STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115110	A. BUILDING _____ B. WING _____	09/02/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF BUCKHEAD	54 PEACHTREE PARK DRIVE N.E. ATLANTA, GA 30309

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 0205 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Tell the resident or the resident's representative in writing how long the nursing home will hold the resident's bed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a bed hold notice was provided to 1 of 12 sampled residents (R12) and/or her responsible party upon transfer to a local hospital. Findings include: Closed record review for Resident (R)12 revealed the resident had a [DIAGNOSES REDACTED]. Review of the resident's computerized financial record revealed the resident failed to pay her patient liability owed to the facility for 3 consecutive months. On 8/29/16 at 2:25 p.m. during an interview with the Business Office Assistant (BOA), she reported she visited the resident in her room on 4/11/16 to issue the resident a 30 day discharge notice. The BOA said the resident refused to accept the paper notice, therefore, she left the notice on the resident's bed side table. Additionally, the BOA reported the contact number the facility had on record for the resident's responsible party, was no longer working. On 4/11/16 at 5:30 p.m. the closed record indicated the resident began yelling and was uncontrollable, therefore, she was sent out to the local hospital for treatment and medication management. The following day the local hospital notified the facility of the resident's status and anticipated transport back to the nursing center. At this time the facility denied R12's readmission for failure to pay. A current policy entitled Bed Hold Policy Requirement and Notification indicated if a resident is transferred out of the facility, the facility will provide written information about the facility's bed hold policy. The Social Service Director (SSD) was interviewed on 8/29/16 at 12:00 p.m. The SSD said no bed hold notice was given to, or sent out with, the transfer paperwork informing the resident of her rights. On 4/11/16 the resident was discharged from the facility according to the Business Office Assistant without any information regarding the facility's Bed Hold Policy. During an interview with the Administrator on 8/29/16 at 2:40 p.m., he confirmed the resident was issued a 30 day discharge notice for failure to pay, and even though R12 had not exhausted her 30 day notice and the facility did not inform the resident and/or her responsible party of the bed hold policy, she was not accepted back to the facility.
F 0282 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were provided with interventions as outlined on the care plan for 1 of 12 sampled residents (R4). Resident (R) 4 sustained injuries during 2 falls at the Nursing facility. One fall resulted in hospitalization (Cross Reference F323). Findings include: Record review for R4 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. The 3/7/16 admission Minimum Data Set (MDS) assessment indicated the resident had no falls in the 6 months prior to admission, required extensive assistance of two for transfers, and scored 12 out of 15 on the Brief Interview for Mental Status (BIMS) - meaning moderate cognitive impairment. Review of the 3/9/16 care plan indicated the resident was at risk for falls related to impaired balance, amputations and vision loss. Interventions included to provide call light within reach, keep area free of clutter, staff to assist with transfers, side rails use as an enabler, provide adequate lighting and report falls to physician and responsible party. Review of the electronic skilled nurses' notes with the Staff Development Coordinator (SDC) revealed a nurse's note dated 3/23/16 timed at 4:15 p.m. indicating R4 was found on the floor. The care plan was updated on 3/23/16, indicating that the resident's fall was related to her leaning over in her wheelchair to pick up her remote control and an intervention was added instructing maintenance to assess the resident's wheelchair for proper functionality and to keep items within reach. Interview with the Maintenance Director on 9/1/16 at 12:30 p.m. regarding his assessment of the resident's wheelchair revealed he had a Maintenance Log Book kept at each nurses' station. He said the Maintenance Book was checked frequently. The Maintenance Director said staff were instructed to document any maintenance request in the book, but staff were inconsistent with documenting their requests. He further reported most staff would simply tell him what needed to be fixed while passing in the hallways or elevator. When asked if he ever assessed a wheelchair on behalf of R4, he reported he remembered the resident when she was in the facility but did not recall a request to assess the wheelchair. He further stated he and the therapy department worked together on wheelchairs and he would double check the Maintenance Log Book. On 9/1/16 at 12:40 p.m. the Maintenance Director reported he was never informed of a request to look at R4's wheelchair and never assessed her wheelchair for proper functioning; the resident's care plan was not implemented.
F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were provided with interventions and supervision to prevent repeat falls for 1 of 12 sampled residents (R4). Resident (R4) sustained injuries during 2 falls at the Nursing facility. One fall resulted in hospitalization . Findings include: Record review for R4 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the 3/7/16 admission Minimum Data Set (MDS) assessment revealed the resident had no falls in the 6 months prior to admission, required extensive assistance of two for transfers, and scored 12 out of 15 on the Brief Interview for Mental Status (BIMS) - meaning moderate cognitive impairment. Closed record review for (R4) on 8/31/16 at 9:40 a.m. revealed upon admission the resident was assessed for falls and a care plan was generated on 3/9/16. Review of the care plan indicated the resident was at risk for falls related to impaired balance, amputations and vision loss. Interventions included to provide call light within reach, keep area free of clutter, staff to assist with transfers, side rails use as an enabler, provide adequate lighting and report falls to physician and responsible party. Review of the electronic skilled nurses' notes with the Staff Development Coordinator (SDC) revealed a nurse's note dated

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

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F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) 3/23/16 timed at 4:15 p.m. indicating R4 who is a bilateral above the knee amputee was heard in her room screaming for help. A Certified Nurse Aide (CNA) went to R4's room and alerted the nurse to come and assist because the resident had fallen and help was needed to get the resident off the floor. Review of a form in the closed record labeled Nursing Assessment dated 3/23/16 revealed the resident sustained [REDACTED]. The resident was seen by the facility's physician and an X-ray was obtained with negative finding. An updated plan of care dated 3/23/16 revealed the resident fall was related to her leaning over in her wheelchair to pick up her remote control and an intervention was added instructing maintenance to assess the resident's wheelchair for proper functionality and keep items within reach. There was no documented evidence of determining the root cause of the fall or implementing other interventions to prevent future falls. Interview with the Maintenance Director on 9/1/16 at 12:30 p.m. regarding his assessment of the resident's wheelchair revealed he had a Maintenance Log Book kept at each nurses' station. He said the Maintenance Book was checked frequently. The Maintenance Director said staff were instructed to document any maintenance request in the book, but staff were inconsistent with documenting their requests. He further reported most staff would simply tell him what needed to be fixed while passing in the hallways or elevator. When asked if he ever assessed a wheelchair on behalf of R4, he reported he remembered the resident when she was in the facility but did not recall a request to assess the wheelchair. He further stated he and the therapy department worked together on wheelchairs and he would double check the Maintenance Log Book. On 9/1/16 at 12:40 p.m. the Maintenance Director reported he was never informed of a request to look at R4's wheelchair and never assessed her wheelchair for proper functioning. During an interview with the SDC on 9/1/16 at 10:30 a.m. she reported, according to the resident's electronic record, the SBAR (Situation, Background, Assessment and Recommendation) note dated 4/5/16 timed 8:00 a.m. revealed the resident again fell from her wheelchair and sustained an injury. The resident was found in her room lying on the floor on her left side. Resident stated she finished brushing her teeth by the bathroom sink and was wheeling herself back to her table when she leaned forward too far and fell . Nurse's notes revealed the resident's injuries consisted of blood coming from her nose and a laceration noted on the bridge of her nose. A hematoma was noted above and around the resident's left eye. Two staff assisted the resident from the floor into the bed and the bleeding stopped. The Nurse Practitioner was in the facility, assessed the resident and instructed staff to send the resident to the hospital for evaluation and treatment. A detailed review of the hospital notes revealed the resident presented to the hospital per stretcher after her fall in the facility. According to the Emergency Physician notes dated 4/5/16, the resident had facial injury and bruising, left facial swelling and nose bleed. Results of Computed Tomography (CT scan) revealed mildly displaced fracture of the left orbital and medial wall. HemoSinus due to trauma, Left periorbital and frontal soft scalp tissue hematoma, Irregularity of the nasal bone and questionable age indeterminate nasal bone fractures. R4's pain was documented in the ER as moderate. The ER physician described the findings as suspicious and documented his concern for the resident safety. The resident did not return to the Nursing Center according to the closed record. She was discharged home from the ER with family and home health on 4/5/16.
F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure records were accurate and complete for 2 of 24 sampled residents (R4, R12). Findings indicated wound care documentation was inaccurate, discharge notes were not systematically organized and dental assessments contained conflicting data. Findings include: 1. Resident (R) 4 Record review for R4 revealed the resident sustained [REDACTED]. Record review for R4 revealed the resident had an open area with drainage and another open area without drainage on her feet, however, the resident had no feet because of bilateral amputations. Record review for R4 revealed the resident had a fall on 4/5/16. A nursing assessment post fall revealed the resident was in her wheel chair when she fell and sustained a gash to the bridge of her nose, nose bleed, hematoma on the right side of her head above and below her right eye and the eye was swollen almost closed shut. However, documentation on the Situation, Background, Assessment, and Recommendation (SBAR) dated 4/5/16 only described the resident as having a hematoma. Record review for R4 revealed the resident was admitted to the facility on [DATE] with no skin issues according to the Treatment Nurse documentation; however, nurse's notes on admission indicated the resident had a skin tear on her right buttock on admission. During an interview with the Staff Development Coordinator (SDC) on 8/31/16 at 9:20 a.m., she reported nurses were instructed not to stage a wound or document any wound as a pressure ulcer. The SDC said nurses were instructed to document skin impairment as a Skin Tear until the Treatment Nurse could observe the wound to stage and verify the skin area was a pressure ulcer. When asked to clarify, the SDC repeated and confirmed documenting a wound as a skin tear was the process the facility nurses followed as only the Treatment Nurse could stage or identify a wound as a pressure ulcer. 2. Record review for R12 revealed the resident was given a 30 day discharge notice on 4/11/16. According to the Business Office Assistant (BOA), who was interviewed on 8/29/16 at 2:25 p.m., the discharge notice was given for failure to pay her monthly liability cost The BOA reported on/8/29/16 at 11:30 a.m. the record was incomplete related to the resident's actual discharge date . The dates on record indicated the resident was sent out to the local hospital for treatment on 3/30/16. The resident returned on 4/4/16 to the facility. R4 was discharged from Medicare on 4/10/16. The resident was given a 30 day discharge notice on 4/11/16 and while out of the facility receiving treatment was discharged from the facility and not allowed to return. According to the record, the resident was discharged on [DATE] because that's when her 7 day bed hold was up.