STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045422	A. BUILDING ____ B. WING ____	C 08/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF MAUMELLE	103 ALEXANDRIA DRIVE MAUMELLE, AR 72113

(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 This 2567 supercedes any previous copy (s) Complaint # 13751 unsubstantiated. Complaint # 13755 substantiated (all or in part) with deficiencies cited at F312 and F314. Complaint # 13782 substantiated (all or in part) with deficiencies cited at F282, 312 and F323. Complaint # 13811 substantiated (all or in part) with deficiencies cited at F312.	F 000		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Complaint # 13782 substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure snacks were provided according to the Physicians order for 1 (Resident # 5) of 2 (Resident # 5, # 9) case mix residents who had physician orders for snacks. The failed practice had the potential to affect 7 residents in the facility with physician's orders for snacks as documented on a form entitled Physician Orders List Supplement provided by the Director of Nurses on 8/11/08 at 1:40 p.m. The findings are: 1. Resident # 5 had diagnoses of Atrial Fibrillation, Secondary Parkinson, Syncope, and Collapse. The Minimum Data Set dated 5/29/08	F 282		

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

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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documented the resident had modified independent cognitive skills for daily decision-making, and required supervision for meals.

a. The plan of care dated 2/24/08 documented, Problem: Weight Loss. Interventions: 2 cal HN, 90 cc (cubic centimeters) tid (three times daily) with medication pass. Snack at 10:00 a.m. and 2:00 p.m. The care plan updated 5/29/08 documented: Continue Dietary Interventions, Weight stable at this time.

b. A Physician ' s order dated 2/24/08 documented, Loss Weight, Snacks at 10 (10:00) a.m. and 2 (2:00) p.m.

c. The facility ' s August 2008 snacks list entitled ' Physician orders List for Supplements at meals, Supplements, Snacks, documented the residents name, room number and Physician name and [time resident was to receive snack] snacks at 10 a.m. and 2 p.m.

d. On 8/13/08 review of the August 2008 meal consumption [percentage] form had no documentation that the resident had been given a snack from 8/1/08 thru 8/13/08.

e. On 8/12/08 at 10:15 a.m., 10:30 a.m., 10:45 a.m., and 11:00 a.m., the resident was lying in the bed with eyes closed. No supplement snack was offered and there were no snacks at bed side.

f. On 8/12/08 at 11:30 a.m., the resident was asked: Have you been offered a snack this morning? The resident stated, " No."

g. On 8/12/08 at 3:30 p.m., the resident was lying

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F 282	Continued From page 2 in the bed awake. The resident was asked : Have you had a snack since lunch? The resident stated "No not yet."	F 282		
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Complaint # 13755 substantiated (all or in part) with these findings. Complaint # 13782 substantiated (all or in part) with these findings. Complaint # 13811 substantiated (all or in part) with these findings. Based on observation, interviews record review, the facility failed to ensure all areas of the perineum and groin was cleansed when providing incontinent care for 3 (Residents # 1 - 3) of 6 (Resident # 1 - 4, 8, 9) case mix residents who were incontinent and dependent on staff for toileting and failed to ensure showers/bathing were provided timely to promote good hygiene for 1 (Resident # 9) of 9 (Residents # 1 - 9) who required assistance with bathing. These failed practices had the potential to affect 43 residents who were incontinent and dependent on staff for toileting and 51 residents in the facility that were dependent on staff for bathing as identified by lists provided by the Director of Nursing on 8/13/08. The findings are: 1. Resident # 1 had diagnoses of Alzheimer's	F 312		

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F 312	Continued From page 3	F 312		

Disease and Congestive Heart Failure. The Minimum Data Set (MDS) dated 4/17/08 documented the resident had moderately impaired cognitive skills for daily decision-making, was incontinent of bladder and required staff assistance with toileting and personal hygiene.

a. The Plan of Care dated 7/31/08 documented, "Stress incontinence due to cognitive impairment. Use proper hygiene practices by peri-care after each incontinent episode and prn (as needed). Self Care Deficit. Provide pericare after each incontinent episode. Assist with toileting needs q (every) 2 hours and PRN (as needed). "

b. On 8/11/08 at 4:00 p.m., the resident had been incontinent of urine. CNA (Certified Nursing Assistant) #1 removed the wet incontinent brief. The resident was turned onto her right side. CNA #1 used one pre-moistened wet wipe and cleansed the posterior buttocks and anal area. The CNA then blotted the area with a dry Kleenex and applied barrier cream. The resident was rolled back onto her back and a new incontinent brief was put on. The CNA did not cleanse the anterior pubic area, the inner thighs or the groin folds. The CNA did not spread the labia and cleanse the area around the urinary meatus or vagina.

2. Resident #2 had diagnoses of Alzheimer Disease, and Presenile Dementia. The Significant Change MDS dated 5/2/08 documented the resident had moderately impaired cognitive skills for daily decision-making, required extensive assistance for personal hygiene and bathing, and was incontinent of bowel and bladder.

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F 312	Continued From page 4 a. The plan of care dated 5/1/08 documented, Problem: Self care deficit resident needs extensive assistance for all ADL's (Activities of Daily Living). Resident is at risk for skin breakdown due to incontinence of bowel and bladder, pads and briefs used daily. Intervention: Provide perineal care every two hours and as needed. May use adult brief/pad as indicated. Assist with toileting needs. Apply protective/preventive barrier creams as indicated and ordered. Assist resident to turn and reposition as needed. b. On 8/11/08 at 3:10 p.m. and at 5:00 p.m., the resident was setting up in a wheel chair fully dressed with a strong urine/bowel movement odor. c. On 8/11/08 at 5:27 p.m., Licensed practical Nurse (LPN) # 2 wheeled the resident to the main dinning room. The LPN spoke to CNA #1 who wheeled the resident from the dining room to her room. The LPN provided privacy and assisted the resident to stand from the wheelchair, placed both of the resident ' s hands on the bedside table and told the resident to hold the table. The CNA pulled the residents blue slacks down. The resident had a strong urine/bowel movement odor. The CNA unsecured the brief. The LPN removed the brief which was saturated with urine and loose brown bowel movement. The LPN stated, "She has been wet a long time." The resident remained standing holding onto the bedside table. The CNA put on gloves, and removed a Premoistened wipe from a package. The CNA then reached between the resident legs and wiped from the top of the vaginal area to the anal area. The wipe was completely covered with bowel movement. The CNA used three different	F 312		

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F 312	Continued From page 5 wipes to the anal area, each wipe was stained with the color of the stool. With a clean wipe the CNA cleansed the residents right buttock, then placed a clean brief on the resident and pulled up her blue slacks. The bowel movement was not completely cleansed from the residents, the labia was not separated and cleansed, and the resident still had an odor of urine and stool. 3. Resident # 3 had diagnoses of Presenile Dementia, Hypertension, Depressive Disorder, and Osteoporosis. The Quarterly MDS dated 05/01/08 documented the resident had moderately impaired cognitive skills for daily decision making and required extensive assistance for personal hygiene, was incontinent bowel and bladder and used pads/briefs. a. The Plan of Care dated 05/01/08 documented, the resident was at risk for skin breakdown due to incontinence of bowel and bladder, pads and briefs used daily. The approaches: Self care deficit resident needs extensive to total assistance for all ADL'S. The approaches are: Keep skin clean and dry, provide pericare every 2 hours and as needed (prn), assist resident to turn and reposition every 2 hours and prn. b. On 8/11/08 at 4:35 p.m., the resident was lying in the bed. CNA #3 and CAN #4 put on disposable gloves and removed the residents brief. The resident had been incontinent of urine. The resident ' s top perineal and vaginal areas were bright red with no open areas. CNA # 4 using a different disposable wipe for each area cleansed the residents left and right groin, and anal area. CNA #3 applied Calmoseptine ointment over the reddened areas. Both CNA'S applied and secured a clean brief on the resident.	F 312		

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F 312	Continued From page 6 The resident ' s labia was not separated and cleansed, the vaginal area, both buttocks and inner thighs, were not cleansed. 4. Resident # 9 had diagnoses of Diabetes, Anxiety, Hypertension, and Surgical Repair of Carpel Tunnel Syndrome. The resident was admitted to the facility on 7/18/08. a. The admission plan of care dated 07/18/08 documented that the resident was admitted for rehabilitation with goal to discharge home. The admission nurses assessment dated 07/18/08 documented the resident was alert and oriented. b. The resident was admitted to the facility on 7/18/08. There was no documentation that the resident was offered or received a shower until 7/26/08, a span of 7 days without bathing. c. The Bath Body Check Sheets provided by the Director of Nursing on 8/14/08 documented the resident had a shower on 7/29/08 but refused showers on 7/30/08 and 8/1/08. There was no documentation that showers were offered on 7/31/08, 8/2/08 or 8/3/08 to make up for the missed showers. d. The Bath Body Check Sheets documented the resident received bed baths on 8/4/08 and 8/6/08. There was no documentation that the resident was offered bathing again until 8/11/08, a span of 4 days without bathing The Bath Body Check sheet documented that on 8/11/08 the resident received a shower on the 7-3 shift. e. On 8/13/08 at 11:15 a.m., the resident stated, "I've been here 3 weeks and have had 2 showers.	F 312		

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F 312	Continued From page 7 The last one was on Monday the 11th. They came this morning to get me for my shower but I was in therapy and they haven't come back yet." f. The Bath Body Check sheet dated 8/13/08, 7-3 shift, documented, "Refused - wants to do it in a.m." g. The (CNA/RNA) Certified Nurse Assistance/Restorative Nurse Assistance Flow Sheet Shower/Tub (Schedule) for August 2008 documented that the resident was scheduled for showers on 7-3 shift Monday, Wednesday, and Friday. The documentation on this form did not match the documentation on the Bath/Body Check sheets provided by the Director of Nursing on 8/14/08. This form documented that the resident received 3 showers on August 6th (Wednesday), 8th (Friday) and the 9th (Saturday). The dates of August 1st (Friday), 7th (Thursday), and 12th (Tuesday), 2008, was blank on the CNA/RNA form. The dates of August 2nd, 3rd, 4th, 5th, 10th, and 11th, 2008, on the form documented a zero.	F 312		
F 314 SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314		

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Complaint # 13755 substantiated (all or in part) with these findings.

Based on observation, interview and record review, the facility failed to ensure a resident was assessed and provided incontinent care at least every two hours to reduce the potential for skin breakdown for 2 (Residents # 2 and # 3) of 6 (Resident # 1 - 4, 8, and 9) case mix residents who were at risk for pressure sores. The failed practice had the potential to affect 40 residents at risk for the development of pressure sores as identified by a list provided by the Director of Nursing on 8/13/08. The findings are:

1. Resident # 2 had the diagnoses of Alzheimer Disease, and Presenile Dementia. The Significant Change Minimum Data Set (MDS) dated 5/2/08 documented the resident had moderately impaired cognitive skills for daily decision-making, required extensive assistance for personal hygiene and bathing, had a pressure relieving device in the bed and in the chair, required other preventative or protective skin care (other than to feet) and was incontinent of bowel and bladder.

a. The Braden Scale for predicting Pressure Sore Risk dated 2/1/08 documented a total score of 20. The form documented that a total score of 12 or less represents high risk.

b. The plan of care dated 5/1/08 documented Problem: Resident is at risk for skin breakdown due to incontinence of bowel and bladder, pads and briefs used daily and cognitive defects is at risk for further decline due to diagnosis Alzheimer, Dementia. Intervention: Provide pressure relieving mattress to bed. Provide

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F 314	Continued From page 9 pressure relieving cushion to chair. Assist resident to turn and reposition as needed. Position with pads and cushions to prevent pressure as indicated. c. On 8/12/08 at 9:00 a.m., the residents brief was marked at left upper side panel with a black marker. At 10:00 a.m., Certified Nursing Assistant (CNA) #2 and Licensed Practical Nurse (LPN) #1 wheeled the resident to her room and attempted to provide personal care. The resident stood half way out of the chair and refused care. The resident was placed back into the wheelchair and care was not provided to the resident at that time. At 11:30 a.m., the resident remained setting in the wheelchair in her room. There was a strong urine and bowel movement odor in the room. At 12:45 a.m., the resident was placed in the bed. CNA #2 and 5 provided incontinent care for the resident. The CNA ' s removed the brief which had the same black mark that had been made at 9:00 a.m. The brief was soaked with urine and formed bowel movement with dried areas of feces on the resident ' s buttocks. The resident had multiple bright red indentions on her skin where the brief fit along both upper thighs. The resident had not been assessed for incontinence from 9:00 a.m. until 12: 45 p.m., a total of 3 hours and 45 minutes. 2. Resident # 3 had diagnoses of Presenile Dementia, Hypertension, Depressive Disorder, and History of Falls. The Quarterly MDS dated 05/01/08 documented the resident had moderately impaired cognitive skills for daily decision making and required extensive assistance for personal hygiene, bed mobility and required total assistance for transfers.	F 314		

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F 314	Continued From page 10 a. The Plan of Care dated 05/01/08 documented the Resident was at risk for skin breakdown due to incontinence of bowel and bladder, needs assistance with bed mobility, and pads and briefs used daily. The approaches are: keep skin clean and dry, provide pericare every 2 hours and prn, assist resident to turn and reposition every 2 hours and as needed (prn). b. The Braden Scale form dated 4/30/08 documented that the residents had a score of 15 that placed the resident at a mild risk for development of pressure ulcers. c. On 08/12/08 at 8:55 a.m., the resident was setting in a wheelchair dressed and had on a brief. The brief was marked with black marker on the upper right corner. The wheelchair cushion was marked with pink florescent tape under the resident's right upper thigh/buttock. At 9:45 a.m., the resident was sitting in a wheelchair in her room. The resident had leg huggers in place. The resident did not have a lap hugger on. At 10:30 a.m., the resident was sitting in a wheel chair in her room with the marked brief on and the marked chair cushion in the same position. The resident was watching television. At 11:22 a.m. the resident was sitting in her room in the wheelchair. The marked brief and chair cushion remained in the same position. At 1: 08 p.m. the resident was being mechanically lifted from wheelchair to the bed by LPN #3 and CNA #5. CNA # 5 removed the marked residents brief. LPN # 3 stated, "What is that	F 314		

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F 314	Continued From page 11 black mark on the brief? " The surveyor stated that time and black mark on the brief was placed on the brief by the surveyor and the time [8:55 a.m.] indicated the time the mark was placed. The resident skin on right thigh had a reddened area approximately 3 inches below her buttock. Approximately 4 inches below her buttocks, the resident ' s buttock was red with an indention were the soiled brief ended. The CNA provided incontinent care for the resident. The resident had been setting in the wheelchair from 8:55 a.m. until 1:12 p.m., a total of 4 hours and 13 minutes.	F 314		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint # 13782 substantiated (all or in part) with these findings. Based on observation, interview and record review, the facility failed to ensure, that a lap hugger was in place when a resident was up in a wheel chair for 1 (Resident # 3) of 1 case mix residents who required the use of a lap hugger, failed to monitor a hot coffee pot and leftovers in the main dining room for 1 (Resident # 2) of 5 case mix residents who were mobile and confused to minimize the potential from injury/illness, failed to ensure the medication cart on the 200 hall was locked while it was	F 323		

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unattended and by securing the beauty shop chemicals from access by mobile confused residents. The failed practices had the potential to affect 7 mobile, confused residents according to the DON on 8/12/08, and 1 resident with physician orders for lap hugger according to the DON on 8/26/08 at 10:28 a.m. The findings are:

1. On 8/11/08 at 1:15 p.m. a medication cart was setting in the hallway by the nurse ' s station near the main dinning room. The medication cart was not locked and there was no staff member present at the cart. Licensed Practical Nurse (LPN) #1 approached and stated, "This is the two hundred hall medication cart, I guess I forgot to lock the cart."

2. On 08/12/08 at 8:55 a.m., on the 400 hall the door to the beauty shop was opened and the shop was unattended. One jar of disinfectant, one bottle of clarifying shampoo, and one can of Vavoon hair spray was sitting on the counter to the left side of the room.

At 8:55 a.m., one resident was observed wheeling her wheelchair down the hallway and past the open beauty shop doorway. No staff was in sight.

At 9:20 a.m. the administrator walked past the beauty shop door, returned and closed the door.

The beauty shop door was observed open and the room was unattended for a total of 25 minutes.

3. Resident # 2 had the diagnoses of Alzheimer Disease, and Presenile Dementia. The Significant Change Minimum Data Set (MDS) dated 5/2/08 documented the resident had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045422	A. BUILDING _____ B. WING _____	C 08/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF MAUMELLE	103 ALEXANDRIA DRIVE MAUMELLE, AR 72113

(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 323	Continued From page 13 moderately impaired cognitive skills for daily decision-making, wheeled self in a wheel chair, needed supervision, required extensive assistance for personal hygiene and bathing and had a history of falls. a. The plan of care dated 5/1/08 documented, Problem: Resident at risk for falls due to history, impaired safety awareness. Intervention: Wheelchair seat sensor alarm when up in chair to alert staff of unassisted transfers. Plan of care dated 4/20/08 documented at risk for wandering and lost in own surroundings related to Dementia. Intervention: continue to orientate and remind resident where the bathroom and personal belongings are. b. On 8/11/08 at 5:10 p.m., the resident was setting in a wheel chair on the 100 hall. She wheeled herself to the clean linen cart opened the cover removed a towel. No staff was assisting. No staff was supervising the confused resident. c. On 8/12/08 at 8:40 a.m., the resident wheeled herself from the back section of the main dinning room to the front section. The resident was observed wheeling herself to a table in the front section of the main dinning room. She picked up an opened carton of 2% milk and drank the milk from the straw. There was no facility staff present in the dinning room. The resident was unsupervised. d. On 8/12/08 at 8:50 a.m., the resident was setting in a wheelchair in the front section of the dinning room. Dietary Employee #1 pushed a cart that contained a hot glass coffee pot filled with coffee, Juices and other snack items. The cart was left approximately 2 to 3 feet away from	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045422	A. BUILDING ______ B. WING ______	C 08/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF MAUMELLE	103 ALEXANDRIA DRIVE MAUMELLE, AR 72113

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F 323	Continued From page 14	F 323		

the resident. The cart was unattended while the Dietary employee went back to the kitchen. No other facility staff was in the Dinning room. There was 1 staff member at the Nurses Station across from the dinning area. At 8:56 a.m. the dietary employee returned and moved the cart. The cart was left unattended and the resident was unsupervised for total of 6 minutes. The surveyor obtained a cup of coffee from the pot the temperature of the coffee was 134 degrees.

e. On 8/12/08 at 9:00 a.m., the resident was setting in a wheelchair in the front section of the dinning room by the artificial tree picking at the leaves. No facility staff was in sight.

4. Resident #3 had diagnoses of Presenile Dementia, Hypertension, Depressive Disorder and History of Falls. The MDS dated 5/01/08 documented the resident had moderately impaired cognitive skills for daily decision-making, had no behavioral symptoms, was dependent on staff for all Activities of Daily Living (ADL's) and had a fall in the last 30 days.

a. The Plan of Care dated 05/01/08 documented, Problem/Need, Resident is at risk for falls, due to history of falls, daily use of antidepressants, and cognitive deficit. Resident attempts unassisted transfers.

b. A physician's orders dated 08/04/08 documented, Velcro Lap Hugger to wheelchair when out of bed to remind resident to not attempt self-transfers.

c. The Nurse's Note dated 08/04/08 documented, "Resident attempted to stand up from wheelchair. Pummel Cushion on wheelchair seat. Fell

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045422	A. BUILDING ____ B. WING ____	C 08/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF MAUMELLE	**103 ALEXANDRIA DRIVE MAUMELLE, AR 72113**

(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 323	Continued From page 15	F 323		

forward. Applied lap hugger, velcro to remind her not to attempt to stand up from wheelchair. Does not bear weight. Mechanical lift for transfers."

d. On 08/11/08 at 5:40 p.m., Certified Nursing Assistant (CAN) # 3 and CNA # 4 placed the resident in a wheelchair. The resident was taken to the main dinning room. There was no Lap Hugger in place on the wheel chair for the resident.

e. On 8/12/08 at 8:45 a.m., the resident had a lap hugger in place on the wheelchair. The Director of Nursing stated, "She can't have this on, she doesn't have an order. " The Director of Nursing removed the lap hugger from the wheelchair.

f. On 08/12/08 at 12:40 p.m., the resident was sitting in a wheelchair at the dinning room table drinking a glass of water with no lapper hugger in place.

g. On 8/13/08 at 8:40 a.m., the resident was sitting in a wheelchair in the main dinning room with no lap hugger in place.

h. On 08/13/08 at 2:05 p.m., the Director of Nursing stated," I put it on her to prevent her from falling, she can't get up, she can't walk, she leaned forward and fell out of the wheelchair."