| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **015119** | A. BUILDING _____ B. WING _____ | **08/19/2016** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **WARREN MANOR HEALTH AND REHABILITATION CENTER** | **11 BELL ROAD SELMA, AL 36701** |

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 0164<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Keep each resident's personal and medical records private and confidential.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, observation and interview, the facility failed to ensure the privacy curtain was pulled in order to completely shield Resident Identifier (RI) #11 from public view when RI #11 was receiving a bath on 08/17/2016.<br>This affected RI #11, one sampled resident observed receiving a bath.<br>Findings Include:<br>A review of a facility policy titled, Resident Dignity & (and) Personal Privacy, with a Release/Revision Date of June 2007, revealed:<br>. 2. Examine and treat residents in a manner that maintains their privacy.<br>a. Use a . drawn curtain . to shield the resident during all personal care .<br>RI #11 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED].<br>A review of RI #11's most recent Significant Change MDS (Minimum Data Set), with an ARD (Assessment Reference Date) of 02/15/2016, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 14, which indicated the resident was cognitively intact. The MDS also revealed the resident was totally dependent on staff for bathing.<br>On 08/17/2016, at 10:35 a.m., EI (Employee Identifier) #21, RCS (Resident Care Specialist), was observed giving RI #11 a bed bath. The privacy curtain was pulled halfway around the bed, allowing the lower half of the resident's body to be visible. When EI #21 rolled RI #11 to the right side and washed the resident's back, the resident's buttocks were exposed. A CNA (Certified Nursing Assistant), who was not providing care to RI #11, walked into the room and looked in the direction of at RI #11.<br>On 08/17/2016, at 11:44 a.m., an interview was conducted with EI #21. EI #21 was asked if the privacy curtain was completely drawn around the bed of RI #11 when she provided the bed bath. EI #21 stated the privacy curtain was not drawn completely around the resident' bed. EI #21 said the curtain was pulled to the lower part of the resident's body. EI #21 was asked what position should the privacy curtain have been in when bathing the resident. EI #21 said pulled all the way around. EI #21 was asked what part of RI #11's body could be seen around the privacy curtain when the resident was turned to the right side. EI #21 said the resident's bottom probably could have been seen. EI #21 was asked what the potential harm was in not completely covering the resident with the privacy curtain during a bath. EI #21 said the resident would feel uncomfortable. |
| F 0250<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide medically-related social services to help each resident achieve the highest possible quality of life.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to implement a Behavioral Management Care Plan for Resident Identifier (RI) #1 to be gotten out of bed when shaking the side rails.<br>This affected RI #1, one of two residents sampled for behaviors.<br>Findings Include:<br>A facility policy titled, Behavior Management Program with a Created Date of 1/1/2016, and a Revised date of 06/01/2016 documented the following:<br>PURPOSE;<br>1. Provide residents with the care and services necessary to attain or maintain the highest practicable physical, mental, and psychosocial well being in accordance with the comprehensive assessments and care plan.<br>2. Residents who display mental or psychological adjustment difficult will receive appropriate treatment and services assess and correct the problem .<br>POLICY;<br>Residents as determined by the Interdisciplinary Team, will be placed on the Behavior Management Program.<br>PROCEDURE:<br>1. A Behavior Management Program will be utilized to monitor, correct or eliminate specified behavior of residents as determined The targeted behaviors are identified on the . Incident Reports in the Clinical Chart and Point Click Care Monitoring Report.<br>. 4. All staff members are oriented on behavior management .<br>RI #1 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED].<br>A most recent Annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 06/27/2016, revealed RI #1 was assessed as having severely impaired vision and scoring a 2 on the Brief Interview for Mental status (BIMS) indicating severely impaired cognition.<br>On 07/29/2016, at 08:40 a.m., an interview was conducted with Employee Identifier (EI) #18, the West Hall/Social Worker. EI #18 was asked how long she had been working at the facility. EI #18 stated she started in November 2015. EI #18 was asked if RI #1 was on a Behavior Management Program. EI #18 stated, no. The surveyor asked EI #18 if RI #1 had any behaviors. EI #18 replied, Not to my knowledge, (he/she) would yell, that was part of (his/her) normal behavior.<br>On 07/29/2016, at 3:00 p.m., an interview was conducted with EI # 5, the Social Services Director. The surveyor asked EI #5 how long she had been the Social Services Director. EI #5 replied it would be 12 months next month (August). EI #5 was asked to print out RI #1's current care plans. EI #5 was asked when the last care plan meeting for RI #1 was conducted. EI #5 replied it was on 07/13/2016. The surveyor asked EI #5 if all of RI #1's care plans were reviewed at that time. EI #5 stated, it should have been all of the care plans that were on RI #1's chart. The surveyor asked EI #5 if RI #1 was on a Behavioral Management Program. EI #5 replied, No. EI #5 was asked why the resident was not on a Behavioral Management program. EI #5 replied, (RI #1) was never referred to Social Services. EI #5 was asked who would be able to refer RI #1 to Social Services. EI #5 stated any clinical staff could refer a resident to Social Services. The surveyor asked EI #5 do you know why RI #1's 10/21/14 Behavior Symptoms Care Plan was not listed with RI #1's current care plans, EI #5 stated No, I do not.<br>On 07/29/2016, at 4:00 p.m., an interview was conducted with EI # 18. The surveyor asked EI #18 if RI #1 was ever referred to Social Services for a Behavioral Management program. EI #18 stated, no. When asked why not, EI #18 stated, if a resident is referred, that resident would be someone who you can do an intervention with. The surveyor asked to reveal EI #18 medical record to look at RI #1's documented behavior symptoms for the month of June 2016 and July 2016. EI #18 stated, Looking at the documented behaviors, I would say yes, but knowing (RI #1's) cognitive impairment, I would say no. The surveyor asked EI #18 if social services or anyone else tried to identify triggers for RI #1's behaviors. EI #18 stated, the yelling and screaming was an anticipated behavior due to (his/her) CVA (Cerebral Vascular Accident). EI #18 was asked |

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

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| F 0250<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>about the shaking of the bed rails, EI #18 replied, No one ever told social services about RI #1 shaking the bed rails. EI #18 was asked what intervention was put in place for RI #1's shaking of the bed rails. EI #18 replied, I don't know. |
| F 0278<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Make sure each resident receives an accurate assessment by a qualified health professional.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interviews, record review and review of a facility policy titled MDS (Minimum Data Set) Accuracy, the facility failed to ensure Resident Identifier (RI) #1 and #11 were accurately assessed to reflect the residents fall status on the Side Rail Safety Review, Fall Risk Evaluations and MDS assessments.<br>The facility further failed to ensure RI #1's Range of Motion (ROM) status was accurately coded on the 06/27/2016 Annual MDS assessment.<br>These deficient practices affected RI #1 and #11, two of six residents sampled for falls.<br>Findings Include:<br>A review of a facility policy titled, MDS Accuracy with a revision date of June 2012 revealed:<br>. Accurate clinical assessment is the cornerstone of . care management processes. The accuracy of the assessment means that the appropriate, qualified, health professional correctly documents the resident's medical, functional . problems . the facility has an increased responsibility to ensure all assessments are representations of the resident's true status.<br>facilities must adopt certain systems to support and enhance accurate assessment of the resident.<br>1. RI #1 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED].<br>A review of an Interdisciplinary Post Fall Review for RI #1, documented:<br>Date of Fall: 2/24/16 Time of Fall: 10:30 (10:30 a.m.) . Description of Fall: Prior to fall resident noted shaking side rail as well as yelling out. There was a bump and yelling noted. Upon entering room resident noted on floor with side rail noted down. Resident noted laying lateral to to bed .<br>A review of RI #1's Fall Risk Evaluation dated 04/12/2016, revealed RI #1 had not sustained a fall in the past three months.<br>A review of RI #1's Side Rail Safety Review dated 06/27/2016, revealed RI #1 did not have a history of falls.<br>An Annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 06/27/2016, assessed RI #1 under Section G - Functional Status, as having impairments on both sides to the upper and lower extremities.<br>RI #1's Resident Care Cardex Worksheet, (no date) documented:<br>. Resident shakes Side rails at times and will turn self upside down in bed.<br>-Resident does hit at staff at times<br>-Loves grabbing and kissing you hand .<br>On 08/17/2016, at 11:34 a.m., the surveyor conducted an interview with EI #13, the Resident Care Management Director. The surveyor asked EI #13 who completed RI #1's Fall Risk Evaluations. EI #13 said she did. The surveyor asked EI #13 should RI #1's 02/24/2016 fall have captured on the 04/12/2016 Fall Risk Evaluation. EI #13 replied, Yes . The surveyor asked EI #13 why the fall was not a coded on the 04/12/2016 evaluation. EI #13 replied, I must have over looked it when I did that chart review or I just forgot to put it on there.<br>On 08/18/2016, at 8:44 a.m., the surveyor conducted an interview with EI #28, the MDS Coordinator. The surveyor asked EI #28 who completed Section G on RI #1's 06/27/2016 MDS assessment. EI #28 said she did. The surveyor asked EI #28 why RI #1 was coded 2 for upper and lower extremities on this MDS assessment. EI #28 said that meant RI #1 had physical limitations to the upper and lower extremities bilaterally. EI #28 said she could not pinpoint what the limitations were, just that RI #1 had limitations. The surveyor asked EI #28 if therapy had completed an evaluation since she mentioned she could not pinpoint RI #1's limitations. EI #28 said she did not see where RI #1 was on a therapy case load. EI #28 said she knew RI #1 could move her upper body and hands but not to what degree. The surveyor asked EI #28 could RI #1 move about in bed. EI #28 replied,(He/She) could move (him/herself) from side to side according to staff.<br>On 08/18/2016 at 10:32 a.m., the surveyor conducted an interview with EI #29, the Licensed Practical Nurse who completed RI #1's 06/27/16, Side Rail Safety Review. The surveyor showed EI #29 RI #1's Side Rail Safety Review and said, I see where you checked no to the question does the resident have a history of falls. EI #29 replied, I checked no because I didn't see anything in the chart. EI #29 said when she entered RI #1's room (on the day she did her assessment), RI #1 was holding onto the side rails. The surveyor asked EI #29 could RI #1 put his/her legs over the side rail. EI #29 replied, (He/She) could. I saw (him/her) do that on that day. (He/She) had (his/her) lower leg over the rail.<br><br>2. RI #11 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED].<br>A review of RI #11's most recent Significant Change MDS with an ARD of 02/15/2016 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 14, which indicated the resident was cognitively intact.<br>A review of the facility's INCIDENT/ACCIDENT REPORT revealed RI #11 had a fall on 09/13/2015.<br>A review of RI #11's FALL RISK EVALUATION form with a date of 09/18/2015 revealed the resident had no falls in the past three months.<br>On 08/17/2016 at 9:40 a.m., an interview was conducted with EI #25, Staff Development Manager. EI #25 was asked if RI #11 had a fall on 09/13/2015. EI #25 said yes. EI #25 was asked what was documented on the FALL RISK EVALUATION form on 09/18/2015 under section B-history of falls. EI #25 said no history of falls in past three months was documented. EI #25 was asked what should be documented on 09/18/2015 under section B-history of falls since the resident had a fall on 09/13/2015. EI #25 said it should be documented that the resident had a fall. EI #25 was asked why the 09/13/2015 fall RI #11 had was not documented on the 09/18/2015 FALL RISK EVALUATION form. EI #25 said she was not aware of the fall. EI #25 was asked if she was made aware of the fall at any time during the resident's assessment period. EI #25 said no. EI #25 was asked if she was responsible for conducting a thorough and accurate assessment. EI #25 said yes. EI #25 was asked who was responsible for making sure the FALL RISK EVALUATION form for RI #11 was correct on 09/18/2015. EI #25 said she was. EI #25<br>was asked if RI #11 was assessed correctly if the 09/13/2015 fall was not documented on the 09/18/2015 FALL RISK EVALUATION<br>form. EI #25 said it would not be correct. EI #25 was asked what the potential harm was in RI #11's FALL RISK EVALUATION form being inaccurate. EI #25 said they (facility staff) may assume the resident had no falls.<br>A review of RI #11's SIDE RAIL SAFETY REVIEW form with a review date of 09/18/2015 revealed the resident had no history of falls.<br>On 08/17/2016 at 9:55 a.m., an interview was conducted with EI #25. EI #25 was asked if RI #11 had a fall on 09/13/2015. EI #25 said yes ma'am. EI #25 was asked what was documented on the SIDE RAIL SAFETY REVIEW form dated 09/18/2015 concerning a<br>history of falls. EI #25 said no history of falls was documented. EI #25 was asked if RI #11 was assessed correctly if the SIDE RAIL SAFETY REVIEW form dated 09/18/2015 documented no history of falls and the resident had a fall on 09/13/2015. EI #25 said no, it was not coded correctly. EI #25 was asked what the potential harm was if a SIDE RAIL SAFETY REVIEW form was coded incorrectly. EI #25 said the resident could have a fall.<br>A review of the facility's INCIDENT/ACCIDENT REPORT revealed RI #11 had a fall on 02/23/2016.<br>A review of RI #11's FALL RISK EVALUATION form with a date of 02/29/2016 revealed the resident had no falls in the past three months.<br>On 08/17/2016 at 5:25 p.m., an interview was conducted with EI #10, LPN (Licensed Practical Nurse). EI #10 was asked if RI #11 had a fall on 02/23/2016. EI #10 said yes. EI #10 was asked what was documented on the FALL RISK EVALUATION form on 02/29/2016 under section B-history of falls. EI #10 said no falls. EI #10 was asked what should be documented on 02/29/2016 under section B. EI #10 said a 2 should be documented, which meant one to two falls in the past three months. EI #10 was asked why the 02/23/2016 fall RI #11 had was not documented on the 02/29/2016 FALL RISK EVALUATION form. EI #10 said she did not have any prior knowledge of the fall. EI #10 was asked where she got knowledge and how would she know the resident had a fall. EI #10 said she could look back on the SBAR (Situation, Background, Appearance, Review) form. EI #10 was asked if she looked back on the SBAR form. EI #10 said no ma'am. EI #10 was asked who was responsible for making sure the FALL RISK EVALUATION form for RI #11 on 02/29/2016 was correct. EI #10 said she was and the supervisor looked at it after she did. EI #10 was asked if RI #11 was assesses correctly if the fall on 02/23/2016 was not documented on the 02/29/2016 FALL RISK EVALUATION form. EI #10 said no. EI #10 was asked what the potential harm was in RI #11's FALL RISK EVALUATION form |

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| F 0278<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 2)<br>being inaccurate. EI #10 said staff would not know if the resident had a prior risk of falls.<br>A review of RI #11's MDS with an ARD of 09/15/2015 revealed the resident had no falls since prior assessment. EI #28, MDS/Care plan RN (Registered Nurse) signed that section J of the MDS was completed on 09/18/2015.<br>A review of RI #11's MDS with an ARD of 09/25/2015 revealed the resident had no falls since prior assessment. EI #28 signed that section J of the MDS was completed on 09/29/2015.<br>On 08/18/2016 at 10:07 a.m., an interview was conducted with EI #28. EI #28 was asked who completed section J on RI #11's MDS with an ARD of 09/15/2015. EI #28 said she did. EI #28 was asked if RI #11 had a fall on 09/13/2015. EI #28 said according to the incident report, yes. EI #28 was asked what was documented on RI #11's MDS with an ARD of 09/15/2015 under section J1800 concerning falls. EI #28 said no was documented. EI #28 was asked what should have been documented under section J1800. EI #28 said yes. EI #28 was asked if the MDS with an ARD of 09/15/2015 was coded correctly since the resident had a fall on 09/13/2015, and section J1800 on the MDS had no evidence of a fall. EI #28 said no. EI #28 was asked who completed section J on RI #11's MDS with an ARD of 9/25/2015. EI #28 said according to the MDS, she did. EI #28 was asked what was documented concerning falls under section J1800 on RI #11's MDS with an ARD of 09/25/2015. EI #28 said no was documented. EI #28 was asked what should be documented under section J1800. EI #28 said yes should be documented. EI #28 was asked if the MDS with an ARD of 09/25/2015 coded correctly since the resident had a fall on 09/13/2015, and section J1800 did not have any evidence of a fall. EI #28 said according to the MDS, no. EI #28 was asked if the MDS with a 09/15/2015 ARD should have captured the 09/13/2015 fall. EI #28 said yes. EI #28 was asked if the MDS with a 09/25/2015 ARD have captured the 09/13/2015 fall. EI #28 said yes. EI #28 was asked what the potential harm was in RI #11's MDS's being coded incorrectly. EI #28 said the MDS drove the care for the residents and it drove the care plans that they developed. |
| F 0279<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interviews and record review, the facility failed to ensure a comprehensive care plan,for the use of side rails, was developed for Resident Identifier (RI) #11.<br>This affected RI #11, one of 14 sampled residents whose plan of care was reviewed.<br>Findings Include:<br>A review of a facility policy titled, Care Planning & (and) Care Conference with a revision date of January 2012 revealed:<br>. COMPREHENSIVE PLAN OF CARE .<br>the Comprehensive Plan of Care must:<br>Address the residents individual needs, strengths and preferences .<br>RI #11 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED].<br>A review of RI #11's most recent Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/15/2016, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS also revealed the resident required extensive assistance of two or more persons for bed mobility.<br>A review of RI #11's SIDE RAIL SAFETY REVIEW form with a review date of 09/18/2015, revealed the resident expressed a desire to have side rails raised while in bed to assist with mobility. The SIDE RAIL SAFETY REVIEW form also revealed the resident used the side rails for positioning or support.<br>A review of RI #11's SIDE RAIL SAFETY REVIEW form with a review date of 02/29/2016, revealed the resident expressed a desire to have side rails raised while in bed for his/her safety and/or comfort. The SIDE RAIL SAFETY REVIEW form also revealed the resident was having problems with balance or poor trunk control.<br>A review of RI #11's RESIDENT CARE CARDEX WORKSHEET revealed: . make (sure) SR (side rails) are locked .<br>A review of RI #11's care plans revealed they did not address his/her side rail use. Employee Identifier (EI)#15, the Restorative Licensed Practical Nurse/Unit Manager of the West Unit, looked through RI #11's care plans on the computer and did not find a side rail care plan. EI #15 also looked through all of RI #11's hard copy care plans and did not find a side rail care plan.<br>On 08/17/2016, at 10:35 a.m., the surveyor observed RI #11 use the bilateral half side rails to assist in turning from side to side while receiving a bath.<br>On 08/18/2016, at 8:38 a.m., an interview was conducted with EI #15. EI #15 was asked if she was responsible for updating RI #11's care plan. EI #15 said yes ma'am. EI #15 was asked if RI #11's care plan addressed the use of side rails. EI #15 said no. EI # 15 was asked why RI #11's care plan did not address side rails. EI #15 said she was not sure. EI #15 was asked if RI #11's care plan should address side rails. EI #15 said the resident used side rails as an enabler and if he/she used the side rails as an enabler, the care plan should address it. EI #15 was asked if the information from the Cardex should be transferred to the resident's care plan. EI #15 said yes ma'am, the care plan and Cardex were essential to each other. EI #15 was asked if a comprehensive care plan was developed for RI #11. EI #15 said no, it was not complete. EI #15 said the plan of care was used to see what was right for the resident and the care plan and Cardex should coincide. |
| F 0285<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Coordinate assessments with the pre-admission screening and resident review program for mentally-ill and mentally-retarded patients.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record reviews and interviews, the facility failed to ensure level II PASRR (Pre-Admission Screen and Resident Review) evaluations were completed as required on two residents.<br>This deficient practice affected Resident Identifier (RI) #4 and #11, two of twenty-one sampled residents.<br>Findings include:<br>A review of an undated facility document revealed, What is PASRR?<br>PASRR is a provision at section 1919 (e) (7) of the Social Security Act. It requires that all Medicaid certified facilities neither admit nor retain individuals with mental illness, intellectual disability or related conditions unless a thorough PASRR evaluation indicates that such placement is both appropriate and the individual's total care needs can be met. Categorical Convalescent Care Rules . When nursing facilities receive the Categorical Convalescent Care Determination, they must contact the OBRA (Omnibus Budget Reconciliation Act) Office immediately upon admission to ensure that the Level II Evaluation is completed.<br>1. RI #11 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED].<br>RI #11's PASRR Level I Screening & (and) Results dated 08/24/15, documented:<br>NOT AN OBRA PASRR LEVEL I DETERMINATION MAY REQUIRE A LEVEL II .<br>A review of RI #11's medical record revealed another PASRR LEVEL I screening was submitted indicating RI #11 had a [DIAGNOSES REDACTED]. Based on the information provided during the screening process, the individual MAY require a Level II. A VALID LEVEL I DETERMINATION WILL BE FAXED. Screening Date: 7/28/2016 9:33 AM .<br>A review of RI #11's Quarterly Minimum Data Set (MDS)assessment dated [DATE] revealed RI #11 had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15. This score indicated RI #11 was cognitively intact for daily decision making skills. RI #11 was assessed as requiring extensive assistance with all Activities of Daily Living (ADLs).<br>An interview was conducted with Employee Identifier (EI) #5, the Social Services Director on 07/28/2016, at 2:25 p.m. EI #5 was asked where are PASRR screenings performed and completed. EI #5 stated the PASRR are completed prior to admission to the facility. EI #5 was asked if a Level II evaluation is due, when was it done. EI #5 answered if it triggered, we get notice on Level I with date scheduled for Mental Health to come in. EI #5 was asked who does the Level II screening. EI #5 answered the facility does the Level II screenings. EI #5 was asked what was the facility policy related to performing Level II PASRR screenings. EI #5 answered once we get Level I with a Categorized admit, the admitting nurse notifies OBRA that the resident is in the facility. EI #5 said the facility will receive a notice with a date due and Mental Health comes in to do the Level II. EI #5 was asked if a Level II screening was performed for RI #4 and RI #11. EI #5 answered no. EI #5 |

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| F 0285<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 3)<br>was asked why not. EI #5 answered, the nurse called the Level I in, but the ball got dropped. EI #5 was asked should a Level II PASRR have been performed. EI #5 answered yes, the trigger for a Level II was there.<br>An interview was conducted with EI #6, a Registered Nurse at 5:12 p.m. on 7/28/2016. EI #6 was asked, when PASRR screenings were performed and completed. EI #6 answered, on admission or when there is a change. EI #6 was asked, if a Level II evaluation is due, when was it done. EI #6 answered, whoever sees it is supposed to call it in. EI #6 said Social services keeps a log. EI #6 was asked, who does the Level II screening. EI #6 answered, the Social Services staff. EI #6 was asked what was the facility policy related to performing Level II PASRR screenings. EI #6 answered, when the resident is admitted , we call them in to Mental Health and they set the date to come do it. EI #6 was asked if a Level II screening was performed for RI #4 and RI #11. EI #6 answered no. EI #6 was asked why not. EI #6 answered she did not know. EI #6 was asked should a Level II PASRR have been performed. EI #6 answered yes it should have been called in.<br><br>2. RI #4 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED].<br>RI #4's OBRA PASRR LEVEL 1 CATEGORICAL DETERMINATION FOR NF (Nursing Facility) CONVALESCENT CARE ADMISSION ONLY form dated<br>04/27/2016, indicated RI #4's [DIAGNOSES REDACTED]. This form also documented:<br>. this NF applicant requires a Level II Evaluation due to the documented serious mental health [DIAGNOSES REDACTED].<br>A review of RI #4's 14 day MDS assessment with an Assessment Reference Date of 06/24/2016, revealed RI #4 had a BIMS score of 11 which indicated that RI #4 was moderately impaired for daily decision making skills. RI #4 required extensive assistance with most ADLs.<br>RI #4's PASRR Level 1 Screening & Results for Mental Illness (MI) / Intellectual Disability (ID) / Related Condition (RC) form with a screening date of 07/28/2016 at 9:55 AM identified RI #4's [DIAGNOSES REDACTED]. The screening concluded . Based on the information provided during the screening process, the individual MAY require a Level II. A VALID LEVEL 1 DETERMINATION WILL BE FAXED. |
| F 0309<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | **Provide necessary care and services to maintain the highest well being of each resident**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interviews, record reviews and review of a facility policy titled, Fall Management, the facility failed to assess Resident Identifier (RI) #1 and RI #5's neurological status, as directed in the policy, after both residents sustained a fall with injuries.<br>RI #1 fell on [DATE], and sustained an injury to the forehead. The assigned nurse indicated she did not follow the facility's Policy and Procedure for Fall Management for residents with potential head injuries. RI #1 was sent out to the emergency room (ER) and the Computed Tomography (CT) revealed C1 (first cervical vertebrae) and C2 (second cervical vertebrae) neck fractures.<br>RI #5 fell on [DATE], and sustained a hematoma to the back of the head. The Assistant Director of Nursing (ADON) admitted the facility did not follow the neurological assessment protocol. The resident was sent out to the local hospital and returned with seven staples. A review of the NON-PRESSURE SKIN CONDITION RECORD dated 12/01/15 documented, site measured<br>when resident returned from the local hospital. Site measures 5 cm (centimeters) long. 7 staples intact to scalp.<br>This deficient practice affected RI #1, and RI #5, two of six residents sampled for falls and placed the health and safety of RI #1, and RI #5 in immediate jeopardy, as it was likely to cause serious injury, harm or death.<br>On 08/18/2016, at 2:00 p.m., Employee Identifier (EI) #1, the Administrator and EI #2, the Director of Nursing (DON) were notified of the findings of Immediate Jeopardy level J in the Area of Quality of Care, F 309.<br>After reviewing the facility's information provided in their Allegation of Credible Compliance (AOCC),<br>The immediate jeopardy began on 02/24/2016, and was abated on 08/19/2016.<br>Findings Include:<br>A facility policy titled Fall Management, with a revision date of August 2012, revealed the following:<br>. RESIDENT WITH POTENTIAL HEAD INJURY<br>.2. Complete the Neurological Record (see Forms Tab) per instructions .<br>1. RI #1 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED].<br>An Interdisciplinary Post Fall Review for RI #1, documented:<br>Date of Fall: 7/24/16 Time of Fall: approx. (approximately) 1600 (4:00 p.m.) - 1630 (4:30 p. m.) . Unwitnessed (was checked) . Description of Fall: Resident noted lying on blue mat on floor . skin tear noted to mid - left forehead - TAO (Triple Antibiotic Ointment) applied . Transferred to ER (emergency room ) for evaluation .<br>On 08/16/2016, at 2:15 p.m., the surveyor conducted an interview with EI #4, the Registered Nurse (RN) assigned to care for RI #1 on 07/24/2016, on the 3p-11p shift. The surveyor asked EI #4 did she observe RI #1 on the floor on 07/24/2016. EI #4 said she did. EI #4 said RI #1 was on a blue mat on the floor laying on his/her left side. The surveyor asked EI #4 what the facility ' s policy instructed her to do after finding a resident on the floor. EI #4 replied, To assess them, assist them back to bed . The surveyor asked EI #4 what she did after RI #1 was found on the floor. EI #4 said she asked the Certified Nursing Assistant (CNA) was there any reason RI #1 was on the floor. EI #4 said RI #1 had a scratch on his/her forehead and put triple antibiotic ointment on it. The surveyor asked EI #4 what type assessment did she perform on RI #1. EI #4 said she looked at RI #1 and saw that RI #1's right eye was opened. EI #4 said she asked the CNAs to put RI #1 back to bed and went to get a tab monitor. The surveyor asked EI #4 did she ask RI #1 anything while RI #1 was on the floor. EI #4 said when she realized who RI #1 was she realized RI#1 would not be able to tell her if (he/she) was hurting. The surveyor asked EI #4 what type of assessment is done when a resident is found on the floor. EI #4 said you had to make sure the resident is awake and alert. EI #4 said she did not know about the facility's policy but you would make sure the resident did not have any injuries, do vitals, and notify the family and physician. The surveyor asked EI #4 was RI #1 moving (his/her) extremities while on the floor. EI #4 replied, No, (he/she) was just lying there The surveyor asked EI #4 did she attempt to move RI #1's extremities. EI #4 said, No I didn't. The surveyor asked EI #4 did she palpate RI #1's head. EI #4 said no. The surveyor asked EI #4 were neuro checks done. EI #4 replied, Not that day . EI #4 was asked to review the Fall Management Policy and then was asked about the neurological assessment. EI #4 said a copy of the Neurological Assessment form was at the nurse's station. EI #4 went to the nurse ' s station and retrieved a copy of the Neurological Record, where the Neurological assessment findings are documented, was presented it to the surveyor for review. The surveyor asked EI #4 was the Neurological assess completed when a resident falls. EI #4 said if the resident was going to stay in the facility after a head injury then the Neurological assessment is completed. The surveyor asked EI #4 did she do level of conscious checks on RI #1. EI #4 replied, I didn't do pupil checks. I didn't do motor skill checks. I didn't do the form (Neurological Record) because we sent (him/her) out. The surveyor asked EI #4 about how long was it before RI #1 was sent out of the facility. EI #4 said about 30-35 minutes.<br>A review of the Incident/Accident Report completed by EI #4, revealed RI #1 was transferred out of the facility at 5:05 p.m.<br>On 08/18/2016 at 12:05 p.m., the surveyor conducted an interview with EI #2, the Director of Nursing (DON). The surveyor asked EI #2, what she expected her staff to do when a resident is observed on the floor. EI #2 replied, I expect the staff to assess the resident . The surveyor asked EI #2 what type assessment she would expect the nurse to perform. EI #2 said if the resident was alert the nurse would ask questions like if they are ok, in pain, and what happened (cause of the fall). EI #2 said the nurse would move the resident's extremities and usually feel the head, legs and palpate for any abnormalities. The surveyor asked EI #2 where the assessments would be performed. EI #2 said if the resident is found on the floor, then the assessment would be done on the resident while he/she is on the floor depending on the severity.<br><br>2. RI #5 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED].<br>The most recent Minimum Data Set, with an Annual Assessment Reference Date of 06/07/2016, documented the following. Section C; Cognitive Patterns coded RI #5 with a Brief Interview for Mental Status (BIMS) score of 13 as being cognitively intact.<br>A review of the Incident/Accident report dated 07/06/2016, documented RI #5 had a fall as 2:05 p.m. RI #5 sustained a hematoma to the right top of his/her head. The report revealed a Nurse Practitioner heard the fall and immediately into RI #5's room.<br>A review of the Nurse Practitioner's Progress Note, dated 07/06/2016, documented the time of the fall as 11:30 a.m. The note revealed the following: . (RI #5) was in (his/her) room when I walked by and heard a crashing sound . Oblong, quarter sized hematoma noted . Neuro Checks initiated . The note also documented under Medical Decision Making: . neuro checks, monitor |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 015119 | A. BUILDING _____ B. WING _____ | 08/19/2016 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| WARREN MANOR HEALTH AND REHABILITATION CENTER | 11 BELL ROAD SELMA, AL 36701 |

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 0309<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | (continued... from page 4)<br>for changes<br>A review of the Neurological Record dated 07/06/2016, documented the following:<br>. Frequency: every 30 min. x 4; every 1 hour x 4 hours; every 4 hours x 24 hours; every 8 hours x for remaining 72 hours or as ordered by physician .<br>A review of the neurological record for 07/06/2016, documented the first time entry as 2:35 p. m. (three hours and five minutes after the resident sustained [REDACTED]. There was no evidence that the resident was assessed under the Eye-Motor-Verbal Responses section.<br>A review of the Neurological Record for 07/06/2016, documented the time as 3:35 p.m. and the nurses initials and vital signs. There was nothing documented under the LOC, Pupil Reaction and Eye Signs.<br>A review of the neurological record for 07/06/2016, documented the times as 4:05 p.m., 5:05 p.m., 6:05 p.m., 7:05 p.m., and 8:05 p.m. There was no assessment documented for LOC, Pupil Reaction and Eye Signs and Eye-Motor-Verbal response.<br>A review of the record for 07/06/2016, documented the time as 12:05 a.m. There was nothing documented under the nurses initials, vital signs, LOC, Pupil Reaction and Eye Signs, Eye-Motor-Verbal Responses.<br>A review of the neurological record for 07/07/2016, revealed there were two entries for this date, but there was nothing documented under the nurses initials, vital signs, LOC, Pupil Reaction and Eye Signs, Eye-Motor-Verbal Responses.<br>On 08/17/2016 at 4:50 p.m., an interview was conducted with EI #3, RN/Assistant Director of Nursing (ADON). The surveyor asked EI #3 to review the 07/06/2016 fall and RI #5's incomplete neurological assessment. When asked what the harm was in not completing the neuro checks EI #3 replied the resident could have had a change in status that staff could not have picked up on readily. The surveyor asked EI #3 why that would be harmful. EI #3 replied, we could have missed something that might have caused the resident to be sent out for further evaluation.<br>On 08/18/2016, at 9:40 a.m., an interview was conducted with Employee Identifier (EI) #23/LPN Medication Nurse. The surveyor asked EI #23 to look at the Incident/Accident Report for 07/06/2016, and asked EI #23 if she completed the form. EI #23 stated to the surveyor, Yes, I did. EI #23 was asked if RI #5's injury was considered a head injury. EI #23 stated she would consider it a head injury because the resident hit their head. EI #23 was asked if she filled out the Neurological record for 07/06/2016. EI #23 admitted , she started the neurological assessment. When asked if she completed the Neurological Record according to facility Policy instructions. EI #23 replied, no, she missed several rows and it was not completed. When asked why the record was incomplete, EI #23 did not know. EI #23 was asked what harm could come to a resident with a head injury if neuro checks are not completed. EI #23 replied something bad could happen to the resident.<br>On 08/18/2016, at 10:15 a.m., an interview was conducted with EI #24/RN Medication Nurse. The surveyor asked EI #24 if she remembered the fall RI #5 had on 07/06/16. EI #24 replied yes, she was the nurse coming on and it was reported that RI #5 had a fall and we needed to do neuro checks. EI #24 was asked if she completed the Neurological assessment checks for RI #5 on 07/06/16. EI #24 admitted she completed the 3:35 p.m., 4:05 p.m., 5:05 p.m., 6:05 p.m., 7:05 p.m. and 8:05 p.m. vital signs entries. When asked what the policy directed staff to do regarding Residents with Potential Head Injury, EI #24 replied to complete the Neurological Record according to instructions. EI #24 was asked if she completed the Neurological assessment checks according to the policy. EI #24 admitted she did not. When asked why not, EI #24 replied, because she did not think she read the Neurological form thoroughly. EI #24 was asked what could be the harm to a resident with a potential head injury if the neurological assessment is not completed. EI #24 replied, the resident's condition could deteriorate and you could miss the signs.<br>These deficiency was cited as the result of the investigation of complaint/report #AL 564.<br>**********<br>On 08/19/2016 at 8:12 p.m., the facility submitted an Allegation of Credible Compliance for F 309, which documented:<br>This AOC preparation and/or execution does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The AOC is prepared and/or executed solely because it is required by the law provisions of federal and state law.<br>F 309 Quality of Care<br>On 7/24/16, RI # I had a fall that resulted in an injury to her forehead. The assigned nurse indicated she did not follow the procedure for residents with head injuries.<br>On 7/6/16, RI #5 had a fall that resulted in hematoma to the back of her head on the right side.<br>Nurses failed to complete the neurological assessment per policy and failed to complete the level of consciousness, pupil reaction, eye motion, and verbal response for these two residents.<br>On 8/18/16, Administrator and Director of Nursing reviewed the fall logs since July 24, 2015 to identify any other resident with a potential head injury. Five residents were identified to have had falls with a possible head injuries. One was RI #11 had a fall on 11/3/15 with possible head injury and was investigated on 8/18/16. The second was RI #5 with a fall on 12/1/15 with possible head injury that was investigated 8/19/16. Rl #5 also had a fall 7/6/16 with a possible head injury that was investigated on 8/18/16. The third resident identified had a fall with possible head injury on 7/2/16 and was been discharged from the facility on 8/5/16. The fourth resident identified had a fall with possible head injury on 2/3/16 and was discharged from on 5/11/16. The fifth resident, RI # 1, had a fall on 7/24/16 with possible head injury was discharged from the facility on 7/24/16.<br>On 8/18/16, Staff Development Coordinator/Designee inserviced all licensed nursing staff on the fall management system with emphasis on the need to complete a neurological assessment on any resident with potential head injury. All license nurses will be inserviced prior to returning to work by SOC/Designee. Director or Nursing and Assistance Director of Nursing will over see the SOC to ensure that all license nurses are inserviced.<br>On 7/24/16, RI # 1 was discharged and is no longer in the facility. The identified nurse who was assigned to RI # 1 on said date has been removed from the schedule until re-education by Staff Development Coordinator/Designee.<br>On 8/18/16, The identified nurse assigned to Rl #5 for fall on 7/6/16 who failed to complete the neurological assessment was re-educated by the Stair Development Coordinator. One nurse identified was re-educated on 8/19/16 on the need to complete the neurological assessment after a resident falls with potential head injury by the Staff Development Coordinator. The remaining identified nurse will be re-educated on the need to complete the neurological assessment for any resident fall with a potential head injury before returning to work.<br>**********<br>On 08/19/2016, EI #1, the Administrator, EI #2, the Director of Nursing , EI #20, District Director of Care Management, EI #25, Staff Development Coordinator, and licensed nursing staff were interviewed regarding completing neurological assessments, according to facility policy. After interviews were conducted, in-service records reviewed, fall investigations reviewed, and personnel files reviewed, it was determined the facility had implemented their AOCC and demonstrated their knowledge of the Fall Management policy and procedure, allowing the survey team to exit the facility at 8:30 p.m. |
| F 0323<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | **Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interviews, record review and facility policy review, the facility failed to thoroughly investigate to determine causative factors of falls for RI #1, #5, and #11:<br>The facility's Incident/Accident Reporting for Residents and General Investigative Guidelines policies directed staff to determine causative factors to prevent future falls from happening, to identify all potential witnesses, and ensure all incidents and accidents are thoroughly investigated.<br>Resident Identifier (RI) #1, a resident with impaired cognition, who was a high risk for falls fell out of bed on 02/24/2016 with a side rail down. This fall was not investigated by the facility. On 07/24/16 RI #1 experienced another fall from bed and was transferred to a local emergency room (ER). The results of a Computed Tomography (CT) scan revealed RI #1 sustained two cervical spine fractures.<br>On 11/03/2015, RI #11 had a fall sustaining a skin tear to the left lateral wrist and a hematoma to the right forehead.<br>On 12/01/2015, RI #5 had a fall and sustained a laceration to the head, was sent to the ER and received 7 staples to the |

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| | **015119** | A. BUILDING _____ B. WING _____ | **08/19/2016** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **WARREN MANOR HEALTH AND REHABILITATION CENTER** | **11 BELL ROAD SELMA, AL 36701** |

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 0323<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 5)<br>scalp. Neither of these falls were investigation to determine causal factors to prevent reoccurrence.<br>These deficient practices affected RI #1, #5 and #11, three of six residents sampled for falls. These failures posed an immediate threat to the safety and health of RI #1, #5 and #11 because it was likely to cause serious harm, injury or death.<br>On 08/18/2016, at 2:00 p.m., Employee Identifier (EI #1), the Administrator and EI #2, the DON (Director of Nursing), were notified of the findings of substandard quality of care at the Immediate Jeopardy level J in the area of Quality of Care, F 323.<br>After reviewing the facility's information provided in their Allegation of Credible Compliance (AOCC),<br>The immediate jeopardy began on 02/24/2016 and was abated on 08/19/2016.<br>Findings Include:<br>A facility policy titled, General Investigative Guidelines, with a revision date of June 2012, documented:<br>POLICY<br>Investigations should be conducted immediately after an incident . Investigations should be thorough, accurate, and fact based. Investigation findings should be well documented, concise, and understandable. Investigation findings should be communicated as needed to appropriate parties and corrective action implemented as necessary .<br>PROCEDURE .<br>5. Identify and make a list of all potential witnesses, including staff, visitors, residents, and or outside professionals. When determining who should be considered a witness, err on the side of inclusion, where warranted .<br>8. Develop an outline of areas to be covered and/or questions to be asked of each witness based on reported facts .<br>9. d. Take notes during the interview.<br>· Document the interview participants, each participant's position, and the date and time . g. Maintain all interviews in the investigative file .<br>· 12. Review findings and determine a conclusion.<br>· a. Conclusions should be supported by written documentation and factual information .<br>·<br>· A facility policy titled, Fall Management with a revision date of August 2012, documented:<br>· OVERVIEW<br>· . If a fall occurs, the IDT (Interdisciplinary Team) conducts an evaluation to ensure appropriate measures are in place to minimize the risk of future falls .<br>·<br>· FALLS DEFINED<br>· Current CMS (Centers for Medicare and Medicaid Services) guidelines regarding falls state that a fall is defined as anytime a resident is found on the floor whether the event was witnessed/un-witnessed.<br>·<br>· CLARIFICATION .<br>· When a resident is found on the floor, the facility is obligated to investigate to determine how he or she got there and put into place an intervention to minimize it from recurring .<br>A facility policy titled, Incident/Accidents Reporting for Residents with a revision date of June 2013, documented:<br>. FUNDAMENTAL INFORMATION<br>. Note: All incidents whether Significant/Serious or not should be thoroughly investigated . 3. The facility initiates an investigation for all incidents .<br>1. RI #1 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED].<br>RI #1's Fall Risk Evaluation dated 01/26/2016, revealed RI #1 had a total score of 18 indicating RI #1 was at high risk for potential falls during this assessment period.<br>An Interdisciplinary Post Fall Review for RI #1, documented:<br>Date of Fall: 2/24/16 Time of Fall: 10:30 (10:30 a.m.) . Unwitnessed (was checked) . Description of Fall: Prior to fall resident noted shaking side rail as well as yelling out. There was a bump and yelling noted. Upon entering room resident noted on floor with side rail noted down. Resident noted laying lateral to (the) bed .<br>RI #1's Fall Risk Evaluation dated 04/12/2016 revealed RI #1 had a total score of 18 indicating RI #1 remained at high risk for potential falls during this assessment period.<br>An Annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date of 06/27/2016, assessed RI #1 as having severely impaired vision and scoring a 2 on the Brief Interview for Mental status indicating severely impaired cognition.<br>A review of RI #1's Side Rail Safety Review dated 06/27/2016, documented:<br>. 11a. Is there a possibility the resident will climb over the side rails? Yes (was indicated) .<br>An Interdisciplinary Post Fall Review for RI #1, documented:<br>Date of Fall: 7/24/16 Time of Fall: approx. (approximately) 1600 (4:00 p.m.) - 1630 (4:30 p.m.) . Unwitnessed (was checked) . Description of Fall: Resident noted lying on blue mat on floor . skin tear noted to mid - left forehead - TAO applied (Triple Antibiotic Ointment) . Transferred to ER for evaluation .<br>RI #1's Resident Transfer Form dated 07/24/2016, (no time), documented:<br>. REASON FOR TRANSFER . c/o (complaint of) skin tear forehead . (possible head injury) . AT RISK ALERTS . Falls (was checked) .<br>A review of RI #1's Diagnostic Imaging Report from the local ER, with an examination date of 07/24/2016, documented:<br>. Reason for Exam: . CT (Computed Tomography) C (Cervical)-Spine W/O (without) Contrast<br>Clinical history: fell out of bed, neck pain .<br>Findings: CT of the cervical spine was performed.<br>There is a nondisplaced fracture of the right lateral aspect of the posterior ring. There is also a nondisplaced vertical fracture of the right lateral mass of C2. That fracture extends into the right transverse process of C2. These fractures are all new .<br>Impression:<br>1. Fracture of the right lateral posterior ring of C1.<br>2. Vertical fracture through the lateral mass of C2, extending to the right transverse process .<br>On 08/11/2016 at 2:09 p.m., the surveyor conducted an interview with EI #28, the MDS (Minimum Data Set) Coordinator. The surveyor asked EI #28 who investigates falls. EI #28 said the person who completes the incident report also completes the Post Fall Review. EI #28 said a determination of the causative factor should be assessed at the time of the incident and an intervention should be put in place based on the causative factor. EI #28 said the next morning the IDT team is suppose to review and discuss the incident and the Post Fall Review to ensure that an intervention was put in place. The surveyor asked EI #28, looking at the 02/24/16, IDT Post Fall Review, what was the causative factors of the fall. EI #28 said the Post Fall Review indicated RI #1 was shaking the side rail and when staff went to investigate, RI #1 was on the floor. EI #28 said the Post Fall Review also indicated the side rail was down when staff entered the room. EI #28 replied, I don't see where it indicates what caused (him/her) to shake the side rail.<br>On 08/11/2016 at 5:04 p.m., the surveyor conducted an interview with EI #3, the Assistant Director of Nursing (ADON). The surveyor asked EI #3, according to Post Fall Review from RI #1's fall on 02/24/16, what happened. EI #3 said the description of the fall read 'Prior to fall resident noted shaking side rail and yelling out. Then there was a bump and yelling noted. Upon licensed nurse entering room resident noted on floor with the side rail down.' The surveyor asked EI #3 who reviews the falls after they happen. EI #3 replied, after falls occur the IDT reviews them the next morning. The surveyor asked EI #3 what the causative factors of RI were #1's fall on 02/24/16. EI #3 replied, . there is nothing that states the cause of the fall on the incident report . The surveyor asked EI #3, when a resident has a fall from bed, what protocol does the facility use. EI #3 replied, We use our Fall Management Policy.<br>On 08/12/2016 at 11:15 a.m., the surveyor conducted an interview with EI #6, the Registered Nurse (RN) Unit Manager of the South Wing. The surveyor asked EI #6 was she at the IDT meeting on 02/25/16. EI #6 said according to her signature she was. The surveyor asked EI #6 what was the reason for the meeting. EI #6 said the morning meeting was where they were notified of incidents or accidents. The surveyor asked EI #6 did the facility investigate the cause of RI #1's fall on 02/24/16. EI #6 said it was a part of the facility's protocol to investigate. The surveyor asked EI #6 if staff was interviewed after |

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|---|---|---|---|
| | 015119 | A. BUILDING _____ B. WING _____ | 08/19/2016 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| WARREN MANOR HEALTH AND REHABILITATION CENTER | 11 BELL ROAD SELMA, AL 36701 |

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| F 0323<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 6)<br>the fall. EI #6 said she was not the Unit Manager for RI #1 so she did not know. The surveyor asked EI #6 if she had been the Unit Manager, what would her responsibilities have been. EI #6 said she would look at the incident report, go and talk to the resident to see what happened if the resident was interviewable and she would do an investigation with all staff involved.<br>On 08/12/2016 at 12:37 p.m., the surveyor conducted an interview with EI #16, the Licensed Practical Nurse (LPN) Treatment Nurse. The surveyor asked EI #16 was she at the IDT meeting on 02/25/16, where RI #1's 02/24/16 fall was discussed. EI #16 said she was. The surveyor asked EI #16 did the facility investigate the cause of RI #1's 02/24/16 fall. EI #16 said when the Post Fall Review was done it was a part of the investigation process as well as looking at the incident report. EI #16 said if there were any witnesses to the incident they would be interviewed. EI #16 said that was a part of the process. The surveyor asked EI #16 were non-witnesses interviewed as well. EI #16 said the person who heard the incident or the person who did the incident report, the nurse completing the report or any staff that assisted during the incident would be interviewed. The surveyor asked EI #16 were statements obtained. EI #16 replied, They would interview the staff, write down what was said and have staff to sign the interview. The surveyor asked EI #16 was this done with RI #1's 02/24/16 fall. EI #16 said she did not know. The surveyor asked EI #16 whose responsibility would it have been to do those things. EI #16 said she thought EI #3, the ADON. EI #16 said if it was the weekend, the Unit Manager would have been responsible for obtaining interviews. The surveyor asked EI #16 was it documented anywhere that an investigation was done. EI #16 replied, I'm not sure . I know the interviews would not have been part of the incident report or Post Fall Review form. The surveyor asked EI #16 how the facility would evaluate circumstances and probable causes of a fall. EI #16 replied, When the fall happens, the person who puts their eyes on the resident should be looking for causative factors initially. The Unit Manager and ADON look more in-depth on a follow up type investigation. The surveyor asked EI #16 what an investigation should consist of. EI #16 said she had not been part of an investigation as far as a fall but from knowing, she knew you would ask for actual facts of what happened and look around to see if there were any causative factors in the resident ' s environment. EI #16 said you would question staff, whether it be the nurse who did the incident report or who found the resident or anyone assisting with the resident.<br>On 08/12/2016 at 2:07 p.m., the surveyor conducted a phone interview with EI #30, the former Unit Manager of the Unit RI #1 resided on. The surveyor asked EI #30 did the facility investigate the cause of RI #1's accident (fall) on 02/24/16. EI #30 said there was always an investigation that occurs after the fall if injury occurred. EI #30 replied, . Only when injury is involved is an investigation done. The surveyor asked EI #30 were staff interviewed after RI #1's 02/24/16 fall. EI #30 replied, No because there were no injuries or witnesses.<br>On 08/12/2016 at 2:42 p.m., the surveyor conducted a phone interview with EI #2, the Director of Nursing (DON). The surveyor asked EI #2 did the facility investigate the cause of RI #1's accident (fall) on 02/24/16. EI #2 said the facility completed the Post Fall Review and that was considered an investigation of the incident. EI #2 said the incident report was considered as part of the investigation as well. The surveyor asked EI #2 was interviewing the resident a part of the investigation. EI #2 replied, it could be. The surveyor asked EI #2 was interviewing the staff a part of the investigation. EI #2 replied, Yes Ma'am. EI #2 said if staff witnessed anything or had any input into the incident the facility would interview them. The surveyor asked EI #2 if she knew if staff was interviewed. EI #2 said she did not know. EI #2 said she would consider EI #10's, the LPN assigned to care for RI #1 when RI #1 fell out of bed on 02/24/16, documentation on the incident report her input. The surveyor asked EI #2 how the facility evaluated circumstances and probable causes of RI #1's 02/24/16 fall. EI #2 replied, I think we figured (his/her) fall on 02/24/16 was caused by (him/her) shaking the side rail. The surveyor asked EI #2 did the facility investigate why RI #1 was shaking the side rail or look at causative factors for RI #1 shaking the side rails. EI #2 said the facility did not. The surveyor asked EI #2 what an investigation would consist of. EI #2 said, interviewing staff involved in the accident, attempting to interview the resident if they are interviewable, interviewing witnesses, making sure these things are documented and signed and kept together in a file. The surveyor asked EI #2 if the facility had an investigative file for RI #2's 02/24/16 fall. EI #2 said not to her knowledge. The surveyor asked EI #2 who is responsible for conducting investigations. EI #2 said ultimately the Administrator and whoever he gets to help him. The surveyor asked EI #2 had she ever reviewed the facility's General Investigation Guidelines policy. EI #2 said she was not familiar with what that policy looked like. The surveyor read the General Investigation Guidelines policy to EI #2. The surveyor asked EI #2, after the surveyor read what the policy instructed the facility to do, did the facility investigate RI #1's falls according to the policy. EI #2 said, not that she could recall on RI #1's 02/24/16 fall.<br>On 08/16/2016 at 11:08 a.m., the surveyor conducted an interview with EI #27, the Certified Nursing Assistant (CNA) who assisted in getting RI #1 off the floor on 02/24/16, when the resident was found on the floor with the side rail down. The surveyor asked EI #27 did anyone ask her any questions or conduct an interview with her about how RI #1 fell out of bed on 02/24/16. EI #17 replied, No.<br>On 08/16/2016 at 1:18 p.m., the surveyor conducted an interview with EI #10, the Licensed Practical Nurse (LPN) assigned to care for RI #1 on the 3p-11p shift on 02/24/16. The surveyor asked EI #10 how RI #1 got on the floor. EI #10 said the side rail was down and she thought RI #1 came out of bed that way. EI #10 said RI #1's left side rail was down. The surveyor asked EI #10 did anyone ask her questions or conduct an interview with her about how or why RI #1 fell out of bed or was observed on the floor on 02/24/16. EI #10 replied, No. The surveyor asked EI #10 did anyone question her about why RI #1 may have been shaking the side rails that night. EI #10 replied, No. The surveyor asked EI #10 did anyone question or ask her what other factors could have contributed to RI #1 shaking the side rails. EI #10 said no. The surveyor asked EI #10 if she interviewed or asked any staff on the shift RI #1 fell out of bed any questions as to why RI #1 had been shaking the side rails. EI #10 replied, No. EI #10 said that would be something the supervisors would do. When asked if anyone checked the side rail to see why it had come down, EI #10 said she did not know.<br>On 08/17/2016 at 4:00 p.m., the surveyor asked EI #1, according to the facility's General Investigation Guidelines policy, when should an incident be investigated. EI #1 replied, Immediately after an incident . The surveyor asked EI #1 what the policy said about witnesses. EI #1 replied, Interviews should be done and they should be questioned about the facts. The surveyor asked EI #1 what the policy said about taking notes during the interview. EI #1 said, Take notes during the interview and document the person you are interviewing, the persons position and the date and time of the interview. The surveyor asked EI #1 what the policy said about an investigative file. EI #1 said the policy said to maintain all interviews in an investigative file and to keep all interviews in the investigative file. EI #1 said the policy also said the conclusion should be documented and fact based. The surveyor asked EI #1 were these things done when RI #1 was observed on the floor on 02/24/16. EI #1 replied, By my knowledge this type of investigation was not done. When asked why not, EI #1 said the facility used the Interdisciplinary Post Fall Review and Incident and Accidents forms as their investigation. When asked by the surveyor where he had gotten the information from that only falls with injuries were investigated, EI #1 said he did not know where he had gotten the information from, he just knew that was how the facility did investigations. The surveyor asked EI #1 what was determined to be the causative factors of RI #1's side rail being observed down on 02/24/16. EI #1 replied, the Interdisciplinary Post Fall Review and Incident and Accidents forms did not give any indication of the cause of the side rail being down. EI #1 said the forms just said RI #1 was shaking the side rails.<br><br>2. Resident Identifier (RI) #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>The most recent Minimum Data Set (MDS), with an Annual Assessment Reference Date (ARD) of 06/07/2016, documented the following: Section C; Cognitive Patterns coded RI #5 with a Brief Interview for Mental Status (BIMS) score of 13 as being cognitively intact.<br>A review of the Incident/Accident Report dated 12/01/2015 documented that RI #5 fell and sustained a laceration to the head and was sent to emergency room (ER).<br>A review of the NON-PRESSURE SKIN CONDITION RECORD dated 12/01/2015 documented site measured when resident returned from the<br>local hospital. Site measures 5 cm (centimeters) long. 7 staples intact to scalp.<br>On 08/17/2016 at 4:50 p.m., an interview was conducted with EI #3/Assistant Director of Nursing (ADON). The surveyor asked EI #3 who investigated RI #5's 12/01/15 fall. EI #3 replied, the Interdisciplinary Team met on 12/02/15 to discuss the fall. EI #3 was asked if there were other staff members on duty during the 12/01/15 fall. EI #3 stated yes, there should have been 2 others. The surveyor asked EI #3 if witness statements were obtained or if someone talked to them, EI #3 replied, No. EI #3 was asked if the 12/01/15 fall should have been thoroughly investigated. EI #3 replied, yes. When asked |

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| F 0323<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 7)<br>if the IDT team determined the casual factors for the 12/01/15 fall, EI #3 replied, we determined that RI #5 was going to the bathroom. The surveyor asked EI # 3 how the IDT team determined the cause of the fall. EI #3 replied, As a team we felt the information that was in the Incident/Accident Report and the Interdisciplinary Post Fall Review we didn't need to conduct an investigation.<br>On 08/17/2015 at 7:45 p.m., an interview was conducted with EI #10/LPN West Unit Charge Nurse. The surveyor asked EI #10 if anyone investigated RI #5's 12/01/15 fall. EI #10 replied, no ma'am.<br><br>3. RI #11 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED].<br>A review of RI #11's most recent Significant Change Minimum Data Set (MDS), with an Assessment Reference Date of 02/15/2016, revealed the resident had a Brief Interview for Mental Status score of 14, which indicated the resident was cognitively intact. The MDS also revealed the resident needed extensive assistance of two persons.<br>According to the Incident/Accident report, RI #11 had a fall on 11/03/2015, where the resident was found on the floor on his/her stomach and sustained a skin tear to the left lateral wrist and a hematoma to the right forehead. The fall was witnessed by the resident's spouse.<br>A review of the Interdisciplinary Post Fall Review form revealed the facility failed to obtain witness statements and determine causative factors of RI #11's 11/03/2015 fall.<br>On 08/17/2016, at 2:05 p.m., an interview was conducted with EI #19, the Registered Nurse (RN) who prepared the Incident/Accident Report for the 11/03/2015 fall. EI #19 confirmed that the Incident/Accident Report and the Interdisciplinary Post Fall Review was the completed investigation for the 11/03/2015 fall. EI #19 was asked what caused the resident's fall. EI #19 said the resident was going to the bathroom and the resident said the walker gave out. EI #19 was asked what the resident meant by gave out. EI #19 said that was just how the resident explained it to them, It gave out. According to EI #19, it did not appear to be anything wrong with the walker when they looked at it. EI #19 was asked who investigated to determine the cause of the fall. EI #19 stated she asked the resident who stated he/she was going to the bathroom. EI #19 was asked if the IDT should have determined a cause of the fall. EI #19 said yes. EI #19 was asked where the Interdisciplinary teams' decision is documented. EI #19 said it was not on the form. EI #19 was asked if the resident's spouse witnessed the fall. EI #19 acknowledged the spouse was in the room and witnessed the fall. When asked about witness statements, EI #19 said there were no witness statements. EI #19 was asked about the facility policy concerning a witnessed fall. EI #19 stated ask witnesses questions about the fall and what they saw. However, EI #19 was unable to provide witness statements for RI #11's fall. EI #19 was asked if the facility's fall policy was followed. EI #19 said as far as getting a statement from the witness, no. EI #19 was asked if the fall was investigated if the witness statement and IDT determination of causative factors were not done. EI #19 said no.<br>On 08/19/2016 at 6:12 p.m., an interview was conducted with EI #16, LPN. EI #16 was asked when was the last time she was in-serviced on falls. EI #16 said yesterday (08/18/2016). EI #16 was asked before that in-service if she was following the facility policy on investigating falls. EI#16 not step by step by the policy.<br>This deficiency was cited as the result of the investigation of complaint/report #AL 564.<br>**********<br>On 08/19/2016 at 8:12 p.m., the facility submitted an Allegation of Credible Compliance for F 323, which documented:<br>This AOC preparation and/or execution does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies, The AOC is prepared and/or executed solely because it is required by the law provisions of federal and state law,<br>F 323 Accidents<br>On 7/24/16, RI#1 had a fall that resulted in fractures to her neck.<br>On 11/3/15, RI#11 had a fall that resulted in a left lateral skin tear and hematoma to his right forehead. On 7/6/16, RI# 5 had a fall that resulted in a hematoma to the right side of her head on the back.<br>The facility failed to follow the policy on General Investigation Guidelines and failed to interview all potential witnesses to determine the causal factor for each fall.<br>On 8/18/16, Staff Development Coordinator/Designee began inservice licensed nursing staff on the General Investigation Guideline to ensure residents identified as having a fall are thoroughly assessed, documentation complete, and all potential witnesses are interviewed. All licensed nursing staff will be inserviced prior to returning to work by SDC/Designee.<br>RI #1 was discharged on [DATE] and is no longer in the facility.<br>RI #5 fall 7/6/16 -On 8/18/16, this fall incident was investigated by licensed nurses per the General Investigation Guidelines. The investigation included the review of the incident report, the interdisciplinary post fall review, and the SBAR assessment for this resident. Witness statements were obtained from · the CRNP who was in the facility and heard a noise that caused him to look into this resident's room. He saw the resident on the floor. Other witness statements included the resident, one LPN, and three Resident Care Specialists (RCS). After review of the findings, it was concluded that the casual factor for this incident was unassisted ambulation by a resident with an unsteady gait. The plan of care was updated on 7/6/16 for staff to ensure that the tab monitor is attached to the resident at all times. Results of this investigation was discussed at the Ad Hoc QAPI meeting on 8/19/16.<br>RI #11 fall 11/3/15 -On 8/18/16 this fall incident was investigated by licensed nurses per the General Investigation Guidelines. The investigation included the review of the incident report, the interdisciplinary post fall review, and the SBAR assessment for this resident. Witness statements were obtained from the resident, resident's wife who is his roommate, two RN, and one RCS. After review of the findings, it was concluded that the causal factor for this incident was that his walker collapsed as he was ambulating to the bathroom. The plan of care was updated on 11/3/15 for resident to call for assistance prior to attempts to ambulated.<br>**********<br>On 08/19/2016, EI #1, the Administrator, EI #2, the Director of Nursing, EI #20, District Director of Care Management, EI #25, Staff Development Coordinator, and licensed nursing staff were interviewed regarding the Incident/Accident Reporting, Fall Management and General Investigation Guidelines, according to the facility policy. After interviews were conducted, in-service records reviewed, fall logs reviewed, fall investigations reviewed, and personnel files reviewed, it was determined the facility had implemented their AOCC and demonstrated their knowledge of the Fall Management policy and procedure, allowing the survey team to exit the facility at 8:30 p.m. |
| F 0356<br><br>**Level of harm -** Potential for minimal harm<br><br>**Residents Affected -** Many | **Post nurse staffing information/data on a daily basis.**<br><br>The facility failed to ensure the Daily Nursing Staffing Posting form was posted prior to the beginning of the day and evening shift on 07/27/2016. This was observed on one of three days of the survey.<br>Findings Include:<br>On 07/27/2016, at 08:05 a.m., the surveyor observed the Daily Nursing Staff Posting form for the 3 pm-11pm shift for 07/26/2016, on the bulletin board beside the North Wing nurses station. The form contained the following information; census, date, shift, number of licensed and unlicensed staff and hours worked.<br>On 07/27/2016 at 09:10 a.m., the surveyor observed the Daily Nursing Staff Posting form for the 11 pm-7am shift for 07/26/2016, on the bulletin board beside the North Wing nurses station. The form contained the following information; census, date, shift, number of licensed and unlicensed staff and hours worked.<br>On 07/27/2016, at 09:25 a.m., the surveyor observed the Daily Inuring Staff Posting form for the 7 am -3pm shift for 07/27/2016, on the bulletin board beside the North Wing nurses station. The form contained the following information; census, date, shift, number of licensed and unlicensed staff and hours worked.<br>On 07/27/2016, at 5:00 p.m., the surveyor observed the Daily Nursing Staff Posting form for the 7 am - 3pm shift to still be posted on the bulletin board beside the North Wing nurses station.<br>On 07/27/2016, at 5:55 p.m., the surveyor observed the Daily Nursing Staff posting for the 7am- 3pm shift for 7/27/2016, to still be posted on the bulletin board beside the North Wing nurses station.<br>On 07/28/2016, at 2:05 p.m., an interview was conducted with Employee Identifier #2, the Director of Nursing . The surveyor asked EI #2, who was responsible for filling out the Daily Nursing Staff Posting form. EI #2 stated the staff coordinator |

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| F 0356<br><br>**Level of harm** - Potential for minimal harm<br><br>**Residents Affected** - Many | (continued... from page 8)<br>was responsible for completing the form but she has been out sick for the past week. EI #2 was asked who filled out the Daily Nursing Staff Posting form for the day and evening shift on 07/27/16. EI #2 replied, I did. The surveyor asked EI #2, when do you fill out the Daily Nursing Staff Posting form. EI #2 replied we fill it out during the morning meeting at 08:00 a.m. and then it is distributed to each unit manager to be posted on each unit. The surveyor then asked EI #2, when does the day shift begin. EI #2 replied, it begins at 07:00 a.m. The surveyor asked EI #2 when does the Daily Nursing Staff Posting form have to be posted. EI #2 replied, at the beginning of each shift. EI #2 was then asked if the Daily Nursing Staff Posting for the 07-27-16 day shift (7-3) and the evening shift (3-11) were posted prior to the beginning of each shift. EI #2 replied No. When asked why, EI #2 stated, It was because we were busy. |
| F 0371<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Store, cook, and serve food in a safe and clean way**<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure:<br>1. The flour and corn meal bins were not observed with a soiled appearance, and food particle were not on top of the containers. The bins were also observed with a use by date of 6/30/2016.<br>2. The dietary worker did not multitask with gloved hands during the tray line on 07/27/2016. The worker was observed to wipe her face, touch her clothing, and place her hands inside the tops of the insulated plate covers with contaminated gloved hands.<br>3. The dietary worker did not plate items on the tray line, on 07/27/2016, with hair not completely covered with the hair restraint; and<br>4. The gray ice cooler was not observed with a dark sticky substance on the top and sides of the cooler that contained dairy items for residents, on one of the halls of the facility.<br>These deficient practices had the potential to affect 100 residents served meals from the kitchen.<br>Findings include:<br>1. Dry Storage:<br>A review of the FDA (Food and Drug Administration) Food Code 2013, 3-05.11 revealed:<br>. Food Storage .<br>Food shall be protected from contamination by storing the FOOD:<br>(1) In a clean, dry location;<br>(2) Where it is not exposed to splash, dust, or other contamination .<br>On 07/27/2016 at 8:30 a.m., during the tour of the kitchen, an observation of the meal and flour bins were observed with a dark soiled appearance on the tops and outside of the containers. The use by dates on both containers were 06/30/16. Food particles were also observed on the tops of the containers.<br>On 07/27/2016 at 2:10 p.m., the meal and flour bins were again observed with a soiled appearance on the tops and outside of the containers. The use by dates of 06/30/16 and food particles remained on the tops of the containers.<br>On 07/27/2016 at 4:20 p.m., the use by dates on both containers remained dated 06/30/16.<br>2. Potential for Cross Contamination:<br>A review of the FDA Food Code 2013, 3-304.15 Gloves, Use Limitations revealed:<br>(A) If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.<br>A review of a form titled, Safe Food Handling, no date, revealed:<br>.Wash hands and surface often<br>Why it matters<br>Illness-causing bacteria can survive in many places around the kitchen, including your hands, utensils, and cutting boards. Unless you wash your hands, utensils, and surface the right way, you could spread bacteria to the food, and the residents.<br>On 07/27/2016 at 5:08 p.m., during the supper tray line observation, a dietary worker was observed to move a food cart around, wipe her face with the back of her arm, touch her clothing, and then proceed to cover plated items. The worker was also observed to touch the inside of the doom covers with the same gloved hands. During these tasks, the worker did not change gloves or wash her hands.<br>A review of the FDA Food Code 2013 Chapter 2- Hygienic Practices revealed:<br>. Hair Restraints 2-402.11 Effectiveness<br>. FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD(s), clean EQUIPMENT, UTENSILS, .<br>During a tray line observation on 07/27/2016 at 5:10 p.m., a dietary worker was observed working on the tray line with approximately 2 inches of hair uncovered at the neck line and on both sides of her head near the temple and ears. The worker continued to touch the inside of the insulated plate covers with contaminated gloves.<br>4. A review of the FDA Food Code 2013, 4-601.11 revealed:<br>. Cleaning of Equipment and Utensils . Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.<br>(A) EQUIPMENT FOOD-CONTACT SURFACE and UTENSILS shall be clean to site and touch.<br>On 7/27/2016 at 6:00 p.m., a gray ice cooler that contained dairy items on one of the halls in the facility, was observed soiled on the top and sides of the cooler. A sticky substance was also on the top and sides of the cooler. The facility's Registered Dietitian, Employee Identifier (EI) #12 was present during the observation.<br>On 7/28/2016 at 4:25 p.m., an interview was conducted with EI #11, the facility's Certified Dietary Manager. The surveyor asked EI #11 what was the facility's policy on the labeling of flour and meal. EI #11 stated, We date on delivery, we date when products are opened, and we put a use by date also. The surveyor discussed the concern of the soiled flour and meal bins, with the use by date of 06/30/16 and on 07/27/16. EI #11 stated, My concern is that is where the aides prep. I'm going to move those bins. They have to be careful about wiping them down each time they complete their task. The dates, I really truly believe they were dated wrong. I went back and re-dated them. The surveyor discussed the concern of of the dietary aid who was observed to multitask with gloved hands during the tray line observation on 07/27/16. The surveyor asked EI #11 what was the concern. EI #11 said Cross contamination. The surveyor asked EI #11 what was the facility's policy on hair restraints. EI #11 said the hair and beard should be fully covered. The surveyor asked EI #11 what was the concern regarding the worker whose hair was exposed on the tray line on 07/27/16. EI #11 said the hair could fall in the food. The surveyor asked EI #11 what was the concern regarding the soiled cooler that contained dairy products, observed on one of the facility's halls on 07/27/16. EI #11 said the concern is they need to be sanitized and cleared from germs. EI #11 said things should not be soiled with resident's items in them. |
| F 0441<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Have a program that investigates, controls and keeps infection from spreading.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, observation and interview, the facility failed to ensure a CNA (Certified Nursing Assistant), Employee Identifier (EI) #21, did not place a plastic bag, containing soiled linen, on the floor while bathing a resident, Resident Identifier (RI) #11 on 08/17/2016.<br>The facility further failed to ensure EI #21 washed her hands after washing RI #11's buttocks and before touching a clean brief on 08/17/2016.<br>The facility also failed to ensure EI #21 did not place a clean brief underneath a urine soiled pad before placing it on RI #11 on 08/17/2016.<br>These deficient practices affected RI #11, one of one sampled resident who was observed receiving a bed bath.<br>Findings Include:<br>A review of the facility's Infection Prevention Manual for Long Term Care with a date of 2012 revealed:<br>INFECTION PREVENTION PROGRAM OVERVIEW . GLOVE USE . E. Perform hand hygiene after removing gloves.<br>A review of Potter and Perry's FUNDAMENTALS OF NURSING EIGHTH EDITION Copyright 2013, Chapter 39 Hygiene page 793 revealed:<br>. Place soiled linen in . bags . To avoid transmitting infection, do not place soiled linen on the floor .<br>RI #11 was admitted to the facility on [DATE], and readmitted on [DATE] with [DIAGNOSES REDACTED].<br>A review of RI #11's most recent Significant Change (Minimum Data Set (MD) with an Assessment Reference Date (ARD) of |

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| F 0441<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 9)<br>02/15/2016, revealed the resident had a Brief Interview for Mental Status score of 14, which indicated the resident was cognitively intact. The MDS also revealed the resident was occasionally incontinent of urine and always incontinent of bowel.<br>A review of a facility document titled, Training Attendance revealed EI #21, RCS (Resident Care Specialist) attended an infection control in-service on 04/26/2016.<br>On 08/17/2016, at 10:35 a.m., EI #21 was observed giving RI #11 a bath. There was a plastic bag that contained soiled linen on the floor. EI #21 wiped the resident's buttocks with a washcloth. EI #21 changed her gloves and put a clean brief underneath urine soiled linen. EI #21 did not wash her hands before touching the clean brief and placing it on the resident.<br>On 08/17/2016, at 11:49 a.m., an interview was conducted with EI #21. EI #21 was asked if RI #11 was wet with urine when she changed him/her. EI #21 said yes, the resident was a heavy wetter. EI #21 was asked where the plastic bag was placed during the resident's bath. EI #21 said she did not think that she had one. The surveyor showed EI #21 the observation documentation and EI #21 said ok, it was on the floor. EI #21 was asked what was in the plastic bag. EI #21 said dirty linen, towels and clothing with urine on it. EI #21 was asked where the plastic bag should have been placed. EI #21 said on the bed. EI #21 was asked what the potential harm was if a plastic bag with soiled linen was placed on the floor. EI #21 said cross contamination. EI #21 was asked what she should have done after she cleaned RI #11's buttocks and before she touched the cleaned brief. EI #21 said change gloves and wash her hands. EI #21 was asked if she washed her hands after she cleaned RI #11's buttocks and before she touched the clean brief. EI #21 said, No. EI #21 was asked where she placed the clean brief. EI #21 said on the bed. EI #21 was asked if she placed the clean brief under the resident's soiled pad. EI #21 said she had it rolled up and she did not think that she did. The surveyor showed EI #21 the observation documentation. EI #21 said, Ok I did a lot of stuff. EI #21 was asked why she placed the clean brief underneath the urine soiled linen. EI #21 said she thought it would be better to put it underneath, but it was still contamination. EI #21 was asked what the potential harm was in placing a clean brief underneath the urine soiled linen and placing it on the resident. EI #21 said contamination. EI #21 was asked what the potential harm was if she did not wash her hands after cleaning the resident's buttocks and before touching a clean brief. EI #21 said skin contamination.<br>On 08/18/2016, at 8:13 a.m., an interview was conducted with EI #3, the Assistant Director of Nursing(ADON). EI #3 was asked if the facility had an Infection Control Committee. EI #3 said yes. EI #3 was asked how often the Infection Control Committee met. EI #3 said on a monthly basis. EI #3 was asked what systems were in place to monitor and investigate the cause of infection and the manner of how infection was spread. EI #3 said the Infection Control nurse monitored all residents monthly that were on antibiotics along with the causes, signs and symptoms, cultures and reports. EI #3 said the Infection Control nurse monitored whether or not a culture was ordered at the end of the antibiotic therapy to identify any trends.<br>On 08/18/2016, at 8:16 a.m., an interview was conducted with EI #25, the Staff Development Manager (former Infection Control Nurse). EI #25 was asked what systems were in place to maintain records of incidents and corrective actions related to infection. EI #25 said the Infection Control log. EI #25 was asked where plastic bags with soiled linen in them should be placed during bathing. EI #25 said either in a chair or at the foot of the bed. EI #25 was asked if it was an acceptable practice of that facility for a CNA to place a plastic bag with soiled linen in it on the resident's floor. EI #25 said no ma'am. EI #25 was asked why that was not acceptable. EI #25 said it was an infection control issue and it spread infections. EI #25 said that was one of the components of the in-service and they were taught they could use the chair or the foot of the bed. EI #25 was asked what a CNA should do after washing a resident's buttocks and before touching a clean brief. EI #25 said they were taught when going from a dirty to a clean area, take gloves off, wash hands and then proceed. EI #25 was asked what the potential harm was if a CNA washed a resident's buttocks and did not wash their hands before they touched a clean brief. EI #25 said it was a potential for spreading infection. EI #25 was asked where the clean brief should be placed during perineal care. EI #25 said they should take soiled pad off, wash, re-glove and start with clean. EI #25 was asked if a CNA should place the clean brief underneath urine soiled pads. EI #25 said no. EI #25 was asked why that should not be done. EI #25 said it was a potential for infection. |
| F 0490<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Be administered in an acceptable way that maintains the well-being of each resident .**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interviews and record reviews, the Administrator, Employee Identifier (EI) #1, who is responsible for the overall management of the facility and EI #2, the Director of Nursing (DON), who is responsible for ensuring nursing staff is providing quality and appropriate resident/patient care, failed to ensure all policies regarding Falls and Incident/Accidents were followed and implemented.<br>This deficient practice affected RI #1, RI #5 and RI #11, three of six residents sampled for falls, and had the potential to affect all 123 residents who resided in the facility at the time of the survey and placed the health and safety of RI #1, RI #5 and RI #11 in immediate jeopardy, as it was likely to cause serious injury, harm or death.<br>On 08/18/2016, at 2:00 p.m., EI #1, the Administrator and EI #2, the DON were notified of the findings of Immediate Jeopardy level J in the Area of Administration, F 490.<br>The immediate jeopardy began on 02/24/2016, and was abated on 08/19/2016.<br>Findings Include:<br>Cross reference F 309 regarding the facility's failure to follow their Policy and Procedure for Fall Management for residents with potential head injuries. RI #1 fell on [DATE], and sustained an injury to the forehead and neck fractues. RI #5 fell on [DATE], and sustained a hematoma to the back of the head requiring seven staples. The Assistant Director of Nursing (ADON) admitted the facility did not follow their neurological assessment protocol.<br>Cross reference F 323 regarding the facility ' s failure to follow their Incident/Accident Reporting for Residents and General Investigative Guidelines policies which directed staff to determine causative factors to prevent future falls from happening, to identify all potential witnesses, and ensure all incidents and accidents are thoroughly investigated for RI #1, #5, and #11.<br>EI #1's Job Description Administrator with a revised date of 01/29/03, documents:<br>. SUMMARY<br>Responsible for the overall management of a facility .<br>ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may be assigned .<br>· Ensures compliance with applicable . regulatory . guideline and standards .<br>EI #2's Job Description for Director of Nursing, with a revised date of 10/01/2003, documented: .SUMMARY .<br>Responsible for the overall direction, coordination and evaluation of nursing care and services provided to the residents.Ensures nursing staff is providing quality and appropriate resident/patient care that meets or exceeds company and regulatory standards.<br>On 08/12/2016, at 2:42 p.m., the surveyor conducted a phone interview with EI #2, the Director of Nursing (DON). The surveyor asked EI #2 what an investigation would consist of. EI #2 said, interviewing staff involved in the accident, attempting to interview the resident if they are interviewable, interviewing witnesses, making sure these things are documented and signed and kept together in a file. The surveyor asked EI #2 who is responsible for conducting investigations. EI #2 said ultimately the Administrator and whoever he gets to help him. The surveyor asked EI #2 had she ever reviewed the facility's General Investigation Guidelines policy. EI #2 said she was not familiar with what that policy looked like.<br>On 08/17/2016, at 4:00 p.m., the surveyor asked EI #1, what training were you provided on the facility's policy titled, General Investigation Guidelines. EI #1 stated, No one sat down and gave me individual training. It would be something I would have to sit down and read if I did an investigation. EI #1 was asked according to the facility's General Investigation Guidelines policy, when should an incident be investigated. EI #1 replied, Immediately after an incident . The surveyor asked EI #1 what the policy said about witnesses. EI #1 replied, Interviews should be done and they should be questioned about the facts. The surveyor asked EI #1 what the policy said about notes during the interview. EI #1 said, Take notes during the interview and document the person you are interviewing, the persons position and the date and time of the interview. The surveyor asked EI #1 what the policy said about an investigative file. EI #1 said the policy said to maintain all interviews in an investigative file and to keep all interviews in the investigative file. EI #1 said the policy also said the conclusion should be documented and fact based. During this interview, EI #1 admitted the facility |

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| F 0490<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 10)<br>only conducted a .full blown . investigation when a resident sustained [REDACTED].#1 was asked where he had gotten this information from that only falls with injuries were investigated. EI #1 stated he did not know where he had gotten the information from, he just knew that was how the facility did investigations.<br>On 08/19/2016, at 7:55 p.m., a follow up interview was conducted with EI #1. EI #1 was asked if he felt the facility did a complete and thorough investigation of falls after his review of the recent falls and re-investigations. EI #1 said no, they (facility) failed to understand and follow their General Investigation Guidelines and Fall Management Policy.<br>This deficiency was cited as the result of the investigation of complaint/report #AL 564.<br>**********<br>On 08/19/2016, at 8:12 p.m., the facility submitted an Allegation of Credible Compliance for F 490, which documented:<br>This AOC preparation and/or execution does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The AOC is prepared and/or executed solely because it is required by the law provisions of federal and state law.<br>August 19, 2016<br>F490 Administration<br>Administration failed to ensure that policy and procedure related to incidents and accidents were followed and implemented for RI#I, #5, and #11.<br>On 8/19/16, the District Director of Care Management re-educated the Administrator and Director of Nursing on the Fall Management System and Incident/ Accident Reporting for Residents. She reviewed with Administrator and Director of Nursing the investigative files for RI #5 and# 11 to ensure compliance per the General Investigation Guidelines. She also attended the Ad Hoc QAPI meeting on 8/19/16.<br>The District Director of Care Management will provide oversight for the Administrator and Director of Nursing during her weekly visits starting 8/19/16. At that time, she will review with Administrator and Director of Nursing resident falls to ensure investigations are completed in accordance with the General Investigation Guidelines. All residents' falls will be reported by the Administrator/Director of Nursing/Designee to the District Director of Care Management the day of the fall or no later than the next business day for review starting 8/19/16.<br>Rl #1 was discharged and is no longer in the facility.<br>RI #5 fall 7/6/16 -On 8/18/16, this fall incident was investigated by licensed nurses per the General Investigation Guidelines. The investigation included the review of the incident report, the interdisciplinary post fall review, and the SBAR assessment for this resident. Witness statements were obtained from the CRNP who was in the facility and heard a noise that caused him to look into this resident's room. He saw the resident on the floor. Other witness statements included the resident, one LPN, and three Resident Care Specialists (RCS). After review of the findings, it was concluded that the casual factor for this incident was unassisted ambulation by a resident with an unsteady gait. The plan of care was updated on 7/6/16 for staff to ensure that the tab monitor is attached to the resident at all times. Results of this investigation was discussed at the Ad Hoc QAPI meeting on 8/19/16.<br>RI #11 fall 11/3/15 -On 8/18/16 this fall incident was investigated by licensed nurse per the General Investigation Guidelines. The investigation included the review of the incident report, the interdisciplinary post fall review, and the SBAR assessment for this resident. Witness statements were obtained from the resident, resident's wife who is his roommate, two RNs, and one RCS. After review of the findings, it was concluded that the causal factor for this incident was that his walker collapsed as he was ambulating to the bathroom. The plan of care was updated on 11/3/15 for resident to call for assistance prior to attempts to ambulated. Results of this investigation was discussed at the Ad Hoc QAPI meeting on 8/19/16.<br>**********<br>On 08/19/2016, EI #1, the Administrator, EI #2, the DON, EI #20, District Director of Care Management, EI #25, Staff Development Coordinator, and licensed nursing staff were interviewed regarding the Fall Management and Incident/Accident Reporting, according to the facility policy. After interviews were conducted, in-service records reviewed, fall investigations reviewed, and personnel files reviewed, it was determined the facility had implemented their AOCC and demonstrated their knowledge of the Fall Management policy and Incident/Accident Reporting procedure, allowing the survey team to exit the facility at 8:30 p.m. |
| F 0493<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **1) Set up a group that is legally responsible for writing and setting up policies for leading and running the nursing home; or 2) hire a properly licensed administrator.**<br><br>Based on interview and review of facility policies, the Corporate Division Director of Operations, Employee Identifier (EI) #31 failed to ensure the facility's Administrator EI #1, was provided oversite and guidance regarding the Fall Management, Incident/Accident and Fall Protocols. The Corporate Division Director of Operations, EI #31 acknowledged the facility did not conduct thorough investigations on each fall.<br>This deficient practice affected RI #1, RI #5 and RI #11, three of six residents sampled for falls with injuries, i.e., scalp lacerations, hematomas to the head and cervical fractures, and placed the health and safety of RI #1, RI #5 and RI #11 in immediate jeopardy, as it was likely to cause serious injury, harm or death.<br>On 08/18/2016, at 2:00 p.m., EI #1, the Administrator and EI #2, the DON (Director of Nursing) were notified of the findings of Immediate Jeopardy level J in the Area of Governing Body, F 493.<br>The immediate jeopardy began on 02/24/2016 and was abated on 08/19/16.<br>Findings Include:<br>Cross reference F 490 regarding the Administrator's, Employee Identifier (EI) #1, and EI #2, the Director of Nursing's (DON), failure to ensure all policies regarding Falls and Incident/Accidents were followed and implemented.<br>On 08/18/2016, at 12:28 p.m., a phone interview was conducted with the Corporate Division Director of Operations, EI #31. EI #31 was asked by the surveyor what his responsibilities were. EI #31 said he reviewed overall operations and looked at how things were operating in the facility. EI #31 said he looked at how the Administrator was doing and looked at any systems in the facility that there may be questions about. The surveyor asked EI #31 what he does to ensure the Administrator receives training/in-services on facility policies. EI #31 said the Administrator went through orientation and sometimes in-services were conducted. The surveyor asked EI #31 what training/in-services had been provided to the Administrator on the Fall Management and General Investigation Guidelines policies. EI #31 said as far as training on policies, the Administrator had attended a meeting in April (2016) and had attended a District meeting since then. The surveyor asked EI #31 what his expectations of staff were when a resident falls. EI #31 said to do incident reports and follow the fall protocol. EI #31 said the Post Fall Reviews were also a part of the fall protocol. EI #31 said it depended on the situation if the facility did .full blown investigations. The surveyor asked EI #31 if the facility's General Investigative Guidelines policy indicated an investigation was to be conducted immediately after an incident, questions were to be asked of each witness, notes were to be taken during the interview, interview were to be maintained in an investigative file and the conclusions were to be supported by written documentation, what was the expectation of the facility staff. EI #31 said he thought the policy said, It may call for an investigation. The surveyor read from the Incident/Accident Reporting for Residents policy under Note: All incidents whether Significant/Serious or not should be thoroughly investigated and asked EI #31, was the facility expected to follow this portion of the policy. EI #31 replied, Sure. The surveyor asked EI #31 were the staff at the facility following the policy. EI #31 said, I hope so, I can't tell you if they are or not.<br>On 08/19/2016, at 7:17 p.m., an interview was conducted with EI #20, District Director of Care Management. EI #20 was asked what she determined after that visit to the facility concerning falls. EI #20 said she thought they (facility) needed to focus on the root cause and needed to do a deeper dive into falls. EI #20 was asked if it was an expectation of the Administrator, DON and District Director of Operations to know if policies and procedures were being implemented by their facility. EI #20 said yes.<br>This deficiency was cited as the result of the investigation of complaint/report #AL 564.<br>**********<br>On 08/19/2016 at 8:12 p.m., the facility submitted an Allegation of Credible Compliance for F 493, which documented: |

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| F 0493<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | (continued... from page 11)<br>This AOC preparation and/or execution does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The AOC is prepared and/or executed solely because it is required by the law provisions of federal and state law.<br>F 493 Governing Body<br>On 8/18/16, The corporate District Director of Operation failed to ensure the Administrator was provided guidance related to incidents, accidents, and fall protocol. He acknowledged the facility failed to conduct a thorough investigation on each fall.<br>On 8/19/16, the District Director of Care Management re-educated the District Director of Operations on the Fall Management System and Incident/ Accident Reporting for Residents.<br>On 8/19/16, the District Director of Care Management attended the Ad Hoc QAPI meeting and reviewed fall investigations for RI #5 and # 11 with Administrator and Director of Nursing to ensure that the General Investigation Guidelines were followed.<br>The District Director of Care Management will provide oversight for the District Director of Operations on a weekly basis starting 8/19/16. At that time, she will review with the District Director of Operations investigations related to residents falls to ensure compliance in accordance with the General Investigation Guidelines.<br>**********<br>On 08/19/2016, EI #1, the Administrator, EI #2, the DON, EI #20, and District Director of Care Management were interviewed regarding the Fall Management and Incident/Accident Reporting, according to the facility policy. After interviews were conducted, in-service records reviewed, fall investigations reviewed, and personnel files reviewed, it was determined the facility had implemented their AOCC and demonstrated their knowledge of the Fall Management policy and Incident/Accident Reporting procedure, allowing the survey team to exit the facility at 8:30 p.m. |
| F 0498<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>The facility failed to ensure correct bathing procedures were used for Resident Identifier (RI) #6. According to the Resident Care Specialist (RCS), Employee Identifier (EI) #22, on 11/05/2015 RI #6 was left on his/her side unattended while EI #22 went to retrieve more water during the bath, and RI #6 slid off of the bed to the floor.<br>This affected RI #6, one of six residents sampled for falls.<br>Findings Include:<br>EI #22's Job Description of a Resident Care Specialist (Certified Nursing Assistant), dated 08/14/13, revealed the following:.<br>. Job Summary<br>The Resident Care Specialist performs multiple care duties that contribute to the health, well-being and quality of life for the Residents of the facility.<br>Essential Duties and Responsibilities<br>· Providing personal care and services to Residents including but not limited to the following:<br>1. Assisting residents with activities of daily living such as transferring, turning and positioning, giving showers, dressing, grooming, feeding, toileting and ensuring residents are clean.<br>· Completing assignments including but not limited to the following:<br>· . Following safety rules and requirements including lift and transfer procedure .<br>A review of the SavaSenior Care Bed Bath Procedure with a revised date of April 15, 2016, revealed the following:<br>Introduction<br>A complete bed bath cleans a patient's skin, stimulates circulation, provides mild exercise .<br>Implementation .<br>· Change the bath water .<br>· Roll the patient on his side or stomach, place a towel beneath him .<br>· Change the bath water again .<br>· Turn the patient on his back .<br>RI #6 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED].<br>The most recent Minimum Data Set (MDS) with a Quarterly Assessment Reference Date (ARD) of 06/08/2016, documented the following. Section C; Cognitive Patterns coded RI #6 with a Brief Interview for Mental Status (BIMS) score of 14 indicated being cognitively intact. Section G: Functional Limitation in Range of Motion, B. Lower Extremity (hip, knee, ankle, foot) coded RI #6 as a 2, indicating impairment on both sides.<br>A review of the RI #6's Incident/Accident Report, dated 11/05/2015, documented the following:<br>. Resident was turned on his/her left side and his/her hands slipped off the SR (side rail) and he/she started to slide out of bed, so RCS lowered him/ her to the floor .<br>A review of RI #6's Interdisciplinary Post Fall Review, dated 11/05/2015, documented the following under Intervention Recommendations:<br>. Other: Staff informed to ensure resident is not completely leaned against side rail when turned and hand positioned on rail properly when turned .<br>On 08/17/2016 ,at 11:15 a.m., an interview was conducted with EI #22/RCS. EI #22 was asked when she went to get more water for RI #6 was RI #6 completely wet. EI #22 stated RI #6's bottom part was wet. EI #22 was asked if the bed sheets were wet and were sheets on the bed. EI #22 stated the sheet was wet and the wet pad was rolled up. EI #22 was asked where the wet pad was positioned. EI #22 stated the wet pad was rolled up behind RI #6's back. EI #22 was asked when did she go get the warm water for RI #6. EI #22 informed the surveyor that RI #6 had already used the bathroom again so she washed his/her and pulled the pad, turned RI #6 over and had RI #6 put his/her hand on the rail. EI #22 stated when she went to get the water, she saw RI #6 coming out of the bed, both legs were hanging off the bed, so she helped ease RI #6 to the floor. The surveyor asked EI #22 why she did not leave RI #6 on his/her back when you went to get the water. EI #6 stated RI #6 turned more by his/herself. EI #22 was asked if she should have rolled RI #6 onto his/her back when she went to get the warm water, could this have prevented the accident. EI #22 stated, (RI #6) turned him/her self.<br>On 08/17/2016, at 10:50 a.m., an interview was conducted with EI #26, a Licensed Practical Nurse (LPN). The surveyor asked EI #26 how was RI #6 positioned when she found him/her on 11/05/2015. EI #26 stated RI #6 was on his/her left side, the side closest to the hall. EI #26 was asked where was the RCS positioned. EI #26 replied, on the opposite side of the bed, the resident was all soapy. The surveyor asked EI #26 what happened when you went into the room. EI #26 replied, (RI #6) slid and was almost on the floor, we went in and got the aid to use the Hoyer lift to get RI #6 back in bed. |
| F 0514<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Keep accurate, complete and organized clinical records on each resident that meet professional standards**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interviews, the facility failed to document the accurate time of a fall Resident Identifier (RI) #5 sustained in the clinical record. This affected RI #5, one of six residents sampled for falls.<br>Findings Include:<br>A facility policy titled Incident/Accident Reporting for Residents with a Revision Date of June 2013 documented the following:<br>POLICY<br>All incidents, accidents, and unusual occurrences involving a resident are documented and reported .<br>Procedure<br>Response to All Incidents, Accidents, or Unusual Occurrences |

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| F 0514<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 12)<br>. 4. The facility documents all incidents (Significant/Serious or not) .<br>RI #5 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED].<br>The most recent Minimum Data Set (MDS) with an Annual Assessment Reference Date (ARD) of 06/07/2016, documented the following: Section C; Cognitive Patterns coded RI #5 with a Brief Interview for Mental Status (BIMS) score of 13 as being cognitively intact.<br>A review of RI #5's SNF (Skilled Nursing Facility)/NF (Nursing Facility)-PROGRESS NOTE dated 07/06/15, documented by the Nurse Practioner that time of the fall was 11:30 (11:30 a.m.).<br>A review of RI #5's Incident/Accident Report, dated 07/06/2016, documented the time of the fall as 14:05 pm (2:05 p.m.).<br>On 08/18/2016, at 9:40 a.m., an interview was conducted with Employee Identifier (EI) #23, a Licensed Practical Nurse (LPN)/Medication Nurse. The surveyor asked EI #23 to look at RI #5's 07/06/16 Incident and Accident Report. The surveyor asked EI #23 if she completed the report. EI #23 stated, I did. EI #23 was asked if she witnessed the fall. EI #23 replied, No, I didn't. EI #23 stated she was sitting at the nurses station and heard the tab alarm sounding and the Nurse Practioner was near the residents room, and when she got to the residents room the Nurse Practioner was already in the room. EI #23 stated the Nurse Practioner had assessed RI #5, and she (EI #23) assessed the resident too.<br>On 08/18/2016, at 10:15 a.m., an interview was conducted with EI #24, a Registered Nurse/Medication Nurse. The surveyor asked EI #24 if she remembered RI #5's fall on 07/06/2016. EI #24 stated yes. EI #23 said she was the nurse coming on and it was reported that RI #5 had a fall and they needed to do neurochecks.<br>On 08/18/2016 at 4:00 p.m., an interview was conducted with the Nurse Practioner. The surveyor asked the Nurse Practioner if he remembered RI #5's 07/06/16 fall. The nurse practioner stated that he did remember the fall and that he was the first one in the RI #5's room and that he documented the date and time of the incident on a progress note. |
| F 0520<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.**<br><br>Based on record review and interview, the facility failed to ensure the QA (Quality Assurance) Committee, which is led by the Administrator, developed and implemented an action plan to determine the cause of falls for residents whether or not injuries were sustained.<br>This deficient practice affected RI #1, RI #5 and RI #11, three of six residents sampled for falls and placed the health and safety of RI #1, RI #5 and RI #11 in immediate jeopardy, as it was likely to cause serious injury, harm or death.<br>On 08/18/2016, at 2:00 p.m., EI #1, the Administrator and EI #2, the DON (Director of Nursing) were notified of the findings of Immediate Jeopardy level J in the Area of Quality Assurance, F 520.<br>The immediate jeopardy began on 02/24/2016 and was abated on 08/19/2016.<br>Findings Include:<br>Cross reference F 323 regarding the facility ' s failure to follow their Incident/Accident Reporting for Residents and General Investigative Guidelines policies which directed staff to determine causative factors to prevent future falls from happening, to identify all potential witnesses, and ensure all incidents and accidents are thoroughly investigated for RI #1, #5, and #11.<br>A review of a facility policy titled, Quality Assurance and Performance Improvement Process with no date revealed:<br>.Facilities are encouraged to look at their resident population as a whole, rather than addressing individual resident matters on the QAPI (Quality Assurance and Performance Improvement) Committee.The ultimate goal of all committees is to identify trends, perform root cause analysis and implement performance Improvement Project (PIP) Teams that address areas identified.<br>Once the root cause of an OFI (Opportunities for Improvement) is identified, an effective and sustainable PIP should be developed, implemented, monitored, and sustained using the PDSA (Plan, Do, Study, Act) cycle of process improvement.<br>On 08/18/2016, at 12:00 p.m., an interview was conducted with EI #1. EI #1 was asked if the facility had a QA Committee. EI #1 said yes. EI #1 was asked who was on the Committee. EI #1 said himself, the DON, the ADON (Assistant Director of Nursing), the Rehabilitation Manager, Pharmacy, Maintenance, the Medical Director, the Treatment Nurse, the MDS (Minimum Data Set) manager, the Business Office Manager, the Administrative Director, the Social Services Manager and a resident. EI #1 was asked how often the Committee met. EI #1 said monthly. EI #1 was asked what formal method the facility used to identify issues which required QA activity. EI #1 said they looked for trends. EI #1 said every discipline brought their issues and they sat down and decided what they needed to follow up on. EI #1 was asked what formal method the facility used to respond to identified quality deficiencies. EI #1 said they did a root cause analysis and identified a PIP. EI #1 said once that was identified, interventions were put in place to track and capture trends to get to the bottom of why it was happening. EI #1 was asked what formal method the facility used to evaluate the effectiveness of that response. EI #1 said the response had to be measurable and they identified if it had increased or decreased or stayed the same. EI #1 was asked to describe the types of quality deficiencies the facility was addressing and how it addressed them. EI #1 said he and a maintenance staff member had gone throughout the facility to find maintenance issues that they needed to improve on. EI #1 was asked if the QA Committee looked at all falls in the facility to determine causal factors. EI #1 said they have not done a PIP on falls. EI #1 was asked if the QA Committee had identified falls as an issue. EI #1 said, We have not. EI #1 was asked if the QA Committee had developed and implemented a plan to address falls. EI #1 said,We have not come up with a formal plan. We discuss them individually, but we haven't come up with a game plan.<br>This deficiency was cited as the result of the investigation of complaint/report #AL 564.<br>**********<br>On 08/19/2016, at 8:12 p.m., the facility submitted an Allegation of Credible Compliance for F 520, which documented:<br>This AOC preparation and/or execution does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The AOC is prepared and/or executed solely because it is required by the law provisions of federal and state law.<br>F 520 Quality Assessment and Assurance<br>The facility failed to ensure that the QAPI committee developed and implemented action plan to determine the cause of residents' falls rather or not injuries were sustained.<br>On 8/18/2016, The Staff Development Coordinator/Designee began inservice all licensed staff on ensuring residents who had a fall are thoroughly investigated to determine the cause of the fall whether or not injuries are sustained. All licensed nursing staff will be inserviced prior to returning to work.<br>On 8/19/2016, District Director of Care educated members of the QAPI committee on their responsibilities to collect, analyze, and trend facility data and develop action plans as indicated per the Quality Assurance and Performance Improvement Process.<br>On 8/19/2016, Ad Hoc QAPl meeting with QAPI members to review falls and identify causal factor of the falls. An action plan was developed to ensure all residents falls are thoroughly investigated in order to determine a causal factor. The Administrator is the driver and desired outcome is to complete a thorough investigation and be able to determine the cause of each fall.<br>Rl # l was discharged and is no longer in the facility.<br>RI #5 fall 7/6/16 -On 8/18/16, this fall incident was investigated by licensed nurses per the General Investigation Guidelines and determined the cause of the fall was unassisted ambulation and unsteady gait. This investigation was reviewed at the Ad Hoc QAPI meeting on 8/19/16.<br>RI #11 fall 11/3/15 -On 8/18/16, this fall incident was investigated per the General Investigation Guidelines and determined the cause of the fall was his walker collapsed as he was ambulating to the bathroom. This investigation was reviewed at the Ad Hoc QAPI meeting on 8/19/16.<br>**********<br>On 08/19/2016, EI #1, the Administrator, was interviewed regarding the Quality Assurance and Performance Improvement Process, according to the facility policy. After interviews were conducted, inservice records reviewed, fall investigations reviewed, and personnel files reviewed, it was determined the facility had implemented their AOCC and demonstrated their |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **015119** | A. BUILDING _____ B. WING _____ | **08/19/2016** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **WARREN MANOR HEALTH AND REHABILITATION CENTER** | **11 BELL ROAD SELMA, AL 36701** |

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 0520<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 13)<br>knowledge of the Quality Assurance and Performance Improvement Process policy and procedure, allowing the survey team to exit the facility at 8:30 p.m. |