STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **045305**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **06/16/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHERN TRACE REHABILITATION AND CARE CENTER	**22515 I 30** **BRYANT, AR 72022**

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 0241 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 observation and record review, the facility failed to ensure a resident was treated with dignity, as evidenced by failure of a Nurse Assistant Instructor to await permission before opening the door and entering a resident's room during incontinent care and failure of the same instructor to request permission before opening the privacy curtain, which potentially caused exposure of the resident's body to other residents or visitors for 1 (Resident #7) of 8 (Residents #1, #2, #5 through #10) case mix residents who required staff assistance for incontinent care. This failed practice had the potential to affect 62 residents who were incontinent, according to a list provided by the Director of Nursing (DON) on 6/13/14 at 3:03 p.m. The findings are: Resident #7 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/22/14 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS), required total assistance of 2 persons for Activities of Daily Living and was always incontinent of bowel and bladder. a. The Resident Plan of Care dated 5/8/14 documented, .Problem: Resident has impaired cognitive skills. Approach: .ensure privacy while providing care. b. On 6/11/14 at 2:05 p.m., Certified Nursing Assistant (CNA) #1 and Licensed Practical Nurse (LPN) #2 provided incontinent care for the resident. CNA #1 and LPN #2 removed all of the resident's clothing and the resident laid completely nude on the bed while care was provided. At 2:15 p.m., CNA Instructor #1 knocked once on the resident's door and, without waiting for permission to enter, opened the door and pulled back the privacy curtain. The resident was fully exposed to the hallway, where CNA students were standing.
F 0246 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure reasonable efforts were made to accommodate activity and social stimulation needs in order to maintain quality of life for 1 (Resident #3) of 1 case mix resident who was placed in contact isolation. The failed practice had the potential to affect 2 residents who were in isolation, according to a list provided by the Director of Nursing (DON) on 6/13/14 at 3:03 p.m. The findings are: 1. Resident #3 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A readmission/return Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/31/14 documented the resident scored 12 (8-12 indicates moderately impaired) on a Basic Interview for Mental Status (BIMS), required extensive assistance of one person for transfers, dressing, toilet use and personal hygiene, required limited assistance of one person for walking in room/corridor and locomotion on/off unit, was independent with eating after set-up and had moderately impaired vision. a. A Physician order [REDACTED]. [MEDICATION NAME] 500 mg (milligrams) PO (by mouth)) TID (three times a day) x (times) 14 days. 2. Contact isolation. b. On 6/10/14 at 2:28 p.m., Resident #3 was heard yelling from the room. When the surveyor arrived at the room, the resident was standing up in front of a chest of drawers, leaning on the arms of a wheelchair. She stated, I want to get my things out of here. I want out of here. You put me here in isolation and all I do is sit. 1.) The resident's room had a chest-of-drawers that contained some of the resident's clothes, an over-bed table, 2 beds, and a smaller chest. There was no television, no radio, no books or any form of distraction/stimulation present. The resident's wheelchair was the only form of seating in the room. 2.) Resident #3 was asked, Do you have anything to do? The resident stated, No, I just sit here by myself. The resident was asked, Do you think if you had a television or something it would help? The resident stated, Yes, I think it would; just something. c. On 6/10/14 at 2:30 p.m., Registered Nurse (RN)#2 was asked, Why doesn't she (Resident #3) have a television or radio or something for stimulation in her room? RN #2 stated, I don't know why they didn't bring her television to her, I will. d. On 6/10/14 at 2:35 p.m., Certified Nursing Assistant (CNA) #2 was asked, How long has (Resident #3) been in isolation? The CNA stated, She wasn't in there (isolation room) Friday (June 6, 2014) but when we came back on Monday (June 9, 2014) she was. The CNA was asked, What did she do for activity when she wasn't in isolation? The CNA stated, She would spend time in the dining room, do some of the activities, would push her wheelchair back to her room, stay there for a little bit. She would always come to the dining room and eat. She would go back and forth pushing her wheelchair. e. On 6/10/14 at 2:40 p.m., the Activity Director was asked, Have you done any activities with (Resident #3) since she was put in isolation? The Activity Director stated, I took something in there to read to her twice, but she was already upset and non-receptive to anything. The Activity Director was asked, Did you ask her why she was upset? The Activity Director stated, I really couldn't get her to talk to me. f. On 6/10/14 at 3:00 p.m., the DON was asked, Were you aware (Resident #3) had no TV or anything for stimulation in her room? The DON stated, No, I didn't, but we have put a TV in there now.
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** Complaint # (AR 27) was substantiated (all or in part) in these findings: Based on observation, record review and interview, the facility failed to ensure incontinent care was promptly provided, to maintain good hygiene and reduce the potential for skin irritation or breakdown for 1 (Resident #1) of 6 (Residents #1, #2, #4, #5 #6 and #10) case mix residents who were dependent on staff for incontinent care. The facility also failed to ensure urine was cleansed from all areas of the skin when a resident voided during incontinent care, to maintain good hygiene and prevent odors for 1 (Resident #2) of 6 case mix residents who were dependent on staff for incontinent care (see identifiers above). This failed practice had the potential to affect 62 residents who were dependent on staff for incontinent care, according to a list provided by the Director of Nursing (DON) on 6/13/14. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/19/14 documented the resident scored 2 (0-7 indicates severe cognitive impairment) on a Brief Interview for Mental Status (BIMS), required extensive assistance from staff for transfers, toileting, personal hygiene and bathing and was always incontinent of bowel and bladder and was at high risk for skin breakdown. a. On 6/9/14 at 4:05 p.m., during initial rounds, the resident was lying on a fall mat beside his low bed. There was a sheet under the resident that had dried feces and brown discolored rings on it. There were also dried feces on the leg of the resident's brief and on the resident's upper thigh. b. On 6/9/14 at 4:10 p.m., Certified Nursing Assistant (CNA) #4, who had been called into the resident's room by Registered Nurse (RN) #2, was asked, Is that dried bowel movement on the resident? CNA # 4 stated, Yes. c. On 6/9/14 at 4:15 p.m., RN# 2 asked CNA #4, (Dried bowel movement) just around the edges? The CNA stated, No, all over. It looked like

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 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) it had been there quite a while. 2. Resident #2 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/22/14 documented the resident scored 2 (0-7 indicates severe cognitive impairment) on a Brief Interview for Mental Status (BIMS), required extensive assistance by staff for transfers, toileting, personal hygiene and bathing, and was always incontinent of bowel and bladder, was at high risk for skin breakdown and currently had a Stage I or higher pressure ulcer. a. On 6/11/14 at 3:00 p.m., Certified Nursing Assistants (CNAs) #2 and CNA#3 provided incontinent care for the resident, who had been incontinent of stool. b. On 6/11/14 at 3:08 p.m., while incontinent care was being provided, the resident voided in bed, soiling the draw sheet and bottom sheet as she was turned to her left side. After the resident's bottom was cleansed the CNA's assisted the resident to turn on her back. The urine soaked sheets were removed from under the resident; however, the CNAs did not cleanse the urine from the resident's left hip and thigh area before placing a clean adult brief on her.
F 0323 **Level of harm -** Actual harm **Residents Affected -** Some	**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, record review and interview, the facility failed to ensure the development and implementation of interventions to prevent falls and to minimize risk of serious injury and to ensure interventions were re-evaluated for effectiveness when the resident had repeated falls for 1 (Resident #4) of 9 (Resident #1, #3, #4, #9, #10, #11, #12, #15 and #18) case mix residents who were at risk for falls. This failed practice resulted in a pattern of actual harm for Resident #4, who had 5 documented falls resulting in 3 fractures with no new interventions implemented to prevent future injuries due to recurrent falls, and had the potential to cause more than minimal harm to 17 residents at risk for falls , as documented on a list provided by the Administrator on 8/18/14 at 10:54 a.m. The findings are: Resident #4 was admitted on [DATE] and had [DIAGNOSES REDACTED]. A Quarterly MDS with an Assessment Reference Date of 10/8/13 documented the resident had a BIMS score of 12, was moderately impaired decision making; required supervision with set-up help only for transfer, walking in room/corridor and locomotion on/off unit; behaviors included wandering; balance moving from seated to standing, walking, turning around while walking and moving on/off toilet was not steady, but able to stabilize without staff assistance; and was always continent of bowel and urine. a. A Fall Risk Assessment with an assessment date of 10/14/13 documented the resident scored 16. A score of 12 or greater indicates resident is at high risk for falls. b. Nurse's Notes dated 11/14/13 at 9:15 a.m., documented, This nurse in hallway passing meds (medication). R (resident) yelled, ' Somebody help me ' This nurse walked in R room and observed R on both knees and holding on to bed. Observed blood on floor. Walker beside R. Observed laceration to right side of head, very small. Observed red spot to top of right shoulder. Asked R to move right arm. R attempted to lift right arm and stated ' I can't, that hurts. ' Observed ST (skin tear) x (times) 2 to top of L (left) ring finger. TX (treatment) nurse applied tx. R stated ' I was leaning over and fell and hit my head on the bed. ' Notified (family) . and (Doctor ' s) APN (Advanced Practice Nurse) . N.O. (new order) to send to . ER (emergency room). Left facility at 1000 (10:00 a.m.). 1) The resident's 'Hospital History and Physical' report dated 11/14/13 at 2:23 p.m. documented, .Admission Diagnosis: [REDACTED]. 2. Scalp Contusion. 3. Hyponatremia. History of Present Illness: The patient is a [AGE] year-old female who presented to the emergency room after she tripped and fell and hit her head. She has a past medical history of [REDACTED]. At the time of presentation to the emergency room her blood pressure was 118/82, her pulse was 76, respirations 20, temperature 98 and oxygen saturation was 98 percent. Onset was today. She fell from a standing position. She suffered a contusion and a humerus facture. The location of the pain was her head and her right upper extremity. Severity on ambulation was moderate pain, worse with movement. Baseline neurologic status is normal. Contributing factors: She does not recall why she fell and she does not remember the fall. Associated symptoms after the fall including being dazed and had a headache and was confused.X-ray revealed a positive humeral head fracture and right humeral fracture. 2) The resident's 'Post Fall Assessment' with an assessment date of 11/14/13 documented the resident scored 16. A score 12 or greater indicates resident is at high risk for falls. 3) A 'Fall Investigation Follow-up' dated 11/15/13 documented, .Date of Incident: 11/14/13, Description of Situation: This nurse observed R in room on knees. Blood on floor. Laceration to R side of head. Bruise to R shoulder. ST x 2 to L ring finger. R could not move R arm. R stated, ' I was leaning over and hit my head on the bed when I fell . ' Notified MD (Medical Doctor). N.O. send to . ER. R walker beside R at time of fall. Summary of Investigation: R noted to have behaviors consisting of moving furniture, leaning or reaching to pick things up out of floor. Recommendations and/or New Interventions: 1. Assessed R, sent to hosp & admitted . 2. Cont. (continue) on Falling Star Program. 3. Therapy screen . The Interdisciplinary Fall Team Meeting dated 5/9/14 documented, .(Resident #4) added to the Falling Star List on 11/5/13 . c. A facility 'Patient Progress Note' dated 11/19/13 documented, .Chief Complaint/Review of Systems: Staff nurse reports that R was recently sent to Hosp for fall and cut to head, DX hyponatremia and FX (fractured) Humerus; Physical exams: General: Up in w/c (wheelchair) self-propelling in hall. NAD (No Apparent Distress) HEENT (Head, eyes, ears, nose, throat): normocephalic, Bruising to Forehead, EXT: (Extremities) Sling to right arm; + (positive) swelling L (left) hand c (with) decreased ROM (Range of Motion), Rt (Right) shoulder Fx of proximal humerus neck. Todays Assessment: 1. Hospital follow-up, 2. Right Humerus fracture, 3. Hx. (History) hyponatremia. PLAN: 1. Follow up c (Doctor) ortho if not already scheduled need to schedule a follow up. 2. X-ray left hand and fingers in AM (morning) due to swelling and decrease ROM. A facility 'Patient Progress Note' dated 11/26/13 documented, .Chief Complaint/Review of Systems: following c (with) ortho for humerus & small finger, Physical exams: ext(extremities): R arm in sling; + bruising & swelling; swelling improved; Lab: x-ray L hand fx at proximal phalanx small finger, Todays assessment: 1. R humerus fracture, 2. fracture proximal phalanx of small finger L hand. d. Nurse's Notes dated 12/31/13 at 2:15 p.m. documented, R found kneeling on one knee holding on to front of w/c. R observed for injury: none noted. Assisted to w/c. R stated, ' I slipped. I did not hit my head. ' R c/o (complained of) pain to right arm c sling in place. Notified Dr. nurse . Notified (family). Will cont. to monitor. An 'Event Investigation Report' dated 12/31/13 documented, Time of Incident: 1415 (2:15 p.m.), Location of Incident: Room. Document an Exact Description of the Incident/Accident and Circumstances Surrounding It: R observed knelt down on one knee holding front of w/c. R observed for injury, none noted. Assisted to w/c. R stated, ' I slipped. I did not hit my head. ' R c/o pain to right arm c sling in place. Will cont. to monitor. R stated, ' I was trying to get my w/c and I slipped onto the floor ' . An 'Investigation Follow-up Report' dated 1/2/14 documented, Recommendations: Educate resident to use call light when wanting to transfer .Contributing Medical Condition; Non-compliance, Weakness. e. An Event Investigation Report dated 1/9/14 documented, .Time of Incident: 1:40 a.m., Location of Incident: Room; Document an Exact Description of the Incident/Accident and Circumstances Surrounding It: Called to room by CNA (Certified Nursing Assistant) ., found R sitting on floor c/o hitting head; no hematoma noted neuro checks started moves all extremities no c/o HA (head ache). RUE (right upper extremity) weakness R/T (related to) fx ; alert and oriented. Recommendations and/or Interventions: Cont (Continue) c therapy to work on safety awareness. Fall Investigation: .3. What did the resident say they were trying to do or go? Going to bathroom. . 7. Did the resident use their walker, cane, w/c, etc? No. .12. Was the call light on? No. If not, was it in reach of the resident? Yes. .Was the call light working? Yes. .20. Did you start an in-service for the new intervention? This area was left blank. **Cannot use the intervention to call for assist and wait for help if they have Dementia and/or are confused. **You must try to figure out why they fell and put an intervention in place to prevent another fall . The Office of Long Term Care (OLTC) 'Witness Statement Form' dated 1/8/14 (actually 1/9/14) at 1:30 a.m. documented, .State in your own words what you witnessed (be very descriptive) and sign below. I was walking up the hall from 500 hall when I heard (Resident #4) ask for help out of the floor. I then went and got the nurse to come and help me. I helped the nurse get (Resident #4) up out of the floor. As of 6/19/14 at 2:30 p.m., there was no documentation of new interventions implemented to prevent further falls or injuries. f. Nurses Notes dated 3/5/14 at 2:05 p.m. documented, At approx (approximately) 1130 this nurse passing meds (medication) in hall heard R yelling ' help me. ' Entered (resident room), observed R w/c beside bed A. R observed in bathroom on knees c blood on floor and forehead. Neuro check done immediately, WNL (Within Normal Limits). VS (Vital Signs) WNL. FSBS (Finger Stick Blood Sugar) 90. L hand grip strong. R (right) hand swelling c pain, unable to grip. Forehead cleaned, pressure applied to stop bleeding. TX (treatment) nurse notified. Small abrasion observed p (after) cleaned. Denies nausea, dizziness, or lightheadedness and blurry vision. . notified. Ordered x-ray to r (right) hand and wrist. APAP 650 mg (milligram) q (every) 4 hours PRN (as needed) for pain. 1) An Event Investigation Report dated 3/5/14 documented, .Location of incident: Room; Document an Exact Description of the Incident/Accident and Circumstances Surrounding It: This nurse in hall passing meds. Heard R yelling, ' Help me. ' Entered

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 2) (resident room) observed R w/c sitting beside bed A. R on knees in bathroom, blood on floor and front of forehead. R stated she was ' brushing hair. ' This nurse call another staff member to get help. 2 nurses assisted R to w/c. Tx nurse notified. Physician notified: Yes; Specific orders: x-ray to hand & wrist. 2) A Fall Investigation Report & Follow-Up dated 3/5/14 documented, .Contributing Medical Condition: Non-compliance; Resident Activity: Attempting to transfer unassisted; Devices: Wheelchair; Resident Symptoms at Time of Fall: Legs gave away; Document interventions/plan below. Inform staff of plan: Assisted R to w/c and dining room. Neuro checks, x-ray, Ortho appt. (appointment) . 3) An x-ray report dated 3/5/14 documented, .Technique: Right hand, 3 views.; Findings: There is fracture at the distal radius with extension to the distal radial articular surface. There is also a new fracture at the ulnar styloid process. There is minimal displacement. No other fracture is seen. No evidence of dislocation. Impression: Acute fractures of the ulnar styloid process and the distal radius . g. A Physician order [REDACTED]. As of 6/10/14 at 2:35 p.m., there was no documentation of new interventions implemented to prevent further falls or injuries. h. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/14 documented the resident scored 7 (0-7 indicates severe impairment) on a Brief Interview for Mental Status (BIMS) (decline since October MDS); required extensive assistance of one person for ambulation in room/corridor, dressing, personal hygiene and bathing and limited assistance of one person for transfer and toilet use (decline since October MDS); balance moving from seated to standing position, surface to surface transfer was not steady, but able to stabilize without staff assistance; balance walking, turning around while walking, moving on and off toilet was not steady, only able to stabilize with staff assistance (decline since October MDS); had limited range of motion to upper and lower extremities on one side; and mobility devices: Wheelchair. The Resident Plan of Care documented, Problem date: 4/2/14 .is at risk for fall related injury .Has history of falls .Approaches .Use fall risk screen to identify risk factors .PT (physical therapy), OT (occupational therapy) to eval (evaluate) and treat as indicated. The care plan did not address the identified risk factors from the fall risk screen. There were no documented interventions to alert staff to falls, to prevent future falls, or to minimize injuries. i. A Change in Condition Progress Note dated 4/28/14 at 1410 (2:10 p.m.), documented, .R (Resident) appears to be noncompliant c (with) w/c (wheelchair) use. Appears to have laceration to above R eye and edema/bruising to R wrist. Nurses Notes (for additional information on the Change in Condition): CNA called this nurse to (resident room). Observed R on floor on knees c sneakers on at foot of B bed. R w/c beside A bed. R states she was ' trying to go to the bathroom. ' Asked why she didn't use w/c. Stated, ' Accidents happen, I guess I'm just hard headed. ' R has 2.5 cm (centimeter) x 1.1 cm laceration to above R eye, pressure applied swelling and bruising noted. Tx nurse cleansed and applied steri-strips. VS WNL (within normal limits). Denies dizziness, pain. R wrist edema and bruising. Assisted to w/c X 2 using gait belt. (Name) in building. Notifies .N.O. to send to . ER for evaluation and tx. 1) An OLTC Witness Statement Form dated 4/28/14 at 2:00 p.m. documented, I (Name) was coming out of (room number) from doing patient care, emptying linen and garbage. Look to right and (Resident #4) was on her knees by (Name) bed called nurse and reported it . 2) Nurses Notes dated 4/28/14 a 6:00 p.m. documented, .Returned from hospital from fall today. Dx: closed head injury. Facial Laceration. Head Contusion, wrist fx c special instructions rest, ice, elevate. Return for worsening symptoms. Family is aware. 3) An Event Investigation Report dated 4/28/14 documented, .Specify Type of Event: Observed on knees on floor. In room at foot of bed B, Behaviors: Continuously attempt to self-ambulate despite frequent education by staff. Physical Status/Function: Poor balance, unsteady gait, weakness. Activity (What was elder doing or trying to do): Trying to go to the bathroom. Transfer: Type of Transfer Assistance Required-Specify: 1 person assist; Type of Transfer/Amount of Assistance Provided: Attempting to self ambulate; Call Light: In reach of elder? On at time of Event? No; Alarm: Bed or Chair or Floor Mat Alarm Present: Specify: N/A (Not Applicable); Environment: Placement of Furniture/Equipment. Fall Mat Present: No fall mat; Any witnesses to event? No; When was elder last seen? Where? What was elder doing at the time? Last seen in bed by (Name); What does elder state happened? What was different this time? Trying to go to the bathroom; Is there any other pertinent information that may have contributed to this event? R often attempts to self-ambulate. Staff frequently assists R back in w/c and explains importance of using w/c . 4) A Safety Committee Event Investigation Follow-Up Report dated 4/29/14 documented, .Past Interventions Attempted (Include Dates): 11/14/13 sent to hospital & admitted ; 12/31/13 Educate res. to use call light; 3/9/14 Neuro checks, x-ray-ortho appointment. Describe corrective actions taken to prevent recurrence of this event: Continue neuro checks, F/U ortho doctor 7-10 days, B&B (Bowel and Bladder) X 2 wks, cont tx as orders indicate. j. On 6/10/14 at 12:12 p.m., the resident was observed up in a wheelchair in the dining room. At 2:15 p.m., the resident was up in the wheelchair in her room. At 3:25 p.m., the resident was in the dining room playing bingo. There was no kind of device on the wheelchair to alert staff if the resident attempted to stand. On 6/11/14, the resident was observed up in a wheelchair at 8:43 a.m. (in her room), at 11:00 a.m. (in dining room), and at 5:15 p.m. (in day room). There was no kind of device on the wheelchair to alert staff if the resident attempted to stand. On 6/13/14 at 11:40 a.m., the resident was up in a wheelchair in her room. k. On 6/12/14 at 11:33 a.m., the DON was asked, After (Resident #4) fell on [DATE] what interventions did you put in place to prevent future falls? The DON stated, I think the only thing we did was to continue her therapy and ask them to work on her strengthening. We continued the falling star program but we did not add any alarms, and we always try to keep things in (Resident #4's) reach so she doesn't have to get up. The DON stated, I was not here for all the falls just the March and April falls. She was ambulatory prior to the fall in October, then when she had the fall in November she had the sling on and was no longer able to use her walker. That's what I was told. At 4:05 p.m., the DON was asked, Is (Resident #4) continent or incontinent at this time? The DON stated, She has periods of incontinence but she will go to the bathroom when we take her. The DON was asked, Do you have to take her to the bathroom? The DON stated, Yes, I haven't seen her but I do believe (Resident #4) at times would attempt to take her-self to the bathroom. The DON was asked, Do you think that would be safe? The DON stated, I do not think that would be safe for her to do that independently. The DON was asked, What interventions have you put into place to alert your staff she was attempting to get up unassisted to prevent her from falling and sustaining another injury? The DON stated, Nothing else than what we have already talked about and that is staff awareness to take her to the bathroom routinely and staff awareness to watch her while she is in her room. We don't have documentation but the staff does have a routine to take her with rounds and when they see her in her room to assist her with toileting.
F 0332 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of the 4:00 p.m. medication pass on 7/29/14 and the 8:00 a.m. medication pass on 7/30/14 and record review, the facility failed to ensure physician's orders were followed to ensure the medication error rate was less than 5% and prevent potential complications for 3 (Residents #14, #15 and #16) of 7 residents observed during the medication passes. Medication errors were made by 2 Licensed Practical Nurses (LPNs) #3 and #4 of 5 nurses who administered medication. This failed practice had the potential to affect 56 residents who received medication from LPNs #3 and #4, as identified by the Administrator on 7/30/14. The medication error rate was 8.33% based on observation of 48 medications administered and a total of 4 errors detected. The findings are: 1. Resident #14 had [DIAGNOSES REDACTED]. a. A Physician Order dated 3/19/14 documented, Calcium - 500 mg (milligrams) with Vitamin D 200 Intl (international) Units 1 tab (tablet) po (by mouth) qd (daily). b. On 7/30/14 at 8:30 a.m., during the 8:00 a.m. medication pass, LPN #3 administered 1 tablet of [MEDICATION NAME] Plus 630 mg with Vitamin D3 500 Intl Units. 2. Resident #15 had [DIAGNOSES REDACTED]. a. A Physician Order dated 3/6/14 documented, Calcium 500 mg with Vitamin D 200 Intl Units 1 tab po BID (twice daily). A Physician Order dated 11/13/12 documented, Vitamin B 12 500 mcg (micrograms) oral tablet 2 tabs po qd. b. On 7/30/14 at 8:35 a.m., during the 8:00 a.m. medication pass, LPN #3 administered 1 tablet of [MEDICATION NAME] Plus (Calcium) 630 mg with Vitamin D 3 500 International Units, and administered 1 tablet of Vitamin B 12 500 mcg, instead of 2 as ordered. This resulted in 2 medication errors. 3. Resident #16 had [DIAGNOSES REDACTED]. a. A Physician Order dated 1/13/13 documented, Carvedilol 6.25 mg oral tablet 1 tab po BID with food. b. On 7/30/14 at 9:15 a.m., during the 8:00 a.m. medication pass, LPN #4 administered the Carvedilol without food. c. On 7/30/14 at 11:50 a.m., LPN #5 stated the resident's breakfast tray was served sometime between 7:30 and 7:45 a.m.
F 0333 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of the 9:00 a.m. medication pass on 6/11/14 and record review, the facility failed to ensure physician's medication orders were followed to prevent significant medication errors, which could result in complications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **045305**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **06/16/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHERN TRACE REHABILITATION AND CARE CENTER	**22515 I 30** **BRYANT, AR 72022**

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 0333 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) for 1 (Resident #13) of 6 residents observed during the medication pass. This failed practice had the potential to affect 4 residents who had a physician order [REDACTED]. 1. Resident #13 had a [DIAGNOSES REDACTED]. a. A physician order [REDACTED]. b. On 6/11/14 at 7:28 a.m., Licensed Practical Nurse (LPN) # 1 administered [MEDICATION NAME] 30 mg instead [MEDICATION NAME] mg. Imdur: [MEDICATION NAME] tablets (extended-release): 30 mg. as documented in the 2013 Nursing: Drug Handbook. Lippincott Williams & Wilkins (p. 767). [MEDICATION NAME]: [MEDICATION NAME] tablets (is not provided in extended release formula) as documented in the 2013 Nursing: Drug Handbook. Lippincott Williams & Wilkins (p. 767). c. On 6/11/14 at 10:15 a.m., when asked to review the resident's medications, the provider pharmacy stated only [MEDICATION NAME] had been dispensed for this resident since the 3/28/14 start date. d. As of 6/11/14, the resident's March 2014 through June 2014 Medication Administration Record [REDACTED]. Nurses' initials were documented from 3/28/14 through 6/11/14 to indicate 76 doses had been administered. f. This medication error was significant due to the frequency of the error.
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure infection control measures were consistently practiced by employees, as evidenced by: failure to ensure licensed nursing staff washed their hands after each direct resident contact during medication pass, in order to prevent cross contamination and the potential spread of infection for 3 (Residents #4,#6 and #17) of 5 (Resident's #4, #6, #13, #14 and #17) case mix residents who received medications from Licensed Practical Nurses (LPNs) #1, #2 and #3; failure to ensure isolation trash and linens were properly contained and kept off of the floor to prevent potential cross-contamination for 1 (Resident #1) of 2 (Residents #1 and #6) case mix residents who required contact isolation; and, failure to ensure an enteral feeding tube tip was covered when not in use to prevent potential contamination that could lead to infection or illness for 1 (Resident #4) of 1 case mix residents who received tube feedings. The failed practices had the potential to affect 64 residents who received medications from LPNs #1, #2 and #3; 3 residents who required isolation precautions and 4 residents who received tube feedings, as documented on lists provided by the Administrator on 7/30/14. The findings are: 1. Resident #17 had a [DIAGNOSES REDACTED]. On 7/29/14 at 4:15 p.m., Licensed Practical Nurse (LPN) #1 administered eye drops to Resident #17 without wearing gloves. After administering the eye drops and without washing her hands, LPN #1 left the room, went to the medication cart and began setting up another resident's medications; opening capsules and placing the contents into applesauce. On 7/30/14 at 2:30 p.m., LPN #1 was asked, Should you wash your hands between administering eye drops and setting up new medications? She stated, Yes. 2. Resident #6 had [DIAGNOSES REDACTED]. On 7/29/14 at 5:00 p.m., LPN #2 entered Resident #6's isolation room. LPN #2 performed a fingerstick blood sugar test on the resident. Without washing his hands, LPN #2 left the room, went to the medication cart and began setting up medications for another resident. 3. Resident #4 had [DIAGNOSES REDACTED]. a. On 7/30/14 at 8:20 a.m., LPN #3 stopped Resident #4's feeding tube and, with her ungloved hands, capped the resident's gastrostomy tube. The tip of the feeding tube touched the resident's skin and gown and, as the LPN brought the tip up toward the feeding pump pole, the tip touched the LPN's chin. The LPN draped the tubing over the pole and completed the medication pass for the resident. After flushing the gastrostomy tube LPN #3 connected and restarted the resident's tube feeding. b. On 7/30/14 at 2:30 p.m., LPN #3 was asked, When you disconnect the feeding tube, should the tip have touched the resident's skin or gown? She stated, No, it should not have. She was asked, Should it have touched your own skin? She stated, No, it should not have touched anything. She was asked, Should the tubing be draped over the pole uncovered? She stated, It should have the cap on it. 4. Resident #1 had a [DIAGNOSES REDACTED]. a. The July 2014 Physician order [REDACTED]. b. On 7/29/14 at 11:40 a.m., an isolation gown and used gloves were on the floor next to the trash can in the resident's bathroom. The resident was sitting in a recliner in her room at this time. 5. The Lippincott Manual of Nursing Practice provided by the Administrator on 7/30/14 documented, .1. Hand hygiene is the single-most important measure to reduce the risks of transmitting microorganisms . 4. When C. (Clostridium) difficile associated disease is suspected or confirmed, hand hygiene with soap, warm water and friction for 15 seconds is recommended, as the spores this organism forms are resistant to alcohol hand gel . Care of Equipment . 1. Soiled linen should be handled, transported and laundered in a manner that avoids transfer of microorganisms.
F 0490 **Level of harm -** Actual harm **Residents Affected -** Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the Facility Administration and the Nursing Administration failed to ensure the development and implementation of interventions to prevent falls and to minimize risk of serious injury and to ensure interventions were re-evaluated for effectiveness when the resident had repeated falls for 1 (Resident #4) of 9 (Resident #1, #3, #4, #9, #10, #11, #12, #15 and #18) case mix residents who were at risk for falls. This failed practice resulted in a pattern of actual harm for Resident #4, who had 5 documented falls resulting in 3 fractures with no new interventions implemented to prevent future injuries due to recurrent falls, and had the potential to cause more than minimal harm for 17 residents at risk for falls, as documented on a list provided by the Administrator on 8/18/14 at 10:54 a.m. The findings are: 1. The Administrator Job Description provided by the Administrator on 6/16/14 at 3:45 pm. documented, Purpose of Your Job Description: The primary purpose of your job position is to direct the day to day functions of the facility in accordance with current Federal, State and local standards, guidelines and regulations that govern the Long-Term Care Facility to assure that the highest degree of quality care can be provided to our residents at all times. Major Duties and Responsibilities: Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed. Safety and Sanitation: .Review accident/incident reports and establish and effective accident prevention program. The Director of Nursing Job Description provided by the Administrator on 6/16/14 at 3:07 p.m. documented, .General Purpose: To direct and manage the overall operation of the Nursing Department in accordance with Company policies, standards of nursing practice and applicable governmental regulations to promote quality of care of all our residents. Essential Job Functions: 8. Provide residents a comfortable, clean, orderly and safe environment. 27. Review findings and implement appropriate interventions/corrective action in response to Infection Control Reports, Medication Incident Reports and Patient Incident Reports . 2. Resident #4 was admitted on [DATE] and had [DIAGNOSES REDACTED]. A Quarterly MDS with an Assessment Reference Date of 10/8/13 documented the resident had a BIMS score of 12, was moderately impaired decision making; required supervision with set-up help only for transfer, walking in room/corridor and locomotion on/off unit; behaviors included wandering; balance moving from seated to standing, walking, turning around while walking and moving on/off toilet was not steady, but able to stabilize without staff assistance; and was always continent of bowel and urine. a. A Fall Risk Assessment with an assessment date of 10/14/13 documented the resident scored 16. A score of 12 or greater indicates resident is at high risk for falls. b. Nurse's Notes dated 11/14/13 at 9:15 a.m., documented, This nurse in hallway passing meds (medication). R (resident) yelled, ' Somebody help me ' This nurse walked in R room and observed R on both knees and holding on to bed. Observed blood on floor. Walker beside R. Observed laceration to right side of head, very small. Observed red spot to top of right shoulder. Asked R to move right arm. R attempted to lift right arm and stated ' I can't, that hurts. ' Observed ST (skin tear) x (times) 2 to top of L (left) ring finger. TX (treatment) nurse applied tx. R stated ' I was leaning over and fell and hit my head on the bed. ' Notified (family) . and (Doctor ' s) APN (Advanced Practice Nurse) . N.O. (new order) to send to . ER (emergency room). Left facility at 1000 (10:00 a.m.). 1) The resident's 'Hospital History and Physical' report dated 11/14/13 at 2:23 p.m. documented, .Admission Diagnosis: [REDACTED]. 2. Scalp Contusion. 3. [MEDICAL CONDITION]. History of Present Illness: The patient is a [AGE] year-old female who presented to the emergency room after she tripped and fell and hit her head. She has a past medical history of [REDACTED]. At the time of presentation to the emergency room her blood pressure was 118/82, her pulse was 76, respirations 20, temperature 98 and oxygen saturation was 98 percent. Onset was today. She fell from a standing position. She suffered a contusion and a humerus facture. The location of the pain was her head and her right upper extremity. Severity on ambulation was moderate pain, worse with movement. Baseline neurologic status is normal. Contributing factors: She does not recall why she fell and she does not remember the fall. Associated symptoms after the fall including being dazed and had a headache and was confused.X-ray revealed a positive humeral head fracture and right humeral fracture. 2) The resident's 'Post Fall Assessment' with an assessment date of 11/14/13 documented the resident scored 16. A score 12 or greater indicates resident is at high risk for falls. 3) A 'Fall Investigation Follow-up' dated 11/15/13 documented, .Date of Incident: 11/14/13, Description of Situation: This nurse observed R in room on knees. Blood on floor. Laceration to R side of head. Bruise to R shoulder. ST x 2 to L ring finger. R could not move R arm. R stated, ' I was leaning over and hit my head on the bed when I fell . ' Notified MD (Medical Doctor). N.O. send to . ER. R walker beside R at time of fall.

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NAME OF PROVIDER OF SUPPLIER **SOUTHERN TRACE REHABILITATION AND CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **22515 I 30 BRYANT, AR 72022**	

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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 0490 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 4) Summary of Investigation: R noted to have behaviors consisting of moving furniture, leaning or reaching to pick things up out of floor. Recommendations and/or New Interventions: 1. Assessed R, sent to hosp & admitted . 2. Cont. (continue) on Falling Star Program. 3. Therapy screen . The Interdisciplinary Fall Team Meeting dated 5/9/14 documented, .(Resident #4) added to the Falling Star List on 11/5/13 . c. A facility 'Patient Progress Note' dated 11/19/13 documented, .Chief Complaint/Review of Systems: Staff nurse reports that R was recently sent to Hosp for fall and cut to head, DX [MEDICAL CONDITION] and FX (fractured) Humerus; Physical exams: General: Up in w/c (wheelchair) self-propelling in hall. NAD (No Apparent Distress) HEENT (Head, eyes, ears, nose, throat): normocephalic, Bruising to Forehead, EXT: (Extremities) Sling to right arm; + (positive) swelling L (left) hand c (with) decreased ROM (Range of Motion), Rt (Right) shoulder Fx of proximal humerus neck. Todays Assessment: 1. Hospital follow-up, 2. Right Humerus fracture, 3. Hx. (History) [MEDICAL CONDITION]. PLAN: 1. Follow up c (Doctor) ortho if not already scheduled need to schedule a follow up. 2. X-ray left hand and fingers in AM (morning) due to swelling and decrease ROM. A facility 'Patient Progress Note' dated 11/26/13 documented, .Chief Complaint/Review of Systems: following c (with) ortho for humerus & small finger, Physical exams: ext(extremities): R arm in sling; + bruising & swelling; swelling improved; Lab: x-ray L hand fx at proximal phalanx small finger, Todays assessment: 1. R humerus fracture, 2. fracture proximal phalanx of small finger L hand. d. Nurse's Notes dated 12/31/13 at 2:15 p.m. documented, R found kneeling on one knee holding on to front of w/c. R observed for injury: none noted. Assisted to w/c. R stated, ' I slipped. I did not hit my head. ' R c/o (complained of) pain to right arm c sling in place. Notified Dr. nurse . Notified (family). Will cont. to monitor. An 'Event Investigation Report' dated 12/31/13 documented, Time of Incident: 1415 (2:15 p.m.), Location of Incident: Room. Document an Exact Description of the Incident/Accident and Circumstances Surrounding It: R observed knelt down on one knee holding front of w/c. R observed for injury, none noted. Assisted to w/c. R stated, ' I slipped. I did not hit my head. ' R c/o pain to right arm c sling in place. Will cont. to monitor. R stated, ' I was trying to get my w/c and I slipped onto the floor ' . An 'Investigation Follow-up Report' dated 1/2/14 documented, Recommendations: Educate resident to use call light when wanting to transfer .Contributing Medical Condition; Non-compliance, Weakness. e. An Event Investigation Report dated 1/9/14 documented, .Time of Incident: 1:40 a.m., Location of Incident: Room; Document an Exact Description of the Incident/Accident and Circumstances Surrounding It: Called to room by CNA (Certified Nursing Assistant) ., found R sitting on floor c/o hitting head; no hematoma noted neuro checks started moves all extremities no c/o HA (head ache). RUE (right upper extremity) weakness R/T (related to) fx ; alert and oriented. Recommendations and/or Interventions: Cont (Continue) c therapy to work on safety awareness. Fall Investigation: .3. What did the resident say they were trying to do or go? Going to bathroom. . 7. Did the resident use their walker, cane, w/c, etc? No. .12. Was the call light on? No. If not, was it in reach of the resident? Yes. .Was the call light working? Yes. .20. Did you start an in-service for the new intervention? This area was left blank. **Cannot use the intervention to call for assist and wait for help if they have Dementia and/or are confused. **You must try to figure out why they fell and put an intervention in place to prevent another fall . The Office of Long Term Care (OLTC) 'Witness Statement Form' dated 1/8/14 (actually 1/9/14) at 1:30 a.m. documented, .State in your own words what you witnessed (be very descriptive) and sign below. I was walking up the hall from 500 hall when I heard (Resident #4) ask for help out of the floor. I then went and got the nurse to come and help me. I helped the nurse get (Resident #4) up out of the floor. As of 6/10/14 at 2:30 p.m., there was no documentation of new interventions implemented to prevent further falls or injuries. f. Nurses Notes dated 3/5/14 at 2:05 p.m. documented, At approx (approximately) 1130 this nurse passing meds (medication) in hall heard R yelling ' help me. ' Entered (resident room), observed R w/c beside bed A. R observed in bathroom on knees c blood on floor and forehead. Neuro check done immediately, WNL (Within Normal Limits). VS (Vital Signs) WNL. FSBS (Finger Stick Blood Sugar) 90. L hand grip strong. R (right) hand swelling c pain, unable to grip. Forehead cleaned, pressure applied to stop bleeding. TX (treatment) nurse notified. Small abrasion observed p (after) cleaned. Denies nausea, dizziness, or lightheadedness and blurry vision. . notified. Ordered x-ray to r (right) hand and wrist. APAP 650 mg (milligram) q (every) 4 hours PRN (as needed) for pain. 1) An Event Investigation Report dated 3/5/14 documented, .Location of incident: Room; Document an Exact Description of the Incident/Accident and Circumstances Surrounding It: This nurse in hall passing meds. Heard R yelling, ' Help me. ' Entered (resident room) observed R w/c sitting beside bed A. R on knees in bathroom, blood on floor and front of forehead. R stated she was ' brushing hair. ' This nurse call another staff member to get help. 2 nurses assisted R to w/c. Tx nurse notified. Physician notified: Yes; Specific orders: x-ray to hand & wrist. 2) A Fall Investigation Report & Follow-Up dated 3/5/14 documented, .Contributing Medical Condition: Non-compliance; Resident Activity: Attempting to transfer unassisted; Devices: Wheelchair; Resident Symptoms at Time of Fall: Legs gave away; Document interventions/plan below. Inform staff of plan: Assisted R to w/c and dining room. Neuro checks, x-ray, Ortho appt. (appointment) . 3) An x-ray report dated 3/5/14 documented, .Technique: Right hand, 3 views.; Findings: There is fracture at the distal radius with extension to the distal radial articular surface. There is also a new fracture at the ulnar styloid process. There is minimal displacement. No other fracture is seen. No evidence of dislocation. Impression: Acute fractures of the ulnar styloid process and the distal radius . g. A Physician order [REDACTED]. As of 6/10/14 at 2:35 p.m., there was no documentation of new interventions implemented to prevent further falls or injuries. h. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/14 documented the resident scored 7 (0-7 indicates severe impairment) on a Brief Interview for Mental Status (BIMS) (decline since October MDS); required extensive assistance of one person for ambulation in room/corridor, dressing, personal hygiene and bathing and limited assistance of one person for transfer and toilet use (decline since October MDS); balance moving from seated to standing position, surface to surface transfer was not steady, but able to stabilize without staff assistance; balance walking, turning around while walking, moving on and off toilet was not steady, only able to stabilize with staff assistance (decline since October MDS); had limited range of motion to upper and lower extremities on one side; and mobility devices: Wheelchair. The Resident Plan of Care documented, Problem date: 4/2/14 .is at risk for fall related injury .Has history of falls .Approaches .Use fall risk screen to identify risk factors .PT (physical therapy), OT (occupational therapy) to eval (evaluate) and treat as indicated. The care plan did not address the identified risk factors from the fall risk screen. There were no documented interventions to alert staff to falls, to prevent future falls, or to minimize injuries. i. A Change in Condition Progress Note dated 4/28/14 at 1410 (2:10 p.m.) documented, . R appears to be noncompliant c (with) w/c (wheelchair) use. Appears to have laceration to above R eye and [MEDICAL CONDITION]/bruising to R wrist. Nurses Notes (for additional information on the Change in Condition): CNA called this nurse to (resident room). Observed R on floor on knees c sneakers on at foot of B bed. R w/c beside A bed. R states she was ' trying to go to the bathroom. ' Asked why she didn't use w/c. Stated, ' Accidents happen, I guess I'm just hard headed. ' R has 2.5 cm (centimeter) x 1.1 cm laceration to above R eye, pressure applied swelling and bruising noted. Tx nurse cleansed and applied steri-strips. VS WNL (within normal limits). Denies dizziness, pain. R wrist [MEDICAL CONDITION] and bruising. Assisted to w/c X 2 using gait belt. (Name) in building. Notifies .N.O. to send to . ER for evaluation and tx. 1) An OLTC Witness Statement Form dated 4/28/14 at 2:00 p.m. documented, I (Name) was coming out of (room number) from doing patient care, emptying linen and garbage. Look to right and (Resident #4) was on her knees by (Name) bed called nurse and reported it . 2) Nurses Notes dated 4/28/14 a 6:00 p.m. documented, .Returned from hospital from fall today. Dx: closed head injury. Facial Laceration. Head Contusion, wrist fx c special instructions rest, ice, elevate. Return for worsening symptoms. Family is aware. 3) An Event Investigation Report dated 4/28/14 documented, .Specify Type of Event: Observed on knees on floor. In room at foot of bed B, Behaviors: Continuously attempt to self-ambulate despite frequent education by staff. Physical Status/Function: Poor balance, unsteady gait, weakness. Activity (What was elder doing or trying to do): Trying to go to the bathroom. Transfer: Type of Transfer Assistance Required-Specify: 1 person assist; Type of Transfer/Amount of Assistance Provided: Attempting to self ambulate; Call Light: In reach of elder? On at time of Event? No; Alarm: Bed or Chair or Floor Mat Alarm Present: Specify: N/A (Not Applicable); Environment: Placement of Furniture/Equipment. Fall Mat Present: No fall mat; Any witnesses to event? No; When was elder last seen? Where? What was elder doing at the time? Last seen in bed by (Name); What does elder state happened? What was different this time? Trying to go to the bathroom; Is there any other pertinent information that may have contributed to this event? R often attempts to self-ambulate. Staff frequently assists R back in w/c and explains importance of using w/c . 4) A Safety Committee Event Investigation Follow-Up Report dated 4/29/14 documented, .Past Interventions Attempted (Include Dates): 11/14/13 sent to hospital & admitted ; 12/31/13 Educate res. to use call light; 3/9/14 Neuro checks, x-ray-ortho appointment. Describe corrective actions taken to prevent recurrence of this event: Continue neuro checks, F/U ortho doctor 7-10 days, B&B (Bowel and Bladder) X 2 wks, cont tx as orders indicate. j. On 6/10/14 at 12:12 p.m., the resident was observed up in a wheelchair in the dining room. At 2:15 p.m., the resident was up in the wheelchair in her room. At 3:25 p.m., the resident was in the dining room playing bingo. There was no kind of device

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHERN TRACE REHABILITATION AND CARE CENTER	**22515 I 30** **BRYANT, AR 72022**

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F 0490 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 5) on the wheelchair to alert staff if the resident attempted to stand. On 6/11/14, the resident was observed up in a wheelchair at 8:43 a.m. (in her room), at 11:00 a.m. (in dining room), and at 5:15 p.m. (in day room). There was no kind of device on the wheelchair to alert staff if the resident attempted to stand. On 6/13/14 at 11:40 a.m., the resident was up in a wheelchair in her room. k. On 6/12/14 at 11:33 a.m., the DON was asked, After (Resident #4) fell on [DATE] what interventions did you put in place to prevent future falls? The DON stated, I think the only thing we did was to continue her therapy and ask them to work on her strengthening. We continued the falling star program but we did not add any alarms, and we always try to keep things in (Resident #4's) reach so she doesn't have to get up. The DON stated, I was not here for all the falls just the March and April falls. She was ambulatory prior to the fall in October, then when she had the fall in November she had the sling on and was no longer able to use her walker. That's what I was told. At 4:05 p.m., the DON was asked, Is (Resident #4) continent or incontinent at this time? The DON stated, She has periods of incontinence but she will go to the bathroom when we take her. The DON was asked, Do you have to take her to the bathroom? The DON stated, Yes, I haven't seen her but I do believe (Resident #4) at times would attempt to take her-self to the bathroom. The DON was asked, Do you think that would be safe? The DON stated, I do not think that would be safe for her to do that independently. The DON was asked, What interventions have you put into place to alert your staff she was attempting to get up unassisted to prevent her from falling and sustaining another injury? The DON stated, Nothing else than what we have already talked about and that is staff awareness to take her to the bathroom routinely and staff awareness to watch her while she is in her room. We don't have documentation but the staff does have a routine to take her with rounds and when they see her in her room to assist her with toileting.