STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	C 03/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 survey started on 03/05/12 and completed on 03/06/12, the sample included six residents for focused review and two closed records.	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	F157 1. Licensed Nursing Staff member who attended to Resident #7 was re-educated on the process of notification of legal representative and on the facility long distance phone code. Licensed Nursing member, who is an Agency Nurse, attending to Resident #6 was re-educated on notification of Physician according to the "Guidelines for Physician Notification" and notification of legal representative. In addition the Agency was notified of these issues so they may provide retraining as they deem appropriate. All Licensed Nursing Staff members were re-educated on March 7th and 8th, 2012. 2. Any resident has the potential to be affected. 3. On February 14, 2012 a memo had been sent to the Licensed Nursing Staff on the process of how to make a long distance phone call, placed in the medication cart. On March 30, 2012 the process of how to make a long distant phone call was additionally placed on the Neighborhood phones. Mandatory Nursing in-services were completed on March 7th and 8th, 2012 on notification of resident physician/legal representative, guidelines for Physician Notification, and code for long distant calls. New forms from Interact II SBAR (Situation, Background, Assessment, Request) and Early Warning sign (Stop and Watch) were implemented after education on March 15, 2012.	04/13/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kurt Steiner	Administrator	4-25-12

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: Based on record review, review of facility policy and procedure, review of the investigation completed by the facility, and staff interview, the facility failed to notify the resident's legal representative in a timely manner regarding a significant change in status (Resident #7) and failed to consult the resident's physician and notify the resident's legal representative regarding a need to alter treatment (Resident #6). Failure to notify Resident #7's legal representative in a timely manner resulted in the family members' inability to comfort the resident as she expired. Failure to notify the legal representative and the physician resulted in the facility staff providing Resident #6 with treatment not ordered by the physician and without the representative's knowledge. Findings include: Review of the facility's policy and procedure, "Physician Notification," occurred on 03/06/12. This document, dated October 2011, stated "Procedure, 1. The physician must be informed by the licensed nursing staff person in the following circumstances. 1.1. Accident involving the resident which results in injury and has the potential for requiring physician intervention. 1.2 Significant change in the resident's physical . . . status (i.e. [in example] a deterioration in health . . . in either life threatening conditions or clinical complications.)	F 157	DON met with Medical Director on March 15, 2012 to review and approve policy and procedure on Physician notification and updated "Guidelines for Physician Notification" (from Interact II). Additional education will be completed April 10, 11, and 12, 2012. 4. The Neighborhood Nurse Manager (or designee) will monitor Physician Notification of resident changes/ accidents/incidents. Monitoring includes review of 24 hour report sheets, interview of the staff, and review of accident/incident report forms to view compliance of Policy and Procedure. Monitoring will be conducted weekly for three months. Results of monitoring will be reported to the DON. The DON will report to the QA Committee monthly for 3 months. 5. April 13, 2012	

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F 157	Continued From page 2 1.3 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.) 1.4 A decision to transfer or discharge the resident from the facility. 2. Document date and time physician notified in resident medical record. 3. Licensed nurses or other staff members must also inform as appropriate and, if known, interested family member or the resident's legal representative in above mentioned circumstances. Guidelines for Physician Notification . . . Abrasion, NON-IMMEDIATE, If bleeding continues or if associated with evidence of local infection. . . . Consciousness, altered, IMMEDIATE, Sudden change in level of consciousness or responsiveness. . . . Laceration, NON-IMMEDIATE, Minor laceration not requiring sutures. . . . Nausea and vomiting, IMMEDIATE, Persistent or recurrent (two or more episodes within 12 hours) vomiting, with or without abdominal pain, bleeding, distension, or fever. . . ." - Review of Resident #7's medical record occurred on 03/06/12. Medical diagnoses included dementia. The annual Minimum Data Set (MDS), dated 01/01/12, identified the resident as having moderately impaired cognition. Review of Resident #7's interdisciplinary progress notes, dated 02/12/12, identified the following: * 1:30 a.m. - "Called to resident's room by aide. Resident had large dark, black brown coffee	F 157		

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F 157	Continued From page 3 grounds emesis, Having difficulty breathing BP [blood pressure] 82/56 P [pulse] 130 . . . Legs mottled up to the knees. Oxygen put on resident via face mask at 3 LPM [liters per minute]. Emesis was coming through the nose as well as the mouth. Attempted to contact local family member and left message on cell phone. Called son in Arizona [emergency contact representative] and he requested she be transported to the hospital . . . " The investigation completed by the facility identified the charge nurse actually didn't contact Resident #7's emergency contact representative until 2:40 a.m., one hour and 10 minutes later than documented, due to inability to locate the facility's long distance telephone code number to place the long distance call. The investigation identified the nurse finally utilized the cell phone of another staff member to contact the emergency contact representative. * 1:45 a.m. - "Orders to transport to hospital obtained via telephone order from on call physician." * 2:15 a.m. - "Called for ambulance . . ." Review of Resident #7's ambulance report (Patient Care Report) identified a "911" call from the facility at 2:44 a.m., a half an hour later than stated in the progress note. * 2:45 a.m. - "Ambulance crew arrives. Resident had no pulse, no BP, no respirations." The Patient Care report identified the ambulance crew arrived at the facility at 2:49 a.m. * 2:55 a.m. - "Resident expired." During an interview on the afternoon of 03/06/12, an administrative nurse (#6) stated she expected the charge nurse to know where to locate the long distance telephone code number and to	F 157		

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F 157	Continued From page 4 contact Resident #7's family in a timely manner. The facility waited for one hour and 10 minutes after the Resident #7 showed signs of respiratory distress and mottling before contacting the family and one hour and 14 minutes before contacting the ambulance service for transportation to the hospital. These actions did not allow Resident #7's family the opportunity to be with her at the time of her death. Review of the medical record and the investigation report identified discrepancies as to when the family and ambulance were contacted. - Review of Resident #6's medical record occurred on March 05-06, 2012. The facility admitted the resident in January 2002. Current diagnoses included Alzheimer's disease. The resident's quarterly Minimum Data Set, dated 01/03/12, identified short and long term memory problems and total assistance of two or more persons for transfers and dressing. Resident #6's current care plan identified the resident required a total lift transfer to and from bed and wheelchair and utilized a tilt in space wheelchair. Observations throughout the day on 03/06/12 showed the resident transferred to and from bed and a tilt in space wheelchair with a full body lift by facility staff members. Resident #6's medical record included an Accident/Incident Report, dated 12/10/11 at 8:00 p.m. This report stated "Primary Diagnosis: Skin tear that is 1.5 cm [centimeters]. . . . Describe Injury . . . Abrasion to right wrist inner aspect. . . . Followup/Interventions . . . Applied antibiotic ointment & [and] steri-strips to prevent infection. .	F 157		

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F 157	Continued From page 5 . . Uses the hoyer lift for all transfers. Could have occurred with transfer. . . ." The Accident/Incident Report sections regarding notification of Resident #6's responsible party and physician were blank. Resident #6's Interdisciplinary Progress Notes, dated 12/27/11 at 4:00 a.m., stated "Late entry for 12/10/2011. Caregiver had reported that resident had a cut on (R) [right] wrist inner aspect. Treated [with] antibiotic ointment after cleansing the area. Steri strip applied to prevent further bleeding and possible infection. It is normal behavior for resident to keep arms crossed against her chest and hands tightly clasped. Caregiver noted bleeding before she had begun cares and reported to nurses immediately." Review of Resident #6's Skin Integrity Record failed to identify the skin tear, cut, or abrasion to Resident #6's right wrist at any time. The resident's medical record lacked any followup regarding healing of the right wrist or physician's orders for treatment. During interview, on 03/06/12 at 3:30 p.m., a supervisory nursing staff member (#1) confirmed Resident #6's medical record lacked evidence the facility staff notified the responsible party and the physician.	F 157		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309	04/13/2012

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F 309	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, review of the Emergency Medical Service (EMS) report, review of the investigation completed by the facility, and staff interview, the facility failed to provide the necessary care and services to ensure prompt treatment including indicated transfer to the hospital which resulted in 1 of 2 sampled residents' (Resident #7) not receiving medical treatment in a timely manner for an acute medical event and for 1 of 1 sampled residents recently diagnosed with a fracture (Resident #1). Failure to provide prompt treatment for an acute condition may have resulted in Resident #7's death. Failure to identify Resident #1's pain; failure to complete the pain screen until ten days after identification of Resident #1's fracture; failure to accurately complete the pain screen; and, failure to complete a comprehensive pain assessment resulted in Resident #1 experiencing pain on 25 of 26 days in January 2012 and delayed the provision of additional pain medication (Fentanyl) until two months after the fracture occurred. Findings include: - Review of Resident #7's medical record occurred on 03/06/12. Medical diagnoses included dementia. The annual Minimum Data Set (MDS), dated 01/01/12, identified the resident as having moderately impaired cognition. Review of the Patient Care Report obtained from	F 309	1. Licensed Nursing Staff member attending Resident #7 was re-educated on the facility long distant phone code, and accurate and timely documentation of resident events. Licensed Nursing Staff member attending Resident #1 for completion of Pain Screen Form was re-educated on the use and definitions for the form. Staff attending Resident #1 were re-educated on screening of pain, review of pain screening and comprehensive pain assessment forms, signs and symptoms of pain, and treatment of pain. All Licensed Nursing Staff members were re-educated on March 7th and 8th, 2012. 2. Any resident has the potential to be affected. 3. On February 14, 2012 a memo had been sent to the Licensed Nursing Staff on the process of how to make a long distance phone call with the facility system. This information was placed in the medication cart on each of the Neighborhoods. On March 30, 2012 the process of how to make a long distance phone call was placed on handset of the telephone at each of the Neighborhood Nurse Stations. Mandatory Nursing in-services were completed on March 7th and 8th, 2012, which included documentation, facility long distant phone code, screening of pain in residents, and completion of pain screening and comprehensive pain assessment. Policy and Procedure for Pain Assessment (Screening and Comprehensive) were reviewed and updated as necessary.	

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F 309	Continued From page 7 EMS, dated 02/12/12, identified a "911" call from the facility at 2:44 a.m. The ambulance crew responded to the call at 2:45 a.m. and arrived at the facility at 2:49 a.m. Review of Resident #7's interdisciplinary progress notes, dated 02/12/12, identified the following: * 1:30 a.m. - "Called to resident's room by aide. Resident had large dark, black brown coffee grounds emesis, Having difficulty breathing BP [blood pressure] 82/56 P [pulse] 130 . . . Legs mottled up to the knees. Oxygen put on resident via face mask at 3 LPM [liters per minute]. Emesis was coming through the nose as well as the mouth. Attempted to contact local family member and left message on cell phone. Called son in Arizona [emergency contact representative] and he requested she be transported to the hospital . . ." The investigation completed by the facility identified the charge nurse actually didn't contact Resident #7's emergency contact representative until 2:40 a.m. due to inability to locate the facility's long distance telephone code number to place the long distance call. The investigation identified the nurse finally utilized the cell phone of another staff member to contact the emergency contact representative. * 1:45 a.m. - "Orders to transport to hospital obtained via telephone order from on call physician." * 2:15 a.m. - "Called for ambulance . . ." This note conflicts with the Patient Care Report which identified a "911" call at 2:44 a.m. * 2:45 a.m. - "Ambulance crew arrives. Resident had no pulse, no BP, no respirations." The Patient Care report identified the ambulance crew arrived at the facility at 2:49 a.m.	F 309	Form for Comprehensive Pain Assessment was updated to include both Cognitively Intact and Impaired Residents. Form for Pain Screening was updated to complete Comprehensive Assessment when score is 3 or greater. Education will be completed on the updated Policy and Procedure and Forms for Pain Assessment on April 10, 11, and 12, 2012. 4. The Neighborhood Nurse Manager (or designee) will be responsible for monitoring pain management which may include completion of Pain Assessment Screen/Comprehensive according to Policy and Procedure, upon admit/hospital return within 24 hours and with each MDS assessment including signs and symptoms of pain, medication administered with results documented, and if treatment ineffective a reassessment process is instituted. This will be monitored weekly and reported to the DON. The DON will report monthly to the QA committee. The DON (or designee) will review acute changes in residents to identify opportunities to enhance care of residents. Indicators to be monitored will include, but not limited to; change in resident, new condition, new signs and symptoms, and other pertinent data. This will be monitored weekly and reported to the QA committee monthly. 5. April 13, 2012.	

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F 309	Continued From page 8 * 2:55 a.m. - "Resident expired." The facility waited for one hour and 14 minutes before contacting the ambulance service for transportation to the hospital. The facility had received a physician order to transfer the resident to the hospital 59 minutes prior to making the "911" call. These actions did not allow Resident #7 the opportunity to receive the necessary care and treatment which may have prevented her death, and did not allow the family the opportunity to arrive to the facility and be with her at the time of her death. Review of the medical record and the investigation report identified discrepancies as to when the family and ambulance were contacted. Refer to F514. - Review of the facility's Pain Screening Form occurred on March 05-06, 2012. This form, revised April 2006, stated ". . . Instructions: This is a screening tool to be used for monitoring of residents to identify any pain that may need a more in depth assessment. . . ." This form also included "Parameter, 1. New Pain . . . 4. Routine medications ordered for pain; 5. Frequency of pain; 6. Conditions/diagnosis associated with potential for pain; 7. Intensity of pain, Pain Scale [0 to 10, no pain to worst]; 8. Observations of pain; Score of 5 or greater indicates comprehensive assessment needed. . . ." Review of Resident #1's medical record occurred on March 05-06, 2012. The facility admitted the resident in April 2009. Current diagnoses included osteoarthritis, osteopenia (reduced bone density), and pathologic fracture left tibia and fibula (identified on 01/05/12). The quarterly MDSs, dated 10/14/11 and 01/14/12, identified severe	F 309		

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F 309	Continued From page 9 cognitive impairment, total assistance of two or more persons for transfers, walking did not occur, and the resident experienced moderate pain. Resident #1's medical record included emergency room records from an acute care facility, dated 01/05/12. These records included radiology reports which stated "Osteopenia is evident. There is a comminuted fracture at the junction of the diaphysis [shaft of the bone] and distal metaphysis [growth plate at the end of the bone] with fracture fragments in gross anatomic alignment. . . ." The medical record also included ". . . Plan: BK [Below Knee] Non Wt [weight] bearing cast . . . Will reassess in 1 wk [week]. Elevate leg. Watch for swelling." Resident #1's care plan, dated 11/01/11, stated "Problem, Impaired physical mobility . . . Chronic knee pain & [and] Lt. [left] upper extremity . . . pain . . . Complains of general aching most days. [Undated update] Fracture left tibia/fibula. . . . Approaches . . . Monitor for level of pain. PRN [As needed] pain medications ordered. Monitor effectiveness of pain medication. [updated 01/12/12] Medicate for pain as needed. . . ." The resident's current care plan, dated 02/03/12, did not include the update of 01/12/12. The facility failed to include care plan approaches regarding Resident #1's pain related to the fracture. Resident #1's physician orders included the following pain medications and the date initiated: *Fentanyl Transdermal Patch (opioid pain reliever) 12 micrograms per hour (mcg/hr), q72h, 03/05/12. *Tylenol 500 milligrams (mg), two tablets, two times each day (bid), 10/27/11.	F 309		

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F 309	Continued From page 10 *Tylenol 500 mg, two tablets, every six hours (q6h), prn, 07/22/10. *Vicodin 5/500 (5 mg hydrocodone (narcotic pain reliever)/500 mg Tylenol), one tablet, q4h, prn, 05/13/10. Resident #1's Medication Administration Record (MAR) identified the facility staff provided the following prn medications: *December 2011 - Tylenol - two times. Vicodin - seven times. *January 01-04, 2012 - Tylenol - one time. Vicodin - four times. *January 05-31, 2012 (after fracture identified) - Tylenol - six times. Vicodin - 27 times, including four times on 01/06/12 and two times on seven additional days. *February 2012 - Tylenol - four times. Vicodin - 8 times, including two times on 02/26/12. *March 01-06, 2012 - Tylenol - none Vicodin - two times Resident #1's MAR included the question "What is your pain level today? . . . 0 no pain and 10 worst . . ." two times each day. For the period January 06-31, 2012, the resident reported pain at least one time each day, except no pain reported on 01/24/12, and rated her pain from "3" on several days to "9" on 01/25/12. Resident #1's Interdisciplinary Progress Notes included the following: *01/02/12 at 10:00 a.m. - "CNA [Certified nursing	F 309		

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F 309	Continued From page 11 assistant] hit foot on wall by elevator. ROM [Range of motion] [without] difficulty. Resident moving foot per self freely, no redness or bruising noted." *01/05/12 at 11:00 a.m. - "Resident c/o [complains of] (L) [left] shin and lower leg area. Resident examined. Pt. [Patient] unable to move leg, when toes flex or ankle moved pt. c/o severe pain. Swelling noted to ankle et [and] shin area. . . . To E.R. [emergency room] per w/c [wheelchair]." *01/05/12 at 4:00 p.m. - "Returned from appt. [appointment]. Cast intact to (L) lower leg. . . . Denies any pain @ [at] this time." *01/16/12 at 4:00 p.m. - "Resident moaning. When asked if she was having pain she said yes all over. When asked if her leg hurt she said 'Just all over aching.' Pain pill given. Resident resting in comfort." *01/27/12 at 5:00 p.m. - "Visited with resident's daughter, [name] about resident's pain and decrease appetite. Stated mother's always had pain from arthritis. Discussed sending fax to doctor regarding pain. Agreed with this. Told her would revisit when heard from doctor. . . ." The medical record lacked evidence of a response from the physician or revisit with the family member until 03/03/12. *02/08/12 at 8:15 p.m. - "Medicated for c/o pain 'all over,' yells et screams, wanting to go to bed." *03/03/12 at 3:40 p.m. - "Visited with daughter, [name], about mother. Sending fax to [physician] about resident's pain and seeing if there is something that will give better pain control. . . ." *03/05/12 at 2:00 p.m. - "Received script [prescription] for Fentanyl patch. . . ." Resident #1's Pain Screening Form, dated 04/20/11, 07/15/11, 10/15/11, and 01/15/12 each	F 309		

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F 309	Continued From page 12 identified ". . . Total Score, 4 . . ." which indicated comprehensive assessments were not needed. The Pain Screening Form, completed on 01/15/12, ten days after identification of Resident #1's left lower leg fracture on 01/05/12, failed to identify the following: 1. New Pain - related to the resident's lower leg fracture. 4. Routine medications ordered for pain - identified as effective, although the resident continued to complain of pain. 5. Frequency of pain - identified as less than daily. Resident #1 complained of pain daily between January 05-15, 2012. 6. Conditions/diagnosis associated with potential for pain - identified one condition/diagnosis. Failed to identify the resident's fracture as a new diagnosis with potential for pain. 7. Intensity of pain - identified as "0 - no pain." Resident #1 complained of pain daily. 8. Observations of pain - identified as "no observations." Resident #1 complained of pain as noted on the MAR and Interdisciplinary Progress Notes. The facility staff identified Resident #1's severe cognitive impairment and moderate degree of pain before the left leg fracture. Following identification of the fracture, the facility staff failed to identify the resident's increased pain, accurately screen the resident for pain, or monitor the resident for pain. The medical record lacked evidence of discussions with family members or physicians regarding additional pain medications until 01/27/12. The medical record lacked information regarding a change in pain medications after the conversation with the family member on 01/27/12. The response to this "fax"	F 309		

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F 309	Continued From page 13 is unknown. During interview, on 03/06/12 at 4:00 p.m., an administrative nursing staff member (#6) confirmed the facility staff failed to accurately complete the Pain Screen on 01/15/12 which resulted in failure to complete a comprehensive pain assessment.	F 309		
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: 1. Based on record review, review of professional reference, and review of Division of Health Facilities files, the facility failed to ensure adequate supervision and assistance to prevent an accident for 1 of 1 sampled resident with a fracture (Resident #1). Failure to ensure proper positioning when entering the elevator caused Resident #1's left foot to hit the elevator frame and had the potential for harm and injury of the Resident's lower extremities. Findings include: Dugan, "Successful Nursing Assistant Care," 2nd edition, Hartman Publishing, Inc., Albuquerque, page 109, states "Preventing Cuts, Scrapes, and	F 323	**F323** As required by federal law and in the spirit of cooperation we are submitting the following plan: 1. Certified Nursing Assistant attending Resident #1 was re-educated on proper positioning of feet on the platform of the tilt-n-space chair. Staff attending Resident #3 were re-educated on resident transfer. Following the survey, Resident #3 was changed to a full assist lift in compliance with Surveyors directive. Resident # 3 will be reassessed by the Consulting Physical Therapist for her in preparation of her next quarterly MDS assessment, which is due April 24, 2012. Care plan and Certified Nursing Assistant Group sheets were up dated to reflect present care. Residents in the facility who utilized the partial assist lift were reassessed for appropriate transfer. 2. Any resident who utilizes a wheelchair and tilt n space for mobility has the potential to be affected. Any resident who utilizes the partial assist lift has the potential to be affected.	04/13/2012

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F 323	Continued From page 14 Other Injuries . . . When moving residents in wheelchairs or stretchers, protect their arms and legs. Hands and feet can be hurt or bumped into walls or doors. . . . Make sure arms and legs are inside of the chair . . . When entering elevators, turn the chair around so that residents are facing forward. . . ." Review of Resident #1's medical record occurred on March 05-06, 2012. The facility admitted the resident in April 2009. Current diagnoses included osteoarthritis, osteopenia (reduced bone density), and pathologic fracture left tibia and fibula (identified on 01/05/12). The quarterly Minimum Data Sets (MDSs), dated 10/14/11 and 01/14/12, identified severe cognitive impairment, total assistance of two or more persons for transfers, walking did not occur, and the resident experienced moderate pain. Resident #1's Interdisciplinary Progress Notes stated: *01/02/12 at 10:00 a.m. - "CNA [Certified nursing assistant] hit foot on wall by elevator. ROM [Range of motion] [without] difficulty. Resident moving foot per self freely, no redness or bruising noted." Resident #1's Skin Integrity Record stated: * 01/03/12 - "Light purple Skin intact." The facility's investigation regarding the origin of Resident #1's fracture, submitted to the Division of Health Facilities stated: "Observation from the security camera's [sic] . . . The resident was noted to have her left foot	F 323	3. Staff were educated on March 7th and 8th, 2012 in regards to proper positioning of feet in wheelchair/tilt n space chair, use of the partial/full assist lifts, and the transfer decision tree. On March 15, 2012 Consulting Physical Therapist completed mandatory in-service on Transfer Decision Tree and different devices utilized during the transfer process. The Transfer Decision Tree has been placed on each of the neighborhoods for guidance of transfers. 4. Neighborhood Nurse Manager (or designee) will monitor proper positioning of the resident's in wheelchair and transfers of residents in partial and full assist lifts. This will be reported to the DON weekly for 3 months. The DON will report monthly to the QA Committee. 5. April 13, 2012	

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F 323	Continued From page 15 slightly off the foot pedal of the tilt and [sic] space recliner. The resident remains in the hallway . . . waiting for the elevator. When the elevator door opens [(CNA) (#11)], pushes [Resident #1] into the elevator. While the resident was being pushed into the elevator the tilt and [sic] space is noted to stop and resident raises her hand. The Certified Nursing Assistants immediately pulled the resident off of the elevator, removed the blankets, and examined her legs. . . . 16. [CNA (#11)] . . . She assured that the resident's feet were in the foot pedals. . . . [CNA (#10)] pushed the resident in the elevator and hit the frame of the elevator with the left foot pedal/foot and the resident stated 'owe.' . . . [CNA (#11)] stated that they removed the resident from the elevator door way and lifted up the blanket to look at the resident's legs and did not notice anything. . . . [CNA (#11)] related that the resident does have a tendency to have her feet hang over the end of the foot pedals or to the side of the foot pedals. . . . 24. [CNA (#10)] . . . [CNA (#10)] related that on Monday she was assisting [CNA (#11)] to get [Resident #1] into the elevator. [CNA (#10)] related that when she was maneuvering the tilt and [sic] space chair into the elevator she hit what she thought was the foot pedal on the side of the door way going into the elevator. She related that [Resident #1] stated 'ouch.' [CNA (#10) stated we ([CNA (#11)]) pulled [Resident #1] back out of the elevator and removed the blanket to look at her leg/foot. . . ." Failure to ensure proper positioning of Resident #1's foot when entering an elevator resulted in Resident #1's left foot striking the elevator and had the potential to result in injury.	F 323		

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F 323	Continued From page 16	F 323		

2. Based on observation, record review, and staff interview, the facility failed to ensure staff used the correct assistive devices to prevent accidents for 1 of 1 sampled resident (Resident #3) who required a mechanical lift with transfers. Failure to use the mechanical lift most appropriate for this resident may have resulted in Resident #3 experiencing pain during lift transfers and placed the resident at risk of falling or sustaining an injury during transfers.

Findings include:

Review of Resident #3's medical record occurred on March 05-06, 2011. The facility admitted the resident in January 2011. Medical diagnoses included Alzheimer's disease, dementia, osteoarthritis, and pain. Daily medications included a fentanyl patch (an opioid analgesic patch applied every 72 hours); Tylenol 1000 milligrams (mg) every six hours as needed (PRN); and Vicodin 5/325 mg (5mg of hydrocodone and 325 mg of acetaminophen) every four hours PRN. The annual Minimum Data Set (MDS), dated 01/24/12, identified the resident required extensive assistance of two staff members for bed mobility and transfers.

Resident #3's current care plan stated, "Problem: Impaired Physical Mobility . . . Approaches: . . . Hoyer lift [a full body mechanical lift] PRN for transfers with 2 assist . . . EZ stand [a sit to stand mechanical lift] for transfers with 2 assist . . ."

Review of Resident #3's PRN medication

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F 323	Continued From page 17 administration records (MARs) from 02/04/12 to 03/06/12, identified the resident received Tylenol nine days in February and four days in March. Resident #3 received Vicodin twice in February and twice in March. The reasons indicated on the MAR for the medication administration were general discomfort, anxiety, headache, and moaning. Review of an interdisciplinary progress note, dated 01/24/12, stated, ". . . Her [Resident #3] condition has deteriorated gradually over the last year. She no longer ambulates . . . dependent on staff for ADLs [activities of daily living] . . ." Observations of Resident #3 showed the following: * On 03/05/12 at 1:40 p.m., two certified nursing assistants (CNAs) (#1 and #2) utilized an EZ stand and assisted Resident #3 to a semi-upright position (squat), changed her brief, and transferred her into bed. Observation showed the resident unable to hold onto the handle grips and her shoulders pulled upward towards her ears. * On 03/05/12 at 3:30 p.m., two CNAs (#2 and #3) assisted Resident #3 to the edge of her bed and applied the EZ stand harness behind her back. Observation showed the resident rigid, leaning backward, and unable to bend at her knees or hold onto the handle grips. The CNAs transferred the resident into a wheelchair. During interview, following this observation, a CNA (#3) stated the resident "never hangs on," and they used to utilize a hoyer lift with her. * On 03/06/12 at 9:25 a.m., two CNAs (#4 and #5) utilized the EZ stand and assisted Resident #3 to an upright position (squat), checked her brief, and transferred her to bed. Observation	F 323		

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F 323	Continued From page 18 showed the resident held onto the left handle grip, her right arm hanging by her side, and her shoulders pulled upward toward her ears. The resident groaned as though in pain. During interview, following this observation, a CNA (#5) stated staff members ask the resident, "Can you stand?" The CNA stated they usually use the EZ stand but some staff members utilize the hoyer lift in the afternoon related to the residents inability to stand. * On 03/06/12 at 11:00 a.m., two CNAs (4# and #5) assisted Resident #3 to the edge of the bed, applied the EZ stand harness, placed the resident's hands on the hand grips and stated, "We're going to stand up, OK, so try to hold on." The CNAs transferred the resident to the wheelchair while she held loosely onto the handle grips. * On 03/06/12 at 3:57 p.m., two CNAs (#7 and #8) assisted Resident #3 to the edge of the bed, applied the EZ stand harness, placed the resident's hands on the hand grips of the lift, and encouraged her to hold onto the hand grips. As the CNAs brought the resident to a standing position, she let go of the right handle grip. The CNAs continued to bring Resident #3 to a standing position as she held onto to the left handle grip, the right arm hanging at her side, and both shoulders pulled upwards towards her ears by the EZ stand harness. The CNAs completed the transfer of Resident #3 to the wheelchair. During interview, following this episode of care, the CNA (#8) reported the facility staff transferred Resident #3 with a standing lift for at least the past three months and the resident transferred "Better today than usual." The medical record lacked evidence facility staff	F 323		

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F 323	Continued From page 19 re-evaluated Resident #3's ability to transfer safely with an EZ stand and the staff interviews identified a lack of knowledge as to what would be considered a safe transfer given Resident #3's lack of participation with the transfers on five occasions observed.	F 323		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional reference, review of Emergency Medical Services (EMS) report, and staff interview, the facility failed to maintain medical records in accordance with accepted professional standards and practices for 1 of 6 sampled residents (Resident #6) and 1 of 2 closed records (Resident #7). Failure to maintain an accurate and functional representation of the actual experience of the residents does not provide a picture of the residents' progress, including changes in condition and changes in	F 514	**F514** 1. Licensed Nursing Staff member attending to Resident # 7 was re-educated on the importance of accuracy of documentation. Licensed Nursing Staff member, who is an Agency Nurse, attending Resident #6 was educated on the timely documentation of events.	04/13/2012

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F 514	Continued From page 20 treatment. Findings include: Review of the facility policy titled "Documentation Guidelines" occurred on 03/06/12. This policy, dated 2006, stated, ". . . 1. Nursing progress notes should be made . . . 1.2 Whenever there is a change in the status of a problem . . . 1.6 Whenever a resident sustains an injury. Progress notes will include physical and mental condition; vital signs; c/o [complaints of] of [sic] the resident; time the physician was notified if applicable . . . 1.9 As needed according to resident condition. 2. When documenting in the medical record, remember: 2.1 Be meticulous 2.2 Do factual documenting . . . 2.4 Chart as if another well trained professional will be looking for errors, discrepancies. 2.5 When adding a late entry, use the first blank space and identify it as a late entry . . ." - Review of Resident #7's medical record occurred on 03/06/12. Medical diagnoses included dementia. Review of the Patient Care Report obtained from EMS, dated 02/12/12, identified a "911" call from the facility at 2:44 a.m. The ambulance crew responded to the call at 2:45 a.m. and arrived at the facility at 2:49 a.m. Review of Resident #7's interdisciplinary progress notes, dated 02/12/12, identified the following: * 1:30 a.m. - "Called to resident's room by aide. Resident had large dark, black brown coffee grounds emesis, Having difficulty breathing . . . Called son in Arizona and he requested she be	F 514	In addition, the Agency was informed informed of these issues so they may provide retraining as they deem appropriate. All staff were re-educated on the importance of accuracy of notes placed in the clinical record as identified on March 7th and 8th, 2012. 2. Any resident has the potential to be affected. 3. Policy and Procedure of Documentation Guidelines will be reviewed and updated to include but not limited to how to make corrections, follow up assessment (and forms utilized), documentation of late entries, and treatments provided. Documentation education was completed on March 7th and 8th 2012. Education on updated Policy and Procedure of Documentation Guidelines will be conducted on April 10, 11, and 12, 2012. 4. Neighborhood Nurse Manager (or designee) will monitor changes in resident condition through the 24 hour report sheet to assure completion of timely and accurate documentation. Monitoring will be conducted weekly for three months. Results of monitoring will be reported to the DON. The DON will report to the QA Committee monthly for 3 months. 5. April 13, 2012	

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F 514	Continued From page 21 transported to the hospital . . ." The investigation completed by the facility identified the charge nurse did not contact Resident #7's emergency contact representative until 2:40 a.m. * 1:45 a.m. (written over an unidentified time) - "Orders to transport to hospital obtained via telephone order from on call physician." * 2:15 a.m. (a line is drawn through 2:35 a.m. and replaced with 2:15 a.m.) - "Called for ambulance . . ." This note conflicts with the Patient Care Report which identified a "911" call at 2:44 a.m. * 2:45 a.m. - "Ambulance crew arrives. Resident had no pulse, no BP, no respirations." The Patient Care report identified the ambulance crew arrived at the facility at 2:49 a.m. * 2:55 a.m. (written over an unidentified time) - "Resident expired." During an interview on the afternoon of 03/06/12, an administrative nurse (#6) stated she expected the documentation in Resident #7's medical record to be complete and the timing of the events need to be accurate. Review of the medical record, Patient Care Report, and the investigation report identified discrepancies with the timing of events leading up to Resident #7's death. - Review of Resident #6's medical record occurred on March 05-06, 2012. The medical record included an Accident/Incident Report, dated 12/10/11 at 8:00 p.m. This report stated "Primary Diagnosis: Skin tear that is 1.5 cm [centimeters]. . . . Describe Injury . . . Abrasion to right wrist inner aspect. . . . Followup/Interventions . . ."	F 514		

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F 514	Continued From page 22 Resident #6's Interdisciplinary Progress Notes, dated 12/27/11 at 4:00 a.m., stated "Late entry for 12/10/2011. Caregiver had reported that resident had a cut on (R) [right] wrist inner aspect. Treated [with] antibiotic ointment after cleansing the area. Steri strip applied to prevent further bleeding and possible infection. . . ." Resident #6's Skin Integrity Record failed to identify the skin tear, cut, or abrasion to Resident #6's right wrist at any time. The resident's medical record lacked any followup regarding healing of the right wrist or physician's orders for treatment. It is unknown what treatment the facility staff provided, how long it was provided, or when the skin tear healed. During interview, on 03/06/12 at 3:30 p.m., a supervisory nursing staff member (#9) confirmed Resident #6's medical record lacked documentation regarding continued treatment and healing of the skin tear.	F 514		