

1391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/10/2013
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NAME OF PROVIDER OR SUPPLIER  CRESCENT HEALTH CARE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 505 NORTH 40TH AVENUE YAKIMA, WA 98908
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F 000 INITIAL COMMENTS

This report is the result of an unannounced Quality Indicator Survey conducted at Crescent Health Care on 1/2/13, 1/3/13, 1/4/13, 1/7/13, 1/8/13, 1/9/13 and 1/10/13. A sample of 38 residents was selected from a census of 82. The sample included 35 current residents and the records of 3 former and/or discharged residents.

The survey was conducted by:

\_\_\_\_\_, RN  
↓  
\_\_\_\_\_, RN  
ID

**Received  
Yakima RCS  
APR 1 2013**

The survey team is 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  
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*[Handwritten Signature]*  
Residential Care Services Date 3/27/13

F 272 483.20(b)(1) COMPREHENSIVE  
SS=D ASSESSMENTS

F 000

Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and it 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 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 days of the survey as a condition to participate in the Title 18 and Title 19 programs. 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. It is understood that the Centers for Medicare and Medicaid Services takes the position that the facility does not have the right to formally appeal any particular disagreements it may have with regard to specific federal citations unless there is a remedy imposed, as the term "remedy" is defined in federal regulations. This facility contends that the refusal of CMS to afford

The facility must conduct initially and periodically

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Handwritten Signature]</i>	TITLE Adm.	(X6) DATE 03/29/13
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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 272 Continued From page 1  
a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:

- Identification and demographic information;
- Customary routine;
- Cognitive patterns;
- Communication;
- Vision;
- Mood and behavior patterns;
- Psychosocial well-being;
- Physical functioning and structural problems;
- Contenance;
- Disease diagnosis and health conditions;
- Dental and nutritional status;
- Skin conditions;
- Activity pursuit;
- Medications;
- Special treatments and procedures;
- Discharge potential;
- Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
- Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced

F 272  
it such appeal rights unconstitutionally violates the facility's fundamental due process rights and that this unconstitutional denial has substantive impact on the facility's rights and property. The Supreme Court affirmed this belief in a landmark decision in 1997. Therefore, the facility reserves the right to challenge the findings of this survey if at any time; the facility determines that the findings are: (1) relied upon to adversely influence or serve as a basis in any way, for the selection and/or imposition of future remedies or any increase in future remedies. (2) Serve, in any way to facilitate or promote an adverse action by any party against the facility.

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F 272 Continued From page 2

by:  
Based on observation, interview and record review, the facility failed to comprehensively assess 1 of 3 residents reviewed (#43) who required assistance with tasks of daily living such as toileting and bathing. Findings include:

Resident #43. Per the admission assessment dated [redacted]/12, Resident #43 was alert and oriented, able to understand and be understood. He had no identified moods or behaviors. Per the assessment, he required assistance for activities of daily living which included extensive assist of one caregiver for transferring, walking in room and corridor; for locomotion on/off unit; dressing, toilet use, personal hygiene and bathing. He was not steady and only able to stabilize self with staff assistance when moving on/off toilet, from seated to standing position, walking, turning, and surface-to-surface transfers.

Nursing Assistant (NA) care directives for Resident #43 were reviewed and included instructions for a sponge bath every day and encourage resident to assist; keep skin clean and dry; lotion to dry areas as needed; peri-care every shift and as needed if incontinent; check every 2 hours for incontinence; may use skin barrier cream to excoriated areas as needed; pressure reduction mattress on bed; notify team leader of red or excoriating skin. NA flow sheets from admission indicated the resident needed some kind of physical help like guided maneuvering of limbs or other non-weight bearing assist of 1 caregiver during the activity of toileting.

Per interview with Staff Member B on 1/8/13 at approximately 1:50 p.m., she stated Resident #43

F 272

F-272 Comprehensive Assessments

02/15/13

The facility will conduct comprehensive assessments as necessary to provide the appropriate care and services for each resident. Each Case Manager is assigned a specific case load and will utilize direct observation and communication with the resident and family as well as communication with licensed and non-licensed staff, the resident's physician and consultants and review of the resident's record as a means to insure a thorough, complete assessment.

NAC's have been in-serviced to immediately report changes in condition or discrepancies between NAC flow sheets and the resident's actual condition.

The Case Manager reviewed and updated Resident #43's plan of care 12/21/13. The updated care plan was printed and placed in the resident record before the surveyor's left the facility 01/10/13

The Case Managers are responsible to assess each resident on admission, annually and within 14 days of a significant change in condition.

The Director of Nursing is responsible to periodically audit comprehensive assessments to insure continued accuracy and compliance.

IDR AMENDED

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

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F 272 Continued From page 3  
was independent with his toileting since he moved in. She said he got himself dressed and toileted himself with no staff assistance. Staff Members E, F, & G, caregivers assigned to Resident #43, were interviewed on 1/10/13 at approximately 10:30 a.m. and all verified he was independent with all cares. They said they set him up for shaving occasionally and ensured his bed was in a low position, but provided no other care for him.

The assessment/care plan described a higher level of care provision necessary for Resident #43 than he actually received and was not accurate. There was no documentation in the record to verify the facility had conducted any further assessments of Resident #43 other than the inaccurate admission assessment.

F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  
SS=D

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and record review, the facility failed to have a system in place to prevent reoccurrence of pressure sore formation for 1 of 4 residents (#43) with a known

F 272 F-272 See plan of correction previous page

F-314 Treatment to Prevent Pressure sores

Studies have shown that certain risk factors increase a residents' susceptibility to develop or not to heal pressure ulcers. Examples of these include: decreased/impaired mobility and decreased functional ability, co-morbid conditions, drugs such as steroids, impaired blood flow, resident refusal of some aspects of care and treatment, cognitive impairment, exposure of skin to urinary and fecal incontinence, under-nutrition and hydration deficits and a healed ulcer.

Resident 43 had a number of unmodifiable risk factors which led to Stage I intact pressure areas.

02/10/13

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F 314 Continued From page 4  
history of pressure sores. Findings include:

Resident #43. Admitted with diagnoses which included generalized weakness, [REDACTED], [REDACTED] and [REDACTED]. Per the nursing admission assessment dated 12, the resident's skin was intact.

Per the admission comprehensive assessment dated 12, the resident was alert and oriented and able to understand and be understood. He had no identified moods or behaviors. He required staff assistance for activities of daily living which included extensive assist of one caregiver for dressing, toilet use, personal hygiene and bathing. He was not steady and only able to stabilize self with staff assistance when moving on/off toilet. He was identified as always continent of urine and bowel. He had no identified areas of pressure. Skin and ulcer treatment interventions included: pressure reducing device for chair/ bed, nutrition/hydration intervention to manage skin problems and pressure ulcer care.

Per the plan of care dated 9/13/12, interventions for skin breakdown prevention included, documentation of skin integrity as needed; notify team leader of any reddened areas; pericare every shift and as needed; may use skin barrier salve to excoriated areas as needed; skin integrity: keep clean and dry; pressure reduction mattress; repositioning per Care Plan #3, incontinent care per Care Plan #4 and nutrition per Care Plan #6; daily therapeutic vitamins with minerals.

A temporary care plan dated 9/19/12 was in place

F 314 F-314 continued

Resident #43 was admitted 12 in a deconditioned state with diarrhea, poor nutrition, recent weight loss, and comorbid conditions and refusal of assistance with care.

Interventions for skin breakdown were instituted as stated by the surveyor.

The resident complained of pain and the facility noted the area on the resident's sacrum and immediately notified the physician. Orders were received. The physician noted on 09/24/12 (six days later) that the area "looks better." The area was healed 10/10/12. The resident's diarrhea resolved, he received therapies for strengthening. He became more independent and refused assistance from staff. He is mobile and continent. His overall nutrition has improved and his weight has increased from an admission weight of 95.2 pounds to his current weight of 112.76. The resident is at a very low risk of pressure ulcers. His skin is clear with no signs of redness.

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F 314	<p>Continued From page 5</p> <p>and identified the presence of a stage 2 pressure ulcer with additional interventions which included reposition resident frequently as well as encourage independent repositioning if able in bed and w/c (wheel chair). Notify team leader and NAC (Nursing Assistant-Certified) staff to initiate a more aggressive repositioning schedule appropriate for specific location of pressure ulcer; notify MD as needed; dietary consults as needed; keep skin clean and dry; notify family upon occurrence and any significant change; notify wound care nurse; supply resident with pressure relieving devices if available--roho cushion, air mattress overlay. A treatment, which was started on 9/20/12, was to cleanse the wound with normal saline, pat dry, apply no sting barrier, and cover with hydrocolloid dressing; check daily, change every 5-7 days and as needed. Per the temporary care plan the area was determined to be resolved on 10/21/12.</p> <p>Per review of progress notes on 9/19/12, a 0.3 cm (centimeter) diameter stage I area was identified on the resident's sacral area after the resident complained of pain and the area was observed. An order was received for an antibiotic for 10 days. The area was measured on 9/20/12 and measured 1.6 x 0.3 cm and described as a Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed).</p> <p>Nursing assistant flow sheets were reviewed and included directives for staff such as: reposition the resident every 2 hours and as needed, apply lotion to skin as needed and notify nursing if any reddened areas were noted on his skin.</p> <p>Per interview with Staff Member B, on 1/8/13 at</p>	F 314	<p>F-314 continued</p> <p>Each resident is assessed on admission for the risk of skin breakdown. The Case managers are responsible to initiate the skin care protocols.</p> <p>Each resident's skin is observed during bathing and or care. The bath NACs will reapproach and then alert the Team Leader if a resident refuses a bath or shower. Skin alert sheets are utilized by the facility to alert the Treatment Nurse, Wound Care Nurse and Director of Nursing to potential skin issues.</p> <p>The NACs will document in the bath book if a resident refuses. The Personnel Education Director reviews the bath book each week.</p> <p>The Case Manager will discuss with residents who refuse baths or skin checks in order to ascertain the reasons. Accommodations will be made for residents who prefer a particular gender of caregiver, time of bath or shower. The risks of refusing baths and/or skin checks will be thoroughly discussed with the resident. If the resident continues to refuse, the facility will contact the physician and/or family to intervene</p>	

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F 314 Continued From page 6  
approximately 1:50 p.m., she stated Resident #43 was independent with his toileting since he moved in. She stated during his first week at the facility, he would not let any staff assist him with anything because he thought he was moving out. Since the discharge plans fell through, he only let staff look at his skin if he complained about it hurting somewhere. She stated he got himself dressed and toileted himself. She said he required assistance with showers but most of the time refused even with multiple approaches. She said that on 1/8/13 she offered him a shower and he said no, it was too cold, he was already dressed and would take one tomorrow. She said she approached him 4 times about it and he refused each time. She said the problem was "tomorrow he would say the same thing and refuse again." She said after he moved in it was after he complained about his backside hurting, they were able to see his skin, the pressure area was already there and then the nurses took care of the problem. She said as far as she knew his skin was currently clear because he wasn't complaining about it. She said because he was so independent with his cares, staff just checked to see if he needed any help and he denied need for help from staff all the time.

On 1/8/13 at approximately 1:00 p.m., Staff Member C, a treatment nurse, was interviewed and stated the initial stage I pressure area was discovered on Resident #43 on 9/19/12 when he complained of his back hurting. It "quickly progressed" to a stage 2. She also stated the resident was supposed to be discharged, however, he would not let staff evaluate his skin, and now he is no longer being discharged yet he still will not let his skin be observed.

F 314  
F-314 continued  
  
In the event a pressure area occurs, the Treatment Nurse and Wound Care Nurse will monitor the area, treatment and interventions currently in place.  
  
A wound care meeting is held bi-monthly with the Wound Care Nurse, Case Managers, Director of Nursing and Administrator to discuss current in house wounds, progress or lack thereof.  
  
The Wound Care Nurse places an updated list of skin issues on each MAR monthly.  
  
The Director of Nursing is ultimately responsible to insure the systems currently in place remain practicable.

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F 314 Continued From page 7

On 1/8/13 at approximately 1:30 p.m. Resident #43 was interviewed in the day room. He stated he was able to do all tasks independently. He said "Oh, I can do all of that and don't bother them too much, there are so many other people here that need so much help, I just do what I can." He said he told the nurses if he had pain, but currently had no pain to speak of. He said he could move himself off the toilet and didn't need help from staff. He appeared to be clean and was dressed appropriately for the weather. His wheel chair cushion consisted of 3 folded up polar fleece blankets and a sweater. He said he needed them all because it set him up well in the wheelchair and was comfortable for him. He said he had no concerns about his skin at the moment.

Per interview with Staff Member D, a RN Staff development nurse, on 1/8/13 at approximately 3:30 p.m., Resident #43 had a bath on 12/5/12 and had refused bathing since that date. She stated staff were unable to get him to bathe. On the day he did bathe, it was only because he gave his word to the staff member and was not able to go back on his word.

Interviews with Staff Members E, F, & G, all caregivers who assisted Resident #43 on a daily basis, occurred on 1/10/13 at approximately 10:30 a.m. They verified Resident #43 received no assistance with toileting or dressing and they never saw his skin. They said he occasionally needed assistance with set up for shaving and they always ensured his bed was in the lowest position, however, that is all the assistance they provided for him.

F 314

F-314 see previous pages

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F 314 Continued From page 8

Given the fact that per Resident #43 and staff, he self-toileted, performed all tasks of daily care independently and refused bathing, it was questionable that staff would be able to evaluate his skin to check for breakdown until he complained, in which case breakdown was in progress. There was no system in place for routine evaluation of his skin for prevention of skin breakdown. There was no documentation in the record that Resident #43 was informed of the consequences involved with refusal of care related to prevention of skin breakdown before it actually happened.

The lack of assessment and plan for review of Resident #43's skin on a routine basis placed him at risk for additional preventable skin breakdown.

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

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.

This REQUIREMENT is not met as evidenced by:  
Based on interview, and record review, the facility failed to ensure the resident remained free of accident hazards and received adequate supervision and assistance to prevent accidents for 1 of 3 residents (#85). The failed facility practice resulted in harm for Resident #85.

F 314

F-323 Free of Accidents, Hazards, Supervision, Devices

The facility disputes this citation in its entirety and has requested an Administrative Law Judge hear our case regarding this citation

The facility consistently provides an environment that is as free from accidents and hazards as possible. It is reasonable to accept some risks as a trade off for the potential benefits, such as maintaining dignity, self-determination, and control over one's daily life. The facility's challenge is to balance protecting the resident's right to make choices and the facility's responsibility to comply with all regulations. The facility's philosophy is to allow each resident as much freedom of movement and independence as possible while developing interventions to prevent accidents.

F 323

For each resident, including resident #85, the facility Restorative Director conducts a comprehensive assessment on admission to measure the capabilities of the resident and to insure that hazards and risks are identified and interventions are implemented. If a resident has a fall, the Restorative Director investigates the incident, interviews staff and the resident when possible and augments interventions currently in place.

02/15/13

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F 323 Continued From page 9

Findings include:

Resident #85, age 87 had fallen at her assisted living home on 12/4/12 and sustained a [REDACTED]. At the hospital she underwent an open reduction, internal fixation surgery on 12/6/12 to repair the [REDACTED]. On [REDACTED]/12 she was admitted to the nursing facility for care, with tentative plans to return eventually to her assisted living home. She had multiple diagnoses, including [REDACTED] and history of [REDACTED].

Initial orders allowed weight bearing as tolerated for transfers with no ambulation. A fall risk evaluation was completed on 12/11/13 by Staff Member H, a Rehabilitation Licensed Nurse (LN). Resident #85 was assessed to be at risk for falls (she was scored at 20 where a score of 10 or greater denotes risk).

The initial care plan dated 12/10/12 indicated that resident #85 had impaired mobility related to her recent [REDACTED] fracture, [REDACTED] and pain with movement. The care plan goal was to maintain strength and endurance, maintain ability to be up in chair three times per day and as desired. The approaches in the care plan (which was the same for all residents admitted with a fall risk, thus not individualized) for fall prevention included:

- Low profile bed
- Toilet Safety Frame
- Call light and personal items within reach
- Make sure floor clean, dry and free of debris.

Between 12/10/12 and 12/16/12, Resident #85

F 323 F-323 continued

Resident #85 was admitted on 2012. The interventions the surveyor mentioned were put in place but the resident was also receiving Physical Therapy to gain strength and was encouraged to remain in common areas.

On 12/13/12, Posey soft rolls were added to maintain hip precautions and safe positioning in bed. The least restrictive interventions were successful for over a week.

On 12/18/12, resident #85 was in the hall when she fell. The surveyor misread the investigation which states "SOME staff were at lunch." Staff do not all leave the floor for breaks or lunch at the same time.

Following the resident's change in condition on 12/19/12, the facility instituted close observations while in wheelchair. The resident was placed near a staff member when up for safety. Staff were in-serviced individually and in stand-up. The resident did not have another fall for nearly two weeks.

On 12/30/12 the resident fell in the dining room. There was staff in the dining room at the time. Again, the surveyor misread the Occurrence report which states "the resident stated she hit her head." Not the licensed nurse. The nurse assessed the resident and found a 3cm skin tear on her

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/10/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CRESCENT HEALTH CARE, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 NORTH 40TH AVENUE YAKIMA, WA 98908</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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appeared to be stable and improving, with comments from the progress notes: "ate 75% of dinner with verbal cues "(12/12/12), "appetite getting better" (12/13/12), "has a big smile" (12/14/12). However, on 12/16/12, nurse noted on progress notes at 1:05 p.m. that "resident made multiple attempts to stand up by herself. She needed frequent reminding to not get up by herself and to keep her right foot on foot pedal."  
  
Progress note of 12/18/12 at 10:20 p.m. noted that the "resident was found on floor leaning on right elbow and stated she was unsure what happened."  
  
The corresponding incident report stated that the time of the occurrence was 7:30 p.m. and that the resident was in the hallway at the time of the fall. It stated that the "resident was found on the floor, legs in front of her, leaning on right side on elbow." The incident report further stated that "during the time of fall, the staff on hall was at lunch break. I will have the team leader designate a staff member to keep resident engaged during all breaks from hall in future." The incident report was signed on 12/20/12 by Staff Member H.  
  
A progress note of 12/19/12 at 9:10 a.m. documented a change in condition for Resident #85. Her blood pressure was noted to be 94/68 and the nurse stated that "resident seems lethargic more today, with less verbal, increase confusion." The progress note on 12/19/12 at 11:30 a.m. documented "weakness to extremities ... facial droop." Note stated that the resident's son was called and he stated that she had a history of TIA (small strokes). At 12:41 p.m. another progress note revealed that resident had

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elbow. There was no hematoma or bruising to her head. In fact, the resident's head was resting on her arm. The resident's NEUROS were within normal limits.  
While the staff member states the occurrence was "un-witnessed", there were four staff members in the dining room but not directly facing the resident.  
  
The surveyor interviewed staff member M who had been employed less than a week and on 01/03/12, became angry, walked off the job before the shift was over and never returned. The surveyor interviewed her over the phone eight days later. The facility believes this employee is far from a credible witness for this citation.  
  
The surveyor is mistaken. The resident's wheelchair is a low profile chair tilted at 20 degrees at all times except when eating.  
  
The Restorative Director had consulted with the Physical Therapist before choosing the low profile chair tilted at 20 degrees as the least restrictive chair. The Restorative Director was on site at the time of the fall and observed the chair at the time of the fall. It was in the tilt position. The Surveyor should not expect a housekeeper would know a tilt chair from any other type of chair.

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rambling speech that could not be understood and that she "would not sit still in wheel chair. Resident had to be near someone all shift because she was not sitting still."  
  
There were no changes noted to the care plan related to mobility and fall prevention following the 12/18/12 fall.  
  
The progress note on 12/30/12 stated that "CNA (Certified Nursing Assistant) came and got LN Licensed Nurse) and asked me to go into the dining room. (Staff Member M) stated someone had fallen and she didn't know who it is." When the LN entered room resident was laying on right side with right arm folded under her. Resident's head was next to wheel chair. LN checked range of motion and found it intact. The resident was able to move her head. LN did state that she hit her head." The LN documented, "approximately a 50 cent size red spot in middle of forehead. "  
  
The corresponding incident report stated that the fall happened at 4:20 p.m. in the dining room. It stated that the resident was last seen by Staff Members M and S in the dining room at 4:15 p.m. The incident report also stated that, "When in the dining room, chair was placed in upright position in anticipation of resident meal. She leaned forward in chair with feet on the ground and did not have core strength to correct so fell out of chair and will have resident chair remain in 20 degree tilt until tray is in front of her and she has assist for meals in the future." The injury was described on the incident report was surface layers of skin on right elbow. The report was signed by Staff Member H and dated 1/2/13. It states that the fall was not witnessed but that she

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The facility is unsure to which investigative report the surveyor is referring. The report attached to the 01/06/13 does not "state there were no changes noted to the care plan related to mobility and fall prevention following the 12/18/13 fall."  
  
In fact Restorative Nurse reviewed her pain management interventions and provided a Roho cushion for the resident stating in the investigative report: "Sometimes movement is a sign of pain as resident may not be able to recognize and verbalize pain." The investigative report will be provided at IDR  
  
The surveyor states that the family reported the resident had a "near miss fall" but a staff member intervened. This statement verifies that the resident was under close supervision and the plan of care was effective. In each case, the resident was observed only moments before the fall.  
  
In each occurrence progressive interventions were instituted always keeping in mind the resident's safety vs dignity and independence.  
  
Following the 01/06/12, additional progressive interventions were instituted. The resident has not since fallen.

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was the first to discover the resident following the incident.

During a phone interview with Staff Member M, a CNA, on 01/11/13 at approximatley 1:00 p.m., she stated that resident #85's wheel chair was in the upright position prior to her fall and that she was the only staff person in the dining area at the time of the fall. Staff Member M was unaware of the supervision of resident #45 and did not know about the change.

On 01/03/13 at approximately 1:30 p.m. Resident #85 was observed seated in the wheel chair in the upright position with no supervision.

Review of a progress note dated 1/6/13 stated that "Resident was on the floor on her right side when I got down to the hall. Resident stated that she fell and hit her forehead again. Resident was alert and also stated that her right hip hurt."

A corresponding incident report revealed that the incident happened at 1:30 p.m. in the hallway and states that "The housekeeper came to the charting area and said someone fell. I went running down the hall and seen the resident on the floor and was laying on her right side. Resident stated she hit her head again and her right hip was hurting." The incident report stated that the resident was last seen by Staff Member T in the East hallway at 1:25 p.m. The type of injury noted on the incident report was "bruise(s) of deep color" and that it was in an "area not generally vulnerable." The action taken was "first aid" and "care plan revision." It was signed by Staff Member H and Staff Member L on 1/8/13. Attached to the incident report was a

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The facility is reluctant to institute restrictive or intrusive interventions which potentially will undermine the dignity of the resident without adequate justification.

The Restorative Director assesses each resident on admission and has protocols in place to institute progressive interventions to prevent falls and other accidents.

The Restorative Director reviews, investigates; including interviewing staff, witnesses all occurrence reports and institutes interventions as needed to prevent accidents. The Restorative Nurse confers with the Director of Nursing and/or Administrator when necessary or when more than one fall has occurred.

Resident accidents are reviewed each month at Safety Committee meeting.

The Restorative Director provides in-services, one-on-one training and discussion in stand-up to insure staff are aware of the interventions in place.

The NAC assignment sheets are utilized to alert staff when there are additional or changes in interventions.

The Director of Nursing is responsible to review all resident occurrences and provide input when needed to insure that systems in place remain viable.

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witness statement submitted by Staff Member J (housekeeping). She documented that she did not witness the fall, but was the first to discover the resident after the incident. She also noted that she was taking a mop bucket down to the North hall, that she "heard a thump turned around and seen her on the floor." Also attached to the incident report was an investigation done by Staff Member H on 1/7/13. It stated that she (resident #85) was visualized at 1:15 p.m. by Staff Member J and there were no changes noted to the care plan related to mobility and fall prevention following the 12/18/12 fall.

In an interview on 1/10/13 at approximately 9:05 a.m., Staff Member J stated that on 1/6/13 she saw resident #85 in her wheel chair in the hallway outside her room (Room 43). She stated that the resident was facing toward the exit door at the east end of the hallway and that her wheel chair was in the upright position. Staff Member J said she exited the housekeeping closet with a mop bucket and traveled down the east hall toward the north hall, going the opposite direction from resident #85. As Staff Member J went past the Director of Nursing Service (DNS) office, she stated that she heard a loud thump. She turned around and saw Resident #85 on the floor. Staff Member J stated that she immediately went to the nurse's station to get help for the resident.

In progress note documentation on 1/6/13 at 10:05 p.m. the nurse noted that the "East hall CNA found part of a tooth in the residents room. No bleeding, no pain per east team leader." In progress note documentation on 1/6/13 at 10:15 p.m. the nurse stated that "CNA brought part of tooth that they found in resident's room to me.

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Charge nurse notified. Checked resident's mouth it was part of her 3rd tooth from the center on the upper right. No bleeding noted. No complaint of tooth ache. Resident was surprised to find out that she had lost part of a tooth. "

On 01/08/13 at 3:45 p.m. in an interview with Resident #85's sister and two of Resident #85 ' s nieces, her sister stated that there was also a "near miss" fall since she arrived here, where a staff person was standing nearby and kept her sister from falling as she tried to stand up from her chair. She did not know what date that happened.

The facility failed to assess and monitor resident interventions implemented to prevent falls and serious injury to Resident #85 with a clear history of falls with substantial injuries. The fall on 12/18/12 in a common area when it was stated on the incident report that the "staff had all gone to lunch." the intervention was to make sure that the," team leader will designate staff member to keep resident engaged." The fall on 12/30/12 was a fall in a common area of the dining room. The staff was going out of the dining area to get other residents for dinner. The resident was left at a table without frequent supervision and fell and sustained a skin tear on her right elbow and hit her head. On 01/06/13 the resident was again in a common area sitting alone in the hallway without supervision and sustained bruising on her face and broken teeth.

There were changes in weight bearing. On [REDACTED]/12 when the resident was admitted the weight bearing status was weight bearing as tolerated with transfers to chair and bed. No

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ambulation." then on 01/04/13 the weight bearing status was "Non-weight bearing" after an appointment with physician. On 01/09/13 the weight bearing status was changed to weight bearing with transfers and non-weight bearing to all other times.

The facility failed to maintain a safe environment for the resident and did not supervise the resident and implement effective interventions to minimize fall risk and subsequent injuries.

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