STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	02/27/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLENBRIDGE HEALTH AND REHABILTATION CENTER	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607

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 0159 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Properly hold, secure and manage each resident's personal money which is deposited with the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, record reviews, and staff interviews, the facility failed to send quarterly statements to 5 of 5 alert and oriented residents sampled for facility management of funds. (Residents #7, #50, #68, #71,and #157). The findings included: 1. Resident #50 was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Her Minimum Data Set (MDS), a significant change dated 12/10/14, coded her as having no cognitive impairments, scoring 15 out of 15 on the Brief Interview for Mental Status. On 02/17/15 at 11:04 AM she stated that she had a personal fund account managed by the facility but she never received a statement informing her of the balance. On 02/19/15 at 3:24 PM Business Office Staff #1 stated resident fund statements were sent to responsible parties on a quarterly basis. If a resident was their own responsible party or did not have a responsible party then the statements were sent to the resident. Resident #50's quarterly statement were sent to her responsible party. She confirmed Resident #50 did not receive a quarterly account statement. Follow up interview with Resident #50 on 02/24/15 at 9:57 AM revealed she wanted a statement informing her of how much money she had in her account. On 02/27/15 at 9:50 AM the Administrator stated that they were going to review each residents' cognition assessment and determine who should receive a copy of their own quarterly statements. 2. Resident #7 was readmitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Her quarterly Minimum (MDS) data set [DATE] coded her as cognitively intact, scoring a 13 out of 15 on the Brief Interview for Mental Status. On 02/17/15 at 10:57 AM Resident #7 stated the facility managed her personal funds account. On 02/19/15 at 3:24 PM Business Office Staff #1 stated resident fund statements were sent to responsible parties on a quarterly basis. If a resident was their own responsible party or did not have a responsible party then the statements were sent to the resident. Resident #7's quarterly statements were sent to her family. Business Office Staff #1 confirmed Resident #7 did not receive quarterly account statements. Upon follow up interview on 02/24/15 at 11:22 AM, Resident #7 stated she thought she had some money in her account but wanted to receive a statement informing her of the balance in addition to her family receiving the statement. On 02/27/15 at 9:50 AM the Administrator stated that they were going to review each residents' cognition assessment and determine who should receive a copy of their quarterly statements. 3. Resident #68 was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. His quarterly Minimum (MDS) data set [DATE] coded him as being cognitively intact scoring a 15 out of 15 on the Brief Interview for Mental Status. During interview on 02/16/15 at 2:19 PM he stated the facility managed a personal fund account for him but that he received no statement regarding the balance. On 02/19/15 at 3:24 PM Business Office Staff #1 stated resident fund statements were sent to responsible parties on a quarterly basis. If a resident was their own responsible party or did not have a responsible party then the statements were sent to the resident. Resident #68's quarterly statements were sent to his family. Business Office Staff #1 confirmed Resident #68 did not receive quarterly account statements. A follow up interview with Resident #68 on 02/24/15 at 10:08 AM revealed he wanted to receive a quarterly balance of his personal fund account. On 02/27/15 at 9:50 AM the Administrator stated that they were going to review each residents' cognition assessment and determine who should receive a copy of their quarterly statements. 4. Resident #71 was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Her quarterly Minimum (MDS) data set [DATE] coded her as being cognitively intact scoring a 15 out of 15 on the Brief Interview for Mental Status. On 02/17/15 at 1:36 PM she stated she had a personal fund account managed by the facility. On 02/19/15 at 3:24 PM Business Office Staff #1 stated resident fund statements were sent to responsible parties on a quarterly basis. If a resident was their own responsible party or did not have a responsible party then the statements were sent to the resident. Resident #71's quarterly statements were sent to her family. Business Office Staff #1 confirmed Resident #71 did not receive quarterly statements. Upon follow up interview on 02/24/15 at 10:08 AM, Resident #71 stated it was alright with her that her family received her personal fund statements. On 02/27/15 at 9:50 AM the Administrator stated that they were going to review each residents' cognition assessment and determine who should receive a copy of their quarterly statements. 5 Resident #157 was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Her most recent Minimum Data Set, an annual assessment dated [DATE] coded her as having no cognitive impairments, scoring a 15 out of 15 on the Brief Interview for Mental Status. On 02/16/15 at 2:22 PM, Resident #157 stated the facility managed her personal funds and she did not receive a statement quarterly informing her of her balance. On 02/19/15 at 3:24 PM Business Office Staff #1 stated resident fund statements were sent to responsible parties on a quarterly basis. If a resident was their own responsible party or did not have a responsible party then the statements were sent to the resident. Resident #157's quarterly statement was sent to her family. Business Office Staff #1 confirmed Resident #157 did not receive quarterly account statements. On 02/24/15 at 11:23 AM, Resident #157 was interviewed again and stated that it was alright if her family received her statements. On 02/27/15 at 9:50 AM the Administrator stated that they were going to look at each residents' cognition assessment and determine who should receive a copy of their quarterly statements.
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 observations, record review and staff interviews, the facility failed to maintain the dignity of residents during

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 0241 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) tray meal service for 5 of 8 residents sampled for dignity. Staff failed to knock on doors before entering residents' rooms with their meal tray (Resident #4 and #50) and staff stood over residents while feeding them (Residents #29, #56, and #106). The findings included: 1. Resident #56 was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Her Minimum (MDS) data set [DATE] coded her as having long and short term memory impairment and severely impaired decision making skills. She was coded as requiring total assistance with eating. On 02/16/15 at 11:25 AM, Nursing Assistant (NA) #3 was observed feeding Resident #56. NA #3 stood while Resident #56 was seated in her wheelchair and NA #3 bent over the resident with each bite as she fed Resident #56. She continued feeding Resident #56 while standing at 12:26 PM. On 02/24/15 at 9:34 AM, NA #3 was interviewed. She stated she had been instructed to stand as she fed residents and not to sit in a chair or on the resident's bed. On 02/19/15 at 5:24 PM Resident #56 was observed sitting in bed which was lowered to the floor. NA #9 was observed sitting in a chair by the bed, the tray in front of the NA. NA #9 would spoon up a bite of food, reach over, lean down and feed the resident each bite. She would hand the cup to Resident #56 and she drank from the cup independently. NA #9 was interviewed on 02/19/15 at 5:41 PM. She related that this was the first time she had fed Resident #56 but that she often assisted with feeding residents at lunch time. She stated she did not think to raise the bed and position the food so she could see it. She stated she should have positioned the resident better. On 02/24/15 at 2:22 PM the Director of Nursing and the Assistant Director of Nursing #2 were interviewed and stated that they expected staff to position themselves at eye level with the resident when they were feeding a resident during meals. 2. Resident #106 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Her quarterly Minimum Data Set, a quarterly dated 01/12/15 coded that she was rarely or never understood and could not be assessed for memory impairments, but that she was coded for having severely impaired decision making skills and needing total assistance with feeding. On 02/19/15 at 5:29 PM, Nurse Aide (NA) #7 was observed feeding Resident #106 while she was in bed. NA #7 was observed standing at bedside leaning over Resident #106 while he fed her each bite. NA #7's waist was at the same height as the resident's face. NA #7 finished feeding Resident #106 via standing at 5:52 PM. On 02/19/15 at 5:52 PM NA #7 was interviewed. He stated that he had been employed at the facility approximately 3 months and normally always stood when he fed residents. He further stated he was trained to sit while he fed but sometimes could not locate a place to sit so he put the bed as high as it would go and fed her standing up. Interview with the Director of Nursing and Assistant Director of Nursing #2 stated that they expected staff to feed residents at eye level. 3. Resident #50 was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Her Minimum Data Set (MDS), a significant change dated 12/10/14, coded her as having no cognitive impairments, scoring a 15 out of 15 on the Brief Interview for Mental Status. On 02/19/15 at 5:19 PM Nurse Aide (NA) #7 did not knock on Resident #50's door before entering with the meal tray. Interview with Resident #50 on 02/19/15 at 5:22 PM revealed she did not hear him knock and she did not like that he entered without knocking. On 02/19/15 at 5:25 PM NA #7 was interviewed about knocking on resident doors, he stated that he did not knock on Resident #50's door because he forgot. He further stated he had been here 3 months and knew he was supposed to knock on the resident door before entering. Interview with the Director of Nursing and Assistant Director of Nursing #2 on 02/24/15 at 2:26 PM revealed they expected staff to knock anytime they entered a resident's room. 4. Resident #29 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the most recent quarterly Minimum Data Set ((MDS) dated [DATE] indicated short term and long term memory problems and severe impairment in cognition for daily decision making. The MDS also indicated Resident #29 was independent with eating and required set up help only. During an observation on 02/19/15 at 5:35 PM Resident #29 was sitting in a wheelchair in her room with a meal tray in front of her on an overbed table. Resident #29 had a spoon in her left hand and was feeding herself small bites of food. At 5:47 PM Resident #29 laid the spoon on her plate and stopped feeding herself. At 5:52 PM Nurse Aide (NA) #10 walked into Resident #29's room and asked if she was still eating and then NA #10 picked up the spoon and started feeding Resident #29 while standing next to her and over her. NA #10 continued to feed Resident #29 while standing until 6:05 PM when Resident #29 started shaking her head and stated no,no,no. During an interview on 02/19/15 at 6:20 PM with NA #10 she stated sometimes Resident #29 fed herself and ate well but sometimes she didn't. She explained she tried to encourage Resident #29 to eat and offered her food to eat when she stopped eating. She stated it was her usual routine to stand next to Resident #29 where she could see her while she fed her. She further stated she had not had any in-services regarding sitting or standing while feeding residents and there was no policy that she was aware of. During an interview on 02/24/15 at 2:22 PM the Director of Nursing and Assistant Director of Nursing #2 stated they expected staff to position themselves at eye level with the resident when they fed them during meals. 5. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the most recent quarterly Minimum Data Set ((MDS) dated [DATE] indicated Resident #4 had short term and long term memory problems and was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #4 required extensive assistance by staff for activities of daily living. During an observation on 02/19/15 at 6:09 PM Nurse Aide (NA) #10 entered Resident #4's room with a meal tray and did not knock before she entered the resident's room. During an interview on 02/19/15 at 6:20 PM with NA #10 she confirmed she entered Resident #4's room with a meal tray without knocking and did not wait for permission to enter the room. She stated she knew she was supposed to knock, introduce herself and then go in. She further stated she tried to knock on resident's doors before she entered the room but when it got busy she just went on in the room without knocking. During an interview on 02/24/15 at 2:26 PM with the Director of Nursing and Assistant Director of Nursing #2 they stated it was their expectation for staff to knock anytime they entered a resident's room. During an interview on 02/26/14 at 12:04 PM with Resident #4 she stated she preferred for staff to knock on her door before they entered the room because she wanted to know who was coming into her room. She further stated she did not like it when staff just barged on in her room without letting her know they were coming in first.
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff, resident and physician interviews the facility failed to do an assessment for 1 resident after she was lowered to the floor by staff while being transferred and failed to assess the resident before she was lifted from the floor into a shower chair for 1 of 12 sampled residents for falls. (Resident #24). Immediate Jeopardy began on 11/15/14 when staff failed to assess Resident #24 after she was lowered to the floor by staff during a transfer. Immediate jeopardy was removed on 02/27/15 at 11:35 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. The findings included: A review of a facility document titled Falls Policy that was not dated, indicated in part, the following procedure is to be followed for any resident that sustains a fall: a full body assessment will be conducted to determine if any injury has occurred and monitored for 24 hours after the fall. Resident #24 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of a Nursing Admission Information sheet dated 02/17/14 indicated Resident #24 was alert and aware, non-verbal but was able to understand others and answered yes and no to questions. The notes also indicated she was dependent for transfers and bed mobility.

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) A review of Resident #24's Fall Risk Assessment on 02/17/14 revealed a score of 14 which indicated a total score of 10 or above represented high risk for falls. A review of a physician's orders [REDACTED]. A review of the admission Minimum Data Set ((MDS) dated [DATE] revealed Resident #24 had severe impairment in cognition for daily decision making. The MDS also indicated Resident #24 was totally dependent on staff for bed mobility and transfers and Resident #24 did not speak but was sometimes understood and usually understood others. The MDS indicated Resident #24 had a fall history with a fall in the last month prior to admission to the facility. A review of a Fall Risk Assessment on 05/24/14 for Resident #24 indicated she was high risk for falls. A review of a care plan with a problem statement for accidents/fall risk with an updated date of 10/25/14 indicated approaches to determine possible causes/patterns associated with falls or accidents and lift for transfers. A review of a care plan with a problem statement for total dependence with an updated date of 10/25/14 indicated Hoyer lift to chair every day. A review of a care plan with a problem statement for activities of daily living with updated date of 10/25/14 indicated lift for transfers and out of bed to chair with lift. A review of the monthly physician's orders [REDACTED]. A review of Medication Administration Records (MARs) for November 2014 indicated activity level for a mechanical lift. A review of nurse's notes dated 11/15/14 revealed there were no nurse's notes during the 7:00 AM - 7:00 PM shift. A review of a nurse's note dated 11/15/14 at 8:30 PM indicated Resident #24 was lying in bed grunting when Nurse #2 went to resident's room to administer bedtime medications. The notes further indicated when the head of the bed was raised Resident #24 began yelling out. The notes revealed Resident #24 was nonverbal due to history of a stroke but could answer questions appropriately by nodding her head for yes and no. The notes further revealed when asked where she was hurting Resident #24 pointed to her right leg. The notes indicated an assessment showed no visual injuries or redness but when an attempt was made to roll Resident #24 over she began screaming loudly and Resident #24's responsible party was notified and hospital was notified for transport to the emergency room . A review of a nurse's note dated 11/15/14 at 9:02 PM revealed emergency medical services (EMS) was in the facility to transport Resident #24 to the hospital emergency room for evaluation. A review of an EMS report dated 11/15/14 indicated EMS was at Resident #24's bedside at 9:03 PM. A section labeled narrative indicated Resident #24 initially stated on scene that she did not fall however upon talking to emergency room staff it was found out that she did indeed have a fall earlier today. A review of a nurse's note dated 11/15/14 at 9:25 PM indicated Nurse #2 had a conference with Nurse Aides (NAs) assigned to care for Resident #24 during the 7:00 PM to 7:00 AM shift and there were no reports of injury received from the previous shift to Nurse #2 or to NAs. A review of a nurse's note dated 11/16/14 at 12:30 AM indicated Nurse #2 called the hospital and was informed Resident #24 was admitted to the hospital with [REDACTED].#2 notified Administrative nurse (Assistant Director of Nursing (ADON)) #1 on call and contacted Resident #24's family to give an update. A review of a nurse's note dated 11/16/14 at 12:42 AM indicated staff from the hospital called the facility and reported when Resident #24 was questioned she indicated she had been dropped onto the floor earlier in the day. The notes further indicated Administrative nurse (ADON #1) was notified. A review of a Physician's Report of Consultation dated 11/16/14 indicated a consulting [DIAGNOSES REDACTED].#24 who had a history of [REDACTED]. The notes revealed Resident #24 was found by the nursing staff lying in bed complaining of hip pain and apparently had a history of [REDACTED]. The notes further indicated Resident #24 was brought to the hospital emergency room and x-rays revealed a displaced intertrochanteric/subtrochanteric (upper quarter of the thigh bone) [MEDICAL CONDITION] hip. A review of an Operative report dated 11/17/14 indicated intertrochanteric/subtrochanteric [MEDICAL CONDITION] hip. The notes further indicated surgery was completed with open reduction (to realign bone fracture into normal position) and internal fixation (hardware used to keep bone fracture stable to heal and prevent infection) with a short gamma nail. A review of a facility document titled Investigation of Resident #24's fracture which was not dated but signed by the Director of Nursing (DON) indicated the following summary in part: On the morning of 11/15/14 NA #1 went in to get resident up and ready for shower. NA #1 asked NA #2 to assist with transferring Resident #24 from bed to chair. The 2 NAs attempted to transfer Resident #24 with an arm and arm method. They stood resident without difficulty but when the NAs started to pivot resident to place her in a shower chair the resident went limp and was unable to continue to assist the NAs with the transfer. NAs attempted to place Resident #24 in shower chair but due to her weight was unable to get her safely into the chair. Both NAs report they together slowly lowered resident to the floor. NA #2 went immediately to alert the nurse of the incident and get NA #3 to assist them in putting Resident #24 in the shower chair. Nurse #1 reported she could not confirm or deny she was immediately notified of the incident. NA #3 assisted NA #1 and NA #2 in transferring Resident #24 from floor to shower chair. NAs report Resident #24 did not complain of pain or show signs or symptoms of pain during this transfer. After lunch NA #1 and NA #3 transferred Resident #24 from wheelchair to bed. The resident participated with the transfer and did not complain of pain or show signs or symptoms of pain. At approximately 2:00 PM NA #1 and NA #4 was changing Resident #24 and she started yelling out and grabbing at her leg. NA (not named) asked the resident if she was in pain and she nodded her head yes. NA #4 went to get Nurse #1 and she went to check the resident and reported that both legs looked symmetrical and she didn't see anything out of the ordinary. Nurse #1 noticed Resident #24 was scratching at her groin area and she had just recently administered scheduled Tylenol to Resident #24. Nurse #1 instructed the NAs to clean resident and apply protective ointment. At 4:00 PM Nurse #1 asked Resident #24 if her leg was still hurting and the resident shook her head no. When night shift came in Resident #24 appeared to be in severe pain and Nurse #2 sent resident to the ER and her [DIAGNOSES REDACTED]. During an interview on 02/19/15 at 11:08 AM with Resident #24 she smiled and nodded her head up and down as a response for yes and made repetitive sounds but was unable to form words when spoken to. She nodded her head up and down yes when questioned if she had a hip injury last November. When asked if she had a fall her facial expression changed and she became tearful and attempted to say something but was unable to form the words and then nodded her head vigorously up and down yes. When questioned if her hip was better she shook her head from side to side as a response for no and moved her left hand toward her right hip in a rubbing motion. During an interview on 02/23/15 at 11:48 AM the Assistant Director of Nursing (ADON) #1 stated after review of Resident #24's nurse's notes for 11/15/14 she did not remember being called on 11/15/14 when the resident was sent to the hospital but if the nurses documented they called her then they probably did. She further stated she did not remember going to the facility on [DATE] or 11/16/14. She explained the only thing she remembered was she heard during morning meeting the following week Resident #24 had complained of severe pain in her hip and was sent to the hospital and she had a [MEDICAL CONDITION]. During an interview on 02/23/15 at 12:14 PM the Director of Nursing (DON) upon review of the nurses notes for Resident #24 on 11/15/14 confirmed there were no nurse's notes or nursing assessment during the 7:00 AM to 7:00 PM shift. During a telephone interview on 02/23/15 at 6:44 PM NA #1 explained she and NA #2 were trying to get Resident #24 out of bed into a shower chair on 11/15/14. She stated therapy staff had been working with Resident #24 to stand and transfer her with 2 staff assist and NA #1 stated she had previously stood Resident #24 next to her bed to transfer her and the resident had done fine and that was the way she usually transferred her. She explained during the transfer on 11/15/14 she had her arm under one of Resident #24's armpits and NA #2 had her arm under the other armpit and they stood her up at the bedside but when they turned her to pivot her she went limp. NA #1 stated when Resident #24 started to slide to the floor they tried to lift her up but they couldn't because she was too heavy. She explained when they realized they could not lift her up they lowered her to the floor and she told NA #2 to go get a nurse. NA #1 further explained she held onto Resident #24's shoulders while she sat in the floor and thought her legs were out in front of her. NA #1 stated NA #2 came back with NA #3 and they picked Resident #24 up off the floor and she took her to the shower room and gave her a shower. She stated she did not notice any obvious redness or bruising when she gave Resident her shower and after the shower NA #2 assisted her to stand Resident #24 up from the shower chair and into a wheelchair. NA #1 further stated after lunch she got NA #2 and NA #3 again to transfer Resident #24 and they stood Resident #24 up from her wheelchair and transferred her to bed. She explained about 3 hours after Resident #24 was lowered to the floor she was moaning and holding her right leg and was rubbing it and

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) she reported it to Nurse #1. During a phone interview on 02/26/15 at 5:48 PM received from NA #1 she stated she had remembered when she sent NA #2 to get Nurse #1 the nurse did not come to the resident's room and Resident #24 was not assessed while she was in the floor or when she was lifted into the shower chair or when she was transferred back to bed after lunch. She further stated when NA #3 came back to the room and stated Nurse #1 said to put Resident #24 in the shower chair they lifted her up off the floor and into the chair. During a telephone interview on 02/23/15 at 7:04 PM with NA #2 she stated she went to help NA #1 transfer Resident #24 on 11/15/14 for a shower. She explained they sat Resident #24 up on the side of the bed for a few seconds, then stood her up and turned her towards the left and she started to buckle. She stated Resident #24's right leg did not turn as her upper body turned and she slid down to the floor. She further stated when Resident #24 was in the floor her left leg was straight out but her right leg was crisscrossed under her left leg and was bent at a 90 degree angle at her knee. NA #2 stated she went to get Nurse #1 and the nurse asked if the resident had fallen or slid to the floor and when she told the nurse the resident had slid to the floor the nurse said ok and to go ahead and get Resident #24 up in the shower chair and give her a shower. NA #2 stated she went back to Resident #24's room and she and NA #1 placed their arms under each of Resident #24's armpits and lifted her from the floor and into the shower chair. She stated Resident #24 complained of her right leg hurting a little bit when she was placed in the shower chair but she thought it was caused by pressure on her legs from the shower chair. She stated she did not assist NA #1 during Resident #24's shower and also verified Nurse #1 did not come to Resident #24's room while the resident was in the floor or after they got her into the shower chair. During an interview on 02/24/15 at 1:54 PM with NA #3 she stated NA #1 or NA #2 came and got her to assist with getting Resident #24 off the floor on 11/15/14 because she had slid to the floor. She stated when she went into Resident #24's room the resident was sitting on the floor and she remembered Resident #24's legs were not straight out in front of her because she couldn't straighten her legs out fully due to a previous stroke with paralysis on her right side. She explained she placed her arm under one of Resident #24's armpits and NA #1 placed her arm under Resident #24's other armpit and they lifted her up off the floor while NA #2 held the shower chair. She confirmed Nurse #1 did not come in the room while she was in Resident #24's room and after they placed Resident #24 in the shower chair she left the room to resume her assignment on a different hall. During an interview on 02/23/14 at 8:13 PM with Nurse #1 she confirmed she did not go to Resident #24's room to assess her on 11/15/14 when NA #2 reported the resident had slid to the floor. She stated she was having a very bad day that day and she took full responsibility for not doing what she was supposed to do. She confirmed the only assessment she did was later in the day when Resident #24 was crying out in pain and was reaching toward her peri area and the area was red. She stated she couldn't remember exactly what she saw but remembered she gave Resident #24 some routine Tylenol for pain but did not report it or document it because she did not think anything had happened or that anything needed to be reported or documented. During a telephone interview on 02/23/15 at 7:56 PM with Nurse #2 she stated she worked on the 7:00 PM to 7:00 AM shift on 11/15/14 and that evening the NAs came and got her because they had taken Resident #24 her bedtime snack and she was screaming in pain. She explained she couldn't assess her or touch her because she was in such pain. She further explained Resident #24 had an incontinent episode but they couldn't clean her or turn her because of the pain. She verified she had not received a report from Nurse #1 during shift change that Resident #24 had slid to the floor earlier that day. She stated she sent the resident to the hospital emergency room for evaluation and treatment because Resident #24 did not usually complain of pain and she couldn't figure out why she was having such severe pain. She explained she called the Administrative nurse on call and verified that was ADON #1. She further explained ADON #1 did not come to the facility that night and told her to be sure and document everything so she wrote all she knew in her nurses notes. She stated later that night a nurse from the hospital called and asked about a fall that Resident #24 had earlier that day. She further stated that was the first time she had been told Resident #24 had a fall. During an interview on 02/24/15 at 3:01 PM with Licensed Physical Therapist #1 he explained therapy staff had been working with Resident #24 on standing and transfers with 2 staff assist prior to her fall on 11/15/14. He stated Resident #24's participation varied and some days she would stand but then she would spontaneously sit down. He stated it was his understanding that nursing staff had been transferring Resident #24 with a mechanical lift and the plan of care would have been to use a mechanical lift for transfers until Resident #24 was cleared by therapy to transfer with a maximum assist of 2 staff. During a phone interview on 02/25/15 at 2:00 PM the physician who was also the facility Medical Director stated he was made aware of Resident #24's fall after she had gone to the hospital. He stated the information he had been told about her sliding to the floor did not explain how the fracture happened but he wondered if she had a previous incident or something that had happened which put her at higher risk for a fracture. He stated it was his expectation for nurses to assess and evaluate residents immediately after a fall or when they were lowered to the floor. He further stated he expected the nurses to call the physician to report what had happened, what the resident's level of comfort was, their level of pain and their level of consciousness. He stated residents should be assessed right away then and there and all falls should be considered to be high risk and staff should do what they could to prevent falls. During an interview on 02/27/15 at 9:36 AM with the Rehabilitation Director she stated it was not therapy's intent for nursing staff to mirror what they were doing with residents during therapy sessions and did not instruct nursing staff to do something different with transfers than what was on the care plan. She explained when nursing staff came to her for questions about how to transfer a resident she instructed them to go to the nurse for clarification. She further stated nursing staff should know what each resident required for transfers. During a follow up interview on 02/27/15 at 11:34 AM the DON stated it was her expectations that the nurse should assess for falls whether they were witnessed or un-witnessed and should follow up to make sure the resident was ok. She explained if the resident was injured the nurse should provide first aid or send the resident to the hospital. She explained the care plan should guide staff with care and the transfer technique should match the care plan. She further explained the closet care plan which guided care provided by NAs that was located in the resident's closet should match the care plan. She stated the closet care plan that was in place prior to Resident #24's fall was discarded when she went to the hospital but she would expect it indicated Hoyer lift for transfers since that was what was documented on the care plans. She further stated they would not change the care plan related to transfers unless therapy had released the resident 100 percent for a change in transfer technique. She stated when staff was notified of Resident #24's fracture she should have also been notified. She further stated she was not aware and was shocked to see there were no nurse's notes for Resident #24 on 11/15/14 for the 7:00 AM to 7:00 PM shift until she was questioned about it during the survey. She also indicated she documented the Investigation of Resident #24's fracture after she talked to staff on Monday 11/17/14 and at that time she did not realize Nurse #1 had not gone to Resident 24's room after she slid to the floor and did not assess her. The facility's Administrator and Director of Nursing were notified of Immediate Jeopardy on 02/24/15 at 3:31 PM for Resident #24. The facility provided a credible allegation of compliance on 02/27/15 at 11:35 AM. The following interventions were put into place by the facility to remove the Immediate Jeopardy. Credible Allegation of Compliance: Resident #24 was sent to the hospital emergency roiagnom on [DATE] with right hip pain resulting in surgical repair. Two nurse aides involved with resident #24's care on 11/15/14 were verbally instructed on 11/16/14, their next scheduled work day, regarding not moving a resident after a fall before a nurse assessed the resident. On 11/17/14 all 3 CNAs involved received verbal education regarding utilization of gait belt for transfers and assessment required to be completed by a licensed nurse prior to moving any resident after a fall. Nurse #1 received a written coaching on 11/17/2014 regarding completing incident reports and completing resident assessments, including assessing a resident after a fall before the resident is moved. She was also educated regarding fall investigation and assessment after falls on 11/21/2014. All documented falls that occurred in November prior to the identified deficient practice were audited to assess compliance with standards of practice on 11/14/14 -11/16/14 and was utilized to determine if there were other falls that occurred with other resident's and/or problems with transfer techniques. There were no other residents identified. Implemented fall clinical meeting daily Monday through Friday on 11/18/14. This is a subcommittee that specifically looks at falls. Fall audit tool initiated 11/18/14 to ensure timely assessment, appropriate documentation, and updated care plan.

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) On February 24, 2015 at 11 pm nurses and nurse aides present was in serviced on: · New falls and fall risk policy and procedure implemented on February 24, 2015. · Assessment and first aid · Record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities · If evidence of significant injury, nursing staff will provide first aid · Once an assessment rules out significant injury, nursing staff will help resident to a comfortable sitting, lying, or standing position. Resident will not be moved until nursing assessment is completed. · Initial documentation regarding fall and notification of physician and family · Defining details of fall · Identifying causes of fall or fall risk · All off the above items will be documented on Fall: Initial Documentation Note/Progress Notes-5 day · This new form implemented on February 22, 2015 will be placed in the MAR and placed in the nurse's notes after completion of 5 day post fall documentation. · Performing a post-fall evaluation · Within 24 hours after a first fall, the nurse on duty should watch the resident rise from the chair, ambulate several steps if able, and return to sitting. If the resident has no difficulty or unsteadiness, further evaluation may not be needed. If the resident has difficulty therapy referral is initiated. This should be documented on Fall: Initial Documentation Note/Progress Notes-5 day · The nurse should assess the resident and determine if there are any changes or complications as a result of a fall every shift for 5 days and document on Fall: Initial Documentation/Progress Note-5 day · Identifying complications of falls · · requirement for immediate assessment of residents who have fallen and documentation in resident's clinical record · the condition the resident was found · assessment data including vital signs, and any obvious injuries · Interventions, first aid, or treatment administered · Notification of physician and family · All of the above to be documented on Fall: Initial Documentation Note/Progress Notes-5 day within · Completion of fall risk assessment · Appropriate interventions taken to prevent further falls · Signature and title of person recording data · Report fall to DON, ADON, or RN Supervisor An in service on falls and fall risk policy & procedure and transfers and mechanical lift will be completed for all nursing department staff by 8 pm on February 25, 2015. Any nursing department employee that has not attended above in service or participated in phone in service by February 25, 2015 at 8 pm will not be allowed to work until the in service is completed by DON, ADON, or RN Supervisor. At 8 pm on February 25, 2015 a list of nursing department employees that did not receive the above in service will be given to the DON. The DON will monitor the daily schedule to ensure that anyone that has not had the above training will not be scheduled to work until the in service is completed. All new nursing department employees will be in serviced during orientation. Immediate jeopardy was removed on 02/27/15 at 11:35 AM with interviews of direct care and licensed nursing staff who confirmed they received in-service training on new falls and fall risk policy and procedure and use of mechanical lifts prior to reporting for duty. A review of in-service sign in sheets contained documentation of staff who had attended the in-services. The DON had a list of all staff who had not attended in-services and these names were cross referenced with staff schedules and there were no staff who had not been trained listed on the schedules for work. Interviews with NAs revealed they had attended in-service training and were knowledgeable to notify a nurse immediately after a fall which included lowering a resident to the floor. Interviews with nurses revealed they had attended in-service training and were knowledgeable to respond and assess residents immediately after a fall or if they were lowered to the floor. They described the expectations for providing first aid, documentation of the incident, notification of physician, responsible party and administrative nursing staff and completion of the fall risk assessment, post fall evaluation and incident report. Record reviews revealed the Fall: Initial Documentation Note/Progress Notes-5 day form was implemented on 02/22/15 and a new fall risk policy and procedure was implemented on 02/24/15.
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff, resident and physician interviews the facility failed to utilize a mechanical (full body) lift during transfers for 1 of 12 sampled residents for falls (Resident #24). The facility also failed to secure a loose side rail for 1 Resident on 1 of 4 hallways (Resident #33). Immediate Jeopardy began on 11/15/14 when staff transferred Resident #24 three times without using a mechanical lift. Immediate jeopardy was removed on 02/27/15 at 11:35 AM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example 2 is at a scope and severity of D. The findings included: A review of a facility document titled Falls Checklist that was not dated, indicated in part, to complete the falls investigation and witness statements; Notify Director of Nursing (DON) and Administrator if injury sustained and resident sent to emergency room ; complete falls investigation to make sure date and time are correct, include what the resident said, include what you observed, what assessments and results for skin, mental, range of motion, vital signs and level of consciousness and plan to prevent further incidents from occurring; complete progress note and it should include in detail all of the above information. 1. Resident #24 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of a Nursing Admission Information sheet dated 02/17/14 indicated Resident #24 was alert and aware, non-verbal but was able to understand others and answered yes and no to questions. The notes also indicated she was dependent for transfers and bed mobility. A review of a Fall Risk Assessment for Resident #24 on 02/17/14 revealed a score of 14 which indicated a total score of 10 or above represented high risk for falls. A review of a physician's orders [REDACTED].#24 was to be transferred with a mechanical lift. A review of the admission Minimum Data Set ((MDS) dated [DATE] revealed Resident #24 had severe impairment in cognition for daily decision making. The MDS also indicated Resident #24 was totally dependent on staff for bed mobility and transfers and Resident #24 did not speak but was sometimes understood and usually understood others. A review of a Fall Risk Assessment for Resident #24 on 05/24/14 revealed a score of 11 which indicated high risk for falls. A review of a care plan with a problem statement for accidents/fall risk with an updated date of 10/25/14 indicated approaches to determine possible causes/patterns associated with falls or accidents and lift for transfers. A review of a care plan with a problem statement for total dependence with an updated date of 10/25/14 indicated mechanical lift to chair every day. A review of a care plan with a problem statement for activities of daily living with updated date of 10/25/14 indicated lift for transfers and out of bed to chair with lift. A review of the monthly physician's orders [REDACTED]. A review of Medication Administration Records (MARs) for November 2014 indicated activity level for a mechanical lift.

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F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 5) A review of nurse's notes dated 11/15/14 revealed there were no nurse's notes during the 7:00 AM - 7:00 PM shift. A review of a nurse's note dated 11/15/14 at 8:30 PM indicated Resident #24 was lying in bed grunting when Nurse #2 went to resident's room to administer bedtime medications. The notes further indicated when the head of the bed was raised Resident #24 began yelling out. The notes revealed Resident #24 was nonverbal due to history of a stroke but could answer questions appropriately by nodding her head for yes and no. The notes further revealed when asked where she was hurting Resident #24 pointed to her right leg. The notes indicated an assessment showed no visual injuries or redness but when an attempt was made to roll Resident #24 over she began screaming loudly and Resident #24's responsible party was notified and hospital was notified for transport to the emergency room . A review of a nurse's note dated 11/15/14 at 9:02 PM revealed emergency medical services (EMS) was in the facility to transport Resident #24 to the hospital emergency room for evaluation. A review of an EMS report dated 11/15/14 indicated EMS was at Resident #24's bedside at 9:03 PM. A section labeled narrative indicated Resident #24 initially stated on scene that she did not fall however upon talking to emergency room staff it was found out that she did indeed have a fall earlier today. A review of a nurse's note dated 11/15/14 at 9:25 PM indicated Nurse #2 had a conference with Nurse Aides (NA's) assigned to care for Resident #24 on the 7:00 PM to 7:00 AM shift and there were no reports of injury received from the previous shift to Nurse #2 or to NAs. A review of a nurse's note dated 11/16/14 at 12:30 AM indicated Nurse #2 called the hospital and was informed Resident #24 was admitted to the hospital with [REDACTED].#2 notified Administrative nurse (Assistant Director of Nursing (ADON)) #1 on call and contacted Resident #24's family to give an update. A review of a nurse's note dated 11/16/14 at 12:42 AM indicated staff from the hospital called the facility with questions and reported when Resident #24 was questioned she indicated she had been dropped onto the floor earlier in the day. The notes further indicated Administrative nurse (ADON #1) was notified. A review of a Physician's Report of Consultation dated 11/16/14 indicated a consulting [DIAGNOSES REDACTED].#24 who had a history of [REDACTED]. The notes revealed Resident #24 was found by the nursing staff lying in bed complaining of hip pain and apparently had a history of [REDACTED]. The notes further indicated Resident #24 was brought to the hospital emergency room and x-rays revealed a displaced intertrochanteric/subtrochanteric (upper quarter of the thigh bone) fracture of the right hip. A review of an Operative report dated 11/17/14 indicated intertrochanteric/subtrochanteric fracture of the right hip. The notes further indicated surgery was completed with open reduction (to realign bone fracture into normal position) and internal fixation (hardware used to keep bone fracture stable to heal and prevent infection) with a short gamma nail. A review of a facility document titled Investigation of Resident #24's fracture which was not dated but signed by the Director of Nursing (DON) indicated the following summary in part: On the morning of 11/15/14 NA #1 went in to get resident up and ready for shower. NA #1 asked NA #2 to assist with transferring Resident #24 from bed to chair. The 2 NAs attempted to transfer Resident #24 with an arm and arm method. They stood resident without difficulty but when the NAs started to pivot resident to place her in a shower chair the resident went limp and was unable to continue to assist the NAs with the transfer. NAs attempted to place Resident #24 in shower chair but due to her weight was unable to get her safely into the chair. Both NAs report they together slowly lowered resident to the floor. NA #2 went immediately to alert the nurse of the incident and get NA #3 to assist them in putting Resident #24 in the shower chair. Nurse #1 reported she could not confirm or deny she was immediately notified of the incident. NA #3 assisted NA #1 and NA #2 in transferring Resident #24 from floor to shower chair. NAs report Resident #24 did not complain of pain or show signs or symptoms of pain during this transfer. After lunch NA #1 and NA #3 transferred Resident #24 from wheelchair to bed. The resident participated with the transfer and did not complain of pain or show signs or symptoms of pain. At approximately 2:00 PM NA #1 and NA #4 was changing Resident #24 and she started yelling out and grabbing at her leg. NA (not named) asked the resident if she was in pain and she nodded her head yes. NA #4 went to get Nurse #1 and she went to check the resident and reported that both legs looked symmetrical and she didn't see anything out of the ordinary. Nurse #1 noticed Resident #24 was scratching at her groin area and she had just recently administered scheduled Tylenol to Resident #24. Nurse #1 instructed the NAs to clean resident and apply protective ointment. At 4:00 PM Nurse #1 asked Resident #24 if her leg was still hurting and the resident shook her head no. When night shift came in Resident #24 appeared to be in severe pain and Nurse #2 sent resident to the ER and her [DIAGNOSES REDACTED]. During an interview on 02/19/15 at 11:08 AM with Resident #24 she smiled and nodded her head up and down as a response for yes and made repetitive sounds but was unable to form words when spoken to. She nodded her head up and down yes when questioned if she had a hip injury last November. When asked if she had a fall her facial expression changed and she became tearful and attempted to say something but was unable to form the words and then nodded her head vigorously up and down yes. When questioned if her hip was better she shook her head from side to side as a response for no and moved her left hand toward her right hip in a rubbing motion. During an interview on 02/23/15 at 11:48 AM the Assistant Director of Nursing (ADON) #1 stated after review of Resident #24's nurse's notes for 11/15/14 she did not remember being called on 11/15/14 when the resident was sent to the hospital but if the nurses documented they called her then they probably did. She further stated she did not remember going to the facility on [DATE] or 11/16/14. She stated the only thing she remembered was she heard during morning meeting the following week Resident #24 had complained of severe pain in her hip and was sent to the hospital and she had a hip fracture. She further stated she did not remember being involved in an investigation regarding Resident #24's fall. During an interview on 02/23/15 at 12:14 PM the Director of Nursing (DON) upon review of the nurses notes for Resident #24 on 11/15/14 confirmed there were no nurse's notes or nursing assessment during the 7:00 AM to 7:00 PM shift. During a follow up interview on 02/23/15 at 12:14 PM the DON explained nursing staff was supposed to call the administrative nurse on call when a resident had a fall or injury and the nurse on call should go to the facility to investigate or call the DON and she would go to the facility to investigate. She confirmed she was not called and did not go to the facility on [DATE] or 11/16/14 to investigate Resident #24's fall. During a telephone interview on 02/23/15 at 6:44 PM NA #1 explained she and NA #2 were trying to get Resident #24 out of bed into a shower chair on 11/15/14. She stated therapy staff had been working with Resident #24 to stand and transfer her with 2 staff assist and NA #1 stated she had previously stood Resident #24 next to her bed to transfer her and the resident had done fine and that was the way she usually transferred her. She explained during the transfer on 11/15/14 she had her arm under one of Resident #24's armpits and NA #2 had her arm under the other armpit and they stood her up at the bedside but when they turned her to pivot her she went limp. NA #1 stated when Resident #24 started to slide to the floor they tried to lift her up but they couldn't because she was too heavy. She explained when they realized they could not lift her up they lowered her to the floor and she told NA #2 to go get a nurse. NA #1 stated she held on to Resident #24's shoulders while she sat in the floor and thought her legs were out in front of her. NA #1 further stated NA #2 came back with NA #3 and they picked Resident #24 up off the floor and she took her to the shower room and gave her a shower. She explained she did not notice any obvious redness or bruising when she gave Resident her shower and after the shower NA #2 assisted her to stand Resident #24 up from the shower chair and into a wheelchair. NA #1 stated after lunch she got NA #2 and NA #3 again to transfer Resident #24 and they stood Resident #24 up from her wheelchair and transferred her to bed. She explained about 3 hours after Resident #24 was lowered to the floor she was moaning and holding her right leg and was rubbing it and she reported it to Nurse #1. During a telephone interview on 02/23/15 at 7:04 PM with NA #2 she stated she went to help NA #1 transfer Resident #24 on 11/15/14 for a shower. She explained they sat Resident #24 up on the side of the bed for a few seconds, then stood her up and turned her towards the left and she started to buckle. She stated Resident #24's right leg did not turn as her upper body turned and she slid down to the floor. She further stated when Resident #24 was in the floor her left leg was straight out but her right leg was crisscrossed under her left leg and was bent at a 90 degree angle at her knee. NA #2 stated she went to get Nurse #1 and the nurse asked if the resident had fallen or slid to the floor and when she told the nurse the resident had slid to the floor the nurse said ok and to go ahead and get Resident #24 up in the shower chair and give her a shower. NA #2 stated she went back to Resident #24's room and she and NA #1 placed their arms under each of Resident #24's armpits and lifted her from the floor and into the shower chair. She stated Resident #24 complained of her right leg hurting a little bit when she was placed in the shower chair but she thought it was caused by pressure on her legs from the shower chair. She stated she did not assist NA #1 during Resident #24's shower and also verified Nurse #1 did not come to

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) Resident #24's room while the resident was in the floor or after they got her into the shower chair. She explained the DON talked to her on Monday 11/17/14 to ask what had happened during the transfer of Resident #24 on 11/15/14 and sometime after that staff had an in-service about use of gait belts and gait belts were issued to everybody but that was all that changed. During an interview on 02/24/15 at 1:54 PM with NA #3 she stated NA #1 or NA #2 came and got her to assist with getting Resident #24 off the floor on 11/15/14 because she had slid to the floor. She stated when she went into Resident #24's room the resident was sitting in the floor and she did not think Resident #24's legs were straight out in front because she couldn't straighten her legs out fully due to a previous stroke with paralysis on her right side. She demonstrated she placed her arm under one of Resident #24's armpits and NA #1 placed her arm under Resident #24's other armpit and they lifted her up off the floor while NA #2 held the shower chair. She confirmed Nurse #1 did not come in the room while she was in Resident #24's room and after they placed Resident #24 in the shower chair she left the room to resume her assignment on a different hall. She stated she did not remember anyone asked her about what had happened or what she saw when she went to Resident #24's room. During an interview on 02/23/14 at 8:13 PM with Nurse #1 she confirmed she did not go to Resident #24's room to assess her on 11/15/14 when NA #2 reported the resident had slid to the floor. She stated she was having a very bad day and took full responsibility for not doing what she was supposed to do. She confirmed the only assessment she did was later in the day when Resident #24 was crying out in pain and was reaching toward her peri area and the area was red. She stated she couldn't remember exactly what she saw but remembered she gave Resident #24 some routine Tylenol for pain but did not report it or document it because she did not think anything had happened or that anything needed to be reported or documented. During a telephone interview on 02/23/15 at 7:56 PM with Nurse #2 she stated she worked on the 7:00 PM to 7:00 AM shift on 11/15/14 and that evening the NAs came and got her because they had taken Resident #24 her bedtime snack and she was screaming in pain. She explained she couldn't assess her or touch her because she was in such pain. She further explained Resident #24 had an incontinent episode but they couldn't clean her or turn her because of the pain. She verified she had not received a report from Nurse #1 during shift change that Resident #24 had slid to the floor earlier that day. She stated she sent the resident to the hospital emergency room for evaluation and treatment because Resident #24 did not usually complain of pain and she couldn't figure out why she was having such severe pain. She explained later that night a nurse from the hospital called her and asked about a fall that Resident #24 had earlier that day. She stated that was the first time she had been told Resident #24 had a fall. She explained she called ADON #1 who was the nurse on call and told her what the hospital had reported. She stated ADON #1 told her to make sure she had everything documented. She stated nobody on her shift knew anything about Resident #24's fall earlier that day because nothing had been reported to them during shift report. She explained she expected to see nursing documentation when a resident had a fall or was lowered to the floor and she thought there should have been some investigation to determine why Resident #24 had a hip fracture since she had been lowered to the floor during transfer earlier that day. During an interview on 02/24/15 at 3:01 PM with Licensed Physical Therapist #1 he explained therapy staff had been working with Resident #24 on standing and transfers with 2 staff assist prior to her fall on 11/15/14. He stated Resident #24's participation varied and some days she would stand but then she would spontaneously sit down. He stated it was his understanding that nursing staff had transferred Resident #24 with a mechanical lift and the plan of care would have been to use a mechanical lift for transfers until Resident #24 was cleared by therapy to transfer with a maximum assist of 2 staff. During a follow up interview on 02/24/15 at 3:24 PM the DON verified she wrote the summary titled Investigation of Resident #24's fracture after she talked to staff who had been assigned to care for Resident #24 on Monday 11/17/14 and it was a summarization of what staff had told her. She stated she could not find an incident report related to Resident #24's fall and there was no incident recorded on the incident logs for Resident on 11/15/14. During a phone interview on 02/25/15 at 2:00 PM the physician who was also the facility Medical Director stated he was made aware of Resident #24's fall after she had gone to the hospital. He stated the information he had been told about her sliding to the floor did not explain how the fracture happened but he wondered if she had a previous incident or something that had happened that put her at higher risk for a fracture. He stated it was his expectation for nurses to assess and evaluate residents immediately after a fall or when they were lowered to the floor. He further stated he expected the nurses to call the physician to report what had happened, what the resident's level of comfort was, their level of pain and their level of consciousness. He stated residents should be assessed right away then and there and all falls should be considered to be high risk and staff should do what they could to prevent falls. During an interview on 02/27/15 at 9:36 AM with the Rehabilitation Director she stated it was not therapy's intent for nursing staff to mirror what they were doing during therapy sessions and they did not instruct nursing staff to do something different than what was on the care plan. She explained when nursing staff came to her for questions about how to transfer a resident she instructed them to go to the nurse for clarification. She further stated nursing staff should know what each resident required for transfers. During another follow up interview on 02/27/15 at 11:34 AM the DON stated it was her expectations that the nurse should assess for falls whether they were witnessed or un-witnessed and should follow up to make sure the resident was ok. She explained if the resident was injured the nurse should provide first aid or send the resident to the hospital. She explained the care plan should guide staff with care and the transfer technique should match the care plan. She further explained the closet care plan which guided care provided by NAs that was located in the resident's closet should match the care plan. She stated the closet care plan that was in place prior to Resident #24's fall was discarded when she went to the hospital but she would expect it indicated mechanical lift for transfers since that was what was documented on the care plans. She further stated they would not change the care plan related to transfers unless therapy had released the resident 100 percent for a change in transfer technique. She stated when the nurse on call was notified of Resident #24's fracture she should have also been notified and an investigation should have been done. She emphasized it was her expectation if a resident had an incident with injury she should be notified immediately. She further stated she was unaware there were no nurse's notes for Resident #24 on 11/15/14 for the 7:00 AM to 7:00 PM shift until she was questioned about it during the survey. She stated Nurse #1 had told her she assessed Resident #24 but she did not realize at that time Nurse #1 had not assessed the resident after she was lowered to the floor or before she was moved from the floor to the shower chair. During an interview on 02/27/15 at 12:20 PM the Administrator explained she had just started to work in the facility on 11/11/14 and identified the facility was lacking processes to address a number of issues which included falls. She explained a lot of work had begun to implement new processes and changes but there was still a lot of work that needed to be done. The facility's Administrator and Director of Nursing were notified of Immediate Jeopardy on 02/24/15 at 3:31 PM for Resident #24. The facility provided a credible allegation of compliance on 02/27/15 at 11:35 AM. The following interventions were put into place by the facility to remove the Immediate Jeopardy. Credible Allegation of Compliance Resident #24 was sent to the hospital emergency roiagnom on [DATE] with right hip pain resulting in surgical repair. Upon readmission on 11/20/14, resident #24 was assessed by ADON, PT, and nurse with regards to impaired cognition, pain, [DIAGNOSES REDACTED], body habitus, and recent history of a fall with fracture and it was determined that the safest transfer method was mechanical lift by 2 person assist. On 11/17/14 Resident care information sheets were checked for accuracy. Updates made to assure safest transfer method was being used for resident resident #24. Resident care information is located in resident's closets for direct care to refer to for care including transfers for residents. Two nurse aides involved with resident #24's care on 11/15/14 were verbally instructed on 11/16/14, their next scheduled work day, regarding not moving a resident after a fall before a nurse assessed the resident. On 11/17/14 all 3 CNAs involved received verbal education regarding utilization of gait belt for transfers and assessment required to be completed by a licensed nurse prior to moving any resident after a fall. Nurse #1 received a written coaching on 11/17/2014 regarding completing incident reports and completing resident assessments, including assessing a resident after a fall before the resident is moved. She was also educated regarding fall investigation and assessment after falls on 11/21/2014. All documented falls that occurred in November prior to the identified deficient practice were audited to assess compliance

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GLENBRIDGE HEALTH AND REHABILTATION CENTER	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) with standards of practice on 11/14/14-11/16/14 and was utilized to determine that there were no other falls that occurred with other resident ' s and/or problems with transfer techniques. Implemented fall clinical meeting daily Monday through Friday on 11/18/14. This is a subcommittee that specifically looks at falls. Fall audit tool initiated 11/18/14 to ensure timely assessment, appropriate documentation, and updated care plan. On February 24, 2015 Fall Risk Evaluation was completed on all residents. Care plans will be reviewed and updated with 100% completion on February 25, 2015. On February 24, 2015 at 11 pm nurses and nurse aides present was in serviced on: · New falls and fall risk policy and procedure implemented on February 24, 2015 · Assessment and first aid · Record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities · If evidence of significant injury, nursing staff will provide first aid · Once an assessment rules out significant injury, nursing staff will help resident to a comfortable sitting, lying, or standing position. Resident will not be moved until nursing assessment is completed. · Initial documentation regarding fall and notification of physician and family · Defining details of fall · Identifying causes of fall or fall risk · All off the above items will be documented on Fall: Initial Documentation Note/Progress Notes-5 day · This new form implemented on February 22, 2015 will be placed in the MAR and placed in the nurse ' s notes after completion of 5 day post fall documentation. · Performing a post-fall evaluation · Within 24 hours after a first fall, the nurse on duty should watch the resident rise from the chair, ambulate several steps if able, and return to sitting. If the resident has no difficulty or unsteadiness, further evaluation may not be needed. If the resident has difficulty therapy referral is initiated. This should be documented on Fall: Initial Documentation Note/Progress Notes-5 day · The nurse should assess the resident and determine if there are any changes or complications as a result of a fall every shift for 5 days and document on Fall: Initial Documentation/Progress Note-5 day · Identifying complications of falls · requirement for immediate assessment of residents who have fallen and documentation in resident's clinical record · the condition the resident was found · assessment data including vital signs, and any obvious injuries · Interventions, first aid, or treatment administered · Notification of physician and family · Completion of fall risk assessment · Appropriate interventions taken to prevent further falls · Signature and title of person recording data · Report fall to DON, ADON, or RN Supervisor · All of the above should be documented on the Fall: Initial documentation/Progress Notes-5 day, to be completed by the end of shift An in service on falls and fall risk policy & procedure and transfers and mechanical lift will be completed for all nursing department staff by 8 pm on February 25, 2015. Any nursing department employee that has not attended above in service or participated in phone in service by February 25, 2015 at 8 pm will not be allowed to work until the in service is completed by DON, ADON, or RN Supervisor. At 8 pm on February 25, 2015 a list of nursing department employees that did not receive the above in service will be given to the DON. The DON will monitor the daily schedule to ensure that anyone that has not had the above training will not be scheduled to work until the in service is completed. All new nursing department employees will be in serviced during orientation All residents were assessed for transfers by DON, ADONs, nurse, and therapy. All affected residents who were identified as two person assistant with transfers were referred to therapy on 2.25.15 for screen to verify safest transfer technique. Every resident fall will be reviewed Monday through Friday each morning at the Clinical Meeting and will ensure initial documentation has been completed. A revised falls audit tool has been implemented on 02/25/2015 and will include documentation and confirmation that all fall strategies are implemented and action taken when a fall occurs. Immediate jeopardy was removed on 02/27/15 at 11:35 AM with interviews of direct care and licensed nursing staff who confirmed they received in-service training on new falls and fall risk policy and procedure and use of mechanical lifts prior to reporting for duty. A review of in-service sign in sheets contained documentation of staff who had attended the in-services. The DON had a list of all staff who had not attended in-services and these names were cross referenced with schedules and no staff that had not been trained was listed on the schedules. Interviews with NAs revealed they had attended in-service training and were knowledgeable to notify a nurse immediately after a fall which included lowering a resident to the floor. Interviews with nurses revealed they had attended in-service training and were knowledgeable to respond and assess residents immediately after a fall or if they were lowered to the floor. They described the expectations for providing first aid, documentation of the incident, notification of physician, responsible party and administrative nursing staff and completion of the fall risk assessment, post fall evaluation and incident report. Record reviews revealed the fall: Initial Documentation Note/Progress Notes-5 day form was implemented on 02/22/15 and a new fall risk policy and procedure was implemented on 02/24/15. 2. Review of the medical record revealed Resident #33 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of a care plan last reviewed 11/24/14, stated Resident #33 was at risk for falls and accidents due to impaired mobility, cognition, vision, hearing and/or decision making skills associated with dementia, COPD, anxiety, history of pelvis fracture, and medications. Included in the goals was an environment as free as possible of accident or fall hazards for the next 90 days. Interventions included notifying the maintenance department of any defective equipment such as bed side rails, hand rails, chairs, and beds. Review of the most recent side rail assessment dated [DATE] revealed Resident #33 required bed rails for turning and repositioning, had cognitive impairment, and could identify bed boundaries. Review of a quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #33 had severely impaired cognition and required extensive assistance of one person for bed mobility and transfers. Review of the log used to notify maintenance staff of repairs for Resident #33's side of the facility revealed there were 7 side rail related problems documented from 01/01/15 through 02/24/15. Resident #33's bed side rails were not listed on the maintenance clip board. Observations of Resident # 33's bilateral ¼ bed side rails were as follows: - On 02/16/15 at 2:22 PM the right side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 2 inches. The left side rail was not loose and fit properly. - On 02/18/15 at 1:00 PM the right side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 2 inches. The left side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 1 inch. - On 02/19/15 at 1:00 PM the right side rail was loose and the top of
F 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff interviews, and pharmacist and physician interviews the facility failed to stop a discontinued medication for 1 of 5 residents sampled for maintaining a drug regimen free of unnecessary medications (Resident #135). The findings included:

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F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) Resident #135 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent quarterly Minimum Data Set ((MDS) dated [DATE] indicated resident #135 was cognitively intact. Further review of the MDS revealed Resident #135 required extensive assistance to being totally dependent for most activities of daily living (ADL's). The MDS also indicated Resident #135 received antibiotic medication 7 days a week. Review of the medical record revealed Resident #135 was admitted to the hospital on [DATE] with a [DIAGNOSES REDACTED]. After he received treatment, he was released back to the facility on [DATE]. physician's orders [REDACTED].) two times daily for 5 days for urinary tract infection. Review of the Medication Administration Records (MAR's) from July of 2014 to February of 2015 revealed the order was transcribed for Resident #135 to be started on [MEDICATION NAME] 250 milligrams (mgs.) two times daily on 07/29/14. Further review of the MAR indicated [REDACTED]. On 02/18/15 at 11:40 AM an interview was conducted with the Assistant Director of Nursing (ADON #1). She was unable to locate the order for the [MEDICATION NAME], or determine when the medication was to be stopped. ADON #1 called the hospital and retrieved Resident #135's discharge summary from the 07/29/14 hospitalization . She stated the orders indicated the [MEDICATION NAME] should have been stopped or the orders should have been clarified by someone when monthly MAR indicated [REDACTED]. She stated it was her expectation that staff would have discovered the medication error during the monthly medication reviews. The ADON stated she would make the correction immediately and notify the physician. On 02/18/15 at 12:20 PM an interview was conducted with the Director of Nursing (DON). She stated the facility had a system in place to review medication orders which included the nurse who admitted the resident, transcribed the orders and checked all MEDICATION ORDERS FOR [REDACTED]. She stated it was her expectation for the process to be followed each month, and it was not done in this case. On 02/18/15 at 3:40 PM another interview was conducted with the DON. She indicated a telephone conference was held with the Medical Director (MD). She stated he acknowledged the medication should have been discontinued after 5 days from the start date of 07/29/14. The DON revealed the MD ordered for the medication to be discontinued and a urology consult was to be obtained for Resident #135 to determine if he needed a long-term antibiotic. On 02/19 15 at 12:00 Noon an interview was conducted with the facility pharmacist. She indicated she had been doing monthly reviews on the resident's medication treatment regimen since August or September of 2014. The pharmacist stated the monthly process of reviewing resident medications involved checking all medications for current [DIAGNOSES REDACTED]. If medications did not include a stop date, she would request a stop date from the physician. She stated the stop date for the [MEDICATION NAME] ordered for Resident #135 should have been discovered during pharmacy reviews and a stop date secured from the physician. On 02/25/15 at 2:00 PM an interview was conducted with the MD. He acknowledged he was aware of the medication error. The MD stated the error should never have occurred and was missed by a number of people responsible for medication reviews. He stated no antibiotic should be provided without a stop date, and medications without stop dates should be clarified with the physician.
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 record reviews, staff interviews, and pharmacist and physician interviews the facility failed to prevent a significant medication error by administering a discontinued medication for 1 out of 5 residents reviewed for medication administration (Resident #135). The findings included: Resident #135 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent quarterly Minimum Data Set ((MDS) dated [DATE] indicated resident #135 was cognitively intact. Further review of the MDS revealed Resident #135 required extensive assistance to being totally dependent for most activities of daily living (ADL's). The MDS also indicated Resident #135 received antibiotic medication 7 days a week. Review of the medical record revealed Resident #135 was admitted to the hospital on [DATE] with a [DIAGNOSES REDACTED]. After he received treatment, he was released back to the facility on [DATE]. physician's orders [REDACTED].) two times daily for 5 days for urinary tract infection. Review of the Medication Administration Records (MAR's) from July of 2014 to February of 2015 revealed the order was transcribed for Resident #135 to be started on [MEDICATION NAME] 250 milligrams (mgs.) two times daily on 07/29/14. Further review of the MAR indicated [REDACTED]. On 02/18/15 at 11:40 AM an interview was conducted with the Assistant Director of Nursing (ADON #1). She was unable to locate the order for the [MEDICATION NAME], or determine when the medication was to be stopped. ADON #1 called the hospital and retrieved Resident #135's discharge summary from the 07/29/14 hospitalization . She stated the orders indicated the [MEDICATION NAME] should have been stopped or the orders should have been clarified by someone when monthly MAR indicated [REDACTED]. She stated it was her expectation that staff would have discovered the medication error during the review process of the monthly medications. The ADON stated she would make the correction immediately and notify the physician. On 02/18/15 at 12:20 PM an interview was conducted with the Director of Nursing (DON). She stated the facility had a system in place to review medication orders which included the nurse who admitted the resident, transcribed the orders and checked all MEDICATION ORDERS FOR [REDACTED]. She stated it was her expectation for the process to be followed each month, and it was not done in this case. On 02/18/15 at 3:40 PM another interview was conducted with the DON. She indicated a telephone conference was held with the Medical Director (MD). She stated he acknowledged the medication should have been discontinued after 5 days from the start date of 07/29/14. The DON revealed the MD ordered for the medication to be discontinued and a urology consult was to be obtained for Resident #135 to determine if he needed a long-term antibiotic. On 02/19 15 at 12:00 Noon an interview was conducted with the facility pharmacist. She indicated she had been doing monthly reviews on the resident's medication treatment regimen since August or September of 2014. The pharmacist stated the monthly process of reviewing resident medications involved checking all medications for current [DIAGNOSES REDACTED]. If medications did not include a stop date, she would request a stop date from the physician. She stated the stop date for the [MEDICATION NAME] ordered for Resident #135 should have been discovered during pharmacy reviews and a stop date secured from the physician. The pharmacist also indicated that long-term adverse effects of [MEDICATION NAME] use could include diarrhea, nausea, vomiting, and loss of intestinal bacteria. She stated an intestinal enzyme could be provided for long-term antibiotic usage to replace depleted bacteria in the intestine. Resident #135 was not receiving an intestinal enzyme. On 02/25/15 at 2:00 PM an interview was conducted with the MD. He acknowledged he was aware of the medication error. He revealed the biggest concern for Resident #135 related to taking [MEDICATION NAME] for such a long period of time would be diarrhea and development of a drug sensitivity or drug reaction. The MD stated the error should never have occurred and was missed by a number of people who should have reviewed the medication regimen. He stated no antibiotic should be provided without a stop date, and medications without stop dates should be clarified with the physician.
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 observations, record review and staff interviews the facility failed to follow contact precautions for 1 of 1 resident reviewed for contact precautions (Resident #192). The findings included: Review of the facility Contact Isolation Policy dated November 2003 revealed contact precautions would be implemented for specific residents known or suspected to be infected or colonized with microorganisms that could be transmitted by direct contact with the resident such as hand or skin contact that occurred from performing resident care that required touching the residents dry skin and by indirect contact such as touching environmental surfaces or resident care items in their room. The policy further revealed gloves should be worn when entering the resident's room on Contact Isolation and removed before leaving the residents room with immediate hand washing. After hand washing and glove removal ensure hands did not touch potentially contaminated environmental surfaces or items in the resident's room to avoid transfer to other residents or environments.

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F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 9) Review of the physician orders [REDACTED].#192 was to be placed on contact isolation for methicillin resistant staphylococcus aureus (MRSA), a multiple drug resistant organism in a stage III sacral pressure wound. An observation was made on 02/16/15 at 11:00 AM of Resident #192's room with a contact precaution sign on the wall beside the door and an over bed table with gloves located outside the room. An observation made on 02/16/15 at 11:35 AM revealed hospitality aide (HA) #1 entered Resident #192's room without gloves on and opened Resident #192's privacy curtain and moved his over bed table. HA #1 left Resident #192's room without washing her hands or using hand sanitizer and entered Resident #92's room without washing her hands and began to set up the lunch tray on the over bed table for Resident #92. An observation made on 02/16/15 at 11:52 AM revealed HA #1 entered Resident #192's room without washing her hands or wearing gloves. HA #1 straightened Resident #192's bed linens, closed his privacy curtain and brought his lunch tray out of his room and placed it on the tray cart. HA #1 did not wash her hands or use hand sanitizer after leaving Resident #192's room. An interview was conducted on 02/16/15 at 1:30 PM with HA #1. She stated she did not wash her hands or wear gloves in Resident #192's room because she did not know he was on contact precautions. She stated she did not see the contact precaution sign or notice the table with gloves outside his room. HA #1 stated she should have washed her hands and worn gloves while she was in his room and discarded the gloves and washed her hands before leaving his room. An interview was conducted on 02/27/15 at 10:50 AM with the Director of Nursing (DON). She stated it was her expectation for staff to follow the contact precaution signs posted on Resident #192's door and wear gloves and wash their hands when entering and leaving the room if they had any contact with the resident or resident items in the room. She stated she was unaware staff had not been following contact precautions for Resident #192.