

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

1372

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/28/2013
NAME OF PROVIDER OR SUPPLIER LANDMARK CARE AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 710 NORTH 39TH AVENUE YAKIMA, WA 98902	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Landmark Care & Rehabilitation Center on 1/18/13 and 1/28/13. A sample of 3 residents was selected from a census of 89. The sample included 1 current resident and the records of 2 former and/or discharged residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2737775 #2741283</p> <p>The survey was conducted by: ██████████ R.N.</p> <p>The survey team was from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902 Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>[Signature]</i> Residential Care Services Date</p> <p>F 157 483.10(b)(11) NOTIFY OF CHANGES SS=D (INJURY/DECLINE/ROOM, ETC)</p>	F 000	<p>ADDENDUM TO PLAN OF CORRECTION</p> <p>Submission of the Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the Facility has prepared and submitted this Plan of Correction solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in the Title 18 and Title 19 programs. The submission of the Plan of Correction within this time frame should in no way be considered or construed as agreement with the allegations of non compliance or admissions by the facility.</p>	

Received
Yakima FCS
FEB 21 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator DATE 2-19-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide timely notification of the resident's legal representative following an</p>	F 157	<p>F-157</p> <ol style="list-style-type: none"> 1. Resident #3's DPOA was notified 12/18/13 of the fall by 8:00am by the charge nurse. 2. The facility will in service all licensed nurses re: notification of changes. 3. Licensed nurse staff in-serviced on facility policy "Notification of Changes" that addresses circumstances that require notification of the resident's physician, legal representative or family member. 4. The Director of Nursing or designee will conduct random audit of 5 residents weekly for 4 consecutive weeks to ensure appropriate notifications are made related to accidents. 5. Corrective action will be completed by 2-22-13. 6. Director of nursing services will be responsible to ensure correction. 	
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F 157	<p>Continued From page 2</p> <p>accident for 1 of 3 residents sampled (#3). Failure to notify timely disallowed the legal representative an opportunity to visit directly following the accident to communicate with the resident, receive timely information, and have an opportunity to provide input concerning the proposed treatment course. Findings include:</p> <p>Resident #3: Review of the medical record revealed the resident was admitted to the facility on [REDACTED] 12 following a [REDACTED] A 12/19/12 1:10 a.m. nursing entry noted the resident was heard moaning in her room and she was found on the floor. A physician was present in the facility and examined the resident. X-rays of the resident's right wrist and full spine were ordered. The following notation appeared to refer to notification of the legal representative, "will inform am in(sic) and cont (continue) to monitor."</p> <p>The facility 12/18/12 investigation identified the fall occurred on 12/18/12 at 11:49 p.m. Noted "possible [REDACTED] contusion (injury without a break in the skin)." The documentation also noted the physician had ordered a lower thoracic (back area located adjacent to the ribs) x-ray in the morning. Documentation recorded physician notification only.</p> <p>Review of the 12/19/12 day shift nursing entries failed to reveal documentation of notification of the resident's legal representative.</p> <p>When interviewed on 1/18/13 at approximately 2:55 p.m., Staff Member H, the Charge Nurse, stated Staff Member D was working that day. Staff Member H also stated there was no note documenting the legal representative was notified</p>	F 157		

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F 157 Continued From page 3 about the resident's 12/18/12 fall.

During investigative interviews with the legal representative, she stated she was the designated Durable Power of Attorney (DPOA) for healthcare and financial decision making. The DPOA stated she had come to the facility at approximately 7:30 a.m. on 12/19/12 (nearly 8 hours after the fall). She passed the nurses station and a staff member asked her, 'Did they call you last night and tell you she fell?' The DPOA stated, "No one called me." The DPOA further stated she would have come to the facility that night to see the resident, to reassure her, and to find out the details related to the fall.

F 157

F 225
SS=D 483.13(c)(1)(ii)-(iii), (c)(2) - (4)
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility failed to notify Resident #3's DPOA in a timely manner related to the resident's 12/18/12 fall with potential injuries in order for her to assist the resident and participate in the decision making process directly post fall.

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

F 225

F225

1. According to "Nursing Home Guidelines" book (Purple Book) the facility must maintain a state "reporting log". The log must be retained in the facility and readily accessible at all times to state licensing and certification staff, and others according to their authority. Resident #1 was investigated and documented on 12/27 & 28/2013 incident logged in the facility reporting log on 12/31/2013. Resident # 2 incident investigated 12/28-12/31/2013 and logged in the facility reporting log on 12/31/2013.

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F 225	<p>Continued From page 4 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that alleged violations of neglect involving 2 of 3 sampled residents (#1 & #2) with accidents were reported to the State survey and certification agency as required by 42 CFR 483.13(c)(2)&(4). Findings include: Resident #1: Review of the medical record and facility investigative documents, revealed that on 12/27/12 Resident #1 was involved in an incident whereby chemicals (nail polish remover and polish) were left out at the nurses station and the resident possibly ingested the nail polish remover</p>	F 225	<p>2. Continue following "Nursing Home Guidelines" (purple book) and reporting guidelines for nursing homes Appendix D.</p> <p>3. Developed incident investigation checklist that includes incidents to be reviewed by two nurse managers to ensure reporting is completed according to guidelines. * Continue with training on "Abuse, Neglect, and reporting" upon hire, annually, and as needed for all staff.</p> <p>4. Weekly review of incident log with two nurse managers and/or administrator to ensure reporting is completed according to guidelines for nursing homes.</p> <p>5. Corrective action will be completed by 2/26/2013.</p> <p>6. Director of Nursing Services will be responsible to ensure corrective action is completed.</p>	

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F 225	Continued From page 5 necessitating a contact with Poison Control and a follow-up intervention. See F323 for further details. The facility failed to report the incident to the State survey agency as required. Resident #2: Review of the medical record revealed the [REDACTED] resident had multiple diagnoses including [REDACTED] weakness. The resident was also receiving [REDACTED] medication. According to the 12/28/12 nursing entry and the facility investigative documents, the resident experienced a fall with serious injuries when a staff member left him in a shower chair without direct supervision. Injuries included a facial laceration, neck fractures, and bleeding on the brain. For additional details see F323. The facility failed to report the incident to the State survey agency as required. On 2/04/13 at approximately 10:30 a.m. and 4:35 p.m. the reporting omissions were reviewed with the facility Administrator and no further information was provided.	F 225			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure professional standards of care were maintained for 1 of 3 residents (#2) reviewed. Resident #2 had an order to hold his [REDACTED] medication following an accident with a brain bleed. Based on lab results from a	F 281	F 281 1. Resident #2: Appointment with neurologist 1/17/13 for evaluation and head CT completed with no noted acute changes compared to previous head CT. Care plan revised related to anticoagulant therapy 1/22/13. 2. See # 3 & # 4 below		

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F 281	<p>Continued From page 6</p> <p>previously scheduled lab test, another physician provided a contradictory order, to administer Coumadin, the [REDACTED] medication. In accordance with professional standards, licensed nurses (LNs) should seek clarification when presented with contradictory orders. Resident #2 was placed at risk for additional bleeding and deterioration of his medical condition. Findings include:</p> <p>Resident #2: Review of the medical record revealed the resident had multiple diagnoses including [REDACTED] weakness, [REDACTED], a [REDACTED] long term use of [REDACTED] medication, and [REDACTED]. The resident's plan of care noted the resident received [REDACTED] a [REDACTED] medication, related to his diagnoses of [REDACTED] and [REDACTED] (a [REDACTED]).</p> <p>Review of the December 2012 medication administration record (MAR) revealed the resident was receiving Coumadin.</p> <p>A 12/28/12 7:10 a.m. nursing entry documented the resident was found lying face down on the floor with a puddle of blood surrounding his head. Emergency services were obtained for the resident and he was transported to the hospital for further evaluation and care.</p> <p>According to the 12/28/12 physician consultation at the hospital, the 12/28/12 CT scan of the resident's head and neck revealed two fractures in his neck, a subtle fracture of C6 (cervical vertebrae) and a fracture of C7. Additionally, the resident had two subdural hematomas (collection sites of blood) on the brain, one on each side of</p>	F 281	<p>3. Developed policy "Provision of Physician Ordered Services" to provide a reliable process for the proper and consistent provision of physician ordered services according to accepted standards of clinical practice.</p> <p>4. In-serviced licensed nurses on "Provision of Physician Ordered Services" policy which includes having two licensed nurses review physician orders for all new admissions for accuracy and licensed nurses will seek clarification when presented with contradictory orders; also in-serviced licensed nurses related to removing all pre-set diagnostic orders for individuals who discharge from Landmark.</p> <p>* Physician orders reviewed daily by charge nurses and case managers to review for discrepancies, clarifications needed.</p> <p>• Continue completing and reviewing medication error forms related to ensuring appropriate notification, clinical follow up, and staff training as needed.</p> <p>5. Corrective action will be completed by 2/26/13.</p> <p>6. Director of nursing services will be responsible to ensure correction.</p>

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F 281	<p>Continued From page 7</p> <p>the brain, and bleeding in another space as well. The resident remained in the hospital for monitoring and non-surgical interventions.</p> <p>Hospital Discharge Medication Instructions, accompanying the 12/31/12 transfer orders, directed there was a "Stop"/hold on [REDACTED] (following identification of the brain bleeding.) A follow-up INR lab test (bleeding ratio as compared to normal) was ordered on 1/14/13.</p> <p>The resident returned to the facility on 12/31/12. According to the [REDACTED] Flow Sheet and a lab report, an INR was obtained on 1/14/13. On 1/14/13 a nursing entry documented the primary care physician faxed [REDACTED] orders in response to the lab value (contrary to the hold order from the hospital).</p> <p>The January 2013 MAR identified the resident received [REDACTED] 8 milligrams on 1/14/13 and 1/15/13. Another INR was obtained on 1/16/13.</p> <p>According to the 1/17/13 medication error report, no harm was identified for the resident. The primary care physician and the physician specialist were both notified of the error.</p> <p>Per the 1/17/13 nursing entry, the physician specialist evaluated the resident and the most recent CT scans. The resident was to remain off [REDACTED]</p> <p>When interviewed on 1/18/13 at approximately 4:45 p.m., Staff Member D, a licensed nurse (LN) stated the resident had been on [REDACTED] 7 milligrams daily long term. The next INR was scheduled on 1/14/13. It reportedly had not been</p>	F 281		
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F 281 Continued From page 8
relayed to all staff to hold the [REDACTED]. When the lab results returned they were forwarded to the primary physician and he provided an order for [REDACTED] 8 milligrams with a follow-up INR in two days. Another LN talked to the resident's spouse later and there was question voiced about a [REDACTED] hold. The issue was reviewed further at that time. The physicians were notified thereafter about the administration of [REDACTED].

F 281

In accordance with professional standards, licensed nurses (LNs) should seek clarification when presented with contradictory orders. Instead of obtaining clarification, the facility administered Resident #2's [REDACTED] for two days, thus, placing him at risk for additional bleeding and deterioration of his medical condition.

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
SS=D

F 309

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

F309

1. Resident #3: Related to pain management: Received Celebrex every day, prednisone as needed, baclofen Bid, and vicodin upon admission on 1/18/2013. Pain was assessed every shift daily and on 12/2/12 with appropriate physician notification daily. On 12/23/2012 resident #3 received vicodin 5/325 in the am. Resident #3 received MS Contin when communication between pharmacist and physician was completed and licensed nurse received

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F 309	<p>Continued From page 9 were not limited to:</p> <p>Resident #3: Review of the closed medical record revealed the resident was admitted to the facility on [REDACTED]/12 at 1:34 p.m. from the hospital where she had [REDACTED]. According to discharge medication instructions from the hospital, the resident was to receive [REDACTED] 0.25 milligrams (mg) three times daily as needed for [REDACTED]. Additionally, the resident had an order for [REDACTED] 5 mg/APAP 325 mg one tablet every 4 hours as needed for [REDACTED]. The hospital medication administration record documented the resident received a dose of [REDACTED] on 12/18/12 at 4:42 a.m.</p> <p>A 12/18/12 nursing entry noted the resident was "anxious this shift." A 12/19/12 1:10 a.m. nursing entry noted the resident was heard moaning in her room (late on 12/18/12) and she was found on the floor. A physician was present in the facility and examined the resident.</p> <p>The 12/19/12 12:27 p.m. nursing entry/assessment documented the resident had "Tremors" and was assessed for [REDACTED]. Measures were suggested "to reduce [REDACTED] and to control breathing." The resident was also experiencing some back and neck pain. A later 12/19/12 a nursing entry continued to describe tremors and measures to reduce [REDACTED]. On 12/19/12 the resident's [REDACTED] medication was changed to three times daily on a routine basis (from the as needed basis).</p> <p>Review of the December 2012 medication administration record (MAR) revealed that no [REDACTED] was administered until 12/20/12 at</p>	F 309	<p>permission to pull medication from emergency kit. Related to anti-anxiety, Resident #3 admitted with order for alprazolam as needed for DX of anxiety. On 12/20/12 received orders to change alprazolam to routine TID related to clarified diagnosis of essential tremors.</p> <ol style="list-style-type: none"> 2. Residents in like situations, policies have been revised and training accordingly; see #3. 3. <ol style="list-style-type: none"> a. Revised pain management policy b. Developed "Provision of Physician Ordered Services" policy to ensure there is a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. c. Developed protocol for licensed nurses related to ordering scheduled medications to ensure residents receive timely quality care to attain or maintain the highest practicable physical, mental, and psychosocial well-being. 4.* Continue assessing and care planning residents' pain upon admission and as needed. 	

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F 309	<p>Continued From page 10 7:05 a.m., more than a day and a half after admission, despite the presence of [REDACTED] symptoms.</p> <p>When interviewed on 1/28/13 at approximately 2:30 p.m., Staff Member D, a licensed nurse (LN), stated she recalled the resident being very anxious the day of admission. The [REDACTED] was not available at the facility until the third day (12/20/12) when someone brought in her [REDACTED] from home and staff were able to administer the medication to the resident. She found out later the resident had taken the medication for years and it also helped her tremors that at times were almost like a rocking movement.</p> <p>During one of the investigative interviews, the resident's Durable Power of Attorney (DPOA) stated the resident had been taking the Alprazolam for at least 10 years. She didn't handle stress well and was noted to be very anxious since her back surgery with her placements in the hospital and nursing home. If the resident didn't receive her medication the resident's whole body would shake. A LN had approached the DPOA and asked her to bring in the resident's home supply of [REDACTED] which she did so the resident could receive the medication. The December 2012 MAR recorded the resident received the medication beginning on 12/20/12.</p> <p>According to the December 2012 MAR the resident had received her 12/23/12 routine [REDACTED] medication in the morning (at 8:45 a.m.). However, the 12/23/12 9:56 a.m. nursing entry from Staff Member I documented the</p>	F 309	<p>* Random interviews quarterly to ensure residents are receiving quality care to help maintain their highest practicable level of mental, physical, psychosocial well-being.</p> <p>* Review at resident council to ensure residents' needs are being met and are receiving quality care. * Continue daily interdisciplinary team meetings to review concerns related to resident care.</p> <p>5. Corrective action will be completed by 2/26/2013.</p> <p>5. Director of nursing services will be responsible to ensure correction.</p>	

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F 309	<p>Continued From page 11</p> <p>resident had "severe uncontrollable pain, location indeterminate. Resident lying in bed moaning.." The resident's physician was contacted and twice daily long acting [REDACTED] was ordered. The DPOA was notified in person of the new order.</p> <p>Review of the facility's list of medications contained in the E-kit (emergency kit) revealed the long acting [REDACTED] was present in the E-kit at the facility.</p> <p>The 12/23/12 nursing entry at 11:25 a.m. documented the [REDACTED] was not given as they were awaiting pharmacy delivery. Finally, the 12/23/12 1:57 p.m. entry recorded the [REDACTED] was given at that time. They had received an okay from pharmacy to pull it from the E-kit (more than 4 hours after receiving the physician's order).</p> <p>When interviewed on 1/31/13 at approximately 9:36 a.m., Staff Member I, a LN who worked on 12/23/12, stated they often had more difficulty obtaining medication on the weekends. Staff Member I stated s/he should have called the pharmacist an hour after receiving the order to request permission to pull the [REDACTED] from the E-kit. The medication "should have been given earlier. She was in pain" (despite receiving her other [REDACTED] medication and [REDACTED] medication).</p> <p>Per the records, the resident waited at least 4 hours to receive the [REDACTED] that relieved her pain.</p> <p>The DPOA was interviewed during investigative interviews and she stated, she was present at the</p>	F 309		
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F 309 Continued From page 12 facility on 12/23/12 and observed the resident moaning and grabbing her hip. She was aware of the new [REDACTED] order. The resident had others with her so the DPOA left for awhile, thought to be 3-4 hours. When she returned later she was told the [REDACTED] was still not available. The DPOA approached a LN and asked again that staff keep the resident comfortable as the resident continued to demonstrate pain (moaning).

F 309

F 323 SS=G 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

F 323

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

F 323

1. Resident #2: Staff member A stated they did not leave resident #2 without supervision—as she went to door they could still visualize resident #2. Resident #2 was immediately assessed and transported to ER for evaluation on 12/28/12. Resident #1: It is unknown if resident ingested nail polish remover. Resident #1 assessed with immediate intervention.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to prevent accidents by ensuring that staff provided immediate supervision when it was needed for 2 of 3 residents reviewed with accidents (#1 & #2). Resident #2 experienced actual harm when he fell forward out of a shower chair onto the floor sustaining blunt head trauma with neck fractures and bleeding in his brain. Cognitively impaired Resident #1 possibly ingested nail polish remover at the nurses station. Findings include but were not limited to:

2. Staff will ensure the environment remains as free of accident hazards as is possible and each resident will receive adequate supervision and assistive devices to prevent accidents by identifying, evaluating, and implementing interventions.

Resident #2: Review of the medical record revealed the resident had multiple [REDACTED]

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F 323 Continued From page 13 including [REDACTED] with [REDACTED] impairment, a [REDACTED], long term use of [REDACTED] medication, and [REDACTED]. The resident's plan of care noted he had generalized weakness and impaired mobility. Resident #2 required the use of a mechanical lift and two assistants to transfer him. He was documented as at moderate risk for falls related to his lack of awareness of his safety needs, confusion, and deconditioning. Additionally, the resident's plan of care noted, "Do not leave (the resident's name) unattended while toileting" because he required assistance for the physical process of toileting related to: "fatigue/lethargy, Imp. (impaired) mobility, Decreased strength/balance." Additionally, the resident's cognition was impaired with noted short term and long term memory losses.

A 12/28/12 7:10 a.m. nursing entry documented the resident was found lying face down on the floor with a puddle of blood surrounding his head. Emergency services were obtained for the resident and he was transported to the hospital for further evaluation and care.

According to the 12/28/12 physician consultation at the hospital, the 12/28/12 CT scan of the resident's head and neck revealed two fractures in his neck, a subtle fracture of C6 (cervical vertebrae) and a fracture of C7. Additionally, the resident had two subdural hematomas (collection sites of blood) on the brain, one on each side of the brain, and bleeding in another space as well. The resident remained in the hospital for monitoring and non-surgical interventions.

Review of the 12/28/12 facility fall investigation

F 323

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F 323	<p>Continued From page 14</p> <p>revealed Staff Members A and B, two nursing assistants (NAs), transferred Resident #2 with a mechanical lift to a shower chair in preparation for his shower. One of the NAs was putting away the lift while the other (Staff Member A) remained with the resident. Staff Member A gave the resident verbal and tactile cues to sit back in the shower chair by looking at him and placing her hand on his shoulder. Then, Staff Member A left the resident's side and went to the doorway to see if the "bath girl" was coming to take him to his bath. When she turned back around, the resident had leaned forward (again) and was falling but she was unable to reach him in time.</p> <p>On 1/18/13 at approximately 1:45 p.m., Staff Member A stated she was familiar with the resident's care needs as she frequently cared for him. Staff Member A stated that while seated in his wheelchair, the resident occasionally leaned forward and staff tilted his wheelchair back for safety. On 12/28/12 the caregivers had transferred the resident to his (upright) shower chair. Staff Member A remained with the resident. He had been "sitting fine" in the shower chair but then he leaned forward and she reminded him to sit back and he did. Staff Member A walked to the door of the room leaving the resident by his bed in the shower chair. The caregiver saw the resident falling forward out of the corner of her eye (but was unable to reach him). Staff Member A further stated the resident "forgets and thinks he can walk." He puts his hands on the arm rests and pushes off with his good hand.</p> <p>When interviewed on 1/18/13 at approximately 2:00 p.m., Staff Member B, the second NA who</p>	F 323		

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F 323	<p>Continued From page 15</p> <p>assisted with the dependent resident transfer into shower chair on 12/28/12 identified the shower chair used that day. The shower chair was an upright model and did not recline. Staff Member B stated on occasion the resident would lean forward in the shower chair.</p> <p>On 1/18/13 at approximately 2:05 p.m., Staff Member C, the Licensed Nurse (LN) on-duty on 12/28/12 recalled responding to the resident's room. Resident #2 had fallen face down onto the floor. Staff Member C maintained the resident's airway and called for assistance. Staff Member C stated the resident was usually in a tilting wheelchair, tilted a little bit as the resident forgets he can't get up. The LN identified the location of where the resident was found, on the floor near the foot of his bed, approximately 5-6 feet from the door into the hallway.</p> <p>When interviewed on 1/28/13 at approximately 11:48 a.m., Staff Member F, Resident Care Manager, stated the resident's care plan directive stating he was not to be left in the bathroom unattended pertained to his poor sitting balance.</p> <p>On 1/28/13 at approximately 11:50 a.m., Resident #2 was observed up in his wheelchair tilted back at approximately 45 degrees. The resident was wearing a soft cervical collar.</p> <p>Despite knowledge of the cognitively impaired resident's behaviors of leaning forward, (even directly before the 12/28/12 fall) and attempting to rise, and care plan directives about not leaving him in the bathroom unattended due to balance problems, Staff Member A left the resident in the shower chair to check on the whereabouts of</p>	F 323		
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F 323	<p>Continued From page 16</p> <p>another staff member. The resident fell forward sustaining a facial laceration requiring sutures, two cervical fractures, and bleeding in his brain, two sub-dural hematomas and a sub-arachnoid bleed in another area.</p> <p>Resident #1: Review of the medical record revealed the resident had [REDACTED] including a [REDACTED] and [REDACTED] with resulting [REDACTED]. According to the resident's plan of care, the resident had impaired cognition related to his head injury, wandered aimlessly in his wheelchair, and had impaired safety awareness. The resident "enjoys sitting at the nurses station. This helps with monitoring his whereabouts also." Additionally, the resident had confusion with disorientation and problematic behaviors including verbal and physical aggression.</p> <p>Review of the 12/16/12 nursing entry revealed the resident was placed on every 15 minutes safety checks following an incident when the resident exited the facility without direct staff supervision.</p> <p>A 12/27/12 8:29 a.m. nursing entry recorded that Resident #1 was found "with an open bottle of nail polish remover in hand." He stated "this tastes pretty good." Poison Control was called and the contact directed that fluids be pushed. Fluids were encouraged and the resident was monitored. No negative resident outcome was identified at that time.</p> <p>Review of the 12/27/12 Fifteen Minute Checks Page #2 failed to identify safety checks that occurred prior to 1415 (2:15 p.m.) on 12/27/12. Safety check documents were provided and</p>	F 323		

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F 323	<p>Continued From page 17 reviewed with the Staff Development Director on 1/18/13.</p> <p>According to the 12/27/12 facility investigation, updated on 12/31/12, nail polish was out on the counter at the nurses station on 12/27/12 as staff had been assisting a patient with her nails.</p> <p>On 1/18/13 at approximately 1:10 p.m. Staff Member E, the investigative LN, stated on 12/27/12 someone, thought to be Staff Member D, found the resident behind the desk in the nurses station with a bottle of nail polish remover "mostly gone" with approximately 1/4 of the fluid in the pink bottle left. The resident had made the statement that "it tastes good." The bottle had been discarded after discovery .</p> <p>Staff Member D, a LN, was interviewed on 1/18/13 at approximately 4:45 p.m. and recalled she was administering medications on 12/27/12 during day shift. She had last seen the resident in his room before breakfast and had directed staff to get him up. Some time later, Staff Member D found the resident unattended in the nurses station. The gate to the nurses station was open and he had a cup of coffee in one hand and a bottle of nail polish remover in the other hand. The Charge Nurse was away from the nurses station attending the morning stand-up meeting at that time. Staff Member D reported the incident to the Resident Care Manager for follow-up. Staff Member D stated a caregiver had used polish and the polish remover the evening before and it was left at the nurses station until it could be returned to the activity department.</p>	F 323		
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F 323	<p>Continued From page 18</p> <p>When interviewed on 1/18/13 at approximately 5:25 p.m., the Activity Director identified the brand of nail polish remover used by the facility. The eight ounce pink bottle was strawberry scented. The warning label included cautions such as: "Keep away from children...Do not breathe the vapors...Harmful if taken internally. If ingested seek medical attention immediately and contact the local poison control center. In case of eye contact, flush with water and seek medical attention..."</p> <p>Staff Member G, a NA, was interviewed on 1/21/13 at approximately 9:25 p.m. and recalled obtaining nail care supplies, polish and remover, from the activity department (on 12/26/12) and she had painted a resident's nails. The NA placed the polish and remover at the nurses station with a plan to have it returned to the activity department the next day. Staff members were aware of the nail care products at the nurses station. On evening shift the gate was reportedly usually closed. Resident #1 was often kept in the area of the nurses station, in front of the desk and occasionally behind it.</p> <p>The [REDACTED] resident was frequently brought behind the nurses station for staff supervision, an intervention described in his plan of care. On 12/27/12 the resident was found unattended at the nurses station. Facility staff failed to ensure the resident was adequately supervised in order to prevent access to potentially harmful products/chemicals.</p>	F 323		
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