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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/16/15 through 6/18/15. Complaints were investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 145 certified bed facility was 140 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents 1 through 21) and seven closed record reviews (Residents 22 through 28).	F 000		
F 278 SS=E	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g) - (j) The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/29/2015

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to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate MDS (Minimum Data Set) assessment for four of 28 residents in the survey sample, Residents # 6, # 8, #19 and # 20.
1. The facility staff failed to complete the pain assessment interview for Resident #6's 4/21/15 significant change MDS (minimum data set) assessment and the 30 (thirty) day MDS assessment with an assessment reference date (ARD) of 5/12/15 .
2. The facility staff failed to complete the pain assessment interview for Resident #8's 4/2/15 quarterly MDS (minimum data set) assessment.
3. The facility staff failed to complete the pain assessment interview for Resident #19's 2/6/15 annual MDS (minimum data set) assessment and 4/24/15 quarterly MDS assessment.
4. The facility staff failed to complete Resident # 20's interview for pain for the 5-day MDS (minimum data set) assessment with an ARD (assessment reference date) of 5/29/15.
The findings include:
1. Resident # 6 was readmitted to the facility on 4/14/15 with diagnoses that included but were not limited to: coronary artery disease (common type of heart disease), urinary tract infection (an infection in the urinary tract), diabetes mellitus (a

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disease in which your blood glucose, or blood sugar levels are too high), osteoporosis (makes your bones weak and more likely to break) dementia (a group of symptoms caused by disorders that affect the brain), depression, encephalopathy (a term that means brain disease, damage, or malfunction), malnutrition and dysphagia (a swallowing disorder).

The most recent MDS (minimum data set), a 30-Day assessment with an ARD (assessment reference date) of 5/12/15 coded the resident as scoring a 2 (two) on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact. Section B0700 "Makes Self Understood" coded Resident # 6 as "Understood" and section B0800 "Able To Understand Others" coded Resident # 6 as "Understands."

Section J "Health Conditions" of the MDS 30-Day assessment with an ARD of 5/12/15 documented, "J0200 Should pain Assessment Interview be Conducted? - Attempt to conduct interview with all residents." A "0" (zero) was coded in the box under section J0200 "No. (resident is rarely/never understood) - Skip to and complete J0800, Indicators of pain or Possible Pain." Further review of the section "Pain Assessment Interview" revealed that it was blank.

The significant change MDS assessment with an ARD of 4/21/15 coded the resident as scoring a 2 (two) on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact. Section B0700 "Makes Self Understood" coded Resident # 6 as "Understood" and section B0800 "Able To Understand Others" coded Resident # 6 as "Understands."

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Section J "Health Conditions" of the significant change assessment with an ARD of 4/21/15 documented, "J0200 Should pain Assessment Interview be Conducted? - Attempt to conduct interview with all residents." A "0" (zero) was coded in the box under section J0200 "No. (resident is rarely/never understood) - Skip to and complete J0800, Indicators of pain or Possible Pain." Further review of the section "Pain Assessment Interview" revealed that it was blank.

On 6/17/15 at 4:45 p.m., an interview was conducted with RN (registered nurse) #1, MDS coordinator regarding Resident # 6's missing interview for pain in the health condition section of the significant change and 30-Day MDS assessments with the ARD of 5/12/15 and 4/21/15. After reviewing Resident # 6's significant change and 30-Day MDS assessments with the ARD of 5/12/15 and 4/21/15, RN #1 stated that section J0200 was not coded correctly. When asked who completed the section on the MDS assessments, RN # 1 stated it was her assistant LPN (licensed practical nurse) # 1.

On 6/17/15 at 4:55 p.m., an interview was conducted with LPN # 1 regarding Resident # 6's missing interview for pain in the health condition section of the significant change and 30-Day MDS assessments with the ARDs of 5/12/15 and 4/21/15. After reviewing Resident # 6's significant change and 30-Day MDS assessments LPN # 1 stated, "It was a coding error." When asked what reference was used for completing the MDS assessments, LPN # 1 stated that the RAI (Resident Assessment Instrument) manual was used.

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Review of "CMS's (Centers for Medicare/Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual" it documented, "Section J: Health Conditions." Under "J0200 Should pain Assessment Interview be Conducted?" it documented, "Item Rationale. Health Related Quality of Life: Most residents who are capable of communicating can answer questions about how they feel; Obtaining information about pain directly from the resident, sometimes call 'hearing the resident's voice' is more reliable and accurate than observation alone for identifying pain; If a resident cannot communicate (e.g, verbal, gesture, written), then staff observations for pain behavior (J0800 and J0850) will be used." Under "Coding Instructions" it documented, "Attempt to complete the interview if the resident is at least sometimes understood and an interpreter is present or not required. Code 0 (zero), no: if the resident is rarely/never understood or an interpreter is required but not available. Skip to Indicators of Pain or Possible Pain item (J0800). Code 1 (one), yes: if the resident is at least sometimes understood and an interpreter is present or not required. Continue to Pain Presence item (J0300)."

The Administrator and DON were made aware of these findings on 6/17/15 at approximately 5:30 p.m.

No further information was provided prior to exit.

2. Resident # 8 was readmitted to the facility on 4/14/15 with diagnoses that included but were not limited to: hypoxemia (low blood oxygen), atrial fibrillation (irregular heart beat), hypertension (high blood pressure), dysphagia (a swallowing disorder), muscle weakness and depression.

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The most recent MDS (minimum data set), was a quarterly assessment with an ARD (assessment reference date) of 4/2/15. Section B0700 "Makes Self Understood" coded Resident # 8 as "Usually Understood" and section B0800 "Able To Understand Others" coded Resident # 8 as "Sometimes Understands."
Section J "Health Conditions" of the quarterly assessment with an ARD of 4/2/15 documented, "J0200 Should pain Assessment Interview be Conducted? - Attempt to conduct interview with all residents." A dash was coded in the box under section J0200. Further review of the section "Pain Assessment Interview" revealed that the boxes in sections J0300, J0400, J0500 and J0600 contained dashes.

On 6/17/15 at 4:45 p.m., an interview was conducted with RN (registered nurse) #1, MDS coordinator regarding Resident # 8's missing interview for pain in the health condition section of the quarterly MDS assessment with the ARD of 4/2/15. After reviewing Resident # 8's quarterly MDS assessment with the ARD of 4/2/15, RN #1 stated that section J0200 was not coded correctly. When asked who completed the section on the MDS assessment, RN # 1 stated it was her assistant LPN (licensed practical nurse) # 1.

On 6/17/15 at 4:55 p.m., an interview was conducted with LPN # 1 regarding Resident # 8's missing interview for pain in the health condition section of the quarterly MDS assessment with the ARD of 4/2/15. After reviewing Resident # 8's quarterly assessment, LPN # 1 stated, "I didn't do the interview because it wasn't within the assessment period." When asked what reference was used for completing the MDS

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assessments, LPN # 1 stated that the RAI (Resident Assessment Instrument) manual was used.

The Administrator and DON were made aware of these findings on 6/17/15 at approximately 5:30 p.m.

No further information was provided prior to exit.

3. The facility staff failed to complete the pain assessment interview for Resident #19's 2/6/15 annual MDS (minimum data set) assessment and 4/24/15 quarterly MDS assessment.

Resident #19 was admitted to the facility on 5/13/13 with diagnoses that included but were not limited to: dementia (a brain disease), high blood pressure and muscle weakness.

Resident #19's annual MDS assessment with an ARD (assessment reference date) of 2/6/15 coded the resident's cognition as being severely impaired. Section B coded Resident #19 as sometimes being able to understand verbal content and as being understood. Section J0200 documented, "Should Pain Assessment Interview be Conducted? Attempt to conduct interview with all residents." A "0" was coded, indicating the pain assessment interview was not conducted; the staff assessment for pain was completed.

Resident #19's most recent MDS, a quarterly assessment with an ARD of 4/24/15, coded the resident's cognition as being severely impaired. Section B coded Resident #19 as sometimes being able to understand verbal content and as being understood. Section J0200 documented,

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"Should Pain Assessment Interview be Conducted? Attempt to conduct interview with all residents." A "0" was coded, indicating the pain assessment interview was not conducted; the staff assessment for pain was completed.

On 6/18/15 at 9:10 a.m., an interview was conducted with LPN (licensed practical nurse) #2, the nurse responsible for completing sections B and J of the above assessments. LPN #2 stated she always attempts the pain assessment interview unless the resident's cognition is severely impaired. LPN #2 stated she coded Resident #19 as sometimes understanding and as being understood on the above assessments. When asked why she didn't attempt the pain assessment interview, LPN #2 stated, "I guess I was basing it on sometimes understanding. She doesn't comprehend what you are saying so I go to the nursing staff and check the documentation." LPN #2 stated she references the RAI (Resident Assessment Manual) when completing MDS assessments.

4. The facility staff failed to complete Resident # 20's interview for pain for the 5-day MDS (minimum data set) assessment with an ARD (assessment reference date) of 5/29/15.

Resident # 20 was admitted to the facility on 5/22/15 with diagnoses that included: arthritis, dementia, failure to thrive, thrombocytopenia, and sever aortic stenosis.

Resident # 20's 5-day Minimum Data Set (MDS) assessment, with an ARD (assessment reference date) of 5/29/15, did not have the pain assessment interview completed with the

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Resident. Review of this assessment revealed documentation that coded the resident in Section B "Hearing, Speech, and Vision" under B0100 "Comatose" a "0" was entered indicating a "No" Resident # 20 was not comatose; under B0700 "Makes Self Understood" a "1" was entered indicating that Resident # 20 was "Usually understood"; Under: "B0800 Ability to Understand Others" a "2" was entered indicating that Resident # 20 "Sometimes understands."

Review of MDS Section J: Under J0200. "Should Pain Assessment Interview be Conducted? Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)." Since Resident # 20 was not comatose and was " not rarely/never understood " directions direct staff to go to Section J0300 " Pain Presence " All sections " J0300 Pain Presence, J0400 Pain Frequency, J0500 Pain Effect on Function, and J0600 Pain Intensity " were not completed.

During an interview on 6/18/15 at approximately 8:55 a.m. with LPN (licensed practical nurse) # 1, an MDS coordinator, LPN # 1 stated that she did not complete Resident # 20's MDS; not because the Resident was comatose but because she (LPN # 1) was not assigned to Resident # 20. LPN # 1 went onto say that if the resident any resident is comatose then one (the staff member assigned) does not do the pain assessment. LPN # 1 stated that the RAI (resident assessment instrument) Manual is the source that is used if there are any questions on how to complete the MDS.

During an interview on 6/18/15 at 9:08 a.m. with LPN # 2, an MDS coordinator, Resident # 20's

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F 278	Continued From page 9 5-Day assessment was reviewed. LPN # 2 stated that the pain assessment should have been completed. LPN # 2 further stated, "I look at the cognition, section B, before I do the assessment." LPN # 2 also stated that the RAI Manual is the reference for filling out the MDS. An attempt was made to interview the staff member that completed Resident # 20's 5-Day assessment but she was not in the building. During the end of day interview on 6/18/15 at 9:50 a.m. with ASM (administrative staff member) # 1, the administrator, this concern about the pain interview not being completed was revealed. No further information was provided prior to exit.	F 278		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d), 483.20(k)(1) A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		

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§483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan for one of 28 residents in the survey sample, Resident #5.

The facility staff failed to develop a comprehensive care plan for the triggered care area of communication on Resident #5's significant change in status Minimum Data Set (MDS) assessment with an ARD (assessment reference date) of 5/19/15.

The findings include:

Resident #5 was admitted to the facility on 11/12/14 with diagnoses that included but were not limited to: dementia (a brain disease), failure to thrive and heart failure.
Resident #5's most recent MDS, a significant change in status assessment with an ARD of 5/19/15, coded the resident's cognition as being severely impaired. Section V "Care Area Assessment Summary" documented, "04. Communication." An "X" was documented in a box under "Care Area Triggered" and "Care Planning Decision," indicating communication would be care planned.
Resident #1's comprehensive care plan with an initial onset date of 5/21/15, failed to document any information regarding communication.
On 6/17/15 at 4:56 p.m., an interview was conducted with LPN (licensed practical nurse) #1,

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the nurse responsible for developing Resident #5's communication care plan. LPN #1 stated when she completed the care area assessment summary on the MDS, she wrote about the resident's communication in the care area assessment but she did not complete a communication care plan because the social services department developed a cognition care plan. LPN #1 stated she should have developed a communication care plan. LPN #1 stated she references the RAI (Resident Assessment Instrument) manual when developing care plans based on the MDS.
On 6/17/15 at 7:05 p.m., the administrator was made aware of the above findings.
The CMS (Centers for Medicare & Medicaid Services) RAI manual documented the following:
"V0200: CAAs and Care Planning
Item Rationale
·Items V0200A 01 through 20 document which triggered care areas require further assessment, decision as to whether or not a triggered care area is addressed in the resident care plan, and the location and date of CAA documentation. The CAA Summary documents the interdisciplinary team's and the resident, resident's family or representative's final decision(s) on which triggered care areas will be addressed in the care plan.
Coding Instructions for V0200A, CAAs
·Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the

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F 279	Continued From page 12 care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation. ·For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision" column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed ..."	F 279		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(h) 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 observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide supervision and an environment free of hazards to prevent injury for 1 of 28 residents in the	F 323		

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survey sample; Resident #22.

The facility staff failed to ensure Resident #22, diagnosed with dementia who was mobile in a wheelchair, with wandering behaviors, and coded as severely impaired for cognition, was not able to exit the facility unsupervised through the automatic front doors. On 6/6/15 at approximately 6:45 p.m. Resident #22 exited the facility through the automatic front doors, unsupervised in her wheelchair and sustained a fall with injury. Resident #22 was transported to a local hospital emergency room and admitted with a fracture of the C1 (first cervical) spine vertebra, extensive nasal bone fractures and laceration to the bridge of the nose and upper lip that required staples and sutures.

The findings include:

Resident #22 was admitted to the facility on 4/16/15 with the diagnoses of but not limited to history of hip fracture, dementia, high blood pressure, hypothyroidism, depression, congestive heart failure, peripheral vascular disease, and osteoporosis.

The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 4/23/15. The resident was coded as being severely cognitively impaired in ability to make daily life decisions, scoring a 4 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring extensive assistance for bed mobility, transfers, dressing, eating, toileting, hygiene, and bathing; limited

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assistance for locomotion on and off the unit in a wheelchair; had no functional limits for range of motion, and was incontinent of bowel and bladder.

A review of the clinical record revealed the following:

A "Nursing Admission Assessment" (a 2 page form) dated 4/16/15 (day of admission) contained a section for "Risk for Falls". This section documented, "Total Score of 10 or above deems Guest at risk; initiate Care Plan." The resident scored a 20. The "Nursing Admission Assessment" further contained a section for "Risk for Wandering/Elopement" which documented the following questions and responses: "1. This is a new admission ___Yes ___No (yes was checked); 2. Is the Guest independently mobile? (No was written in the line next to the number); 3. Does the Guest have a history of wandering? (No was written in the line next to the number); 4. Is the Guest currently taking any medication which may cause confusion or disorientation? (No was written in the line next to the number); 5. Is the Guest resistant to being placed in a long-term care facility? (No was written in the line next to the number); 6. Are there any indications of dementia? (Yes was written in the line next to the number). A "yes" answer to any question #2 through #6 means that the Guest is at risk. A "yes" answer to question #1, AND any other question means that the resident is at high risk; apply bracelet and Care Plan." The resident was not care planned for this nor was a wanderguard bracelet placed on the resident. Nowhere in the clinical record was it documented if the resident did or did not require a wanderguard, or the factors on which that decision was based.

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Another "Admission Nursing Assessment" (a 4 page form) dated 4/17/15 documented the following: In the "Psychosocial Functioning" section was an area for "Behavioral Symptoms" which contained the following options to check: Wandering, Verbally Abusive, Physically Abusive, Socially inappropriate/Disruptive, Resists Care, and None. A check was placed in the line next to "None." In the section "Current ADL Status" was a section for documenting devices used. This section included, "Wheelchair Only, Wheelchair/Propels Self." Neither option was selected. Nothing in this section was completed. In the section "Safety" was documented "Fallen in the past 90 days" with a check in the line next to this item. In the section "Musculoskeletal" was documented, "Moves All Extremities" with a check in the line next to this item; "Assistive Devices" with the word 'wheelchair' handwritten in the line next to this item; In the section for "Risk for Falls" was documented, "Total Score of 10 or above deems Guest at risk; initiate Care Plan." The resident scored a 20. The "Nursing Admission Assessment" further contained a section for "Risk for Wandering/Elopement" which documented the following questions and responses: "1. This is a new admission ___Yes ___No (yes was checked); 2. Is the Guest independently mobile? (No was written in the line next to the number); 3. Does the Guest have a history of wandering? (No was written in the line next to the number); 4. Is the Guest currently taking any medication which may cause confusion or disorientation? (No was written in the line next to the number); 5. Is the Guest resistant to being placed in a long-term care facility? (No was written in the line next to the number); 6. Are there any indications of dementia? (Yes was written in the line next to the

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number). A "yes" answer to any question #2 through #6 means that the Guest is at risk. A "yes" answer to question #1, AND any other question means that the resident is at high risk; apply bracelet and Care Plan." The resident was not care planned for this nor was a wanderguard bracelet placed on the resident. Nowhere in the clinical record was it documented if the resident did or did not require a wanderguard, or the factors on which that decision was based.

A "Pre-Restraint Intervention Evaluation" dated 4/20/15 documented the following: "Guest's cognitive status (check all that apply)." Check marks were placed next to the items Alert, Long-term memory deficits, Short-term memory deficits, Poor decision-making. In addition, next to "Oriented to" the resident was only checked as being oriented to "person." She was not oriented to place and time.

A "Determination of Device Usage" form dated 4/20/15 documented, under item #2 "Evaluate the guest in the area of each of the following and mark yes or no" the resident was marked "yes" for "Can guest propel wheelchair even short distances?" The resident was marked "no" for "Is the guest immobile."

A "Pre-Restraint Intervention Evaluation" undated, documented the following: Under "Medical symptoms/behaviors/events/clinical findings leading to consideration of device usage (check all that apply)" the resident was checked for "Guest does not understand safety with standing/transfer" and "Guest unable to independently stand/transfer/ambulate." Under "How often have these medical symptoms/behaviors/events/clinical findings

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occurred in the last 30 days? (check one)" a check was documented for, "Continuously." Under "Guest's cognitive status (check all that apply)." Check marks were placed next to the items Alert, and Poor decision-making. In addition, next to "Oriented to" the resident was only checked as being oriented to "person." She was not oriented to place and time. Under "Is guest aware of safety risk at all times of day and night? (check one) "No" was checked.

A "Determination of Device Usage" form dated 5/7/15 documented, under item #2 "Evaluate the guest in the area of each of the following and mark "yes or no" the resident was marked "yes" for "Can guest propel wheelchair even short distances?" The resident was marked "no" for "Is the guest immobile."

Further review of the clinical record revealed that on 5/8/15, the resident was started in the Restorative Nursing Program. This form documented the resident as receiving 15 minutes a day for 6 to 7 days per week with the goal of being able to transfer from chair to bed; and from bed to chair.

The clinical record revealed a "Behavior Data and Analysis" document, dated 5/5/15, which documented, "Guest added to behavior mtg (monitoring) due to falls. Guest also have intervention in place. Guest wanders in other guest rooms. She can become tearful. Staff will continue to monitor."

A review of the care plan revealed one for ADL's (activities of daily living) initiated on 4/27/15, which documented, written in, (undated) the intervention "Restorative Nursing."

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Review of the care plan revealed one for Mood, initiated on 4/27/15, which contained a hand-written problem area, dated 4/28/15, "Wanders into other guest's rooms."

The clinical record revealed hospital records from the previous facility, which documented, that the resident sustained a fall with a left hip fracture on 3/19/15 and was readmitted to them on 3/24/15. Therapy notes were included (from the hospital at the time of the hip fracture) and reviewed. These notes documented that on 3/20/15, the resident was able to "self propel (the wheelchair) 50 feet..."

The clinical record contained a nurse's note dated 6/7/15 at 1:40 p.m., which documented, "Late entry - Writer was on 300 hall passing meds (medications). A nurse from another unit was passing thru hall and said "come quick there's an emergency." Writer followed nurse. Guest noted on ground. Guest last seen around 6:30pm in hallway around nurse's station. Guest just came from social dining room. Guest is able to propel w/c by self and normally goes to PM activities by herself or visits other guest's in their rooms. When found on ground guest was noted /c (with) blood coming from nose. Unable to state if she hit her head (secondary to) baseline confusion and dementia. (No) c/o (complaints of) pain or discomfort. MD/RP made aware. Guest sent out to (name of hospital) via EMS."

A review of the internal incident report documented the date and time of the incident as 6/6/25 at 6:45 p.m. The injury documented was laceration to nose. The location of the incident was the parking lot. The resident was found on

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the ground. Continued review of the incident report documented under "Circumstances of Fall" that "guest found in middle of fire lane, w/c (wheelchair) found upright on curb." The internal incident report further documented that the resident's alarm was in place (fall alarm) and was sounding.

Further review of the incident report revealed a statement from the DON (Director of Nursing) which documented a conversation she had with the resident's daughter-in-law on 6/7/15, wherein it was asked if the resident had a history of wandering at her previous facility and the family member stated, "that is how she got the last fracture."

On 6/18/15 at 8:16 a.m., an interview was conducted with CNA #4 (Certified Nursing Assistant - the aid that observed the incident). She stated that it was a little after 6:30 p.m., and she was walking past the lobby area, where visitors were congregating and chatting. She looked over in that direction, and saw Resident #22 outside the doors on the concrete patio area in her wheelchair. She noted the resident was alone, with no staff present. She stated it appeared from that distance that the resident's wheelchair was moving (the patio slants downward from the doors, down to the curb at the fire lane). She stated she ran towards the doors, and as she got closer she could definitely see that the resident's wheelchair was moving down towards the curb, and that she was not able to get to the resident in time before the wheelchair got to the curb and the resident was thrown out of it onto the blacktop of the fire lane. She stated she saw that the resident was injured and bleeding, and ran back inside to get help and

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then back to the resident where she remained until help arrived.

On 6/17/15 at 2:06 p.m., an interview was conducted with the DON. She stated that the resident had no previous history of exit-seeking behavior.

On 6/18/15 at 10:43 a.m., in an interview with ACS #3 the corporate QA nurse (Administrative/Corporate Staff) and the Administrator, ACS#3 again stated the resident had no exit-seeking behavior. When asked if that was the only criteria for using a wanderguard, the Administrator stated, "No." When asked about the admission assessment wherein the resident was scored as requiring a wanderguard, she stated the decision was made that the resident did not require one. When asked where this was documented in the clinical record, the facility was unable to evidence this. (A request was made for evidence of the discussion in any internal meeting documentation. None was provided. At 11:34 a.m., the Administrator stated there was no documentation in the morning meeting notes.) When asked about a resident with a BIMS of a 4 and who was wandering around the facility in a wheelchair, and was care planned as wandering into other residents rooms, they stated at the time of admission, the resident was not mobile in the wheelchair, but mobility increased once the resident was in the Restorative Nursing Program. When asked if the resident should have been reassessed for a wanderguard once she became mobile (after being in the Restorative Nursing Program), the Administrator stated, "You could make an argument for that." In discussing the level of supervision for the resident, ACS#3 stated that the facility could not provide

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one-to-one staff and that this was the resident's home and she had the right to move about freely, and the Administrator stated that it was a dignity issue to put a wanderguard on someone if they did not have exit-seeking behaviors. When it was discussed about a resident who had severe dementia and was not exit-seeking, but just mindlessly wandering about the facility and happen to wander outside through the unsupervised automatic front doors, it was stated that the resident was not on their radar for being one that would require a wanderguard and that in hindsight; she could have been reassessed when she became mobile.

On 6/18/15 at 10:25 a.m., an interview was conducted with LPN #8 (Licensed Practical Nurse). She stated that initially (at admission) the resident was not self-propelling herself in her wheelchair, but that she should have been reassessed when she became mobile, as a wandering risk.

On 6/18/15 at 11:06 a.m., an interview was conducted with CNA #6 (Certified Nursing Assistant). When given the scenario of a resident with dementia and that was mobile in a wheelchair, she stated that such a resident should be supervised to prevent elopement and that it is neglect if such a resident gets outside unsupervised.

On 6/18/15 at 11:08 a.m., an interview was conducted with LPN #9. When given the scenario of a resident with dementia and that was mobile in a wheelchair, she stated that such a resident should be supervised to prevent elopement and that it is neglect if such a resident

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gets outside unsupervised. She further stated a resident such as this should have a wanderguard on.

On 6/17/15, the front lobby area where the resident got out the front automatic doors unsupervised, was monitored from 6:41 p.m. to 8:03 p.m. During this time, the area was not manned by assigned staff. Staff, residents, and visitors were noted to pass by or through the area 44 times, ranging in a time span of a few seconds, up to 11 minutes apart between times someone walked by or through the area. An activity was going on in the dining room adjacent to the lobby. There were windows from the dining room to the lobby. Staff present in the activity room, were not observant of activity in the lobby. The majority of the residents that were observed passing by the area were doing so independent of staff supervision. After 8:00 p.m., the automatic sliding glass front doors were noted to have locked automatically as evidenced by the alarms sounding when the doors were approached. Before this time, there were no alarms as anyone approached the doors unsupervised. There were no wanderguards noted on any residents that came into the lobby area. Prior to 8:00 p.m., the automatic front doors were easily accessible and automatically opened to anyone that approached them.

On 6/17/15 at 6:22 p.m., OSM #8 (Other Staff Member #8, the activities assistant) was manning the front desk. When asked about staff monitoring the lobby, she stated there isn't anyone after 6:30 p.m., and that she did not think they (the facility) ever lock the front doors.

On 6/18/15 at 8:02 a.m., an interview was

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conducted with OSM #9 (a weekend receptionist). She stated that on 6/6/15 was the first time she had seen Resident #22 in the lobby area by herself, and that the resident transferred herself from the wheelchair to one of the chairs in the lobby. She stated this was earlier in the day.

On 6/18/15 at 8:49 a.m., an interview was conducted with OSM #10, a receptionist. She stated that she works from 8:30 to 4:30. She stated that if she has to leave the desk, she puts the phone on "night ring" so that it will ring to other extensions in the building; that she is relieved for 30 minutes for lunch but that otherwise if she has to leave the desk, there is no relief for her. She stated she leaves the desk area for bathroom breaks and to make copies or deliver faxes.

On 6/18/15 at 11:30 a.m., in an interview with the Administrator and ACS #3, when asked about how the front doors work, and if the resident had a wanderguard on, would the doors have locked? The Administrator stated they (the doors) most likely would have, that the inside door would open, but the second set leading to the outside would have locked and an alarm would have sounded.

A review of the hospital records revealed the following: A CT of the head without contrast documented, "Impression: No acute intracranial process, hemorrhage, or skull fracture. Moderate diffuse atrophy and chronic small vessel disease." A CT of the C-Spine without contrast documented, "Impression: Nondisplaced fracture through the right lamina of the C1 vertebra as described above. No other fracture identified." A CT of the facial bones without contrast

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documented, "Findings/Impression: Extensively comminuted nasal bone fractures. Fragments are displaced leftward. Adjacent soft tissue gas is noted suggesting a possible penetrating injury. No additional fracture. No sinus fluid. No orbit lesion is evident. Advanced degenerative changes noted in both temporomandibular joints (pair of joints connecting the mandible of the jaw to the temporal bone of the skull*)." Further review of the hospital record revealed the following note from a consult physician about the injuries: "A CT of the C-spine reported nondisplaced fracture through the right lamina of the C1 vertebrae. The pt (patient) was seen and I spoke to neurosurgeon (name of doctor). Rec (recommends) just cont (continue) the soft collar and activity as tolerated. As per his notes: "Impression: Closed head injury with cervical C1 arch fracture since it is unilateral and it only involves the arch, this is a stable fracture. There is absolutely no surgical intervention necessary and I suspect that she would be very uncomfortable in a hard cervical collar and I do believe it is necessary to place her in that soft collar for comfort only, can be used if necessary. I discussed this with the emergency room physician, there being no further neurosurgical intervention necessary..." In addition, the history and physical note documented, "ENT:...lacerations bridge of nose and area between upper lip and nose...Procedures: Laceration Management. Location of wound: bridge of nose and upper lip through and through...number of sutures/staples: 8...number of sutures subcutaneous: 6...Closure layers: 2..."

On 6/17/15 at 3:30 p.m., the Administrator and ACS #3 were made aware of the concern for harm.

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From Fundamentals of Nursing, 7th edition, 2009; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 5: "Client safety is a priority in health care. You need to protect clients from physical and emotional injury by continually assessing for and eliminating safety hazards."

According to Fundamentals of Nursing, Fifth Edition, Lippincott, Williams, & Wilkins, page 1258, Safety becomes a primary concern for clients with progressively impaired judgment. In institutional settings, safety measures for clients with chronic confusion involve frequently checking on clients and interacting with them.....supervising wandering behavior; gently redirecting lost or wandering clients; providing secured locks or alerting systems for elevators and door; providing motion detection devices that can be applied to the client or to the bed to signal nursing staff when movement occurs; staying with clients who are agitated; and removing items that may be potentially harmful from the area ....The desire for wandering behaviors intensifies, falls are not prevented, and risk of serious injury from falls increases. May long-term care facilities are becoming more creative in their safety management. Innovations such as enclosed courtyards provide unlimited access for clients with dementia to wander within a protected confine.

COMPLAINT DEFICIENCY
* This information was obtained from the website: <http://medical-dictionary.thefreedictionary.com/temporomandibular+joint>

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F 514 F 514 SS=E	Continued From page 26 RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.75(l)(1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure a complete and accurate clinical record for Residents #12, # 13 and #14. 1. Facility staff failed to ensure a complete MAR (Medication Administration Record) for the month of April 2015 for Resident #12. 2a. Facility staff failed to ensure a complete MAR (Medication Administration Record) for the months of April, May and June 2015 for Resident # 13. 2b. Facility staff failed to ensure Resident #13's chart was free from inaccurate documentation.	F 514 F 514		

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3. Facility staff failed to ensure a complete MAR (Medication Administration Record) for the month of April 2015 for Resident # 14.

The findings include:

1. Resident #12 was admitted to the facility on 12/22/14 with diagnoses that included but not limited to atrial fibrillation, lung cancer, anemia, cognitive communication deficit, pressure ulcer (sacrum), chronic obstructive pulmonary disease and diabetes.

Resident #12's most recent MDS (minimum data set) was a quarterly review assessment with an ARD (assessment reference date) of 3/19/15. The resident was coded as being moderately impaired in the ability to make daily life decisions, scoring 10 out of 15 on the BIMS (Brief Interview for Mental Status) Exam. The resident was coded as requiring extensive assistance from staff for dressing, toileting, bathing and personal hygiene. The resident was coded as being totally dependent on staff for transfers and independent with meals.

A review of the April 2015 MARs revealed no electronic signatures for the following medications:
- "Hydrocodone-Acetaminophen 5-325*: One tab every 12 hours; oral for pain" for dates 4/1/15 at 9:00 a.m., 4/4/15 and 4/22/15 at 9:00 p.m.

- "Metoprolol Tartate 25 MG TAB*: 1 tablet by mouth every twelve hours for hypertension" for dates 4/4/15 and 4/22/15 at 9:00 p.m.

- "TraZODone TAB 50 MG* FOR: DESYREL TAB 50MG: one-half tab once a day at bedtime; oral

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for depression with sleep disturbance" for dates 4/4/15 and 4/22/15 at 9:00 p.m.

Further review of the clinical record including the nurses' notes revealed no documentation of Resident #12 refusing medications on these dates or times.

On 6/18/15 at 9:35 a.m., an interview was conducted with LPN #10. : LPN #10 was asked to review Resident #12's MARs. After reviewing the MARS, LPN #10 was asked what it means when there are blank spaces or no signatures for a medication. LPN #10 stated, "The medication wasn't given." LPN #10 stated, "If the MAR is blank, we pull the chart to see if a note was written stating why the MAR is empty." LPN #10 stated, "There shouldn't be any holes. If a resident refused a medication there is even a drop down menu where you can select resident refused. You can also create a progress note stating the reason."

On 6/18/15 at 10:00 a.m., administration was made aware of the above findings. No further information was presented at this time.

According to facility policy titled, "Medication Administration":

"..10. Initial the guest's Medication Administration Record (MAR) immediately following administration.

11. Record any medication omissions including date, time, and reason on the back of the Medication Administration Record (MAR). "

According to Fundamentals of Nursing Made

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Incredibly Easy, Lippincott Williams and Wilkins, Philadelphia PA, page 23: "Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team."
*Hydrocodone-Acetaminophen is used to decrease severity of moderate pain. Metoprolol Tartate is used to decrease blood pressure and heart rate. Trazadone is used for major depression, insomnia, and chronic pain syndromes. This information was obtained from: Davis's Drug Guide 11 ed. p. 637, p. 815, and p. 1200

2. a. Facility staff failed to ensure a complete MAR (Medication Administration Record) for the months of April, May and June 2015 for Resident # 13.

Resident #13 was admitted to the facility on 4/23/13 with a readmission date of 11/25/13. Resident #13 was admitted with diagnoses that included but not limited to osteoarthritis, lumbar spondylosis, obstructive hydrocephalus, CVA (cerebral vascular accident) and aftercare trauma to the lower leg.
Resident #13's most recent MDS (minimum data set) was a quarterly review assessment with an ARD (assessment reference date) of 5/27/15. The resident was coded as being moderately

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impaired in the ability to make daily life decisions, scoring 09 out of 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as understanding others and making self understood. Resident #13 was coded as requiring extensive assistance from staff for transfers, dressing, toileting, and personal hygiene. The resident was coded as being totally dependent on staff for bathing and independent with meals.
A review of Resident # 13's April, May and June 2015 MARs revealed no electronic signatures for the following medications:

- "DIVALPROEX SOD DR 500 MG TAB*: one tab at bedtime; oral for seizures" for dates 4/2/15, 4/5/15, 4/10/15, 4/15/15, 4/21/15, 4/24/15, 4/28/15, 6/4/15 at 9:00 p.m.

- "DIVALPROEX SOD DR TAB 250MG FOR: 1 tablet by mouth once a day -am for seizures" for dates 5/18/15 at 9:00 a.m.

- "Gabapentin Cap 100MG* FOR: one cap three times daily; oral for neuropathy" for dates 4/1/15, 4/22/15, 4/23/15, 4/30/15, 5/18/15, 6/12/15 at 2:00 p.m.; 4/2/15, 4/6/15, 4/10/15, 4/15/15, 4/21/15, 4/28/15 at 8:00 p.m.

- "Omperazole CAP 20 MG FOR*: one cap per day; oral for gastro esophageal reflux disease" for dates 4/3/15, 4/14/15, at 6:30 a.m.

"TraZODone Tab 50 MG FOR: DESYREL TAB 50 MG: one tab once a day at bedtime; oral for insomnia" for the following dates: 4/1/15, 4/2/15, 4/6/15, 4/7/15, 4/10/15, 4/16/15, 4/21/15, 4/28/15, and 5/19/15 at 9:00 p.m.

"Aspirin 81 TAB 325MG FOR******: one tab once

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per day; oral for cva (stroke)" for dates 5/18/15 at 9a.m.

"DOXAZOSIN MESYLATE 1MG TAB*: one tab per day; oral for hypertension" for dates 5/18/15 at 9:00 a.m.

Further review of the clinical record including the nurses' notes revealed no documentation of Resident #13 refusing medications on these dates or times.

On 6/18/15 at 9:35 a.m., an interview was conducted with LPN #10. LPN #10 was asked to review Resident #13's MAR. After reviewing the MAR, LPN #10 was asked what it means when there are blank spaces or no signatures for a medication. LPN #10 stated, "The medication wasn't given." LPN #10 stated, "If the MAR is blank, we pull the chart to see if a note was written stating why the MAR is empty." LPN #10 stated, "There shouldn't be any holes. If a resident refused a medication there is even a drop down menu where you can select resident refused. You can also create a progress note stating the reason."

On 6/18/15 at 10:00 a.m., administration was made aware of the above findings. No further information was presented at this time.

DIVALPROEX SODIUM DR is used for manic episodes associated with bipolar disorder and suppression of seizure activity. Gabapentin is used for chronic pain, prevention of migraine headache, bipolar disorder, and decreased incidence of seizures. Omeprazole is used to diminish accumulation of acid in the gastric lumen

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and lessens gastric reflux. Aspirin is used to produce analgesia and reduce inflammation and fever. Aspirin is also used to decrease the incidence of stroke and heart attack by thinning the blood. DOXAZOSIN MESYLATE used to lower blood pressure. This information was obtained from: Davis's Drug Guide 11ed. p.1212, p. 591, p. 908, p. 1087 and p. 451 is

2. b. Facility staff failed to ensure Resident #13's chart was free from inaccurate documentation.

A review of the clinical record revealed a note that documented:
"06-11-15 02:43pm, ALL:
Discharge
DISCHARGE NOTE FOR (RESIDENT'S NAME) COLLECTED 6/11/2015 2:43:16 PM BY (NURSE'S NAME)
Patient discharge home with sister at 1040. patient (sic) took allher (sic) personal belongings but was unable to find TV remote. Patient's meds (medications) for the rest of the day given. Went through medication list and times of administration including route with sister. educated (sic) on the importance to take meds and on time. Patient had no skin issues but an old dried scar to the lower abdomen. All copies of discharge instructions given to patient and family. Family voiced understanding, patient denies pain at time of discharge. V/S were 124/68, 74, 20, 97.8. patient (sic) assisted by CNA outside with the wheelchair.."
Resident #13 was in the building and receiving care on dates 6/16/15 through 6/18/15 during the time of survey.
On 6/17/15 at 4:07 p.m. an interview was conducted with LPN #4, the unit manager and LPN #1, the MDS coordinator. When asked if

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Resident # 13 was discharged from the facility and recently readmitted, LPN #4 stated, "No, the resident hasn't been anywhere." LPN #1 looked at the discharged note and stated, "I am thinking this is another resident who left. I can't remember the other person who was just discharged but I would have to check. It sure does state that Resident # 13 was discharged in the note."
On 6/17/15 at 6:30 p.m., the administrator was made aware of the above findings. No further information was presented during the time of survey.

3. Facility staff failed to ensure a complete MAR (Medication Administration Record) for the months of April 2015 for Resident # 14.

Resident #14 was admitted to the facility on 7/2/09 with a readmission date of 8/1/14.
Resident #14 was admitted with diagnoses that included but not limited to arthropathy, anxiety, depression, hypertension, dysthymic disorder, unspecified muscle weakness, and recurrent UTI (Urinary Tract Infection).
Resident #14's most recent MDS (minimum data set) was a quarterly review assessment with an ARD (assessment reference date) of 3/31/15.
The resident was coded as being cognitively intact in the ability to make daily life decisions, scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status) Exam. The resident was coded as understanding others and making self understood. Resident #13 was coded as requiring extensive assistance from staff for toileting, bathing and personal hygiene; limited assistance with dressing and independent with meals and transfers.
A review of Resident # 14's April 2015 MARs revealed no electronic signatures for the following

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medications:

- "ACETAMINOPHEN TAB 325MG*: two tab twice daily" for dates 4/2/15 at 8:00 p.m.

- "CARBID/LEVO TAB 10/100 MG FOR: SINEMET*: one tab twice daily for facial tremors" for dates 4/2/15 at 8:00 p.m.

- "LORAZEPAM 1MG TABLET*: one tab twice daily; oral for anxiety" for dates 4/2/15 at 8:00 p.m.

Further review of the clinical record including the nurses' notes revealed no documentation of Resident #14 refusing medications on these dates or times.

On 6/18/15 at 9:35 a.m., an interview was conducted with LPN #10. LPN #10 was asked to review Resident #14's MARs. After reviewing the MARs, LPN #10 was asked what it means when there are blank spaces or no signatures for a medication. LPN #10 stated, "The medication wasn't given." LPN #10 stated, "If the MAR is blank, we pull the chart to see if a note was written stating why the MAR is empty." LPN #10 stated, "There shouldn't be any holes. If a resident refused a medication there is even a drop down menu where you can select resident refused. You can also create a progress note stating the reason."

On 6/18/15 at 10:00 a.m., administration was made aware of the above findings. No further information was presented at this time.

Acetaminophen is used for mild pain or fever.

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F 514	Continued From page 35 Carbidopa/Levodopa (Sinimet) is used for relief of tremor and rigidity in Parkinson's disease. Lorazepam is used for sedation, decrease anxiety and seizures. This information was obtained from: Davis's Drug Guide 11 ed. p. 187, p. 744, and p. 762.	F 514		