Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009120	A. BUILDING: _____ B. WING _____	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAUL'S HOME	1021 WEST E STREET BELLEVILLE, IL 62220

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S9999	Final Observations Statement of Licensure Violations 300.610a) 300.690a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999		

Attachment A Statement of Licensure Violations

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review the Facility failed to operationalize and follow its Abuse Prevention Policy to thoroughly investigate incidents of unknown origin/potential abuse. This has the potential to affect all 93 residents living in the facility.

Finding include:

1. R1's Nurse's Notes dated 11/02/2014 at 6:30 AM documents "Certified Nurses Aide (CNA) informed this nurse of residents (leg) having been fractured (fx). This nurse went down and saw residents left leg which seemed to be dislocated. When asked what happened she stated she fell. There wasn't a fall report. Call placed to Doctor waiting on call back".

R1's hospital "Electronic Health Record Medical Necessity Recommendation", dated 11/02/2014, documents "Pertinent Findings, Imaging X-ray of: Left tibia/fibula: Abnormal findings: Complete oblique fracture mid tibia with mild comminution and a proximal fibula shaft fracture. X-ray of the left ankle: complete transverse fracture mid tibia with some bayonetting, complete transverse fracture of the distal fibula shaft with comminution, and a spiral, nondisplaced fracture

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of the distal tibia. X-ray of the left knee: Probable complete fracture of the proximal fibula with overriding. X-ray of the left foot: Diffuse soft tissue swelling".

The "INCIDENT REPORT FORM - IDPH NOTIFICATION" dated 11/2/2014 documents, " Describe what happened, cause of injury: Unknown origin. Resident unable to explain what happened. Left leg was swollen 2 weeks ago. Doppler was done (and) negative. Was on antibiotic therapy (ABT) for possible cellulitis sent to emergency room (ER) on 10/23/2014. Sent back to Facility with an increase ABT dose. This AM complained of (c/o) pain left (L) leg. X-ray ordered. Final : X-ray L leg shows acute mildly displaced Fx of the mid shaft & tibia & distal fibula. Send to ER". The x-ray referred to was a mobile x-ray performed in the facility. E2, the Director of Nurses (DON) review the incident report and signed off that the investigation was completed on 11/3/2014. The investigation documents: "Exact cause not identified but potential causes identified. Resident unable to ambulate. Staff used mechanical lift lift to transfer. Resident's daughter would insist on her mother to be assisted up (with) a walker ambulate to B/R (bathroom) with wt (weight bearing) on leg possible injury during these times (with) daughter (with) staff present".

The Facility collected statements from 6 staff members, dated 11/6/14, which was 3 days after E2 concluded her investigation for R1's multiple leg fractures. The 6 statements collected were only from CNA's and pertained only to the potential of R1 falling, and did not thoroughly investigate other causative factors, including the potential for abuse.

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On 11/13/2014 at 2:50 PM, E21 Assistant Director of Nurses (ADON), stated that when she did the investigation into R1's leg fracture, she did not investigate abuse because she was not thinking of abuse. E21 also stated that she does not know how the fracture of R1's left leg occurred.

The Facility Policy "Reporting Incidents of Resident Abuse" dated 1/28/14, documents: POLICY: The staff of Facility shall promptly report any incident or suspected incident of residents abuse, including injuries of unknown origin. PROCEDURES: 2. Any incident or suspected incident, occurring at the Facility, involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of resident property, must be reported immediately to the Administrator.
3. All staff, residents, visitors, are encouraged to report incidents of residents abuse or suspected incidents of abuse".

2. R6's Nurses's Notes dated 03/31/2014, at 11:00 AM document "Resident alert with confusion, up sitting in reclining chair complaint of right arm pain right wrist swollen".

R6's Nurses' Notes, dated 4/1/2014, at 6:00 AM documents "Order received for x-ray of right hand and wrist'.

The portable x-ray report of R6's right hand, dated 04/01/2014, documents: "Impressions: 1: Defect involving capitate bone that may represent a nondisplaced fracture. 3. Severe degree of osteoporosis. 4. Moderate osteoarthritis".

The Facility "Investigation of Unknown Swelling", undated, documents: "On 3/30/14, residents

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daughter approached me regarding her observation of swelling and discomfort of resident's right wrist and lower portion of arm portion adjacent to wrist. Noted area felt slightly warm to touch. Dr. notified. Orders received to give Tylenol for pain. During observation, DON noted resident was previously taking Meloxicam, which is a medication for inflammation for osteoporosis, osteoarthritis, and arthritis. This medication was discontinued two weeks prior to R4's edema of the wrist. On 4/4/14, new orders were received for x-ray of right wrist and hand which revealed defect involving capitate bone that may represent a non displaced fracture Fx with a severe degree of osteoporosis and moderate osteoarthritis. Wrist splint applied by physical therapy after evaluation". This document was signed by E2, DON. This investigation lacked documentation that a thorough investigation was done to determine how this injury of unknown origin and/or potential abuse happened.

On 11/19/2014 at 2:47 PM, when asked about R6's injury to her right hand, E26 CNA stated, "I heard it was swollen, I didn't think it was broke." At 2:54 PM, when asked about R6's injury to her right hand, E27 CNA stated "I came in and it was swollen, it was x-rayed and she got a brace. I do not know what happened." At 3:00 PM, when asked about R6's injury to her right hand, E29 Licensed Practical Nurse (LPN) stated, "I remember something wrong with her hand, I did not think it was fractured but it was swollen." At 2:52 PM, when asked about R6's injury to her right hand, E28 CNA stated "I thought it was sprained or something. I do not know anything about how it happened."

3. R4's Nurses' Notes document that on 10/20/14 "staff informed nurse that (R4) had a

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bruise to the right eye when doing rounds. Assessment reveals right eye purple starting at eyebrow down to inner eyelid. R4 unable to tell what happened. Displays no sign of pain, no bleeding. Noted slight swelling. R4 has a habit of wandering, is very confused and walks independently. Has a history of falls, bruises easily."

The "Resident Incident Report", dated 10/20/14, documents the following: "Type of incident: bruise, Details of incident: Resident able to communicate what occurred? NO; What was the resident doing prior to incident? sleeping; Explain in detail what occurred: staff informed of discoloration on residents right eye. Assessment reveals discoloration, purple- in-color starting at right eyebrow down to inner eyelid; Is cause of the injury known? Yes; Summary of Probable Cause of Accident and intervention to reduce risk of Recurrence: Probably bumped into door or another object. Wanders in hallway and in/out of rooms. Staff will continue to observe residents when about and attempt to sit with resident for short rest periods".

On 11/12/14 at 1:00 PM, E21, Assistant Director of Nursing, (ADON) stated "I don't know anything about R4's eye bruising and did not get any incident report on it."

On 11/12/14 at 1:10 PM, E23, Licensed Practical Nurse, LPN stated he (E23) came on shift the morning after R4's black eye was noted. E23 stated "R4 scratched it or something."

On 11/12/14 at 2:45 PM, E21, ADON stated "there is no investigation into the causative factors of R4's black eye or how R4's black eye occurred. "

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On 11/13/14 at 1:30 PM, E2, DON, stated she did not recall R4's black eye.

On 11/18/14 at 10:00 AM, E1, Administrator, stated she was not the Administrator at the time of R4's black eye.

On 11/17/14 at 2:45 PM, E3 stated that there is no further investigation in the reports for R4's black eye.

4. R18's Nurses' Notes dated 9/25/14 document "Upon awakening right ankle noted to be swollen and purplish in color. Electronic ankle bracelet in place on left ankle. Z2, Physician Assistant to see R18 today related to right ankle."

R18's Nurses' Notes, dated 9/26/14, document "X-ray report received and Z2 notified of acute mildly displaced fracture of distal tibial metaphysis".

R18's X-ray Report dated 9/26/14 documents "Impressions: 1. Acute mildly displaced fracture, distal tibial metaphysis. 2. Mild medial soft tissue swelling. 3. Moderate osteoporosis demonstrated. 4. Mild degenerative arthritis".

R18's Progress Notes dated 9/25/14 documents "asked to see patient for right lower extremity swelling and discoloration. No reported injury to leg. Sudden onset."

The "Incident Report Form-IDPH Notification" documents "Describe what happened, cause, injury: Preliminary Report. Resident X-ray on 9/26/14 revealed displaced fracture of right tibia. 9/30/14 Unable to determine origin. Investigation complete. 10/1/14 Additional documentation

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regarding this occurrence" The initial notification, dated 9/30/14, written by E30, acting administrator at the time of occurrence, documents "A complete investigation was completed regarding resident R18. Based on the documentation and interview, there is no conclusion as to how this fracture may have occurred. There is no evidence of abuse or neglect." The final report, written by E30, documents "Based on the documentation and interviews, there is no conclusion as to how this fracture may have occurred. There is no evidence of abuse or neglect."

On 11/13/14 at 1:30 PM, E2, DON stated she did not recall R18's leg being broken.

On 11/19/14 at 2:40 PM, E21, ADON, stated she does not know or remember anything about R18's broken leg. E21 stated there is no other documentation regarding R18's broken leg.

On 11/13/14 at 11:30 PM, E21, ADON stated "I don't know what the facility policy is on abuse and I don't know what tags are". There is no further information or documentation on investigation for R4's black eye or R18's broken leg-not sure how they happened."

On 11/18/14 at 10:00 AM, E1, Administrator was interviewed and stated she was not the Administrator of the Facility at the time of R4, R6 and R18's incidents. E1 confirmed that the Facility had not thoroughly investigated R1, R4, R6 and R18's injuries of unknown origin according to the Facility's policy and procedures.

5. The Resident Census and Conditions of Residents, CMS 672, dated 11/10/14, documents that there are 93 resident's in the Facility.

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(A)

300.610a)
300.1210b)
300.1210d)5)
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing

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care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on record review and interview, the Facility failed to identify risk factors for the development of a pressure sore and implement interventions based on the identified factors for 1 (R19) of 4 residents with a history of pressure sores in the sample of 19. This failure resulted in R19 developing a Stage III pressure sore from a leg brace.

Findings include:

The Facility "Investigation Summary", dated 9/7/14, documents, "On 9/7/14 at 8:30 PM, R19 attempted to transfer self from bed because she said another resident (male) had entered her

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room. R19 fell on the floor causing an injury to her left knee. Assessed by nurse, assisted to bed by staff when nurse noted some swelling and warmth to knee. Physician notified, orders received to send to hospital for evaluation. R19 admitted to hospital with diagnosis of distal left femur fracture. No surgery performed. On 9/16/14, R19 returned to the Facility with left knee brace. Prior to incident, resident's power of attorney had stated that resident has been bed bound for three years. "

R19's Hospital Transfer Summary, dated 9/16/14, documents, "Patient complains of discomfort with the brace. Velcro knee immobilizer in place. Patient complained that the brace was rubbing. Stockinette was placed on the limb and brace readjusted with good relief of discomfort."

R19's Discharge Instructions, dated 9/16/14, document, "Leg Fracture: Cast or splint care: Check the skin around the cast or splint every day. "

The "Skin/Wound Log" documents the following for R19: the week of 9/17/14 - "cast/brace left leg, skin clear, the week of 9/22/14 - cast intact; the week of 9/29/14 - brace intact. "

R19's Nurses Note's documents, "9/16/14, 4:50 PM, (R19) refused to remove brace to left leg for skin assessment. " There is no other documentation regarding skin assessments for R19 in the clinical record until her development of a pressure sore on 9/28/14.

R19's Nurses Notes dated 9/28/14, 7:00 PM, document, "Summoned to R19's room by resident's power of attorney, stated that she noticed some drainage on resident's pillow slip.

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S9999	Continued From page 11 Leg brace removed and extremity inspected. Upon assessment, Stage 2 or 3 decubitus noted to posterior left lower extremity. Area measures approximately 3 centimeters (cm) round, redness around boarder noted". E3, Care Plan Coordinator, confirmed in an interview on 11/17/14 at 2:45 PM, that there is no other documentation regarding the condition of R19's skin around or underneath the splint prior to the development of a Stage III pressure sore from the splint and there is no documentation that R19's skin around the splint was being checked on a daily basis. The "Weekly Pressure Ulcer Log" documents the following for R19's Facility Acquired Pressure Sore of the left lower leg: The week of 9/29/14 - "Stage III measuring 2.3 cm in length by 1.5 cm in width and 1.0 cm in depth". The week of 10/6/14 - "Stage III measuring 2.0 cm in length by 2.3 cm in width (the area on the form for recording depth is blank)". The week of 10/13/14 - "Stage III measuring 1.9 cm in length by 2.3 cm in width and 0.2 cm in depth". The week of 10/20/14 - "Stage III measuring 1.7 cm in length by 2.0 cm in width (the area on the form for recording depth is blank)". The week of 10/28/14 - "hospital". The week of 11/3/14 - "Stage III measuring 1.0 cm in length by 1.7 cm in width and 0.3 cm in depth". The week of 11/10/14 - "deceased". There is no further documentation regarding R19's pressure sore on the "Weekly Pressure Ulcer Log".	S9999		

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S9999	Continued From page 12 The Facility "Nursing Service Policy and Procedure Manual, Pressure Sore Care", documents "Observe daily for the following signs of potential pressure signs and report accordingly: 1) redness or a darker, deeper bruise-like color. 2) Heat. 3) Tenderness. 4) Pain or discomfort. 5) Cracks in the skin. 6) Excessive dryness. 7) Sores, cuts or abrasions". (A) 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999		

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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) COMPLETE DATE
S9999	Continued From page 13	S9999		

practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on record review and interview, the Facility failed to identify potential safety hazards and implement progressive interventions to reduce those hazards for 1 of 6 (R7) residents with injuries in the sample of 19. This failure resulted in R7 falling and sustaining an Acute Cerebellar Hemorrhage.

Findings include:

1. R7's Minimum Data Set (MDS), dated 4/27/14, documents the following: Brief Interview for Mental Status (BIMS), "05", with 15 being the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009120	A. BUILDING: _____ B. WING _____	11/24/2014

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S9999	Continued From page 14	S9999		

highest level of cognitive functioning; does not ambulate; not steady and only able to stabilize with staff assistance for walking and surface-to-surface transfers; and requires the extensive assistance of one person for transfers.

The Facility "Resident Fall Report/Fall Investigation" documents that on 7/21/14, at 10:30 AM, R7 fell in the dining room. The report further documents "Type of fall - Unwitnessed Fall, Skin abrasion/bruise, Head Injury or Probable Head injury, fell out of wheelchair, found on the floor. Resident Diagnosis/Medical Conditions - muscle weakness, hypertension, depression. Potential cause of fall - incorrect wheelchair.
Fall preventative devices in use at the time of fall: None.
Probable cause and Interventions to Recurrence - at 10:30 AM, this nurse was called to dining area. Upon entering resident was observed lying on the floor in front of wheelchair. Resident had been observed leaning forward in chair prior to fall. Probable cause: resident had fallen forward out of wheelchair. Incorrect wheelchair for resident. New wheelchair in place. Resident found on floor in dining room. Apparently fell asleep in wheelchair and fell forward to floor. Apparently resident was not in correct wheelchair. Appropriate wheelchair provided. Offer resident to lay down if falling asleep in wheelchair. Injuries: redness to left arm, swelling and bruising to right knee, redness to middle of forehead and abrasion to bridge of nose".

The Facility nurses notes document: "7/21/14, 10:30 AM, this nurse was called to dining area. Upon entering resident was observed lying on floor in front of wheelchair. Resident had been previously observed leaning

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S9999	Continued From page 15	S9999		

forward in chair. Resident had fallen out of wheelchair related to incorrect chair. Appropriate chair now in place.
11:30 AM, send resident to emergency room."

The "Nursing Assistant Resident Fall Report", dated 7/21/14, documents "R7 was with the activity aide in the activity room and was leaning forward in the wheelchair".

E13, Certified Nurses Aide (CNA), stated in an interview on 11/19/14 at 9:55 AM, that she was the CNA who completed the "Fall Report". E13 said that E14, Activity Aide, was pushing R7 out of the dining room in her wheelchair and she fell forward out of the wheelchair. E13 said that she did not witness the incident but, was told that was what had occurred.

E14, Activity Aide, was interviewed on 11/13/14 at 1:30 PM, and stated that she does not really remember what happened to R7. E14 said that she thinks it happened during church but she's not sure. E14 said "R7 leans a lot in her wheelchair".

The "Nursing Home to Hospital Transfer Form", dated 7/21/14, documents "Reason for transfer: Fall and elevated blood pressure". The form documents R7's blood pressure was 218/100 and pulse was 50.

R7's "Emergency Room Visit Report", dated 7/21/14, documents "Clinical Impression: Falls, Acute Cerebellar Hemorrhage. Progress Note: Discussed Head Computerized Tomography (CT) finding with primary care physician and patient's family. Family does not want aggressive measures, refuses transfer. Blood pressure controlled here. Physician and family okay with

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S9999	Continued From page 16 discharging R7 back to the care Facility". R7's plan of care, with an original date of 8/6/09, documents "Problems: Falls. I am at risk for falls. I have balance deficits, and decline in functional status. I have a history of falls". Approaches for this Problem include: "Apply chair alarm". The care plan documents the Approach "Offer to lay resident down if falling asleep in wheelchair" was added on 7/21/14. E21, Assistant Director of Nursing (ADON), confirmed in an interview on 11/13/14 at 1:10 PM, that the Facility failed to thoroughly investigate the cause of R7's fall on 7/21/14, and assess R7 for leaning forward in her wheelchair prior to the fall which resulted in an Acute Cerebral Hemorrhage. E21 stated that she did not know what the "wrong" or "right" type of wheelchair was for R7 and did not know how it contributed to her fall. (A)	S9999		

This plan of correction is submitted to meet the applicable OBRA regulation. It is not to be construed as an admission of the truth of the factual allegations of the survey or the department's theories of violation.

F225

I. Corrective action for residents identified in the deficiency

At the time of the events, R1, R6, R4, and R18's injuries of unknown origin were promptly reported to the charge nurse, Director of Nursing, Administrator and IDPH according to regulations and policy. All were investigated and none were determined to be abuse.

II. Identifying other residents with potential for being affected and corrective action

All residents with an injury of unknown origin and/or potential abuse have the potential to be affected.

III. Systemic changes to reasonably assure deficiency does not recur

On November 18 – 19, 2014, employees received in-servicing regarding identification and investigation of injuries of unknown origin and incidents of abuse. Also, employees receive education on the community's abuse and neglect policy during orientation and at least annually.

IV. How corrective action will be monitored
Reports of resident injuries of unknown origin and their subsequent investigations will be reviewed by the interdisciplinary team after the morning meetings.

V. Correction Date: December 6, 2014 accepted

F226

I. Corrective action for residents identified in the deficiency
At the time of the events, R1, R6, R4, and R18's injuries of unknown origin were promptly reported to the charge nurse, Director of Nursing, Administrator and IDPH according to regulations and policy. All were investigated and none were determined to be abuse.

II. Identifying other residents with potential for being affected and corrective action
All residents with an injury of unknown origin and/or potential abuse have the potential to be affected.

 Attachment B Imposed Plan of Correction

III. Systemic changes to reasonably assure deficiency does not recur
On November 18 – 19, 2014, employees received in-servicing regarding identification and investigation of injuries of unknown origin and incidents of abuse. Also, employees receive education on the community's abuse and neglect policy during orientation and at least annually.

IV. How corrective action will be monitored
Reports of resident injuries of unknown origin and their subsequent investigations will be reviewed by the interdisciplinary after the morning meetings.

V. Correction Date: December 6, 2014 accepted

F280

I. Corrective action for residents identified in the deficiency
(1) Each time R7 had a fall, a root cause analysis was conducted and a new intervention was put into place. R7's care plan was last updated on 7-21-14. R7 has not fallen since then.
(2) R1's care plan did address the method that the staff was utilizing to transfer R1. On November 19, 2014, the Care Plan was updated per the State Surveyor's request to reflect the daughter's intent to transfer R1.

II. Identifying other residents with potential for being affected and corrective action
All residents who have had a fall with an injury have the potential to be affected.

III. Systemic changes to reasonably assure deficiency does not recur
Care Plans are being updated by the interdisciplinary team following the morning meeting.

IV. How corrective action will be monitored
The Director of Nursing or designee will audit care plans of residents who have multiple falls in order to assure compliance.

V. Correction Date: December 6, 2014 accepted

F312

I. Corrective action for residents identified in the deficiency
Another CNA went in and provided proper perineal care to R10 according the community's Perineal Care Policy.

II. Identifying other residents with potential for being affected and corrective action
Any male resident who receives perineal care could potentially be affected.