STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/25/2012

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F 000	INITIAL COMMENTS A Quality Indicator Survey (QIS) was conducted on September 18 through 25, 2012. The deficiencies are based on observation, record review and resident and staff interview for 33 sampled residents.	F 000	Carroll Manor Nursing and Rehabilitation Center makes its best effort to operate in substantial compliance with both Federal and state laws. Submission of this plan of correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees, or agents, as the truth of the facts alleged or validity of the conditions set forth on the statement of deficiencies. This plan of correction (POC) is prepared and or executed because it is required by the State and Federal laws.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tina Singh	Administrator	11/16/2012

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

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 33 sampled residents, it was determined that facility staff failed to notify the physician and Responsible Party (RP) of an alteration in skin integrity sustained by Resident #153. The findings include: An observation of a dressing change was conducted on September 24, 2012 at approximately 10:20 AM. During the dressing change observation, a partially healed, hypopigmented lesion was noted on the resident ' s left leg/shin. It measured approximately six (6) to eight (8) centimeters by one (1) to two (2) centimeters and was moist appearing with peeling skin. A review of the Resident #153 ' s clinical record lacked documentation regarding the altered skin integrity observed on the resident ' s left leg/shin. Employee #11 was queried regarding the origin of the altered skin and its treatment. The employee was also queried whether the physician and the resident ' s RP were notified of the lesion on the resident ' s left leg/shin. The employee acknowledged that neither the physician nor the RP was notified of the lesion. The record was reviewed on September 24, 2012. Facility staff failed to notify the physician and	F 157	F157 483.10(b)(11) NOTIFY OF CHANGES INJURY/DECLINE/ROOM, ETC. 1. Resident #153 leg/shin was assessed. Area was healed. M.D. and family were notified. 2. All residents with alteration in skin integrity have been identified. It has been determined that Physician and responsible parties have been notified. 3. Licensed staff have been in–serviced on facility skin policy. 4. Monthly audits will be conducted by the wound nurse or designee. Results will be submitted to the DON or designee for presentation at the quarterly QA/QI meeting.	10/24/12 11/9/12 11/9/12 Ongoing

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F 157	Continued From page 2 Responsible Party (RP) of an alteration in skin integrity sustained by Resident #153.	F 157		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made on August 21, 2012 at approximately 10:30 AM and on August 21, 2012 at approximately 3:15 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by a loose toilet paper holder in one (1) of five (5) residents rooms on 5 East, torn privacy curtains in two (2) of five (5) residents rooms on 5 East, marred door frames in one (1) of five (5) residents rooms on 5 East, a malodorous smell in one (1) of three (3) hallways on the first floor unit and a soiled carpet in one (1) of three (3) hallways on the first floor unit. The findings include: 1. The toilet paper holder in room #564 on 5 East (Hospital) was partially detached from the wall in one (1) of five (5) residents rooms. 2. One (1) of one (1) privacy curtain in room	F 253	F253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 1. 1. The toilet paper holder in room 564 on 5 east was repaired. 2. All rooms on 5 east were inspected and repairs were initiated where needed. 3. Staff were in-serviced on how to properly report damaged fixtures. 4. Random audits will be conducted by EVS supervisor or designee and results of the audits will be reported quarterly at the QA/QI meeting. 2. 1. The curtains in rooms 565 & 566 have been replaced. 2. All room curtains on 5 east were inspected and replaced where needed.	9/21/12 11/14/12 11/14/12 Ongoing 11/14/12 11/14/12

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F 253	Continued From page 3 #565 on 5 East (Hospital) was torn and one (1) of two (2) privacy curtains in room # 566 on 5 East was also torn in two (2) of five (5) residents rooms. 3. The door frames were marred in room #568 (Hospital) in one (1) of five (5) residents rooms. 4. The hallway on 1 North had a malodorous smell in one (1) of three (3) hallways on the first floor unit. 5. The carpet on 1 North was soiled throughout in one (1) of three (3) hallways on the first floor unit. The first three (3) observations were made on 5 East in the presence of Employee #22 and the last two (2) observations were made in the presence of Employee #19. They both acknowledged the findings.	F 253	3. Staff will be in-serviced on the proper installation and reporting of damaged curtains. 4. Random audits will be conducted by EVS supervisor or designee and results will be reported quarterly at the QA/QI meeting. 3. 1. 1 North hall carpet was cleaned. 2. All other halls on the first floor have been cleaned and there is no malodorous odor at this time.	11/14/12 Ongoing 11/15/12 11/15/12
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically 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;	F 272		

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F 272	Continued From page 4 Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; 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 by: Based on record review and staff interview for one (1) of 33 sampled residents, it was determined that facility staff failed to accurately code Minimum Data Sets (MDS) for skin condition. Resident #153. The findings include:	F 272	3. Staff were in-serviced on carpet cleaning techniques. 4. Audits will be completed quarterly by EVS supervisor or designee and results will be reported quarterly at the QA/QI meeting. F272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS 1. Resident #153's MDS was correctly coded on the most recent MDS with ARD of 8/26/12. 2. All residents with pressure ulcers have been identified and it has been determined that their MDS's are coded accurately. 3. All MDS staff have been in-serviced on accurately coding section M of the MDS assessment. 4. Random audits on section M of completed MDS assessments will be reviewed prior to transmission. Results will be submitted to the DON or designee for presentation at the quarterly QA/QI meeting.	11/15/12 Ongoing 8/26/12 11/9/12 11/9/12 Ongoing

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F 272	Continued From page 5 The quarterly MDS with an Assessment Reference Date [ARD] of June 5, 2012 was blank [No coding] under Section M, Skin Conditions. The significant change MDS with an ARD of March 7, 2012 revealed that the MDS was coded inaccurately for a surgical wound instead of a pressure ulcer. A face-to-face interview was conducted with Employee #21 at approximately 11:30 AM on September 24, 2012. The employee was queried regarding the type of wound on the resident ' s right thigh. The employee acknowledged that the resident ' s wound was present when the June 5, 2012 MDS was completed and should have been coded. The employee also acknowledged that the resident did not have a surgical wound and that the March 7, 2012 MDS was coded incorrectly. A face-to-face interview was also conducted with Employee #21 at approximately 2:00 PM on September 24, 2012. He/she reviewed the documents and acknowledged that the MDS coding was incorrect. The record was reviewed on September 24, 2012. Facility staff failed to accurately code the Minimum Data Sets (MDS) (Quarterly and Significant Change) for skin conditions.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

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F 279	Continued From page 6 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 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for four (4) of 33 sampled residents, it was determined that facility staff failed to develop care plans for: two (2) residents with altered skin integrity; one (1) resident receiving Hospice services and one (1) resident who exhibited mental/psychosocial concerns and non-compliance with care. Residents #16, #103, #289 and #376. The findings include: 1. Facility staff failed to develop a care plan for Resident #16 ' s alteration in skin integrity. A review of the " Progress Notes By Resident "	F 279	F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 1. 1. Resident #16 was discharged from the facility at the time of this observation and the plan of care was unable to be retroactively corrected. 2. All residents with alteration in skin integrity have been identified and care plans have been developed. 3. All licensed staff have been in–serviced on developing care plans to address alteration in skin integrity. 4. Monthly audits will be conducted by the Nurse Manager or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting. 2. 1. Resident #103's care plan was updated to include an integrated care plan for hospice.	5/29/12 11/9/12 11/9/12 Ongoing 9/21/12

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F 279	Continued From page 7 dated May 5, 2012 11:23 AM revealed that Resident #16 was admitted to the facility with an alteration in the integrity of the skin of his/her coccyx area. Review of the care plans last updated May 29, 2012 lacked evidence of a care plan with appropriate goals and approaches to address altered skin integrity. A face-to-face interview was conducted with Employee #3 on September 21, 2012 at approximately 1:00 PM. After review of the above, the employee acknowledged the findings. The record was reviewed on September 21, 2012. 2. Facility staff failed to develop an integrated care plan for hospice services for Resident #103. According to a physician ' s interim order dated June 30, 2011 directed, " Please admit to [name of agency] hospice. " According to an " Admission & Annual Physical Exam Form " dated June 4, 2012 revealed, " Advance Directives: DNR [Do Not Resuscitate]/ DNI [Do Not Intubate], No Artificial Feeding, No dialysis, Hospice. " A review of the active clinical record revealed the last updated hospice care plan was October,	F 279	2. All residents receiving hospice care have been identified and integrated care plans for hospice services are in place. 3. Licensed staff have been in-serviced on integrating care plans for hospice services. 4. Monthly audits will be conducted by the Nurse Manager or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting. 3. 1. Resident #289 was discharged from the facility at the time of this observation and the plan of care was unable to be retroactively corrected. 2. All residents have been identified and care plans are in place. 3. All licensed staff have been in-serviced on developing care plans to address altered skin integrity. 4. Monthly audits will be conducted by the Nurse Manager or designee. Results will be submitted to the DON	11/9/12 11/9/12 Ongoing 5/29/12 11/9/12 11/9/12

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F 279	Continued From page 8 2011. A review of the facility ' s care plans; last updated April 11, 2012 lacked evidence that the care plan was integrated with goals and approaches to specify the various aspects of hospice care for Resident #103. A face-to-face interview was conducted with Employee #7 on September 21, 2012 at approximately 10:30 AM. After reviewing the clinical record; he/she acknowledged that the care plan did not incorporate the hospice services for Resident #103. A face-to-face interview was conducted with Employee #25 on September 21, 2012 at approximately 4:30 PM. He/she stated that the hospice nursing notes were used instead of a care plan and that process began in October 2011. The clinical record was reviewed on September 21, 2012. 3. Facility staff failed to develop a care plan for Resident #289 ' s altered skin of the malleolus. Review of the " Progress Notes by Resident " dated April 25, 2012 at 21:35 revealed that Resident #289 was admitted to the facility with	F 279	for presentation to the quarterly QA/QI meeting. 4. 1. Resident #376's care plan for alleged suicidal ideation and non-compliance with care was initiated. 2. All residents with suicidal ideation and non-compliance with care have been identified. It has been determined that care plans are in place. 3. All licensed staff have been in-serviced on initiating care plans for suicidal ideation and non-compliance with care. 4. Monthly audits will be conducted by the Nurse Manager or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting.	Ongoing 9/21/12 11/9/12 11/9/12 Ongoing

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an alteration in the integrity of the skin of the right ankle.

A review of the resident ' s care plan last updated May 5, 2012 lacked evidence of a care plan with appropriate goals and approaches to address altered skin integrity of the right ankle.

A face-to-face interview was conducted with Employee #3 on September 21, 2012 at approximately 1:00 PM. After review of the above, he/she acknowledged the findings.
The record was reviewed on September 21, 2012.

4. Facility staff failed to initiate a care plan with goals and approaches to address Resident #376 ' s alleged suicidal ideations and non-compliance with care.

A review of progress notes in Resident # 376 ' s active clinical record revealed:

"July 10, 2012 at 08:01 ...old scratches noted on [his/her] body, Resident said [he/she] scratches [him/herself] ...[he/she] screamed on and off, she slept for sometimes, woke up again [started] screaming, resident said [he/she] wants to go to [his/her] house ..."

"July 11, 2012 at 03:06 ...Slept on and off, scream and yelling occasionally loudly"

"July 11, 2012 at 15:12 ...repetitive health

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complaints, [cried] and tearful most of the shift. Does not like being alone. Mood problems not easily changed."

"July 12, 2012 at 14:30 ...persistent screaming..."

"July 14, 2012 at 23:12 ...call by the front desk secretary to go and see resident in [his/her] room because of [his/her] pain. [He/she] stated that resident has been calling that if [he/she] did not get relief from [his/her] pain, [he/she] is going to hurt [him/herself]. Upon getting to [his/her] room I observed [multiple] open areas on the resident ' s hip/thigh area with bright red blood. Skin tears measured about 0.7cm x 0.8cm some of them unmeasurable. [Primary Attending] made aware and family also made aware. Calmoseptine [ointment] to be applied [every] shift. Resident remains alert, confused and stable."

'July 14, 2012 at 23:45-Resdient throughout the PM repeatedly called out to the hallway for help, and called on the telephone to the receptionist. Resident was seen with both legs dangling at the side of the bed ...Resident complained of pain, stated, " It ' s my hemorrhoids, they been hurting for 48 hours. Given Tylenol 650 mg and re-assessed with minimal effect. Incontinent of large BM [bowel movements], no hemorrhoids seen. Assessed for behavior and also for skin area of which resident has scratched multiple times. [His/her] left gluteus. Left gluteus has multiple denuded scratches. [Primary physician] was made aware of behaviors and complaints of pain. Order for Ativian 0.5 mg every 8 hours PRN ordered for Anxiety. Calmoseptine for the skin areas. [responsible party] informed via phone of behaviors ...he/she informed, " I would

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not mind if you all gave him/her something for anxiety. And [he/she] scratched [him/herself] in the hospital too..."

"July 16, 2012 at 23:34 ...refused to be turned and repositioned ..."

"July 17, 2012 at 14:02 ...Resident is readmit back to Carroll Manor with ESRD (End Stage Renal Disease" and refuses Dialysis at this time. Remains a full code ..."

"July 18, 2012 at 15:26 ...Resident had periods of yelling ...."

"July 19, 2012 at 20:15 ...The writer tried to administer [medication] times two but resident continue to refuse. Attempted to give patient teaching, but resident was not ready to listen, [he/she] said, " I do not want to hear anything from anybody. "

"July 19, 2012 at 22:59 ...complaining to feeling pain all over [his/her] body ...This writer approached the resident to assess the level and exact location of the pain but resident declined and said, " I do not want any medicine for pain. " I feel much better now, I do not have pain ... "

"July 21, 2012 at 20:28 ...Resident refused all of [his/her] [medications]"

"July 22, 2012 at 22:49 ...Refused to be turned side to side ..."

"July 24, 2012 at 17:21 ...[Social worker] visited with resident in a quiet corner in the living room and resident expressed unhappiness at being in

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LTC (long term care) setting. [Social worker] explored ADL [activities of daily living] needs with resident, and resident asserted, " [he/she] can do everything for [him/herself] and doesn ' t need any help. " Resident stated [he/she] feels like [he/she] is " in prison " and " just look at these people. " Per resident [his/her] sleep and appetite have improved. [He/she] would prefer to be at home " doing everything [he/she] use to do " . Resident showed little insight about [his/her] current health status ...[Social Worker] reminded resident of the circumstances surrounding his/her admission (multiple intubations) and resident agreed [he/she] almost died-and said [he/she] sometimes " wishes God would take [him/her]. " Resident denied [suicidal] and hallucinations or delusions. He/she quickly added that " suicide is a sin and God forgive me. " [Social worker] will share this with IDT [interdisciplinary team] and recommend psychiatric consult for depressive symptoms. "

"July 26, 2012 at 23:34 ...Resident refused all [his/her] medication this shift."

"July 27, 2012 at 14:15 ...Resident habitually will refuse [his/her] [medications], scream and cry for help often."

"July 29, 2012 at 14:30 ...Resident had a behavioral problem with the certified Nurse Aide ..."

"July 30, 2012 at 14:59 ...Resident was resistant to take morning medicine, but eventually agreed to take them. Resident declined to get out of bed today. Resident was noted to be crying today ... "

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	095034	A. BUILDING _____ B. WING _____	09/25/2012

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"July 30, 2012 at 16:49 ...pending psychiatry consult"

"July 30, 2012 at 19:28 ...Refused all [medications] this evening ...Resident stated, " I am not gonna take those medicine until you take me to the hospital. "

"July 31, 2012 at 11:09 ...[Social Worker] met with resident in his/her room after CNA (certified nurse aide) reported resident has been irritable. Resident said, " Get me outta here. " Social Worker discussed discharge planning resources and need for 24-hour care. Resident expressed firm belief that [he/she] was " walking and well " when [he/she] came into this place, " and now [he/she] keeps being told, " You ' re sick " and can ' t leave. [Social Worker] reviewed resident ' s rights and explored discharge options. Resident continues to believe that [facility named] and [hospital] staff wish to keep him/her here. [He/she] expressed anger, frustration and disbelief about [his/her] current health status. [He/she] said [he/she] wished [he/she] was dead but denied suicidality, stating " Suicide is a sin. " Resident did not respond to supportive counseling or redirection but did say [he/she] understood that someone would need to care for [him/her] at [his/her] home. [Social Worker] to share [his/her] thoughts of death with [nursing] and pastoral care."

"August 2, 2012 at 22:33 ... Resident refused [his/her] [medications] ..."

"August 6, 2012 at 23:20...Resident refused [his/her] [medications] ..."

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F 279	Continued From page 14 "August 10, 2012 at 05:00 ...Resident did not sleep during the night. [He/she] stated that [he/she] is nervous and is afraid to die. Saying. " I just want someone to hold my hand until I fall asleep. " CNA stayed in the room with [him/her] and [talked], and encouraged [him/her] ..." "August 11, 2012 at 20:30 ...Arguing and getting angry over simple things ..." "August 14, 2012 at 23:18 ...Resident have been refusing Remeron x 2 [times two] days now ..." "August 16, 2012 at 08:47 ...Resident was seen by Psych [Psychiatric] for suicidal thoughts and asking [his/her] therapist to assist [him/her] in executing his/her thoughts. According to rehab [staff name] the resident told [him/her] that [he/she] wanted to kill [him/herself] by jumping through [his/her] window. [He/she] said the resident also asked [him/her] to please help him/her do so. Resident was seen last week by Psych; [he/she] did express suicidal thoughts and [his/her] high level of anxiety ... " A review of the care plan revealed that there was no care plan initiated to address the resident ' s refusal of care, refusal to take his/her medications as prescribed and thoughts of harming his/herself/suicidal thoughts. A face-to-face interview was conducted on September 21, 2012 at approximately 10:30 AM with the Employee #13. He/she acknowledged that care plans were not initiated to address the resident ' s refusal of care, refusal to take his/her	F 279		

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F 279	Continued From page 15 medications as prescribed and thoughts of harming his/herself suicidal thoughts. The record was reviewed on September 21, 2012.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 33 sampled residents, it was determined that facility staff failed to update care plans to include goals and approaches for the management of syncope for one (1) resident and one (1) that sustained a fall with fracture. Residents #138 and #173.	F 280	F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE – REVISE CP 1. 1. Resident number #138's care plan was updated to include goals and approaches in the management of syncopal episodes. 2. All residents with syncopal episodes have been identified. It has been determined that care plans are in place. 3. All licensed staff have been in-serviced on updating care plans to include goals and approaches for management of syncopal episodes. 4. Monthly audits will be conducted by the Nurse Manager or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting.	9/24/12 11/9/12 11/9/12 Ongoing

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F 280	Continued From page 16 The findings include: 1. Facility staff failed to update the care plan to include goals and approaches in the management of syncopal episodes for Resident #138. A " Transfer Summary " dated March 29, 2012 revealed; " Diagnosis: Syncope/Vasovagal); Treatment: (1). Syncope- Monitor [blood pressure] stable, encourage [fluids by mouth], stand up slowly. " According to a progress note dated March 28, 2012; " Transferred to hospital for evaluation of syncope-readmitted back to facility March 29, 2012. " According to a " Resident Summary " dated March 29, 2012 (no time indicated), " No episode of syncope on this shift. " A review of the resident ' s care plan lacked documentation related to the management of syncopal episodes. A face-to- face interview was conducted with Employee #12 on September 24, 2012. After reviewing the care plans; he/she stated the care plan was not updated to include resident ' s syncopal episodes. The clinical record was reviewed on September 24, 2012. 2. Facility staff failed to revise Resident #173's	F 280	2. 1. Resident #173's care plan was revised S/P fall with injury to include physical therapist recommendations. 2. All residents S/P fall with injury were identified. It has been determined that all care plans have been updated. 3. All licensed staff have been in-serviced in updating care plan S/P fall with injury. 4. Monthly audits will be completed by the Nurse Manager or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting.	9/21/12 11/9/12 11/9/12 Ongoing

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F 280	Continued From page 17 care plan status post a fall with injury. According to the " Interdisciplinary Progress Notes" : September 17, 2012; Rehab- [Status Post] fall on September 14, 2012- Notified of patient fall after Friday at dinner time. Fall occurred as resident interacted with another resident who was in a wheelchair [Resident] leaned forward and became off balance. September 19, 2012- Rehab [Physical Therapy] - " Evaluation completed on this resident. Recommend he/she remain at [wheelchair] level for now. May ambulate with nursing to meals with rolling walker. May benefit from skilled [physical therapy] for strengthening and gait. " September 20, 2012- Nurse Practitioner - " Readmit-Resident evaluated and admitted to [hospital] September 15-18, 2012 after falling sustaining injury. X-rays revealed [bilateral nasal fractures]. CT [Computerized Tomography] Scan of head negative. [Ear Nose and Throat] consulted, prophylactic antibiotic coverage and nasal packing provided. " A review of the resident ' s fall care plan revealed that it was updated September 19, 2012 and included the fall on September 14, 2012. The care plan lacked documentation to indicate the physical therapist recommendation(s). A face-to-face interview was conducted with Employees #11 and 12 at approximately 4 PM on September 21, 2012. It was acknowledged that the care plan had not been reviewed/revised	F 280		

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F 280	Continued From page 18 to include the physical therapist ' s recommendations. It was stated the " care plan would be updated.. " The clinical record was reviewed on September 21, 2012.	F 280	F281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS 1. The resident was seen and assessed by the Psychiatrist and interventions were put in place. The identified physical therapist has been disciplined and re-educated in the standard of practice for physical therapists.	8/16/12
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 33 sampled residents, it was determined that facility staff failed to meet professional standards of quality as evidenced by a physical therapist ' s failure to act timely in conveying to the healthcare team, a resident ' s verbalization of suicidal ideation. Resident #376. The findings include: According to American Physical Therapy Association, " Physical therapists provide patient/client-centered services that include patient care, consultation, prevention, and/or promotion of health, wellness, and fitness throughout the continuum of health and life span ... " A review of progress notes for Resident #376 ' s included the following progress notes: A review of Interdisciplinary Progress Notes	F 281	2. Any resident that verbalizes suicidal ideation during a PT/OT/ST treatment will be reported to nursing services and social services immediately. The incident will be documented in the medical record upon completion of the resident's treatment. 3. All rehabilitative services staff were in-serviced on the proper procedure for notifying and documenting residents verbalizing suicidal ideation.	11/9/12 11/9/12

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F 281	Continued From page 19 dated August 15, 2012 [no time indicated] revealed, " Late entry note for tx [treatment] given August 13, 2012, Pt [patient] extremely agitated. c/o [complain of] pressure abdomen with pain LB [lower back]. Pt discussed wanting to commit suicide by throwing [his/herself] out of the 2nd flr (floor) window. [He/she] c/o being concerned about meds [medication] causing confusion. [He/she] says he/she asked for the meds to help decrease his/her anxiety but he/she regrets it. Pt said the doctors and nurses were trying to kill him/her because he/she did not accept dialysis. She then said, " If they can treat me then why won ' t they send me somewhere where they can treat me. " Pt discussed main reasons for these emotions with me. His/her pain was [unable to read]. Encouraged Pt to try moist heat ...However when PT went to leave she stated, " Don ' t leave me alone he/she followed by stating you care about me won ' t you help me kill myself. Pt then fell asleep. Pts statements reported to social services upon RTW (return to work) by therapist today. Spoke further with [pastoral representative] and Employee # 23 who interviewed this therapist re: above. Pt seen by MD ... " August 16, 2012 at 08:47 ...Resident was seen by Psych for suicidal thoughts and asking his/her therapist to assist him/her in executing his/her thoughts. According to rehabilitation [staff name] the resident told him/her that he/she wanted to kill him/herself by jumping through his/her window. He/she said the resident also asked him/her to please help him/her do so. Resident was seen last week by Psych, he/she did express	F 281	4. Items identified for chart review will now include the documentation of a resident verbalizing suicidal ideation. Review results will be presented by the Director of Rehabilitation or designee quarterly at the QA/QI meeting.	Ongoing