



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED C 01/08/2015
NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 198 BERRYMAN ROAD FRENCHBURG, KY 40322	
(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 abbreviated standard survey (KY22631, KY22647) was initiated on 01/07/15 and concluded on 01/08/15. Both complaints were substantiated. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	F225 Investigate/Report Allegations/Individuals The facility has ensured the following corrective actions:	
F 225 SS=D	483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	<ul style="list-style-type: none"> On 1/9/15, the 'How to Complete the Investigative Report' protocol was developed outlining steps the staff must take when completing an investigation of abuse/neglect, including required interviews. (Attachment #1) <p>The facility has taken the following corrective action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> On 1/15/15, the Social Services Director interviewed all alert and oriented residents regarding being approached or enticed by another resident in any manner that made them feel uncomfortable. No residents reported any issues regarding Resident #4. On 1/19/15, the Director of Nursing completed a review of weekly skin assessments on all facility residents for the time period of the incident. No suspicious markings or findings were noted. On 1/7/15, the DON and SSD reviewed all mood and behavior records for residents with a BIMS score of 8 or less for potential changes. There were no indications 	

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

Anne Mills

TITLE

Administrative

(X6) DATE

1/30/15

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 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's investigation and policy and procedures, it was determined the facility failed to assess all residents in the facility to determine if abuse occurred for one (1) of four (4) abuse/neglect investigations. A review of the facility investigation revealed Nurse Aide (NA) #1 observed Resident #4 standing beside Resident #3's Gari-chair in the hallway, Resident #3 was asleep and the resident's brief was unfastened. Resident #4 had his/her hand inside Resident #3's brief. A review of the facility's investigation revealed Resident #3 was assessed for injuries and Resident #4 was interviewed about the incident; however, the facility failed to assess other non-interviewable residents for signs of abuse, and failed to interview residents to determine if they had been affected.</p> <p>The findings include: A review of the facility policy titled "Resident Abuse and Neglect/Abuse and Neglect Protocol," with a revision date of 03/04/13, revealed all reported suspicions of resident abuse would be followed up and investigated by the facility. The policy further revealed all parties would be interviewed and written statements obtained. Continued review of the policy revealed the</p>	F 225	<p>of social withdrawal or other behavioral changes for any of the records reviewed.</p> <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> On 1/16/15, the Administrator provided In-Service training (Attachment #2) to the facility's nursing staff on the revised policy (Resident Abuse and Neglect – Attachment #3) and the 'How to Complete the Investigative Report' protocol. (See Attachment #1). All facility staff received the annual orientation review on 1/16/15, with training that included the Resident Abuse and Neglect Policy. (Attachment #4). <p>The facility will sustain performance through the following monitoring practices:</p> <ul style="list-style-type: none"> On review of the initial findings on the Investigative Report following an allegation of abuse / neglect (the next business day if after hours / on weekends or same day if event occurs during normal working hours), the Investigative Team (ADM, DON, SSD) will either ensure the completion of required interviews by the nursing staff, or

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F 226	<p>Continued From page 2</p> <p>resident or residents would be assessed for signs of abuse by the charge nurse on duty or the Director of Nursing (DON) immediately following the allegation.</p> <p>A review of the medical record for Resident #4 revealed the facility admitted the resident on 12/05/14 with diagnoses including Chronic Renal Insufficiency, Hypertension, and Pneumonia. Further review of the medical record revealed the resident was discharged home to the care of family on 01/08/15. A review of Resident #4's admission Minimum Data Set assessment, dated 12/12/14, revealed the resident had a score of 5 on the Brief Interview for Mental Status (BIMS), which revealed the resident had severe cognitive impairment.</p> <p>A review of the facility Investigative Report, dated 01/03/15, revealed NA #1 observed Resident #3 in the hallway asleep in a Geri-chair as the NA went into another resident's room to provide care. Further review of the investigation revealed when NA #1 exited the resident's room a couple of minutes later, she observed Resident #4 beside Resident #3's Geri-chair. Resident #3's brief was undone and Resident #4 had his/her hand in the resident's brief. Continued review of the investigation revealed Resident #3 was immediately taken to the nurses' station and the incident was reported to the nurse while another NA took Resident #4 to the resident's room and the resident was immediately placed on one-on-one supervision. The investigation revealed Resident #3 was assessed and no injuries were identified. Continued review of the investigation revealed the staff attempted to interview Resident #4 about the incident and the resident responded angrily, "it's none of your</p>	F 226	<p>Initiate interviews as part of a continued investigation.</p> <ul style="list-style-type: none"> The correct completion of the Investigative Report, including required interviews, will be monitored by the Director of Nursing as part of the monthly Nursing Department Quality Assurance indicators to ensure compliance with facility protocol. Results of the monthly audit will be presented to the Administrator in the monthly nursing QA reports and summarized in a quarterly report for the Medical Director. (Attachment #5). <p>COMPLETION DATE: 1/16/15</p>		

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F 225	<p>Continued From page 3</p> <p>business," and refused to answer the staff's questions about the incident. The investigation contained one other resident interview, a resident who possibly witnessed the incident. However, there was no documented evidence other residents had been interviewed to determine if they had been affected by similar violations. In addition, the investigation contained no documented evidence the facility assessed non-interviewable residents to determine if there were signs of abuse.</p> <p>A review of NA #1's witness statement, dated 01/03/15, revealed the NA had left Resident #3 asleep in a Geri-chair outside of the resident's room while the NA went into another resident's room to provide care. NA #1 stated when she walked up the hallway, she observed Resident #4 in his/her room, lying on the bed. Further review of the witness statement revealed when the NA exited the resident's room she observed Resident #4 beside Resident #3's Geri-chair. Resident #4 had his/her hand in Resident #3's brief. Continued review of the witness statement revealed Resident #3 was immediately taken to the nurses' station, the incident was reported to the nurse, and Resident #4 was taken to his/her room.</p> <p>Interview on 01/07/15 at 4:20 PM with Registered Nurse (RN) #2 revealed the RN initiated the investigation of the incident with Residents #3 and #4. The RN stated she immediately assessed Resident #3 for injuries and no injuries were identified and the resident did not appear to be in any distress. The interview further revealed staff attempted to interview Resident #4, but the resident was angry and refused to answer questions. The interview revealed the RN</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>Interviewed one resident about the incident and the resident denied seeing anything unusual in the hallway; however, other residents were not interviewed because the residents were asleep during the incident. The RN revealed she did not assess other residents for signs of abuse because Resident #4 was monitored every 15 minutes prior to the incident and she did not feel that other residents had been at risk.</p> <p>Interview on 01/07/15 at 8:40 PM with the Social Worker revealed the investigation did not include interviews with other residents because the residents on that hall were in bed so they could not have witnessed an incident in the hallway.</p> <p>Interview on 01/07/15 at 5:30 PM with the DON revealed an investigation related to an allegation of abuse should have included resident interviews and skin assessments should have been completed on the residents that were not interviewable to determine if other similar allegations of abuse had occurred. The interview further revealed interviews were not completed because staff did not think other residents had witnessed the incident because the other residents were in bed. Staff did not consider the potential that other residents may have been abused.</p> <p>Interview on 01/07/15 at 8:45 PM with the Administrator revealed staff did not interview other residents related to the incident because the staff did not feel that other residents had witnessed the incident. The interview further revealed an investigation should contain interviews with other residents and skin assessments of non-interviewable residents to determine if there were other related incidents of</p>	F 225		

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F 225	Continued From page 5 abuse.	F 225	F280 Right To Participate Planning Care – Revise CP		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility policy, it was determined the facility failed to ensure residents' comprehensive care plans were reviewed and revised for three (3) of four (4) sampled residents (Residents #1, #2, and #3). Interview and record review revealed Resident #1 had a fall on 11/24/14; however, the facility failed to revise the resident's care plan to include a new intervention that was implemented.	F 280	The facility has ensured the following corrective actions: <ul style="list-style-type: none"> The Director of Nursing and Assistant Director of Nursing reviewed the medical records for Residents #1, 2, and 3, to ensure that all falls occurring during the past quarter were updated in the resident care plan. The DON provided direct counseling / training with nurse staff who were responsible for the completion of the Fall Report for Residents #1, 2, and 3. Counseling / training included staff failure to follow the facility's Fall Protocol, which includes: Assessment, Causal Factors, Safety Factors, Interventions, and Care Plan documentation. Attachments # 1 (A and B). <p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> The DON and ADON completed a review of all facility resident Care Plans and made revisions as needed for falls that have occurred within the past quarter. 		

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F 280	<p>Continued From page 8</p> <p>A review of Resident #2's medical record revealed the resident had fallen on 10/18/14 and 12/01/14. Staff identified the causative factor of the falls but failed to review/revise the resident's plan of care to prevent further accidents for Resident #2. A review of Resident #3's medical record revealed the resident sustained falls on 10/03/14, 11/14/14, 12/07/14, and 12/23/14. The facility failed to assess the resident to identify the cause of the falls and why the resident was attempting to get up unassisted, and failed to revise the resident's care plan with interventions to prevent further falls.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Care Planning for the Resident," last revised 05/01/14, revealed facility staff was to establish a process for the development of a resident's care plan upon admission, and was to modify the plan of care as necessary to ensure an appropriate care planning process.</p> <p>1. A review of the medical record for Resident #1 revealed the facility admitted the resident on 04/07/10 with diagnoses of Depression, Osteoarthritis, Degenerative Joint Disease, and Prostate Cancer.</p> <p>A review of Resident #1's Fall Review Assessments dated 11/24/14 revealed the resident was observed lying on the floor in front of his/her electric recliner. The assessment revealed Resident #1 had raised the electric recliner to the "highest level" and slid out onto the floor. The Fall Review Assessment form revealed staff would ensure the resident's recliner was unplugged as an intervention to prevent further</p>	F 280	<ul style="list-style-type: none"> In-service training was provided to all facility nurse staff by the Director or Nursing regarding required steps outlined in the Fall Protocol. Emphasis was placed on the correct completion of resident assessment following the occurrence of a fall and included: Comprehensive Assessment, possible causal factors, interventions, and Care Plan revision as outlined in the protocol. Attachments #2 (A-C) <p>The facility has initiated the following systemic changes to prevent this practice from recurring"</p> <ul style="list-style-type: none"> The DON will review all Resident fall documentation using the Fall Review Assessment Form (Attachment #3), taking immediate steps to correct any noted deficits with assigned staff. The Fall Review Assessment will be reviewed at the weekly Fall / Risk Committee meeting for additional interventions, follow-up, or other Interdisciplinary Team action. The MDS Coordinator will attend Fall / Risk Committee weekly and will enter any changes made by the Interdisciplinary Team into the resident Care Plan. 		

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F 280	<p>Continued From page 7 falls from occurring.</p> <p>A review of Resident #1's care plan last reviewed/revised on 12/18/14 revealed staff identified the resident was at risk for falls; however, the care plan revealed no evidence Resident #1 had experienced a fall on 11/24/14, or that the resident's electric recliner had been identified as a safety hazard. The facility failed to revise the resident's care plan to ensure staff was aware that Resident #1's electric recliner should remain unplugged for safety.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 01/07/15 at 4:30 PM revealed she completed the Fall Review Assessment for Resident #1 on 11/24/14. The LPN identified the causative factor of the resident's fall but failed to include the intervention on the resident's care plan. LPN #1 stated she was required to update the resident's plan of care to include newly implemented interventions to prevent further falls from occurring. However, LPN #1 stated she "struggled with care plans" and "wasn't sure" how to update care plans.</p> <p>2. A review of Resident #2's medical record revealed the facility admitted the resident on 02/25/14 with diagnoses of Hypertension and Osteoporosis.</p> <p>A review of Resident #2's Fall Review Assessments dated 10/16/14 revealed the resident was observed sitting on the floor of his/her room. The resident stated he/she had fallen because "I went to sit down in my wheelchair and it moved." Continued review of the Fall Review Assessment dated 12/01/14 revealed the resident sustained another fall. Staff</p>	F 280	<p>The facility will sustain performance through the following monitoring practice:</p> <ul style="list-style-type: none"> The Nursing Department Monthly Quality Assurance Report has been modified to include a summary of any noted deficits that occurred in nurse documentation following a resident fall, and will include steps take to address the problem. (Attachment #4). A copy of the monthly QA report will be provided to the Administrator for review. A summary of the quarterly QA reports will be provided to the Medical Director and the Administrator and reviewed at the quarterly Quality Assurance meeting. <p>COMPLETION DATE: 1/30/15</p>		

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F 280	<p>Continued From page 8</p> <p>documented the causative factor of the fall was that the "Resident went to sit down in wheelchair at nursing station and it rolled;" he/she "didn't have it locked."</p> <p>A review of Resident #2's care plan last reviewed/revised on 11/20/14 revealed staff had identified the resident was at risk for falls. The care plan revealed no evidence Resident #2 had experienced falls or that a causative factor had been identified and interventions implemented to prevent further falls when the resident fell on 10/18/14 or 12/01/14.</p> <p>An interview with Registered Nurse (RN) #1 on 01/07/15 at 5:00 PM revealed she completed the Fall Review Assessments for Resident #2 on 10/18/14 and 12/01/14. The RN stated she had identified that the causative factor of both falls was that Resident #2 failed to lock his/her wheelchair. RN #1 stated she was required to investigate, identify causative factors, and update the resident's plan of care when falls occurred. However, the RN failed to implement new interventions and failed to review and revise the plan of care for Resident #2 when falls occurred on 10/18/14 or 12/01/14.</p> <p>3. A review of the medical record for Resident #3 revealed the facility admitted the resident on 10/19/12 with diagnoses including Alzheimer's disease, Hypertension, Diabetes Mellitus, and Anxiety.</p> <p>A review of Resident #3's care plan dated 11/11/13 revealed staff identified the resident was at risk for falls and implemented interventions including a bolster mattress to the resident's bed, a low bed with elevated upper side rails, and</p>	F 280			

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F 280	Continued From page 9 positioning the resident's bed against the wall. A review of Resident #3's Fall Review Assessments revealed the resident sustained four falls from 10/03/14 through 12/23/14. On 10/03/14, the resident was sitting in a chair, got up, and tripped over the bedside table. A review of Resident #3's nursing progress notes, dated 10/07/14, revealed staff discussed the resident's fall at the Fall Committee Meeting and no further recommendations were made. Further review of Resident #3's Fall Review Assessments revealed on 11/14/14, staff witnessed the resident attempting to get out of bed. The resident's blanket was around the resident's feet and the resident fell to the floor. There was no documented evidence the facility assessed Resident #3 to identify why the resident attempted to get out of bed unassisted on 10/03/14 and 11/14/14. In addition, the facility failed to revise the resident's care plan to protect the resident from further falls. A review of Resident #3's Fall Review Assessments revealed on 12/07/14 and 12/23/14, staff found the resident on the floor. There was no documented evidence that the facility attempted to identify the cause of the falls, or if the resident was in bed or a chair prior to the fall. A review of the resident's physician orders dated 12/11/14, revealed an order for the resident to be up in a Geri-chair as tolerated with an alarm-activated seatbelt; however, there was no evidence the facility revised the resident's care plan with the new intervention. Interview on 01/07/15 at 4:20 PM with RN #2	F 280			

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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) COMPLETION DATE	
F 280	<p>Continued From page 10</p> <p>revealed the RN completed Resident #3's Fall Review Assessment for the falls that occurred on 10/03/14 and 12/23/14. The RN stated nurses were responsible for updating the residents' care plans when new orders were received; however, Resident #3 already had several interventions in place to prevent falls so no new orders were given and the care plan was not updated.</p> <p>interview on 01/07/15 at 4:30 PM with LPN #1 revealed the LPN completed the Fall Review Assessment for Resident #3's falls that occurred on 11/14/14 and 12/03/14. The interview further revealed she was required to revise a resident's care plan when new physician orders were obtained. LPN #1 stated the resident's physician did not order any new interventions and the resident's plan of care was not updated with newly implemented interventions.</p> <p>An interview with the Minimum Data Set (MDS) Coordinator on 01/07/14 at 6:15 PM revealed staff nurses were responsible for updating residents' comprehensive plans of care when falls occurred. She further stated she was not responsible for reviewing care plans to ensure they had been reviewed/revised as required.</p> <p>An interview with the Administrator on 01/07/15 at 6:45 PM revealed she was aware the facility's care plans "needs work." The Administrator stated she had discussed care plan concerns with the former Director of Nursing, who was no longer employed at the facility, but the Administrator acknowledged that the facility had no current system to ensure resident care plans were reviewed and revised as required.</p>	F 280			
F 323	483.25(h) FREE OF ACCIDENT	F 323			

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NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 106 BERRYMAN ROAD FRENCHBURG, KY 40322	
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F 323 SS=E	<p>Continued From page 11 HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the residents' environment was as free from accident hazards as possible for three (3) of four (4) sampled residents (Residents #1, #2, and #3). Interview and record review revealed Resident #1 had a fall on 11/24/14. Staff identified the causative factor of the resident's fall to be his/her electric recliner, and had implemented an intervention to leave the resident's recliner unplugged but failed to update Resident #1's care plan to include the newly implemented intervention. Interview and record review revealed Resident #2 had fallen on 10/18/14 and 12/01/14. When both falls occurred, the causative factor was identified to be that Resident #1 had failed to lock his/her wheelchair. Even though staff identified the causative factor for the resident's falls, staff failed to revise the resident's care plan to include the interventions and failed to implement interventions to reduce the risk of further accidents for Resident #2. Resident #3 sustained falls on 10/03/14, 11/14/14, 12/07/14, and 12/23/14. The facility failed to assess the resident to identify the cause of the falls and why the resident was attempting to get up unassisted,</p>	F 323	<p>F323 Free of Accident Hazards/Supervision/Devices</p> <p>The facility has ensured the following corrective actions:</p> <ul style="list-style-type: none"> The Director of Nursing and Assistant Director of Nursing reviewed the medical records for Residents #1, 2, and 3, to ensure that all falls occurring during the past quarter were updated in the resident care plan. The DON provided direct counseling / training with nurse staff who were responsible for the completion of the Fall Report for Residents #1, 2, and 3. Counseling / training included staff failure to follow the facility's Fall Protocol, which includes: Assessment, Causal Factors, Safety Factors, Interventions, and Care Plan documentation. Attachments # 1 (A and B). <p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> The DON and ADON completed a review of all facility resident Care Plans and made revisions as needed for falls that have occurred within the past quarter. 	

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F 323	<p>Continued From page 12</p> <p>and failed to revise the resident's care plan with interventions to prevent further falls.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Fall Protocol," last revised 05/01/14, revealed facility staff was to provide a process for fall reviews and prevention management. The policy further stated to minimize the risk of serious injury, staff was to recognize risks and causes of falls, and implement fall interventions to prevent further falls from occurring. The policy stated an interdisciplinary team review would be conducted weekly, and the team was to document measures to prevent further falls and to minimize the potential for serious injury to facility residents.</p> <p>1. A review of the medical record for Resident #1 revealed the facility admitted the resident on 04/07/10 with diagnoses of Depression, Osteoarthritis, Degenerative Joint Disease, and Prostate Cancer.</p> <p>A review of Resident #1's Significant Change Minimum Data Set Assessment (MDS) dated 12/08/14 revealed the facility assessed the resident to require extensive assistance of two staff members for transferring, toileting, and bathing. Staff assessed the resident to be rarely/never understood and not interviewable.</p> <p>A review of Resident #1's Fall Review Assessments dated 11/24/14 revealed the resident was observed lying on the floor in front of his/her electric recliner. The assessment revealed Resident #1 had raised the electric recliner to the "highest level" and slid out onto the floor. The Fall Review Assessment form revealed</p>	F 323	<ul style="list-style-type: none"> In-service training was provided to all facility nurse staff by the Director of Nursing regarding required steps outlined in the Fall Protocol. Emphasis was placed on the correct completion of resident assessment following the occurrence of a fall and included: Comprehensive Assessment, possible causal factors, interventions, and Care Plan revision as outlined in the protocol. Attachments #2 (A-C) <p>The facility has initiated the following systemic changes to prevent this practice from recurring"</p> <ul style="list-style-type: none"> The DON will review all Resident fall documentation using the Fall Review Assessment Form (Attachment #3), taking immediate steps to correct any noted deficits with assigned staff. The Fall Review Assessment will be reviewed at the weekly Fall / Risk Committee meeting for additional interventions, follow-up, or other Interdisciplinary Team action. The MDS Coordinator will attend Fall / Risk Committee weekly and will enter any changes made by the Interdisciplinary Team into the resident Care Plan. 		

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F 323	<p>Continued From page 13</p> <p>staff would ensure the resident's recliner was unplugged as an intervention to prevent further falls from occurring.</p> <p>A review of Resident #1's care plan last reviewed/revised on 12/18/14 revealed staff identified the resident was at risk for falls. The care plan revealed no evidence Resident #1 had experienced a fall on 11/24/14, or that the resident's electric recliner had been identified as a safety hazard. The care plan failed to instruct staff to ensure Resident #1's electric recliner remained unplugged for safety.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 01/07/15 at 4:30 PM revealed she completed the Fall Review Assessment for Resident #1 on 11/24/14. The LPN identified the causative factor of the resident's fall and implemented a new intervention. LPN #1 stated she was required to update the resident's plan of care to include newly implemented interventions to prevent further falls from occurring. However, LPN #1 stated she "struggled with care plans" and "wasn't sure" how to update care plans, and failed to update Resident #1's care plan as required on 11/24/14 to include interventions to prevent further falls from occurring.</p> <p>2. A review of Resident #2's medical record revealed the facility admitted the resident on 02/25/14 with diagnoses of Hypertension and Osteoporosis. A review of the resident's quarterly MDS dated 11/18/14 revealed the facility assessed the resident to require setup help only with transferring, walking in his/her room, and dressing. Facility staff assessed Resident #2 to be interviewable, with a Brief Interview for Mental Status (BIMS) score of 15.</p>	F 323	<p>The facility will sustain performance through the following monitoring practice:</p> <ul style="list-style-type: none"> The Nursing Department Monthly Quality Assurance Report has been modified to include a summary of any noted deficits that occurred in nurse documentation following a resident fall, and will include steps take to address the problem. (Attachment #4). A copy of the monthly QA report will be provided to the Administrator for review. A summary of the quarterly QA reports will be provided to the Medical Director and the Administrator and reviewed at the quarterly Quality Assurance meeting. <p>COMPLETION DATE: 1/30/15</p>	

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F 323	Continued From page 14 A review of Resident #2's Fall Review Assessments dated 10/16/14 revealed the resident was observed sitting on the floor of his/her room. The assessment further revealed the resident stated he/she had fallen because "I went to sit down in my wheelchair and it moved." Continued review of the Fall Review Assessment dated 12/01/14 revealed the resident sustained another fall. Staff documented that the causative factor of the fall was that the "Resident went to sit down in wheelchair at nursing station and it rolled;" he/she "didn't have it locked." A review of Resident #2's care plan last reviewed/revised on 11/20/14 revealed staff had identified the resident was at risk for falls. The care plan revealed no evidence Resident #2 had experienced falls or that interventions were implemented to prevent further falls after the resident fell on 10/16/14 or 12/01/14. An interview with Registered Nurse (RN) #1 on 01/07/15 at 5:00 PM revealed she completed the Fall Review Assessments for Resident #2 on 10/16/14 and 12/01/14. The RN stated she had identified that the causative factor of both falls was that Resident #2 failed to lock his/her wheelchair. RN #1 stated she was required to investigate, identify causative factors, and update the resident's plan of care when falls occurred. However, the RN failed to implement new interventions and failed to review and revise the plan of care for Resident #2 when falls occurred on 10/16/14 or 12/01/14. 3. A review of the medical record for Resident #3 revealed the facility admitted the resident on 10/19/12 with diagnoses including Alzheimer's	F 323		

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F 323	<p>Continued From page 15</p> <p>disease, Hypertension, Diabetes Mellitus, and Anxiety. Review of Resident #3's Quarterly MOS assessment, dated 12/01/14, revealed the resident required extensive assistance of two staff members for transfers, toileting, and personal hygiene. Staff assessed that the resident was not interviewable.</p> <p>A review of Resident #3's care plan, dated 11/11/13 revealed staff identified the resident was at risk for falls and implemented interventions including a bolster mattress to the resident's bed, a low bed with elevated upper side rails, and positioning the resident's bed against the wall.</p> <p>A review of Resident #3's Fall Review Assessments revealed the resident sustained four falls from 10/03/14 through 12/23/14. On 10/03/14, the resident was sitting in a chair, got up, and tripped over the bedside table. A review of Resident #3's nursing progress notes, dated 10/07/14, revealed staff discussed the resident's fall at the Fall Committee Meeting and no further recommendations were made.</p> <p>Further review of Resident #3's Fall Review Assessments revealed on 11/14/14, staff witnessed the resident attempting to get out of bed. The resident's blanket was around the resident's feet and the resident fell to the floor. Continued review of the Fall Review Assessment revealed no documented evidence the facility assessed the resident to determine why the resident was getting out bed unassisted or that interventions were implemented to protect the resident from further falls.</p> <p>A review of Resident #3's Fall Review Assessments revealed on 12/07/14 and 12/23/14.</p>	F 323		

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F 323	<p>Continued From page 16</p> <p>staff found the resident on the floor. There was no documented evidence that the facility attempted to identify the cause of the falls or if the resident was in bed or a chair prior to the fall. A review of the resident's physician orders dated 12/11/14, revealed an order for the resident to be up in a Geri-chair as tolerated with an alarm-activated seatbelt; however, there was no evidence the facility revised the resident's care plan with the new intervention.</p> <p>Interview on 01/07/15 at 4:20 PM with RN #2 revealed the RN completed Resident #3's Fall Review Assessment for the falls that occurred on 10/03/14 and 12/23/14. The RN stated nurses were responsible for updating the residents' care plans when new orders were received; however, Resident #3 already had several interventions in place to prevent falls so no new orders were given and the care plan was not updated.</p> <p>Interview on 01/07/15 at 4:30 PM with LPN #1 revealed the LPN completed the Fall Review Assessment for Resident #3's falls that occurred on 11/14/14 and 12/03/14. The interview further revealed she was required to revise a resident's care plan when new physician orders were obtained. LPN #1 stated the resident's physician did not order any new interventions and the resident's plan of care was not updated with newly implemented interventions.</p> <p>An Interview with the MDS Coordinator on 01/07/14 at 6:15 PM revealed staff nurses were responsible for updating residents' comprehensive plans of care when falls occurred. She further stated she was not responsible for reviewing care plans to ensure they had been reviewed/revised as required.</p>	F 323		

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F 323	Continued From page 17 An interview with the Administrator on 01/07/15 at 6:45 PM revealed she was aware the facility's care plans "needs work." The Administrator stated she had discussed care plan concerns with the former Director of Nursing, who was no longer employed at the facility. The Administrator acknowledged that the facility had no current system to ensure resident care plans were reviewed and revised as required.	F 323			