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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365290	A. BUILDING ______ B. WING _____	**05/21/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER-KIRTLAND	**9685 CHILLICOTHE RD KIRTLAND, OH 44094**

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 -** Minimal harm or potential for actual harm **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 record review and interview, the facility failed to ensure the responsible party and physician of Resident #179 were notified of an incident of sexual abuse. This affected one resident (Resident #179) of three residents reviewed for notification. The facility census was 157 residents. Findings include: Review of the medical record for Resident #179 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #179 was assessed as being rarely or never understood; having disorganized thinking; and being severely impaired in decisions regarding tasks of daily life. Review of a progress note dated 04/11/14 in Resident #178 ' s medical record revealed Resident #178 was found with his hand up Resident #179's shirt touching her breast. The progress note stated that the residents were separated. There was no progress note in the medical record for Resident #179 concerning the incident, or Resident #179's response to the incident. There was no documentation in Resident #179's medical record that the resident's responsible party or physician were notified of the incident. Interview with the director of nursing (DON) on 05/20/14 at 11:16 A.M. confirmed the lack of documentation in the medical record for Resident #179 concerning this incident on 04/11/14. The DON also confirmed there was no documentation in the medical record for Resident #179 that the responsible party or physician of Resident #179 were notified of the incident.
F 0223 **Level of harm -** Minimal harm or potential for actual harm **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 record review and interview, the facility failed to provide supervision and appropriate interventions to prevent Resident #179 and Resident #137 from being sexually abused. This affected three residents (Resident #178, Resident #179, and Resident #137). The facility census was 157 residents. Findings include: Review of the medical record revealed Resident #178 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set assessment, dated 07/18/13, revealed Resident #178 was assessed to be severely cognitively impaired. Review of a care plan dated 03/12/14 for Resident #178 revealed the resident sometimes demonstrated sexually inappropriate behaviors, exhibited by masturbation in public and inappropriate touching. A goal dated 03/12/14 indicated the resident would interact with others appropriately during social and care situations. Interventions for this focus on the care plan dated 03/12/14 included diversions of offering something else the resident liked; helping the resident avoiding situations or people that tend to trigger behaviors; quietly attempting to redirect and remind the resident that the residents behavior was inappropriate; allowing the resident privacy; and treating the resident with dignity and respect regardless of any behaviors. Review of a progress note in the medical record for Resident #178, dated 04/11/14, revealed Resident #178 was found with his hand up Resident #179's shirt touching her breast. The progress note stated that Resident #178 and Resident #179 were separated. There was no progress note in the medical record for Resident #179 concerning the incident. A progress note dated 04/12/14 stated Resident #178 was roaming the facility touching women. The Nurse Practitioner for Resident #178 was contacted and an order was received to send Resident #178 to the hospital. Resident #178 returned to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of a progress note dated 04/13/14 at 11:26 A.M. revealed Resident #178 had multiple attempts at placing his hands on female residents and staff. The progress note also stated that Resident #178 was redirected multiple times; given fluids and food; provided one-to-one activity; removed from activities; and placed next to nurses station. The progress note then stated that these interventions were not effective thus far and that staff would continue one-to-one supervision, redirection, and monitoring. Review of a progress note dated 04/14/14 revealed Resident #178 had made several attempts to place hands on staff and other residents, with interventions being unsuccessful including redirecting the resident, one-to- one supervision, and offering fluids and food. The nurse practitioner for Resident #178 was contacted and an order received for the resident to receive a psychiatric consult and ordered an anti-depressant medication. Review of a progress note dated 04/15/14 at 11:44 A.M. revealed the physician for Resident #178 was in to see the resident and decreased the anti-depressant medication that was ordered on [DATE] by the nurse practitioner, and that the resident was scheduled to for a psychiatric consult on 04/23/14. Another progress note dated 04/15/14 at 11:47 A.M. revealed Resident #178 continued to make several attempts to place hands on residents and staff with an interventions attempted of redirecting the resident and one-to-one supervision, and that these interventions were ineffective. There were no other interventions documented in the medical record to prevent Resident #178 from continuing to touch female residents inappropriately. Review of a progress note dated 04/18/14 at 1:15 P.M. revealed Resident #178 was witnessed by a visitor with his hand down the front of a female resident's shirt. The female resident was identified in a police report dated 04/18/14 as Resident #137. Review of a Self-Reported Incident (SRI) form dated 04/18/14 revealed Resident #178 was found by a visitor with his hand on a female resident's breast and that the visitor hit Resident #178 on the arm to stop the behavior. Review of a progress note dated 04/18/14 at 4:28 P.M. stated that the local hospital was contacted regarding an order for [REDACTED].#178 at that time. A progress note on 04/18/14 at 6:26 P.M. stated Resident #178's physician was in to see the resident and wrote an order for [REDACTED]. Review of a progress note dated 04/19/14, 04/21/14, and 04/22/14 documented Resident #178 continued with attempts at approaching female residents requiring frequent redirection. There were no new interventions documented in Resident #178's medical record to prevent Resident #178 from continuing to attempt to touch female residents in the facility. Interview with the director of nursing (DON) on 05/20/14 at 11:16 A.M. revealed the interventions to prevent the sexually inappropriate behavior included sending Resident #178 to the hospital; providing the resident with anti-depressant medication and, ordering laboratory tests. The DON stated that Resident #178 was not provided with continuous one-to-one observation by a staff member to prevent Resident #178 from touching female residents inappropriately due to the facility did not have enough staff to complete one-to-one monitoring for residents. The DON also stated that the facility did not have a policy and procedure regarding sexually inappropriate behavior, or a policy and procedure regarding one-to-one supervision. Interview with Assistant Director of Nursing (ADON) #200 on 05/21/14 at 7:26 A.M. revealed, Resident #178 was never placed on a one-to-one observation with a staff member continuously. ADON #200 stated that one-to-one intervention provided as stated in Resident #178's progress notes was during the time frame of the progress note, staff were attempting to keep the resident within eye sight. ADON #200 also confirmed at this time that there was no documentation of monitoring of Resident #178's behavior after 04/15/14 until the resident was found with his hand down the shirt of a female resident on 04/18/14.
F 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating**

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **365290**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **05/21/2014**

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F 0225

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 1)
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 record review and interview, the facility failed to thoroughly investigate an incident of physical abuse for Resident #178; failed to report an incident of sexual abuse involving Resident #178 and Resident #179; and failed to thoroughly investigate injuries of unknown origin for Resident #180 and #165. This affected four of nine residents reviewed for abuse. The facility census was 157 residents. Findings include: 1. Review of the medical record revealed Resident #178 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set assessment, dated 07/18/13, revealed Resident #178 was assessed to be severely cognitively impaired. Review of a care plan dated 03/12/14 for Resident #178 revealed the resident sometimes demonstrated sexually inappropriate behaviors, exhibited by masturbation in public and inappropriate touching. A goal dated 03/12/14 indicated the resident would interact with others appropriately during social and care situations. Interventions for this focus on the care plan dated 03/12/14 included diversions of offering something else the resident liked; helping the resident avoiding situations or people that tend to trigger behaviors; quietly attempting to redirect and remind the resident that the residents behavior was inappropriate; allowing the resident privacy; and treating the resident with dignity and respect regardless of any behaviors. Review of a progress note in the medical record for Resident #178, dated 04/11/14, revealed Resident #178 was found with his hand up Resident #179's shirt touching her breast. The progress note stated that Resident #178 and Resident #179 were separated. Review of a facility Self-Reported Incident (SRI) dated 04/18/14 revealed Resident #178 was found by a visitor with his hand on a female resident's breast and the visitor hit Resident #179 on the arm to stop the behavior. Review of the facility's investigation documentation revealed no documentation that any staff member from the facility discussed the incident with the visitor who hit Resident #179 on the arm. In addition, there was no evidence that the facility reported the incident of sexual abuse to the State agency as required. Interview with the director of nursing (DON) on 05/20/14 at 11:16 A.M. confirmed that the facility did not report the incident of sexual abuse the State Agency as required. Interview with Assistant Director of Nursing (ADON) #200 on 05/21/14 at 7:26 A.M. confirmed there was no documentation in the facility Self-Reported Incident, or in the facility investigation documentation, that the incident was discussed with the visitor by facility staff.

2. Review of the record of Resident #180 revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of her quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively impaired and required the extensive assistance of one staff member for bed mobility and transfers. Review of a nursing note dated 12/18/13 at 3:23 A.M. revealed the nurse was called to the room at 2:30 A.M. by the state tested nursing assistant (STNA) when Resident #180 stated she had pain to the right foot and ankle. The note indicated the resident had pain with range of motion and palpation to the right foot and ankle. The right outer ankle and top of right foot was noted with a discernible deformity. The injury area was warm to touch and free of discoloration. The resident's physician was notified and an order was given for a STAT (immediate) x-ray to the right foot and ankle. The note indicated the radiology service was notified and would arrive by 5:00 A.M. A note dated 12/18/13 at 7:56 A.M. revealed results from the X-ray were returned and indicated an oblique fracture to the distal tibula. The resident was sent to the hospital at that time, returning to the facility on [DATE] at 12:30 P.M. with a fiberglass cast to the right leg. Review of the investigation revealed a statement dated 12/17/13 by STNA #302 who worked 11:00 P.M. to 7:00 A.M. shift. The note indicated when she went into the room to do patient care for Resident #180, the resident stated, Ow, my foot hurts. It's broken. The resident stated it happened when getting into bed. STNA #302 reported the information to the charge nurse. A statement by STNA #303, who also worked on the 11:00 P.M. to 7:00 A.M. shift on 12/17/13 into 12/18/13, revealed she entered the resident's room to do care and the resident stated that her foot was broken and it looked swollen. The statement indicated that Licensed Practical Nurse (LPN) #305 was notified. Review of an investigation of the incident revealed a statement by the LPN #305 that she was the nurse on the unit who was notified by the STNA about the resident's pain and did the initial examination. The statement revealed the resident told her the incident happened getting into bed or the car last night. Review of the investigation revealed only one statement by an STNA who worked on the 3:00 P.M. to 11:00 P.M. shift on 12/17/13, the shift indicated by the resident as when she was put to bed and hurt her foot. That statement by STNA #306, revealed she was the resident's aide on 12/17/13. It stated that the resident did not show signs of pain or had any complaints. The statement did not indicate if she had transferred the resident to her bed on 12/17/13. Interview with the other LPN (#307) who worked on the unit the evening into night shift on 12/17/13, revealed he did not provide care for the resident in the last week. Interview with STNA #308, who also worked the night shift beginning on 12/17/13, revealed he did not have contact with the resident. Review of the statement by the MDS assessment nurse, RN #309, dated 12/18/14 at 2:36 P.M., revealed the resident stated I told that girl my leg was like that and then I heard two snaps. Review of the staffing schedule revealed there were three other STNAs (STNA # 310, STNA #311, and STNA #312) who worked the 3:00 P.M. to 11:00 P.M. shift on 12/17/13 and may have transferred or assisted in a transfer of Resident #180 during the time she indicated her foot was injured. There was no statement by these STNA's contained in the investigation, or any other staff who cared for her on a shift in the 24 hours prior to the incident. Review of other statements contained in the investigation revealed STNA #313 did not care for the resident; STNA #314 stated he did not provide care or witness an injury and the resident did not complaint of pain on 12/16/13 when he did care for her; and STNA #315 did not work on 12/16/13 or 12/17/13. Statements were also obtained from LPN #316 and LPN #317, both of whom indicated they had not cared for the resident in the time prior to the incident. Interview with the director of nursing on 05/20/14 at 11:00 A.M. verified that all interviews that had been conducted with staff were contained in the investigation of the incident. She verified that only one staff member (STNA #306), who had worked on a shift prior to the time that the resident indicated the injury occurred and that her statement did not indicate whether she had transferred the resident. Three other STNA's had worked the 3:00 P.M. to 11:00 P.M. shift on 12/17/13 and 4 STNA's had worked on the unit on the day shift on 12/17/14. Two nurses had worked the 12 hour day shift on 12/17/13 and were also not interviewed. The director of nursing verified Resident #180 told three staff members (LPN #305, RN #309 and STNA #30) her injury happened when she was transferred into her bed the night before her injury was discovered (12/17/13). She verified the state reported investigation summary indicated the resident was unable to give a statement regarding what had happened related to her dementia, and she had told staff that she was injured getting into a car and told the hospital staff she had kicked a bus driver and got into a fight. She verified the conclusion did not relate the resident's statements about being injured during a transfer and did not reveal any possible conclusion as to the reason for the resident's fracture, even though the resident stated to three staff that she was injured during a transfer. The director of nursing verified she had not obtained statements from any staff member describing transfers of the resident to bed in the time prior to the residents complaints of pain and the subsequent discovery of a fracture. 3. Review of the record revealed that Resident #165 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data
Set (MDS) assessment dated [DATE] revealed the resident was extensive assist of two staff for bed mobility; dependent on two staff for transfers; did not propel himself on the unit or in his room; and required the extensive assistance of one staff member for dressing, toileting and hygiene. He was assessed as a fall risk on 09/27/13 due to impairments in cognition, decision making, and vision. He was to be a mechanical lift for transfers, and a care plan dated 10/02/13 revealed impaired decision making and communication was due to impaired cognition, inattention, and disorganized thinking. He also had a care plan for falls dated 09/27/13 and updated through 06/29/13, which revealed interventions to use a mechanical lift for transfers, the call light to remain within reach and the environment to be well lit and free from clutter. The resident also had an order for [REDACTED]. Review of a nursing note dated 03/18/14 at 6:47 P.M. revealed the resident was found with a reddish bruise on his lower right arm that was observed by a family member. The note indicated the resident had reddish bruising extending from the bend of the right elbow to the right wrist on the brachial side of the arm, and a small 1.5 inch by 1.5 inch area on the back of the left forearm. The note indicated the resident had a new order written on that day that he wear long sleeves or geri-sleeves (thin fabric which fits like a glove to the resident's forearms.) Review of the investigation of the injury revealed it had not been reported to the state agency as an injury of unknown origin. The investigation provided by the director of nursing did not contain any statements by staff members as to

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

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F 0225

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 2)
the possible cause of the bruise. On 05/20/14 at 4:00 P.M., the director of nursing verified there was no investigation into the cause of the large bruised area between the resident's right elbow and wrist and area on the left arm. She verified the affected area was a bruise, not a skin tear, which was the usual indication for the use of geri-sleeves, and that a bruise of that size could have been caused by care, as the resident's quarterly assessment indicated he was not able to provide care without the extensive assistance of staff, and could not walk or propel himself in the facility. She verified the investigation did not include statements by staff members who had cared for the resident in the days prior to the discovery of the bruise and that the injury of unknown origin had not been reported to the state agency as required.

F 0309

Level of harm - Minimal harm or potential for actual harm

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 observation, interview and record review, the facility failed to ensure accurate and complete documentation of a fistula for Resident #18's [MEDICAL TREATMENT] site. This affected one of one residents who reside in the facility and receive [MEDICAL TREATMENT]. The facility census was 157 residents. Findings include: Review of the record revealed Resident #18 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Interview with the resident on 05/19/14 at 3:00 P.M. revealed she was knowledgeable about her disease and the [MEDICAL TREATMENT]. She showed the surveyor her left arm, which appeared with scarring on the lateral forearm from a prior [MEDICAL TREATMENT] shunt site. The resident stated that shunt was no longer functional and that access for [MEDICAL TREATMENT] was obtained from a shunt in her upper left arm. She stated that recently the shunt has not been fully functional at [MEDICAL TREATMENT], clotting off during the treatment. She stated that she was concerned about the area and that she would need to have another shunt inserted. She stated that she feels the area with her hand frequently and can feel the thrill of the blood flow in the shunt. She stated that staff did not routinely look at the area, or complete an assessment. Review of the resident's care plan for [MEDICAL TREATMENT], dated 05/12/10 and updated through 08/12/14, revealed an intervention to check shunt needle site every shift for bleeding. Review of the resident's record did not reveal evidence of assessment of the shunt site. Review of the facility [MEDICAL TREATMENT] guideline, revised in 2013, revealed that as part of the post [MEDICAL TREATMENT] protocol,
the fistula should be checked for bruit (listening to the fistula) or feel for a thrill (by touching the fistula). The policy stated this should be done daily, best after the dressing was removed. The policy indicated if a pulse was not felt or a bruit was not heard, it could be rechecked and if still a negative assessment, the [MEDICAL TREATMENT] center or physician should be called immediately Interview with Registered Nurse (RN) #301 on 05/20/14 at 4:15 P.M. revealed she did not routinely assess the shunt site for Resident #18. She stated she did not think the shunt actually worked, and thought the resident's [MEDICAL TREATMENT] was done through an intravenous site. She stated that the facility treatment administration records, that are computerized, did not prompt or require her to enter an assessment of the shunt site. Resident #18 was in her room on 05/20/14 at 4:20 P.M. and was approached by the surveyor and RN #301 . She had returned from [MEDICAL TREATMENT] within the last hour. She had two bandages with tape over the upper shunt site on her left arm. She stated that her [MEDICAL TREATMENT] was done through the shunt site, even thought it didn't always work effectively. RN #301 felt the area of the shunt with her hand and verified that she could feel the thrill. RN #301 verified that she knew an assessment should be completed for a shunt, feeling for the thrill and listening for bruit, but verified that there was no documentation of this in the record. Interview with the director of nursing on 05/21/14 at 8:20 A.M. verified no further information was available concerning the shunt site for Resident #18 and that staff should be assessing the area routinely according to the care plan and facility policy.

F 0323

Level of harm - Actual harm

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 observation, interview and record review, the facility failed to ensure necessary care and services were provided to Resident #138 in a manner to prevent harm, which resulted in a fractured left arm. The facility also failed to ensure care and services were provided to prevent falls for Resident #31 and Resident #165. This affected three of six resident investigated for accidents. The facility census was 157 residents. Findings include: 1. Resident #138 was admitted to the facility on [DATE]. Her current [DIAGNOSES REDACTED]. The comprehensive assessment dated [DATE] indicated the resident had
physical behavioral symptoms directed towards others (hitting, pushing, scratching, and grabbing) which occurred one to three days of the assessment period. Under the area of verbal behavioral symptoms directed towards others, the behavior of this type also occurred one to three days of the assessment period. The resident was also noted to require extensive assistance of two staff for dressing, mobility, and transfers. The care plan indicated the resident was resistive to care, blind, and had impaired communication. Interview with Licensed Practical Nurse (LPN) #202 on 05/18/2014 at 2:36 P.M. revealed the resident sustained [REDACTED]. Review of the 'Verification of Investigation dated 05/03/14 at 10:00 A.M. revealed 'R (resident) during HOC (hands on care) shaking/swinging BIL (bilateral) arms vigorously at staff members while attempting to put shirt on. STNA (state tested nursing assistant) at this time noted to hear a loud cracking in left arm. STNA's immediately stopped care and got both nursing staff on unit to assess R. The resident sustained [REDACTED]. The two STNA's involved in the incident were STNA's #205 and #206. Review of the personnel record for STNA #205 revealed a 05/07/14 Separation Action Form with the reason of incomplete certified nursing assistant training. Further comment indicated the STNA took the certification test three times and did not pass. The STNA had been hired on 01/18/14, after successfully completing nurse aide training on 01/16/14. Interview on 05/20/14 at 2:00 P.M. with the DON (director of nursing) revealed there was no continuing education or inservicing for the STNA's that were involved in the incident. on how to assist resident who resist care. Review of inservices on resident care for resistive residents revealed the facility had conducted a training on 04/24/14 titled Bathing The Difficult Patient the sign in sheet had STNA #206 designated as termed (verified by the DON who stated the staff person is still employed). The signature for STNA #205 stated terminated (DON verified that the staff person had been terminated). Review of the grievance log dated 05/02/14 indicated the family of resident #138 no longer wanted the STNA's to work with the resident after the fracture occurred. The staff failed to follow facility policy and the residents care plan that indicated when the resident is resistive to care the staff are to stop providing care, and alert the nurse to the behavior. The STNA's continued care of the resident which resulted in a fracture left femur. 2. Resident #31 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The comprehensive assessment dated [DATE]
indicated the resident required a two person extensive assistance with transfers. On 05/18/14 at 2:40 P.M., interview with the charge nurse revealed the resident had sustained a fall within the past thirty days. Review of the residents care plan indicated the resident was at risk for falls related to impaired mobility, impaired decision making, and impaired safety awareness. The intervention was to transfer with two persons. The Fall investigation dated 11/05/13 which indicated the resident sustained [REDACTED]. There were no apparent injury. The investigation indicated the STNA was re-inserviced. Interview on 05/20/14 at 3:00 P.M. with the DON revealed no inservice could be found. On 05/20/14 at 9:51 A.M., interview with STNA #204 revealed the resident required transfers with the assist of one or two staff members. The surveyor asked the STNA when two staff should transfer the resident. She stated when she takes her to the bathroom, she can't always stand and hold the handrail so she needs two staff. The STNA seemed to be unaware of the comprehensive assessment, and care plan that indicated the resident requires two staff for transfers. Resident #31 was transferred with one staff person and sustained a fall.

3. Review of the record revealed that Resident #165 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. He was assessed as a fall risk on 09/27/13 due to impairments in cognition, decision making, and vision. He was to be a mechanical lift for transfers, and a care plan dated 10/02/13 revealed impaired decision making and communication was due to impaired cognition, inattention and disorganized thinking. He also had a care plan for falls, dated 09/27/13 and updated through 06/29/13, which revealed interventions to use a mechanical lift for transfers; the call light to remain within reach; and the environment to be well lit and free from clutter. The resident also had an order for [REDACTED]. Review of a nursing note dated 04/25/14 at 6:20 P.M. revealed the resident was found on the floor laying on the left side parallel to the bed. Review of the investigation of the incident revealed that he had been ordered to have side rails in place on his

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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 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) bed but they had not been applied to the bed as ordered. The resident had rolled out of his bed onto the floor. The intervention to prevent further falls was that the side rails were to be installed on the bed as previously ordered. Interview with the director of nursing on 04/20/14 at 4:00 P.M. verified the side rails were not in place as ordered prior to the resident being found on the floor on 04/25/14.
F 0356 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Post nurse staffing information/data on a daily basis.** Based on observation, record review and interview, the facility failed to ensure the required nurse staffing information was posted in a prominent place accessible to residents and visitors. This had the potential to affect all 157 facility residents. Findings include: During the initial tour on 05/18/14 at 9:15 A.M., the posted nurse staffing information was found in the lobby area of the entrance to the dementia unit of the facility, which was a separate building from the rest of the facility, accessible by a long breezeway. The form indicated the census and numbers of staff working, but did not indicate the hours worked by registered nurses, licensed practical nurses, and state tested nursing assistants. The surveyor was unable to find another nurse staffing information posting in the main entrance to the facility. The administrator showed the surveyor the nurse staffing information in a glass enclosed bulletin board. The bulletin board was on the wall near the receptionist desk, but to read the information, a resident or visitor would have to partially enter the area near the receptionist, passing by her desk. The posted information was the same as the posting in the dementia unit, which did not include the required hours worked by registered nurses, licensed practical nurses, and state tested nursing assistants. The administrator and director of nursing verified on 05/21/14 at 2:00 P.M. that the posting did not contain the required hours worked and that the posting was visible in the main lobby only by walking partially into the administrative area of the facility past the receptionist.
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 observation and interview, the facility failed to follow appropriate infection control procedures while completing a dressing change. This affected one resident (Resident # 71). The facility census was 157 residents. Findings include: Review of the medical record for Resident #71 revealed a most recent re-admission date of [DATE] with [DIAGNOSES REDACTED]. Review of wound evaluation flow sheets dated 05/01/14 revealed Resident #71 had a pressure ulcer to the sacrum and the left heel. A physician order [REDACTED]. Another physician order [REDACTED]. On 05/21/14 at 9:11 A.M., observation of the dressing change for Resident #71's sacral wound with Licensed Practical Nurse (LPN) #207 and State tested Nursing Assistant (STNA) #208, revealed LPN #207 had placed two wound measurement grids directly on Resident #71's over bed table without placing a barrier on the table. STNA #208 then rolled Resident #71 to his right side while LPN #207 removed the existing dressing applied to Resident #71's sacral area. After the dressing was removed from the sacrum, Resident #71 was rolled back on his/her back, onto an incontinence brief exposing the open wound to an incontinence brief that was soiled with a small amount of bowel movement. LPN #207 had then cleansed the wound and measured the wound with a wound grid that had been previously resting directly on Resident #71's over bed table. The wound grid used was observed to have come in direct contact with the sacral wound. On 05/21/14 at 9:32 A.M., observation of the dressing change to Resident #71's left heel revealed LPN #207 measured the left heel wound with a wound measurement grid that had been previously been resting on the over bed table of Resident #71 that did not have a protective covering. The wound grid was observed to have come in direct contact with the heel wound. Interview with LPN #207 on 05/21/14 at 9:42 A.M. confirmed Resident #71's wound was exposed to a soiled incontinence brief when the resident was rolled onto his/her back with no covering over the wound. LPN #207 also confirmed that the wound grids used to measure the sacral and heel wounds were previously placed on Resident #71's over bed table prior to being used did not have a barrier covering the surface of the table and that the grids came in direct contact with the wounds.
F 0514 **Level of harm -** Minimal harm or potential for actual harm **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 record review and interview, the facility failed to document an incident involving a resident in the medical record. This affected two residents (Resident #179 and Resident #178). The facility census was 157 residents. Findings include: Review of the medical record for Resident #179 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #179 was assessed as rarely or never understood; having disorganized thinking; and being severely impaired with making decisions regarding tasks of daily life. Review of a 04/11/14 progress note in the medical record for Resident #178 revealed the resident was found with his hand up Resident #179's shirt touching her breast. However, there was no progress note in the medical record for Resident #179 concerning the incident or Resident #179's response to the incident. On 05/20/14 at 11:16 A.M., interview with the director of nursing (DON) confirmed the lack of documentation in the medical record for Resident #179 concerning this 04/11/14 incident. 2. Review of the medical record revealed Resident #178 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #178 was assessed to be severely cognitively impaired. Review of a progress note dated 04/18/14 at 1:15 P.M. stated Resident #179 was witnessed by a visitor to have his hand down the front of a female resident's shirt. The female resident was identified in a police report dated 04/18/14 as Resident #137. Review of a facility Self-Reported Incident form, dated 04/18/14, stated that Resident #179 was found by a visitor with his hand on a female resident's breast, and that the visitor hit Resident #179 on the arm to stop the behavior. There was no documentation in the medical record for Resident #178 stating that Resident #178 was hit by a visitor. Interview with the DON on 5/20/14 at 11:16 A.M. confirmed the lack of documentation in the medical record for Resident #179 that the resident was hit by a visitor. Interview with Social Worker #201 on 05/21/14 at 8:54 A.M. revealed the care plan for Resident #178 dated 03/12/14 was generated due to being informed by staff that the resident was having behaviors of masturbating in public and touching female staff. However, there was no evidence in the medical record documenting Resident #179's behaviors during this time period when the care plan was generated.