STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106034	A. BUILDING _____ B. WING _____	C 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON PLAZA NURSING AND REHABILITATION CENTER	1861 NW 8TH AVENUE MIAMI, FL 33136

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted at Jackson Plaza Nursing and Rehabilitation Center on . through , in conjunction with complaint (2019017363). The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review facility failed to provide supervision to prevent for one resident (resident #59) out of two residents sampled for . . during this survey. The findings included: Observation on at 11:25 am revealed no . . . . floor mats next to the bed Observation on . . . . at 11:56 am revealed resident in wheelchair in the dining room. Resident has had a chair alarm located on the left side of her wheelchair. Observation on at 9:32 am revealed	F 689		

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

Electronically Signed /2020

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 689	Continued From page 1 resident #59 in bed sleeping. The bed was in a low position with bed rails, there were no floor mats next to her bed. Record Review of Physician's Order dated revealed there was an order for floor mats while in bed for safety and precautions measures every shift. Record Review of Minimum Data Set (MDS) dated revealed Section J- - One - one injury Section P- floor mat alarm daily, chair alarm daily, Bed alarm daily. Care plan dated -Revealed Resident is at risk for due to: , mobility, , , medication. Resident sustained a on at 4:14 pm in her room ...Resident sustained a right ...Returned from hospital with right arm The use of daily floor mats while in bed was not revised to the care plan. Interview with Staff B Certified Nursing Assistant on at 2:03 pm revealed , sometimes Resident #59 is more alert than others, sometimes she responds easily, some days she is more and some days she is in bed, it depends on resident #59's . Staff B stated that Resident # 59 needs complete assistance and required two persons to assist with getting out of bed. Staff B explained that when Resident # 59 is in bed, the bed is lowered. Staff B stated, "we put the blue mattress on the floor and we put the light alarm and the bed alarm". Staff B stated that Resident #59 needs the floor mats when she is in bed.	F 689		

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F 689	Continued From page 2 Observation and interview on with Staff A, Licensed Practical Nurse, and staff B Certified Nursing Assistant at 9:23 am revealed the resident was in bed sleeping. The Certified Nursing Assistant (Staff B) stated the reason that she did not have the floor mats yesterday was because for some reason they didn't find them so she went to restorative herself to speak with them. Staff B stated , "They said they don't know if someone else made an order to switch them or change them". Interview with Staff A, (LPN) on at 9:34 am revealed; Resident # 59 was alert times one (person). Staff a revealed that Resident #59 has in the facility about a month and a half ago. Staff A reported that when Resident #59 she was working with her. Resident #59 tried to get out of bed to go to the bathroom, a to assessment was completed , the doctor was notified , resident was complaining of , and was medicated and an , was done immediately. The doctor ordered resident to be sent to the hospital as soon as the results for , was received. Staff A stated that Resident #59 was in the hospital Emergency Room for about 2 to 3 hours and returned to the facility with a and she had a for about 3 weeks ....Staff B stated Resident has not had any other . Staff B revealed that Resident #59 has an alarm on the bed and on the chair. Staff A acknowledged that it is a concern that Resident # 59 did not have the floor mats in place as ordered.	F 689		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111322A	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON PLAZA NURSING AND REHABILITATION C	1861 NW 8TH AVENUE MIAMI, FL 33136

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N 000	INITIAL COMMENTS An unannounced Re licensure survey was conducted at Jackson Plaza Nursing and Rehabilitation Center on ,,2019 through in conjunction with a complaint (2019017363. Deficiencies were identified at the time of the survey.	N 000		
N 054	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to follow Physician's orders for one resident (Resident # 59) out of two residents sampled for during this survey. The findings included: Observation on at 11:25 am revealed no floor mats next to the bed Observation on at 11:56 am revealed resident in wheelchair in the dining room. Resident has had a chair alarm located on the left side of her wheelchair. Observation on at 9:32 am revealed resident #59 in bed sleeping. The bed was in a	N 054		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 054	Continued From page 1 low position with bed rails, there were no floor mats next to her bed. Record Review of Physician's Order dated revealed there was an order for floor mats while in bed for safety and precautions measures every shift. Record Review of Minimum Data Set (MDS) dated revealed Section J- - One - one injury Section P- floor mat alarm daily, chair alarm daily, Bed alarm daily. Care plan dated -Revealed Resident is at risk for due to: , mobility, , medication. Resident sustained a on at 4:14 pm in her room ...Resident sustained a right ...Returned from hospital with right arm The use of daily floor mats while in bed was not revised to the care plan. Interview with Staff B Certified Nursing Assistant on at 2:03 pm revealed , sometimes Resident #59 is more alert than others, sometimes she responds easily, some days she is more and some days she is in bed, it depends on resident #59's . Staff B stated that Resident # 59 needs complete assistance and required two persons to assist with getting out of bed. Staff B explained that when Resident # 59 is in bed, the bed is lowered. Staff B stated, "we put the blue mattress on the floor and we put the light alarm and the bed alarm". Staff B stated that Resident #59 needs the floor mats when she is in bed. Observation on at 9:19 am revealed resident #59 in bed sleeping she had bed	N 054		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 054	Continued From page 2 rails and floor mats . Observation and interview on with Staff A, Licensed Practical Nurse, and staff B Certified Nursing Assistant at 9:23 am revealed the resident was in bed sleeping. The Certified Nursing Assistant (Staff B) stated the reason that she did not have the floor mats yesterday was because for some reason they didn't find them so she went to restorative herself to speak with them. Staff B stated , "They said they don't know if someone else made an order to switch them or change them". Interview with Staff A, (LPN) on at 9:34 am revealed; Resident # 59 was alert times one (person). Staff a revealed that Resident #59 has in the facility about a month and a half ago. Staff A reported that when Resident #59 she was working with her. Resident #59 tried to get out of bed to go to the bathroom, a to assessment was completed , the doctor was notified , resident was complaining of , and was medicated and an , was done immediately. The doctor ordered resident to be sent to the hospital as soon as the results for , was received. Staff A stated that Resident #59 was in the hospital Emergency Room for about 2 to 3 hours and returned to the facility with a and she had a for about 3 weeks ....Staff B stated Resident has not had any other . Staff B revealed that Resident #59 has an alarm on the bed and on the chair. Staff A acknowledged that it is a concern that Resident # 59 did not have the floor mats in place as ordered. Class III	N 054		

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N 110	Continued From page 3	N 110		
N 110 SS=D	400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike 400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. 59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to: 1) Provide safe physical environment for 1 resident (resident # 59) who had a physician's order for floor mats while in bed. The findings included: Observation on at 11:25 am revealed no floor mats next to the bed Observation on at 11:56 am revealed resident in wheelchair in the dining room. Resident has had a chair alarm located on the left side of her wheelchair. Observation on at 9:32 am revealed resident #59 in bed sleeping. The bed was in a low position with bed rails, there were no floor mats next to her bed. Record Review of Physician's Order dated revealed there was an order for floor mats while in bed for safety and precautions measures every shift.	N 110		

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N 110	Continued From page 4 Record Review of Minimum Data Set (MDS) dated [illegible] revealed Section J- [illegible] - One - one injury Section P- floor mat alarm daily, chair alarm daily, Bed alarm daily. Care plan dated [illegible] -Revealed Resident is at risk for [illegible] due to: [illegible] mobility, [illegible] medication. Resident sustained a [illegible] on [illegible] at 4:14 pm in her room ...Resident sustained a right [illegible] ...Returned from hospital with right arm [illegible]. The use of daily [illegible] floor mats while in bed was not revised to the care plan. Interview with Staff B Certified Nursing Assistant on [illegible] at 2:03 pm revealed , sometimes Resident #59 is more alert than others, sometimes she responds easily, some days she is more [illegible] and some days she is in bed, it depends on resident #59's [illegible]. Staff B stated that Resident # 59 needs complete assistance and required two persons to assist with getting out of bed. Staff B explained that when Resident # 59 is in bed, the bed is lowered. Staff B stated, "we put the blue mattress on the floor and we put the light alarm and the bed alarm". Staff B stated that Resident #59 needs the floor mats when she is in bed. Observation on [illegible] at 9:19 am revealed resident #59 in bed sleeping she had bed rails and floor mats . Observation and interview on [illegible] with Staff A, Licensed Practical Nurse, and staff B Certified Nursing Assistant at 9:23 am revealed the resident was in bed sleeping. The Certified	N 110		

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N 110	Continued From page 5 Nursing Assistant (Staff B) stated the reason that she did not have the floor mats yesterday was because for some reason they didn't find them so she went to restorative herself to speak with them. Staff B stated , "They said they don't know if someone else made an order to switch them or change them". Interview with Staff A, (LPN) on at 9:34 am revealed; Resident # 59 was alert times one (person). Staff a revealed that Resident #59 has in the facility about a month and a half ago. Staff A reported that when Resident #59 she was working with her. Resident #59 tried to get out of bed to go to the bathroom, a to assessment was completed , the doctor was notified , resident was complaining of , and was medicated and an , was done immediately. The doctor ordered resident to be sent to the hospital as soon as the results for , was received. Staff A stated that Resident #59 was in the hospital Emergency Room for about 2 to 3 hours and returned to the facility with a and she had a for about 3 weeks ....Staff B stated Resident has not had any other . Staff B revealed that Resident #59 has an alarm on the bed and on the chair. Staff A acknowledged that it is a concern that Resident # 59 did not have the floor mats in place as ordered. Class III	N 110		

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F 000	INITIAL COMMENTS An unannounced recertification survey was conducted at Jackson Plaza Nursing and Rehabilitation Center on . through , in conjunction with complaint (2019017363). The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review facility failed to provide supervision to prevent for one resident (resident #59) out of two residents sampled for . . during this survey. The findings included: Observation on at 11:25 am revealed no . . . . floor mats next to the bed Observation on . . . . at 11:56 am revealed resident in wheelchair in the dining room. Resident has had a chair alarm located on the left side of her wheelchair. Observation on at 9:32 am revealed	F 689	IMMEDIATE CORRECTIVE ACTION: The medical record for resident #59 was reviewed ; physician order for floor mattress was noted and was placed immediately on the floor beside resident's bed. Staff In service training conducted on . . . . regarding precautionary measures and supervision of residents to minimize the risk for . . IDENTIFICATION OF RESIDENTS: An audit of all residents who are at risk for and residents who has history of incident was conducted on The facility has determined that residents that are at risk for and with orders for	

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

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F 689	Continued From page 1 resident #59 in bed sleeping. The bed was in a low position with bed rails, there were no floor mats next to her bed. Record Review of Physician's Order dated revealed there was an order for floor mats while in bed for safety and precautions measures every shift. Record Review of Minimum Data Set (MDS) dated revealed Section J- - One - one injury Section P- floor mat alarm daily, chair alarm daily, Bed alarm daily. Care plan dated -Revealed Resident is at risk for due to: , mobility, , , medication. Resident sustained a on at 4:14 pm in her room ...Resident sustained a right ...Returned from hospital with right arm The use of daily floor mats while in bed was not revised to the care plan. Interview with Staff B Certified Nursing Assistant on at 2:03 pm revealed , sometimes Resident #59 is more alert than others, sometimes she responds easily, some days she is more and some days she is in bed, it depends on resident #59's . Staff B stated that Resident # 59 needs complete assistance and required two persons to assist with getting out of bed. Staff B explained that when Resident # 59 is in bed, the bed is lowered. Staff B stated, "we put the blue mattress on the floor and we put the light alarm and the bed alarm". Staff B stated that Resident #59 needs the floor mats when she is in bed.	F 689	floor mattress had the potential to be affected by the deficient practice. SYSTEMIC CHANGES: The policy and procedure regarding and Preventing was reviewed and updated on . Staff re-educated on regarding Prevention and Supervision of residents Unit Managers and or designee will conduct random weekly audits to identify residents who are at risk for to ensure that staff are placing mats on the floor as ordered. Restorative Nurse and or designee will review resident's with order for floor mattress and will conduct visual inspection daily to ensure the floor mattress is in place. A monitoring log is created every shift to reflect this observation. MONITORING: The Director of Nursing and/or designee will conduct random observations weekly. Observation report findings will be reported to the QA committee for three months or until substantial compliance has been achieved as determined by the committee.	

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F 689	Continued From page 2 Observation and interview on with Staff A, Licensed Practical Nurse, and staff B Certified Nursing Assistant at 9:23 am revealed the resident was in bed sleeping. The Certified Nursing Assistant (Staff B) stated the reason that she did not have the floor mats yesterday was because for some reason they didn't find them so she went to restorative herself to speak with them. Staff B stated , "They said they don't know if someone else made an order to switch them or change them". Interview with Staff A, (LPN) on at 9:34 am revealed; Resident # 59 was alert times one (person). Staff a revealed that Resident #59 has in the facility about a month and a half ago. Staff A reported that when Resident #59 she was working with her. Resident #59 tried to get out of bed to go to the bathroom, a to assessment was completed , the doctor was notified , resident was complaining of , and was medicated and an , was done immediately. The doctor ordered resident to be sent to the hospital as soon as the results for , was received. Staff A stated that Resident #59 was in the hospital Emergency Room for about 2 to 3 hours and returned to the facility with a and she had a for about 3 weeks ....Staff B stated Resident has not had any other . Staff B revealed that Resident #59 has an alarm on the bed and on the chair. Staff A acknowledged that it is a concern that Resident # 59 did not have the floor mats in place as ordered.	F 689		

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N 054	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to follow Physician's orders for one resident (Resident # 59) out of two residents sampled for during this survey. The findings included: Observation on at 11:25 am revealed no floor mats next to the bed Observation on at 11:56 am revealed resident in wheelchair in the dining room. Resident has had a chair alarm located on the left side of her wheelchair. Observation on at 9:32 am revealed resident #59 in bed sleeping. The bed was in a	N 054	IMMEDIATE CORRECTIVE ACTION: The medical record for resident #59 was reviewed ; physician order for floor mattress was noted and was placed immediately on the floor beside resident s bed. Staff In service training conducted on regarding precautionary measures and supervision of residents to minimize the risk for . IDENTIFICATION OF RESIDENTS: An audit of all residents who are at risk for and residents who has history of incident was conducted on . The facility has determined that residents that are at risk for and with orders for floor mattress had the potential to be	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111322A	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON PLAZA NURSING AND REHABILITATION C	1861 NW 8TH AVENUE MIAMI, FL 33136

(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
N 054	Continued From page 1 low position with bed rails, there were no floor mats next to her bed. Record Review of Physician's Order dated revealed there was an order for floor mats while in bed for safety and precautions measures every shift. Record Review of Minimum Data Set (MDS) dated revealed Section J- - One - one injury Section P- floor mat alarm daily, chair alarm daily, Bed alarm daily. Care plan dated -Revealed Resident is at risk for due to: , mobility, , medication. Resident sustained a on at 4:14 pm in her room ...Resident sustained a right ...Returned from hospital with right arm The use of daily floor mats while in bed was not revised to the care plan. Interview with Staff B Certified Nursing Assistant on at 2:03 pm revealed , sometimes Resident #59 is more alert than others, sometimes she responds easily, some days she is more and some days she is in bed, it depends on resident #59's . Staff B stated that Resident # 59 needs complete assistance and required two persons to assist with getting out of bed. Staff B explained that when Resident # 59 is in bed, the bed is lowered. Staff B stated, "we put the blue mattress on the floor and we put the light alarm and the bed alarm". Staff B stated that Resident #59 needs the floor mats when she is in bed. Observation on at 9:19 am revealed resident #59 in bed sleeping she had bed	N 054	affected by the deficient practice. SYSTEMIC CHANGES: The policy and procedure regarding and Preventing was reviewed and updated on . Staff re-educated on regarding Prevention and Supervision of residents Unit Managers and or designee will conduct random weekly audits to identify residents who are at risk for to ensure that staff are placing mats on the floor as ordered. Restorative Nurse and or designee will review resident's with order for floor mattress and will conduct visual inspection daily to ensure the floor mattress is in place. A monitoring log is created every shift to reflect this observation. MONITORING: The Director of Nursing and/or designee will conduct random observations weekly. Observation report findings will be reported to the QA committee for three months or until substantial compliance has been achieved as determined by the committee.	

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N 054	Continued From page 2 rails and floor mats . Observation and interview on with Staff A, Licensed Practical Nurse, and staff B Certified Nursing Assistant at 9:23 am revealed the resident was in bed sleeping. The Certified Nursing Assistant (Staff B) stated the reason that she did not have the floor mats yesterday was because for some reason they didn't find them so she went to restorative herself to speak with them. Staff B stated , "They said they don't know if someone else made an order to switch them or change them". Interview with Staff A, (LPN) on at 9:34 am revealed; Resident # 59 was alert times one (person). Staff a revealed that Resident #59 has in the facility about a month and a half ago. Staff A reported that when Resident #59 she was working with her. Resident #59 tried to get out of bed to go to the bathroom, a to assessment was completed , the doctor was notified , resident was complaining of , and was medicated and an , was done immediately. The doctor ordered resident to be sent to the hospital as soon as the results for , was received. Staff A stated that Resident #59 was in the hospital Emergency Room for about 2 to 3 hours and returned to the facility with a and she had a for about 3 weeks ....Staff B stated Resident has not had any other . Staff B revealed that Resident #59 has an alarm on the bed and on the chair. Staff A acknowledged that it is a concern that Resident # 59 did not have the floor mats in place as ordered. Class III	N 054		

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N 110	Continued From page 3	N 110		
N 110 SS=D	400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike 400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. 59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to: 1) Provide safe physical environment for 1 resident (resident # 59) who had a physician's order for floor mats while in bed. The findings included: Observation on at 11:25 am revealed no floor mats next to the bed Observation on at 11:56 am revealed resident in wheelchair in the dining room. Resident has had a chair alarm located on the left side of her wheelchair. Observation on at 9:32 am revealed resident #59 in bed sleeping. The bed was in a low position with bed rails, there were no floor mats next to her bed. Record Review of Physician's Order dated revealed there was an order for floor mats while in bed for safety and precautions measures every shift.	N 110	IMMEDIATE CORRECTIVE ACTION: The medical record for resident #59 was reviewed ; physician order for floor mattress was noted and was placed immediately on the floor beside resident's bed. Staff In service training conducted on regarding precautionary measures and supervision of residents to minimize the risk for . IDENTIFICATION OF RESIDENTS: An audit of all residents who are at risk for and residents who has history of incident was conducted on The facility has determined that residents that are at risk for and with orders for floor mattress had the potential to be affected by the deficient practice.	

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N 110	Continued From page 4 Record Review of Minimum Data Set (MDS) dated [illegible] revealed Section J- [illegible] - One - one injury Section P- floor mat alarm daily, chair alarm daily, Bed alarm daily. Care plan dated -Revealed Resident is at risk for [illegible] due to: [illegible] mobility, [illegible] medication. Resident sustained a [illegible] on [illegible] at 4:14 pm in her room ...Resident sustained a right ...Returned from hospital with right arm [illegible] The use of daily floor mats while in bed was not revised to the care plan. Interview with Staff B Certified Nursing Assistant on [illegible] at 2:03 pm revealed , sometimes Resident #59 is more alert than others, sometimes she responds easily, some days she is more and some days she is in bed, it depends on resident #59's [illegible]. Staff B stated that Resident # 59 needs complete assistance and required two persons to assist with getting out of bed. Staff B explained that when Resident # 59 is in bed, the bed is lowered. Staff B stated, "we put the blue mattress on the floor and we put the light alarm and the bed alarm". Staff B stated that Resident #59 needs the floor mats when she is in bed. Observation on [illegible] at 9:19 am revealed resident #59 in bed sleeping she had bed rails and floor mats . Observation and interview on [illegible] with Staff A, Licensed Practical Nurse, and staff B Certified Nursing Assistant at 9:23 am revealed the resident was in bed sleeping. The Certified	N 110	SYSTEMIC CHANGES: The policy and procedure regarding and Preventing was reviewed and updated on . Staff re-educated on regarding Prevention and Supervision of residents Unit Managers and or designee will conduct random weekly audits to identify residents who are at risk for to ensure that staff are placing mats on the floor as ordered. Restorative Nurse and or designee will review resident□s with order for floor mattress and will conduct visual inspection daily to ensure the floor mattress is in place. A monitoring log is created every shift to reflect this observation. MONITORING: The Director of Nursing and/or designee will conduct random observations weekly. Observation report findings will be reported to the QA committee for three months or until substantial compliance has been achieved as determined by the committee.	

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N 110	Continued From page 5 Nursing Assistant (Staff B) stated the reason that she did not have the floor mats yesterday was because for some reason they didn't find them so she went to restorative herself to speak with them. Staff B stated , "They said they don't know if someone else made an order to switch them or change them". Interview with Staff A, (LPN) on at 9:34 am revealed; Resident # 59 was alert times one (person). Staff a revealed that Resident #59 has in the facility about a month and a half ago. Staff A reported that when Resident #59 she was working with her. Resident #59 tried to get out of bed to go to the bathroom, a to assessment was completed , the doctor was notified , resident was complaining of , and was medicated and an , was done immediately. The doctor ordered resident to be sent to the hospital as soon as the results for , was received. Staff A stated that Resident #59 was in the hospital Emergency Room for about 2 to 3 hours and returned to the facility with a and she had a for about 3 weeks ....Staff B stated Resident has not had any other . Staff B revealed that Resident #59 has an alarm on the bed and on the chair. Staff A acknowledged that it is a concern that Resident # 59 did not have the floor mats in place as ordered. Class III	N 110		