STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00		pleted 9/2018
	PROVIDER OR SUPPLIE	R	123 MA	ADDRESS, CITY, STATE, ZIP COI AIN ST HERE, US 00000	)	
(X4) ID PREFIX TAG = 000	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
- 000 Bldg. 00	Complaints. Survey date: Ja Facil Provid	or the Investigation of nuary 9, 2018 ity number: 000000 der number: 00000000 number: 000000000	F 0000	F 689 Free of accidents hazards/supervision/de The facility requests pacompliance for this cita This Plan of Correct the center's credible allegation of complia Preparation and/or exect this plan of correction do constitute admission or a by the provider of the true facts alleged or conclusi forth in the statement of deficiencies. The plan o correction is prepared an executed solely because required by the provision federal and state law.	vices per tion. ion is ance. ution of es not agreement th of the ons set f nd/or e it is	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED:

02/06/2018

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

	R MEDICARE & MEDIC		(376) 1 -		ONSTRUCTION	•	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 000000		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
		A. BU B. W	JILDING	00	COMPL 01/09/		
		000000	В. W			01/09/	2010
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
STONE	ALLEY CARE			123 M/	AIN ST HERE, US 00000		
STONE				ANTW	HERE, 03 00000		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE				PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	Quality review of	completed on $1/12/18$ .					
0689	483.25(d)(1)(2)						
SS=D	Free of Accident						
Bldg. 00	Hazards/Supervis						
	§483.25(d) Accid						
	The facility must	ensure that - e resident environment					
		f accident hazards as is					
	possible; and						
	§483.25(d)(2)Eac	h resident receives					
		sion and assistance devices					
	to prevent accide		EA	<00			00/00/20
		ed on observation, record review, and		F 0689	F 689 Free of accidents hazards/supervision/devices		02/08/201
		cility failed to ensure fall			liazarus/supervision/devices	•	
	prevention inter	ventions were in place					
	related a Dycem	n (anti-skid) mat not in place					
	as per the residents plan of care for 1 of 3 residents reviewed for recent falls. (Resident				The facility requests paper compliance for this citation.		
	L)						
	,						
	Finding include	s.			This Plan of Correction is	2	
		~.			the center's credible	•	
	0n 1/0/18  at  2.2	35 p.m., Resident L was					
		•			allegation of compliance.		
	-	a chair in her room. No staff					
	-	the room. CNA 1 entered					
		sisted the resident to a			Preparation and/or execution	of	
	standing positio	n. No Dycem was in place			this plan of correction does no		
	on the seat of th	e Broda chair. The CNA			constitute admission or agree		
	confirmed no D	ycem was in place.			by the provider of the truth of t		
	1	- I			facts alleged or conclusions se	et	

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STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         000000       000000		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/09/2018		
	PROVIDER OR SUPPLIE		D	STREET	ADDRESS, CITY, STATE, ZIP COD AIN ST HERE, US 00000	01100	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	the chair and ex checked the Ka	isted the resident back into tited the room. The CNA rdex system in the hallway. icated the Dycem was to be Broda chair.			forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	e plan of ared and/or pecause it is rovisions of	
	reviewed on 1/9 included, but w Alzheimer's dis depressive diso A Fall Initial O on 12/12/17, ind unwitnessed fal slipped out of th buttock. The re- No injuries obse	ord for Resident L was 0/18 at 2:35 p.m. Diagnoses ere not limited to, ease, anxiety disorder, and rder. ccurrence Note, completed dicated the resident had an 1 in her room. The resident he Broda chair and onto her esident stated "I just slipped." erved. Actions taken were to b the wheel chair when up.			<ol> <li>Immediate actions tak for those residents identified</li> <li>Resident L care plan reviewed dyscem was replaced on cha and all fall interventions were reviewed and ensured they we place.</li> </ol>	ed and air e vere in	
	During an inter LPN 2 indicated for Resident L. was not in place plans. She had n	view on 1/9/18 at 2:45 p.m., d she was assigned to care The Dycem pad intervention e on the electronic care not been aware the Dycem ce on the Broda chair.			<ul> <li>2) How the facility idention</li> <li>other residents:</li> <li>Plans of Care &amp; Kardex for a residents at high risk for falls</li> <li>be reviewed. Fall Prevention</li> <li>be reviewed to ensure that the measures are appropriate are in place.</li> </ul>	ll will n will ne	
	the facility Adn	view on 1/9/18 at 2:53 p.m., ninistrator indicated the the nave been in place on the					

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. ,				(X3) DATE SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER 000000	A. BUILDING B. WING	<u>UU</u>	COMPLETED 01/09/2018	
PROVIDER OR SUPPLIE	2R				
ALLEY CARE					
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
The Federal tag IN00249672.	relates to Complaint		3) Measures put into place System changes: .Nursing staff will be in-servic regarding Fall Prevention Measures and the Kardex System.		
			4) How the corrective actions will be monitored: Random weekly checks on al shifts will be conducted per the DON/ADON or DON's designed 3 residents who are determined high risk for falls per week to ensure that the appropriate measures are in place per the Care Plan & Kardex	e ee on ed	
			The results of these audits wil reviewed in Quality Assurance Meeting monthly for 6 months until 100% compliance is achi x3 consecutive months. The 0 Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated	e or eved QA ends e	
	OF CORRECTION PROVIDER OR SUPPLIE /ALLEY CARE SUMMARY (EACH DEFICIE REGULATORY C The Federal tag	OF CORRECTION IDENTIFICATION NUMBER 000000 PROVIDER OR SUPPLIER /ALLEY CARE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION The Federal tag relates to Complaint	OF CORRECTION       IDENTIFICATION NUMBER       A. BUILDING         000000       B. WING         PROVIDER OR SUPPLIER       STREET         /ALLEY CARE       123 M/         SUMMARY STATEMENT OF DEFICIENCIE       ID         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         REGULATORY OR LSC IDENTIFYING INFORMATION       TAG         The Federal tag relates to Complaint       Image: Complaint	OF CORRECTION         DENTIFICATION NUMBER 00000         A. BUILDING B. WING         OD           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP COD 123 MAIN ST ANYWHERE, US 00000         STREET ADDRESS, CITY, STATE, ZIP COD 123 MAIN ST ANYWHERE, US 00000           SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION         ID PREFIX TAG         PROVIDERS HAN OF ORBERTION INCOMEST HAN OF ORBERTION CONSERTEMENTS TO THE APPORTM TAG           The Federal tag relates to Complaint IN00249672.         JM Measures put into plac System changes: JNUrsing staff will be in-service regarding Fall Prevention Measures and the Kardex System.         J           4)         How the corrective actions will be monitored: Random weekly checks on al shifts will be conducted per th DON/ADON or DON's design 3 residents who are determine high risk for falls per week to ensure that the appropriate measures are in place per the Care Plan & Kardex           The results of these audits wil reviewed in Quality Assurance Meeting monthly for months undi 100% compliance is achi x3 consecutive months. The Committee will identify any the or patterns and make	

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PRINTED: 02/06/2018

PRINTED: 02/06/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155277 B. WING 01/09/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 123 MAIN ST STONEVALLEY CARE ANYWHERE, US 00000 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 5) Date of compliance: February 8, 2018

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