residents" was revised. 3) Face sheet was revised on 4/14/14. New communication note was shown to staff on 5/20/14 and will go into effect when form arrives. (New form for communication note was designed and ordered.) 4) The QA department or nursing designee will monitor monthly x 3 then quarterly x one year. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA department	5/31/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CFO & Acting CEO / Administrator — (X6) DATE: 6/23/14

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/15/13. Based on information provided by the complainant, record review, review of facility policy, and staff interview, the facility failed to notify family members for 2 of 6 sampled residents (Resident #2 and #5) requiring dental care. Failure to notify the family members does not allow them the opportunity to provide input and/or consent to the resident's treatment plan. Findings include: Information provided by the complainant indicated the facility failed to notify family members (identified as the resident's first contact) of appointments prior to procedures being performed. Review of the facility policy titled "Contacting Family of Residents" occurred on 04/09/14. This policy, revised February 2006, stated, ". . . contact family in the event of changes in the resident's condition. . . . There will be 2 family members listed in the client's chart to notify in emergency. They will be contacted in the order listed. . . ." - Resident #2's medical record, reviewed on April 8-9, 2014, identified diagnoses including dementia and pain, and identified next of kin and a responsible party. Resident #2's nurse's note, dated 11/22/13, identified, "Returned from Dentist [with] orders for	F 157	will submit a report monitoring the results to the QA committee at each scheduled meeting. 5) Social Services has changed the face sheets of residents #2 and #5 and all other residents' face sheets as of 4/14/14. QA or designated nursing staff will monitor communication note on resident #2 and #5 and all other residents monthly x 3 then quarterly times 1 year. Monitor will begin once new communication note arrives.	

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Primary MD [medical doctor] to give orders for Coumadin to be held - awaiting orders before tooth extractions can be scheduled."

During an interview on 04/08/14 at 4:20 p.m., an administrative staff member (#1) stated "The extractions were canceled and never rescheduled due to illness."

Resident #2's medical record lacked evidence facility staff informed family of the appointments to see the dentist, to have the teeth extracted, of the cancellation, and of the need to withhold medication.

- Resident #5's medical record, reviewed on April 8-9, 2014, identified diagnoses including history of transient ischemic attacks (TIAs) and cerebral infarction, anxiety, and pain, and identified next of kin, a responsible party, and a sticky-note stating "Contact [name] also for all medical appointments."

Resident #5's nurse's notes identified the following:
* 01/09/14, "Resident has appt [appointment] Feb [February] 5 [at] 1:00 p.m. with [dentist] to have a tooth (#25) extracted."
* 01/10/14, "Orders received to hold Coumadin 5 days prior to dental appt on Feb 5."
* 02/05/14, "To appt to see [dentist] via van with staff member . . ."
* 02/07/14, "No c/o [complaints of] pain from teeth extraction . . ."
* 03/12/14, "[Family member] is still to be contacted for all appointments [and] concerns, this is [Resident #5]'s wish."

Resident #5's medical record lacked evidence

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F 157	Continued From page 3 facility staff informed family of the appointments to see the dentist and to have the teeth extracted and of the need to withhold his medication. During an interview on 04/08/14 at 3:20 p.m., when asked which family member (next of kin, responsible party, or those identified on a sticky-note) facility staff are to notify regarding changes in medical condition and/or scheduled appointments, an administrative nursing staff member (#3) stated, "If I were the floor nurse, I'd be confused as to who to call."	F 157		
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	F 225	MBH will meet this requirement as evidenced by: 1) Nursing staff were instructed on the policy titled "Abuse, Neglect, and Misappropriation Reporting". This instruction was for resident #3 and #4 as well as any other resident who may be affected. 2) The incident report for resident #3 was reviewed at the nurses' meeting on 5/20/14. Staff were educated on the importance of completing the form and making sure they document exactly what happened. An abuse investigation was conducted on 4-9-14 regarding resident #4's report noted in chart on 2-10-14. Results were documented and reported to State and Administrator as indicated. 3) The QA department or nursing designee will monitor the completeness of filed incident reports monthly x 3, then quarterly times one year. Results will be	6/02/14

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F 225	Continued From page 4 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 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 procedure, staff interview, and resident interview, the facility failed to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin, were reported immediately to the administrator of the facility and/or to other officials in accordance with State law and failed to thoroughly investigate for 1 of 6 sampled residents (Resident #4) an allegation of mistreatment and for 1 of 6 sampled residents (Resident #3) who experienced a fall during an outing. Failure to report and/or investigate allegations of mistreatment places all residents at risk of abuse or neglect. Findings include: Review of the facility policy titled "Abuse, Neglect, and Misappropriation Reporting" occurred on 04/09/14. This policy, revised March 2012, stated, ". . . Employees are required to immediately report any reasonable suspicion or witnessed incidents of abuse, neglect . . . to the	F 225	reported to DON. If concerns are identified, immediate corrective action will be implemented. The QA department will submit a report monitoring the results to the QA committee at each scheduled meeting. 4) QA or designated nursing staff will monitor resident #3 and #4 and other residents requiring an incident report monthly x 3, then quarterly x 1 year. Monitoring will begin 6/2/14.	

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Administrator, DON, Charge Nurse, and/or Director of Social Services. . . . The Director of Social Services will assist in the investigation process . . ."

Review of the facility policy titled "Post-Fall Guidelines" occurred on 04/09/14. This policy, revised February 2006, stated, ". . . DOCUMENTATION: 1. Circumstances of fall, 2. Your assessment of injuries . . . 5. Interventions . . . 6. Any new safety devices implemented . . ."

- Review of Resident #4's medical record occurred on April 8-9, 2014. A quarterly Minimum Data Set (MDS), dated 02/10/14, identified the resident as cognitively intact.

Resident #4's progress note, dated 02/03/14, stated, "Resident spoke to this nurse and showed 2 small bruises and a scratch on R [right] side calf. Resident stated 'She hurt me this morning. She did this when putting my Ted hose on yesterday morning she had them so twisted.' Nurse asked resident if the morning nurse checked her stockings or did she say anything to the nurse at the time. Resident stated, 'No, it was that CNA [certified nursing assistant] from [city].' Incident report filled out and [physician] notified."

During an interview on 04/09/14 at 10:45 a.m., when asked questions regarding Resident #4's allegations of mistreatment, an administrative staff member (#1) stated, "I had no awareness of the bruises, scratches, and statement. No one told me this happened. No abuse investigation was done."

When requested the facility failed to provide a copy of the 02/03/14 incident report.

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Facility staff failed to immediately report Resident #4's allegation of mistreatment to the administrator of the facility and to other officials in accordance with State law, and failed to thoroughly investigate the allegation of mistreatment.

- Resident #3's medical record, reviewed on April 8-9, 2014, identified diagnoses including muscle weakness and bilateral below the knee amputation. An annual MDS, dated 01/15/14, identified the resident as cognitively intact and having a fall with injury. The Fall Care Area Assessment (CAA), dated 01/21/14, identified, "Res [resident] has hx [history] of falls. He remains [at] high risk. . . ."

The "Pre-Restraining Evaluation," dated 07/08/13, identified, ". . . BALANCE (When Sitting) . . . leans sideways . . . AMBULATION . . . Leans forward . . . RECOMMENDATIONS . . . safety belt . . ."

The ADL care plan identified the following approach, "07/01/13 . . . Res is to wear safety belt while in elec [electric] w/c [wheelchair] . . ."

The interdisciplinary progress notes identified the following:
* 11/12/13 at 5:00 p.m., "Resident fell. . . . First aid applied to end of right stump for abrasion."
* 11/12/13 at 5:30 p.m., "Resident slipped out of w/c during outing."
* 11/18/13 [A late entry], "Resident had a fall on 11/12/13. He was outside the facility at a doctor's appointment in a regular wheel chair and slipped out of the chair as the chair went over the curb of the street. He had a small abrasion to his stump."

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F 225	Continued From page 7 The incident report, dated 11/12/13 at 3:30 p.m., identified, ". . . Description of incident . . . slid out of w/c . . . (CNA) (#5) pushed w/c down curb. . . . Witnesses: [CNA (#5)] . . . Injury: First aide to end of right stump - bruise . . . Contributing Factors: Improper w/c use . . ." The "Fall Investigation and Interventions" report, dated 11/12/13, identified, "Circumstances of Fall: . . . w/c tipped forward on curb [at] time of unloading patient." The report also identified the resident as having "no" balance problems or assistive devices, which conflicts with the pre-restraining evaluation, dated 07/08/13, and the ADL care plan approach, dated 07/01/13. Failure to thoroughly assess an incident/injury for causative factors, identify, evaluate, and analyze hazards and risks, implement interventions and monitor their effectiveness, placed Resident #3 at risk of another incident/injury. Failure to report an alleged incidence of neglect to other officials in accordance with State law and thoroughly investigate limited the facility's ability to ensure the safety of Resident #3 and placed all residents at risk of possible neglect.	F 225		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to	F 281	MBH will meet this requirement as evidenced by: 1) Nursing staff were instructed on 5/20/14 regarding documenting falls: the proper way to fill out a post fall investigation form and an incident report, and the importance of completion of these forms. This instruction was for	6/02/2014

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thoroughly investigate falls for 1 of 1 sampled resident (Resident #2) who experienced a fall with head injury. Failure to thoroughly complete an incident report, including the investigation of the precipitating factors, how the incident could have been prevented, whether equipment/items in the room should have been adjusted, and/or any other interventions the facility attempted in order to prevent a reoccurrence, has the potential to result in additional incident's of injury.

Findings include:

Kozier & ERB's "Fundamentals of Nursing Concepts, Process, and Practice," 9th Edition, 2012, page 75 stated, ". . . An incident report . . . is an agency record of an accident or unusual occurrence. . . . The report should be completed as soon as possible . . . The purpose of the report form is to alert the risk manager to the event. The person who identifies that the incident occurred should complete the incident report. . . . Nurses may be required to answer such questions as what they believe precipitated the accident, how it could have been prevented, and whether any equipment should be adjusted. . . ."

- Resident #2's medical record, reviewed on April 8-9, 2014, identified diagnoses including dementia, epilepsy, and pain. A quarterly Minimum Data Set (MDS), dated 02/05/14, identified the resident as cognitively intact and independent transferring and walking in room, corridor, and on/off unit.

The current care plan, dated 08/21/13, identified, ". . . Problem: Falls: Residents [sic] is at risk for falls . . . Approaches: Falling Star program, Encourage Resident to ask for help when

resident #2 and any other residents who may require a post fall investigation form and an incident report to be filled out.

2) All post fall reports will be reviewed by fall committee at least monthly for completeness.

3) The QA department or nursing designee will monitor the post fall investigation form to be sure it is filled out completely. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA director will submit a report of the monitoring results to the QA committee at each scheduled meeting.

4) QA or designated nursing staff will monitor resident #2 and all other residents requiring a post fall investigation form to be completed monthly times 3, then quarterly for one year. Monitoring to begin 6/2/14.

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needed. . . ." The facility added "secure care bracelet to (R) [right] ankle" on 04/03/14.

Resident #2's nurse's notes identified the following:
* 04/01/14 at 4:20 a.m., "This writer into assist [with] assess [sic] of resident s/p [status post] unwitnessed fall in her room . . . resident found face down on the floor by CNAs [certified nursing assistants]. At time of assess [sic] - resident is [up] in w/c [wheelchair] and not readily responding to nurse questions. Eyes . . .(had to hold them open as patient was not able/willing). Sm [small] (3 mm [millimeter] c-shaped) lac [laceration] to outer canthus area of R [right] eye (just superior) approximates well - steristrips applied to butterfly close (without) issue. Noted early ecchymosis [and] swelling from R eyebrow to temple, to . . . mid . . . cheek area all other skin intact. Denies pain or other area of injury. Difficult to assess grip as resident won't/is unable to comply with request to grasp. Speech is clear when she speaks however. Resident is chronically anticoagulated [with] Coumadin. Will notify [physician] . . ."
* 04/01/14 at 4:30 a.m., "Pt [patient] found laying on floor in pool of blood. Was found to have small cut next to Rt [right] eye [with] bruising. Looks like she slipped from bed [and] fell forward. . . ."

The post fall investigation, dated 03/01/14 [sic], identified, "Pt found laying face down on floor - bleeding from cut by Rt eye. Slid from bed [and] fell forward. . . . Pt has been awake all night . . . then staring off into space. Went back to room at 03:55 a.m. . . . found on floor at 4:10 a.m. Does not answer questions. . . . contacted [physician]. To do neuro [check]s. . . ." It is unclear if the staff member found Resident #2 at 03:55 a.m. or at

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F 281	Continued From page 10 4:10 a.m. the morning of 04/01/14. The post fall investigation, dated 03/01/14 [sic] also conflicts with the nurse's note, dated 04/01/14, which indicates Resident #2 was found at 4:30 a.m. During an interview on 04/09/14 at 10:45 a.m., when asked for the staff member's conclusion as to the cause of Resident #2's cut near her right eye, an administrative staff member (#1) stated, "There is no indication anywhere of the cause of her cut, that they looked at her room. There are still questions." The post fall investigation failed to identify why the resident was discovered in a pool of blood if she slid from her bed (from a supine or seated position) and failed to identify the source of the cut near her right eye (force of the fall, an object in her room, etc).	F 281		
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 record review, review of facility policy, staff interview, and resident interview, the facility failed to ensure safe transport for 1 of 1 sampled resident (Resident #3) who fell while outside the facility. Failure to ensure the use of an assistive	F 323	MBH will meet this requirement as evidenced by: 1) On 5/20/14 nursing staff were instructed to make sure when transporting resident #3 in a wheelchair outside the facility that a wheelchair seat belt is fastened and all other residents will be screened for necessity of a seat belt when being transported outside the facility. Staff were also instructed that when pushing resident #3 and all other residents in and out of a van, the resident must go up the ramp forwards and go down the ramp backwards. 2) All those employees that go with residents to appointments will be	6/02/14

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device (wheelchair seatbelt) resulted in Resident #3 experiencing a fall with injury.

Findings include:

Review of the facility policy titled "Falls Protocol" occurred on 04/09/14. This policy, revised 03/05/06, stated, ". . . Each resident will be assessed for fall risk . . . Interventions to minimize risk of falls and/or injury of falls will be developed for the care plan. . . . Each time a resident experiences a fall the charge nurse will: . . . Complete an incident report . . . [and] a 'Fall Investigation and Interventions' form . . ."

Review of the facility policy titled "Post-Fall Guidelines" occurred on 04/09/14. This policy, revised February 2006, stated, ". . . DOCUMENTATION: 1. Circumstances of fall, 2. Your assessment of injuries . . . 5. Interventions . . . 6. Any new safety devices implemented . . ."

- Resident #3's medical record, reviewed on April 8-9, 2014, identified diagnoses including Parkinson's disease, muscle weakness and bilateral below the knee amputation. An annual Minimum Data Set (MDS), dated 01/15/14, identified the resident as cognitively intact, requiring extensive assist for transfers, and having had a fall with injury. The Fall Care Area Assessment (CAA), dated 01/21/14, identified, "Res [resident] has hx [history] of falls. He remains [at] high risk. . . ."

The "Pre-Restraining Evaluation," dated 07/08/13, identified, ". . . BALANCE (When Sitting) . . . leans sideways . . . AMBULATION . . . Leans forward . . . RECOMMENDATIONS . . . safety belt . . ."

F 323 educated and evaluated on the proper way to load residents in and out of a van when they are in a wheelchair and to make certain the wheelchair seat belt is fastened.

3) The QA department, nursing, or environmental services will monitor the proper loading of residents in a wheelchair. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA department will submit a report monitoring the results to the QA committee at each scheduled meeting.

4) QA, designated nursing staff, or environmental services will monitor resident #3 and all other residents regarding the proper loading of those residents that are in a wheelchair in and out of the van monthly x 3, then quarterly x 1 year. Monitoring will begin 6/2/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355044	A. BUILDING _____ B. WING _____	C 04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	615 6TH ST SE STANLEY, ND 58784

(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
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The activities of daily living (ADL) care plan identified the following approach, "07/01/13 . . . Res is to wear safety belt while in elec [electric] w/c [wheelchair] . . ."

The interdisciplinary progress notes identified the following:
* 11/12/13 at 5:00 p.m., "Resident fell. . . . First aid applied to end of right stump for abrasion."
* 11/12/13 at 5:30 p.m., "Resident slipped out of w/c during outing."
* 11/18/13 [A late entry], "Resident had a fall on 11/12/13. He was outside the facility at a doctor's appointment in a regular wheel chair and slipped out of the chair as the chair went over the curb of the street. He had a small abrasion to his stump. Education provided to staff taking residents to appointments to make sure the chair is taken off the ramps in the correct direction and to have staff in the correct placement to prevent residents from falling forward."

The incident report, dated 11/12/13 at 3:30 p.m., identified, ". . . Description of incident . . . slid out of w/c [administrative staff member #4] parked to far from curb and [certified nursing assistant (CNA) (#5)] pushed w/c down curb. . . . Witnesses: [CNA (#5)] . . . Injury: First aide to end of right stump - bruise . . . Contributing Factors: Improper w/c use . . ."

The "Fall Investigation and Interventions" report, dated 11/12/13, identified, "Circumstances of Fall: Resident was in transport to appt [appointment] downtown Stanley - w/c tipped forward on curb [at] time of unloading patient." The report also identified the resident as having "no" balance problems or assistive devices. (This contradicts

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the restraint assessment and the careplan.)

During an interview on 04/08/14 at 5:00 p.m., when asked to describe the circumstances surrounding the 11/12/13 fall, an administrative staff member (#3) stated, "[CNA (#5)] was pushing [Resident #3]. She hit the curb and dumped the resident forward." (This contradicts the earlier description of the resident sliding or slipping out of his wheelchair.) This staff member was unsure if one or two staff members were present at the time of the fall. This staff member was unable to locate evidence of the education provided to CNA (#3) and other staff members.

During an interview on 04/09/14 at 9:10 a.m., when asked to describe the circumstances surrounding the 11/12/13 fall, the CNA (#5) stated, "We were going back to the van. The curb was like a six-to-eight inch drop." She described Resident #3 as "an amputee. He has no balance." When asked if the resident was careplanned to use a seat belt, she stated, "He has a safety belt on his electric wheelchair. We should have put a belt around him." When asked to describe the fall itself, the CNA (#5) stated, "We saw him slip forward. We grabbed him and sat him on the ground, on the pavement. (This contradicts the earlier descriptions of one person assisting the resident and of the resident sliding, slipping and/or being dumped out of his wheelchair.) He did not hit. He did not have an injury. (This contradicts the earlier descriptions of the resident receiving first aid to the abrasion/bruise on his stump.) We couldn't lift him - he was dead weight." (This contradicts her earlier statements regarding sitting the resident

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F 323	Continued From page 14 on the ground.) During an interview on 04/09/14 at 2:15 p.m., when asked to describe the circumstances surrounding the 11/12/13 fall, Resident #3 (identified by the facility as being interviewable) stated, "The one in charge [administrative staff member #4] parked too far away, the ramp didn't reach the curb. The other one [CNA (#5)] didn't know what she was doing. She dropped me off the curb. (This contradicts the CNA's description of a two person assist.) I fell with the wheelchair on top of me. (This contradicts the CNA's description of sitting the resident on the ground.) They didn't catch me. It all happened so fast. I just fell right out." Failure to utilize a wheelchair seatbelt during transport when Resident #3 was unable to maintain his balance in the wheelchair resulted in Resident #3 sustaining an abrasion/bruising to his stump requiring first aide. Failure to complete a thorough investigation of the circumstances surrounding the fall, reassess the interventions that were in place, determine if additional interventions would benefit the resident, and/or determine if additional staff education was warranted, may result in Resident #3 falling in the future and sustaining another injury.	F 323		