STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445331	A. BUILDING _____ B. WING _____	**03/28/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACELAND NURSING CENTER	**1250 FARROW ROAD MEMPHIS, TN 38116**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation and interview, it was determined the facility failed to timely notify the attending physician of a significant change of condition of 1 of 6 (Resident #22) residents reviewed for abuse/neglect of the 52 residents included in the stage 2 sample. The failure of the facility to appropriately assess and timely notify the physician of swelling of the right arm, of a resident who was at a high risk for [MEDICAL CONDITIONS], resulted in delay of care and placed Resident #22 in immediate jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment or death). In the activity room on 5/2/14 at 3:45 PM, the Administrator and Director of Nursing (DON) were informed of the immediate jeopardy (IJ). The IJ is ongoing. The findings included: 1. Review of the facility's Situation, Background, Assessment, Request (SBAR) Action and Notification protocol documented, Policy- It is the intent of this facility to assess and document changes in a resident's health, mental or psychosocial status in an efficient and effective manner; to relay assessment information to physician and to document actions. the facility will consult with the resident and notify the resident's physician, and the legal representative or interested family member of but not limited to the following: A significant change in the resident's physical. status, A need to alter treatment significantly. Procedure- 1. Licensed staff will assess any change in condition through observation, physical examination to monitor. at the onset of the change. 4. Review all findings with the physician and non-physician practitioner. 5. Document in the medical record. Change of Condition. nursing documentation for change in status. 2. Medical record review for Resident #22 documented an admitted 9/3/05 with [DIAGNOSES REDACTED]. The nursing admission information assessment completed on 3/19/14 documented Resident #22 was readmitted to the facility from the hospital and documented [MEDICAL CONDITION] N (no). The history and physical examination [REDACTED] The care plan dated 4/3/14 documented, Problem- Resident has potential for discomfort/pain, bruising and swelling r/t (related to) fragile skin, h/o (history of) [MEDICAL CONDITION] / muscle mass RUE (right upper extremity) /PAD (peripheral artery disease). Approach Frequency. 4. Observed RUE for swelling and bruising. 5. Notify MD (medical doctor) for changes in status. A nutrition services progress note dated 4/11/14 documented, [MEDICAL CONDITION] noted to hand. There was no documentation by the nursing staff of [MEDICAL CONDITION] to the right hand or upper extremity until 4/24/14. An acute visit assessment dated [DATE] completed by the Nurse Practitioner (NP) documented, .RUE hand c (with) 2 t (plus) [MEDICAL CONDITION], R (right) forearm 1 t [MEDICAL CONDITION], R upper arm 2 t [MEDICAL CONDITION] with ^ (increased) heat to touch. The NP ordered a doppler to RUE. The final report of the doppler to RUE dated 4/21/14 documented, .There is incomplete compression, echogenic material and decreased flow in the [MEDICATION NAME], axillary, and brachial veins. Non-occlusive [MEDICAL CONDITION] is demonstrated. Soft tissue [MEDICAL CONDITION] is present. A nurses note dated 4/21/14 documented, .T (positive) Findings regarding Doppler. N.O. (new order) [MEDICATION NAME] (medication to prevent blood clots) 60 mg (milligrams) subq q (subcutaneous every) 12 (symbol for hours) (start today) 2. [MEDICATION NAME] (medication to prevent blot clots) 5 mg PO (by mouth) daily (start today) 3. INR (International normalized ratio (a laboratory test to determine therapeutic levels of blood thinning medication)) daily (start in AM) 4. Continue [MEDICATION NAME] until INR -> (symbol for equal to or greater than) 2 (target INR range) for two consecutive days. A nurses noted dated 4/24/14 documented, .(symbol for decrease) [MEDICAL CONDITION] to Rt. (right) arm/hand. There was no documentation of the [MEDICAL CONDITION] in the right hand/arm by the nurses until this note, yet a nutrition services progress note dated 4/11/14 documented, [MEDICAL CONDITION] noted to hand. Observations in Resident #22's room on 5/2/14 at 12:00 PM, revealed Resident #22 on her left side with wedge pillow present, right hand on pillow and with [MEDICAL CONDITION] noted. Observations in Resident #22's room on 5/2/14 at 6:00 PM, revealed a family member at the bedside and Resident #22 had just been turned back to her left side, oxygen on at 2 liters per nasal cannula, right arm on pillow with [MEDICAL CONDITION] noted, noted facial twitching and mouth breathing. During an interview in the activity room on 5/2/14 at 8:45 AM, Resident #22's family member reported, My mother is (named Resident #22) has been here 9 years and is in late stages of Alzheimer's, not expecting her to live many more days, is comatose. She was in the hospital, can't remember exact dates March/April 2014, when she came back here her right hand was swollen. It swelled up her arm. I asked about it, told nurses, and finally just last week (4/21/14) they addressed it and said it was a blood clot, she got started on [MEDICATION NAME] During an interview at the 500/600 nurses' station on 5/2/14 at 11:50 AM, Nurse #13 stated, I started working here full time about 2 weeks ago on this hall, prior to that I worked as needed. Nurse #13 was asked about Resident #22. Nurse #13 stated, She has [MEDICAL CONDITION] in her right hand, we elevate it on pillows. Nurse #13 was asked how long resident has had [MEDICAL CONDITION] in the right upper extremity. Nurse #13 stated, She has been in the same condition as she is now since the first day I saw her. Has had [MEDICAL CONDITION]. We kept her hand elevated on a pillow. Nurse #13 was asked what was the procedure if there was a change in a resident's condition. Nurse #13 stated, If there was a change in condition, I would evaluate resident and notify the doctor. During an interview at the 500/600 nurses' station on 5/2/14 at 12:10 PM, Nurse #3 was asked about the [MEDICAL CONDITION] in Resident #22's right hand. Nurse #3 stated, The daughter found it and told me on 4/21/14 the day of the Doppler, the NP was in the facility and was notified and ordered the Doppler. The daughter is a nurse. She is quite involved in her care. During another interview in the activity room on 5/2/14 at 12:26 PM, Nurse #13 was asked about documentation of Resident #22's hand and arm [MEDICAL CONDITION] and notifying the doctor. Nurse #13 stated, No, I don't see any documentation about the [MEDICAL CONDITION] until the 4/21/14 Doppler order. No, I don't see any documentation about the doctor being notified about the [MEDICAL CONDITION] prior to 4/21/14. During an interview in the activity room on 5/2/14 at 12:45 PM, the DON was asked what was expected of nurses if a resident developed [MEDICAL CONDITION] in the hand and arm. The DON stated, I expect nurse to evaluate, notify doctor, and keep hand and arm elevated. During an interview in the activity room on 5/2/14 at 5:00 PM, Resident #22's family member was asked what staff had she reported the swelling to. Resident #22's family member stated, I told a CNA (certified nursing assistant) on 3-11 shift, don't know her name. I ask them to keep it (arm) on a pillow, also told a male nurse (named Nurse #14) who works 3-11. My Mother has a history of blood clots. During a telephone interview on 5/5/14 at 4:10 PM, Nurse #14 was asked about Resident #22's hand and arm [MEDICAL CONDITION]. Nurse #14 stated, I do remember caring for (named Resident #22). I do not remember her daughter reporting to me anything about swelling of her right arm, but I do remember being told of that swelling during a shift change report by another nurse but I do not remember the date and can't recall what I did in regards to the arm swelling. The facility failed to timely assess and notify the physician of [MEDICAL CONDITION] of the right arm which resulted in a delay of treatment, actual harm, neglect and placed Resident #22, who was at a high risk of developing [MEDICAL CONDITION], in immediate jeopardy.
F 0166 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Try to resolve each resident's complaints quickly.**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 0166 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of a shift assignment sheet, medical record review and interview, it was determined the facility failed to fully investigate grievances voiced by 2 of 52 (Residents #218 and 7) residents included in the stage 2 sample. The failure of the facility to thoroughly investigate grievances; implement new, appropriate and measurable interventions to prevent psychological harm and potential resident to resident altercations resulted in immediate jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death) for Resident #218 who stated she was afraid of Resident #220 and could not rest at night because he might come into her room. In the activity room on 5/2/14 at 3:45 PM, the Administrator and Director of Nursing (DON) were informed of the immediate jeopardy (IJ). The IJ is ongoing. The findings included: 1. Review of the facility's Investigating a Resident Grievance or Complaint policy documented, .all grievances and /or complaints be investigated by the appropriate facility staff and recorded on the grievance/complaint log. the Social Services Director. will begin an investigation into the allegations. 2. Medical record review for Resident #218 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Resident #218 resides in a private room that is next door to Resident#220. The physician's orders [REDACTED]. Review of the annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 8/29/13 and the quarterly MDS with an ARD of 2/25/14 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating that Resident #218 was cognitively intact. There are no behaviors documented on the annual or quarterly MDS. During an interview in Resident #218's room on 4/28/14 at 3:33 PM, Resident #218 was asked if there had been any concerns or problems with a roommate or any other resident. Resident #218 stated, The man (Resident #220) next door comes into my room. I told the nurse and they put the stop banner up. Resident #218 was asked if the staff addressed this concern to her satisfaction. Resident #218 stated, No. He (Resident #220) crawls up under the banner. During an interview in the DON's office on 5/1/14 at 8:55 AM, the DON was asked what should happen when a resident reports a concern to a CNA. The DON stated, The CNA reports it to the charge nurse to try and resolve it and then inform me. The DON was asked if she had any reported concerns regarding Resident #218 and Resident #220. The DON stated, Haven't heard anything. During an interview in Resident #218's room on 5/1/14 at 9:00 AM, Resident #218 was asked how many times Resident #220 had come into her room and what did he do when he came in. Resident #218 stated, Has been in here 3 times. One time he came in and started pulling on door (pointed to bathroom door) and started pulling his pants down. The second time he came into room he was standing by the curtain (privacy curtain) looking in the corner. The third time he crawled under the sign (STOP banner). I was in bed resting, around 2 in the afternoon. I always lay down after dinner (lunch). Have to lay down in the evening (after the lunch meal) cause I can't rest at night. I'm afraid he would come in here. Resident #218 was asked what do you do when Resident #220 comes into her room. Resident #218 stated, When I yell he heads for the door. Resident #218 was asked if she had reported it to anyone else. Resident #218 stated, I told that nurse (Nurse #12) that was smart with me. Didn't want to report it anymore after that. Didn't think I was supposed to. My daughter reported it to the supervisor. I don't want that man coming into my room scaring me and making me have a set-back. During an interview in the social worker's office on 5/1/14 at 10:21 AM, the Social Worker was asked if anyone had reported any issues or concerns about Resident #220. The Social worker stated, I just heard about it a few minutes ago. Resident #218 was scared and afraid to rest due to Resident #220 wandering into her room. Resident #220 had wandered into her room on 3 different occasions. Resident #220 had recently hit a staff member while the staff was attempting to redirect him. Resident #218 stated that she yelled at Resident #220 when he wandered into her room. The facility failed to follow up on grievances voiced by Resident #218, who is unable to sleep at night for fear of Resident #220 entering her room at night. The facility failed to implement new, appropriate and measurable interventions to keep Resident #218 safe resulted in immediate jeopardy. 3. Medical record review for Resident #7 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. The annual MDS dated [DATE] and the quarterly MDS dated [DATE] documented a BIMS score of 15 indicating the resident had no cognitive impairments, required set up help with eating, and had bilateral upper extremity impairment on both sides. The care plan dated 10/16/13 and updated on 4/9/14 documented, Problem-Impaired mobility w (with) / self-care deficit r/t/ (related to) h/o (history of)[MEDICAL CONDITION]/ Rt. (right) hemi (stroke with right paralysis), h/o GSW (gunshot wound) to head. Approach-Frequency 1. Provide full staff assistance w/bathing, dressing, personal hygiene, grooming, oral, and incontinent care. 3. Set-up all equipment for personal care. 4. Assist resident w/oral care. During an interview in Resident #7's room on 4/28/14 at 3:20 PM, Resident #7 stated, (Named CNA #22) left trays without opening items, happens all the time, have told (Named Nurse #5). During an interview at the 100/200 nurses' station on 4/30/14 at 4:00 PM, Nurse #5 (unit manager) was asked about any complaints regarding care reported by Resident #7. Nurse #5 stated, Yes, she did complain to me right after I started here (empolyed 2/2014) about (named CNA #22). She complained she (CNA #22) did not put her to bed when she wanted to and did not open her items on her trays for her. I talked to both of them (Resident #7 and CNA #22). I removed (named CNA #22) from caring for (named Resident #7). Nurse #5 was asked if there were any investigations of these complaints. Nurse #5 stated, No, I did not write this up anywhere. No, do not have a grievance log. No, I did not document this anywhere. I just talked to them. Nurse #5 was asked about how charge nurses were informed of her removing CNA #22 of caring for Resident #7. Nurse #5 stated, They (nurses) know, they do not assign (named CNA #22) to (named Resident #7). The surveyor asked to review the 4/30/14 3-11 shift assignment sheet. The assignment sheet documented Resident #7 was assigned on paper to CNA #22. Nurse #5 stated, She (named CNA #22) knows not to go in her (Resident #7's) room. She (CNA #22) will get one of the other CNA's to do (named Resident #7) for her. Nurse #5 was asked how staff know this. Nurse #5 stated, They know. During an interview in the activity room on 5/2/14 at 9:30 AM, the Administrator (the Abuse Coordinator) was asked what was expected if an allegation of abuse was reported to a unit manager. The Administrator stated, I would expect the unit manager to investigate the situation and report it to me. I was not aware of the situation with (Named Resident #7 and CNA #22) until yesterday. The facility failed to thoroughly investigate and follow up on Resident #7's voiced grievances of not providing preference and needed care for dining and personal hygiene. 4. The facility failed to resolve grievances voiced by Residents #7 and 218.
F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of the 24 hour nursing log, medical record review, observation and interview, it was determined the facility failed to prevent psychological harm and potential resident to resident altercation for 1 of 6 (Resident #218) residents reviewed for abuse of the 52 residents included in the stage 2 sample. The failure of the facility to thoroughly investigate incidents; implement new, appropriate and measurable interventions to prevent psychological harm and potential resident to resident altercations resulted in immediate jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death) for Resident #218, who stated she was afraid of another resident (Resident #220) and could not rest at night because he might come into her room. In the activity room on 5/2/14 at 3:45 PM, the Administrator and Director of Nursing (DON) were informed of the immediate jeopardy (IJ). The IJ is ongoing. The immediate jeopardy for F223 J constitutes substandard quality of care. An extended survey was completed on 5/5/14. The findings included: 1. Review of the facility's ABUSE, NEGLECT AND MISAPPROPRIATION policy documented, .POLICY. Verbal, sexual, physical, and mental abuse. of the resident. are prohibited. V. Protection of the Resident. A. All allegations of abuse are to be reported immediately to charge nurse. D. The charge nurse will immediately notify the Administrator, DON. VI. Resident to Resident. A. If a resident is observed exhibiting any form of abuse towards another resident, staff will intervene immediately. C. Administrator and/or DON will be notified immediately. D. Residents will be closely supervised. VII. All allegations of abuse will be investigated and reported to the appropriate agencies. 2. Medical record review for Resident #218 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Resident #218 resided in a private room next door to Resident #220. The physician's orders [REDACTED]. Review of the annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 8/29/13 and the quarterly MDS with an ARD of 2/25/14 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating that Resident #218 was cognitively intact. There are no behaviors documented on the annual or quarterly MDS. Review of the resident care plan with a start date of 8/30/13 does not address the use of a STOP banner across Resident #218's doorway, fears/concerns with wandering male resident or issues with sleep. The facility was unable to provide an incident report or other investigation related to Resident #218's fear of Resident #220 wandering into her room. Review of the 24 hour nursing log from 3/25/14 through 4/15/14 did not document any report for Resident #218. Observations on the 300 hall on 4/28/14 at 1:06 PM and 5:00 PM,

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F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) 4/29/14 at 8:10 AM, 4/30/14 at 8:30 AM, 5/1/14 at 9:30 AM and 2:30 PM, 5/2/14 at 9:45 AM, 5/3/14 at 10:00 AM and 2:30 PM and on 5/5/14 at 9:30 AM and 5:00 PM, revealed a STOP banner across the doorway of Resident #218's room. During an interview in Resident #218's room on 4/28/14 at 3:33 PM, Resident #218 was asked if there had been any concerns or problems with a roommate or any other resident. Resident #218 stated, The man next door comes into my room. I told the nurse and they put the stop banner up. Resident #218 was asked if the staff addressed this concern to her satisfaction. Resident #218 stated, No. He (Resident #220) crawls up under the banner. During an interview in Resident #218's room on 4/28/14 at 5:00 PM, Resident #218 was asked for additional information on the nurses response when it was reported to her that Resident #220 was in her room. Resident #218 stated, When I told the nurse (Nurse #12) about him (Resident #220) coming in the room she got smart with me. She (Nurse #12) said I know it's your room but he doesn't know it. Resident #218 was asked when did this happen. Resident #218 stated, Happened about a month ago. I don't know for sure but my daughter does. I'm afraid of him (Resident #220) and I don't rest well. I'm scared he might come into my room. Resident #218 was asked if she had reported this to anyone else besides Nurse #12. Resident #218 stated, My daughter reported it to the supervisor (Registered Nurse (RN) Supervisor #1). During an interview in Resident #218's room on 4/30/14 at 8:29 AM, Resident #218 was asked if she knew the name of the resident that comes into her room. Resident #218 stated, They (staff) call him (named Resident #220). During an interview on the 300 hall on 5/1/14 at 8:30 AM, Certified Nursing Assistant (CNA) #17 was asked the reason for the 'STOP' banner across Resident #218's doorway. CNA #17 stated, A resident (named Resident #220) comes into her room in the evening. CNA #17 was asked if Resident #218 had reported this to her. CNA #17 stated, She told me about 3 weeks ago. Resident #218 was asked if she reported it to anyone. CNA #17 stated, Yes, my charge nurse (Nurse #18). During an interview in the DON's office on 5/1/14 at 8:55 AM, the DON was asked what should happen when a resident reports a concern to a CNA. The DON stated, The CNA reports it to the charge nurse to try and resolve it and then inform me. The DON was asked if she had any reported concerns regarding Resident #218 and Resident #220. The DON stated, Haven't heard anything. During an interview in Resident #218's room on 5/1/14 at 9:00 AM, Resident #218 was asked how many times Resident #220 had come into her room and what did he do when he came in. Resident #218 stated, Has been in here 3 times. One time he came in and started pulling on door (pointed to bathroom door) and started pulling his pants down. The second time he came into room he was standing by the curtain (privacy curtain) looking in the corner. The third time he crawled under the sign (STOP banner). I was in bed resting, around 2 in the afternoon. I always lay down after dinner (lunch). Have to lay down in the evening (after the lunch meal) cause I can't rest at night. I'm afraid he would come in here. Resident #218 was asked what do you do when Resident #220 comes into her room. Resident #218 stated, When I yell he heads for the door. Resident #218 was asked if she had reported it to anyone else. Resident #218 stated, I told that nurse (Nurse #12) that was smart with me. Didn't want to report it anymore after that. Didn't think I was supposed to. My daughter reported it to the supervisor. I don't want that man coming into my room scaring me and making me have a set-back. During an interview in the activity room on 5/1/14 at 1:30 PM, the DON stated, I've talked to (Resident #218). We need to have him (Resident #220) evaluated. The DON was asked who would do this evaluation. The DON stated, (named hospital with behavioral unit). Resident #220 was discharged on [DATE]. During an interview in Resident #218's room on 5/1/14 at 5:40 PM, Resident #218's daughter was asked if she had the dates that Resident #220 had come into her mother's room. Resident #218's daughter stated, About a month ago he came in and she told him this wasn't his room. He's done it when I'm here too. I scribbled the dates on the calendar. The first time it happened in March (2014), the second time was on 4/3 (2014). That's when he (Resident #220) tried to get into the bathroom. I talked to (named Registered Nurse (RN) Supervisor #1). Happened again on 4/9 (4/9/14) and I talked to (named RN Supervisor #1) again. She said she would write up a report. During an interview at the A hall nurses' station on 5/1/14 at 6:30 PM, RN Supervisor #1 was asked what she does when a resident or family has a concern or complaint. RN Supervisor #1 stated, I try to investigate it and correct it on my shift. Then I pass it along to the next shift. RN Supervisor #1 was asked if Resident #218's daughter had reported that a male resident was coming into her mother's room and it scared her mother. RN Supervisor #1 stated, Yes. I told the floor nurse to document (named Resident #220) behavior and keep him out of the room and then to pass it along to the next shift. RN Supervisor #1 was asked how she passed it along to the next shift. RN Supervisor #1 stated, I put it on the 24 hour log and that goes to (DON). During an interview in the unit managers office on 5/2/14 at 9:15 AM, Nurse #11 (Unit Manager) was asked if there are any reports for Resident #218 on the 24 hour nursing log. Nurse #11 (Unit Manager) stated, I did not find anything on the 24 hour report. I looked from March 25 through April 14 (2014). During an interview in Resident #218's room on 5/2/14 at 9:45 AM, Resident #218 was asked how she slept last night. Resident #218 stated, I slept so good. It was so nice. Resident #220 had been discharged to the hospital on [DATE]. 3. Medical record review for Resident #220 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the significant change MDS with an ARD date of 2/18/14 documented a BIMS score of 3 indicating that his cognitive skills are severely impaired. Review of Resident #220's care plan with a start date of 2/24/14 addressed wandering and elopement risk. The care plan was revised on 4/23/14 to include refusing/rejecting care and on 4/24/14 to include combative/verbally abusive. There is no documentation in Resident #220's medical record related to him wandering into Resident #218's room. Review of a daily skilled nurses note dated 4/22/14 on the 3-11 shift for Resident #220 documented, .requires constant attention by staff. When the new admission arrived this resident went in the tx (treatment) nurse office urinated and had a bowel movement. The other nurse said she tried to stop him from going in tx nurse office stated he had a chart and he hit her. 4. Resident #218 was scared and afraid to rest due to Resident #220 wandering into her room. He has wandered into her room on 3 different occasions. Resident #220 had recently hit a staff member while the staff was attempting to redirect him. Resident #218 stated that she yelled at Resident #220 when he wandered into her room. The facility failed to document the incidents; failed to thoroughly investigate the incidents; and failed to implement new, appropriate and measurable interventions to keep the resident safe which placed Resident #218 in immediate jeopardy.
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of the daily staff sheets, review of 24 hour nursing log, review of an incident report, medical record review, observation and interview, it was determined the facility failed to provide care and services necessary to prevent neglect for 3 of 6 (Residents #22, 218 and 220) residents reviewed for abuse and neglect of the 52 residents included on the stage 2 sample. The failure of the facility to appropriately assess and timely notify the physician of the swelling of the right arm resulted in a delay in treatment for [REDACTED].#218 reported being fearful and not resting at night due to Resident #220 entering her room and failure to address Resident #220's behaviors of wandering, exit seeking and elopement from the facility all resulted in immediate jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment or death). In the activity room on 5/2/14 at 3:45 PM, the Administrator and Director of Nursing (DON) were informed of the immediate jeopardy (IJ). The IJ is ongoing. The immediate jeopardy for F224 K constitutes substandard quality of care. An extended survey was completed on 5/5/14. The findings included: 1. Review of the facility Abuse, Neglect and Misappropriation protocol documented, POLICY. A. physical, and mental abuse. neglect. are prohibited. B. All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other officials in accordance with State law through established guidelines. VII Investigation All allegations of abuse will be investigated and reported to the appropriate agencies. A. The Administrator / designee will make all reasonable efforts to investigate and address alleged reports, concerns, and grievances. B. The person (s) observing the incident will immediately report and provide a written statement that includes name of resident, date and time incident occurred, where it occurred, staff involved and a description of what occurred. VIII Follow up A. Allegations are to be report within the timeframe allotted by state agency B. Social Service/Chaplain will follow up with resident to monitor resident's emotional well-being following the incident. Referral for Psychological/Psychiatric services will be made as needed. E. All allegations of abuse are reviewed at QA (quality assurance) meetings for any further resolution related to educational opportunities. 2. Review of the facility's Situation, Background, Assessment, Request (SBAR) Action and Notification protocol documented, Policy- It is the intent of this facility to assess and document changes in a resident's health, mental or psychosocial status in an efficient and effective manner; to relay assessment information to physician and to document actions. the facility will consult with the resident and notify the resident's physician, and the legal representative or interested family member of but not limited to the following: A significant change in the resident's

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	445331	A. BUILDING _____ B. WING _____	**03/28/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACELAND NURSING CENTER	**1250 FARROW ROAD MEMPHIS, TN 38116**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0224

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 3)
physical. status, A need to alter treatment significantly. Procedure- 1. Licensed staff will assess any change in condition through observation, physical examination to monitor. at the onset of the change. 4. Review all findings with the physician and non-physician practitioner. 5. Document in the medical record. Change of Condition. nursing documentation for change in status. Medical record review for Resident #22 documented an admitted 9/3/05 with [DIAGNOSES REDACTED]. The nursing admission information assessment completed on 3/19/14 documented Resident #22 was readmitted to the facility from the hospital and documented [MEDICAL CONDITION] N (no). The history and physical examination [REDACTED] The care plan dated
4/3/14 documented, Problem- Resident has potential for discomfort/pain, bruising and swelling r/t (related to) fragile skin, h/o (history of) [MEDICAL CONDITION] / muscle mass RUE (right upper extremity) /PAD (peripheral artery disease). Approach Frequency. 4. Observed RUE for swelling and bruising. 5. Notify MD (medical doctor) for changes in status. A nutrition services progress note dated 4/11/14 documented, .some [MEDICAL CONDITION] noted to hand. There was no documentation by the nursing staff of [MEDICAL CONDITION] to the right hand or upper extremity. An acute visit assessment dated [DATE] completed by the Nurse Practitioner (NP) documented, .RUE hand c (with) 2 t (plus) [MEDICAL CONDITION], R (right) forearm 1 t [MEDICAL CONDITION], R upper arm 2 t [MEDICAL CONDITION] with ^ (increased) heat to touch. The NP ordered a doppler to RUE. The final report of the doppler to RUE dated 4/21/14 documented, .There is incomplete compression, echogenic material and decreased flow in the [MEDICATION NAME], axillary, and brachial veins. Non-occlusive [MEDICAL CONDITION] is demonstrated. Soft tissue [MEDICAL CONDITION] is present. A nurses note dated 4/21/14 documented, .T
(positive) Findings regarding Doppler. N.O. (new order) [MEDICATION NAME] (medication to prevent blood clots) 60 mg (milligrams) subq q (subcutaneous every) 12 (symbol for hours) (start today) 2. [MEDICATION NAME] (medication to prevent blot clots) 5 mg PO (by mouth) daily (start today) 3. INR (International normalized ratio (a laboratory test to determine therapeutic levels of blood thinning medication)) daily (start in AM) 4. Continue [MEDICATION NAME] until INR -> (symbol for equal to or greater than) 2 (target INR range) for two consecutive days. A nurses noted dated 4/24/14 documented, .(symbol for decrease) [MEDICAL CONDITION] to Rt. (right) arm/hand. There was no documentation of the [MEDICAL CONDITION]
in the right hand/arm by the nurses until this note dated 4/24/14, yet a nutrition services progress note dated 4/11/14 documented, [MEDICAL CONDITION] noted to hand. An acute visit dated 4/29/14 completed by the NP documented, .History of complex mass arm may cause flow issues. d/c (discontinue) [MEDICATION NAME], d/c [MEDICATION NAME], risks > (greater than)
benefit. Observations in Resident #22's room on 5/2/14 at 12:00 PM, revealed Resident #22 on her left side with wedge pillow present, right hand on pillow and with [MEDICAL CONDITION] noted. Observations in Resident #22's room on 5/2/14 at 6:00 PM, revealed family at bedside and Resident #22 had just been turned back to her left side, oxygen on at 2 liters per nasal cannula, right arm on pillow with [MEDICAL CONDITION] noted, noted facial twitching and mouth breathing. During an interview in the activity room on 5/2/14 at 8:45 AM, Resident #22's family member reported, My mother is (named Resident #22) has been here 9 years and is in late stages of Alzheimer's, not expecting her to live many more days, is comatose. She was in the hospital, can't remember exact dates March/April 2014, when she came back here her right hand was swollen. It swelled up her arm, I asked about it, told nurses, and finally just last week (4/21/14) they addressed it and said it was a blood clot, she got started on [MEDICATION NAME] During an interview at the 500/600 nurses' station on 5/2/14 at 11:50 AM, Nurse #13 stated, I started working here full time about 2 weeks ago on this hall, prior to that I worked as needed. Nurse #13 was asked about Resident #22. Nurse #13 stated, She has [MEDICAL CONDITION] in her right hand, we elevate it on pillows. Nurse #13 was asked how long resident has had [MEDICAL CONDITION] in the right upper extremity. Nurse #13 stated, She has been in the same condition as she is now since the first day I saw her. Has had [MEDICAL CONDITION]. We kept her hand elevated on a pillow. Nurse #13 was asked what was the procedure if there was a change in a resident's condition. Nurse #13 stated, If there was a change in condition, I would evaluate resident and notify the doctor. During an interview at the 500/600 nurses' station on 5/2/14 at 12:10 PM, Nurse #3 was asked about Resident #22 and stated, (Named Resident #22) was sent out to hospital due to decreased intake at her daughters request. Nurse #3 was asked about the [MEDICAL CONDITION] in Resident #22's right hand. Nurse #3 stated, The daughter found it and told me on 4/21/14 the day of the Doppler, the NP was in the facility and was notified and ordered the Doppler. The daughter is a nurse. She is quite involved in her care. During another interview in the activity room on 5/2/14 at 12:26 PM, Nurse #13 was asked about documentation of Resident #22's hand and arm [MEDICAL CONDITION] and notifying the doctor. Nurse #13 stated, No, I don't see any documentation about the [MEDICAL CONDITION] until the 4/21/14 Doppler order. No, I don't see any documentation about the doctor being notified about the [MEDICAL CONDITION] prior to 4/21/14. Review of the daily staff sheets for the shifts Nurse #13 had worked from 4/11/14 (when [MEDICAL CONDITION] was noted by dietary) through 4/21/14 revealed she had worked on 4/11/14, 4/15/14, 4/16/14 and 4/18/14. During an interview in the activity room on 5/2/14 at 12:45 PM, the DON was asked what was expected of nurses if a resident developed [MEDICAL CONDITION] in the hand and arm. The DON stated, I expect nurse to evaluate, notify doctor, and keep hand and arm elevated. During an interview at the 500/600 nurses' station on 5/2/14 at 4:10 PM, Certified Nursing Assistant (CNA) #16 was asked about Resident #22's arm [MEDICAL CONDITION]. CNA #16
stated, I am a floater. I work with her usually at least once a week. I am not sure when hand and arm swelled. I remember her daughter asking us to put her arm up on a pillow. She thought is was swelled, that was in April but not sure exact date. During a telephone interview on 5/5/14 at 4:10 PM, Nurse #14 was asked about Resident #22's hand and arm [MEDICAL CONDITION]. Nurse #14 stated, I do remember caring for (named Resident #22). I do not remember her daughter reporting to me anything about swelling of her right arm, but I do remember being told of that swelling during a shift change report by another nurse but I do not remember the date and can't recall what I did in regards to the arm swelling. Review of the daily staff sheets for the shifts Nurse #14 had worked from 4/11/14 (when [MEDICAL CONDITION] was noted by dietary) through 4/21/14 revealed he had worked on 4/14/14, 4/15/14, 4/16/14, 4/17/14, 4/19/14 and 4/20/14. During an interview in the activity room on 5/2/14 at 5:00 PM, Resident #22's family member was asked what staff had she reported the swelling to. Resident #22's family member stated, I told a CNA on 3-11 shift, don't know her name. I ask them to keep it (arm) on a pillow, also told a male nurse (named Nurse #14) who works 3-11. My Mother has a history of blood clots. The facility failed to timely assess and notify the physician of [MEDICAL CONDITION] of the right arm which resulted in a delay of treatment, actual harm, neglect and placed Resident #22, who was at a high risk of developing [MEDICAL CONDITION], in immediate jeopardy. 3. Medical record review for Resident #218 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Resident #218 resided in a private room next door to Resident #220. The physician's orders [REDACTED]. Review of the annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 8/29/13 and the quarterly MDS with an ARD of 2/25/14 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating that Resident #218 was cognitively intact. There are no behaviors documented on the annual or quarterly MDS. Review of the resident care plan with a start date of 8/30/13 does not address the use of a STOP banner across Resident #218's doorway, fears / concerns with wandering male resident or issues with sleep. The facility was unable to provide an incident report or other investigation related to Resident #218's fear of Resident #220 wandering into her room. Review of the 24 hour nursing log from 3/25/14 through 4/15/14 did not document any report for Resident #218. Observations on the 300 hall on 4/28/14 at 1:06 PM and 5:00 PM, 4/29/14 at 8:10 AM, 4/30/14 at 8:30 AM, 5/1/14 at 9:30 AM and 2:30 PM, 5/2/14 at 9:45 AM, 5/3/14 at 10:00 AM and 2:30 PM and on 5/5/14 at 9:30 AM and 5:00 PM, revealed a STOP banner across the doorway into Resident #218's room. During an interview in Resident #218's room on 4/28/14 at 3:25 PM, Resident #218 was asked if the staff treat her with dignity and respect. Resident #218 stated, No. Resident #218 was then asked how the staff treated her that wasn't with dignity and respect. Resident #218 stated, (Nurse #18) Slow about changing [MEDICAL CONDITION] bag like they don't want to do it. Resident #218 was asked if anyone said anything to her about changing her [MEDICAL CONDITION]. Resident #218 stated, Nobody
said anything but you can tell by their attitude and body language. During an interview in Resident #218's room on 4/28/14 at 3:33 PM, Resident #218 was asked if there had been any concerns or problems with a roommate or any other resident. Resident #218 stated, The man next door comes into my room. I told the nurse and they put the stop banner up. Resident #218 was asked if the staff addressed this concern to her satisfaction. Resident #218 stated, No. He (Resident #220) crawls up under the banner. During an interview in Resident #218's room on 4/28/14 at 5:00 PM, Resident #218 was asked for additional information on the nurses response when it was reported to her that Resident #220 was in her room. Resident #218 stated, When I told the nurse (Nurse #12) about him coming in the room she got smart with me. She (Nurse #12) said I know it's your room but he doesn't know it. Resident #218 was asked when did this happen. Resident #218 stated, Happened about a month ago. I don't know for sure but my daughter does. I'm afraid of him (Resident #220) and I don't rest well. I'm scared he might come into my room. Resident #218 was asked if she had reported this to anyone else besides Nurse #12. Resident #218 stated, My daughter reported it to the supervisor (Registered Nurse (RN) Supervisor #1). During an interview in Resident #218's room on 4/30/14 at 8:29 AM, Resident #218 was asked if she knew the name of the resident that comes into her room.

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) Resident #218 stated, They (staff) call him (named Resident #220). During an interview on the 300 hall on 5/1/14 at 8:30 AM, CNA #17 was asked the reason for the 'STOP' banner across Resident #218's doorway. CNA #17 stated, A resident (named Resident #220) comes into her room in the evening. CNA #17 was asked if Resident #218 had reported this to her. CNA #17 stated, She told me about 3 weeks ago. Resident #218 was asked if she reported it to anyone. CNA #17 stated, Yes, my charge nurse (Nurse #18). During an interview in the DON's office on 5/1/14 at 8:55 AM, the DON was asked what should happen when a resident reports a concern to a CNA. The DON stated, The CNA reports it to the charge nurse to try and resolve it and then inform me. The DON was asked if she had any reported concerns regarding Resident #218 and Resident #220. The DON stated, Haven't heard anything. During an interview in Resident #218's room on 5/1/14 at 9:00 AM, Resident #218 was asked how many times Resident #220 had come into her room and what did he do when he came in. Resident #218 stated, Has been in here 3 times. One time he came in and started pulling on door (points to bathroom door) and started pulling his pants down. The second time he came into room he was standing by the curtain (privacy curtain) looking in the corner. The third time he crawled under the sign (STOP banner). I was in bed resting, around 2 in the afternoon. I always lay down after dinner (lunch). Have to lay down in the evening (after the lunch meal) cause I can't rest at night. I'm afraid he would come in here. Resident #218 was asked what do you do when Resident #220 comes into her room. Resident #218 stated, When I yell he heads for the door. Resident #218 was asked if she had reported it to anyone else. Resident #218 stated, I told that nurse (Nurse #12) that was smart with me. Didn't want to report it anymore after that. Didn't think I was supposed to. My daughter reported it to the supervisor. I don't want that man coming into my room scaring me and making me have a set-back. During an interview in the activity room on 5/1/14 at 1:30 PM, the DON stated, I've talked to (Resident #218). We need to have him (Resident #220) evaluated. The DON was asked who would do this evaluation. The DON stated, (named hospital with behavioral unit). Resident #220 was discharged on [DATE]. During an interview in Resident #218's room on 5/1/14 at 5:40 PM, Resident #218's daughter was asked if she had the dates that Resident #220 had come into her mother's room. Resident #218's daughter stated, About a month ago he came in and she told him this wasn't his room. He's done it when I'm here too. I scribbled the dates on the calendar. The first time it happened in March (2014), the second time was on 4/3 (2014). That's when he (Resident #220) tried to get into the bathroom. I talked to (named RN Supervisor #1). Happened again on 4/9 (4/9/14) and I talked to (named RN Supervisor #1) again. She said she would write up a report. During an interview at the A hall nurses' station on 5/1/14 at 6:30 PM, RN Supervisor #1 was asked what she does when a resident or family has a concern or complaint. RN Supervisor #1 stated, I try to investigate it and correct it on my shift. Then I pass it along to the next shift. RN Supervisor #1 was asked if Resident #218's daughter had reported that a male resident was coming into her mother's room and it scared her mother. RN Supervisor #1 stated, Yes. I told the floor nurse to document (named Resident #220) behavior and keep him out of the room and then to pass it along to the next shift. RN Supervisor #1 was asked how she passed it along to the next shift. RN Supervisor #1 stated, I put it on the 24 hour log and that goes to (DON). During an interview in the unit managers office on 5/2/14 at 9:15 AM, Nurse #11 (Unit Manager) was asked if there are any reports for Resident #218 on the 24 hour nursing log. Nurse #11 (Unit Manager) stated, I did not find anything on the 24 hour report. I looked from March 25 through April 14 (2014). During an interview in Resident #218's room on 5/2/14 at 9:45 AM, Resident #218 was asked how she slept last night. Resident #218 stated, I slept so good. It was so nice. Resident #220 had been discharged to the hospital on [DATE]. Resident #218 was scared and afraid to rest due to Resident #220 wandering into her room. He has wandered into her room on 3 different occasions. Resident #220 had recently hit a staff member while the staff was attempting to redirect him. Resident #218 stated that she yelled at Resident #220 when he wandered into her room. The facility failed to document the incidents; failed to thoroughly investigate the incidents; and failed to implement new, appropriate and measurable interventions to keep the resident safe which placed Resident #218 in immediate jeopardy. 4. Medical record review for Resident #220 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the physician orders [REDACTED]. Review of the significant change MDS with an ARD date of 2/18/14 documented a BIMS score of 3 indicating that his cognitive skills are severely impaired. The preference and frequency of wandering is documented to occur 1 to 3 days during the assessment period. Review of the resident care plan with a start date of 2/24/14 documented, .Wandering / Elopement Risk. Ensure that resident is wearing a wanderguard and that it is working properly. Review of a facility incident report dated 4/15/14 documented, .Resident (#220) got out of the building by himself wandered over to (named grocery store), Wanderguard intact to right ankle. Resident brought back to facility. Appears NAD (no apparent distress) without skin tears, skin discoloration, or [MEDICAL CONDITION] There is no documentation on the incident report that the facility checked the functioning of his wanderguard or the facility alarm system after he returned to the facility. A written statement from RN Supervisor #1 documented, .I was notified by (named Nurse #17) at 10:33 pm, that the alarm had gone off and a man was seen leaving the building. I went to check on (named another resident) room he was asleep in bed. Someone checked (named Resident #220) and he wasn't there. staff was notified to search the building. He was found at (named grocery store) by staff, and returned to the building. No injury. There was no statement from Nurse #17 in the facility's investigation or an investigation of how Resident #220 got out of the facility. During an interview in the DON's office on 5/1/14 at 9:00 AM, the DON was asked what she expects a nurse to do if they hear the wanderguard alarm and see someone leave the building. The DON stated, Go after them. During an interview while make rounds to check the door alarms on 5/2/14 beginning at 4:30 PM, the maintenance man was asked once the alarm is set off by a resident what happens. The maintenance man stated, When a resident with a wanderguard gets near the door another red light comes on, then when they push on the door it starts sounding and will open after 15 seconds, the alarm will keep sounding until someone resets it. It (alarm) will not stop sounding until it's reset. During an interview on the 100 hall on 5/3/14 at 2:05 PM, Nurse #15 was asked what do you do when you find you have a missing resident. Nurse #15 stated, I'd let my charge nurse know that a patient is missing. Nurse #15 was then asked what she would do if she heard a wanderguard alarm. Nurse #15 answered, Notify a supervisor. Call the AWOL (absence without leave) code. Nurse #15 was then asked, Would you not stop what you were doing to go look? Nurse #15 stated, It depends on what I was doing. I'm an agency nurse and really don't know what the policy is. The facility failed to ensure staff were knowledgeable of the facility's policy requirements when a resident is discovered missing by not knowing the facility's elopement code. Refer to F518. During an interview in the activities room on 5/5/14 at 8:15 AM, the Administrator, was informed of above nurses response to question of responding to wanderguard alarm and asked if the facility had an orientation for the agency nurses. The Administrator stated, From what I understand, the agency nurses are oriented to the patients they will be taking care of but we don't have an organized, structure orientation for agency nurses, but we will now. Resident #220 eloped from the facility on 4/15/14 around 10:33 PM. A nurse heard the alarm and saw a man leave but did not go after him. According to the Maintenance Director the wanderguard alarm will ring until it is reset. Resident #220 had to cross a street and walk approximately 0.4 miles to a named grocery store. The facility failed to thoroughly investigate this incident and failed to implement new, appropriate and measurable interventions which placed Resident #220 in immediate jeopardy.
F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of a facility's investigation, medical record review, observation and interview, it was determined the facility failed to thoroughly investigate an injury of unknown origin for 1 of 2 (Resident #1) investigations reviewed. The failure of the facility to complete a thorough investigation and the failure of staff to provide two person assistance for Resident #1 resulted in actual harm when the resident sustained [REDACTED]. The findings included: Review of the facility's Incident Reporting policy documented, Policy It is the intent of this facility to provide a safe and healthful work environment. This facility shall ensure that the resident's environment shall remain as free of accident hazards as possible, and that each resident shall receive adequate supervision and assistive devices that shall reduce accidents. Procedure. Incident/Occurrence Investigation Form initiated by the Charge Nurse with completion by DON (Director of Nursing)/designee. Medical record review for Resident #1 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] documented the resident had adequate hearing, clear speech, able to make self understood, understands with clear comprehension, and had adequate vision. The resident's cognitive a summary score was 10 out of a possible 15 indicating moderate cognitive impairment. Functionally the

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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) resident was totally dependent for transfers, full staff performance every time, two persons physical assist due to functional limitation in range of motion of the lower extremity, impairment on both sides. Review of the most recent MDS dated [DATE] documented a cognitive summary score of 13 out of a possible 15 indicating the resident was cognitively intact. Functional status remained the same. Review of the care plan dated 7/5/13 documented, .Laceration to toe next to great toe on right foot. monitor stitches for s/s (signs and symptoms) of infection. Resident has a fracture of L (left) knee with a immobilizer. Immobilizer d/c'd (discontinued) 8/26/13. The care plan was updated 8/15/13 and documented, .Total assist with lift with transfers. Review of the facility's investigation of Resident #1's injury on 7/5/13 did not include an Incident / Occurrence Investigation Form which would include interviews, conclusion, and corrective action. An undated and unsigned hand written note documented, (Named Certified Nursing Assistant (CNA) #1), states that he reported what he saw to the charge nurse, he noted blood coming from the resident's right foot. Unsure as to what happened. Observations in Resident #1's room on 1/15/14 at 11:15 AM and 3:55 PM and 2/4/14 at 1:00 PM, revealed Resident #1 was lying on a specialty air mattress bed, a trapeze bar was over the head of the bed, unable to move lower extremities, and the resident was noted to have bilateral foot drop. During an interview in Resident #1's room on 1/15/14 at 3:55 PM, Resident #1 was asked if he had ever been treated roughly or injured by the facility staff. Resident #1 stated, He (CNA #1) was a rookie. Split my toes. He didn't know what he was doing, but it was not done intentionally. Resident #1 continued and stated that he was paraplegic and had no feeling in his lower extremities. He didn't know what the CNA hit his foot on to split it. He had to go to the emergency room and get stitches but did not recall having had a fracture. During an interview in the conference room on 2/5/14 at 10:30 AM, the Administrator was asked, How do you decide which injuries of unknown origin should be investigated? The Administrator stated, Investigate all occurrences to determine reasonable outcome, how the injury occurred. The Administrator, who started working at the facility in December 2013, also confirmed the facility was unable to provide documentation of a thorough investigation related to Resident #1's injuries.
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of incident reports, medical record review, observation and interview, it was determined the facility staff failed to implement their abuse/neglect policy for investigating and/or reporting allegations of abuse and neglect for 2 of 6 (Residents #218 and 220) residents reviewed for abuse and neglect of the 52 residents reviewed included in the stage 2 sample. The facility staff failed to ensure allegations of fear and elopement from the facility were thoroughly investigated and/or reported to administration when Resident #218 reported the inability to sleep at night for fear of Resident #220 entering her room; Resident #220's behaviors of wandering, exit seeking and elopement from the facility which resulted in immediate jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death). In the activity room on 5/2/14 at 3:45 PM, the Administrator and Director of Nursing (DON) were informed of the immediate jeopardy (IJ). The IJ is ongoing. The immediate jeopardy for F226 J constitutes substandard quality of care. An extended survey was completed on 5/5/14. The findings included: 1. Review of the facility Abuse, Neglect and Misappropriation protocol documented, POLICY A. physical, and mental abuse. neglect. are prohibited. B. All allegations of abuse involving abuse. are reported immediately to the charge nurse and/or administrator of the facility along with other officials in accordance with State law through established guidelines. VII Investigation All allegations of abuse will be investigated and reported to the appropriate agencies. A. The Administrator / designee will make all reasonable efforts to investigate and address alleged reports, concerns, and grievances. B. The person (s) observing the incident will immediately report and provide a written statement that includes name of resident, date and time incident occurred, where it occurred, staff involved and a description of what occurred. VIII Follow up A. Allegations are to be report within the timeframe allotted by state agency B. Social Service/Chaplain will follow up with resident to monitor resident's emotional well-being following the incident. Referral for Psychological/Psychiatric services will be made as needed. E. All allegations of abuse are reviewed at QA (Quality Assurance) meetings for any further resolution related to educational opportunities. 2. Medical record review for Resident #218 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Resident #218 resided in a private room next door to Resident #220. The physician's orders [REDACTED]. Review of the annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 8/29/13 and the quarterly MDS with an ARD of 2/25/14 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating that Resident #218 was cognitively intact. There are no behaviors documented on the annual or quarterly MDS. Review of the resident care plan with a start date of 8/30/13 does not address the use of a STOP banner across Resident #218's doorway, fears/concerns with wandering male resident or issues with sleep. The facility was unable to provide an incident report or other investigation related to Resident #218's fear of Resident #220 wandering into her room. Review of the 24 hour nursing log from 3/25/14 through 4/15/14 did not document any report for Resident #218. Observations on the 300 hall on 4/28/14 at 1:06 PM and 5:00 PM, 4/29/14 at 8:10 AM, 4/30/14 at 8:30 AM, 5/1/14 at 9:30 AM and 2:30 PM, 5/2/14 at 9:45 AM, 5/3/14 at 10:00 AM and 2:30 PM and on 5/5/14 at 9:30 AM and 5:00 PM, revealed a STOP banner across the doorway into Resident #218's room. During an interview in Resident #218's room on 4/28/14 at 3:33 PM, Resident #218 was asked if there had been any concerns or problems with a roommate or any other resident. Resident #218 stated, The man next door comes into my room. I told the nurse and they put the stop banner up. Resident #218 was asked if the staff addressed this concern to her satisfaction. Resident #218 stated, No. He (Resident #220) crawls up under the banner. During an interview in Resident #218's room on 4/28/14 at 5:00 PM, Resident #218 was asked for additional information on the nurses response when it was reported to her that Resident #220 was in her room. Resident #218 stated, When I told the nurse (Nurse #12) about him coming in the room she got smart with me. She (Nurse #12) said I know it's your room but he doesn't know it. Resident #218 was asked when did this happen. Resident #218 stated, Happened about a month ago. I don't know for sure but my daughter does. I'm afraid of him (Resident #220) and I don't rest well. I'm scared he might come into my room. Resident #218 was asked if she had reported this to anyone else besides Nurse #12. Resident #218 stated, My daughter reported it to the supervisor. During an interview in Resident #218's room on 4/30/14 at 8:29 AM, Resident #218 was asked if she knew the name of the resident that comes into her room. Resident #218 stated, They (staff) call him (named Resident #220). During an interview on the 300 hall on 5/1/14 at 8:30 AM, Certified Nursing Assistant (CNA) #17 was asked the reason for the 'STOP' banner across Resident #218's doorway. CNA #17 stated, A resident (named Resident #220) comes into her room in the evening. CNA #17 was asked if Resident #218 had reported this to her. CNA #17 stated, She told me about 3 weeks ago. Resident #218 was asked if she reported it to anyone. CNA #17 stated, Yes, my charge nurse (Nurse #18). During an interview in the DON's office on 5/1/14 at 8:55 AM, the DON was asked what should happen when a resident reports a concern to a CNA. The DON stated, The CNA reports it to the charge nurse to try and resolve it and then inform me. The DON was asked if she had any reported concerns regarding Resident #218 and Resident #220. The DON stated, Haven't heard anything. During an interview in Resident #218's room on 5/1/14 at 9:00 AM, Resident #218 was asked how many times Resident #220 had come into her room and what did he do when he came in. Resident #218 stated, Has been in here 3 times. One time he came in and started pulling on door (points to bathroom door) and started pulling his pants down. The second time he came into room he was standing by the curtain (privacy curtain) looking in the corner. The third time he crawled under the sign (STOP banner). I was in bed resting, around 2 in the afternoon. I always lay down after dinner (lunch). Have to lay down in the evening (after the lunch meal) cause I can't rest at night. I'm afraid he would come in here. Resident #218 was asked what do you do when Resident #220 comes into her room. Resident #218 stated, When I yell he heads for the door. Resident #218 was asked if she had reported it to anyone else. Resident #218 stated, I told that nurse (Nurse #12) that was smart with me. Didn't want to report it anymore after that. Didn't think I was supposed to. My daughter reported it to the supervisor. I don't want that man coming into my room scaring me and making me have a set-back. During an interview in the activity room on 5/1/14 at 1:30 PM, the DON stated, I've talked to (Resident #218). We need to have him (Resident #220) evaluated. The DON was asked who would do this evaluation. The DON stated, (named hospital with behavioral unit). Resident #220 was discharged on [DATE]. During an interview in Resident #218's room on 5/1/14 at 5:40 PM, Resident #218's daughter was asked if she had the dates that the resident (#220) had come into her mother's room. Resident #218's daughter stated, About a month ago he (Resident #220) came in and she told him this wasn't his room. He's done it when I'm here too. I scribbled the dates on the calendar. The first time it happened in March (2014), the second time was on 4/3 (2014). That's when he (Resident #220) tried to get into the bathroom. I talked to (named Registered Nurse (RN) Supervisor #1). Happened again on 4/9 (4/9/14) and

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	445331	A. BUILDING _____ B. WING _____	03/28/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) I talked to (named RN Supervisor #1) again. She said she would write up a report. During an interview at the A hall nurses' station on 5/1/14 at 6:30 PM, RN Supervisor #1 was asked what she does when a resident or family has a concern or complaint. RN Supervisor #1 stated, I try to investigate it and correct it on my shift. Then I pass it along to the next shift. RN Supervisor #1 was asked if Resident #218's daughter had reported that a male resident was coming into her mother's room and it scared her mother. RN Supervisor #1 stated, Yes. I told the floor nurse to document (named Resident #220) behavior and keep him out of the room and then to pass it along to the next shift. RN Supervisor #1 was asked how she passed it along to the next shift. RN Supervisor #1 stated, I put it on the 24 hour log and that goes to (DON). During an interview in the unit managers office on 5/2/14 at 9:15 AM, Nurse #11 (Unit Manager) was asked if there are any reports for Resident #218 on the 24 hour nursing log. Nurse #11 (Unit Manager) stated, I did not find anything on the 24 hour report. I looked from March 25 through April 14 (2014). During an interview in Resident #218's room on 5/2/14 at 9:45 AM, Resident #218 was asked how she slept last night. Resident #218 stated, I slept so good. It was so nice. Resident #220 was discharged to the hospital on [DATE]. Resident #218 was scared and unable to sleep due to Resident #220 wandering into her room. He has wandered into her room on 3 different occasions. Resident #218 stated that she yelled at Resident #220 when he wandered into her room. Resident #220 had recently hit a staff member while the staff was attempting to redirect him. The facility was unable to provide an incident report or an investigation related to Resident #218's reported fear of Resident #220 wandering into her room. The facility failed to implement the abuse policy related to documenting incidents; failed to thoroughly investigate and follow up on voiced grievances; and failed to implement new, appropriate and measurable interventions to keep the resident safe which placed Resident #218 in immediate jeopardy. 3. Review of the facility's Incident Reporting policy documented, Policy. It is the intent of this facility to provide a safe and healthful work environment. This facility shall ensure that. each resident shall receive adequate supervision and assistive devices that shall reduce accidents. Medical record review for Resident #220 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the physician orders [REDACTED]. Review of the significant change MDS with an ARD date of 2/18/14 documented a BIMS score of 3 indicating that his cognitive skills are severely impaired. The preference and frequency of wandering is documented to occur 1 to 3 days during the assessment period. Review of the resident care plan with a start date of 2/24/14 documented, .Wandering / Elopement Risk. Ensure that resident is wearing a wanderguard and that it is working properly. Review of a facility incident report dated 4/15/14 documented, .Resident (#220) got out of the building by himself wandered over to (named grocery store), Wanderguard intact to right ankle. Resident brought back to facility. Appears NAD (no apparent distress) without skin tears, skin discoloration, or [MEDICAL CONDITION] There is no documentation on the incident report that the facility checked the functioning of his wanderguard or the facility alarm system after he returned to the facility. A written statement from Registered Nurse (RN) Supervisor #1 documented, .I was notified by (named Nurse #17) at 10:33 pm, that the alarm had gone off and a man was seen leaving the building. I went to check on (named another resident) room he was asleep in bed. Someone checked (named Resident #220) and he wasn't there. staff was notified to search the building. He was found at (named grocery store) by staff, and returned to the building. No injury. There was no statement from Nurse #17 in the facility's investigation or an investigation of how Resident #220 got out of the facility. During an interview in the DON office on 5/1/14 at 9:00 AM, the DON was asked what she expects a nurse to do if they hear the wanderguard alarm and see someone leave the building. The DON stated, Go after them. During an interview while make rounds to check the door alarms on 5/2/14 beginning at 4:30 PM, the maintenance man was asked once the alarm is set off by a resident what happens. The maintenance man stated, When a resident with a wanderguard gets near the door another red light comes on, then when they push on the door it starts sounding and will open after 15 seconds, the alarm will keep sounding until someone resets it. It (alarm) will not stop sounding until it's reset. During an interview on the 100 hall on 5/3/14 at 2:05 PM, Nurse #15 was asked what do you do when you find you have a missing resident. Nurse #15 stated, I'd let my charge nurse know that a patient is missing. Nurse #15 was then asked what she would do if she heard a wander guard alarm. Nurse #15 answered, Notify a supervisor. Call the AWOL (absence without leave) code. Nurse #15 was then asked, Would you not stop what you were doing to go look? Nurse #15 stated, It depends on what I was doing. I'm an agency nurse and really don't know what the policy is. The facility failed to ensure staff were knowledgeable of the facility's policy requirements when a resident is discovered missing by not knowing the facility's elopement code. Refer to F518. During an interview in the activities room on 5/5/14 at 8:15 AM, the Administrator, was informed of above nurses response to question of responding to wanderguard alarm and asked if the facility had an orientation for the agency nurses. The Administrator stated, From what I understand, the agency nurses are oriented to the patients they will be taking care of but we don't have an organized, structure orientation for agency nurses, but we will now. Resident #220 eloped from the facility on 4/15/14 around 10:33 PM. Nurse #17 heard the alarm and saw a man leave but did not go after him. According to the Maintenance Director the wanderguard alarm will ring until it is reset. Resident #220 had to cross a street and walk approximately 0.4 miles to a named grocery store. The facility failed to implement the abuse policy to thoroughly investigate this incident and failed to implement new, appropriate and measurable interventions which placed Resident #220 in immediate jeopardy.
F 0241 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation and interview, it was determined the facility failed to provide care that enhanced a resident's dignity when Nurse #18 exhibited an attitude and exhibited offensive body language and Nurse #12 got smart with 1 of 11 (Resident #218) residents who were interviewed about dignity of the 11 residents included in the stage 1 sample. The facility failed to ensure 3 of 21 staff members (Certified Nursing Assistants (CNAs) #5 and 23 and Nurse #10) provided care that enhanced each residents' dignity when staff failed to assist residents with eating; referred to residents as 'feeders'; posted personal information about residents on the wall and staff failed to obtain permission to enter residents' rooms for 4 of 52 (Residents #17, 33, 95 and 181) residents included in the stage 2 sample. The findings included: 1. Review of the facility's NOTICE OF RESIDENT RIGHTS policy documented, .To personal privacy and confidentiality, to include accommodations, written and telephone communications, personal care, visits, and meetings of family and resident groups. 2. Medical record review for Resident #218 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the current physician's orders [REDACTED]. During an interview in Resident #218's room on 4/28/14 at 3:25 PM, Resident #218 was asked if the staff treat her with dignity and respect. Resident #218 stated, No. Resident #218 was then asked how the staff treated her that wasn't with dignity and respect. Resident #218 stated, (Nurse #18) Slow about changing [MEDICAL CONDITION] bag like they don't want to do it. Resident #218 was asked if anyone said anything to her about changing her [MEDICAL CONDITION]. Resident #218 stated, Nobody said anything but you can tell by their attitude and body language. During an interview in Resident #218's room on 4/28/14 at 5:00 PM, Resident #218 was asked for additional information on the nurses response when it was reported to her that Resident #220 was in her room. Resident #218 stated, When I told the nurse (Nurse #12) about him (Resident #220) coming in the room she got smart with me. She (Nurse #12) said I know it's your room but he doesn't know it. 3. Medical record review for Resident #17 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/29/13 and 2/26/14 section C was coded 03 indicating the resident is severely impaired in decision-making skills, section G Functional Status-H/Eating was coded as 1/1 indicating Supervision-oversight, encouragement or cueing and set-up help only. Observations in the assistive dining room on 4/28/14 at 12:10 PM, Resident #17 was seated at a table eating her lunch with her fingers. There were no observations of staff intervening or assisting residents to use silverware. 4. Medical record review for Resident #33 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the MDS with an ARD of 3/17/14 section C-Cognitive Skills for Daily Decision Making was coded as 3 indicating the resident was severely impaired - never/rarely makes decisions and section G-Functional Status/Dressing was coded as 4/2 indicating extensive assistance and one person physical assist. Review of the care plan dated 3/19/14 documented, .Problem. Resident is totally dependent on staff for all care needs r/t (related to) cognitive/communication problems, functional limitations, incontinence, and blind. Approach/Frequency. Provide total care for all ADL's (Activities of Daily Living). Observations in Resident #33 room on 5/1/14 at 4:08 PM, and on 5/3/14 at 1:00 PM, revealed a sign on the wall at the head of the bed that documented, THIS PATIENT SHOULD NOT SLEEP IN SOCKS. She Is Diabetic And Socks Restrict Circulation. During an interview in Resident #33's room on 5/5/14 at 2:30 PM, Nurse #4 was asked if the sign should be at the head of the

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F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) resident's bed. Nurse #4 stated, .It shouldn't be up there like that. During an interview in Resident's #33's room on 5/5/14 at 2:32 PM, Nurse #5 was asked about the sign at the head of the resident's bed. Nurse #5 stated, No, it shouldn't be up there like that. 5. Medical record review for Resident #95 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the MDS with an ARD of 12/12/13 and 3/10/14 section C-Cognitive Patterns was coded as 3 indicating the resdient is severely impaired in decision making skills, section G-Functional Status/H-Eating was coded as 2/2 indicating the resident needed limited assistance/one person physical assist. Review of the care plan dated 3/14/14 did not address the resident's need for assistance with eating. Review of a physician's orders [REDACTED]. Observations in the assistive dining room on 4/28/14 at 12:10 PM, and on 4/30/14 at 7:10 AM, revealed Resident #95 seated at a table eating her lunch with her fingers. There were no observations of staff intervening or assisting residents to use silverware. During an interview in the D hall unit manager's office on 4/30/14 at 9:36 AM, Nurse #8 was asked what were his expectations if a resident was eating with their fingers. Nurse #8 stated, I would expect them (referring to staff) to offer them a spoon or to help them. 6. Medical record review for Resident #181 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Observations in Resident #181's room on 4/30/14 at 9:00 AM, 1:40 PM and 2:50 PM and on 5/1/14 at 7:15 AM, revealed the resident lying in bed with the head of bed elevated receiving [MEDICATION NAME] per PEG at 70 milliliters per hour. A sign posted on a board at the bedside documented, Feeding Routine - sip of liquid, spoon of food, sip of liquid, spoon of food. During an interview in room [ROOM NUMBER] on 5/1/14 at 10:00 AM, Nurse #9 was asked about the sign in Resident #181's room. Nurse #9 stated, Families will post signs, families will tell us often what they want and we will print a sign off for them, not sure about this one. CNA #3 remove the sign from the board, left room and returned and stated, He got speech therapy and they put that sign up. He no longer gets therapy and does not eat by mouth. 7. Dining observations on the 700 hall on 4/28/14 beginning at 12:30 PM revealed the following: a. CNA #5 entered room [ROOM NUMBER] without knocking prior to entering the room. CNA #5 subsequently entered room [ROOM NUMBER] without knocking prior to entering the room. b. CNA #23 entered Resident room [ROOM NUMBER]W without knocking prior to entering the room. 8. Observations outside of room [ROOM NUMBER] on 4/28/14 at 12:35 PM, Nurse #10 entered room [ROOM NUMBER] A, assisting with tray set up. Another staff member came to the door and asked Nurse #10 What more do you have to do. Nurse #10 stated, We have 3 feeders left.
F 0246 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and interview, it was determined the facility failed to ensure a resident's individual needs and preferences were provided for 1 of 52 (Resident #7) residents included in the stage 2 sample. The findings included: 1. Medical record review for Resident #7 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. The annual minimum data set ((MDS) dated [DATE] and the quarterly MDS dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 15 indicating the resident had no cognitive impairments, required set up help with eating, and had bilateral upper extremity impairment on both sides. The care plan dated 10/16/13 and updated on 4/9/14 documented, Problem-Impaired mobility w (with) / self-care deficit r/t/ (related to) h/o (history of)[MEDICAL CONDITION]/ Rt. (right) hemi (stroke with right paralysis), h/o GSW (gunshot wound) to head. Approach-Frequency 1. Provide full staff assistance w/bathing, dressing, personal hygiene, grooming, oral, and incontinent care. 3. Set-up all equipment for personal care. 4. Assist resident w/oral care. During an interview in Resident #7's room on 4/28/14 at 3:20 PM, Resident #7 stated, (Named Certified Nursing Assistant (CNA) #22) left trays without opening items, happens all the time, have told (Named Nurse #5). Observations in Resident #7's room on 4/28/14 at 3:20 PM revealed Resident #7 with noted left [MEDICAL CONDITION] with left arm and hand contractures. A nurses note dated 3/3/14 documented, .feed self with set up. A nurses note dated 3/7/14 documented, .fed self p (after) tray set up. A Nurses note dated 4/7/14 documented .feeds self p set up. During an interview at the 100/200 nursing station on 4/30/14 at 4:00 PM, Nurse #5 (unit manager) was asked about any complaints regarding care reported by Resident #7. Nurse #5 stated, Yes, she did complain to me right after I started here about (named CNA #22). She complained she did not put her to bed when she wanted to and did not open her items on her trays for her. I talked to both of them (Resident #7 and CNA #22). I removed (named CNA #22) from caring for (named Resident #7). Nurse #5 was asked if there were any investigations of these complaints. Nurse #5 stated, No, I did not write this up anywhere. No, do not have a grievance log. No, I did not document this anywhere. I just talked to them. Nurse #5 was asked about how charge nurses were informed of her removing CNA #22 of caring for Resident #7. Nurse #5 stated, They (nurses)know, they do not assign (named CNA #22) to (named Resident #7). The surveyor asked to review the 4/30/14 3-11 shift assignment sheet. The assignment sheet documented Resident #7 was assigned on paper to CNA #22. Nurse #5 stated, She (named CNA #22) knows not to go in her (Resident #7's) room. She (CNA #22) will get one of the other CNA's to do (named Resident #7) for her. Nurse #5 was asked how staff know this. Nurse #5 stated, They know. During an interview at the 100/200 nurses' station on 4/30/14 at 4:00 PM, Nurse #17 was asked about care needed by Resident #7 and how she monitors care provided. Nurse #17 stated, I am up and down hall and watch for turning, incontinence care, transfers. I watch meal service either on hall or in dining room. I monitor the care provided. (Named Resident #7) has to have assistance with transfers, toileting, pericare, the aides have to set her trays up for her, she is totally out on her left arm and has no use of it. During an interview at the 500/600 nurses' station on 5/1/14 at 6:00 PM, the Registered Nurse (RN) Supervisor #1 was asked the procedure for handling CNA assignments who have resident restrictions. RN Supervisor #1 stated, I tell the Charge Nurses the CNA cannot care for the resident. The CNA is told not to care for the resident. The Charge Nurses will put the CNA assignment on the assignment sheet. During an interview in the Director of Nursing's (DON) office on 5/1/14 at 3:30 PM with CNA #22 revealed the following: CNA #22 was asked about her assignment. CNA #22 stated, I have worked here 8 years. I have set assignment of rooms 105 through 112 and 101. I cannot go into room [ROOM NUMBER] (Resident #7's room). CNA #22 was asked why she could not go in room [ROOM NUMBER]. CNA #22 stated, (Named Resident #7) does not want me in her room. She doesn't like me because I would not take her money and go to the snack machine and get her cookies. It is a rule here we cannot take money from the residents. I explained that to her. She got mad at me. She also would ask me to take her into the bathroom to change her. I told her I could not do that for her safety she might fall. I put her to bed and change her brief. She doesn't like that. CNA #22 was asked if the other CNAs put her (Resident #7) to bed to change her brief. CNA #22 stated, They take her in the bathroom. CNA #22 was asked if other CNAs get snacks out of machine for residents. CNA #22 stated, Yes, they break the rules. I don't break the rules. CNA #22 was asked how she found out not to go in room [ROOM NUMBER]. CNA #22 stated, (Named Nurse #5) told me (named Resident #7) did not want me in her room anymore. CNA #22 was asked how she and other CNA's know their assignments. CNA #22 stated, Nurses write it on the assignment sheet that I do room [ROOM NUMBER] and other CNA does 106. CNA #22 was asked if she had been oriented / trained on abuse. CNA #22 stated, Yes. CNA #22 was asked what type of training she got on abuse. CNA #22 stated, Don't talk negative to residents, don't hit them, honor their privacy. CNA #22 was asked when was the last time she had abuse training. CNA #22 stated, Last month. CNA #22 was asked what type of training she had received on resident rights. CNA #22 stated, Yes, got trained on resident rights. CNA #22 was asked what she was taught. CNA #22 stated, They have the right to make choices, decide what they want, have privacy. I explained to (named Resident #7) it was not safe for me to change her in the bathroom. She wanted to go in there hold on to the sink. CNA #22 was asked when she cared for Resident #7 what type of care she did provide. CNA #22 stated, I would change her, put her to bed, deliver her tray and open up her items. CNA #22 was asked if she had delivered her a tray this week. CNA #22 stated, No. CNA #22 was asked if Resident #7 could open up any of her tray items. CNA #22 stated, She can open her silverware and take the lid off of her soup, but I opened everything else up. CNA #22 denied that she had not opened up tray items. During an interview on the 100 hall on 5/2/14 at 7:30 AM, CNA #15 (assigned to and providing care for Resident #7) was asked what type of care she provided. CNA #15 stated, I assist her with bath, change her, deliver and set up her tray. CNA #15 was asked how the bath is done or how toileting is done. CNA #15 stated, She (Resident #7) gets her bath in the bathroom, she stands up, holds to sink, yes, she does real good like that.

F 0253 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide housekeeping and maintenance services.** Based observation and interview, it was determined the facility failed to provide effective maintenance and housekeeping services to maintain a sanitary, orderly and comfortable environment as evidence by loose and hanging wallpaper, scuffed walls with sheetrock missing, brown build up around baseboards in resident's rooms and bathrooms, door on bedside table broken, knob missing from night stand, bedside table roller broken, dirty floors in resident rooms and bathrooms, dirty, sticky handrails, toilets stained with yellow substance, urine odors and walls stained with unknown substances in 15 of 120 (rooms 106, 107, 208, 510, 512, 600, 609, 614, 701, 804, 807, 808, 809, 814 and 816) resident rooms. The findings included: 1. Observations during the initial tour of the facility on 4/28/14 beginning at 9:15 AM, revealed the following: a. Room

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F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) 106 - wall paper above D bed was loose and hanging, wall at closets scuffed with sheetrock missing, several areas on the wall around the room have sheetrock scuffed up. b. Room 107 - knob missing from D bed night stand and over bed table had a broken roller preventing it from rolling. c. Room 208 - bathroom has urine odor. d. Room 510 - black scuff marks on the wall near the doorway. e. Room 512 - yellowish/brown substance at base of toilet and strong urine odor in bathroom. f. Room 600 - dirty substance in the corners of the room. g. Room 609 - the base of the toilet had yellow/brownish substance in the bathroom and brown substance in the corners of room. h. Room 614 - the cover over the controls off the air conditioning unit was in the floor, urine stains down the front and at the base of the toilet bowl and a strong urine odor in the bathroom. i. Room 701 - blackish/brown substance on the floor tile around W bed and in front of the air conditioner, toilet had yellow substance around base and bowl and a strong urine odor in the bathroom. j. Room 804 - black scuff marks on the wall. k. Room 807 - stale urine odors. l. Room 808 - peeling wallpaper behind the D bed m. Room 809 - a spill on the floor beside D bed and urine down the front of toilet bowl and around the base of the toilet and strong urine odors in the resident's room and bathroom. n. Room 814 - dirt around the corners of the room, toilet bowl base stained with a yellowish substance and a strong urine odor in bathroom. o. Room 816 - walls were scuffed with white areas and there was peeling baseboard near the bathroom. 2. Observations in room 809 on 4/28/14 at 12:56 PM and on 4/29/14 at 10:24 AM, 12:23 PM, 2:00 PM and 3:15 PM and on 5/1/14 at 3:35 PM, revealed strong urine odors in the room and in the bathroom. Observations in room 809's bathroom on 4/29/14 at 10:24 AM, revealed the bathroom floor was dirty with brown stains. 3. Observations in room 808 on 4/29/14 at 11:02 AM, revealed peeling wallpaper behind the bed and on the wall near the doorway. 4. Observations in room 816 on 4/29/14 at 11:19 AM, revealed scuff marks on the walls with white areas and a peeling baseboard near the bathroom. 5. Observations in room 804 on 4/29/14 at 12:41 PM, revealed there were black scuff marks on the walls. 6. Observations in room 106 on 4/30/14 at 8:15 AM, revealed the wall paper above D bed was loose and hanging, wall at the closets was scuffed with sheetrock missing, several areas on the wall around the room have sheetrock scuffed up, brown buildup around the baseboards in the room and bathroom, and the bedside table next to D bed was scuffed up with a broken door that was pushed into the cabinet. 7. Observations in room 807 on 5/1/14 at 3:33 PM, revealed stale urine odors. 8. During an interview in the activities room on 5/1/14 at 4:55 PM, the Maintenance Director was asked who maintains the resident rooms. The Maintenance Director answered, We do that. During an interview in the activities room 5/1/14 at 5:15 PM, the Administrator was asked who maintains resident rooms. The Administrator stated, Am aware there are issues with the building.
F 0258 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Maintain comfortable sound levels.** Based on observation and interview, it was determined the facility failed maintain comfortable sound levels as evidenced by loud laundry barrels and carts on 3 of 8 (100, 200 and 500 halls) halls. The findings included: 1. Observations on the 100 hall on 4/28/14 at 3:30 PM, revealed staff pushing empty laundry barrels down the hallway that were very noisy. Observations on the 100 hall on 4/29/14 at 8:15 AM, revealed staff pushing an empty laundry cart down the hallway that was very noisy. Observations on the 100 hall on 4/30/14 at 8:15 AM and 3:15 PM, revealed staff pushing empty laundry barrels down the hallways that were very noisy. Observations on the 100 hall on 5/1/14 at 8:15 AM, revealed staff pushing laundry barrels down the hallway and they were very noisy. 2. Observations on the 200 hall on 4/30/14 at 8:15 AM and 3:15 PM, revealed staff pushing empty laundry barrels down the hallway that were very noisy. 3. Observations on the 500 hall on 5/1/14 at 4:40 PM, revealed staff pushing laundry barrels down the hallway that were very noisy. 4. During an interview on the 100 hall on 4/30/14 at 3:45 PM, Certified Nursing Assistant (CNA) #23 was asked if there had been any complaints about the barrels being noisy. CNA #23 stated, Yes, residents have complained about them being noisy. 5. During an interview in the activity room on 5/1/14 at 4:55 PM, the Maintenance Director was asked if he had any residents to complain about the barrels being noisy. The Maintenance Director stated, No never had any residents to complain, but they are noisy, sound like a train going down the hall.
F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of a facility report, medical record review, observation and interview, it was determined the facility failed to follow the care plan interventions for monitoring a resident's skin and reporting change of conditions to the physician, to protect from wandering and exit seeking behavior, complete wander guard checks and ensure a bed alarm and mat was in place for 4 of 34 (Residents #22, 220, 108 and 247) sampled residents of the 52 residents reviewed on the stage 2 sample. The failure of the facility to follow the care plan intervention for monitoring a resident's arm and timely notification of condition changes to the physician resulted in a delay of treatment for [REDACTED].#220 from elopement and entering another resident's room resulted in immediate jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death when Resident #22 who was at high risk for [MEDICAL CONDITIONS] developed a [MEDICAL CONDITION] and Resident #220 wandered into another resident's room and eloped from the facility. In the activity room on 5/2/14 at 3:45 PM, the Administrator and Director of Nursing (DON) were informed of the immediate jeopardy (IJ). The IJ is ongoing. The findings included: 1. Review of the facility's Situation, Background, Assessment, Request (SBAR) Action and Notification protocol documented, Policy- It is the intent of this facility to assess and document changes in a resident's health. in an efficient and effective manner; to relay assessment information to physician and to document actions. facility will consult with the resident and notify the resident's physician, and the legal representative or interested family member of but not limited to the following: A significant change in the resident's physical, mental or psychosocial status, A need to alter treatment significantly. Procedure- 1. Licensed staff will assess any change in condition through observation, physical examination. 4. Review all findings with the physician and non-physician practitioner. 5. Document in the medical record. Change of Condition. Medical record review for Resident #22 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. The care plan dated 4/3/14 documented, Problem- Resident has potential for discomfort/pain, bruising and swelling r/t (related to) fragile skin, h/o (history of) [MEDICAL CONDITION] / muscle mass RUE (right upper extremity) /PAD (peripheral artery disease). Approach Frequency. 4. Observed RUE (right upper extremity) for swelling and bruising. 5. Notify MD (medical doctor) for changes in status. A nutrition services progress note dated 4/11/14 documented, [MEDICAL CONDITION] noted to hand. There was no documentation by the nursing staff of [MEDICAL CONDITION] to the right hand or upper extremity. An acute visit assessment dated [DATE] completed by the Nurse Practitioner (NP) documented, .RUE hand c (with) 2 t (plus) [MEDICAL CONDITION], R (right) forearm 1 t [MEDICAL CONDITION], R upper arm 2 t [MEDICAL CONDITION] with ^ (increased) heat to touch. The NP ordered a doppler to RUE. The final report of the doppler to RUE dated 4/21/14 documented, .There is incomplete compression, echogenic material and decreased flow in the [MEDICATION NAME], axillary, and brachial veins. Non-occlusive [MEDICAL CONDITION] is demonstrated. Soft tissue [MEDICAL CONDITION] is present. A nurses noted dated 4/24/14 documented, .(symbol for decrease) [MEDICAL CONDITION] to Rt. (right) arm/hand. There was no documentation of the [MEDICAL CONDITION] in the right hand/arm by the nurses until this note dated 4/24/14, yet a nutrition services progress note dated 4/11/14 documented, [MEDICAL CONDITION] noted to hand. Observations in Resident #22's room on 5/2/14 at 12:00 PM, revealed Resident #22 on her left side with wedge pillow present, right hand on pillow and with [MEDICAL CONDITION] noted. Observations in Resident #22's room on 5/2/14 at 6:00 PM, revealed family at bedside and Resident #22 had just been turned back to her left side, oxygen on at 2 liters per nasal cannula, right arm on pillow with [MEDICAL CONDITION] noted, noted facial twitching and mouth breathing. During an interview in the activity room on 5/2/14 at 8:45 AM, Resident #22's family member reported, My mother is (named Resident #22). can't remember exact dates March/April 2014, when. her right hand was swollen. It swelled up her arm, I asked about it, told nurses, and finally just last week (4/21/14) they addressed it and said it was a blood clot. During an interview at the 500/600 nurses' station on 5/2/14 at 11:50 AM, Nurse #13 was asked what was the procedure if there was a change in a resident's condition. Nurse #13 stated, If there was a change in condition, I would evaluate resident and notify the doctor. During another interview in the activity room on 5/2/14 at 12:26 PM, Nurse #13 was asked about documentation of Resident #22's hand and arm [MEDICAL CONDITION] and notifying the doctor. Nurse #13 stated, No, I don't see any documentation about the [MEDICAL CONDITION] until the 4/21/14 Doppler order. No, I don't see any documentation about the doctor being notified about the [MEDICAL CONDITION] prior to 4/21/14. During an interview in the activity room on 5/2/14 at 12:45 PM, the DON was asked what was expected of nurses if a resident developed [MEDICAL CONDITION] in the hand and arm. The DON stated, I expect nurse to evaluate, notify doctor, and keep hand and arm elevated. The facility failed to follow the care plan intervention for monitoring the right arm by failing to complete timely assessments and notification of [MEDICAL CONDITION] to the physician which resulted in a delay of treatment, actual harm, neglect and placed Resident

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	445331	A. BUILDING _____ B. WING _____	03/28/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACELAND NURSING CENTER	1250 FARROW ROAD MEMPHIS, TN 38116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) #22, who was at a high risk of developing a [MEDICAL CONDITION], in immediate jeopardy. 2. Medical record review for Resident #220 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the significant change Minimum Data Set (MDS) with an assessment reference date (ARD) date of 2/18/14 documented a brief interview for mental status (BIMS) score of 3 indicating that his cognitive skills are severely impaired. The preference and frequency of wandering is documented to occur 1 to 3 days during the assessment period. Review of the resident care plan with a start date of 2/24/14 documented, .Wandering / Elopement Risk. when resident begins to wander, provide comfort measures. remove resident from other's room and unsafe situations as needed. Review of a facility incident report dated 4/15/14 documented, .Resident (#220) got out of the building by himself wandered over to Kroger. Wanderguard intact to right ankle. Resident brought back to facility. Appears NAD (no apparent distress) without skin tears, skin discoloration, or [MEDICAL CONDITION] There is no evidence the care plan was effective to protect Resident #220 from eloping from the facility. During an interview at the A hall nurses' station on 5/1/14 at 6:30 PM, Registered Nurse (RN) Supervisor #1 was asked if Resident #218's daughter had reported that a male resident was coming into her mother's room and it scared her mother. RN Supervisor #1 stated, Yes. I told the floor nurse to document (named Resident #220) behavior and keep him out of the room and then to pass it along to the next shift. RN Supervisor #1 was asked how she passed it along to the next shift. RN Supervisor #1 stated, I put it on the 24 hour log and that goes to (DON). There is no evidence Resident #220's care plan was implemented to keep him from wandering into Resident #218's room which caused psychological harm to Resident #218 when she voiced her inability to rest due to fear of Resident #220 entering her room. The facility failed to implement interventions to address wandering and exit seeking behavior to keep the resident's safe and free from psychological harm and elopement which placed Resident #218 and Resident #220 in immediate jeopardy. Refer to F223. 3. Review of the Wanderer Monitoring System policy documented, .Policy. To provide a reliable system for protecting residents who have a history of wandering. Daily documentation by nursing staff to ensure wanderguard is intact. MAR (Medication Administration Record) or ADL (Activities of Daily Living) flow sheet to document the check. Medical record review for Resident #108 documented an admission date of [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of the care plan dated 5/1/14 documented, Problem. Resident h/o (history of) wandering as well as an elopement risk. Approach/Frequency. Provide resident with wanderguard for safety. Check resident wanderguard for proper functioning at beginning of shift and end of shift. Review of the August 2013 medication record documented, there were 93 opportunities for the wanderguard to be checked and there were 18 times when there was no documentation of the alarm being checked. During an interview in the C hall unit manager's office on 5/5/14 at 11:30 AM, Nurse #3 was asked who checks wanderguards and how often are they checked. Nurses #3 stated, The Restorative Nurse (Named Nurse #2) they are checked weekly and are checked on each resident that has a wanderguard. During an interview in the Restorative Nurses' office on 5/5/14 at 11:35 AM, Nurse #2 was asked when are wanderguards checked. Nurse #2 stated, I check them on Monday, Wednesday and Friday on all residents that have them. We have a machine that we use to check them. The facility failed to follow the care plan intervention to check Resident #108's wanderguard for proper functioning at beginning of shift and end of shift. 4. Medical record review for Resident #247 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the care plan dated 3/21/14 documented, .Problem. Resident at risk for falls r/t (related to) cognitive loss, functional limitation in ROM (Range of Motion) and dx (diagnosis) of [MEDICAL CONDITION] Approach. Frequency. Bed alarm. Observations in Resident #247's room on 5/3/14 at 2:20 PM, revealed the resident lying in bed, there was no bed alarm in place as care planned. During an interview in Resident #247's room on 5/3/14 at 2:22 PM, Nurse #11 verified there was no bed alarm in place as care planned.
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of the daily staff sheets, medical record review, observation and interview, it was determined the facility failed to provide care and services necessary to maintain the highest practicable physical, mental, and psychosocial well-being of residents when staff failed to timely assess and notify the physician of swelling of the right for 1 of 52 (Resident #22) resident reviewed of the 52 residents included in the stage 2 sample. The failure of the facility to appropriately assess and timely notify the physician of swelling of the right arm, of a resident who was at a high risk for [MEDICAL CONDITION], resulted in delay of care and placed Resident #22 in immediate jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment or death). In the activity room on 5/2/14 at 3:45 PM, the Administrator and Director of Nursing (DON) were informed of the immediate jeopardy (IJ). The IJ is ongoing. The immediate jeopardy for F309 J constitutes substandard quality of care. An extended survey was completed on 5/5/14. The findings included: 1. Review of the facility's Situation, Background, Assessment, Request (SBAR) Action and Notification protocol documented, Policy- It is the intent of this facility to assess and document changes in a resident's health, mental or psychosocial status in an efficient and effective manner; to relay assessment information to physician and to document actions. Except in a medical emergency or when a resident is deemed incompetent, the facility will consult with the resident and notify the resident's physician, and the legal representative or interested family member of but not limited to the following: A significant change in the resident's physical, mental or psychosocial status, A need to alter treatment significantly. Procedure- 1. Licensed staff will assess any change in condition through observation, physical examination to monitor vital signs (temperature, pulse respiration, blood pressure, oxygen saturation, pain level) at the onset of the change and as ordered by the physician. 4. Review all findings with the physician and non-physician practitioner. 5. Document in the medical record all physician contacts and notifications. The Change of Condition Evaluation Tool will serve as the official nursing documentation for change in status. Medical record review for Resident #22 documented an admitted 9/3/05 with [DIAGNOSES REDACTED]. The nursing admission information assessment completed on 3/19/14 documented Resident #22 was readmitted to the facility from the hospital and documented [MEDICAL CONDITION] N (no). The history and physical examination [REDACTED] The care plan dated 4/3/14 documented, Problem- Resident has potential for discomfort/pain, bruising and swelling r/t (related to) fragile skin, h/o (history of) [MEDICAL CONDITION] (deep vein thrombus) / muscle mass RUE (right upper extremity) /PAD (peripheral artery disease). Approach Frequency. 4. Observed RUE for swelling and bruising. 5. Notify MD (medical doctor) for changes in status. A nutrition services progress note dated 4/11/14 for Resident #22 documented, [MEDICAL CONDITION] noted to hand. There was no documentation by the nursing staff of [MEDICAL CONDITION] to the right hand or upper extremity. An acute visit assessment dated [DATE] completed by the Nurse Practitioner (NP) documented, .RUE hand c (with) 2 t (plus) [MEDICAL CONDITION], R (right) forearm 1 t [MEDICAL CONDITION], R upper arm 2 t [MEDICAL CONDITION] with ^ (increased) heat to touch. The NP ordered a doppler to RUE. The final report of the doppler to RUE dated 4/21/14 documented, .There is incomplete compression, echogenic material and decreased flow in the [MEDICATION NAME], axillary, and brachial veins. Non-occlusive [MEDICAL CONDITION] is demonstrated. Soft tissue [MEDICAL CONDITION] is present. A nurses note dated 4/21/14 documented, .T (positive) Findings regarding Doppler. N.O. (new order) [MEDICATION NAME] (medication to prevent blood clots) 60 mg (milligrams) subq q (subcutaneous every) 12 (symbol for hours) (start today) 2. [MEDICATION NAME] (medication to prevent blot clots) 5 mg PO (by mouth) daily (start today) 3. INR (International normalized ratio (a laboratory test used to determine therapuetic levels for a blood thinning medication)) daily (start in AM) 4. Continue [MEDICATION NAME] until INR -> (symbol for equal to or greater than) 2 (target INR range) for two consecutive days. A nurses noted dated 4/24/14 (was the first time nurses documented swelling) documented, .(symbol for decrease) [MEDICAL CONDITION] to Rt. (right) arm/hand. There was no documentation of the [MEDICAL CONDITION] in the right hand/arm by the nurses until this note dated 4/24/14, yet a nutrition services progress note dated 4/11/14 documented, [MEDICAL CONDITION] noted to hand. An acute visit dated 4/29/14 completed by the NP documented, .History of complex mass arm may cause flow issues. d/c (discontinue) [MEDICATION NAME], d/c [MEDICATION NAME], risks > (greater than) benefit. Observations in Resident #22's room on 5/2/14 at 12:00 PM, revealed Resident #22 on her left side with wedge pillow present, right hand on pillow and with [MEDICAL CONDITION] noted. Observations in Resident #22's room on 5/2/14 at 6:00 PM, revealed family at bedside and Resident #22 had just been turned back to her left side, oxygen on at 2 liters per nasal cannula, right arm on pillow with [MEDICAL CONDITION] noted, noted facial twitching and mouth breathing. During an interview in the activity room on 5/2/14 at 8:45 AM, Resident #22's family member reported, My mother is (named Resident #22) has been here 9 years and is in late stages of Alzheimer's, not expecting her to live many more days, is comatose. She was in the hospital, can't remember exact dates March/April 2014, when she came back here her right hand was swollen. It swelled up her arm. I asked about it, told nurses, and finally just

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	445331	A. BUILDING _____ B. WING _____	03/28/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACELAND NURSING CENTER	1250 FARROW ROAD MEMPHIS, TN 38116

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 10) last week (4/21/14) they addressed it and said it was a blood clot, she got started on [MEDICATION NAME] During an interview at the 500/600 nurses' station on 5/2/14 at 11:50 AM, Nurse #13 stated, I started working here full time about 2 weeks ago on this hall, prior to that I worked as needed. Nurse #13 was asked about Resident #22. Nurse #13 stated, She has [MEDICAL CONDITION] in her right hand, we elevate it on pillows, she has a poor appetite, the last 2 days has had no to little po (my mouth) intake and no medications taken. Nurse #13 was asked how long resident has had [MEDICAL CONDITION] in the right upper extremity. Nurse #13 stated, She has been in the same condition as she is now since the first day I saw her. Has had [MEDICAL CONDITION]. We kept her hand elevated on a pillow. Nurse #13 was asked what was the procedure if there was a change in a resident's condition. Nurse #13 stated, If there was a change in condition, I would evaluate resident and notify the doctor. During another interview in the activity room on 5/2/14 at 12:26 PM, Nurse #13 was asked about documentation of Resident #22's hand and arm [MEDICAL CONDITION] and notifying the doctor. Nurse #13 stated, No, I don't see any documentation about the [MEDICAL CONDITION] until the 4/21/14 Doppler order. No, I don't see any documentation about the doctor being notified about the [MEDICAL CONDITION] prior to 4/21/14. Review of the daily staff sheets for the shifts Nurse #13 had worked from 4/11/14 (when [MEDICAL CONDITION] was noted by dietary) through 4/21/14 revealed she had worked on 4/11/14, 4/15/14, 4/16/14 and 4/18/14. During an interview at the 500/600 nurses' station on 5/2/14 at 12:10 PM, Nurse #3 was asked about Resident #22 and stated, (Named Resident #22) was sent out to hospital due to decreased intake at her daughters request. she was there 2 to (-) 3 days and returned still not eating. Nurse #3 was asked about the [MEDICAL CONDITION] in Resident #22's right hand. Nurse #3 stated, The daughter found it and told me on 4/21/14 the day of the Doppler, the NP was in the facility and was notified and ordered the Doppler. The daughter is a nurse. She is quite involved in her care. During an interview in the activity room on 5/2/14 at 5:00 PM, Resident #22's family member was asked what staff had she reported the swelling to. Resident #22's family member stated, I told a CNA (certified nursing assistant) on 3-11 shift, don't know her name. I ask them to keep it (arm) on a pillow, also told a male nurse (named Nurse #14) who works 3-11. My Mother has a history of blood clots. During a telephone interview on 5/5/14 at 4:10 PM, Nurse #14 was asked about Resident #22's hand and arm [MEDICAL CONDITION]. Nurse #14 stated, I do remember caring for (named Resident #22). I do not remember her daughter reporting to me anything about swelling of her right arm, but I do remember being told of that swelling during a shift change report by another nurse but I do not remember the date and can't recall what I did in regards to the arm swelling. Review of the daily staff sheets for the shifts Nurse #14 had worked from 4/11/14 (when [MEDICAL CONDITION] was noted by dietary) through 4/21/14 revealed he had worked on 4/14/14, 4/15/14, 4/16/14, 4/17/14, 4/19/14 and 4/20/14. During an interview at the 500/600 nurses' station on 5/2/14 at 4:10 PM, CNA #16 was asked about Resident #22's arm [MEDICAL CONDITION]. CNA #16 stated, I am a floater, I work with her usually at least once a week. I am not sure when hand and arm swelled. I remember her daughter asking us to put her arm up on a pillow. She thought is was swelled, that was in April but not sure exact date. During an interview in the activity room on 5/2/14 at 12:45 PM, the DON was asked what was expected of nurses if a resident developed [MEDICAL CONDITION] in the hand and arm. The DON stated, I expect nurse to evaluate, notify doctor, and keep hand and arm elevated. The facility failed to timely assess and notify the physician of [MEDICAL CONDITION] of the right arm which resulted in a delay of treatment, actual harm, neglect and placed Resident #22, who was at a high risk of developing [MEDICAL CONDITION], in immediate jeopardy.
F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary assistance with tray set up or positioning during dining for 6 of 52 (Residents #4, 7, 59, 109, 188 and 210) residents reviewed of the 52 residents included in the stage 2 sample. The findings included: 1. Review of the facility's Positioning/Moving Resident policy documented, .Sitting in chair. Place small pillow behind neck or headrest to prevent hyperextension and slumping (optional). Place pillow at small of back or whole back to prevent slumping and to promote breathing and eating (optional). Place the feet flat on the floor or support with footrests or foot stools. 2. Medical record review for Resident #4 documented an admission date of [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of the minimum data set (MDS) with an assessment reference date (ARD) of 12/22/13 and 3/19/14 section G- Functional Status/B-Transfer was coded as 3/2 indicating extensive assist and one person physical assist and section G0400 Functional Limitations in Range of Motion (ROM) was coded as 2/2 indicating limitations in ROM both sides upper and lower extremities. Observations in the assistive dining room on 5/1/14 at 7:10 AM and 5:10 PM, revealed Resident #4 seated in a Rock N' Go chair and leaning forward in the chair while eating. Resident #4 was not properly positioned for eating. 3. Medical record review for Resident #7 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. The annual minimum data set ((MDS) dated [DATE] and the quarterly MDS dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 15 indicating the resident had no cognitive impairments, required set up help with eating, and had bilateral upper extremity impairment on both sides. The care plan dated 10/16/13 and updated on 4/9/14 documented, Problem-Impaired mobility w (with) / self-care deficit r/t/ (related to) h/o (history of)[MEDICAL CONDITION]/ Rt. (right) hemi (stroke with right paralysis), h/o GSW (gunshot wound) to head. Approach-Frequency 1. Provide full staff assistance w/bathing, dressing, personal hygiene, grooming, oral, and incontinent care. 3. Set-up all equipment for personal care. 4. Assist resident w/oral care. During an interview in Resident #7's room on 4/28/14 at 3:20 PM, Resident #7 stated, (Named Certified Nursing Assistant (CNA) #22) left trays without opening items, happens all the time, have told (Named Nurse #5). Observations in Resident #7's room on 4/28/14 at 3:20 PM revealed Resident #7 with noted left [MEDICAL CONDITION] with left arm and hand contractures. A nurses note dated 3/3/14 documented, .feed self with set up. A nurses note dated 3/7/14 documented, .fed self p (after) tray set up. A Nurses note dated 4/7/14 documented .feeds self p set up. During an interview at the 100/200 nursing station on 4/30/14 at 4:00 PM, Nurse #5 (unit manager) was asked about any complaints regarding care reported by Resident #7. Nurse #5 stated, Yes, she did complain to me right after I started here (employed 2/2014) about (named CNA #22). She complained she did not put her to bed when she wanted to and did not open her items on her trays for her. I talked to both of them (Resident #7 and CNA #22). I removed (named CNA #22) from caring for (named Resident #7). Nurse #5 was asked if there were any investigations of these complaints. Nurse #5 stated, No, I did not write this up anywhere. No, do not have a grievance log. No, I did not document this anywhere. I just talked to them. Nurse #5 was asked about how charge nurses were informed of her removing CNA #22 of caring for Resident #7. Nurse #5 stated, They (nurses)know, they do not assign (named CNA #22) to (named Resident #7). The surveyor asked to review the 4/30/14 3-11 shift assignment sheet. The assignment sheet documented Resident #7 was assigned on paper to CNA #22. Nurse #5 stated, She (named CNA #22) knows not to go in her (Resident #7's) room. She (CNA #22) will get one of the other CNA's to do (named Resident #7) for her. Nurse #5 was asked how staff know this. Nurse #5 stated, They know. During an interview at the 100/200 nurses' station on 4/30/14 at 4:00 PM, Nurse #17 was asked about care needed by Resident #7 and how she monitors care provided. Nurse #17 stated, I am up and down hall and watch for turning, incontinence care, transfers. I watch meal service either on hall or in dining room. I monitor the care provided. (Named Resident #7) has to have assistance with transfers, toileting, pericare, the aides have to set her trays up for her, she is totally out on her left arm and has no use of it. During an interview at the 500/600 nurses' station on 5/1/14 at 6:00 PM, the Registered Nurse (RN) Supervisor #1 was asked the procedure for handling CNA assignments who have resident restrictions. RN Supervisor #1 stated, I tell the Charge Nurses the CNA cannot care for the resident. The CNA is told not to care for the resident. The Charge Nurses will put the CNA assignment on the assignment sheet. During an interview in the Director of Nursing's (DON) office on 5/1/14 at 3:30 PM with CNA #22 revealed the following: CNA #22 was asked about her assignment. CNA #22 stated, I have worked here 8 years. I have set assignment of rooms 105 through 112 and 101. I cannot go into room [ROOM NUMBER] (Resident #7's room). CNA #22 was asked why she could not go in room [ROOM NUMBER]. CNA #22 stated, (Named Resident #7) does not want me in her room. She doesn't like me. She also would ask me to take her into the bathroom to change her. I told her I could not do that for her safety she might fall. I put her to bed and change her brief. She doesn't like that. CNA #22 was asked if the other CNAs put her (Resident #7) to bed to change her brief. CNA #22 stated, They take her in the bathroom. CNA #22 was asked if other CNAs get snacks out of machine for residents. CNA #22 stated, Yes, they break the rules. I don't break the rules. CNA #22 was asked how she found out not to go in room [ROOM NUMBER]. CNA #22 stated, (Named Nurse #5) told me (named Resident #7) did not want me in her room anymore. CNA #22 was asked how she and other CNA's know their assignments. CNA #22 stated, Nurses write it on the assignment sheet

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	445331	A. BUILDING _____ B. WING _____	03/28/2014

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GRACELAND NURSING CENTER	1250 FARROW ROAD MEMPHIS, TN 38116

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F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) that I do room [ROOM NUMBER] and other CNA does 106. CNA #22 was asked what type of training she had received on resident rights. CNA #22 stated, Yes, got trained on resident rights. CNA #22 was asked what she was taught. CNA #22 stated, They have the right to make choices, decide what they want, have privacy. I explained to (named Resident #7) it was not safe for me to change her in the bathroom. She wanted to go in there hold on to the sink. CNA #22 was asked when she cared for Resident #7 what type of care she did provide. CNA #22 stated, I would change her, put her to bed, deliver her tray and open up her items. CNA #22 was asked if she had delivered her a tray this week. CNA #22 stated, No. CNA #22 was asked if Resident #7 could open up any of her tray items. CNA #22 stated, She can open her silverware and take the lid off of her soup, but I opened everything else up. CNA #22 denied that she had not opened up tray items. During an interview on the 100 hall on 5/2/14 at 7:30 AM, CNA #15 (assigned to and providing care for Resident #7) was asked what type of care she provided. CNA #15 stated, I assist her with bath, change her, deliver and set up her tray. CNA #15 was asked how the bath is done or how toileting is done. CNA #15 stated, She (Resident #7) gets her bath in the bathroom, she stands up, holds to sink, yes, she does real good like that. 4. Medical record review for Resident #59 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the MDS with an ARD of 7/19/13 and 1/15/14 section G transfer was coded as 4/2 indicating total dependence and one person physical assist, section G/H Eating was coded as 3/2 indicating Extensive assist/one person physical assist and section G0400 Functional Limitations in ROM was coded as 2/2 indicating impairment on both sides upper and lower extremities. Observations in the assistive dining room on 5/1/14 at 7:47 AM and 5:10 PM, Resident #59 was seated in a reclined gerichair eating. The gerichair was not in an upright position and the resident was leaning forward in the chair to eat. The resident was not properly position to eat. 5. Medical record review for Resident #109 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the MDS with an ARD of 3/31/14 section G functional status was coded as requires extensive assistance with transfer and limited assist with bed mobility both with 1 personal physical assist. Observations in Resident #109's room on 4/29/14 at 8:04 AM, revealed Resident #109 lying in bed with his head under the overbed table and hanging off the side of the bed. Observations in Resident 109's room on 4/29/14 at 8:44 AM, revealed the head of the bed was elevated with Resident #109 slumped down and lying near the edge of the bed. Observations in the dayroom on 4/30/14 at 9:57 AM, revealed Resident #109 seated in a gerichair with his right leg dangling off the footrest. Resident #109 was not properly positioned in the above noted observations. During an interview at the C hall nurses' station on 5/1/14, Nurse #11 was asked where Resident #109 eats his meals. Nurse #11 stated, He eats his breakfast in his room and eats lunch and dinner in the back dining room. Nurse #11 was asked if Resident #109 needs assistance with his breakfast. Nurse #11 stated, Yes. Nurse #11 was then told about the way he was found with his head underneath the overbed table. Nurse #11 stated, Nobody told me that. 6. Medical record review for Resident #188 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the MDS with an ARD of 9/28/13 and 3/24/14 section G/H was coded as 4/2 indicating Total dependence and one person physical assist, section G0400 Functional limitations in ROM was coded as 2/2 indicating impairment on both sides upper and lower extremities. Review of the care plan dated 3/27/14 addressed the resident's need for assistance with all ADLs and her limitations in ROM. Observations in the assistive dining room on 4/28/14 beginning at 12:10 PM, Resident #188 was seated in a gerichair being fed by staff. The gerichair was not in a complete upright position and Resident #188 was leaning up in the chair as he was being fed. Observations in the assistive dining room on 4/29/14 beginning at 7:10 AM, Resident #188 was seated in a gerichair being fed by staff. The gerichair was not in a complete upright position and the resident was leaning forward in the chair. Resident #188 was not properly positioned in the gerichair. 7. Medical record review for Resident #210 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the MDS with an ARD of 12/20/13 and 3/18/14 section B/Transfer was coded as 4/3 indicating total dependence/2 person physical assist, H/Eating was coded as 4/2 indicating total dependence and one person physical assist and section G0400 was coded as 2/2 indicating impairment on both sides upper and lower extremities. The care plan dated 3/4/14 addressed the resident's need for ADL care as well as limitations in ROM. Observations in the assistive dining room on 4/28/14 beginning at 12:10 PM, Resident #210 was seated in a gerichair, being fed by staff. The gerichair was not in a complete upright position and the resident was leaning forward in the chair when being fed. Observations in Resident #210's room on 4/30/14 at 2:30 PM, and on 5/1/14 at 1:20 PM, Resident #210 seated in a reclined gerichair leaning forward in the chair, there was no support behind the resident's back. 8. During an interview in the D hall unit manager's office on 4/30/14 at 9:36 AM, Nurse #8 was asked how he expected residents to be positioned during dining. Nurse #8 stated, The gerichair should be in an upright position.
F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of the facility's Pressure Ulcers Acquire List, medical record review, observation and interview, it was determined the facility failed to consistently and accurately complete skin assessments for 2 of 3 (Residents #11 and 12) sampled residents reviewed with wounds and failed to follow the care plan for 1 of 3 (Resident #11) sampled residents reviewed with wounds. The findings included: 1. Review of the facility's Skin Management and Prevention policy documented, .The admission nurse will complete the Braden Scale and the full skin check of entire body (Nursing Admission form). The weekly skin rounds sheet will be utilized to determine if any new skin alterations have developed. Clinical nurses, or nurse designee, on the unit are responsible for the weekly completion of these weekly skin rounds sheet. It is the responsibility of the clinical team (DON (Director of Nursing) / ADON (Assistant Director of Nursing) / Nurse Managers) to determine who will ensure compliance related to completion and audits of these forms for completeness. Review of the facility's Care Plan policy documented, .The resident's care plan provides guidance to all staff caring for the resident and communicates changes in care to all direct care staff. An interdisciplinary approach to identification of problems and developing solutions and goals provides individualization and coordination of resident care. 2. Review of the facility's Pressure Ulcers Acquire List documented a stage II in-house acquired pressure ulcer for Resident #11 identified on 1/3/14. Resident #12 was discovered to have a stage III wound identified on 1/13/14. Both of these residents resided on B Station. For clarification, the weekly skin rounds sheet as documented in the facility's policy actually goes by the title of WEEKLY SKIN INTEGRITY REVIEW. 3. Medical record review for Resident #11 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] documented a summary score of 4 out of a possible 15 indicating the resident was severely cognitively impaired. Review of the care plan dated 4/23/13 documented, .Incontinent of bowel and bladder with potential for skin breakdown. related to functional limitation, incontinence, history of ulcers. Perform / document weekly systemic skin assessment. Nursing documented the identification of Resident #11's left heel stage II pressure wound in a physician communication sheet dated 1/3/14. Treatments were ordered, given, and the wound healed 1/24/14. Review of the WEEKLY SKIN INTEGRITY REVIEW documented no skin condition assessment was completed for the week of 12/21/14 or the week of 12/31/14. The resident's skin condition was inaccurately documented as Skin Intact on the 1/8/14 and 1/15/14 weekly assessment which were completed after the wound had been identified on 1/3/14. 4. Medical record review for Resident #12 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE] documented a cognitive summary score of 4 out of a possible 15 indicating the resident was severely cognitively impaired. Review of the Nursing Admission form dated 12/13/13 documented multiple wounds on the right side of the resident's body, however, did not document a wound on the resident's right outer ankle. Review of a physician communication sheet dated 1/13/14 documented, .scab fell off R (right) outside ankle. Review of a wound progress note dated 1/13/14 documented, .Notified by floor nurse of an open area R ankle. stage III. Review of the Wound Treatment Record dated 1/15/14 documented wound measurements as length 1.6 cm (centimeters), width 1.0 cm, depth 0.2 cm and appearance of the wound bed was 75% (percent) slough. Measurements on 2/5/14 were length 1.4 cm, width 1.1 cm, depth 0.1 cm and the appearance of the wound bed was pink, no slough. The facility was unable to provide documentation of completed WEEKLY SKIN INTEGRITY REVIEW for December 2013 or January 2014. Observations in the dining area at B Station on 2/24/14 at 2:20 PM, revealed Resident #12 sitting up in a wheelchair. A clean, dry dressing was intact to the resident's right outer ankle. During an interview in the conference room on 2/5/14 at 3:35 PM, the Director of Nursing (DON) was asked about the weekly skin assessments. The DON stated the nurses are to do weekly skin assessments and document what they have observed. The DON was asked if the nurses had completed the weekly skin assessments. The DON stated, They (nurses) didn't do them. The DON, a certified wound specialist, was then asked if the treatment nurse had accurately documented Resident #12's wound. The DON stated, .wound on the ankle was identified for the first time when the scab was knocked off. A scab

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F 0314 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 12) that could have been treated if identified and documented. Don't know what is under a scab until it comes off or heals. She came in with a black eye and. trauma to the body all on the right side. Her wound was on the right outer ankle. Stage III was never identified as a pressure wound. If it is an open wound it has to be staged. The DON felt the wound had been present at the time of admission. During an interview at the B Station nurses station on 2/5/14 at 5:00 PM, the B Station Unit Manager was asked about Resident #12's wound. The Unit Manager stated, .I identified the wound early AM hours on 1/13/14. I was in the room with the CNA, saw the scab and drainage on the sheet. 5. During an interview at the B Station nurses station on 1/15/14 at 11:00 AM, Nurse #3 was asked how the residents were monitored for skin issues. Nurse #3 stated, Weekly shower sheets are filled out by the CNAs (Certified Nursing Assistant). Nurse signatures behind CNA. Nurses also do a weekly skin assessment.
F 0319 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Give the right treatment and services to residents who have mental or psychosocial problems adjusting.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of an incident report, medical record review and interview, it was determined the facility failed to ensure care and treatment for [REDACTED].#220) residents with wandering behaviors of the 52 residents included in the stage 2 sample. The failure of the facility to effectively treat behaviors and implement new interventions for wandering and exit seeking behavior resulted in immediate jeopardy (in a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death) when Resident #220 eloped from the facility. In the activity room on 5/2/14 at 3:45 PM, the Administrator and Director of Nursing (DON) were informed of the immediate jeopardy (IJ). The IJ is ongoing. The immediate jeopardy for F319 J constitutes substandard quality of care. An extended survey was completed on 5/5/14. The findings included: 1. Review of the facility's ELOPEMENT / WANDERING RESIDENTS policy documented, .Care plans and individual behavior plans will address wandering as a specific problems. Approaches will be formulated, patterns identified and the causes determined will be addressed . 2. Medical record review for Resident #220 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the significant change Minimum Data Set (MDS) with an assessment reference date (ARD) date of 2/18/14 documented a brief interview for mental status (BIMS) score of 3 indicating that his cognitive skills are severely impaired. The preference and frequency of wandering is documented to occur 1 to 3 days during the assessment period. Review of the resident care plan with a start date of 2/24/14 documented, .Wandering / Elopement Risk. Ensure that resident is wearing a wanderguard and that it is working properly. when resident begins to wander, provide comfort measures. remove resident from other's room and unsafe situations. Review of a facility incident report dated 4/15/14 documented, .Resident (#220) got out of the building by himself wandered over to (named grocery store), Wanderguard intact to right ankle. Resident brought back to facility. Appears NAD (no apparent distress) without skin tears, skin discoloration, or [MEDICAL CONDITION] A written statement from Registered Nurse (RN) Supervisor #1 documented, .I was notified by (named Nurse #17) at 10:33 pm, that the alarm had gone off and a man was seen leaving the building. Someone checked (named Resident #220) and he wasn't there. staff was notified to search the building. He was found at (named grocery store) by staff, and returned to the building. No injury. There is no evidence that the care plan was revised after the elopement on 4/1514. Review of the behavior intervention monthly flow record for 4/15 (2014) documented the behavior of agitation. One episode of agitation is documented on 4/1/14 and on 4/15/14 on the day shift. On 4/27/14 seven episodes are documented on the day shift. Zeros are documented on the day shift on 4/26/14; the evening shift on 4/14/14 - 4/18/14 and 4/21/14 - 4/26/14 and 4/28/14 - 4/30/14; and on the night shift on 4/15/14 - 4/20/14, and 4/22/14 - 4/30/14. All other dates are blank. There is no evidence the facility was tracking wandering. There is no evidence that Resident #220 was seen by Psychology services until 4/25/14. During an interview in Resident #218's room on 4/28/14 at 3:33 PM, Resident #218 was asked if there had been any concerns or problems with a roommate or any other resident. Resident #218 stated, The man next door comes into my room. I told the nurse and they put the stop banner up. Resident #218 was asked if the staff addressed this concern to her satisfaction. Resident #218 stated, No. He (Resident #220) crawls up under the banner. During an interview in Resident #218's room on 5/1/14 at 9:00 AM, Resident #218 was asked how many times Resident #220 had come into her room and what did he do when he came in. Resident #218 stated, Has been in here 3 times. One time he came in and started pulling on door (pointed to bathroom door) and started pulling his pants down. The second time he came into room he was standing by the curtain (privacy curtain) looking in the corner. The third time he crawled under the sign (STOP banner). I was in bed resting, around 2 in the afternoon. I always lay down after dinner (lunch). Have to lay down in the evening (after the lunch meal) cause I can't rest at night. I'm afraid he would come in here. I don't want that man coming into my room scaring me and making me have a set-back. During an interview at the A hall nurses' station on 5/1/14 at 6:30 PM, Registered Nurse (RN) Supervisor #1 was asked if Resident #218's daughter had reported that a male resident was coming into her mother's room and it scared her mother. RN Supervisor #1 stated, Yes. I told the floor nurse to document (named Resident #220) behavior and keep him out of the room and then to pass it along to the next shift. RN Supervisor #1 was asked how she passed it along to the next shift. RN Supervisor #1 stated, I put it on the 24 hour log and that goes to (DON). During an interview in the activities room on 5/5/14 at 8:15 AM, the Administrator, was informed of above nurses response to question of responding to wanderguard alarm and asked if the facility had an orientation for the agency nurses. The Administrator stated, From what I understand, the agency nurses are oriented to the patients they will be taking care of but we don't have an organized, structure orientation for agency nurses, but we will now. The facility failed to implement new, appropriate and measurable interventions to address wandering and exit seeking behavior which placed Resident #220 in immediate jeopardy when he eloped.
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of a facility's investigation, medical record review, observation and interview, it was determined the facility failed to provide two person assistance for transfer to ensure resident safety for 1 of 3 (Resident #1) residents reviewed with accidents. The failure to provide two person assistance for Resident #1 resulted in actual harm when the resident sustained [REDACTED]. The findings included: Review of the facility's Incident Reporting policy documented, Policy It is the intent of this facility to provide a safe and healthful work environment. This facility shall ensure that the resident's environment shall remain as free of accident hazards as possible, and that each resident shall receive adequate supervision and assistive devices that shall reduce accidents. Review of the facility's investigation of Resident #1's injury on 7/5/13 did not include an Incident / Occurrence Investigation Form which would include interviews, conclusion, and corrective action. An undated and unsigned hand written note documented, (Named Certified Nursing Assistant (CNA) #1), states that he reported what he saw to the charge nurse, he noted blood coming from the resident's right foot. Unsure as to what happened. Medical record review for Resident #1 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] documented the resident had adequate hearing, clear speech, able to make self understood, understands with clear comprehension, and had adequate vision. The resident's cognitive a summary score was 10 out of a possible 15 indicating moderate cognitive impairment. Functionally the resident was totally dependent for transfers, full staff performance every time, two persons physical assist due to functional limitation in range of motion of the lower extremity, impairment on both sides. Review of the most recent MDS dated [DATE] documented a cognitive summary score of 13 out of a possible 15 indicating the resident was cognitively intact. Functionally the resident remained the same. Review of the nurses notes documented the following: a. 7/5/13 at 6:40 AM written by the Night Supervisor - .Called to room per charge nurse (Nurse #1). foot with towel wrap around foot bright red blood noted on towel & top sheet R (right) foot with 3+ (plus) pitting edema dried red blood noted to foot area clean with noted splits between each toe No c/o (complaint of) pain or discomfort noted or voiced, when asked resident what happen he (Resident #1) stated you know how my feet are the CNA (certified nursing assistant) got me up to w/c (wheelchair) & (and) it (foot) started bleeding. b. 7/5/14 at 7:50 AM written by Nurse #2 - in addition to the laceration to the right foot, bilateral knee swelling, a dime size abrasion to the right knee, and a one and one-half inch scratch to the left knee. The physician was notified and orders received to send Resident #1 to the emergency room for evaluation. c. 7/5/14 at 12:00 PM written by Nurse #2 - the resident had returned to the facility status [REDACTED]. Review of the care plan dated 7/5/13

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 13) documented, .Laceration to toe next to great toe on right foot. monitor stitches for s/s of infection. Resident has a fracture of L (left) knee with a immobilizer. Immobilizer d/c'd (discontinued) 8/26/13. The care plan was updated 8/15/13 and documented, .Total assist with lift with transfers. Observations in Resident #1's room on 1/15/14 at 11:15 AM and 3:55 PM and on 2/4/14 at 1:00 PM, revealed Resident #1 lying on a specialty air mattress bed, a trapeze bar was over the head of the bed, the resident was unable to move lower extremities, and the resident was noted to have bilateral foot drop. During an interview in Resident #1's room on 1/15/14 at 3:55 PM, Resident #1 was asked if he had ever sustained an injury by the facility staff. Resident #1 stated, He (Certified Nursing Assistant (CNA) #1) was a rookie. Split my toes. He didn't know what he was doing but it was not done intentionally. Resident #1 continued and stated that he was paraplegic and had no feeling in his lower extremities. He didn't know what the CNA hit his foot on to split it. He had to go to the emergency room an get stitches but did not recall having had a fracture. During a telephone interview on 2/12/14 at 9:45 AM, Nurse #1 was asked If she remembered Resident #1 and could she tell me anything about how he was injured in July of 2013. Nurse #1 stated she had written notes of the incident and would call me back when she got home. At 12:30 PM, Nurse #1 returned the call and stated that CNA #1 worked for an agency. It was the facility's protocol to orient agency staff to the section, where things were and go through the CNA care plan and assignment sheet that has all the activities of daily living (ADL) care needs for the CNAs to follow. CNA #1 had come to her and .Told me he had had an accident. He had got him (Resident #1) up in the wheelchair and he was bleeding. I went to (Named Resident #1's) room and he was bleeding from his right foot. There was blood on the sheets, towel, even on his gown. I wrapped the foot with a towel and notified the supervisor for night shift. When the bleeding had stopped we were able to see between the toes. It was a deep cut. The CNA had body lifted him by himself. Anytime the CNAs got him up for a shower or anything else they used a lift. During a telephone interview on 2/18/14 at 3:45 PM, the Night Supervisor was asked could she tell me anything about how Resident #1 was injured in July of 2013. The Night Supervisor stated, .I was called to the room at 6:15 to 6:30 AM. Appeared as little splits between the toes. Couldn't see the cut. They said they had to move the toes to see it. The agency CNA (#1) said he didn't know how it happened. He (Resident #1) is assessed for lift and 2 person assist. During an interview at the D nurses station on 2/21/14 at 11:15 AM, Nurse #2 was asked could she tell me anything about how Resident #1 was injured in July of 2013. Nurse #2 stated, .It happened on 11P to (-) 7Ashift. Didn't know the CNA. I came on that morning. Raised to look at his foot and noticed he was going to have to have stitches. A head to toe assessment was done. Pulled the cover back and had abrasions on both knees. Fracture turned out to be just one leg. He denied pain. No body really knew what had happened. (Resident #1) denied falling or dropping. Nurse #2 was asked how agency staff was oriented to their assigned station. Nurse #2 stated the nurse on that shift fills out the assignment sheet and another CNA walks through the unit with the new CNA. The CNA care plan in the ADL book lets them know if the resident can get up and the assistance needed. (Resident #1) uses a lift to get up. His legs are straight. The failure to provide two person assistance for Resident #1 resulted in actual harm when the resident required stitches to the underside of the right foot and sustained a non-displaced fracture of the left tibial tuberosity.
F 0365 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide food in a way that meets a resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility failed to ensure a resident was provided with the diet prescribed by the physician for 1 of 35 (Resident #130) residents of the 52 residents included in the stage 2 sample. The findings included: Medical record review for Resident #130 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Physician telephone orders documented the following: a. 10/22/13 - .Change diet to mechanical soft for 7 days due to dental extraction. b. 11/1/13 through 11/30/13 - .Diet. Regular. No Added Salt. c. 12/1/13 through 12/31/13 - .Diet. Regular. No Added Salt. d. 1/1/14 through 1/30/14 - .Diet. Regular. No Added Salt. e. 2/1/14 through 2/30/14 - .Diet. Regular. No Added Salt. f. 3/1/14 through 3/30/14 - .Diet. Regular. No Added Salt. g. 4/1/14 through 4/30/14 - .Diet. Regular. No Added Salt. Review of the NUTRITION PROGRESS REPORT documented the following: a. 8/8/13 - .CURRENT DIET.Reg (Regular) NAS (no added salt). b. 11/14/13 - .CURRENT DIET.mech (mechanical soft) NAS. c. 1/31/14 - .CURRENT DIET.MS (mechanical soft) NAS. Observations in Resident #130's room on 4/28/14 at 7:58 AM, Resident #130's breakfast was a hard boiled egg and some type of unrecognizable chopped up meat. Resident #130 did not know what the food item was on this mechanical soft diet. The resident was not served a regular diet as ordered. During an interview in Resident #130's room on 4/29/14 at 9:28 AM, Resident #130 was asked does the food look good and appetizing. Resident #130 stated, Doesn't look right and I've never seen it before. During an interview at the C hall nurses' station on 4/30/14 at 11:41 AM, Nurse #3 was asked why Resident #130 was on a mechanical soft diet. Nurse #3 stated, Because of teeth. she had a tooth extraction. Nurse #3 was asked if resident had an order for [REDACTED].#3 shook her head no. During an interview in the Resident's room on 5/2/14 at 12:35 PM, Resident#130 was served a regular texture lunch meal. Resident #130 lifted the top off of her plate and stated, WOW! Chicken.
F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Store, cook, and serve food in a safe and clean way** Based on observation and interview, it was determined the facility failed to ensure foods were served under sanitary conditions by desserts being uncovered and 1 of 21 Certified Nursing Assistants (CNA #15) nursing assistants handled food with bare hands without performing hand hygiene. The findings included 1. Observations on the 600 hall on 4/28/14 at 12:30 PM, the pudding desserts were placed on the meal cart and served to all the residents without a cover on the desserts. 2. Observations in room 608 on 4/30/14 at 7:52 AM, CNA #15 setting up a tray and then buttered toast and peeled 2 hard boiled eggs with bare hands without performing hand hygiene. Observations in room 609 on 4/30/14 at 7:53 AM, CNA #15 setting up a tray and spreading butter and jelly on the toast while holding the toast down with a bare finger without performing hand hygiene. Observations in room 611B on 4/30/14 at 7:58 AM, CNA #15 peeled a hardboiled egg and spread butter and jelly on the toast with bare hands without performing hand hygiene. During an interview in the Director of Nursing's (DON) office on 5/3/14 at 2:20 PM, the DON was asked should staff handle a resident's food with their bare hands. The DON stated, No, Ma'am.
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, it was determined the facility failed to provide evidence employees were free from communicable disease for 1 of 11 (Nurse #12) personnel files reviewed and failed to ensure practices to prevent the spread of infection and cross contamination were maintained when 1 of 21 Certified Nursing Assistants (CNA #15) handled food with bare hands without performing hand hygiene. The findings included: 1. Review of an employee personnel file revealed Nurse #12 had not had a Purified Protein Derivative (PPD) since 2012. 2. Observations in room [ROOM NUMBER] on 4/30/14 at 7:52 AM, CNA #15 set up a tray, buttered the toast and peeled 2 hard boiled eggs with bare hands without performing hand hygiene. Observations in room [ROOM NUMBER] on 4/30/14 at 7:53 AM, CNA #15 set up a tray, spread butter and jelly on the toast while holding the toast down with a bare finger, without performing hand hygiene. Observations in room [ROOM NUMBER]B on 4/30/14 at 7:58 AM, CNA #15 peeled a hardboiled egg and spread butter and jelly on the toast with bare hands without performing hand hygiene. During an interview in the Director of Nursing's (DON) office on 5/3/14 at 2:20 PM, the DON was asked should staff handle a resident's food with their bare hands. The DON stated, No, Ma'am.
F 0465 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation and interview, it was determined the facility failed to ensure the environment was clean, sanitary and free of odors on 4 of 8 (500, 600, 700 and 800 halls) halls and the main entrance. The findings included: 1. Observations during the initial tour of the facility on 4/28/14 beginning at 9:15 AM revealed the following: a. A strong, musty, urine odor in the main entrance. b. Handrails on the 500, 600, 700 and 800 halls were sticky with a dark residue. c. 800 hall - strong urine odor on the hall. During an interview in the activities room on 5/1/14 at 4:55 PM, the Maintenance Director was asked who maintains the resident rooms. The Maintenance Director answered, We do that. During an interview in the activities room 5/1/14 at 5:15 PM, the Administrator was asked who maintains resident rooms. The Administrator stated, Am aware there are issues with the building.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **Be administered in an acceptable way that maintains the well-being of each resident .**

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	445331	A. BUILDING _____ B. WING _____	03/28/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACELAND NURSING CENTER	1250 FARROW ROAD MEMPHIS, TN 38116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of incident reports, review of 24 hour nursing log, review of daily staffing sheets, medical record review, observation and interview, it was determined the facility failed to be administered in a manner that ensured residents were protected from psychological harm and potential resident to resident altercation; administration failed to ensure the abuse policies were implemented to ensure allegations of abuse and neglect were thoroughly investigated and reported to administration; administration failed to ensure staff provided timely care and timely physician notification of condition changes to prevent neglect; administration failed to ensure interventions for behaviors of wandering and/or exiting seeking residents were effective; administration failed to fully investigate grievances; administration failed to ensure the facility had an organized, structural orientation for the agency nurses and failed to ensure each staff member was knowledgeable of the facility missing resident policy; administration failed to ensure staff completed wanderguard checks and ensure a bed alarm and mat were in place for 6 of 52 (Residents #7, 22, 108, 218, 220 and 247) residents reviewed of the 52 residents included in the stage 2 sample. Administration failed to ensure the quality assurance program was effective in identifying issues and concerns within the facility. The failure of the facility to thoroughly investigate and/or report to administration allegations of abuse and neglect resulted in immediate jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death) for Residents #22, 218 and 220. In the activity room on 5/2/14 at 3:45 PM, the Administrator and Director of Nursing (DON) were informed of the immediate jeopardy (IJ). The IJ is ongoing. The findings included: 1. Administration failed to ensure staff assessed and timely notified the physician of swelling of the right arm, of a resident who was at a high risk for [MEDICAL CONDITION] which resulted in delay of care and placed Resident #22 in immediate jeopardy. Refer to F157. 2. Administration failed to ensure residents were protected from psychological harm and potential resident to resident altercation; ensure the abuse policies were implemented to ensure allegations of abuse and neglect were thoroughly investigated and reported to administration; administration failed to ensure staff provided timely care and timely physician notification of condition changes to prevent neglect; administration failed to ensure interventions for wandering and/or exiting seeking behaviors were effective and administration failed to fully investigate grievances for Residents 7, 22, 218 and 220. Refer to F166, F223, F224, F225, F226 and F319. 3. Administration failed to ensure necessary care and services were provided to maintain the highest practicable physical, mental, and psychosocial well-being of residents when staff failed to timely assess and notify the physician of swelling of the right arm for Resident #22. Refer to F309. 4. Administration failed to ensure staff provided supervision when staff failed to respond to an alarm when a resident was leaving the facility or ensure a wanderguard was checked as ordered by the physician for Residents #108 and 220. Administration also failed to ensure handrails did not have nails sticking to cause potential injuries. Refer to F323. 5. The administration failed to ensure the facility had an organized, structural orientation for the agency nurses and failed to ensure each employee was knowledgeable of the facility's missing resident policy. During an interview in the activities room on 5/5/14 at 8:15 AM, the Administrator, was informed of above nurses response to question of responding to wanderguard alarm and asked if the facility had an orientation for the agency nurses. The Administrator stated, From what I understand, the agency nurses are oriented to the patients they will be taking care of but we don't have an organized, structure orientation for agency nurses, but we will now. Refer to F518. 6. Administration failed to ensure the Quality Assessment (QA) and Assurance committee established and implemented a method of identifying concerns identified and implement plans of actions to correct identified concerns of abuse, neglect and an elopement. The administrator gave an acceptable plan of correction (PoC) for the abbreviated survey completed on 3/28/14 with a compliance date of 4/30/14. The abbreviated revisit on 5/1/14 validated the facility was not in substantial compliance as specified in the written PoC. During the abbreviated survey of 3/28/14, F314 was cited at a D level and remained at a D level, and continues in substantial non compliance. The deficiency levels for F225, F323 and F514 cited in the abbreviated survey actually increased in scope and severity to immediate jeopardy (F225 J, F323 J and F514 J) and continues in substantial non compliance. Refer to F520.
F 0497 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**1) Review the work of each nurse aide every year; and 2) give regular in-service training based upon these reviews.** Based on review of a personnel file and interview, it was determined the facility failed to ensure performance evaluations were done annually for 1 of 11 (certified nursing assistants (CNA) #22) personnel files reviewed. The findings included: Review of CNA #22's personnel file revealed last performance review was done in 2011. During an interview in the activity room on 5/5/14 at 10:00 AM, the director of Nursing (DON) was asked about the performance evaluations for certified nursing assistants. The DON stated, I have not done performance evaluations since I have been here (2 months). I don't know how they were done in the past. During an interview in the activity room on 5/5/14 at 2:30 PM, the Administrator was asked about performance reviews for the staff. The Administrator stated, I am ashamed to say the last evaluations were done around 2011. They are suppose to be yearly.
F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and interview, it was determined the facility failed to ensure 1 of 17 (Resident #9) sampled residents reviewed had complete medical records. The findings included: Medical record review for Resident #9 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set assessment dated [DATE] documented the resident had clear speech, was usually able to make self understood and usually understands conversation, had a cognitive summary score was 6 out of a possible 15 indicating severe cognitive impairment, and had impairment in functional range of motion on the upper and lower extremity on one side. Review of the DAILY SKILLED NURSE'S NOTES from 1/11/14 to 1/13/14 documented no skilled note for 1/12/14. Review of a physician's ACUTE VISIT progress note completed by the Nurse Practitioner (NP) dated 1/13/14 documented, .(Named Resident #9) reports sl (slightly) slurred speech onset yesterday after lunch - he says was stuttering. Observations on the 400's hall, in the facility's lobby area, on 1/16/14 at 2:00 PM and on 2/4/14 at 10:15 AM, revealed Resident #9 to be alert and oriented to person and place, had right-sided paralysis, and slightly slurred speech. Resident #9 displayed some hesitation before speaking, but his responses were appropriate. Resident #9 was able to propel himself in the wheelchair throughout the facility independently. During an interview, by request of Resident #9's Responsible Party (RP), in the conference room on 1/15/14 at 4:25 PM, the RP stated she was concerned with the nursing care Resident #9 was receiving because on Saturday 1/11/14 she had noticed the resident was slurring his speech and the .Temp (temporary) Services didn't know anything about him. The RP stated the resident's speech was more slurred on Sunday 1/12/14, she spoke with the same nurse again, and didn't get an answer to her concerns until she spoke with the B Station Nurse Manager on Monday 1/13/14. During an interview at the B nurses' station on 1/16/14 at 2:30 PM, Nurse #3 and the B Station Unit Manger were asked if Resident #9 had had a change in condition over the past weekend, 1/11/14 and 1/12/14. Nurse #3 stated, .He wasn't ever talking clearly. I was here Sunday. He was talking fine, more dragging of his leg than a change in speech, occurring intermittently. The B Station Unit Manager stated that she had worked Sunday from 9:30 PM until Monday at 10:00 AM and didn't notice changes in Resident #9's speech or use of his right side. She had been in Resident #9's room Monday morning early and had held the wheelchair for him while he independently transferred from the bed to the chair. During an interview in the conference room on 1/24/14 at 3:00 PM, the Director of Nursing (DON) confirmed the DAILY SKILLED NURSE'S NOTES for 1/12/14 was missing from Resident #9's chart. During an interview on the 400 hall on 2/4/14 at 6:50 PM, an Agency Nurse was asked what kind of orientation she received from facility staff. The Agency Nurse stated, Been about 2 months since here last. Shown where to get supplies, the residents in my area, who to ask with questions, make walking rounds, given verbal report and review of the 24 hour report. During an interview in the conference room on 2/5/14 at 11:20 AM, the DON was asked how Agency personnel were oriented to the station they are assigned. The DON stated the nurses leaving and coming in to work make walking rounds. The 24 hour report, documentation by each shift of changes in orders, resident behaviors, and nursing concerns, is reviewed. Also, hot spots which are family or patients that have a lot of concerns are reviewed. They are told how often to document and if there is a change in status how to fill out the physician communication sheet. The medication administration records are

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 15) very detailed. The contracted Agency verifies current license, abuse registry, training on infection control and resident rights. During an interview in the conference room on 2/24/14 at 2:00 PM, the NP was asked about the possible change in Resident #9's status over the weekend of 1/11/14 and 1/12/14. The NP stated that when she saw him of Monday 1/13/14 she could not tell that his speech had worsened, however, the resident .felt like he was stuttering. That was significant to me. The NP stated that the brain scan was completed and indicated there had not been a new stroke.
F 0518 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Train all employees on what to do in an emergency, and carry out announced staff drills.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of an incident report and staff interviews, it was determined the facility failed to ensure staff were competent in emergency preparedness for when residents are discovered missing and were not aware of the elopement code for 4 of 8 (Certified Nursing Assistants (CNA) #20 and 21 and Nurses #15 and 16) staff interviewed. The failure of the facility to respond to a sounding alarm and follow a resident observed leaving the facility resulted in immediate jeopardy (in a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death) for Resident #220 who elopement from the facility. In the activity room on 5/2/14 at 3:45 PM, the Administrator and Director of Nursing (DON) were informed of the immediate jeopardy (IJ). The IJ is ongoing. The findings included: 1. Review of the facility's Missing Resident policy documented, .When a resident is suspected of missing. 2. The nursing supervisor will announce overhead Code Green to alert facility employees of the missing resident. 2. During an interview on the 300 hall on 5/5/14 at 3:10 PM, CNA #20 was asked what the code for elopement was. CNA #20 stated, I don't know the code to announce elopement. 3. During an interview on the 400 hall, on 5/5/14 at 3:30 PM, CNA #21 was asked what the code for elopement was. CNA #21 answered, I don't remember what the code is for elopement. I'm new and don't remember codes for any of the emergencies. 4. During an interview on the 100 hall on 5/3/14 at 2:05 PM, Nurse #15 was asked what would she do if she heard a wanderguard alarm going off. Nurse #15 answered, .call the AWOL (Absent Without Leave) code. Nurse #15 was then asked, .Would you not stop what you were doing to look? Nurse #15 stated, It depends on what I was doing. I'm an agency nurse and really don't know what the policy is. no. I guess I should stop what I am doing, check the facility and then outside. call the AWOL code. During an interview in the activities room [ROOM NUMBER]/5/14 at 8:15 AM, the Administrator, was informed of above nurses response to question of responding to wanderguard alarm and asked if the facility had an orientation for the agency nurses. The Administrator stated, From what I understand, the agency nurses are oriented to the patients they will be taking care of but we don't have an organized, structure orientation for agency nurses, but we will now. 5. During an interview on the 100 hall on 5/3/14 at 1:40 PM, Nurse #16 was asked what do you do when you find you have a missing resident. Nurse #16 stated, .(call) AWOL code. The facility failed to ensure each employee was knowledgeable of each of the components in the missing resident policy. Not all of the staff were aware of Code Green which is used when a resident is missing. Refer to the findings of elopement in regard to Resident #220 in citation F323.
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on policy review, review of incident reports, review of shift assignment sheet, review of 24 hour nursing log, medical record review, observation and interview, it was determined the facility's Quality Assessment (QA) and Assurance committee established and implemented a method of identifying concerns identified and implement plans of actions to correct identified concerns of abuse, neglect and an elopement. The failure of the QA committee to identify and address concerns resulted in immediate jeopardy, a situation in which the provider's noncompliance has caused, or is likely to cause serious injury, harm, impairment or death for Residents #22, 218 and 220. In the activity room on 5/2/14 at 3:45 PM, the Administrator and Director of Nursing (DON) were informed of the immediate jeopardy (IJ). The IJ is ongoing. The findings included: 1. Review of the facility Abuse, Neglect and Misappropriation protocol documented, POLICY A. physical, and mental abuse. neglect. are prohibited. B. All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other officials in accordance with State law through established guidelines. VII Investigation All allegations of abuse will be investigated and reported to the appropriate agencies. A. The Administrator / designee will make all reasonable efforts to investigate and address alleged reports, concerns, and grievances. B. The person (s) observing the incident will immediately report and provide a written statement that includes name of resident, date and time incident occurred, where it occurred, staff involved and a description of what occurred. VIII Follow up A. Allegations are to be report within the timeframe allotted by state agency B. Social Service/Chaplain will follow up with resident to monitor resident's emotional well-being following the incident. Referral for Psychological/Psychiatric services will be made as needed. E. All allegations of abuse are reviewed at QA (quality assurance) meetings for any further resolution related to educational opportunities. The failure of the facility to thoroughly investigate and/or report to administration allegations of abuse and neglect resulted in immediate jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment or death) for Residents #22, 218 and 220. 2. During an interview in the activities room on 5/5/14 at 8:15 AM, the Administrator, was informed of above nurses response to question of responding to wanderguard alarm and asked if the facility had an orientation for the agency nurses. The Administrator stated, From what I understand, the agency nurses are oriented to the patients they will be taking care of but we don't have an organized, structure orientation for agency nurses, but we will now. During an interview in the activity room on 5/5/14 at 4:40 PM, the Administrator was asked if the QA Committee had looked at abuse. The Administrator stated, Nothing specific. The Administrator was asked if the QA Committee had looked at elopements, the Administrator stated, No. 3. The facility's QA committee failed to address identified issues such as abuse, neglect and elopement. 4. The facility's QA committee failed to ensure the plans of action to correct identified quality deficiencies cited on the abbreviated survey completed on 3/28/14, with a compliance date of 4/30/14, were effective. The following plan of actions were not followed: a. F225 - the facility will ensure all incidents will be thoroughly investigated. b. F314 - 9 of 103 licensed staff failed to attend inservice on performing head to toe assessments. c. F323 - the facility failed to ensure the resident's environment was free of accident hazards. d. F514 - 9 of 103 licensed staff failed to attend inservice for documentation. The revisit validated the facility was not in substantial compliance as specified in the written PoC. During the abbreviated survey of 3/28/14, F225 was cited at a D level, F314 was cited at a D level, F323 was cited at a G level and F514 was cited at a D level. The citation F314 was cited at a D level and remained at a D level, and continues in substantial non compliance. The deficiency levels for F225, F323 and F514 cited on the abbreviated survey actually increased in scope and severity to immediate jeopardy (F225 J, F323 J and F514 J) and continue in substantial non compliance. Refer to F157, F166, F223, F224, F225, F226, F282, F309, F319, F323, F514 and F518.