POC accepted 1/17/13 JC

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	566000	A. BUILDING _____ B. WING _____	C 11/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1111 LANE 12 LOVELL, WY 82431

(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 The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse CAA: Care Area Assessment LPN: Licensed Practical Nurse ADLs: Activities of Daily Living Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 323 SS=H	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 medical record review, staff interview and review of incident reports, the facility failed to ensure effective supervision and interventions to prevent falls for 5 of 12 sample residents (#4, #14, #26, #29, #33, #79). As a result, serious avoidable injuries occurred to sample residents #4, #25, #33, and #79. The findings were: 1. Review of the medical record for resident #4 showed s/he had diagnoses that included	F 323	The facility will ensure that the resident and environment will remain as free of accident hazards as possible; and each resident will receive adequate supervision and interventions to prevent falls. A.) Resident #79 is deceased. B.) Resident #4 is deceased. C.) Effective supervision with dates and specific, well defined interventions to prevent falls will be in place for residents #14, #25, #26, and #33 and all other residents by all staff. D.) Interdisciplinary Team Fall Incident Forms and fall review for residents #14, #25, #26, #33 and all other residents will completed thoroughly.	~~01/25/13~~ 1/3/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keith S. Snyder	LNHA	12/14/12

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.

Charges per phone call on 1/2/13 @ 4:16pm with Kirk Snyder, NHA
Jaccee Cook, ONIC

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F 323	Continued From page 1 dementia and hypertension. Review of the history and physical dated 11/18/11 showed the resident was admitted to the nursing home in 2008 and has had a gradual decline in both motor and cognitive skills. Review of the 9/21/12 annual MDS assessment showed the resident required limited assistance with one person physical assist for walking and for locomotion. In addition, section GG300 of this MDS assessment showed the resident was "Not steady, only able to stabilize with human assistance" for moving from seated to standing position, walking, turning around, moving on and off toilet, and surface to surface transfer. Review of incident information showed the resident had fallen 5 times since September 2012. The resident fell twice on 9/10/12 both times while trying to independently sit in a chair, on 9/21/12 the resident was found in his/her own room on the floor with a minor injury, a skin tear to the left elbow. additionally, when the resident was found on the floor, s/he was incontinent of bowel and bladder. On 10/13/12 the resident was found on the floor of another resident's room with no injury noted. On 10/20/12 the resident was witnessed to fall while standing face-to-face with another resident. This fall resulted in a fractured hip and surgical intervention. Review of the CAA for falls dated 9/20/12 showed the resident was at risk and had a history of recent falls, had dementia, and wandered on the secure unit. In addition, the CAA analysis of findings was inconsistent with the data in the MDS assessment showing the resident ambulated by self with the use of an assistive device. The analysis identified the risk as "fall with injury." A decision was made to proceed with a care plan. The following concerns were identified with the failure to develop effective	F 323	E.) The special care unit will have adequate staffing as evidenced by at least two staff members from 5:00 a.m. until 11:00 p.m. on the unit at all times. F.) Staff will perform hourly rounding on every resident to ensure that the resident and environment will remain as free of accident hazards as possible on the secured unit and document on the hourly rounding flow sheet. G.) Education will be provided to the IDT and charge nurses on the process and importance completing incident report forms and post-fall forms completely and accurately. All staff will be educated on hourly rounding. H.) Monitoring of compliance will be done weekly by random reviews of hourly rounding forms of two residents by supervisors and review of two incident reporting forms per week by CNO by using the quality improvement monitoring tool, until substantial compliance has been met. I.) Staff not utilizing specific interventions and dates on care plans, not completing fall incident forms completely and correctly, and staff failing to ensure two staff are on special care unit at all times, will receive immediate in-servicing and corrective actions will be taken. J.) Results will be reported quarterly at the Quality Meeting as part of the facility Quality Assurance Program.	

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F 323	Continued From page 2 interventions to help prevent falls: a. Review of the care plan showed alteration in ADLs and risk of falls was initiated on 12/6/10. The goal was to have "No injury fall over the next 90 days" the review date on the care plan showed 9/25/12. There were several interventions listed which failed to be specific. These included; "assist with transfers when possible...anticipate needs...guide resident with ambulation when needed...monitor when wandering." Further review of the care plan showed there were no dates associated with interventions to show what had been added or changed related to the resident's recurrent falls. b. Review of the fall investigation worksheets and the occurrence report for the 10/28/12 fall which resulted in a broken hip, showed the resident fell while ambulating. It further showed the resident ambulates without assist, and the fall was witnessed. According to this 10/28/12 report, the witness was a housekeeping staff member. The investigation worksheet and the report failed to identify the lack of monitoring and supervision for the resident by direct care staff. This resident had been identified on the 9/21/12 annual MDS assessment as being unsteady and needing physical assistance for walking. The interdisciplinary team review of the fall was completed on 11/1/12. However, review of this form showed the area for discussing the interventions used to prevent falls for this resident was blank. According to the previous IDT fall review dated 10/18/12, the IDT recommended to "monitor when wandering." c. Interview with the MDS coordinator on 11/7/12 at 10:30 AM verified the care plan failed to specifically identify how wandering would be monitored.	F 323		

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F 323	Continued From page 3 d. Interview with the DON on 11/7/12 at 10:40 AM verified staffing in the secure unit had been problematic for the past several months. 2. Review of 7/6/12 annual MDS assessment for resident #25 showed s/he had diagnoses that included macular degeneration, Parkinson's disease, and anxiety. According to the 7/6/12 timed at 4 PM nurses note, the resident was dependant on staff for ADL's requiring extensive assistance with bed mobility, transfers, ambulating, dressing, eating, toileting, personal hygiene, and bathing. The note further showed the resident was quite unsteady and was a fall risk and "very frail." Observation on 11/6/12 at 2:50 PM showed the resident was seated in his/her recliner next to the bed. The recliner was automated with a remote to lower the foot rest, and to raise up the seat to ease getting up into a standing position. The remote for the chair was situated next to the resident in the chair. However, the chair was not plugged into the wall which disabled the remote. Interview with CNA #1 on 11/6/12 at 2:55 PM revealed the resident was not safe to use the remote, because of previous falls, so they unplugged it. She further revealed the aides would plug it back in to lower and raise the foot rest for the resident because there was not any manual lever. Review of the alteration in ADLs and risk for falls care plan dated 8/9/11 for the resident showed interventions that included extensive to total assist with ADLs...assess pain daily...room free of clutter...chair alarm...low bed...floor mat alarm and check on him/her frequently. The review date on the care plan was 7/10/12. There were not any specific dates associated with the interventions. Continued review of the care plan showed a new problem for	F 323		

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F 323	Continued From page 4 alteration in comfort related to Parkinson's and falls was developed on 7/10/12. These interventions included anticipate needs, and keep chair remote out of reach. Review of the fall incident reports and IDT reviews showed the resident had sustained two falls both of which were related to getting up from the chair while unassisted. One fall was on 7/12/12, another was on 9/6/12. Review of the 7/12/12 nurses note for the 6 PM to 10 PM shift, and the 7/13/12 untimed nurses note showed the fall on 7/12/12 resulted in a serious injury to the resident's left eye which required sutures and ocular surgery. The following concerns were identified with implementing effective strategies to prevent falls: a. Review of the 7/12/12 fall investigation worksheet showed the fall occurred at 6 PM on 7/12/12, the fall was unwitnessed and staff were alerted by the resident's chair alarm going off. The resident was found on the floor between the recliner and the bedside table. The worksheet failed to describe if the resident had been in control of the chair remote, possibly contributing to the fall. Further, the worksheet failed to include any information from the resident related to what had happened to cause the fall. b. Review of the IDT (interdisciplinary treatment team) fall review for the 7/12/12 fall with serious injury failed to include any documentation regarding the 7/10/12 care plan intervention to keep the chair remote out of the reach of the resident. The interventions in place were listed as: chair alarm, call bell in reach, low bed and floor alarm. The area to show "were they in use" (the interventions) showed a "yes" next to the line for chair alarm, and the lines for the other interventions listed were left blank. In addition the recommendations/new interventions were not	F 323		

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F 323	Continued From page 6 specific to the resident or well defined. The documentation showed the team recommended, "all interventions in place-monitor." b. Review of the 9/6/12 fall investigation worksheet showed the resident raised the chair to the highest position and slid out of the recliner. Review of the occurrence report for the 9/6/12 fall showed the fall was unwitnessed and there was no injury. Review of the undated IDT fall review showed the team failed to document the portion of the form related to the interventions that were or were not in place at the time of the fall. Additionally, there was no answer to the question to update the care plan. The recommendations/new interventions section showed the team decision was, "keep control out of reach." 8. Review of the 6/14/12 hospital history and physical for resident #79 showed s/he had diagnoses including altered mental status, intractable neuropathic pain in the right lower extremity, joint pain involving multiple sites, anxiety, and dementia. Review of the 7/6/12 initial MDS assessment showed the resident required extensive assistance with bed mobility, transfer and ambulation. Continued review of this assessment showed the resident was not steady and was only able to stabilize him/herself with staff assistance. Finally, review of this assessment showed the resident required the use of a walker or wheel chair due to lower extremity limitation in range of motion. The following concerns with supervision and fall prevention management were identified: a. Review of the 6/28/12 nursing notes timed at 7:10 AM showed the resident was found lying on the floor by the side of his/her bed. Review of	F 323		

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F 323	Continued From page 8 the falls investigation worksheet dated 6/28/12 showed recommendations for a chair and bed alarm and a low bed. Further review of the 6/28/12 timed at 7:10 AM nursing notes showed a chair alarm was placed. Review of these nursing notes showed no evidence an alarm was placed on the resident's bed. Review of the 7/6/12 fall assessment showed the resident was at risk for falls and the interventions in place included a low bed and use of a walker. There was no evidence a chair or bed alarm was in place at this time. b. Review of the 8/28/12 physical therapy evaluation showed the resident had experienced a decline in ambulation. Review of the 10/6/12 nursing notes timed at 8:15 AM showed the resident was found sitting between the bed and bathroom and was incontinent of feces. This fall was unwitnessed but staff noted the resident's walker was in the bathroom out of his/her reach. Review of the 10/11/12 interdisciplinary team fall review showed the call bell was not in place. Review of the current care plan, dated 7/2/12, showed the resident was at risk of falls. Interventions included monitor for needs, call bell in reach, keep walker and wheelchair available for locomotion, keep room free of clutter, encourage socialization, help with ADLs as needed. Review of the emergency room report showed this fall resulted in a skull fracture with subsequent death of the resident. 4. Review of the medical record for resident #33 showed s/he was admitted with diagnoses including history of cerebral vascular accident (stroke) and chronic dizziness. This resident resided in the secured dementia unit. Review of the 3/2/12 annual MDS assessment showed the resident was not steady when walking or turning	F 323		

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F 323	Continued From page 7 around while walking but was able to steady him/herself without staff assistance. In addition, according to this MDS assessment the resident had lower extremity limitations and required the use of a walker. Review of the CAA dated 3/6/12 showed the resident did not wear shoes and therefore required gripper socks due to being at risk for falls. The following concerns were identified: a. Review of the 5/12/12 nursing notes and the May 2012 fall report showed the resident had a fall with minor injury to the right knee on 5/12/12 at 2:40 PM. Review of the 5/12/12 falls investigation worksheet did not indicate whether or not the resident was wearing gripper socks as instructed in the care plan. Review of the interdisciplinary post fall assessment dated 5/17/12 showed the only recommendation was to "monitor" and there were no changes to the care plan. b. Review of the 6/14/12 nursing notes timed at 1:55 AM showed the resident had a fall and sustained fractured ribs. Review of the interdisciplinary post fall assessment, undated, showed the recommendation was again to "monitor" and encourage to use the walker. No changes were made to the care plan c. Interview with the DON on 11/7/12 at 10:40 AM verified staffing in the secure unit had been problematic for the past several months. 5. Review of the 8/16/12 physician note showed resident #14 had diagnoses including congestive heart failure, history of transient ischemic attacks, a cerebral vascular accident, and Alzheimer's with dementia. The resident resided on the secure dementia unit. According to the fall reports from April 2012 through October 2012, the resident	F 323		

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F 323	Continued From page 8 had 16 falls with all but 3 unwitnessed. The following concerns with safety management and supervision to prevent falls were identified: a. Review of the 2/10/12 quarterly MDS assessment showed the resident required extensive assistance with bed mobility and transfers, did not ambulate, and required total assistance with locomotion on or off the unit. In addition the resident was not steady when moving from a seated to standing position, moving on and off the toilet and for surface to surface transfers. Finally, the assessment showed the resident required a wheel chair for mobility. Review of the 4/15/12 nursing notes timed at 3:30 PM showed the resident was found lying on the floor in the atrium. Review of the 4/15/12 falls investigation worksheet showed the only intervention recommended was "monitoring." b. Review of the 5/4/12 annual MDS assessment showed the resident required extensive assistance with bed mobility, transfers, and ambulation. The resident required total assistance with locomotion on or off the unit and continued to have an unsteady gait and required human assistance for stabilization. The MDS showed the resident now used a walker or a wheel chair. Review of the 5/3/12 nursing notes timed at 6:15 AM showed the resident was found crawling on the floor in front of the recliner s/he had been sitting in. Review of the fall investigation worksheet showed a possible cause for the fall was the resident had been administered a routine rectal suppository earlier. Continued review of the worksheet showed a recommendation to more closely supervise the resident after being administered a rectal suppository "(staff permitting)." Review of the medical record also showed the resident fell out of the wheel chair on	F 323		

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F 323	Continued From page 9 5/16/12 at 8:20 AM after lunging forward. On 6/22/12 at 5:40 AM the resident stood up out of the wheel chair and crumbled to the floor. Review of the falls investigation worksheet showed recommendations to "put in recliner [not] WC [wheel chair] when unattended." According to the aforementioned MDS assessment, the resident required extensive assistance with mobility and ambulation. c. Review of the fall investigation worksheets for June 2012 showed the resident had falls on 6/5/12 at 7:15 AM from the wheel chair and on 6/9/12 at 2:40 PM from the recliner. The falls investigation worksheet for both of these falls had recommendations to "monitor." No new interventions were put into place. On 6/14/12 at 4:15 PM the resident had a fall from the recliner. Review of the 6/14/12 falls investigation worksheet showed the recommendation "Do not leave alone." d. Review of the 6/15/12 fall investigation showed the resident fell on 6/15/12 at 5:30 PM when s/he pushed the locked wheel chair away from the table and slid onto the floor. The recommendation noted on the falls investigation worksheet after this fall was for a one to one during dining. However, the resident again pushed his/her locked wheel chair away from the table on 6/25/12 at 6:15 PM, slid to the floor, and experienced pain as a result from this fall. There was no evidence in the medical record the resident was on a one to one for dining during this fall. Recommendations by the interdisciplinary fall team after this fall included do not lock the brakes on the wheel chair while at the table and to wear gripper socks. e. Review of the July 2012 fall investigations showed the resident was found on the floor in	F 323		

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F 323	Continued From page 10 front of a tipped over recliner. The recommendation noted on the falls investigation worksheet showed "more staff" and "someone to sit in atrium while CNAs get other [residents up]." Review of the interdisciplinary team evaluation showed the resident did not have gripper socks or shoes on as recommended from a previous fall. f. The resident had another fall on 7/5/12 at 11 PM, again s/he slid out of the recliner. Review of the interdisciplinary team review showed the resident was not wearing the recommended gripper socks at the time of the fall. g. Review of the 7/21/12 nursing notes timed at 5:10 PM showed the resident's chair alarm was going off while the CNAs were toileting another resident. When the CNAs were able to assist the resident s/he was on the floor, having fallen out of his/her wheel chair. h. Review of the 7/27/12 timed at 5:30 PM falls investigation worksheet showed the resident was found in the family room seated on the floor between his/her wheel chair and a recliner. Review of the fall notes showed the chair alarm clip came off the resident's shirt and did not alarm to alert staff. The 6/8/12 care plan showed the resident should have extensive assistance with ambulation, should wear gripper socks and staff should "monitor as much as possible." i. Review of the 8/2/12 quarterly MDS assessment showed the resident needed extensive assistance with mobility, transfers, and ambulation and was totally dependent upon staff for locomotion on and off the unit. Also, the resident had an unsteady gait that s/he could not stabilize without staff assistance. Review of the medical record showed the resident had a fall on 8/29/12 at 4:45 PM. Review of the falls investigation worksheet showed the resident	F 323		

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(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 323	Continued From page 11 attempted to lay down in bed and when s/he got up out of the wheel chair the clip on the alarm slipped off his/her shirt and did not alarm. Review of the 8/8/12 care plan showed interventions for fall prevention that were added included making sure the alarm clip was secure and extensive to total assistance. j. Review of the October 2012 fall reports showed the resident had a fall on 10/8/12 at 6:50 PM. Review of the falls investigation worksheet showed the alarm sounded but by the time staff arrived to assist the resident s/he was lying on the floor in front of the wheel chair. No recommendations were noted on the worksheet. On 10/11/12 at 9 PM the resident leaned forward in the wheel chair and fell forward onto the floor. k. Interview with the DON on 11/7/12 at 10:40 AM verified staffing in the secure unit had been problematic for the past several months. 6. Review of the medical record showed resident #26 had diagnoses including Down syndrome and seizures, and s/he resided in the secured dementia unit. Review of the March 2012 fall report and March 2012 nursing notes showed the resident had a fall on 3/4/12 with a minor injury. Review of the 3/23/12 quarterly MDS assessment showed s/he wandered less and was no longer independent with mobility. Review of this MDS assessment showed the resident required limited assistance of one staff member for ambulation. Review of the nursing notes and fall report for April 2012 showed the resident had additional falls on 4/15/12 and 4/16/12, both unwitnessed and without injury. Review of the 6/15/12 quarterly MDS assessment showed the resident continued to wander but no longer required assistance with	F 323		

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F 323	Continued From page 12 ambulation, even though s/he had falls on 5/25/12 and 6/10/12 both unwitnessed. Review of the 9/7/12 significant change MDS assessment showed the resident required extensive assistance with mobility and the use of a wheel chair. Review of the August and September 2012 nursing notes and fall reports showed the resident had falls on 8/18/12 with minor injury, on 8/21/12 without injury, on 9/3/12 without injury, and on 9/8/12 without injury. Review of the 10/12/12 significant change MDS assessment showed the resident wandered and was again independent in mobility. Review of October 2012 nursing notes and the October 2012 fall report showed the resident had falls on 10/13/12, 10/18/12 and 10/28/12. Review of the current care plan showed the potential for falls was identified as a problem on 3/27/12 and showed interventions were to monitor when wandering and to check the resident frequently. Also included as interventions were "encourage to slow down if running, monitor when agitated, keep room free of clutter, medication as ordered, and do not leave unattended in the bathroom." Review of the care plan showed there were no dates associated with interventions to show what had been added or changed related to the resident's recurrent falls. The following concerns with safety and supervision to prevent falls were identified: a. Review of the 9/3/12 post fall assessment showed the resident was left in the bathroom alone while the CNA obtained gloves and other supplies. Review of the 9/3/12 nursing notes timed at 8:20 PM verified the resident was left unattended in the bathroom by the staff member. Review of the current care plan showed the resident was not to be left unattended in the	F 323		

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F 323	Continued From page 13 bathroom. b. Review of the post fall assessment for 9/6/12 showed the resident was seated in a wheel chair with a chair alarm in place when s/he stood up, turned, then sat on the floor. According to the 9/6/12 nursing notes timed at 6:30 PM, the "chair alarm strings were too long causing a delayed response from [the] chair alarm. Strings shortened to appropriate length..." c. Review of the post fall assessment from the fall on 10/13/12 at 1 PM showed the resident was walking with another resident. According to the 9/7/12 significant change MDS assessment, the resident required extensive assistance with ambulation and should not have been walking without staff assistance. d. Review of the 10/12/12 significant change MDS assessment showed the resident wandered and was again independent in mobility. Review of October 2012 nursing notes and the October 2012 fall report showed the resident had falls on 10/13/12, 10/18/12 and 10/28/12. Review of the October 2012 nursing notes showed no evidence the resident was being monitored frequently while wandering as instructed on the care plan. e. Review of the medical record and fall documents showed this resident had 12 falls within eight months, six were unwitnessed even though the care plan indicated the resident should be monitored frequently while wandering or ambulating. f. Interview with the MDS coordinator on 11/7/12 at 10:30 AM verified the care plan failed to specifically identify how wandering would be monitored. g. Interview with the DON on 11/7/12 at 10:40 AM verified staffing in the secure unit had been problematic for the past several months.	F 323		

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F 323	Continued From page 14 7. Interview with the nurse manager on 11/6/12 at 9:55 AM revealed the facility was aware of the large number of falls within the facility. She said most were in the evenings and they had tried to put preventions in place but residents continued to fall. The nurse manager said the facility had just ordered and received hip protectors in order to minimize injury when residents had falls.	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff	F 353	The facility will have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident as determined by resident assessments and individual plans of care. A.) Resident #4 is deceased. B.) The facility will ensure there is adequate staffing on the special care unit to supervise the needs for residents #14, #26, and #33 and all other residents in the facility. C.) The special care unit will have adequate staffing as evidenced by at least two staff during the	1/31/13 01/25/13

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F 353	Continued From page 16 Interview, and medical record review, the facility failed to ensure adequate staffing to supervise the needs for the residents on 1 of 4 units. Four of 7 sample residents (#4, #14, #26, #33) who were at risk for falls and resided in the secure dementia unit were not adequately supervised to prevent falls. The findings were: Review of the falls report from January 2012 to October 2012 showed the following data on falls in the secure unit. In January there were 10 falls, February showed 2 falls, March showed there were 9 falls, April there were 13 falls, in May the secure unit had 15 falls, June showed 13 falls, in July 13 falls were reported, and August showed there were 8. Finally, review of the falls report for September showed there were 16 falls and in October there were 21 falls in the secure unit. Interview with the MDS coordinator on 11/7/12 at 10:45 revealed the majority of the falls occurred on the evening and night shifts. Interview with the nurse manager at the same time revealed routine staff in the unit on evenings was two CNAs and one shared nurse (with another unit) and on the night shift one CNA and a shared nurse. The secure unit had twenty beds and was mostly full according to the RN on duty on 11/6/12 at 6:45 PM. The following concerns with staffing in the secured unit were identified: 1. Review of the medical record for resident #4 showed s/he had diagnoses that included dementia and hypertension. Review of the history and physical dated 11/18/11 showed the resident was admitted to the nursing home in 2008 and has had a gradual decline in both motor and cognitive skills. Review of the 9/21/12 annual MDS assessment showed the resident required	F 353	hours of 5:00 a.m. until 11:00 p.m. D.) Education will be provided to all staff about the importance of keeping adequate staffing on the special care unit. E.) Monitoring of compliance will be done by daily review of the At-A-Glance before shift to verify scheduling and by weekly random rounds on the special care unit to ensure two staff members are present at all times between 5:00 a.m. and 11:00 p.m. Reviews and rounding will be done by supervisory staff. F.) Staff not following special care unit staffing protocol correctly will receive immediate in-servicing and corrective actions will be taken by the supervisor. G.) Results will be reported quarterly as part of the facility Quality Assurance Program.	

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F 353	Continued From page 16 limited assistance with one person physical assist for walking and for locomotion. In addition, section G0300 of this MDS assessment showed the resident was "Not steady, only able to stabilize with human assistance" for moving from seated to standing position, walking, turning around, moving on and off toilet, and surface to surface transfer. Review of incident information showed the resident had fallen 5 times since September 2012. The resident fell twice on 9/10/12 both times while trying to independently sit in a chair, on 9/21/12 the resident was found in his/her own room on the floor with a minor injury, a skin tear to the left elbow; additionally, when the resident was found on the floor, s/he was incontinent of bowel and bladder. On 10/13/12 the resident was found on the floor of another resident's room with no injury noted. On 10/28/12 the resident was witnessed to fall while standing face-to-face with another resident. This fall resulted in a fractured hip and surgical intervention. Review of the CAA for falls dated 9/26/12 showed the resident was at risk and had a history of recent falls, had dementia, and wandered on the secure unit. The analysis identified the risk as "fall with injury." The following staffing concerns were identified: a. Review of the fall investigation worksheets and the occurrence report for the 10/28/12 fall showed the resident fell while ambulating, ambulation without assist, and the fall was witnessed. According to this 10/28/12 report, the witness was a housekeeping staff member. The investigation worksheet and the report failed to identify the lack of monitoring/supervision for the resident by direct care staff. This resident had been identified on the 9/21/12 annual MDS assessment as being unsteady and needing	F 353		

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F 353	Continued From page 17 limited physical assistance for walking. The interdisciplinary team review of the fall was completed on 11/1/12; However, review of this form showed the area for discussing the interventions used to prevent falls for this resident was blank. According to the previous IDT (interdisciplinary treatment team) fall review dated 10/18/12, the IDT recommended to "monitor when wandering." c. Interview with the DON on 11/7/12 at 10:40 AM verified staffing in the secure unit had been problematic for the past several months. 2. Review of the medical record showed resident #28 had diagnoses including Down syndrome and seizures, and s/he resided in the secured dementia unit. Review of the March 2012 fall report and March 2012 nursing notes showed the resident had a fall on 3/4/12 with a minor injury. Review of the 3/23/12 quarterly MDS assessment showed s/he wandered less and was no longer independent with mobility. Review of this MDS assessment showed the resident required limited assistance of one staff member for ambulation. Review of the nursing notes and fall report for April 2012 showed the resident had additional falls on 4/15/12 and 4/16/12, both unwitnessed and without injury. Review of the 6/15/12 quarterly MDS assessment showed the resident continued to wander but no longer required assistance with ambulation, even though s/he had falls on 5/25/12 and 6/10/12 both unwitnessed. Review of the 9/7/12 significant change MDS assessment showed the resident required extensive assistance with mobility and the use of a wheel chair. Review of the August and September 2012 nursing notes and fall reports	F 353		

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F 353	Continued From page 18 showed the resident had falls on 8/18/12 with minor injury, on 8/21/12 without injury, on 9/3/12 without injury, and on 9/6/12 without injury. Review of the 10/12/12 significant change MDS assessment showed the resident wandered and was again independent in mobility. Review of October 2012 nursing notes and the October 2012 fall report showed the resident had falls on 10/13/12, 10/18/12 and 10/26/12. Review of the current care plan showed the potential for falls was identified as a problem on 3/27/12 and showed interventions to monitor when wandering and to check frequently. Also included as interventions were encourage to slow down if running, monitor when agitated, keep room free of clutter, medication as ordered, and do not leave unattended in the bathroom. Review of the care plan showed there were no dates associated with interventions to show what had been added or changed related to the resident's recurrent falls. Staffing ratios were the standard two CNAs and one shared nurse on evenings and one CNA and one shared nurse on nights. The following concerns with safety and supervision to prevent falls were identified: a. Review of the 9/3/12 post fall assessment showed the resident was left in the bathroom alone while the CNA obtained gloves and other supplies. Review of the 9/3/12 nursing notes timed at 6:20 PM verified the resident was left unattended in the bathroom by the staff member. Review of the current care plan showed the resident was not to be left unattended in the bathroom. b. Review of the post fall assessment for 9/6/12 showed the resident was seated in a wheel chair with a chair alarm in place when s/he stood up, turned, then sat on the floor. According to the	F 353		

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F 353	Continued From page 19 9/6/12 nursing notes timed at 6:30 PM, the "chair alarm strings were too long causing a delayed response from (the) chair alarm. Strings shortened to appropriate length..." c. Review of the post fall assessment from the fall on 10/13/12 at 1 PM showed the resident was walking with another resident. According to the 9/7/12 significant change MDS assessment, the resident required extensive assistance with ambulation and should not have been walking without staff assistance. d. Review of the 10/12/12 significant change MDS assessment showed the resident wandered and was again independent in mobility. Review of October 2012 nursing notes and the October 2012 fall report showed the resident had falls on 10/13/12, 10/18/12 and 10/28/12. Review of the October 2012 nursing notes showed no evidence the resident was being monitored frequently while wandering as instructed on the care plan. e. Review of the medical record and fall documents showed this resident had 12 falls within eight months, six were unwitnessed even though the care plan indicated the resident should be monitored frequently while wandering or ambulating. f. Interview with the MDS coordinator on 11/7/12 at 10:30 AM verified the care plan failed to specifically identify how wandering would be monitored. g. Interview with the DON on 11/7/12 at 10:40 AM verified staffing in the secure unit had been problematic for the past several months. 3. Review of the 8/16/12 physician note showed resident #14 had diagnoses including congestive heart failure, history of transient ischemic attacks, a cerebral vascular accident, and Alzheimer's with	F 353		

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F 353	Continued From page 20 dementia. The resident resided on the secure dementia unit. According to the fall reports from April 2012 through October 2012, the resident had 16 falls with all but 3 unwitnessed. The following concerns with safety management and supervision to prevent falls were identified: a. Review of the 2/10/12 quarterly MDS assessment showed the resident required extensive assistance with bed mobility and transfers, did not ambulate, and required total assistance with locomotion on or off the unit. In addition the resident was not steady when moving from a seated to standing position, moving on and off the toilet and for surface to surface transfers. Finally, the assessment showed the resident required a wheel chair for mobility. Review of the 4/15/12 nursing notes timed at 3:30 PM showed the resident was found lying on the floor in the atrium. Review of the 4/15/12 falls investigation worksheet showed the only intervention recommended was "monitoring". b. Review of the 5/4/12 annual MDS assessment showed the resident required extensive assistance with bed mobility, transfers, and ambulation. The resident required total assistance with locomotion on or off the unit and continued to have an unsteady gait and required human assistance for stabilization. The MDS showed the resident now used a walker or a wheel chair. Review of the 5/3/12 nursing notes timed at 5:15 AM showed the resident was found crawling on the floor in front of the recliner s/he had been sitting in. Review of the fall investigation worksheet showed a possible cause for the fall was the resident had been administered a rectal suppository earlier. Continued review of the worksheet showed a recommendation to more closely supervise the resident after being	F 353		

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F 353	Continued From page 21	F 353		

administered a rectal suppository "(staff permitting!)." Review of the medical record also showed the resident fell out of the wheel chair on 6/16/12 at 8:20 AM after lunging forward. On 6/22/12 at 5:40 AM the resident stood up out of the wheel chair and crumbled to the floor. Review of the falls investigation worksheet showed recommendations to "put in recliner (not) WC (wheel chair) when unattended." According to the aforementioned MDS assessment, the resident required extensive assistance with mobility and ambulation.

c. Review of the fall investigation worksheets for June 2012 showed the resident had falls on 6/6/12 at 7:15 AM from the wheel chair and on 6/9/12 at 2:40 PM from the recliner. The falls investigation worksheet for both of these falls had recommendations to "monitor." No new interventions were put into place. On 6/6/12 there were two CNAs and one LPN at the time of the fall. On 6/14/12 at 4:15 PM the resident had a fall from the recliner. Review of the 6/14/12 falls investigation worksheet showed the recommendation "Do not leave alone." The staff at the time of this fall was two CNAs and one LPN. The resident again fell on 6/15/12 at 5:30 PM when s/he pushed the locked wheel chair away from the table and slid on to the floor. Staffing at this time was one CNA and one nurse. The recommendation noted on the falls investigation worksheet after this fall was for a one to one during dining. However, the resident again pushed his/her locked wheel chair away from the table on 6/25/12 at 6:15 PM and slid to the floor resulting in pain. There was no evidence in the medical record the resident was on a one to one for dining during this fall. The staffing level during this fall was two CNAs and one RN.

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F 353	Continued From page 22 Recommendations by the interdisciplinary fall team after this fall included do not lock the brakes on the wheel chair while at the table and to wear gripper socks. d. Review of the July 2012 fall investigations showed the resident was found on the floor in front of a tipped over recliner. The recommendation noted on the falls investigation worksheet showed "more staff" and "someone to sit in atrium while CNAs get other [residents up]" Review of the interdisciplinary team evaluation showed the resident did not have gripper socks or shoes on as recommended from a previous fall. e. The resident had another fall on 7/5/12 at 11 PM, again s/he slid out of the recliner. Review of the interdisciplinary team review showed the resident was not wearing the recommended gripper socks. f. Review of the 7/21/12 nursing notes timed at 5:10 PM showed the resident's chair alarm was going off while the CNAs were toileting another resident. When the CNAs were able to assist the resident s/he was on the floor, having fallen out of his/her wheel chair. g. Review of the 7/27/12 timed at 5:30 PM falls investigation worksheet showed the resident was found in the family room seated on the floor between his/her wheel chair and a recliner. Review of the fall notes showed the chair alarm clip came off the resident's shirt and did not alarm to alert staff. The 5/8/12 care plan showed the resident should have extensive assistance with ambulation, should wear griper socks and staff should "monitor as much as possible." h. Review of the 8/2/12 quarterly MDS assessment showed the resident needed extensive assistance with mobility, transfers, and ambulation and was totally dependent upon staff	F 353		

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	535030	A. BUILDING _____ B. WING _____	C 11/07/2012

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F 353	Continued From page 23 for locomotion on and off the unit. Also, the resident had an unsteady gait that s/he could not stabilize without staff assistance. Review of the medical record showed the resident had a fall on 8/29/12 at 4:45 PM. Review of the falls investigation worksheet showed the resident attempted to lay down in bed and when s/he got up out of the wheel chair the clip on the alarm slipped off his/her shirt and did not alarm. Review of the 8/8/12 care plan showed interventions for fall prevention that were added included making sure the alarm clip was secure and extensive to total assistance. i. Review of the October 2012 fall reports showed the resident had a fall on 10/8/12 at 8:50 PM. Review of the falls investigation worksheet showed the alarm sounded but by the time staff arrived to assist the resident s/he was lying on the floor in front of the wheel chair. No recommendations were noted on the worksheet. On 10/11/12 at 9 PM the resident leaned forward in the wheel chair and fell forward onto the floor. j. Interview with the DON on 11/7/12 at 10:40 AM verified staffing in the secure unit had been problematic for the past several months. 4. Review of the medical record for resident #33 showed s/he was admitted with diagnoses including history of cerebral vascular accident (stroke) and chronic dizziness. This resident resided in the secured dementia unit. Review of the 9/2/12 annual MDS assessment showed the resident was not steady when walking or turning around while walking but was able to steady him/herself without staff assistance. In addition, according to this MDS assessment the resident had lower extremity limitations and required the use of a walker. Review of the CAA dated 9/9/12	F 353		

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F 353	Continued From page 24 showed the resident did not wear shoes and therefore required gripper socks due to being at risk for falls. a. Review of the 5/12/12 nursing notes and the May 2012 fall report showed the resident had a fall with minor injury to the right knee on 5/12/12 at 2:40 PM. Review of the 5/12/12 falls investigation worksheet did not indicate whether or not the resident was wearing gripper socks as instructed in the care plan. Review of the interdisciplinary post fall assessment dated 5/17/12 showed the only recommendation was to "monitor" and there were no changes to the care plan. b. Review of the 6/14/12 nursing notes timed at 1:55 AM showed the resident had a fall and sustained fractured ribs. Review of the interdisciplinary post fall assessment, undated, showed the recommendation was again to "monitor" and encourage to use the walker. No changes were made to the care plan. Staffing consisted of two CNAs and one nurse. c. Interview with the DON on 11/7/12 at 10:40 AM verified staffing in the secure unit had been problematic for the past several months. 5. Observation on 11/6/12 at 1 PM showed only one CNA #2 was in the atrium of the secure dementia unit when she was heard to call out to another staff member to go get some help from another unit. The CNA said "I need help, I'm toileting people." Interview with this CNA at 1:13 PM that same day revealed she thought the secure dementia unit did not have enough staff. The nurse in the room at the time of the interview, RN #1, said "it is a big area." The CNA said the census at the time was 18 and there were two CNAs working. Observation at 3:50 PM that same	F 353		

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F 353	Continued From page 25 day showed CNA #2 was the only staff member in the secure dementia unit because the other CNA was on break. CNA #2 said "yeah we definitely need another person back here."	F 353		1/3/13 01/25/13
F 520 SS=E	483.75(a)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary, and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the CMS 2567 (Centers for Medicare and Medicaid) Statement of Deficiencies, and review of facility documents,	F 520	The Facility Quality Assessment and Assurance Committee will meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary. The facility will also ensure the Quality Assurance Assessment Committee develops and implements appropriate plans of action to correct identified quality deficiencies on a timely basis. A.) The current facility Quality Assurance Assessment for current week will be reviewed by the IDT in the Utilization Review Meeting to discuss current Quality Assurance Assessment issues and identify quality deficiencies and implement appropriate plans of action in a timely manner. B.) The facility Quality Assurance Assessment Committee will meet monthly with the Medical Director to review quality assurance assessment activities to assist in identification of any quality assurance assessment deficiencies by review of Utilization Review Meeting minutes.	

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F 620	Continued From page 26 the facility failed to ensure the quality assurance and performance improvement (QAPI) program was timely and effective in resolving identified concerns about falls. The findings were: Interview with the DON, nurse manager, and MDS coordinator on 11/7/12 at 10:30 AM revealed data was collected and tracked on falls as part of the MDS coordinator's responsibilities. This data was provided to the QAPI committee. The MDS coordinator said she identified falls as a concern in June 2012 and began to put interventions in place. The following concerns were identified: a. Review of the January 2012 through May 2012 falls report showed there had been a high number of falls even prior to June. Review of the falls report sheet showed there were 23 falls in January 2012, 15 falls in February 2012, 27 falls in March 2012, 32 falls in April 2012, and 43 falls in May 2012. b. Continued interview with these three staff members revealed because of the high number of falls, a QAPI audit tool was implemented to monitor use of chair and bed alarms being in place, beds being in the low position, and proper gait belt use. However, this audit was not initiated until July 2012. c. The falls committee started making unit rounds but not until 6/20/12. d. Interview with the staff members also revealed they developed a post fall huddle program but that it had just been implemented in November 2012. While these interventions were appropriate, the lack of timeliness may have contributed to 37 falls in June 2012, 28 falls in July 2012, 19 falls in	F 620	C.) Education will be provided to the Quality Assurance Assessment Committee by the facility Quality Program Director on the importance of identifying deficiencies in a timely manner and initiating the Quality Assurance Assessment. D.) Monitoring of compliance of facility Quality Assurance Assessment will be done by quarterly review of quality assurance reports by the facility Quality Improvement Director. E. Noncompliance of timely initiation of Quality Assurance Assessment interventions will result in immediate in-servicing and corrective actions. F.) Results will be reported quarterly as part of the facility Quality Assurance Program.	