

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

PRINTED: 12/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 12/23/2015
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299		
(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 onsite re-visit was concluded on 12/23/15 and found the facility in compliance on 12/10/15 as alleged in their PoC.	{F 000}			
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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NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299	
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F 000	<p>INITIAL COMMENTS</p> <p>Amended 12/09/15</p> <p>An Abbreviated Survey was initiated on 10/01/15 to investigate complaint KY23888. The complaint was substantiated. After supervisory review a Recertification/Extended/Abbreviated Survey was initiated on 10/12/15 and concluded on 10/29/15; another complaint KY23923 was investigated and substantiated.</p> <p>Immediate Jeopardy was identified on 10/16/15 and determined to exist on 09/07/15 at 42 CFR 483.20 Resident Assessment (F280 and F282) at a scope and severity of a "K"; 42 CFR 483.25 Quality of Care (F323) at a scope and severity of a "K"; and, 42 CFR 483.75 Administration (F514 and F520) at a scope and severity of a "K". Substandard Quality of Care was at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 10/16/15.</p> <p>After supervisory and CMS review, 42 CFR 483.75 Administration (F490) was cited at a scope and severity of a "K". The facility provided an acceptable Allegation of Compliance (AOC) on 12/03/15 with a compliance date of 10/23/15. The scope and severity was lowered to an "E".</p> <p>On 09/07/15 Resident #1 sustained an unwitnessed fall that resulted in injury and transfer to the hospital. Review of the Emergency Room record, dated 09/07/15, revealed the resident sustained a 2.5 centimeter laceration to the cheek/eye area, two (2) rib fractures and a Flailed Chest injury (a life threatening medical condition that occurs when a segment of the rib cage breaks under extreme stress and becomes</p>	F 000		

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

TITLE

(X6) DATE

X *Korufford*

X ED

X 12-10-15

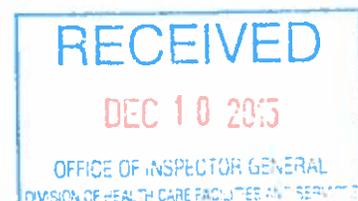
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

OFFICE OF INSPECTOR GENERAL
DIVISION OF INSPECTOR GENERAL SERVICES

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F 000	Continued From page 1 detached from the rest of the chest wall. So a part of the chest wall moves independently). Review of the Death Summary, dated 09/07/15, revealed the resident passed, thirteen (13) hours after the fall, on 09/07/15, due to the injuries sustained from the fall which led to respiratory failure. The facility provided an acceptable Allegation of Compliance (AOC) on 10/22/15 which alleged removal of the Immediate Jeopardy on 10/23/15. The State Survey Agency verified Immediate Jeopardy was removed on 10/23/15 as alleged prior to exit on 10/29/15. The scope and severity was lowered to an "E" at F280, F282, F323, F514, and F520, while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance. Additional deficiencies were cited as a result of the abbreviated and recertification surveys at 42 CFR 483.10 Resident Rights (F157) at a scope and severity of a "D"; 42 CFR 483.25 Quality of Care (F309) at a scope and severity of a "D"; 42 CFR 483.35 Dietary Services (F371) at a scope and severity of an "F" and (F372) at a scope and severity of a "D", 42 CFR 483.65 Infection Control (F441) at a scope and severity of a "D"; and, 42 CFR 483.70 (F456) at a scope and severity of an "F".	F 000			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an	F 157			



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F 157	<p>Continued From page 2</p> <p>accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the resident's physician and responsible party was notified immediately of a medication error that required physician intervention for one (1) of twenty-five (25) sampled residents (Resident #16). RN #5 administered a medication to Resident #16 that</p>	F 157	<p>Notification of medication error was made to MD on 10/11/15. Orders were received for stat BMP lab. Lab results reflected Potassium was in normal range, creatinine slightly elevated at 1.39 and BUN normal. Orders were received to encourage fluids. Responsible party was notified on 10/12/15. Lab results and orders were communicated as well. Resident #16 was discharged from the facility on 10/13/15. Orders were obtained for home health to follow to include PT/OT/ST and nursing.</p> <p>All other residents have the potential to be affected by the deficient practice. Inservice, re-education of staff and audits will ensure physician/family notification is timely.</p>		

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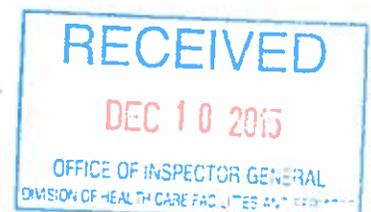
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F 157	<p>Continued From page 3</p> <p>was ordered for another resident and failed to notify the physician, family and Director of Health Services (DHS).</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Medication Error and Adverse Drug Reaction, revised 09/17/12, revealed in the event a significant medication error, immediate action was to be taken as necessary to protect the resident's safety and welfare. The Physician was to be notified promptly, and the resident would be monitored closely for twenty-four (24) to seventy-two (72) hours as directed. The incident would be documented on the shift change report to alert staff to monitor the resident.</p> <p>Review of the facility's policy regarding Family Notification, effective 11/09/10, revealed the responsible party would be notified of a change in condition or diagnostic testing results in a timely manner.</p> <p>Review of the medical record for Resident #16, revealed the facility admitted the resident on 10/01/15 with diagnoses of Intestinal Obstruction, Chronic Kidney Disease Hypokalemia and Parkinson Disease. Review of the Minimum Data Set (MDS) assessment, dated 10/08/15, revealed the facility assessed the resident's cognition using the Brief Interview for Mental Status (BIMS) test and determined the resident was cognitively intact with a BIMS score of thirteen (13) out of possible fifteen (15) meaning the resident was interviewable.</p> <p>Review of the physician orders for Resident #16,</p>	F 157	<p>All nurses were inserviced concerning the campus procedure for physician/family notification guidelines 12/8/15 and 12/9/15 by Director of Clinical Compliance (who is serving as Interim DHS). Systemic change is that nurse leaders will review all new events in CCM daily to ensure timely family and MD notification. During weekend hours, the DHS or ADHS will review 3 resident events to ensure timely notification.</p> <p>DHS and/or ADHS will review 5 new events daily for timely</p>		

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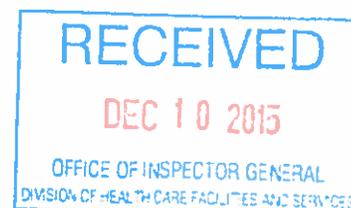
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F 157	<p>Continued From page 4</p> <p>revealed an order was entered on 10/09/15 for Lasix eighty (80) milligrams (mg) two (2) times a day and discontinued on 10/09/15. A second order was entered for Lasix eighty (80) mg two (2) times a day on 10/09/15 and was discontinued on 10/10/15.</p> <p>Review of the Medication Administration Record (MAR) for Resident #16, revealed Lasix eighty (80) mg was to be administered two (2) times a day starting on 10/09/15 and the medication was discontinued on 10/10/15. The resident received the morning dose on 10/10/15 and refused the evening dose.</p> <p>Review of the Event Report- Medication Error Circumstance for Resident #16, revealed Registered Nurse (RN) #5 recorded, on 10/12/15 at 12:28 AM, Resident #16 received one (1) dose of Lasix eighty (80) mg on 10/10/15 in the AM. The facility's investigation revealed the medication was not prescribed for this resident, but for another resident. The report revealed the resident's physician was not notified until 10/11/15 at 4:28 PM. The Nurse Practitioner gave orders to encourage fluids and draw labs on 10/14/15. The family was not notified until 10/11/15 after they questioned staff about the medications. The physician had was not notified of the medication error until Sunday afternoon, 10/11/15.</p> <p>Interview with the Responsible Party (RP) of Resident #16, on 10/13/15 at 12:45 PM, revealed the resident called the RP on Saturday, 10/10/15, and told them there was an extra pill with his/her morning medications. The RP stated the resident questioned staff as to why he/she was urinating so much and refused the dose scheduled for that evening. The RP stated they came in on Sunday</p>	F 157	<p>notification of family and physicians. Frequency of these audits will be 5 times per week for 1 month; then 3 times per week for one month, then weekly for 6 months. Results forwarded to QA committee and will continue quarterly thereafter.</p> <p>Completion 12/10/15</p>		



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F 157	<p>Continued From page 5</p> <p>and questioned RN #5 about the medications and RN #5 told them the resident had received Lasix eighty (80) mg that was not prescribed by the physician. The RP stated they were not notified of the medication error until they questioned the staff that day.</p> <p>Interview with RN #4, on 10/13/15 at 3:38 PM, revealed the nurse who took off the orders also signed off the orders. She stated she wrote the order for the Lasix on 10/09/15 at 10:23 PM and realized it was the wrong resident and discontinued the medication on 10/09/15 at 10:31 PM. She stated somehow a second order was put into the system, but denied putting the order in. She stated the computer must have had a glitch. She stated RN #5 called her on Saturday night and to ask her about the Lasix and she told her it was not ordered for Resident #16.</p> <p>Interview with RN #5, on 10/14/15 at 11:19 AM, revealed she was passing medication on Saturday night, 10/10/15. When she took the medications in to Resident #16's room, she explained Lasix was not usually given at bedtime and then the resident refused to take the medication. She said she called RN #4 that evening and the nurse told her Resident #16 was not to receive that medication. She stated RN #4 told her not to report the medication error, so she didn't fill out the Event Occurrence. She stated she did not notify the DHS, the Physician, or family upon discovery of the medication error. She stated she knew the resident was clinically stable, but the risk could be dehydration.</p> <p>Interview with the DHS, on 10/15/15 at 10:05 AM, revealed she was not notified of the medication error for Resident #16 until Sunday 10/11/15,</p>	F 157			



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F 157	Continued From page 6 around 5:30 PM. She stated RN #5 told her she found the error on Saturday evening, but when she called RN #4, she had begged her not to report the error. The DHS stated she instructed RN #5 to complete an event occurrence, call the physician and notify the responsible party. She stated staff had been trained on what to do when a medication error had been discovered and should have checked for new orders to verify the medications in the next Clinical Care Meeting. She stated Resident #16's medications would not have had a second check until Monday, 10/12/15.	F 157			
F 280 SS=K	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.	F 280			

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F 280	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure resident care plan interventions were revised related to fall prevention interventions in order to prevent further falls for six (6) of twenty-five (25) sampled residents. (Resident's #5, #8, #9, #10, #11, and #13)</p> <p>On 09/26/15 Resident #8 sustained an unwitnessed fall that resulted in a right non-displaced lateral 8th rib fracture. The staff heard the resident yelling for help, went to investigate and found the resident on the floor. The resident sustained bruising and a skin tear to the right elbow, abrasion to mid-lower spinal bony prominence and complained of right lower rib pain. The care plan was not revised to prevent further falls.</p> <p>On 09/09/15 Resident #9 was found on the floor by the resident's son. The resident's right foot was bleeding and the resident continued to be extremely confused. The resident's bed alarm was noted on the floor and non-functioning with a tear in the wiring. The family transported the resident to the hospital for evaluation. The resident received ten (10) sutures to the right foot, underneath and between the fourth and fifth toes and a closed non-displaced transverse fracture of the right fifth metatarsal. The facility failed to revise the care plan to prevent further falls or injury.</p> <p>On 09/30/15 Resident #10 was found on the floor by staff complaining of back pain. The resident</p>	F 280	<p>Resident #5 experienced falls on 7/1/15, 8/11/15, 8/19/15, and 8/20/15. New interventions were implemented after each fall. For the fall occurring on 7/1/15, a bed/chair alarm was implemented. For the fall on 8/11/15, intervention was to increase observation after the fall by asking the resident to transfer to a room closer to the nurses station. On 8/19/15, interventions were to review medications to determine if contributing factor and to obtain UA/C&S. For 8/20/15, the intervention initiated was not documented. Falls reassessment completed by DHS and Clinical Support Nurses was completed October 12, 13 and October 17, 2015. Care plan was revised by MDS nurses and interventions updated based on reassessment on 10/17/15. MDS nurses updated to include personal safety alarm (already in place) and wanderguard. No further</p>		

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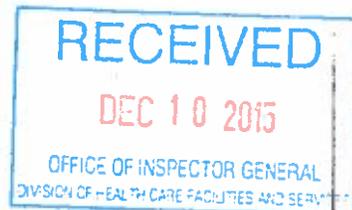
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F 280	<p>Continued From page 8</p> <p>stated he/she had attempted to get to their walker and it tipped over with the resident going over with it. Emergency Medical Services were called and transferred the resident to the hospital. Hospital x-ray result, revealed a thoracic compression fracture at T9. The resident continued to have severe pain and muscle spasms and a back brace was ordered. The facility failed to revise the care plan to prevent further falls or injury.</p> <p>In addition, Resident #5, #11 and #13 sustained falls without revisions to the care plans to prevent further falls and/or injuries.</p> <p>The facility's failure to have an effective system in place, to ensure care plans were revised for residents with a history of falls has caused or is likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was determined to exist on 09/07/15.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 10/22/15 which alleged removal of the Immediate Jeopardy on 10/23/15. The State Survey Agency verified Immediate Jeopardy was removed on 10/23/15 as alleged prior to exit on 10/29/15. The scope and severity was lowered to an "E" at F280, while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Interdisciplinary Team Care Plan Guidelines, dated June 2015, revealed the purpose was to ensure appropriateness of services and</p>	F 280	<p>updates indicated based on reassessment.</p> <p>Resident #8 experienced a fall on 9/26/15. New interventions included encouraging resident to rest and provide personal safety alarm, to check placement and function every shift. Falls risk reassessment was completed by DHS and Clinical Support Nurses beginning on October 12 and 13, 2015. Care Plan was revised by MDS nurses and interventions updated based on reassessment on October 12, 13 and 17, 2015. Resident was discharged on October 17, 2015 to home with family with plan in place for 24 hour supervision.</p> <p>Resident #9 experienced falls on 9/9/15 and 10/2/15. Resident discharged from facility on 10/4/15.</p>		



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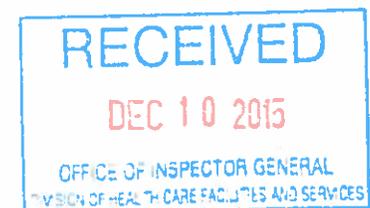
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F 280	<p>Continued From page 9 .</p> <p>communication that would meet the resident's needs, severity/stability of conditions, impairments, disability, or disease in accordance with state and federal guidelines. The care plan interventions would be reflective of the impact the risk area(s), disease process(es) have on the individual resident. Goals would be measurable and attainable. Interventions would be reflective of the individual's needs and risk influence as well as the resident's strengths.</p> <p>Review of the facility's policy regarding Clinical Documentation Systems, Circumstance, and Reassessment Forms, not dated, revealed the purpose was to provide a tool to document an investigation as to the root cause of an episodic event. Reassessment of the resident's risk factors that may have contributed to the event and evaluate the current care of plan interventions for effectiveness and select additional interventions if required. The care plan would be reviewed for effectiveness of the current interventions in place to minimize or eliminate the risk factors. New interventions would be implemented as appropriate.</p> <p>Review of the facility's policy for Falls Management, dated February 2015, revealed the facility would maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. Should the resident experience a fall the attending nurse would complete the Fall Circumstance and Reassessment Form. The form included an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of a repeat and a review by the Interdisciplinary Team to</p>	F 280	<p>Resident #10 experienced falls on 9/30/15 and 10/9/15. New interventions placed after the 9/30/15 fall included placement of personal safety alarm. The fall on October 10 resulted in transfer to hospital. Falls risk reassessment completed on October 12 and 13. Care plan was revised and updated by MDS nurses on October 12, 13 and 17, 2015 based on reassessment. MDS nurses updated to include remaining with resident while being toileted and hourly rounding.</p>		



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F 280	<p>Continued From page 10</p> <p>evaluate thoroughness of the investigation and appropriateness of the interventions. The resident care plan/profile would be updated to reflect any new or change in interventions.</p> <p>1. Review of the clinical record for Resident #8 revealed the facility admitted Resident #8 on 08/04/15 with diagnoses of Colon Cancer, Respiratory Failure and Atrial Fibrillation. The resident had a hospital admission on 09/15/15 and was re-admitted to the facility on 09/24/15. Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 09/29/15, revealed the facility assessed the resident using the Brief Interview for Mental Status with a score of fourteen (14) of fifteen (15) meaning the resident was interviewable. The facility also assessed the resident as needing the extensive assistance of one with transfers, walking, and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when moving from a seated to standing position, walking, moving on and off the toilet and from surface to surface.</p> <p>Review of the Comprehensive Care Plan for Resident #8 revealed the facility developed a plan of care related to skin integrity and falls on 09/15/15 with updated goals and target dates for 12/15/15. The goals stated the resident would have no falls with major injury and would maintain intact skin. The approaches directed staff to check placement and function of the bed/chair alarm, assist the resident with transfers, and keep the call light within reach.</p> <p>Resident #8 had an unwitnessed fall on 09/26/15 and sustained a skin tear, bruise to the right elbow, and a right rib fracture. However, review</p>	F 280	<p>Resident #11 discharged from facility on 8/27/15.</p> <p>Resident #13 experienced a fall on 7/7/15. New intervention implemented after the fall included placing bed in lowest position and toileting every 2 hours. Falls risk reassessment was completed by DHS and clinical support nurse.</p> <p>Resident #19 experienced a fall on 9/18/15. New interventions implemented after the fall included encouraging rest, continuing personal safety alarm and immobilizer to extremity. Falls risk reassessment was completed by DHS and clinical support nurses beginning October 12, 13 and 17, 2015 and care plan was revised and updated by MDS nurses beginning on October 12 and 13, 2015 based on reassessment.</p>		



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F 280	<p>Continued From page 11</p> <p>of Resident #8's plan of care for falls revealed the facility did not revise the plan until eleven (11) days later on 10/07/15.</p> <p>Interview with Minimum Data Set (MDS) Nurse #1 on, 10/27/15 at 11:05 AM, revealed she had revised Resident #8's plan of care on 10/07/15. She stated the date at the bottom of the plan of care was the date the care plan had been revised. She stated normally she revised care plans the next business day after the event. She stated nursing staff would have to verbally tell each other if they developed additional care plan interventions for a resident until she was able to make revisions to the computerized plan of care.</p> <p>Interview with Licensed Practical Nurse (LPN) #8, on 10/14/15 at 8:10 PM, revealed Resident #8 did have a bed alarm on prior to the last admission to the hospital; however, it was not reinstated after the resident was readmitted to the facility. She stated a bed alarm should have been put in place after readmission to alert staff of the resident's attempts to transfer without assistance. She revealed she did not make revisions to care plans and that MDS nursing staff made them. She stated her part of care plan revision was completed when she filled out a facility Event Form. She stated the forms had areas for her to click for possible interventions to be added to the care plan; however, the care plan itself was not updated until sometime later when the management team met to review the event information. She stated if she implemented an intervention she would verbally tell staff, but if they did not tell others, the information would not be known by all. She stated revising care plans and communicating the information timely would ensure resident care needs were met.</p>	F 280	<p>All residents have the potential to be affected by the deficient practice. Inservice, re-education and audits will ensure effective system in place to ensure resident care plan interventions are revised to prevent further falls.</p> <p>All resident care plans reviewed began on October 12, 2015. Care plans reviews continued on October 13 and 17-21, 2015, External Audit Support nurse, MDS Support Nurse and MDS nurse, to ensure alarms status of</p>		

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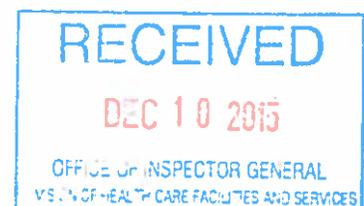
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F 280	<p>Continued From page 12</p> <p>Interview with the Director of Health Services (DHS), on 10/16/15 at 3:00 PM, revealed Resident #8's plan of care should have been revised to address the fail to ensure the resident needs were met.</p> <p>2. Review of the clinical record for Resident #10 revealed the facility admitted the resident on 09/23/15 with a history of falls with hip fractures and kidney transplant. The resident had diagnoses of Spinal Stenosis, Colon Cancer, and Deep Vein Thrombosis.</p> <p>Review of Resident #10's five-day Minimum Data Set (MDS) assessment, completed on 09/30/15, revealed the facility assessed the resident using the BIMS with a score of fourteen (14) of fifteen (15) meaning the resident was interviewable. The facility also assessed the resident as needing the extensive assistance of one with transfers, bed mobility and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when: moving from a seated to standing position, walking, moving on and off the toilet and from surface to surface.</p> <p>Review of the Comprehensive Care Plan for Resident #10 revealed the facility developed a plan of care related to activities of daily living and falls on 08/28/15 with updated goals and target dates for 08/28/15. The approaches directed staff to provide assistance with mobility. The care plan stated the resident needed the assistance of one when transferring, used a rolling walker with staff assistance and needed a wheelchair for long distances. The care plan also stated the resident required assistance with; oral care, grooming,</p>	F 280	<p>resident and interventions current. Any identified residents whose care plans needed revisions or updates were updated at the time of review.</p> <p>Education was completed by Assessment Support Nurse and External Audit nurse on 10/19/15 for the Interdisciplinary Team which included Administrative Nurses, Social Services, Activities, Therapy Program Director and Facility MDS nurses. Comprehension was validated by verbal questions and answers. Emphasis was on the importance of timely and accurate revisions of care plans.</p>		

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F 280	<p>Continued From page 13</p> <p>bathing and dressing. In addition, the fall care plan approaches directed staff not to leave the resident alone up in the wheelchair for extended periods of time, keep the call light within reach and remind the resident to use it. Further review revealed nursing staff did not revise the care plans after the resident sustained the unwitnessed injury fall on 09/30/15.</p> <p>Review of Resident #10's Nursing Notes, dated 09/30/15 at 1:52 PM, revealed staff found the resident on the floor complaining of back pain. Nursing noted the resident stated he/she had attempted to use their rolling walker and it tipped over causing the resident to go over with it. Emergency Medical Services was called and transferred the resident to the hospital for evaluation and treatment. The resident was diagnosed with a thoracic compression fracture at T9. The resident continued to have severe pain and muscle spasms and a back brace was ordered and the resident returned to the facility on 10/05/15.</p> <p>Interview with LPN #4, on 10/09/15 at 12:55 PM, revealed Resident #10 experienced an unwitnessed fall with injury on 09/30/15. She stated she did not revise the plan of care because the resident was sent to the hospital.</p> <p>Interview with the DHS, on 10/16/15 at 3:00 PM, revealed the care plan was not revised due to the resident not immediately returning to the facility. However, review of the plan of care for activities of daily living and falls revealed no revisions for fall interventions had been made since the resident's return. Per interview, an intervention that could have been put in place would be for staff to continually check on the resident to</p>	F 280	<p>Systemic change is front line were inserviced concerning reviewing plan of care on EMR and implementing immediate interventions to prevent a future fall on 12/8/15 and 12/9/15 by Director of Clinical Compliance (Interim DHS). Staff to update profile book with new fall interventions when implemented. During CCM, MDS or DHS will update care plans when change of conditions occur.</p> <p>DHS or ADHS will monitor 3 residents with changes to assure care plans are updated. Frequency of these audits will be 5 times per week for 1 month; then 3 times per week for one month, then weekly for 6 months. Results forwarded to</p>		



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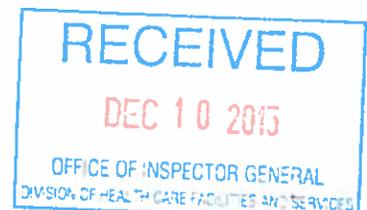
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F 280	<p>Continued From page 14</p> <p>anticipate their needs. She stated the plan of care directed staff on how to meet the needs of the resident.</p> <p>3. Review of the closed clinical record for Resident #9 revealed the facility admitted the resident on 09/09/15 with diagnoses of Gastro-intestinal Hemorrhage, Urinary Retention, Weakness and Difficulty Walking.</p> <p>Review of Resident #9's Admission Minimum Data Set (MDS) assessment, completed on 09/16/15, revealed the facility assessed the resident using the BIMS and scored the resident as a twelve (12) of fifteen (15) meaning the resident was interviewable. The facility also assessed the resident as needing the extensive assistance of two with transfers, bed mobility and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when: moving from a seated to standing position, walking, moving on and off the toilet and from surface to surface.</p> <p>Review of the Comprehensive Care Plan for Resident #9 revealed the facility developed a plan of care for fall prevention on 09/14/15 with updated goals and target dates for 11/14/15. On 09/09/15, the plan of care noted the resident was found on the floor (family at bedside) and sustained a cut to the foot requiring the resident to be sent to the emergency room for evaluation. The plan of care was edited on 10/01/15 and stated the bed/chair alarm was discontinued; however, no revisions were made after this edit. In addition, Resident #9 had a care plan related to short term memory loss and recall impairments. The goal stated the resident's cognitive impairment would not interfere with care routine</p>	F 280	<p>QA committee and will continue quarterly thereafter.</p> <p>Completion date 12/10/15</p>		

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F 280	<p>Continued From page 15 or quality of life. Review of the approaches revealed no revisions were made after the development of the plan of care.</p> <p>Review of the Nursing Notes, dated 09/09/15, revealed the facility admitted the resident on 09/09/15 at 1:51 PM and nursing noted seven (7) hours later, at 8:45 PM, that Resident #9 was found on the floor by the resident's son. The resident's right foot was bleeding and the resident continued to be extremely confused. The resident's bed alarm was on the floor and non-functioning with a tear in the wiring. The family transported the resident to the hospital for evaluation and the resident received ten (10) sutures to the right foot, underneath and between the fourth and fifth toes. The X-ray results at the hospital revealed a closed non-displaced transverse fracture of the right fifth metatarsal.</p> <p>Review of Resident #9's Fall Circumstance Event Form (FCEF), dated 09/09/15, revealed nursing did not implement any new interventions that would prevent/decrease the opportunity for another fall. The Interventions listed were to apply direct pressure to the wound and elevate the extremity.</p> <p>Review of the Fall Circumstance Event Form, dated 10/02/15, revealed Resident #9 had an unwitnessed fall from the wheelchair, without injury. Continued review of the FCEF, revealed nursing did not revise the care plan or implement any additional interventions to prevent another fall.</p> <p>Interview with LPN #9, on 10/15/15 at 11:40 AM, revealed she believed the resident was still under the effects of anesthesia when he/she was</p>	F 280			



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F 280	<p>Continued From page 16</p> <p>admitted on 09/09/15. She stated the son found the resident on the floor and notified staff and staff could not determine exactly what the resident was trying to do at the time of the fall. She stated the second incident occurred when the resident was reaching for a hat and fell out of the wheelchair. She stated the resident told her he/she had forgotten to lock the wheelchair and slid out onto the floor. She stated she did not revise the resident's plan of care as it was not her responsibility. She stated she also forgot to completely fill out the Fall Circumstance Event Form. She stated updating the resident's plan of care ensured the resident's changing care needs were met.</p> <p>4. Review of the closed clinical record for Resident #11 revealed the facility admitted the resident on 06/01/15 with diagnoses of Coronary Artery Disease, Difficulty Walking with Abnormal Gait and Pain.</p> <p>Review of Resident #11's Admission Minimum Data Set (MDS) assessment, completed on 07/31/15, revealed the facility assessed the resident using the BIMS and scored the resident as an eleven (11) of fifteen (15) meaning the resident was interviewable. The facility also assessed the resident as needing the extensive assistance of two with transfers, bed mobility and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when moving from a seated to standing position, walking, moving on and off the toilet and from surface to surface.</p> <p>Review of the Comprehensive Care Plan for Resident #11 revealed the facility developed a plan of care for falls on 07/06/15 with updated</p>	F 280			

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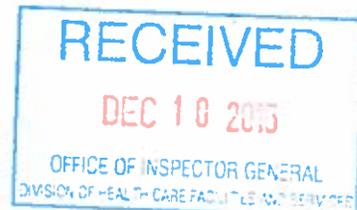
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F 280	<p>Continued From page 17</p> <p>goals and target dates for 10/06/15. The goal stated the resident would have no falls with major injury while a resident at the facility.</p> <p>Review of the clinical record revealed Resident #11 sustained a fall on 06/18/15, 07/06/15 and 08/14/15.</p> <p>Continued review of the care plan revealed the facility did not revise the plan of care after each fall event with interventions to prevent another fall. The information listed on the care plan after the fall on 06/18/15 stated the resident had a fall with no injuries and the intervention listed stated, place the bed in the low position; even though the fall occurred when the resident transferred themselves from the toilet. The care plan documentation for the 07/06/15 fall, stated the resident had a fall with a hematoma and the intervention to prevent another fall was to send the resident to the emergency department for evaluation. The 08/15/15 fall intervention information listed on the plan of care, stated education was provided to staff to transfer the resident the way the daughter transferred the resident. Even though the facility assessed the resident as needing the assistance of two with transfers; and determined the daughter had transferred the resident alone.</p> <p>Interview with LPN #4, on 10/08/15 at 2:25 PM, revealed Resident #11 had an unwitnessed fall on 07/06/15 but she must have forgotten to fill out the Fall Circumstance Event Form in the computer. She stated the form had areas for her to click on to add possible interventions to prevent another fall. She stated the MDS Nurses actually revised resident's plans of care after an event. She stated if a resident's care plan did not</p>	F 280			

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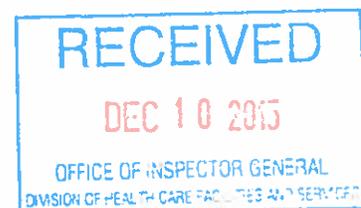
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F 280	<p>Continued From page 18</p> <p>get revised with interventions to prevent another fall the resident could experience another fall.</p> <p>Interview with LPN #7, on 10/16/15 at 12:00 PM, revealed she did not revise care plans because she was not the person to do so. She stated revising care plans ensured staff would meet the changing needs of the resident. She stated if a care plan did not get revised a bad outcome could occur to the resident.</p> <p>Interview with LPN #13, on 10/26/15 at 5:30 PM, revealed if an event occurred an electronic form was filled out that required staff to click on interventions which could be implemented to prevent another incident. However, she did not revise the residents' actual plans of care, and as far as she knew the interventions she clicked on did not automatically populate over to the resident's actual plan of care. She stated she had to verbally tell other staff if she implemented a new intervention, but if they did not continue to tell others the information might not be known to everyone.</p> <p>Interview with Minimum Data Set Nurse #1, on 10/08/15 at 10:40 AM and 10/27/15 at 11:05 AM, revealed resident care plans were usually revised the next business day after an event occurred. She stated the revision that stated, send Resident #11 to the emergency room after the fall, would not prevent another fall. She stated the plan of care should have been revised to include interventions that would actually prevent another fall. She stated without the revisions the resident could experience another fall.</p> <p>Interview with the Director of Health Services, on 10/16/15 at 3:00 PM, revealed Resident 11's care</p>	F 280			



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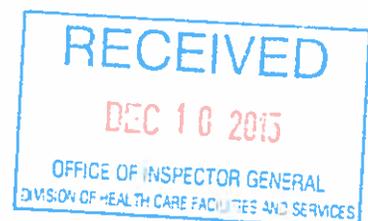
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F 280	<p>Continued From page 19</p> <p>plan should have been revised with interventions that would prevent another fall. She stated sending the resident to the emergency room would not prevent another fall. She stated she had not identified the information added to Resident #11's plan of care would not prevent another fall event until discussion with the surveyor. She stated revising the care plan with an intervention to provide increased supervision or a scheduled toileting program would have been interventions to prevent additional falls.</p> <p>5. Review of the clinical record for Resident #13 revealed the facility admitted the resident on 07/03/15 from an acute hospital with the following diagnoses: Dementia, Fracture of the Left Femur that required surgical interventions, After Care of the fractured leg, Abnormality Gait, and History of Falling.</p> <p>Review of the admission MDS assessment, dated 07/10/15, revealed the facility assessed the resident to have severe cognition impairment with a BIMS score of five (5) out of a possible fifteen (15). The facility assessed the resident to need extensive assistance from staff for bed mobility, transfers, locomotion, toilet use, and ambulation. The facility assessed the resident to have a balance deficit with unsteady gait and impaired with range of motion on one side. The resident was assessed to be high risk of falling.</p> <p>Review of the comprehensive care plan, created 07/15/15 revealed the facility had identified the resident at risk for falling due to weakness, incontinence, history of falls, medications, and needing assistance from staff with all ADLs. The goal was for the resident to remain free from major injuries during the resident's stay at the</p>	F 280			



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F 280	<p>Continued From page 20</p> <p>facility. The care plan approaches included to keep call light within reach, provide clutter free walkway; adequate footwear, appropriate lighting, and remind the resident to call for assistance prior to getting up. In addition, the resident was to remember to lock the wheelchair brakes before getting up.</p> <p>Review of the clinical record revealed Resident #13 had sustained falls on 08/12/15, on 09/06/15, and on 10/01/15. Review of the resident's care plan revealed no documented evidence the care plan was revised after the fall on 09/06/15 and on 10/01/15 the resident fell and sustained a skin tear to the left elbow, and the resident's right knee, left forehead, and left side of face was red with complaints of left shoulder/arm pain (6 out of 10 on the pain scale).</p> <p>Interview with MDS Coordinator #1, on 10/16/15 at 8:20 AM, revealed after the 09/06/15 fall (where the resident was found alone in the bathroom), the team did not revise the care plan but continued to implement the intervention to check the PSA for placement and function. She revealed the interventions for the resident to use the call light and request assistance prior to transfer was not effective. She stated the resident did not use the call light and request staff assistance prior to the three (3) previous falls and stated the resident didn't know to use the call light.</p> <p>Interview with the Director of Health Services (DHS), on 10/16/15 at 9:50 AM, revealed she reviewed Resident #13's care plan and stated the care plan was not appropriate for the resident because due to the resident's impaired cognition, the resident was not able to utilize the call light</p>	F 280			



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F 280	<p>Continued From page 21 and recall safety instructions.</p> <p>6. Review of the clinical record for Resident #5, revealed the facility admitted the resident on 03/05/14 with diagnoses of Dementia, Anxiety, Depression, Seizure Disorder, Hypertension, Transient Cerebral Ischemic Attack, Diabetes Type 2, and Anemia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/05/15, revealed the facility assessed Resident #5 with a score of five (5) of fifteen (15) on the Brief Interview for Mental Status (BIMS) assessment, which meant the resident could not be interviewed. The facility also assessed the resident as needing the extensive assistance of one with transfers, bed mobility and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when: moving from a seated to standing position, moving on and off the toilet and from surface to surface.</p> <p>Review of the updated Comprehensive Care Plan, dated 08/19/15, revealed the resident was at risk for falls related to the need for extensive assistance with most Activities of Daily Living (ADL's), a history of falls, and the use of psychotropic medications. In addition, the resident had a care plan developed for safety and the need for assistance with transferring. The goal related to fall prevention, stated the resident would be free from falls during their stay at the facility. The goal related to activities of daily living stated the resident would be as independent as possible with ADL's. The goal related to safety stated the use of the chair/bed alarm would alert staff of the resident's need for assistance. The approaches directed staff to provide assistance</p>	F 280			



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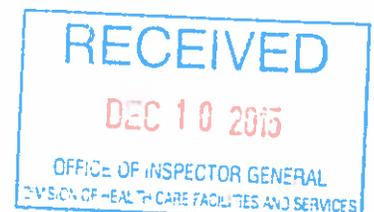
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F 280	<p>Continued From page 22 with transfers, and check the bed/chair alarm for placement and functionality every shift.</p> <p>Review of the Fall Circumstance Event Form, dated 07/11/15, revealed Resident #5 sustained an unwitnessed fall and was found on his/her back on the bathroom floor next to the wheel chair on 07/11/15. Resident #5's personal safety chair alarm had not sounded and the resident was unable to explain what he/she was doing due to cognition. Review of Resident #5's care plan revealed no new intervention was placed for the 07/11/15 fall event.</p> <p>Interview with the RN #2, on 10/15/15 at 3:15 PM, revealed she completed Resident #5's Fall Circumstance Event Form, on 07/11/15 and was not aware she had not implemented an immediate intervention. Per interview, she had not viewed Resident #5's care plan because she was not responsible for making changes to the care plan.</p> <p>Review of the Fall Circumstance Event Form, dated 08/11/15, revealed Resident #5 sustained an unwitnessed fall on 08/11/15 when he/she transferred unassisted to the bathroom. There were no contributing factors noted on the Fall Circumstance Event Form and no evidence the interventions were revised on the care plan to prevent further falls.</p> <p>Interview with LPN #14, on 10/15/15 at 2:35 PM, revealed she was not aware Resident #5 had prior falls in the bathroom. LPN #14 stated when documenting in the Fall Event Report, she could not review the care plan to determine what interventions were already in place because it was in the computer and she did not know how to</p>	F 280			

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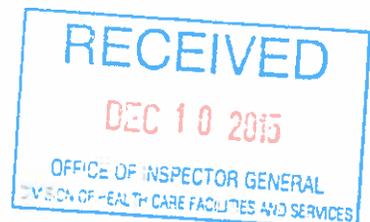
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F 280	<p>Continued From page 23 retrieve it.</p> <p>Interview with the DHS, on 10/09/15 at 12:20 PM, revealed the MDS Coordinators were responsible for reviewing the Fall Care Plan interventions during the IDT meeting and she was unaware this was not consistently occurring. The DHS stated Resident #5's repeated falls might not have occurred if the IDT and MDS Coordinators had identified the discrepancies in the Fall Event Reports and lack of appropriate immediate interventions.</p> <p>Continued interview with MDS Coordinator #1, on 10/16/15 at 8:20 AM, revealed all falls are discussed in the morning Clinical Care Meeting and the interdisciplinary team determine appropriate care plan interventions. She stated the team always reviews the Fall Circumstance Event Report during the meetings.</p> <p>Continued interview with the DHS, on 10/16/15 at 9:50 AM, revealed the staff nurses are supposed to complete the Fall Circumstance Event Report and find out what caused the fall. She reviewed all Fall Circumstance Event Reports during the meeting and the team would review the care plan to determine if the care plan inventions were appropriate and would prevent additional falls. She continued to state the team looked at existing care plan interventions to see if they are working and remove if not.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 10/22/15 and took the following actions to remove the Immediate Jeopardy on 10/23/15:</p> <p>1. The facility conducted a review of the</p>	F 280			



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F 280	<p>Continued From page 24</p> <p>sixty-three (63) current residents' care plans from October 12-20, 2015 by the Minimum Data Set (MDS) nurses to ensure care plan interventions were current. Eight (8) care plans required revision. Change in condition (including falls) will be reviewed with care plan revision as needed during the Clinical Care Meeting. The Director of Health Services will be responsible for overseeing the meetings with follow up on events that have occurred within the last twenty-four (24) hours. Education was provided for the Interdisciplinary Team (Administrative Nurses, Social Services, Activities, Therapy Director, and MDS Nurses on 10/19/15 by the Assessment Support Nurse and the External Audit Nurse.</p> <p>2. A Care Plan Audit tool was developed and will be used to ensure care plans are reviewed and revised during the Clinical Care Meeting (Monday-Friday) and weekend days by the Director of Health Services, Assistant Director of Health Services, or MDS Nurse.</p> <p>3. A Profile binder with current safety interventions (based on the care plan) for each resident was placed on each unit, on 10/21/15, for the nursing aides. The binders will be updated daily after the Clinical Care Meeting by the MDS or Medical Records. Audits will be completed daily.</p> <p>4. Charge Nurses will round daily during the Medication Pass to observe for compliance with safety interventions according to the plan of care. Audits will be conducted on the first and second shift and Night Shift Nurses will conduct routine rounds that included observing for safety interventions for five (5) random residents.</p>	F 280			



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F 280	<p>Continued From page 25</p> <p>5. Falls will be reviewed during the weekly Clinical at Risk meetings to ensure effective interventions are in place. Residents who sustained a fall will be followed in these meetings for four (4) weeks.</p> <p>6. Safety Device audits (five residents per day) will be conducted daily by department leaders, on random shifts, to ensure devices are in place and functioning.</p> <p>7. An audit was conducted on 10/18/15 of each resident's medical record to ensure proper information related to Advance Directives were in the Soft File at each unit. Advance Directives information will be obtained at admisson with appropriate papers signed and placed into the Soft File at each unit. This would include each resident's code status.</p> <p>8. Education for the Executive Director, Medical Record Staff, Director of Health Services and her assistant, and Social Services were completed on 10/19/15, by the Clinical Director, of the Importance of maintaining the integrity of medical record and Advance Directives information being available for Charge Nurses in the event of a resident was transferred to the hospital.</p> <p>9. Scanning guidelines will be followed based on protocols for the Electronic Health Record. Daily audits will be conducted by the DHS, ADHS, MDS, and Medical Records to ensure completion of all admission records and Advance Directive information placed into the Soft Files. These audits will be reviewed during the daily Clinical Care Meeting.</p> <p>10. A Quality Assurance (QA) Meeting was</p>	F 280			

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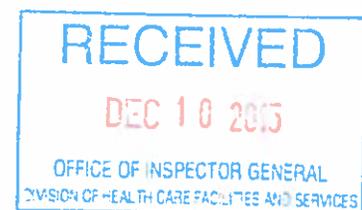
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F 280	<p>Continued From page 26</p> <p>conducted on 09/18/15 to review Falls Trending. Another QA meeting was held on 10/19/15 with the Medical Director in attendance to review the Guidelines and protocol for conducting Quality Assurance Meetings.</p> <p>11. Education was provided by the Clinical Director to the Executive Director, Director of Health Services and her assistant, and other department leaders that included issues of fall management, Advance Directives, and monitoring of care plans. Corrective plans were developed based on trends prevalent in a system not in compliance. Action plans developed with focus on goals and protocols for Clinical Care Meeting and its direct relationship to Quality Assurance activities.</p> <p>12. Audits Implemented will be reviewed during the monthly QA meeting and during the Clinical Support Nurse's routine visits that occur once a week. Audits included Safety Device, Advance Directive, and Soft files, Clinical Care Meetings, Clinical at Risk Meetings, Care Plans, and QA.</p> <p>The State Survey Agency (SSA) validated the implementation of the facility's AOC as follows:</p> <p>1. Record review revealed Residents #5, #8, #10, #13, and #19 care plans were revised. Resident #20 was sampled during the extended survey due to being the only resident with a fall since the alleged Immediate Jeopardy abatement date of 10/23/15. The resident's care plan was reviewed during the Clinical Care Meeting and revised as needed.</p> <p>Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, revealed the</p>	F 280			

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F 280	<p>Continued From page 27</p> <p>Interdisciplinary team received training on care plan revision and implementation. She stated she was responsible for overseeing the Clinical Care Meetings and ensured the care plan was revised and all events received follow-up monitoring to ensure the event reports were completed. In addition, she randomly reviewed one-two care plans daily to ensure completion.</p> <p>2. Sampled Resident #20's fall (10/25/15) was discussed in the Clinical Care Meeting and revision of the care plan was completed. Review of the care plan audits revealed revision of the care plans were occurring after an event or change in the resident. Review of the sampled residents for the extended survey revealed the care plan had been revised after a change in the resident's status to include falls.</p> <p>3. Observation of the 400, 500, and Health Care Units, on 10/27/15 at 11:30 AM and again at 4:00 PM, revealed Profile Binders at each unit that included specific information about each resident including code status. Observation on 10/27/15 at 4:35 PM, revealed staff updating the Profile Binder on the Healthcare Unit. Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, validated the binders are updated after the Clinical Care Meetings with any new care plan interventions. The MDS Nurses were at a training offsite and unavailable for interview during the extended survey.</p> <p>4. Observation, on 10/28/15 at 10:00 AM, (on the 500 Unit) revealed the nurse was conducting rounds in the residents rooms during the medication pass for safety devices and call light placement.</p>	F 280			



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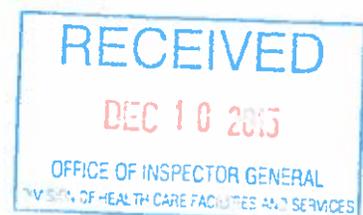
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F 280	<p>Continued From page 28</p> <p>Interviews with LPN #5, on 10/26/15 at 4:00 PM, LPN #12 on 10/27/15 at 11:15 AM, and LPN #6 on 10/28/15 at 9:00 AM, revealed the nurses conducted walking rounds to check for safety devices and call lights at the beginning of the work shift and again when they administered medications. Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, revealed she had randomly observed walking rounds between the nursing aides and nurses giving report.</p> <p>Review of the safety devices/call light audits revealed at least five (5) residents were observed daily for safety device and call light placement and proper functioning of the devices.</p> <p>5. Review of the Fall Circumstance Event Report for Resident #20, revealed the fall was discussed in the Clinical Care Meeting. Audits revealed Resident #20 was included. Interview with LPN #5, on 10/26/15 at 4:00 PM, revealed the resident slid from the bed and experienced no injury.</p> <p>Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, Executive Director, on 10/28/15 at 3:00 PM, and Clinical Director, on 10/29/15 at 12:00 PM, revealed all falls and any change in condition were discussed during the Clinical Care Meetings. Review of the audits revealed the meetings were held on October 21, 22, 23, 26, and 27. A meeting was held on 10/28/15 at 10:00 AM and validated by observation of the SSA.</p> <p>Review of the Changes in condition, including fall investigation and root cause analysis will be discussed during the Clinical Care Meetings. The Fall Circumstance Event Reports are reviewed for completion and ensure appropriate safety</p>	F 280			

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F 280	<p>Continued From page 29</p> <p>interventions had been implemented to reduce the risk of future falls.</p> <p>6. The facility reviewed all safety devices and conducted assessments with some safety devices discontinued. There were seven (7) residents with safety devices during the extended survey. Review of the audits revealed five (5) or more residents were audits to ensure safety devices were in place and functioning.</p> <p>7. Review of the Soft Files for the 500, 400, and Health Care Units revealed each resident had been offered Advance Directives and each resident had a code status. These forms were scanned into the electronic record and the original signed form was kept in the Soft File at each unit.</p> <p>Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, revealed she had received training on the Soft Files, scanning forms into the electronic record, and maintaining the medical record. She stated she was responsible for conducting audits of new admission paperwork to ensure the code status and Advance Directive forms are signed and placed into the Soft File on each unit.</p> <p>Observation of the new admission process revealed Advance Directive forms were signed and placed into the soft file. Resident #21, #22, and #23 were sampled during the extended survey to validate the admission paperwork was completed and Advance Directive forms signed and placed into the Soft File.</p> <p>8. Review of the training record revealed education was provided on 10/19/15 as stated in</p>	F 280			



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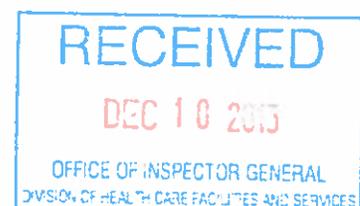
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F 280	<p>Continued From page 30</p> <p>the AOC. Interview with the Medical Records, on 10/28/15 at 2:40 PM, Director of Health Services, on 10/28/15 at 1:50 PM, and Social Services on 10/28/15 at 2:48 PM, revealed they had received the training.</p> <p>9. Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, revealed she received training on the scanning guidelines. She stated she now had additional staff to help with the scanning of the medical record into the electronic record. She stated audits were conducted daily to ensure scanning guidelines are followed.</p> <p>Review of the Daily Care plan audit forms, Falls Interventions audit forms, Call Light audit forms, Fall Investigation audit forms, the Safety/Assistive Device audit forms, and the Admission audit forms revealed they were all completed.</p> <p>10. Review of the QA signature sheets revealed QA meetings were held on 10/19/15 and 10/29/15. Interview with the Executive Director, on 10/28/15 at 3:00 PM, and the Clinical Director on 10/29/15 at 12:00 PM validated the QA meetings were held on those dates.</p> <p>Interview with the Clinical Director and the Clinical Support Nurse, on 10/29/15 at 12:00 PM, revealed the QA meeting on 10/19/15 was to develop the Plan of Action to correct the Immediate Jeopardy, develop audits, and capture any trends of non-compliance. The Clinical Director stated staffing was reviewed to determine if it contributed to the non-compliance and she was looking at staffing as part of the solution. She stated the facility had been given extra hours for staffing and was in the process of determining where the hours would be best</p>	F 280			

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F 280	<p>Continued From page 31</p> <p>spent. The Clinical Director stated the QA meeting of 10/29/15 was to review audits, and evaluate the plans of actions. She stated the audits revealed no problems and the AOC was implemented and monitored as stated. She stated the facility would continue to meet monthly and she would be at the facility almost daily to assist the new Executive Director and ensure compliance. The Clinical Support Nurse stated she would visit the facility at least twice a week and as needed to ensure the Clinical Care and Clinical at Risk meetings were conducted according to the AOC. The Clinical Director stated she would attend the monthly QA meetings for at least six (6) consecutive months.</p> <p>11. Interview with the Clinical Director, on 10/29/15 at 12:00 PM, revealed she provided the education to the Executive Director and Director of Health Services on 10/19/15. Review of the training records validated the training.</p> <p>Interview with the Executive Director and Director of Health Services on 10/29/15 at 12:15 PM, revealed they received training on Advanced Directives, revision of care plans, documentation, audits, monitoring, scanning guidelines, systems related to falls, and the protocols for Quality Assurance.</p> <p>12. Review of the audits revealed the facility conducted the audits as stated in the AOC.</p> <p>Interview with the Executive Director, on 10/28/15 at 3:00 PM, and the Clinical Director, on 10/29/15 at 12:00 PM, revealed the audits were conducted and forwarded to them for review of compliance. The audits were brought to the 10/29/15 QA meeting to review and discuss trending.</p>	F 280			



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F 282 SS=K	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and manufacturer's guidelines, it was determined the facility failed to have an effective system in place to ensure residents' care plan interventions were implemented related to supervision, placement and the functionality of bed and chair alarms, and the availability of fluids to ensure hydration. The facility's failure affected five (5) of twenty-five (25) residents (Resident #1, #2, #5, #6, and #12).</p> <p>The staff failed to transfer Resident #1 with assistance of one, failed to keep the call light within reach, and ensure the bed alarm was functioning which resulted in a fall on 09/07/15 when the resident sustained a 2.5 centimeter laceration to the cheek/eye area, two rib fractures and a Flailed Chest injury (a life threatening medical condition that occurs when a segment of the rib cage breaks under extreme stress and becomes detached from the rest of the chest wall so a part of the chest wall moves independently). Review of the Death Summary, dated 09/07/15, revealed the resident passed, thirteen (13) hours after the fall, on 09/07/15, due to the injuries sustained from the fall which led to respiratory failure.</p> <p>In addition, on 08/04/15 Resident #12 sustained</p>	F 282	<p>Resident #1 was discharged to hospital on 9/7/15.</p> <p>Resident #2 had Point of Care Profile and care plan interventions related to accidents reviewed by MDS nurses on October 12, 13, 2015 to insure being followed by staff based on care observation. Treatment records were also reviewed on 10/20/15 by LPN Mentor to insure interventions were being followed as outlined on care plan.</p>		

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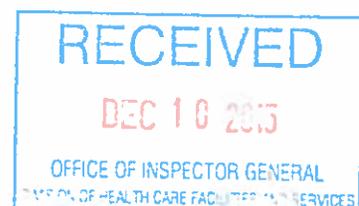
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F 282	<p>Continued From page 33</p> <p>an unwitnessed fall with injury. Nursing documented that the resident stated he/she tried to get up from the potty chair and fell. Nursing assessment revealed the resident had swelling and an abrasion with bleeding to the nose. The Event Report documentation revealed there were no possible contributing factors present at the time of the fall. However, the care plan directed staff to assist with transfers to the bathroom. Review of Nursing Notation, dated 08/05/15 at 3:30 AM, revealed the resident returned from the hospital with a diagnosis of a nasal fracture.</p> <p>The staff failed to monitor for placement and functionality of bed and chair alarms as care planned for Residents #2, #5, and #6.</p> <p>Further staff failed to keep fluids within reach to ensure hydration as care planned for dehydration/urinary tract infection for Resident #2.</p> <p>The facility's failure to have an effective system in place, to ensure care plans were implemented has caused or is likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was determined to exist on 09/07/15.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 10/22/15 which alleged removal of the Immediate Jeopardy on 10/23/15. The State Survey Agency verified Immediate Jeopardy was removed on 10/23/15 as alleged prior to exit on 10/29/15. The scope and severity was lowered to an "E" at F282 while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.</p> <p>The findings include:</p>	F 282	<p>Resident #5 experienced falls on 7/1/15, 8/11/15, 8/19/15, and 8/20/15. New interventions were implemented after each fall. For the fall occurring on 7/1/15, a bed/chair alarm was implemented. For the fall on 8/11/15, intervention was to increase observation after the fall by asking the resident to transfer to a room closer to the nurses station. On 8/19/15, interventions were to review medications to determine if contributing factor and to obtain UA/C&S. For 8/20/15, the intervention initiated was not</p>		

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F 282	<p>Continued From page 34</p> <p>Review of the facility's policy regarding Interdisciplinary Team Care Plan Guidelines, dated June 2015, revealed the purpose was to ensure appropriateness of services and communication that would meet the resident's needs, severity/stability of conditions, impairments, disability, or disease in accordance with state and federal guidelines. The care plan interventions should be reflective of the impact the risk area(s) and disease process(es) have on the individual resident. Goals should be measurable and attainable. Interventions should be reflective of the individual's needs and risk influence as well as the resident's strengths.</p> <p>Review of the facility's policy regarding Clinical Documentation Systems, Circumstance, and Reassessment Forms, not dated, revealed the purpose was to provide a tool to document an investigation as to the root cause of an episodic event; to reassess the resident's risk factors that may have contributed to the event; evaluate the current care plan interventions for effectiveness; and, select additional interventions if required. The care plan should be reviewed for effectiveness of the current interventions in place to minimize or eliminate the risk factors. New interventions should be implemented as appropriate.</p> <p>Review of the facility's policy for Falls Management, dated February 2015, revealed the facility would maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. The fall risk assessment was included as part of the Admission and Monthly Nursing Assessment and Review and Circumstance forms. Identified risk factors should</p>	F 282	<p>documented. Falls reassessment completed by DHS and Clinical Support Nurses was completed October 12, 13 and October 17, 2015. Care plan was revised by MDS nurses and interventions updated based on reassessment on 10/17/15. MDS nurses updated to include personal safety alarm (already in place) and wanderguard. No further updates indicated based on reassessment.</p> <p>Resident #6 was discharged on 11/6/15. Care plan interventions were reviewed on 10/18/15. Resident experienced no falls during this time. Resident discharged 11/6/15.</p> <p>Resident #12 was discharged on 8/6/15.</p>		



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F 282	<p>Continued From page 35</p> <p>be evaluated for the contribution they may have to the resident's likelihood of falling. In addition, care plan interventions developed from the fall risk assessment which addressed the resident's risk factors, should be implemented.</p> <p>Further review revealed the facility did not provide a policy related to the bed/chair alarms that would direct staff in how to follow the care plan intervention to check the alarms for functionality. However, review of the manufacturer's guidelines for the three (3) types of bed/chair alarm systems, revealed the facility used Medline, Posey and Universal Medical Products.</p> <p>Review of the Medline bed/chair alarm brand revealed it was the responsibility of the facility to implement structured training procedures for all employees using the system. Failure to adequately train employees may cause system failure due to user error. In addition, incorrect use of the equipment may also result in system failure. The company recommended all expired, soiled or contaminated pads be disposed of in accordance with the law and facility policy. The sensor pads had a limited expected useful life. The facility must record the warranty date in the area provided on the label. The facility must not use the sensor pad after the in-service warranty expiration date. To set up the system first visually inspect the pad and wires for damage. Power the unit by inserting a 9-volt battery, use adhesive strips on the bottom of the pad before putting in place to prevent shifting. When securing the system, take up extra slack in the cord that could become tangled with the resident, bed or chair. Failure to do so may result in resident injury. Insert the pad plug into the sensor pad, and the control unit should flash a green light and beep.</p>	F 282	<p>All residents have the potential to be affected by the deficient practice. Through inservice, re-education and monitoring through audits outlined in this Plan of Correction we will ensure implementation of the plan of care interventions.</p> <p>Education was conducted on 10/12/15 by Director of Clinical Compliance for nursing staff related to following care plan interventions.</p> <p>Additional education was conducted by Staff Development, Director of Clinical Compliance and Assessment Support for all</p>		

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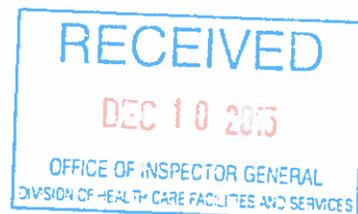
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F 282	<p>Continued From page 36</p> <p>In addition, the unit could be silenced for 30 seconds, by pressing the silence button. If the resident does not return to the pad within thirty seconds the unit turns itself off requiring the staff to reset it again.</p> <p>Review of the Posey manufacturer recommendations, revealed "before leaving a resident unattended staff should always follow these steps each time: Check to make sure that the sensor cable and unit were intact and undamaged, place weight on sensor pad, turn alarm unit on and verify the green light blinks, verify the unit had fresh batteries in place, listen for intermittent chirp that alerted staff of a low battery, check to make sure the audible alarm functioned properly by applying and lifting weight off the sensor pad in several spots to activate alarm. Check to make sure sensor cable was out of the way and did not pose a tripping hazard." The manufacturer's information stated a nine (9) volt battery provided up to 280 hours of continuous alarm. Alarm may fail to sound if the sensor pad was bent or folded under the resident or not directly under the resident's buttocks.</p> <p>Further review revealed the Posey brand had a warning statement that informed the user to "never connect the Posey brand sensor pads to other manufacturers' alarm units or connect other manufacturers' sensor pads to the Posey brand alarm units."</p> <p>Review of the Universal Medical Products (UMP) revealed the UMP pressure pads were designed for use with UMP monitors only. Do not substitute any other fall monitoring devices. In addition, the company directed user's to write on the pad the date the pad was put into use. The UMP stated</p>	F 282	<p>nursing staff related to importance of following care plan interventions October 18, 19, 20, 21, and 22, 2015.</p> <p>Systemic change is a binder with current safety interventions for each resident based on care plan and will be placed at each nurses station for CRCAs to easily access is updated by DHS/ADHS when changes occur.</p> <p>These binders will be updated daily with changes by the DHS or charge nurse on the weekends. Staff nurses will round daily to observe that safety interventions are being followed and document on the TAR.</p>		

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F 282	<p>Continued From page 37</p> <p>the user should test the system before each use and inspect pads and monitor regularly to make sure they were not damaged. Users should test the system by pressing firmly on the pad for three (3) seconds. When pressure was removed from the pad, the alarm should sound. Reset the alarm. Place the UMP pad directly under the resident so that the bulk of the resident's weight (buttock area) would rest on the pad. Plug the end of the pad cable into the jack on the bottom of the monitor. For added safety from accidental pulls on the cord, route the cable through the strain relief slot on the bottom of the monitor. When the resident's weight was placed on the pad, the user would hear a brief confirmation tone letting them know the pad was operational. UMP standard bed pads were designed to withstand normal wear and tear for a period of 45-day, 90-day, 180-day or 1-year depending on the model. Beyond this time, the pad may fall and fail without warning due to prolonged use and other factors, e.g. bending, exposure to moisture, punctures, repeated cord pulls and connector damage. Be sure that facility protocols directed staff to log the 45-day, 90-day, 180-day and 1-year "Date Put in Use" date in the blank provided on the pad itself and in the resident's chart. If the pad was used on more than one resident, the original "Date put in use" date must be transferred from chart to chart.</p> <p>Interview with the Director of Health Services (DHS), on 10/05/15 at 2:00 PM, revealed she had not read the manufacturer's recommendations for the three (3) types of bed/chair alarm in use at the facility. She stated she did not know each had a different process to check the functionality of the alarms. In addition, she stated the facility had not provided training to staff using the</p>	F 282	<p>Nurse managers will perform audits of CRCA care to assure plan of care is followed on 3 residents 5 times per week for one month, then weekly with results forwarded QA monthly for 6 months then quarterly thereafter for review and further suggestions/comments.</p> <p>Completion date: 12/10/15</p>		



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F 282	<p>Continued From page 38</p> <p>manufacturer's guidelines. She stated staff would need to know this information in order to follow the care plan intervention related to checking functionality.</p> <p>1. Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 06/08/13 with diagnoses of Senile Psychosis, Atrial Fibrillation, and Orthostatic Hypotension. Review of Resident #1's Significant Change in Status Minimum Data Set (MDS) assessment, completed on 08/20/15, revealed the facility assessed Resident #1 with a score of eleven (11) of fifteen (15) on the Brief Interview for Mental Status (BIMS) assessment meaning the resident was not interviewable. The facility also assessed the resident as needing the extensive assistance of one with transfers, personal hygiene, and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when moving from a seated to a standing position, walking, moving on and off the toilet and surface to surface, such as between the bed and chair or chair to wheelchair.</p> <p>Review of the Comprehensive Care Plan for Resident #1 revealed the facility developed a plan of care for falls and assistance with activities of daily living on 08/26/15, with updated goals and target dates for 11/26/15. Problems on the care plans stated the resident was at a risk for falls related to weakness, history of falls and the need for extensive assistance with activities of daily living, transfers and mobility. The goals stated the resident would stay free of falls, in order to be as independent as possible, while keeping the resident safe and comfortable. The approaches stated staff would provide assistance with</p>	F 282			

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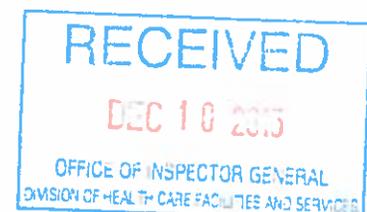
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F 282	<p>Continued From page 39</p> <p>activities of daily living and the assistance of one with transferring and mobility. Staff would keep the call light within the residents' reach and check on the resident frequently. The resident used a bed and chair alarm for safety and staff would check it for functionality every shift and if they heard it alarm they were to check on the resident to ensure their safety.</p> <p>Review of the Fall Event Form, dated 05/07/15, revealed Resident #1 had a fall on 05/07/15 with no injuries. The plan of care was revised to include the use of a bed/chair alarm and to check it for placement and functionality every shift.</p> <p>Review of the Fall Event Form, dated 09/07/15 at 4:04 AM, revealed the resident experienced an unwitnessed fall with injuries. The form noted the resident's mental status was at baseline; which was confused and forgetful, but able to recall their name. The form noted there were no possible contributing factors to the fall and the immediate measures taken to prevent another fall was to use a bed alarm; even though one was already in place at the time of the fall. The form also noted the outcome of interventions as "No Interventions Used".</p> <p>On 10/02/15 at 8:44 AM, interview with Certified Nursing Assistant (CNA) #1, revealed Resident #1 required the assistance of one to transfer and ambulate. She stated the resident had a bed and chair alarm and staff had to check it for placement and functionality every shift. She stated she had checked on Resident #1, around 12:00 AM on 09/07/15 but she did not check the bed alarm or look to see if the call light was within reach. She stated around 3:45 AM she heard Resident #1 yelling for help and went to</p>	F 282			

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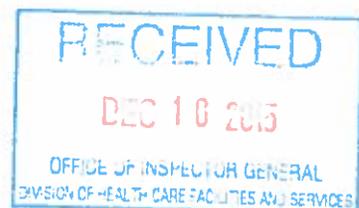
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F 282	<p>Continued From page 40</p> <p>investigate. She stated it was determined the resident's call light was not within reach and the bed alarm was turned off. She stated following the resident's plan of care related to ensuring the resident's call light was within reach and the bed alarm was functioning was part of meeting the resident's care needs.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 10/02/15 at 9:30 AM, revealed she was off the unit using the bathroom when the resident fell while attempting to transfer without assistance. She stated she did not check the bed alarm for functionality prior to the fall because she had all shift to check it. She stated she did not check it after the fall because she was tending to the resident's needs. She stated the resident sustained a cut to the eye and cheek area and began to have breathing trouble and Emergency Medical Services were contacted to transport the resident to the hospital.</p> <p>On 10/05/15 at 2:00 PM, interview with the Director of Health Services (DHS), revealed the facility determined the cause of Resident #1's fall with injury was due to the resident not using the call light to ask staff for assistance. She stated Resident #1's care plan directed staff to make sure the call light was in reach, nursing staff would check the bed/chair alarm every shift for functionality and placement, and staff would frequently check on the resident. The DHS stated although interviews conducted after the fall determined Resident #1's call light was not within reach, the bed alarm had not sounded, and staff was not available to provide frequent supervision; the facility did not identify, staff had not followed the resident's care plan interventions. She stated care plan interventions should be followed to</p>	F 282			



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F 282	<p>Continued From page 41 ensure resident safety.</p> <p>On 10/05/15 at 2:40 PM, interview with the Interim Executive Director, revealed the interviews and statements obtained from staff were not taken into account. She stated the facility determined the root cause of the fall was the resident frequently did not use the call light to ask for assistance prior to transferring. She stated the facility did not determine the staff failed to follow the care plan interventions related to ensuring bed alarm functionality, call light kept in reach or checking on the resident frequently; even though interviews and written statements obtained stated the bed alarm did not sound. In addition, interviews and statements indicated the bed rail was in the down position with the call light attached and not within reach of the resident.</p> <p>On 10/05/15 at 3:20 PM, interview with the Executive Director, revealed he had briefly reviewed Resident #1's incident/event file after he began his employment on 09/21/15. He stated after reviewing the event he did not provide any further direction to staff to determine if there was a system issue with not following care plan interventions. He stated if he had conducted the investigation and determined the bed alarm did not sound he would have directed staff to conduct an audit of the alarms to determine if staff were ensuring they were functional at all times. He stated if he had determined the call light had not been in reach of the resident he would have conducted audits of call light accessibility. He stated if he had determined staff was not available to meet the needs of the resident he would have looked into that also. He stated following the resident's plan of care was the responsibility of all staff to ensure resident safety.</p>	F 282			



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F 282	<p>Continued From page 42</p> <p>2. Review of Resident #12's clinical record revealed the facility admitted the resident on 06/12/15 with diagnoses Difficulty Walking, Weakness, Pneumonia and Respiratory Failure. Review of Resident #12's Annual Minimum Data Set (MDS) assessment, completed on 06/19/15, revealed the facility assessed Resident #12 with a score of six (6) of fifteen (15) on the Brief Interview for Mental Status (BIMS) assessment meaning the resident was not interviewable. The facility assessed the resident as needing the limited assistance of one to transfer and to ambulate. In addition, the resident required the extensive assistance of one with dressing and toileting. The facility assessed the resident's balance as not steady and only able to stabilize with staff assistance when walking, turning around or moving on and off the toilet and from bed to chair or wheelchair.</p> <p>Review of the Comprehensive Care Plan for Resident #12 revealed the facility developed an admission safety plan of care on 06/13/15 with interventions to ensure the call light remained accessible, staff would provide assistance for transfers and ambulation, and would observe the resident for compliance with safety interventions.</p> <p>Review of Resident #12's Fall Circumstance Event Form, dated 08/04/15 at 11:37 PM, revealed the resident sustained an unwitnessed fall with injury. Nursing documented the resident stated he/she tried to get up from the potty chair and fell. The nursing assessment revealed the resident had swelling and an abrasion with bleeding to the nose. The Event Report documentation revealed there were no possible contributing factors present at the time of the fall.</p>	F 282			

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F 282	Continued From page 43 Interviews on 10/26/15 with CNA #9 at 2:05 PM, CNA #11 at 2:15 PM, and CNA #5 at 2:30 PM revealed they did not recall Resident #12's fall incident; however, stated following residents care plan interventions would be important to maintain their safety. Interview with the Registered Nurse (RN) #4, on 10/15/15 at 2:45 AM, revealed the facility had just started the new Electronic Medical Record (EMR) and she was still learning how to navigate through the computerized medical record. She stated she had not looked at Resident #12's care plan and did not know where to locate it in the new EMR. She stated she depended on shift to shift report for resident care information and review of the Medication and Treatment Administration Records to tell her the care needs of the resident. She stated following care plan interventions was important to meet the needs of the resident. Interview with the Assistant Director of Health Services, on 10/27/15 at 11:30 AM, revealed Resident #12 always tried to get up without assistance. He stated according to the plan of care the resident required assistance with transferring and used a bedside commode when toileted. He stated the resident preferred to have the bedside commode placed across the room from the bed close to the bathroom door. He stated the plan of care directed staff in the care needs of the resident and staff should have provided assistance with transferring. 3. Review of the clinical record for Resident #5, revealed the facility admitted the resident on 03/05/14 with diagnoses of Dementia, Anxiety,	F 282			

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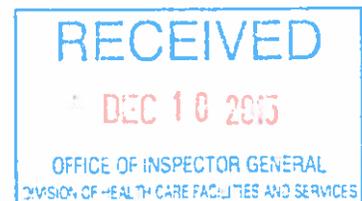
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F 282	<p>Continued From page 44</p> <p>Depression, Seizure Disorder, Hypertension, Transient Cerebral Ischemic Attack, Diabetes Type 2, and Anemia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/05/15, revealed the facility assessed Resident #5 with a score of five (5) of fifteen (15) on the Brief Interview for Mental Status (BIMS) assessment, which meant the resident could not be interviewed. The facility also assessed the resident as needing the extensive assistance of one with transfers, bed mobility and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when: moving from a seated to standing position, moving on and off the toilet and from surface to surface.</p> <p>Review of the updated Comprehensive Care Plan, dated 08/19/15, revealed the resident was at risk for falls related to the need for extensive assistance with most Activities of Daily Living (ADL's), a history of falls, and the use of psychotropic medications. In addition, the resident had a care plan developed for safety and the need for assistance with transferring. The goal related to fall prevention, stated the resident would be free from falls during their stay at the facility. The goal related to activities of daily living stated the resident would be as independent as possible with ADL's. The goal related to safety stated the use of the chair/bed alarm would alert staff of the resident's need for assistance. The approaches directed staff to provide assistance with transfers, and check the bed/chair alarm for placement and functionality every shift.</p> <p>Review of the Fall Event Report, dated 07/11/15 at 4:12 PM, revealed Resident #5 sustained an</p>	F 282		
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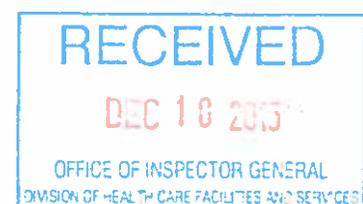
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F 282	<p>Continued From page 45</p> <p>unwitnessed fall and was lying on his/her back on the bathroom floor next to the wheelchair. The chair alarm had not sounded and the resident was unable to explain what he/she was doing due to cognition.</p> <p>Interview with the Registered Nurse (RN) #2, on 10/15/15 at 3:15 PM, revealed she completed Resident #5's Fall Circumstance Event Form after the fall on 07/11/15. RN #2 stated after Resident #5 sustained the unwitnessed fall in the bathroom she had determined the chair alarm was broken. She stated typically nursing staff checked the alarms at the beginning of their shift for placement and functionality. However, she could not remember if she had checked the alarm for functionality or placement on 07/11/15, per the plan of care. RN #2 stated she was not responsible for determining if staff followed care plan interventions.</p> <p>Observation of Resident #5's UMP bed alarm pad, on 10/02/15 at 2:20 PM, revealed the pad did not have a date written on the label that informed staff when it expired or was put in service.</p> <p>Interview and observation with CNA #4, on 10/02/15 at 2:20 PM, revealed Resident #5 was care planned for being at risk for falls and used a bed/chair alarm to alert staff if they attempted to transfer without assistance. She stated staff were responsible for checking it for placement and functionality every shift as part of the plan of care. She stated the resident had a pad on the bed; however, did not know the pad was undated. Observation revealed CNA #4 removed a black marker from her pocket and wrote 10/02/15 on the pad. She stated following resident care plan</p>	F 282			

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F 282	<p>Continued From page 46</p> <p>interventions ensured resident needs were met.</p> <p>Interview with LPN #4, on 10/02/15 at 2:30 PM, revealed Resident #5 was at risk for falls and had a care plan intervention that directed staff to check the alarm for placement and functionality every shift. She stated dating the pad was part of the process. She did not know Resident #5's pad had not been dated and believed all pads in the facility were good for 90 days. She stated following the care plan interventions related to the alarms ensured staff would meet the needs of the resident.</p> <p>Interview with the DHS, on 10/05/15 at 2:00 PM, revealed Resident #5 was at risk for falls and had care plan intervention that required staff to check on the resident frequently, provide assistance with transferring, and to check the bed/chair alarm for placement and functionality. She stated staff should date the alarm pads with an expiration date to ensure functionality. She stated it was her expectation that staff follow the resident's care plan interventions to ensure resident needs were met.</p> <p>4. Review of the clinical record for Resident #2 revealed the facility admitted the resident on 12/16/14 with diagnoses of Depression with Delusions, Dementia, Cerebral Vascular Accident, and Weakness.</p> <p>Review of Resident #2's Quarterly Minimum Data Set (MDS) assessment, completed on 09/29/15, revealed the facility assessed Resident #2 with a score of four (4) of fifteen (15) on the Brief Interview for Mental Status (BIMS) assessment meaning the resident was not interviewable. The facility also assessed the resident as needing the</p>	F 282			



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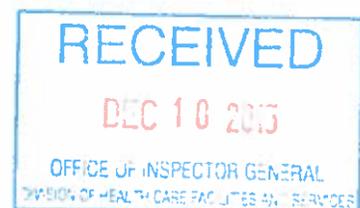
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F 282	<p>Continued From page 47</p> <p>extensive assistance of one with transfers, personal hygiene, and toileting. The facility assessed the resident's balance, as not steady on their feet, and only able to stabilize with staff assistance when: moving from a seated to standing position, walking, moving on and off the toilet and from surface to surface.</p> <p>Review of the care plan, dated 07/15/15, revealed the facility developed care plans related to fall risk, dehydration and resident's history of Urinary Tract Infections (UTI) with updated goals and target dates for 10/15/15.</p> <p>The care plan stated the resident was at a risk for falls and needed extensive assistance with activities of daily living, transfers and mobility due to weakness. The goal related to falls stated the resident would stay free of falls, in order to be as independent as possible, while keeping the resident safe and comfortable. The approaches stated staff would check the placement and functionality of the bed and chair alarm every shift, in addition to keeping the call light and frequently used items within easy reach of the resident.</p> <p>The care plan related to UTI's stated the resident was at risk for dehydration related to history of UTI's. The goal related to dehydration, activities of daily living and UTI's stated the resident would improve the current level of self-care, and have no UTI's. Interventions for the history of UTI's and potential for dehydration directed staff to keep fresh ice water within reach of the resident and to encourage the resident to drink fluids as tolerated.</p> <p>Observations, on 10/13/15 at 10:40 AM, on</p>	F 282			

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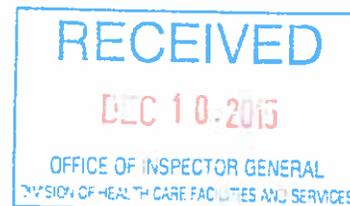
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F 282	<p>Continued From page 48</p> <p>10/14/15 at 8:00 AM, on 10/14/15 at 10:00 AM, revealed Resident #2 was in bed and the water pitcher or fluids and cup was not within reach of the resident.</p> <p>Interview with CNA #3, on 10/14/15 at 11:30 AM, revealed Resident #2 had a current Urinary Tract Infection (UTI) and was in isolation precautions because of the infection. She stated she did not know the resident's water pitcher had not been within reach and thought maybe someone had moved the bed side table and just did not put it back within reach of the resident. She stated again she did not have time to read all of her resident's plans of care in the computer. But it was important to follow the plan of care to have fluids within reach of Resident #2 due to his/her current UTI.</p> <p>Interview with LPN #7, on 10/16/15 at 12:00 PM, revealed Resident #2 had a Urinary Tract Infection and staff were to ensure fluids were within reach of the resident according to the care plan. She stated following care plan interventions would meet the resident's care needs related to the infection and if not followed the resident's condition could get worse.</p> <p>Observation of Resident #2, on 10/01/15 at 12:45 PM and 1:18 PM, revealed the resident was sitting on the bed and the resident's call light cord was wrapped around the bottom of the bed rail and not within reach of the resident during each observation. In addition, observations of the Posey bed alarm unit revealed the light was not blinking to tell you the unit was turned on.</p> <p>Observation, on 10/01/15 at 3:00 PM, revealed Resident #2 was sitting in a recliner next to the</p>	F 282			



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F 282	<p>Continued From page 49</p> <p>bed and both call lights were located on the bed and not within reach of the resident.</p> <p>Interview with CNA #3, on 10/01/15 at 1:22 PM and 10/02/15 at 2:35 PM, revealed she did not know how Resident #2's bed rail had gotten in the down position; preventing the resident from having access to the call light. She stated the call light should always be accessible to the resident, per the plan of care, for the resident to make staff were aware of their needs.</p> <p>Continued observation of Resident #2 being assisted to the bathroom from the bed, on 10/01/15 at 1:18 PM by CNA #3, revealed a small blue rectangular pad was underneath the resident and no alarm sounded from the unit attached to it when the resident was assisted up from the bed.</p> <p>Interview with CNA #3, on 10/01/15 at 1:22 PM, revealed Resident #2 was at risk for falls and had bed/chair alarms in place as part of their plan of care. She stated the alarm system alerted staff when a resident attempted to transfer without assistance. She stated the pad should cause the alarm to go off when the resident got up from the bed and said it probably was malfunctioning. She stated the pad should also have a date of expiration written on it, but it did not. She stated staff had the responsibility of dating the pad, with the date it expired, after removing it from its packaging. She stated this process was part of the resident's plan of care and should be followed to ensure their safety.</p> <p>Interview with LPN #7, on 10/01/15 at 1:25 PM, revealed she had not checked Resident #2's bed/chair alarm for functionality only for placement. She stated the certified nursing</p>	F 282			



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F 282	<p>Continued From page 50</p> <p>assistants checked for functionality when they got the resident up or transferred them. She stated checking for placement and functionality was a part of the resident's plan of care and interventions should be followed to ensure resident safety.</p> <p>Interview with the DHS, on 10/05/15 at 11:45 AM, revealed she expected staff to ensure resident call lights were accessible at all times, fluids were within reach and the bed/chair alarms were checked for placement and functionality every shift to maintain resident safety. She stated following care plan interventions ensured resident needs were met.</p> <p>5. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 09/02/15, with diagnoses of Parkinson, Hypertension, Dementia and history of Chronic Deep Vein Thrombosis.</p> <p>Review of Resident #6's Admission Minimum Data Set (MDS) assessment, completed on 09/09/15, revealed the facility assessed Resident #6 with a score of eight (8) of fifteen (15) on the Brief Interview for Mental Status (BIMS) assessment meaning the resident was interviewable. The facility also assessed the resident as needing the extensive assistance of one with transfers, walking, and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when: moving from a seated to standing position, walking, moving on and off the toilet and from surface to surface.</p> <p>Review of the Comprehensive Care Plan for Resident #6 revealed the facility developed a plan</p>	F 282			

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F 282	<p>Continued From page 51</p> <p>of care for falls on 09/15/15 with updated goals and target dates for 12/15/15. The goal stated the resident would have no falls with major injury. The approaches directed staff to check for bed/chair alarm placement and functionality every shift, check on the resident frequently and to keep the call light within reach.</p> <p>Review of the Physician order obtained on 10/02/15, revealed the resident had a bed/chair alarm and the order directed staff to check for placement and functionality every shift.</p> <p>Observation, on 10/02/15 at 2:20 PM, revealed Resident #6's bed alarm did not have a date of expiration written on it to make staff aware when the pad needed to be discarded.</p> <p>Interview, on 10/02/15 at 2:20 PM, with CNA #6 revealed part of the plan of care for Resident #6 was to mark the alarm pad with an expiration date. She stated a new pad was put in place; however she had forgot to mark the alarm pad with the date of expiration after taking it out of the package and placing it on Resident #6's bed. She stated it was important to follow the resident's plan of care and marking the pad was a part of the plan.</p> <p>Interview with LPN #4, on 10/02/15 at 2:30 PM, revealed Resident #6 had been ordered a bed/chair alarm and the nursing aides usually were the ones to put them in place. She stated when an order for the use of a bed/chair alarm was received the care plan had an update made to it that directed staff to check for placement and functionality every shift. She stated she believed all the pads in the facility were good for ninety (90) days. She stated she was not aware CNA #6</p>	F 282			

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F 282	<p>Continued From page 52</p> <p>did not mark the pad after opening. She stated following care plan interventions for falls and the use of the alarms, would maintain resident safety.</p> <p>Interview with the DHS, on 10/16/15 at 3:00 PM, revealed if a resident had a bed/chair alarm it was the responsibility of staff and part of the plan of care to check for placement and functionality. She stated if staff did not follow care plan interventions, resident care needs would not be met.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 10/22/15 and took the following actions to remove the Immediate Jeopardy on 10/23/15:</p> <ol style="list-style-type: none"> 1. The facility conducted a review of the sixty-three (63) current residents' care plans from October 12-20, 2015 by the Minimum Data Set (MDS) nurses to ensure care plan interventions were current. Eight (8) care plans required revision. Change in condition (including falls) will be reviewed with care plan revision as needed during the Clinical Care Meeting. The Director of Health Services will be responsible for overseeing the meetings with follow up on events that have occurred within the last twenty-four (24) hours. Education was provided for the Interdisciplinary Team (Administrative Nurses, Social Services, Activities, Therapy Director, and MDS Nurses on 10/19/15 by the Assessment Support Nurse and the External Audit Nurse. 2. A Care Plan Audit tool was developed and will be used to ensure care plans are reviewed and revised during the Clinical Care Meeting (Monday-Friday) and weekend days by the Director of Health Services, Assistant Director of 	F 282			

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F 282	<p>Continued From page 53 Health Services, or MDS Nurse.</p> <p>3. A Profile binder with current safety interventions (based on the care plan) for each resident was placed on each unit, on 10/21/15, for the nursing aides. The binders will be updated daily after the Clinical Care Meeting by the MDS or Medical Records. Audits will be completed daily.</p> <p>4. Charge Nurses will round daily during the Medication Pass to observe for compliance with safety interventions according to the plan of care. Audits will be conducted on the first and second shift and Night Shift Nurses will conduct routine rounds that included observing for safety interventions for five (5) random residents.</p> <p>5. Falls will be reviewed during the weekly Clinical at Risk meetings to ensure effective interventions are in place. Residents who sustained a fall will be followed in these meetings for four (4) weeks.</p> <p>6. Safety Device audits (five residents per day) will be conducted daily by department leaders, on random shifts, to ensure devices are in place and functioning.</p> <p>7. An audit was conduct on 10/18/15 of each resident's medical record to ensure proper information related to Advance Directives were in the Soft File at each unit. Advance Directives information will be obtained at admission with appropriate papers signed and placed into the Soft File at each unit. This would include each resident's code status.</p> <p>8. Education for the Executive Director, Medical</p>	F 282			

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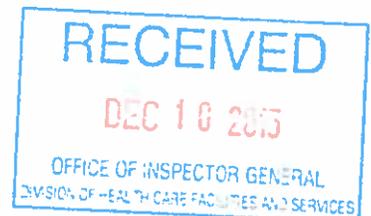
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F 282	<p>Continued From page 54</p> <p>Record Staff, Director of Health Services and her assistant, and Social Services were completed on 10/19/15, by the Clinical Director, of the importance of maintaining the integrity of medical record and Advance Directives information being available for Charge Nurses in the event of a resident was transferred to the hospital.</p> <p>9. Scanning guidelines will be followed based on protocols for the Electronic Health Record. Daily audits will be conducted by the DHS, ADHS, MDS, and Medical Records to ensure completion of all admission records and Advance Directive information placed into the Soft Files. These audits will be reviewed during the daily Clinical Care Meeting.</p> <p>10. A Quality Assurance (QA) Meeting was conducted on 09/18/15 to review Falls Trending. Another QA meeting was held on 10/19/15 with the Medical Director in attendance to review the Guidelines and protocol for conducting Quality Assurance Meetings.</p> <p>11. Education was provided by the Clinical Director to the Executive Director, Director of Health Services and her assistant, and other department leaders that included issues of fall management, Advance Directives, and monitoring of care plans. Corrective plans were developed based on trends prevalent in a system not in compliance. Action plans developed with focus on goals and protocols for Clinical Care Meeting and its direct relationship to Quality Assurance activities.</p> <p>12. Audits implemented will be reviewed during the monthly QA meeting and during the Clinical Support Nurse's routine visits that occur once a</p>	F 282		



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F 282	<p>Continued From page 55</p> <p>week. Audits included Safety Device, Advance Directive, and Soft files, Clinical Care Meetings, Clinical at Risk Meetings, Care Plans, and QA.</p> <p>The State Survey Agency (SSA) validated the implementation of the facility's AOC as follows:</p> <ol style="list-style-type: none"> Record review revealed Residents #5, #8, #10, #13, and #19 care plans were revised. Resident #20 was sampled during the extended survey due to being the only resident with a fall since the alleged Immediate Jeopardy abatement date of 10/23/15. The resident's care plan was reviewed during the Clinical Care Meeting and revised as needed. <p>Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, revealed the Interdisciplinary team received training on care plan revision and implementation. She stated she was responsible for overseeing the Clinical Care Meetings and ensured the care plan was revised and all events received follow-up monitoring to ensure the event reports were completed. In addition, she randomly reviewed one-two care plans daily to ensure completion.</p> <ol style="list-style-type: none"> Sampled Resident #20's fall (10/25/15) was discussed in the Clinical Care Meeting and revision of the care plan was completed. Review of the care plan audits revealed revision of the care plans were occurring after an event or change in the resident. Review of the sampled residents for the extended survey revealed the care plan had been revised after a change in the resident's status to include falls. Observation of the 400, 500, and Health Care 	F 282			



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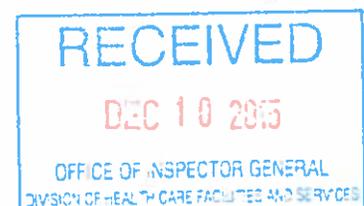
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F 282	<p>Continued From page 56</p> <p>Units, on 10/27/15 at 11:30 AM and again at 4:00 PM, revealed Profile Binders at each unit that included specific information about each resident including code status. Observation on 10/27/15 at 4:35 PM, revealed staff updating the Profile Binder on the Healthcare Unit. Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, validated the binders are updated after the Clinical Care Meetings with any new care plan interventions. The MDS Nurses were at a training offsite and unavailable for Interview during the extended survey.</p> <p>4. Observation, on 10/28/15 at 10:00 AM, (on the 500 Unit) revealed the nurse was conducting rounds in the residents rooms during the medication pass for safety devices and call light placement.</p> <p>Interviews with LPN #5, on 10/26/15 at 4:00 PM, LPN #12 on 10/27/15 at 11:15 AM, and LPN #6 on 10/28/15 at 9:00 AM, revealed the nurses conducted walking rounds to check for safety devices and call lights at the beginning of the work shift and again when they administered medications. Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, revealed she had randomly observed walking rounds between the nursing aides and nurses giving report.</p> <p>Review of the safety devices/call light audits revealed at least five (5) residents were observed daily for safety device and call light placement and proper functioning of the devices.</p> <p>5. Review of the Fall Circumstance Event Report for Resident #20, revealed the fall was discussed in the Clinical Care Meeting. Audits revealed Resident #20 was included. Interview with LPN</p>	F 282			

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F 282	<p>Continued From page 57</p> <p>#5, on 10/26/15 at 4:00 PM, revealed the resident slid from the bed and experienced no injury.</p> <p>Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, Executive Director, on 10/28/15 at 3:00 PM, and Clinical Director, on 10/29/15 at 12:00 PM, revealed all falls and any change in condition were discussed during the Clinical Care Meetings. Review of the audits revealed the meetings were held on October 21, 22, 23, 26, and 27. A meeting was held on 10/28/15 at 10:00 AM and validated by observation of the SSA.</p> <p>Review of the Changes in condition, including fall investigation and root cause analysis will be discussed during the Clinical Care Meetings. The Fall Circumstance Event Reports are reviewed for completion and ensure appropriate safety interventions had been implemented to reduce the risk of future falls.</p> <p>6. The facility reviewed all safety devices and conducted assessments with some safety devices discontinued. There were seven (7) residents with safety devices during the extended survey. Review of the audits revealed five (5) or more residents were audits to ensure safety devices were in place and functioning.</p> <p>7. Review of the Soft Files for the 500, 400, and Health Care Units revealed each resident had been offered Advance Directives and each resident had a code status. These forms were scanned into the electronic record and the original signed form was kept in the Soft File at each unit.</p> <p>Interview with the Medical Record Director, on</p>	F 282			



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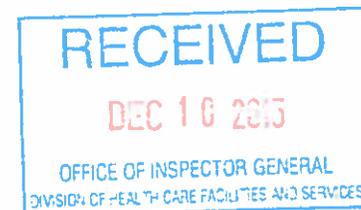
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F 282	<p>Continued From page 58</p> <p>10/28/15 at 2:40 PM, revealed she had received training on the Soft Files, scanning forms into the electronic record, and maintaining the medical record. She stated she was responsible for conducting audits of new admission paperwork to ensure the code status and Advance Directive forms are signed and placed into the Soft file on each unit.</p> <p>Observation of the new admission process revealed Advance Directive forms were signed and placed into the soft file. Resident #21, #22, and #23 were sampled during the extended survey to validate the admission paperwork was completed and Advance Directive forms signed and placed into the Soft file.</p> <p>8. Review of the training record revealed education was provided on 10/19/15 as stated in the AOC. Interview with the Medical Records, on 10/28/15 at 2:40 PM, Director of Health Services, on 10/28/15 at 1:50 PM, and Social Services on 10/28/15 at 2:48 PM, revealed they had received the training.</p> <p>9. Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, revealed she received training on the scanning guidelines. She stated she now had additional staff to help with the scanning of the medical record into the electronic record. She stated audits were conducted daily to ensure scanning guidelines are followed.</p> <p>Review of the Daily Careplan audit forms, Falls Interventions audit forms, Call Light audit forms, Fall Investigation audit forms, the Safety/Assistive Device audit forms, and the Admission audit forms revealed they were all completed.</p>	F 282			

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F 282	<p>Continued From page 59</p> <p>10. Review of the QA signature sheets revealed QA meetings were held on 10/19/15 and 10/29/15. Interview with the Executive Director, on 10/28/15 at 3:00 PM, and the Clinical Director on 10/29/15 at 12:00 PM validated the QA meetings were held on those dates.</p> <p>Interview with the Clinical Director and the Clinical Support Nurse, on 10/29/15 at 12:00 PM, revealed the QA meeting on 10/19/15 was to develop the Plan of Action to correct the Immediate Jeopardy, develop audits, and capture any trends of non-compliance. The Clinical Director stated staffing was reviewed to determine if it contributed to the non-compliance and she was looking at staffing as part of the solution. She stated the facility had been given extra hours for staffing and was in the process of determining where the hours would be best spent. The Clinical Director stated the QA meeting of 10/29/15 was to review audits, and evaluate the plans of actions. She stated the audits revealed no problems and the AOC was implemented and monitored as stated. She stated the facility would continue to meet monthly and she would be at the facility almost daily to assist the new Executive Director and ensure compliance. The Clinical Support Nurse stated she would visit the facility at least twice a week and as needed to ensure the Clinical Care and Clinical at Risk meetings were conducted according to the AOC. The Clinical Director stated she would attend the monthly QA meetings for at least six (6) consecutive months.</p> <p>11. Interview with the Clinical Director, on 10/29/15 at 12:00 PM, revealed she provided the education to the Executive Director and Director of Health Services on 10/19/15. Review of the</p>	F 282			



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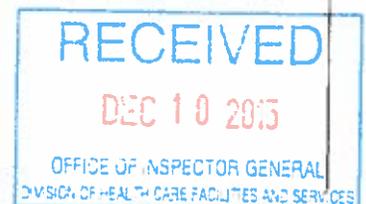
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F 282	Continued From page 60 training records validated the training. Interview with the Executive Director and Director of Health Services on 10/29/15 at 12:15 PM, revealed they received training on Advanced Directives, revision of care plans, documentation, audits, monitoring, scanning guidellines, systems related to falls, and the protocols for Quality Assurance. 12. Review of the audits revealed the facility conducted the audits as stated in the AOC. Interview with the Executive Director, on 10/28/15 at 3:00 PM, and the Clinical Director, on 10/29/15 at 12:00 PM, revealed the audits were conducted and forwarded to them for review of compliance. The audlts were brought to the 10/29/15 QA meeting to review and discuss trending.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure Physician	F 309	A Medication Error Circumstance form initiated on 7/14/15 for Resident #13. Physician and responsible party notified on 7/14/15. The Tramadol order was discontinued on7/14/15. No negative outcomes documented		

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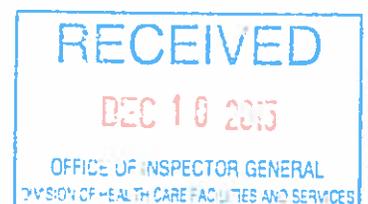
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F 309	<p>Continued From page 61</p> <p>Orders were followed for two (2) of twenty-five (25) sampled residents (Resident #13 and #16). The nursing staff administered fourteen (14) doses of pain medication to Resident #13 that was the wrong dose. Registered Nurse (RN) #5 administered one (1) dose of medication, Lasix 80 mg, to Resident #16 which was not prescribed by the physician.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Medication Orders, not dated, revealed each resident would be under the care of a licensed physician where care was provided and would be seen in accordance with regulations. Orders would be signed and dated in accordance with state regulations.</p> <p>Review of the facility's policy regarding Medication Error and Adverse Drug Reaction, revised 09/17/12, revealed in the event a significant medication error, immediate action would be taken as necessary to protect the resident's safety and welfare. The Physician would be notified promptly, and the resident would be monitored closely for twenty-four (24) to seventy-two (72) hours as directed. The incident would be documented on the shift change report to alert staff to monitor the resident.</p> <p>1. Review of Resident #13's clinical record revealed the facility admitted the resident on 07/03/15 from an acute hospital with diagnoses of Dementia, Fracture of the Left Femur that required surgical interventions, After Care of the fractured leg, Abnormal Gait, and History of Falling. Review of the hospital's discharge medications orders, dated 07/03/15, revealed an</p>	F 309	<p>for resident after 72 hour follow up.</p> <p>Resident #16 Notification of medication error was made to MD on 10/11/15. Orders were received for stat BMP lab. Lab results reflected Potassium was in normal range, creatinine slightly elevated at 1.39 and BUN normal. Orders received to encourage fluids. Responsible party was notified on 10/12/15. Lab results and orders were communicated as well. Resident #16 was discharged from the facility on 10/13/15. Orders were obtained for home health to follow and include PT/OT/ST and nursing.</p>		



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F 309	<p>Continued From page 62</p> <p>order for Tramadol 25 mg (1) every six (6) hours, as needed. Review of the prescription slip signed by the physician for Scheduled Drugs, dated 07/03/15, revealed the physician had ordered thirty (30) tablets of Tramadol 25 mg (1) every six (6) hours, as needed for pain.</p> <p>Review of the pain medication care plan, dated 07/15/15, revealed the resident would receive pain medication per physician orders.</p> <p>Review of the Medication Error Circumstance Event Report, dated 07/14/15 at 5:53 PM, revealed Resident #13 had received the wrong dose of a Scheduled IV pain medication. Review of the Electronic Medication Administration Record (MAR) for July 2015 revealed the resident received fourteen (14) doses of the medication at the wrong dose. The MAR had instructions to administer Tramadol 25 mg every six (6) hours as needed for pain.</p> <p>Interview with License Practical Nurse (LPN) #5, on 10/15/15 at 4:31 PM, revealed she was the nurse who completed the admission paperwork for Resident #13 on 07/03/15. She stated she put the admission medication orders into the computer system. However, the computer software program did not list Tramadol 25 mg, only the 50 mg dose. She said she put in the Tramadol 50 mg and provided additional comments that stated to give 25 mg instead of the 50 mg. She stated she realized later (after the medication error was discovered) she should have used Ultram 25 mg that was listed in the computer's software library. She stated once she entered the medication orders, the orders were forwarded to the contract pharmacy to fill. She stated the pharmacy did not read her comments</p>	F 309	<p>All residents have the potential to be affected by the deficient practice. Inservice, re-education and monitoring through audits to ensure execution of physician orders related to medication administration.</p> <p>Medications for all residents were reviewed and checked against MD orders to assure accuracy by pharmacy staff (consultant pharmacist and nurse) on 12/3/15 and 12/4/15.</p> <p>All nurses were educated on medication pass guidelines and documentation required for a medication error by Director of Clinical Compliance (Interim DHS) on December 8-9, 2015. Systemic changes include all nurses will</p>		



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F 309	<p>Continued From page 63</p> <p>and sent Tramadol 50 mg with orders to give one (1) tablet every six (6) hours as needed. She stated the pharmacy should have sent a half tablet of the 50 mg pill because the nursing facility nurses were not allowed to score and break tablets. Pharmacy must send the medication already broken into 1/2 tablet in a sealed packet. Review of the pharmacy manifest revealed thirty (30) tablets of Tramadol 50 mg were delivered on 07/08/15.</p> <p>A telephone interview with the Contract Pharmacist, on 10/27/15 at 2:50 PM, revealed he had investigated the medication error and found the pharmacy had sent 50 mg tablets of Tramadol instead of breaking the medication in half to equal 25 mg. He stated he discovered that not all of the safety checks at the pharmacy were followed by the Pharmacy Technician during the Pharmacist's last check of the medication. He said the Pharmacist should have scored and broke the 50 mg tablet into half tablets and packaged them separately as one dose. He stated the investigation revealed two (2) mistakes from the pharmacy. Once, when the Pharmacist Technician filled the wrong dose and then when the pharmacist failed to conduct the final check. Although the pharmacist took responsibility for the medication error, he stated the facility's nurses had been trained in the Five Rights of medication administration and should have discovered the medication error prior to administering to the resident.</p> <p>Interview with LPN #3, on 10/28/15 at 9:00 AM, revealed she discovered the medication error during the medication pass. She stated she called the resident's physician and was told to monitor the resident. LPN #3 stated the higher dose of</p>	F 309	<p>complete a medication pass competency by Director of Clinical Compliance (Interim DHS) and clinical support nurses December 8-10, 2015, and annually thereafter.</p> <p>DHS or ADHS will complete an audit of 3 residents medication pass daily to ensure MD orders are followed 5 times a week for one month then 3 times a week for a month then weekly with results forwarded to the QA committee monthly for 6 months and quarterly thereafter for review and further suggestions/comments.</p> <p>Completion date 12/10/15</p>		



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F 309	<p>Continued From page 64</p> <p>pain medication actually helped the resident so the physician ordered Tramadol 50 mg (1) every six (6) hours as needed for pain. The nurse stated she entered the medication error into the Event Report and the medication error should have been discussed during the morning Clinical Care Meeting. She stated she informed the DHS of the medication error. LPN #3 stated she could not recall any training provided after the medication error was discovered.</p> <p>Interview with the (Director of Health Services) DHS, on 10/16/15 at 9:50 AM, revealed the medication error was reported, but she could not recall if the Event Report was discussed in the Clinical Care Meeting the next day. She reviewed the Medication Error Circumstance Event Report and stated it must have been discussed because the Interdisciplinary Team documented they had reviewed and she had closed out the event. She said she had spoken with the Pharmacist and discovered the pharmacy had sent Tramadol 50 mg tablet instead of a half tablet to equal 25 mg. She stated nurses are taught to conduct the Five Rights of administering medication and the right dose was included. She stated the nurse who administered the first dose of the medication should have picked up that the medication was the wrong dose. She stated there had been no additional training provided to the nurses except talking with the nurses about the medication error.</p> <p>2. Review of the clinical record for Resident #16 revealed the facility admitted the resident on 10/01/15 with diagnoses of Intestinal Obstruction, Chronic Kidney Disease Hypokalemia and Parkinson Disease. Review of the Comprehensive Minimum Data Set (MDS)</p>	F 309			

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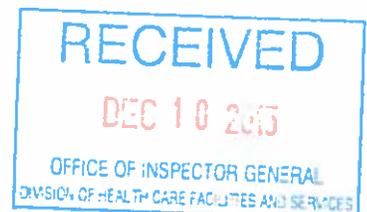
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F 309	<p>Continued From page 65</p> <p>Assessment, dated 10/08/15, revealed the facility assessed the resident's cognition using the Brief Interview for Mental Status, (BIMS) test and determined the resident was cognitively intact with a BIMS score of thirteen (13) out of possible fifteen (15) meaning the resident was interviewable.</p> <p>Review of the Physician's orders for Resident #16, revealed an order was entered on 10/09/15 for Lasix (a diuretic) eighty (80) milligrams (mg) two (2) times a day and discontinued on 10/09/15. A second order was entered for Lasix eighty (80) mg two (2) times a day on 10/09/15 and was discontinued on 10/10/15.</p> <p>Review of the Medication Administration Record (MAR) for Resident #16, revealed Lasix eighty (80) mg was to be administered two (2) times a day starting on 10/09/15 and the medication was discontinued on 10/10/15. The resident received the morning dose on 10/10/15 and refused the evening dose.</p> <p>Review of the Event Report- Medication Error Circumstance for Resident #16, revealed Registered Nurse (RN) #5 recorded, on 10/12/15 at 12:28 AM, that Resident #16 received one (1) dose of Lasix eighty (80) mg on 10/10/15 in the AM. A second dose was written for bedtime that was not given due to the time and the resident refused the medication. The medication was discontinued for further investigation and was found that it was not indicated for this resident, but for another resident. That resident did receive the medication. The report stated the resident's physician was not notified until 10/11/15 at 4:28 PM. Stat labs were ordered and the results were called to the Nurse Practitioner. The</p>	F 309			

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F 309	<p>Continued From page 66</p> <p>resident's Potassium was within normal limits with the Creatinine slightly elevated at 1.39 from the previous level. The Nurse Practitioner gave orders to encourage fluids and draw labs on 10/14/15. The family was not notified until 10/11/15, after they questioned staff about the medications.</p> <p>Observation, on 10/13/15 at 11:45 AM, revealed Resident #16 in his/her room. The resident was able to communicate but was difficult to understand. The resident's granddaughter was in the room and repeated what the resident was trying to say. Resident #16's family transferred the resident to another facility.</p> <p>Interview with the responsible party of Resident #16, on 10/13/15 at 12:45 PM, revealed the resident called the responsible party on Saturday, 10/10/15, and told them there was an extra pill with his/her morning medications. The responsible party stated the resident questioned staff as to why he/she was urinating so much and refused the dose scheduled for that Saturday evening. The responsible party stated they came in on Sunday and questioned RN #5 about the medications, and RN #5 told them the resident had received Lasix eighty (80) mg that was not prescribed for him/her by the physician. The nurse stated she had discovered the medication error on Saturday evening. The responsible party stated they were not notified about the medication error until they questioned staff that day. In addition, the physician was not notified until Sunday afternoon, 10/11/15, with labs ordered stat.</p> <p>Interview with RN #4, on 10/13/15 at 3:38 PM, revealed she had worked at the facility for two (2)</p>	F 309			



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F 309	<p>Continued From page 67</p> <p>months. She stated she was trained on the electronic medical record and how to enter physician orders. She stated the nurse who took off the orders also signed off the orders. RN#4 stated she created the order for the Lasix on 10/09/15 at 10:23 PM and realized it was the wrong resident and discontinued the medication on 10/09/15 at 10:31 PM. She stated somehow a second order was put in, but she denied putting the order in the system. She stated the computer must have had a glitch. RN #4 stated RN #5 called her on Saturday night and asked her about the Lasix and she told her it was not ordered for Resident #16.</p> <p>Interview with RN #5, on 10/14/15 at 11:19 AM, revealed she was passing medication on Saturday night, 10/10/15. When she took the medications in to Resident #16's room, she explained Lasix was not usually given at bedtime and then the resident refused to take the medication. She said she called RN #4 that evening and the nurse told her Resident #16 was not to receive that medication. She stated RN #4 told her not to report the medication error, so she didn't fill out the Event Occurrence. She stated she failed to notify the Director of Health Services (DHS), the Physician, or family upon discovery of the medication error. She stated she knew the resident was clinically stable, but the risk could be dehydration.</p> <p>Interview with the DHS, on 10/15/15 at 10:05 AM, revealed she was not notified of the medication error for Resident #16 until Sunday 10/11/15, around 5:30 PM. She stated RN #5 told her she found the error on Saturday evening, but when she called RN #4, she had begged her not to report the error. The DHS stated she instructed</p>	F 309			

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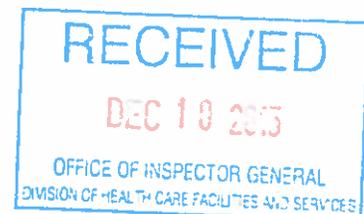
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F 309	Continued From page 68 RN #5 to complete an event occurrence, call the physician and notify the responsible party. She stated staff had been trained on what to do when a medication error had been discovered. She stated the process for checking new orders was to verify the medications in the next Clinical Care Meeting. The DHS stated Resident #16's medications would not have had a second check until Monday, 10/12/15.	F 309		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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: Based on observation, interview, record review and review of the manufacturer's guidelines and the facility's policy, it was determined the facility failed to have an effective system in place to ensure staff provided adequate supervision to prevent accidents. In addition, the facility failed to ensure the facility's bed/chair alarms were used in accordance with the manufacturer's recommendations, and failed to complete the Fall Circumstance forms and/or determine the root cause for the falls. The facility's failure affected ten (10) of twenty-five (25) sampled residents. (Residents #1, #2, #5, #6, #8, #9, #10, #11, #12 and #13).	F 323	Resident #1 was discharged to hospital on 9/7/15. Resident #2 sustained a skin tear of unknown origin. MD and responsible party were notified on 9/7/15 by charge nurse. Treatment orders obtained and implemented to cleanse with normal saline and apply triple antibiotic ointment. Other interventions included geri sleeves to prevent further injuries. Resident had fall on 7/1/15. Upon investigation by IDT, it was determined that the fall was witnessed while resident was attempting to close blinds. Staff could not get to the resident	



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F 323	<p>Continued From page 69</p> <p>On 09/07/15, Resident #1 sustained an unwitnessed fall that resulted in injury and transfer to the hospital. Review of the Emergency Room record, dated 09/07/15, revealed the resident sustained a 2.5 centimeter laceration to the cheek/eye area, two rib fractures and a Flailed Chest injury (a life threatening medical condition that occurs when a segment of the rib cage breaks under extreme stress and becomes detached from the rest of the chest wall, so a part of the chest wall moves independently). Review of the Death Summary, dated 09/07/15, revealed the resident passed, thirteen (13) hours after the fall on 09/07/15, due to the injuries sustained from the fall which led to respiratory failure. Staff stated they were busy off the unit or tending to other residents on another hall when Resident #1 fell. Additional interview with staff revealed the bed alarm unit was not turned on and the resident's call light was not within reach at the time of Resident #1's fall.</p> <p>On 09/30/15 Resident #10 sustained an unwitnessed fall. The staff found the resident on the floor complaining of back pain. The resident told the staff he/she had attempted to get to their walker; however, the walker tipped over and the resident fell. Emergency Medical Services was called and transferred the resident to the hospital. Hospital x-ray results revealed a thoracic compression fracture at T9. The resident continued to have severe pain and muscle spasms and a back brace was ordered.</p> <p>On 09/09/15 Resident #9 sustained an unwitnessed fall. The resident was found on the floor by the resident's son. The resident's right foot was bleeding and the resident continued to be extremely confused. The resident's bed alarm</p>	F 323	<p>to prevent the fall. Therapy screened and resident condition did not indicate skilled therapy services necessary. Care plan and profile updated to reflect current. Resident has had no additional falls with current interventions.</p> <p>Resident #5 experienced fall on 7/1/15, 8/11/15, 8/19/15, 8/20/15. Physician and responsible party notification made at the time of the events. New intervention for the 7/1 fall included replacement of alarm. 8/11 intervention included toileting every 2 hours. 8/19 intervention included increased observation and monitoring. Interventions for 8/20 Included</p>		



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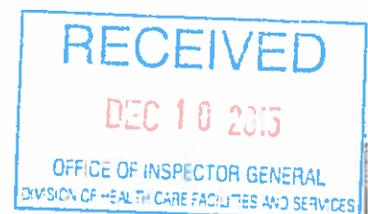
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F 323	<p>Continued From page 70</p> <p>was noted on the floor and non-functioning with a tear in the wiring. The family transported the resident to the hospital for evaluation and the resident required ten (10) sutures to the right foot, underneath and between the fourth and fifth toes. The hospital X-ray results revealed a closed non-displaced transverse fracture of the right fifth metatarsal.</p> <p>On 08/04/15 Resident #12 sustained an unwitnessed fall with injury. The resident reported he/she tried to get up from the potty chair and fell. The resident had swelling and an abrasion with bleeding to the nose. The Event Report revealed there were no possible contributing factors present at the time of the fall. The resident returned from the hospital with a diagnosis of a nasal fracture.</p> <p>In addition, the facility failed to ensure staff provided assistance to residents for toileting to prevent falls for Residents #11 and #13 and failed to monitor and follow the manufacture's recommendations for use of sensor pads for Residents #2, #5, and #6.</p> <p>The facility's failure to have an effective system in place to ensure adequate supervision to prevent accidents has caused or is likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was determined to exist on 09/07/15.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 10/22/15 which alleged removal of the Immediate Jeopardy on 10/23/15. The State Survey Agency verified Immediate Jeopardy was removed on 10/23/15 as alleged prior to exit on 10/29/15. The scope and severity was lowered to an "E" at F323, while the facility</p>	F 323	<p>continuing observation. Therapy screened after each fall. For 8/11, fall IDT determined root cause to be resident being left unattended while toileting. For 8/19, IDT determined resident had been toileted 30 minutes prior and took self to bathroom by transferring herself. She needs assist. For 8/20 fall, resident was attempting to toilet self. As a result of repeat falls, supervision will involve toileting every 2 hours, personal alarm and bringing resident to common areas when not in room to increase observation. Resident condition did not indicate skilled therapy services at this time. Care plan and profile updated as</p>		

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F 323	Continued From page 71 implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance. The findings include: Review of the facility's policy for Falls Management, dated February 2015, revealed the facility would maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. The fall risk assessment was included as part of the Admission and Monthly Nursing Assessment and Review and Circumstance forms. Identified risk factors should be evaluated for the contribution they may have to the resident's likelihood of falling. In addition, care plan interventions developed from the fall risk assessment which address the resident's risk factors, should be implemented. Should the resident experience a fall the attending nurse shall complete the "Fall Circumstance and Reassessment Form". The form includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat and a review by the Interdisciplinary Team to evaluate thoroughness of the investigation and appropriateness of the interventions. The resident "I care plan/profile" should be updated to reflect any new or change in interventions. Nursing staff will monitor and document continued resident response and effectiveness of interventions for seventy-two (72) hours; discuss risks and interventions with resident and/or responsible party; and, communicate interventions during shift report and update the twenty-four hour report and the nursing assistant assignment worksheet.	F 323	necessary to reflect current condition. Resident #6 was discharged on 11/6/15. Care plan interventions were reviewed on 10/18/15. Resident experienced no falls during this time. Resident discharged 11/6/15. Resident #8 was discharged to home on 10/17/15 with home health. Resident #10 experienced a fall on 9/30/15 while attempting to get walk and it tipped resulting in her fall. Resident was transferred to hospital. Upon return to facility, prevention care plan in place which included proper footwear, resident was re-educated on use of walker. Care plan and profile updated at the time and reviewed again on October 17 and 18, 2015 by MDS		



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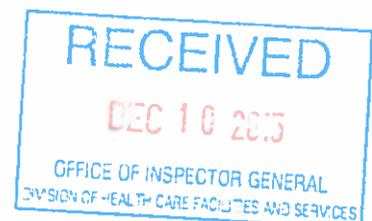
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F 323	<p>Continued From page 72</p> <p>Review of the facility's policy regarding Clinical Documentation Systems, Circumstance, and Reassessment Forms, not dated, revealed the purpose was to provide a tool to document an investigation as to the root cause of an episodic event. Reassessment of the resident's risk factors that may have contributed to the event and evaluate the current care of plan interventions for effectiveness and select additional interventions if required.</p> <p>The facility did not provide a policy related to the bed/chair alarms that would direct staff in how to check the alarms for functionality. However, observation on 10/02/15 at 2:10 PM, and review of the manufacturer's guidelines revealed the facility had three (3) different bed/chair alarm systems the facility used Medline, Posey and Universal Medical Products (UMP).</p> <p>Interview with the Director of Health Services (DHS), on 10/05/15 at 2:00 PM; and, on 10/09/15 at 12:20 PM, revealed the facility had not provided training to the staff for quite sometime. She stated she began her role in February of 2015 and she had not provided training and had not instructed anyone else to train staff on the bed/chair alarms. She stated she had not read the manufacturer's recommendations and was not aware there were three (3) different brands in use. She stated malfunctions could occur if staff did not know how to test the alarms appropriately and resident harm could occur.</p> <p>Review of the Medline bed/chair alarm brand revealed it was the responsibility of the facility to implement structured training procedures for all employees using the system. Only users who</p>	F 323	<p>nurses. No additional interventions indicated based on reassessment. Resident was on therapy caseload at the time and therapists were made of the fall. IDT review of all indicated to insure supervision to prevent accidents, residents will need proper footwear, walker in reach, encourage use of call light and offer rest periods during the day.</p> <p>Resident #11 was discharged from facility on August 27, 2015.</p> <p>Resident #12 was discharged from facility on August 6, 2015.</p>		

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F 323	<p>Continued From page 73</p> <p>have received adequate training on the use of the system should use the system. Failure to adequately train employees may cause system failure due to user error. In addition, incorrect use of the equipment may also result in system failure. The company recommended all expired, soiled or contaminated pads be disposed of in accordance with the law and facility policy. The sensor pads had a limited expected useful life. The facility must record the warranty date in the area provided on the label. The facility must not use the sensor pad after the in-service warranty expiration date. To set-up the system first visually inspect the pad and wires for damage. Power the unit by inserting a 9-volt battery, use adhesive strips on the bottom of the pad before putting in place to prevent shifting. When securing the system, take up extra slack in the cord that could become tangled with the resident, bed or chair. Failure to do so may result in resident injury. Insert the pad plug into the sensor pad, and the control unit should flash a green light and beep. In addition, the unit could be silenced for 30 seconds, by pressing the silence button. If the resident does not return to the pad within 30 seconds the unit turns itself off requiring the staff to reset it again.</p> <p>Interview on 10/02/15 at 2:30 PM, with LPN #4, revealed she did not know if the facility had a policy regarding the bed/chair alarms. She stated she had not received training on the alarms from the facility or the manufacturer.</p> <p>Review of the Posey manufacturer recommendations, revealed before leaving a resident unattended staff should always follow these steps each time: check to make sure that</p>	F 323	<p>Resident #13 experienced a fall on 10/1/15. Resident sustained a skin tear. MD and responsibility party notified on 10/1/15 by charge nurse at 11:00pm. Treatment order obtained and implemented. Resident was on therapy caseload for PT and receiving treatment to improve ambulation. Care plan and profile updated to reflect current status. Care plan reviewed again on 10/17 and 10/18/15 by MDS nurses. IDT review indicates necessity of long call light in reach, wheelchair and walker for mobility, wear eye glasses to insure alarm in place and functioning.</p> <p>Resident #19 was discharged from facility on 10/31/15.</p>		



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F 323	<p>Continued From page 74</p> <p>the sensor cable and unit were intact and undamaged; place weight on sensor pad; turn alarm unit on and verify the green light blinks; verify the unit had fresh batteries in place; listen for intermittent chirp that will alert staff of a low battery; and, check to make sure the audible alarm functioned properly by applying and lifting weight off the sensor pad in several spots to activate alarm. Check to make sure sensor cable was out of the way and did not pose a tripping hazard. The manufacturer's information stated a nine (9) volt battery provided up to 280 hours of continuous alarm. The alarm may fail to sound if the sensor pad was bent or folded under the resident or not directly under the resident's buttocks.</p> <p>Review of the Posey brand revealed a warning statement that informed the user to never connect the Posey brand sensor pads to other manufacturers' alarm units or connect other manufacturers' sensor pads to the Posey brand alarm units.</p> <p>Review of the Universal Medical Products (UMP) also stated UMP pressure pads were designed for use with UMP monitors only and not substitute any other fall monitoring devices. In addition, the company directed user's to write on the pad the date the pad was put into use. The UMP stated the user should test the system before each use and inspect pads and monitor regularly to make sure they were not damaged. Users should test the system by pressing firmly on the pad for three (3) seconds. When pressure was removed from the pad, the alarm should sound and then reset the alarm. Place the UMP pad directly under the resident so that the bulk of the resident's weight (buttock area) would rest on the pad. Plug the</p>	F 323	<p>All residents have the potential to be affected by the alleged deficient practice. Staff re-education, inservice, and monitoring/auditing will ensure the campus has an effective system in place to ensure staff provides adequate supervision to prevent accidents. In addition, the campus will ensure bed/chair alarms are used in accordance with manufacturer's recommendations, and the campus will complete the Fall Circumstance event to assist with determining root cause for falls.</p> <p>All current residents at the campus at risk for falls have been reviewed to ensure appropriate</p>		

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F 323	<p>Continued From page 75</p> <p>end of the pad cable into the jack on the bottom of the monitor. For added safety from accidental pulls on the cord, route the cable through the strain relief slot on the bottom of the monitor. When the resident's weight was placed on the pad, the user would hear a brief confirmation tone letting them know the pad was operational. The UMP standard bed pads were designed to withstand normal wear and tear for a period of 45-day, 90-day, 180-day or 1-year depending on the model. Beyond this time, the pad may fail and fail without warning due to prolonged use and other factors, e.g. bending, exposure to moisture, punctures, repeated cord pulls and connector damage. The information stated that facility protocols should direct staff to log the 45-day, 90-day, 180-day and 1-year "Date Put in Use" date in the blank provided on the pad itself and in the resident's chart. If the pad was used on more than one resident, the original "Date put in use" date must be transferred from chart to chart.</p> <p>Interview on 10/02/15 at 2:20 PM, with CNA #4 revealed she had not received training on the alarms from the facility or the manufacturer. She stated the facility reminded her to ensure the alarms were in place but did not train her on the specific characteristics of each system.</p> <p>1. Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 06/08/13, with diagnoses of Senile Psychosis, Atrial Fibrillation, and Orthostatic Hypotension.</p> <p>Record review revealed the resident had fallen at the facility on 05/07/15. Review of the Fall Circumstance Event Form, dated 05/07/15, revealed Resident #1 had an unwitnessed fall on</p>	F 323	<p>care plans are in effect to prevent accident/incidents.</p> <p>Staff education was conducted on 10/12/15 and 11/16/15 by the Director of Clinical Compliance and Staff Development related to falls prevention and management. A list of falls prevention interventions was discussed (call lights, alarm use, reachers, etc). Nursing Administration and Executive Director were educated by the Director of Clinical Support on 10/19/15 related to falls investigation and root cause analysis. Campus staff inserviced on December 8-9, 2015 by the Director of Clinical Compliance (Interim DHS)_ alarm usage in accordance with manufacturer's guidelines.</p>		



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F 323	<p>Continued From page 76</p> <p>05/07/15 with no injuries. Review of the Fall Circumstance Form, dated 05/07/15, revealed the resident transferred without assistance from the couch. It was determined the resident's alarm pad was on the wheelchair seat instead of under the resident on the couch. The root cause determined by the interdisciplinary team was the resident fell due to a wet floor. Review of the resident's plan of care stated to continue the use of the bed/chair alarm and to check it for placement and functionality every shift.</p> <p>Review of Resident #1's Significant Change in Status Minimum Data Set (MDS) assessment, completed on 08/20/15, revealed the facility assessed the resident as needing the extensive assistance of one with transfers, personal hygiene, and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance with moving from a seated to standing position, walking, moving on and off the toilet and surface to surface, such as between the bed and chair or chair to wheelchair. The facility assessed Resident #1 with a score of eleven (11) of fifteen (15) on the Brief Interview for Mental Status (BIMS) assessment, indicating the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan for Resident #1 revealed the facility developed a plan of care for falls and assistance with activities of daily living on 08/26/15, with updated goals and target dates for 11/26/15. Problems on the care plans stated the resident was at a risk for falls related to weakness, history of falls and the need for extensive assistance with activities of daily living, transfers and mobility. The goals stated the resident would stay free of falls, in order to be as independent as possible, while keeping the</p>	F 323	<p>Systemically, any change in condition, including falls, are reviewed Monday – Friday during clinical meeting (CCM). During the weekend, DHS or ADHS will review falls events to determine complete investigation, follow up and implementation of appropriate intervention to reduce risk of future falls. The DHS and/or ADHS oversees the CCM along with MDS, Medical Records, Staff Development, Executive Director, Social Services and Therapy Program Director in attendance. Charge nurses will be responsible for initiating circumstance forms at</p>		

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F 323	<p>Continued From page 77</p> <p>resident safe and comfortable. The approaches stated staff would provide assistance with activities of daily living and the assistance of one with transferring and mobility. Staff would keep the call light within the residents' reach and check on the resident frequently. The resident used a bed and chair alarm for safety and staff would check it for functionality every shift and if they heard it alarm they were to check on the resident to ensure their safety.</p> <p>Review of Resident #1's Emergency Room documents and the Death Summary, both dated 09/07/15, revealed the resident sustained a fall from the bed that resulted in a 2.5 centimeter laceration to the left eye/cheek area. The resident also sustained rib fractures to the second and third ribs on the left side with a Flailed Chest. The resident experienced respiratory failure requiring a breathing tube to be placed. The patient's sons arrived and discussion of the resident's prognosis, including the likelihood of death, if the resident was extubated. The resident's sons agreed that extubation was what the resident would have wanted and the resident was extubated and passed away at 4:50 PM on 09/07/15.</p> <p>Review of the Fall Circumstance Event Form (FCEF), dated 09/07/15 at 4:04 AM, revealed the resident experienced an unwitnessed fall with injuries. The documentation noted the resident's mental status was at baseline; which was confused and forgetful, but able to recall their name. The FCEF stated the resident sustained a laceration to the face from the corner of the left eye to the cheek and complained of pain to the left shoulder and arm pain with decreased movement. Assessment findings stated the</p>	F 323	<p>the time an event occurs. MDS will be responsible for reviewing and updating care plans during the CCM/clinical meeting based on IDT review. Falls will be reviewed weekly during Clinical at Risk (CAR) meetings to ensure effective interventions are in place and follow up completed. These residents will be monitored during CAR meeting for a minimum of four weeks. Safety device audits will be conducted daily by department leaders to ensure devices are in place and functioning.</p>		



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F 323	<p>Continued From page 78</p> <p>resident's oxygen saturation level was at 76% (normal 95%-100%) after the fall. Assessment of lung fields revealed gurgles and crackles from the left side of the chest. The form noted there were no possible contributing factors to the fall and the immediate measure taken to prevent another fall was to use a bed alarm; even though one was already in place at the time of the fall. The form also noted the outcome of interventions was "No Interventions Used".</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 10/02/15 at 8:44 AM, revealed she went down the 100 Hall around midnight because she heard a resident's alarm going off. She stated she peeked in on Resident #1, but it was not Resident #1's alarm that was sounding; however, she noted the resident's oxygen tubing was not in place. She stated she placed the tubing back in the resident's nose and left the room and no other care or services were provided. She stated after leaving she went down the 200 Hall and found the resident with the bed alarm sounding and assisted them. After this she began performing rounds on other residents with CNA #2. She stated they returned to the nurses' station area around 3:45 AM, and heard someone calling for help. They went to investigate and found Resident #1 on the floor next to the bed with a very deep cut to the eye that went down to the cheek. She stated when they entered the room, the resident's call light was not on or within reach of the resident and the bed alarm was not sounding and was not turned on. CNA #1 stated CNA #2 went to find the nurse while she stayed with the resident. Per interview, the aides worked as a team when making rounds because it would take two people to turn and change incontinent residents. She stated if they were in a room</p>	F 323	<p>DHS and/or ADHS will monitor 5 residents at risk for accidents/incidents to assure interventions are effective 5 times a week for one month then 3 times a week for a month then weekly with results forwarded to the QA committee monthly for 6 months and quarterly thereafter for review and further suggestions/comments.</p> <p>Completion date 12/10/15</p>		

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F 323	<p>Continued From page 79</p> <p>providing care they could not always hear the call lights or alarms sounding.</p> <p>Interview with CNA #2, on 10/02/15 at 2:05 PM and on 10/14/15 at 9:15 AM, revealed she had checked on the resident around 10:30 PM. The resident had a Posey brand alarm. CNA #2 stated she observed the alarm box but she did not see a blinking light on it. CNA #2 stated she had not received any recent training regarding the alarms and she did not know that a green blinking light on the Posey brand alarms meant the alarm was turned on. CNA #2 stated she and CNA #1 worked as a team on night shift, and around 3:00 AM, they were providing care to another resident and then returned to the nurses' station sometime after 3:00 AM. Per interview, they heard a resident yelling for help. They went to investigate and found Resident #1 on the floor beside the bed. She stated CNA #1 stayed with the resident and she went to find the nurse. She stated she approached the nurse as she was returning to the unit and informed her, Resident #1 had sustained a fall with injury. She stated Licensed Practical Nurse (LPN) #1 assessed the resident and called emergency medical personnel to transfer the resident to the hospital. CNA #2 stated she did not know how to locate a resident's plan of care in the new electronic medical record. She stated prior to the new computerized system the aides had a paper document telling them the care each resident required. She stated now the new system required her to answer questions about the resident's level of assistance needed during care provided.</p> <p>Interview with LPN #1, on 10/02/15 at 9:30 AM, revealed she was off the unit using the bathroom when the resident fell. She stated when she</p>	F 323		



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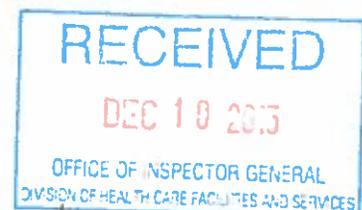
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F 323	<p>Continued From page 80</p> <p>returned to the nurses' station CNA #2 notified her Resident #1 had sustained a fall with injury. She stated the resident had a cut to the eye and cheek area and began to have breathing trouble. She stated Emergency Medical Services was called to transport the resident to the hospital. LPN #1 stated she did not review resident care plans normally, but depended on the medication and treatment records to direct her care of residents. She stated she received shift to shift reports from the off going nursing staff and that was how she knew of Resident #1's care needs. She stated all residents were checked on every two hours and if a care plan intervention stated check on resident frequently, then residents would be checked on every two hours. She stated if residents needed increased supervision, an order would be written for hourly checks; however, Resident #1 did not have hourly checks ordered. She stated she did not check the bed alarm for functionality prior to the fall because she had all shift to check it. She stated she did not check the alarm after the fall because she was tending to the resident's needs. LPN #1 stated she had not been trained on the manufacturers recommendations for each type of bed/chair alarms in the facility. She stated ensuring the residents' fall interventions were implemented would maintain resident safety. LPN #1 stated she did not conduct the investigation into the fall or determine the root cause. She stated those activities were completed by Management.</p> <p>Interview with the Director of Health Services (DHS), on 10/05/15 at 2:00 PM and on 10/09/15 at 12:20 PM, revealed the facility determined the cause of Resident #1's fall with injury was due to the resident not using the call light to ask staff for assistance. She stated to keep the resident safe</p>	F 323			

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F 323	<p>Continued From page 81 and meet their needs, staff should ensure the resident's call light was always in reach, the bed/chair alarm was checked every shift for functionality and placement, and staff should frequently check on the resident. The DHS stated although interviews conducted after the fall determined Resident #1's call light was not within reach, the bed alarm had not sounded, and staff was not available to provide frequent supervision; the facility did not identify staff had not provided the necessary care and services to meet the resident's needs for safety and fall prevention. She stated the resident should have called for assistance prior to transferring self.</p> <p>Interview with the Interim Executive Director, on 10/05/15 at 2:40 PM, revealed interviews and statements obtained from staff were not taken into account. She stated the facility determined the root cause of the fall was the resident frequently did not use the call light to ask for assistance prior to transferring. She stated the facility did not determine the staff failed to follow care plan interventions related to ensuring bed alarm functionality, call light was kept in reach or checking on the resident frequently; even though interviews and written statements obtained stated the bed alarm did not sound, the bed rail was in the down position with the call light attached and not within reach of the resident. Interviews and written statements also indicated the nurse was off the unit and the two (2) CNAs were busy providing care to another resident at the time of the fall.</p> <p>Interview with the Executive Director, on 10/05/15 at 3:20 PM, revealed he briefly reviewed Resident #1's incident/event file after he began his employment on 09/21/15. He stated after</p>	F 323			



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F 323	<p>Continued From page 82</p> <p>reviewing the event he did not provide any further direction to staff to determine if there were system issues in relation to meeting the care needs of the resident. He stated if he had conducted the investigation and determined the bed alarm had not sounded; he would have directed staff to conduct an audit of the alarms to determine if they were functional at all times. He stated if he had determined the call light had not been in reach of the resident he would have conducted audits of call light accessibility. He stated if he had determined staff was not available to meet the needs of the resident he would have looked into that also. He stated it was the facility's responsibility to ensure resident safety.</p> <p>2. Review of the clinical record for Resident #8 revealed the facility admitted the resident on 08/04/15 with diagnoses of Colon Cancer, Respiratory Failure and Atrial Fibrillation. The resident had a hospital admission on 09/15/15 and was re-admitted to the facility on 09/24/15.</p> <p>Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 09/29/15, revealed the facility assessed the resident as needing the extensive assistance of one with transfers, walking, and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when moving from a seated to standing position, walking, moving on and off the toilet and from surface to surface. The facility assessed Resident #8 with a score of fourteen (14) of fifteen (15) on the BIMS assessment, indicating the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan for</p>	F 323			

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F 323	<p>Continued From page 83</p> <p>Resident #8 revealed the facility developed a plan of care related to skin integrity and falls on 09/15/15 with updated goals and target dates for 12/15/15. The goals stated the resident would have no falls with major injury and would maintain intact skin.</p> <p>Review of Resident #8's Fall Circumstance Event Form, dated 09/26/15, revealed Resident #8 sustained an unwitnessed fall with injury. The report stated staff heard the resident yelling for help and found the resident on the floor next to the bed. The resident sustained bruising and a skin tear to the right elbow, abrasion to mid-lower spinal bony prominence, and complained of right lower rib pain. The possible contributing factors noted on the form were cardiac/respiratory disease, discomfort/pain, and antihypertensive/antipsychotic medications. The interventions immediately taken to prevent another fall were noted as a bed alarm, first aid, and rest. However, there was no documented evidence a review of the fall was conducted by the Interdisciplinary Team or of the seventy-two hours of nursing assessment documentation regarding the resident's response to treatments or the effectiveness of the interventions as per the facility's policy.</p> <p>Review of Radiology Report, dated 09/26/15, revealed Resident #8 had a right non-displaced lateral 8th rib fracture.</p> <p>Interview with Resident #8, on 10/07/15 at 8:16 AM, revealed on 09/26/15 he/she had used the call light to ask staff for assistance with toileting. However, staff did not arrive timely so he/she attempted to toilet without assistance and fell. The resident stated he/she hit their back and side</p>	F 323			

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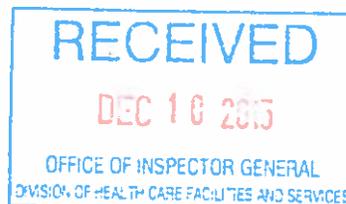
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F 323	<p>Continued From page 84</p> <p>on the chair next to the bed; and, sustained a rib fracture and the laceration to the right arm, along with other bruises.</p> <p>Interview with CNA #13, on 10/14/15 at 9:30 PM, revealed the resident could not walk without assistance and at night would get very confused. She stated the electronic medical record had information regarding the resident's activities of daily living for her review; however, she did not routinely have time to review that information during her shift. She stated she had been told in report, at the beginning of her shift, that Resident #8 was confused and had been frequently getting up to use the bed pan in the chair without assistance. She stated the resident did not have a bedside commode. She stated she was not provided direction or additional safety interventions during report or at any time prior to Resident #8's fall. CNA #13 stated at the time of resident #8's unwitnessed fall she was providing care to another resident. She stated the resident was found on the floor with stool all over their bottom. She stated a bed alarm and/or closer supervision could have been put in place prior to the event to prevent Resident #8's fall with injuries.</p> <p>Interview with LPN #8, on 10/14/15 at 8:10 PM, revealed Resident #8's short term memory was not good and the resident had periods of confusion. She stated the resident would get up frequently between 2:00 AM and 3:00 AM to try and toilet self. She stated staff made rounds on all residents every two hours and the resident was not on a toileting program due to this type of rounding. She stated the resident did have a bed alarm prior the last admission to the hospital; however, it was not put back into use after the</p>	F 323			

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F 323	<p>Continued From page 85</p> <p>resident was readmitted to the facility. She stated a bed alarm should have been put in place after readmission to alert staff of the resident's attempts to transfer without assistance. She stated an intervention to toilet the resident consistently at 2:00 AM, could have prevented the resident's fall also. She stated after a fall she completed a Fall Circumstance Event Form and that form had areas for her to denote contributing factors of the fall and possible additional care plan interventions. However, she did not make revisions to care plans because that was the responsibility of the MDS nursing staff. In addition, LPN #8 stated she did not determine the root cause of resident falls. She stated nursing would ask the resident what happened or what they were trying to do at the time of the fall only. She stated if she implemented an intervention she would verbally tell staff, but if the information did not get transferred by telling others, it would not be known by all.</p> <p>Interview with the DHS, on 10/16/15 at 3:00 PM, revealed staff should have assisted Resident #8 with toileting on the night of the fall. In addition, staff should have developed a scheduled toileting program for the resident, knowing the resident frequently wanted to toilet around 2:00 AM.</p> <p>3. Review of the clinical record for Resident #10 revealed the facility admitted the resident on 09/23/15, with the diagnoses of Spinal Stenosis, Colon Cancer, and Deep Vein Thrombosis. The resident also had a history of falls with hip fractures and a kidney transplant. Review of Resident #10's five day MDS assessment, completed on 09/30/15, revealed the facility assessed the resident as needing the extensive assistance of one with transfers, bed mobility and</p>	F 323			



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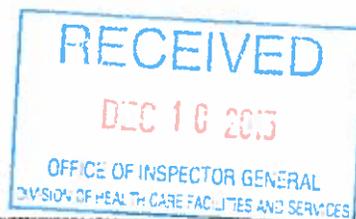
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F 323	<p>Continued From page 86</p> <p>toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when moving from a seated to standing position, walking, moving on and off the toilet and from surface to surface. The facility assessed Resident #10 with a score of fourteen (14) of fifteen (15) on the BIMS assessment indicating the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan for Resident #10 revealed the facility developed a plan of care related to activities of daily living and falls on 08/28/15 with updated goals and target dates for 08/28/15. The approaches directed staff to provide assistance with mobility. The care plan stated the resident needed the assistance of one when transferring, the resident used a rolling walker with staff assistance and needed a wheelchair for long distances. The care plan also stated the resident required assistance with oral care, grooming, bathing, and dressing. In addition, the fall care plan approaches directed staff not to leave the resident alone up in the wheelchair for extended periods of time, keep the call light within reach and remind the resident to use it.</p> <p>Review of the Nursing Notes, dated 09/30/15 at 1:52 PM, revealed Resident #10 sustained an unwitnessed fall with injury. The resident complained of back pain, requiring Emergency Medical Services to transfer the resident to the hospital for treatment. Nursing noted the resident stated he/she had attempted to get to their walker and it tipped over with the resident going over with it.</p> <p>Review of the hospital History and Physical, dated 10/01/15, revealed the resident fell trying to get to</p>	F 323			

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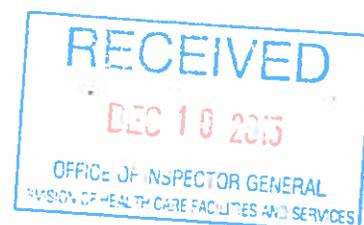
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F 323	<p>Continued From page 87</p> <p>his/her walker. The x-ray results revealed a thoracic compression fracture at T9. The resident continued to have severe pain and muscle spasms and a back brace was ordered. The resident was admitted back to the facility on 10/05/15.</p> <p>Interview with Resident #10, on 10/09/15 at 3:20 PM, revealed he/she fell on 09/30/15, after attempting to rise from the wheelchair to use their roller walker. Resident #10 stated the rolling walker flipped over and he/she flipped over with it. The resident stated they fractured their spine at T9 and now must wear a brace when out of bed. Resident #10 stated they were in a lot of pain and still required pain medication for the fracture.</p> <p>Interview, on 10/09/15 at 2:30 PM, with CNA #3 revealed she had assisted Resident #10 to the bathroom on 09/30/15, put tooth paste on the resident's tooth brush and left the room to go complete charting. She stated twenty to thirty minutes later a housekeeper notified her that the resident had fallen. She stated she went to Resident #10's room and found the resident on the floor behind the entry door to the room. She stated the resident said he/she was trying to use their rolling walker and it flipped over with them. She stated she had only taken care of Resident #10 two or three times prior to the fall and had not reviewed the plan of care. She stated she thought she could leave the resident alone in the bathroom.</p> <p>Review of Resident #10's medical record revealed no evidence a Fall Circumstance Event Form was completed for the fall event on 09/30/15.</p>	F 323			



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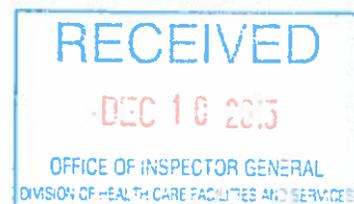
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F 323	<p>Continued From page 88</p> <p>Interview with LPN #4, on 10/09/15 at 12:40 PM, revealed a nursing assistant notified her of Resident #10's fall on 09/30/15. She stated due to the resident's complaints of back pain after the fall the resident was transferred to the hospital for further evaluation. She stated she forgot to complete a Fall Circumstance Event Form after the event. She stated the form had areas for her to document her assessment, the contributing factors and immediate actions taken after the event to prevent another. She stated the resident returned to the facility and she did not know what happened in regards to the investigation into the event or additional interventions developed to prevent the resident from sustaining another fall at the facility.</p> <p>Interview with the DHS, on 10/16/15 at 3:00 PM, revealed she did not know LPN #4 had forgotten to complete a Fall Circumstance Event Form after Resident #10's fall. She stated she was not sure how the event got missed; but, it might have been missed because the resident went to the hospital and did not immediately return back to the facility.</p> <p>4. Review of the closed clinical record for Resident #9 revealed the facility admitted the resident on 09/09/15 with diagnoses of Gastro-intestinal Hemorrhage, Urinary Retention, Weakness and Difficulty Walking.</p> <p>Review of Resident #9's Admission MDS assessment, completed on 09/16/15, revealed the facility assessed the resident as needing the extensive assistance of two with transfers, bed mobility and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when moving from a seated to standing position, walking,</p>	F 323			



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F 323	<p>Continued From page 89</p> <p>moving on and off the toilet and from surface to surface. The facility assessed Resident #9 with a score of twelve (12) of fifteen (15) on the BIMS assessment indicating the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan for Resident #9 revealed the facility developed a plan of care for fall prevention on 09/14/15 with updated goals and target dates for 11/14/15. On 09/09/15 the plan of care noted the resident was found on the floor (family at bedside) and sustained a cut to the foot requiring the resident to be sent to the emergency room for evaluation. Interventions in place included an alarm to the bed and chair to remind the resident to ask for assistance with transfers and to alert the staff if the resident attempted an unassisted transfer.</p> <p>Review of the Nursing Note, dated 09/09/15, revealed the resident was admitted to the facility on 09/09/15 at 1:51 PM and nursing noted seven (7) hours later, at 8:45 PM, that Resident #9 was found on the floor by the resident's son. The resident's right foot was bleeding and the resident continued to be extremely confused. The resident's bed alarm was on the floor and non-functioning with a tear in the wiring. The family transported the resident to the hospital for evaluation.</p> <p>Continued review of the Nursing Notation, dated 09/10/15 and timed at 4:28 AM, revealed the son returned to the facility with the resident. Nursing noted the resident received 10 sutures to the right foot, underneath and between the fourth and fifth toes. Review of the hospital's X-ray results revealed a closed non-displaced transverse fracture of the right fifth metatarsal.</p>	F 323			



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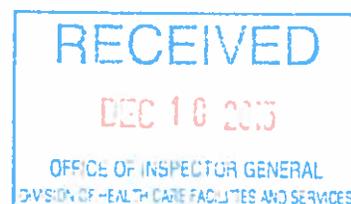
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F 323	<p>Continued From page 90</p> <p>Review of Resident #9's Fall Circumstance Event Form (FCEF), dated 09/09/15, revealed Resident #9 sustained an unwitnessed fall with injury. Nursing noted the resident had slurred speech and was confused at the time of the fall. During the fall the resident sustained a laceration to the right foot. Review of nursing interventions listed on, the 09/09/15 FCEF, revealed nursing did not implement any new interventions that would prevent/decrease the opportunity for another fall. The interventions listed were to apply direct pressure to the wound and elevate the extremity. In addition, the form did not have seventy-two hours of reassessment documentation of the resident's response to treatments or the effectiveness of the interventions per the facility's policy. Continued review of the form revealed the Interdisciplinary Team did not document a review regarding the evaluation, thoroughness or effectiveness of the actions taken.</p> <p>Interview with LPN #9, on 10/15/15 at 11:40 AM, revealed she believed the resident was still under the effects of anesthesia when he/she was admitted on 09/09/15. She stated the son found the resident on the floor and notified staff and staff could not determine exactly what the resident was trying to do at the time of the fall. She stated the resident was assessed and family transported the resident to the hospital. She stated when the resident returned he/she had sutures to the foot and x-ray results were positive for a fracture</p> <p>Further review of the resident's plan of care revealed the care plan was edited on 10/01/15 and stated the bed/chair alarm was discontinued.</p>	F 323			

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F 323	<p>Continued From page 91</p> <p>Review of the Nursing Note, dated 10/02/15, revealed the nurse was notified by the Certified Nursing Assistant that Resident #9 had fallen out of the wheelchair while trying to reach for his/her hat that was in their luggage.</p> <p>Review of the Fall Circumstance Event Form, dated 10/02/15, revealed Resident #9 had an unwitnessed fall from the wheelchair, without injury. Continued review of the FCEF, revealed nursing did not implement any additional interventions to prevent another fall. In addition, the form did not have reassessment documentation of the resident's response to treatments or the effectiveness of the interventions. Continued review of the form revealed the Interdisciplinary Team did not document a review regarding the evaluation, thoroughness or effectiveness of the actions taken.</p> <p>Further review of the resident's plan of care revealed no revisions were made after the 10/02/15 fall.</p> <p>Continued interview with LPN #9, on 10/15/15 at 11:40 AM, revealed the second incident occurred when the resident was reaching for a hat and fell out of the wheelchair. She stated the resident told her he/she had forgotten to lock the wheelchair and slid out onto the floor. She stated the resident was re-educated on the importance of locking the wheelchair and that was the only intervention to prevent another similar fall. She stated it was a facility policy to perform neurological checks on all residents that sustained an unwitnessed fall. She stated she forgot to do this for Resident #9. She stated she also forgot to completely fill out the Fall Circumstance Event Form. She stated if</p>	F 323			



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F 323	<p>Continued From page 92</p> <p>nursing did not fill out a form completely management would inform her and she would go and make a late entry and complete the form, but she had not received any notice from management staff regarding incomplete documentation in Resident #9's chart.</p> <p>Interview, on 10/16/15 at 3:00 PM, with the DHS revealed she believed Resident #9 was still under the effects of anesthesia, after being admitted to the facility; and believed this was the reason for the fall. She stated it was her responsibility to ensure nursing completed all documentation in the resident's medical record. However, she failed to identify that all the areas on Fall Circumstance Event Form were not completed. She stated the Interdisciplinary Team (IDT) met every day, except on weekends and holidays, to discuss events that happened the previous day. She stated if the team determined a form had not been completed or had areas left blank they would inform the nurse that she needed to complete the form. However, she had no memory of informing LPN #9, of the need to complete the form, and the team did not keep a record of such notification. She stated if the forms were not complete it would be difficult for the team to analyze the information or use it for tracking and trending purposes.</p> <p>5. Review of Resident #12's clinical record revealed the facility admitted the resident on 06/12/15 with diagnoses Difficulty Walking, Weakness, Pneumonia and Respiratory Failure. Review of Resident #12's Annual MDS assessment, completed on 06/19/15, revealed the facility assessed the resident to need the limited assistance of one to transfer and to ambulate. In addition, the resident required the</p>	F 323			

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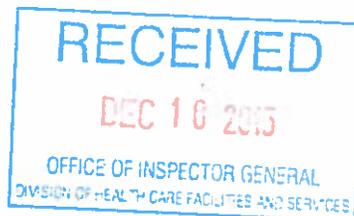
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 93</p> <p>extensive assistance of one with dressing and toileting. The facility assessed the resident's balance as not steady and only able to stabilize with staff assistance when walking, turning around or moving on and off the toilet and from bed to chair or wheelchair. The facility assessed Resident #12 with a score of six (6) of fifteen (15) on the BIMS assessment indicating the resident had cognitive impairment.</p> <p>Review of the Comprehensive Care Plan for Resident #12 revealed the facility developed an admission safety plan of care on 06/13/15 with interventions to ensure the call light remained accessible, staff would provide assistance for transfers and ambulation, and would observe resident for compliance with safety interventions.</p> <p>Review of Resident #12's Fall Circumstance Event Form, dated 08/04/15 at 11:37 PM, revealed the resident sustained an unwitnessed fall with injury. Nursing documented the resident stated he/she tried to get up from the potty chair and fell. The Nursing assessment revealed the resident had swelling and an abrasion with bleeding to the nose. The Event Report documentation revealed there were no possible contributing factors present at the time of the fall. In addition, the form did not have seventy-two hours of reassessment documentation of the resident's response to treatments or the effectiveness of the interventions per the facility's policy. Continued review of the form revealed the Interdisciplinary Team did not document a review regarding the established root cause, evaluation, thoroughness or effectiveness of the actions taken.</p> <p>Review of the Nursing Notation, dated 08/05/15 at</p>	F 323			

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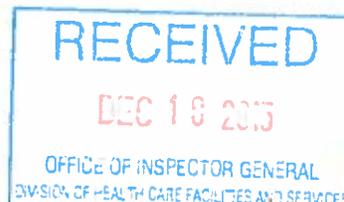
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F 323	<p>Continued From page 94</p> <p>3:30 AM, revealed the resident returned from the hospital with a diagnosis of a nasal fracture.</p> <p>Interviews with CNA #9 at 2:05 PM, CNA #11 at 2:15 PM, and CNA #5 at 2:30 PM on 10/26/15 revealed they did not recall Resident #12's fall incident and stated following residents care plan interventions would be important to maintain their safety. However, interview revealed the CNAs did not know Resident #12's fall interventions.</p> <p>Interview with Registered Nurse (RN) #4, on 10/15/15 at 2:45 AM, revealed Resident #12 fell on 08/04/15 around 6:05 PM, when he/she tried to get up from the bed side commode. She stated the resident hit their nose during the fall which caused swelling, an abrasion, and bleeding from the nose. She stated the facility had just started the new Electronic Medical Record (EMR) and she was still learning how to navigate through the computerized medical record. She revealed she had not looked at Resident #12's care plan and did not know where to locate it in the new EMR. She stated she depended on shift to shift report for resident care information and review of the Medication and Treatment Administration Records to tell her the care needs of the resident. She further stated the Assistant Director of Health Services (ADHS) assessed the resident's nose and informed her residents had the right to fall. Which meant if a resident chose not to call for assistance after being provided education to do so; the resident could make that decision, even though Resident #12 had BIMS' score of six (6) with cognitive impairment, they could not do anything about it.</p> <p>Interview with the ADHS, on 10/27/15 at 11:30 AM, revealed Resident #12 always tried to get up</p>	F 323			



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F 323	Continued From page 95 without assistance. He stated according to the plan of care the resident required assistance with transferring and used a bedside commode when toileted. He stated the resident preferred to have the bedside commode placed across the room from the bed close to the bathroom door. He stated he was informed of the resident's fall on 08/04/15 and went to assess the resident. The ADHS stated the resident had an abrasion and bleeding to the nose and in hindsight could have obtained a portable x-ray of the nose to check for a fracture but did not. The ADHS stated he also did not interview the CNA that provided care to the resident the night of the fall. He stated it would have been a good idea to do that in order to determine additional information into the event. He stated later in the evening the resident's family member came in and transported the resident to the hospital. Upon the resident's return to the facility they were informed the resident sustained a nasal fracture. He stated the plan of care directed staff in the care needs of the resident and staff should have provided assistance with transferring. It stated the contributing factor of the fall was the resident did not ask for assistance prior to transferring. He stated the Interdisciplinary Team reviewed events and determined what caused the resident fall; however he could not remember if the team had determined Resident #12 root cause of the fall. The ADHS stated he believed the root cause of Resident #12's fall was the resident had not been compliant with the use of the call light and could not retain education provided on its use. He stated staff could have started a toileting program and performed hourly checks to prevent the fall from occurring. He stated the team had not determined any other issues with the documentation or event investigation process in	F 323			



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F 323	<p>Continued From page 96 their review.</p> <p>6. Review of the closed clinical record for Resident #11 revealed the facility admitted the resident on 06/01/15 with diagnoses of Coronary Artery Disease, Difficulty Walking with Abnormal Gait and Pain. The resident was hospitalized twice on 06/18/15 and on 07/06/15 and readmitted to the facility on 07/24/15.</p> <p>Review of Resident #11's Admission MDS assessment, completed on 07/31/15, revealed the facility assessed the resident to need the extensive assistance of two with transfers, bed mobility and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when moving from a seated to standing position, walking, moving on and off the toilet and from surface to surface. The facility assessed Resident #11 with a score of eleven (11) of fifteen (15) on the BIMS assessment indicating the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan for Resident #11 revealed the facility developed a plan of care for falls on 07/06/15 with updated goals and target dates for 10/06/15. The goal stated the resident would have no falls with major injury while a resident at the facility.</p> <p>Review of Resident #11's Fall Circumstance Event Form, dated 06/18/15, revealed the resident had an unwitnessed fall while transferring self to the toilet. Nursing documented the resident was at risk for falls due to cognitive and memory impairment that effected safety and judgement. The intervention immediately taken after the fall was to ambulate the resident with</p>	F 323			

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F 323	<p>Continued From page 97</p> <p>assistance, toilet, hydration, a night light and place the bed in the low position. The form stated there were no possible contributing factors to the fall. Further review of the documentation revealed the Interdisciplinary Team (IDT) reviewed the nursing documentation and determined the root cause of the fall was due to the resident's confusion and inability to use the call light. The IDT noted they agreed with the implemented preventative measures documented by the nurse and did not revise or add interventions to the plan of care.</p> <p>Further review of the resident's care plan revealed the resident fell on 06/18/15 with no injuries and the intervention listed was to place the bed in the low position; even though the fall occurred when the resident transferred themselves from the toilet.</p> <p>Review of the Nursing Notation, dated 07/06/15, revealed the resident had an unwitnessed fall in the bathroom and sustained a large hematoma (collection of blood under the skin from a ruptured blood vessel) to the left side of the head. Continued review of the electronic medical record revealed no evidence a Fall Circumstance Event Form was completed.</p> <p>Interview with LPN #4, on 10/08/15 at 2:25 PM, revealed Resident #11 had an unwitnessed fall on 07/06/15. She stated the resident sustained a hematoma to the head from the fall. She stated she must have forgotten to fill out the Fall Circumstance Event Form in the computer. She stated the form had areas for her to click on to add possible interventions to prevent another fall. She stated the Minimum Data Set Nurses actually revised resident's plans of care after an event.</p>	F 323			

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F 323	<p>Continued From page 98</p> <p>She stated if a resident's care plan did not get revised with interventions to prevent another fall the resident could experience another fall.</p> <p>Review of the resident's care plan revealed the resident fell on 07/06/15 and sustained a hematoma and the intervention to prevent another fall was to send the resident to the emergency department for evaluation. There was no documented evidence the resident's plan of care was revised to prevent recurrence of falls.</p> <p>Interview with the DHS, on 10/16/15 at 3:00 PM, revealed she had no evidence to provide that the facility had determined the contributing factors or the root cause of Resident #11's fall on 07/06/15. Per interview, the facility did not keep records of the IDT meetings.</p> <p>Review of Resident #11's Fall Circumstance Event Form, dated 08/14/15, revealed the resident sustained a non-injury fall from the toilet due to the daughter transferring the resident without staff assistance. Nursing documented there were no possible contributing factors for the fall and the immediate measures taken were to ambulate with staff assistance. The IDT did not establish/document a root cause for the fall and agreed with the nurses implemented preventative measures taken. In addition the IDT did not revise or add interventions to the residents plan of care.</p> <p>Review of the resident's plan of care revealed the resident fell on 08/15/15 and education was provided to staff to transfer the resident the way the daughter transferred the resident (per interview this was one assist). Even though the facility assessed the resident as needing the assistance of two with transfers; and determined</p>	F 323			



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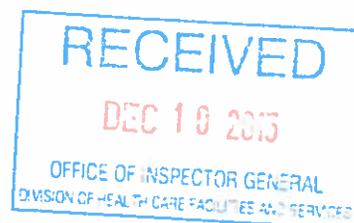
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F 323	<p>Continued From page 99 the daughter had transferred the resident alone.</p> <p>On 10/26/15, interviews with CNA #9 at 2:05 PM, CNA #11 at 2:15 PM, and CNA #5 at 2:30 PM, revealed they did not recall Resident #11's fall incidents; however, stated they could look up residents activities of daily living and care needs in the computer, but would not know where to find the plan of care. They stated if a nurse implemented a new intervention they would be told and they would have to tell the on coming staff. However, if someone forgot to tell them about a change in care needs they would not know. Interview with the CNAs revealed they were not aware of the fall interventions for Resident #11.</p> <p>Interview, on 10/16/15 at 12:00 PM, with LPN #7, revealed she could barely remember Resident #11's fall event. But believed Resident #11's daughter had attempted to transfer the resident off the toilet and the resident's legs gave out requiring the daughter to lower the resident to the floor. LPN #7 stated to her, this did not meet the definition of a fall and no intervention was needed. She stated the resident required the assistance of two with transfers, but the daughter would transfer the resident without them. She stated she was not sure if the daughter was educated regarding this or not and after reviewing the medical record did not find documentation of any education provided to daughter. She stated when she completed the fall event form she would click on possible interventions to prevent another fall and she was not sure if they were transferred to the resident's care plan or not.</p> <p>On 10/08/15 10:40 AM and 10/27/15 at 11:05 AM, interview with Minimum Data Set (MDS) Nurse</p>	F 323			

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F 323	<p>Continued From page 100</p> <p>#1, revealed the revision that stated, send Resident #11 to the emergency room after the fall, would not prevent another fall. She stated the plan of care should have been revised to include interventions that would actually prevent another fall. She stated without the revisions the resident could experience another fall.</p> <p>On 10/16/15 at 3:00 PM, interview with the DHS revealed sending the resident to the emergency room would not prevent another fall. She stated she had not identified the information added to the Resident #11's plan of care would not prevent another fall event until discussion with the Surveyor. She stated revising the care plan with an intervention to provide increased supervision or a scheduled toileting program would have been interventions to prevent additional falls.</p> <p>7. Review of the clinical record for Resident #13 revealed the facility admitted the resident on 07/03/15 from an acute hospital with the following diagnoses: Dementia; Fracture of the Left Femur that required surgical interventions; After Care of the fractured leg; Abnormality Gait; and, History of Falling. Review of the hospital's discharge documentation, dated 07/03/15, revealed the resident sustained a fall at the resident's personal home that resulted in the hip fracture.</p> <p>Review of the admission MDS assessment, dated 07/10/15, revealed the facility assessed the resident to have severe cognitive impairment with a BIMS score of five (5) out of a possible fifteen (15). The facility assessed the resident to need extensive assistance from staff for bed mobility, transfers, locomotion, toilet use, and ambulation. The facility assessed the resident to have a balance deficit with unsteady gait and impaired</p>	F 323			



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F 323	<p>Continued From page 101</p> <p>range of motion on one side. The resident was assessed to be a high risk for falling.</p> <p>Review of the comprehensive care plan, created 07/15/15 and edited on 08/14/15 and 10/02/15, revealed the facility had identified the resident at risk for falling due to weakness, incontinence, history of falls, medications, and needing assistance from staff with all ADLs. The goal was for the resident to remain free from major injuries during the resident's stay at the facility. The care plan approaches included keeping the call light within reach, provide a clutter free walkway, adequate footwear, appropriate lighting, and remind the resident to call for assistance prior to getting up. In addition, the resident was to remember to lock the wheelchair's brakes before getting up. Although the MDS assessed the resident with a BIMS of 5 and a cognitive deficit.</p> <p>Review of the Fall Circumstance Event Report, dated 08/12/15 at 4:00 PM, revealed Resident #13 was found in his/her room, sitting on the floor beside the resident's bed. The resident was assessed and found to have no injuries. The resident stated he/she was attempting to go to the bathroom and couldn't recall what happened after that. A personal safety alarm (PSA) was attached to the resident, but did not sound. Further investigation revealed the PSA had been turned off. The nurse turned the PSA back on and the alarm sounded. The resident was reminded to use the call light for assistance. Continued review of the Fall Event Report revealed a section titled "Other Clinical Observation" where the clinically at risk team reviewed the fall event and wrote the resident attempted an unassisted transfer and added a care plan intervention to toilet the resident every two (2) hours for three (3) days.</p>	F 323			

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F 323	<p>Continued From page 102</p> <p>The form did not address the fact the PSA had been turned off.</p> <p>Interview with LPN #5, on 10/14/15 at 4:00 PM, revealed she had found the resident on the floor on 08/12/15. She stated she had been walking down the hallway and saw the resident on the floor, next to the bed, in front of the resident's wheelchair. She stated the resident's door had been opened. She did not know how long the resident had been on the floor because the fall was not witnessed. She stated she assessed the resident and found no injuries and then assisted the resident back into the wheelchair. She revealed the PSA had not alarmed and when she checked the device, she found it had been turned off. She said she had not interviewed any staff that was working that night to determine why the PSA had been turned off. She did report her findings to the ADHS, but did not know what had happened after that. She stated the staff had been checking for placement of the PSA, but not whether the device was working and turned on. LPN #5 validated she had completed the Fall Circumstance Event Report on 08/12/15. She said the only training she received was how to complete the Fall Circumstance Event Report, but did not know how to investigate a fall.</p> <p>Interview with the ADHS, on 10/15/15 at 5:15 PM, revealed he did not recall LPN #5 telling him the PSA device had been turned off after the resident's fall on 08/12/15. He could not recall if the issue was discussed during the Clinical Care Meeting the next day. He stated the nurse should have asked the staff why the alarm was turned off.</p> <p>Interview with the DHS, on 10/16/15 at 9:50 AM,</p>	F 323			



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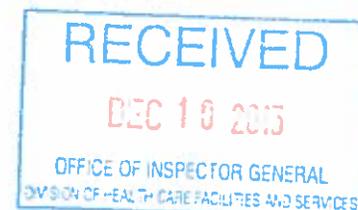
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F 323	<p>Continued From page 103</p> <p>revealed she did not recall discussing the PSA being turned off at the Clinical Care Meeting after the resident's fall on 08/12/15. She stated she would have conducted an investigation to determine why the PSA had been turned off and by whom. She then would have provided re-education. She stated she reviewed all Fall Circumstance Event Reports during the meeting and the team would review the care plan to determine if the care plan inventions were appropriate to prevent additional falls. She continued to state the team looked at existing care plan interventions to see if they were working and remove them if not. She stated the personal alarm would not prevent a fall, other interventions were needed such as hourly checks and increased supervision of the resident. However, she revealed she had not implemented either of these interventions for this resident.</p> <p>Continued interview with the DHS revealed the staff nurses are supposed to complete the Fall Circumstance Event Report and find out what caused the fall. The only education the staff nurses received was how to complete the report. The DHS stated when the facility used paper forms, the process worked. She stated the staff, including her, was still trying to figure out the computer program on the portion regarding analysis of a fall. She reviewed Resident #13's care plan and stated the care plan was not appropriate for the resident because due to the resident's impaired cognition, the resident was not able to utilize the call light and recall safety instructions.</p> <p>Interview with the MDS Coordinator #1, on 10/16/15 at 8:20 AM, revealed she could not recall the Event Report that revealed Resident</p>	F 323			

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F 323	<p>Continued From page 104</p> <p>#13's alarm had been turned off. That would have been something the team would have discussed during the meeting. She stated staff was supposed to check for placement of the PSA and determine if the device was working properly. She stated the DHS or the ADHS would take notes during the meetings. She said the staff nurses who fill out the Fall Circumstance Event Report are responsible for investigating the fall and determine the root cause of the fall. She said the Event Report was the fall investigation.</p> <p>Review of the Fall Circumstance Event Report, dated 09/06/15 at 10:11 AM, revealed the PSA was alarming and when staff responded, and found the resident lying on the bathroom floor. The resident was assessed and found no injuries. The form stated the care plan was revised; however, did not state how it was revised and no new interventions were added to the care plan.</p> <p>Review of the Fall Circumstance Event Report, dated 10/01/15 at 10:00 PM, revealed the resident's PSA was alarming and when staff responded and found the resident face down on the floor with his/her left arm under them. The resident complained of left shoulder/arm pain (6 out of 10 on the pain scale), sustained a skin tear to the left elbow, and the resident's right knee, left forehead, and left side of the face was red. On 10/02/15, the resident complained of hip pain. A portable X-ray was obtained that revealed no fracture.</p> <p>The MDS Coordinator reviewed each Fall Circumstance Event Report with the surveyor. The care plan intervention after the fall Resident #13 sustained on 08/12/15 was to toilet the resident every two (2) hours for three (3) days.</p>	F 323			



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

PRINTED: 12/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299		
(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	<p>Continued From page 105</p> <p>She stated she did not know the results of the toileting intervention and did not know if the care plan intervention was effective. After the 09/06/15 fall (where the resident was found alone in the bathroom), the team did not revise the care plan but continued to implement the intervention to check the PSA for placement and function. However, during this fall, the PSA was alarming. After the 10/01/15 fall, the care plan intervention was to obtain a urinalysis to determine if the resident had a Urinary Tract Infection.</p> <p>Continued interview with the MDS Coordinator, on 10/16/15 at 8:20 AM, revealed the team discussed providing more activities; however, the resident did not want to come out of the room. She stated no additional supervision of the resident was implemented. She stated the staff conducted rounds every two (2) hours and therapy and administrative staff are down the hallways frequently. However, the resident fell at 10:00 PM, when therapy and administrative staff are not at the facility. She revealed the interventions for the resident to use the call light and request assistance prior to transfer was not effective. She stated the resident did not use the call light and request staff assistance prior to the three previous falls and stated the resident didn't know to use the call light.</p> <p>8. Review of the clinical record for Resident #5 revealed the facility admitted the resident on 03/05/14 with diagnoses of Dementia, Anxiety, Depression, Seizure Disorder, Hypertension, Transient Cerebral Ischemic Attack, Diabetes Type 2, and Anemia.</p> <p>Review of the quarterly MDS assessment, dated 08/05/15, revealed the facility assessed Resident</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299		
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F 323	<p>Continued From page 106</p> <p>#5 with a score of five (5) of fifteen (15) on the BIMS assessment, which meant the resident could not be interviewed. The facility also assessed the resident as needing the extensive assistance of one with transfers, bed mobility and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when moving from a seated to standing position, moving on and off the toilet and from surface to surface.</p> <p>Review of the resident's Comprehensive Care Plan, dated 08/19/15, revealed the resident was at risk for falls related to the need for extensive assistance with most Activities of Daily Living (ADL's), a history of falls, and the use of psychotropic medications. In addition, the resident had a care plan developed for safety and the need for assistance with transferring. The Problem stated, two (2) falls in the past ninety (90) days, both with no injury. Further review of the plan of care revealed the goal related to fall prevention stated the resident would be free from falls during their stay at the facility. The goal related to activities of daily living stated the resident would be as independent as possible with ADL's. The goal related to safety stated the use of the chair/bed alarm would alert staff of the resident's need for assistance. The approaches directed staff to provide assistance with transfers, monitor location frequently during the shift and check the bed/chair alarm for placement and functionality every shift.</p> <p>Review of the clinical record revealed Resident #5 had five (5) falls within the past 90 days (06/27/15, 07/11/15, 08/11/15, 08/19/15, and 08/20/15).</p>	F 323			

