

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

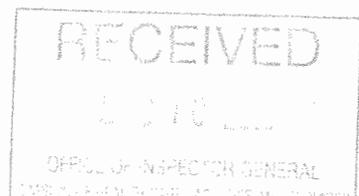
PRINTED: 12/09/2015
FORM APPROVED
OMB NO. 0938-0391

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 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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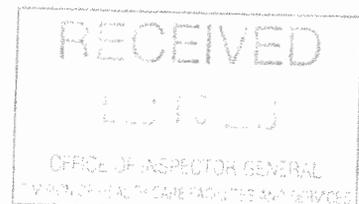
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F 323	Continued From page 78 resident's oxygen saturation level was at 76% (normal 95%-100%) after the fall. Assessment of lung fields revealed gurgles and crackles from the left side of the chest. The form noted there were no possible contributing 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". 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	F 323	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. Completion date 12/10/15		

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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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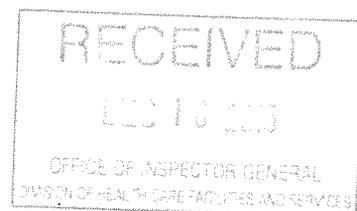
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F 323	<p>Continued From page 80</p> <p>returned to the nurses' station CNA #2 notified her Resident #1 had sustained a fall with injury. She stated the resident had a cut to the eye and cheek area and began to have breathing trouble. She stated Emergency 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	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. 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. 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	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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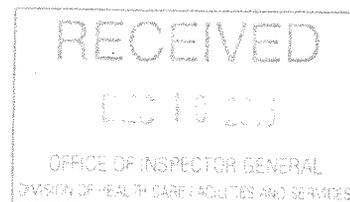
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F 323	<p>Continued From page 84</p> <p>on the chair next to the bed; and, sustained a rib fracture and the laceration to the right arm, along with other bruises.</p> <p>Interview with CNA #13, on 10/14/15 at 9:30 PM, revealed the resident could not 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			

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
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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	



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

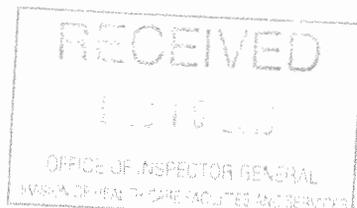
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F 323	<p>Continued From page 86</p> <p>toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when moving from a seated to standing position, walking, moving on and off the toilet 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		

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

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

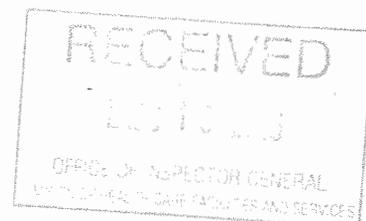
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F 323	<p>Continued From page 87</p> <p>his/her walker. The x-ray results revealed a thoracic compression fracture at T9. The resident continued to have severe pain and muscle spasms and a back brace was ordered. The resident was admitted back to the 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			



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

PRINTED: 12/09/2015
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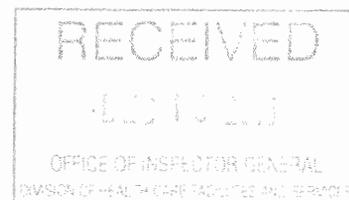
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F 323	<p>Continued From page 88</p> <p>Interview with LPN #4, on 10/09/15 at 12:40 PM, revealed a nursing assistant notified her of Resident #10's fall on 09/30/15. She stated due to the resident's complaints of back pain after the fall the resident 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			



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

PRINTED: 12/09/2015
FORM APPROVED
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F 323	Continued From page 89 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. 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. 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. 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.	F 323			



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

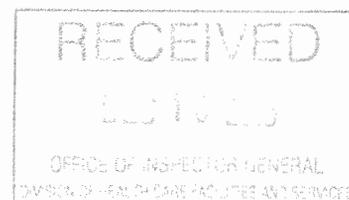
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F 323	Continued From page 90 Review of Resident #9's Fall Circumstance Event Form (FCEF), dated 09/09/15, revealed Resident #9 sustained an unwitnessed fall with injury. Nursing noted the resident had slurred speech and was confused at the time of 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 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. 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 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.	F 323			

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

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

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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		



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

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

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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			

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

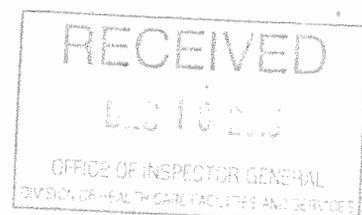
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F 323	<p>Continued From page 93</p> <p>extensive assistance of one with dressing and toileting. The facility assessed the resident's balance as not steady and only able to stabilize with staff assistance when walking, turning around or moving on and 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		

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

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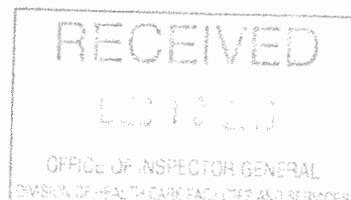
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F 323	<p>Continued From page 94</p> <p>3:30 AM, revealed the resident returned from the hospital with a diagnosis of a nasal fracture.</p> <p>Interviews with CNA #9 at 2:05 PM, CNA #11 at 2:15 PM, and CNA #5 at 2:30 PM on 10/26/15 revealed they did 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			



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

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

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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			



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
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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		

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

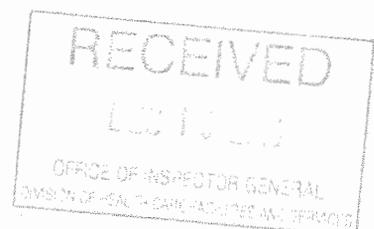
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F 323	Continued From page 97 assistance, toilet, hydration, a night light and place the bed in the low position. The form stated there were no possible contributing factors to the fall. Further review of the documentation revealed the Interdisciplinary 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.	F 323			
	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. 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. 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.				

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

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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			



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

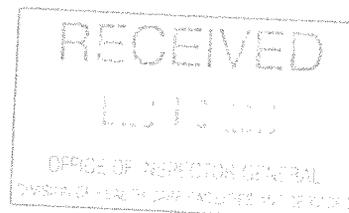
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F 323	<p>Continued From page 99 the daughter had transferred the resident alone.</p> <p>On 10/26/15, interviews with CNA #9 at 2:05 PM, CNA #11 at 2:15 PM, and CNA #5 at 2:30 PM, revealed they did not recall Resident #11's fall incidents; however, 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		

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

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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		



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

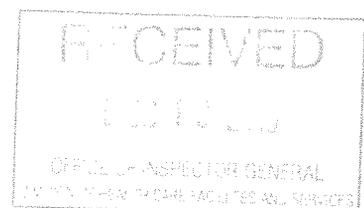
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F 323	<p>Continued From page 101</p> <p>range of motion on one side. The resident was assessed to be a high risk for falling.</p> <p>Review of the comprehensive care plan, created 07/15/15 and edited on 08/14/15 and 10/02/15, revealed the facility 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			

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

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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		



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

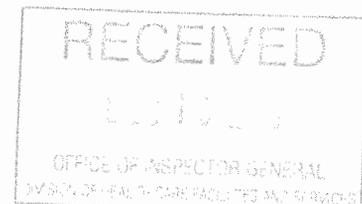
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F 323	<p>Continued From page 103</p> <p>revealed she did not recall discussing the PSA being turned off at the Clinical Care Meeting after the resident's fall on 08/12/15. She stated she would have conducted an investigation to determine why the PSA 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			

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

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FORM APPROVED
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F 323	Continued From page 104 #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.	F 323		
	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. 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. 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.			



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

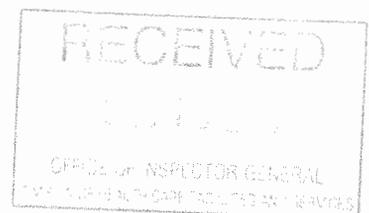
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F 323	Continued From page 105 She stated she did not know the results of the toileting intervention and did not know if the care plan intervention was effective. After the 09/06/15 fall (where the resident was found alone in the bathroom), the team 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.	F 323			
	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. 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. Review of the quarterly MDS assessment, dated 08/05/15, revealed the facility assessed Resident				

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

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F 323	Continued From page 106 #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. 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. 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).	F 323			



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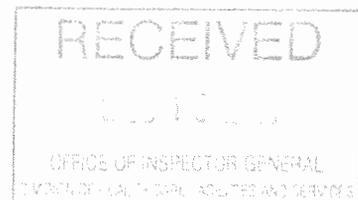
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F 323	<p>Continued From page 107</p> <p>Review of the Resident Progress Notes, dated 07/23/15, revealed a nurse notation from the clinically at risk (CAR) meeting which stated Resident #5 attempted to transfer self, personal safety alarm was sounding and fell on 06/27/15. The facility was unable to produce the Fall Circumstance Event Form for the 06/27/15 fall.</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. The nursing post fall assessment noted Resident #5 had a pink area to the crown of his/her head and the resident had confirmed his/her head was hit. There were no contributing factors noted on the Fall Circumstance Event Form. The immediate intervention noted by the nurse was the personal safety chair alarm was replaced and reinforced because the connection between the pad and the alarm box had broke off and was not connected at the time of the fall. There was no evidence the interdisciplinary team determined a root cause. 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. RN #2 stated she had fixed the broken alarm and concluded that was the root cause of the fall. RN #2 stated she had not viewed Resident #5's care plan because she</p>	F 323			

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

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

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F 323	<p>Continued From page 108</p> <p>was not responsible for making changes to the care plan. She stated she needed additional training on the new computer system.</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. Resident #5 went to his/her room and closed the bedroom and bathroom door behind him/her. The personal chair alarm was sounding and heard by the staff. Resident #5 was found on the bathroom floor with no injuries noted. There were no contributing factors noted on the Fall Circumstance Event Form. There was no evidence the interdisciplinary team determined a root cause and the care plan stated to assist with transfers. However, this intervention was already in place.</p> <p>Interview with LPN #14, on 10/15/15 at 2:35 PM, revealed she completed Resident #5's Fall Circumstance Event Form for the date of 08/11/15 and implemented toileting every two (2) hours as an immediate post fall intervention. She was not aware Resident #5 already had an intervention to assist with transfers in place on the falls care plan. LPN #14 stated she had not viewed Resident #5's care plan and could not recall why.</p> <p>Review of the Fall Circumstance Event Form, dated 08/19/15, revealed Resident #5 sustained an unwitnessed fall in the bathroom on 08/19/15. It was determined the resident transferred to the bathroom unassisted with no injuries noted. There were no contributing factors noted on the Fall Circumstance Event Form for the 08/19/15 fall event. Review of Resident #5's care plan stated the interventions were to review</p>	F 323			



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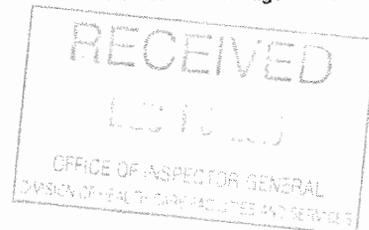
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F 323	<p>Continued From page 109</p> <p>medications, obtain a urinalysis, culture and sensitivity (UA C&S), and toilet every two hours for seventy-two hours. There was no evidence the interdisciplinary team determined a root cause.</p> <p>Review of the Fall Circumstance Event Form, dated 08/20/15, revealed Resident #5 sustained an unwitnessed fall on 08/20/15. It was determined the resident Resident #5 transferred unassisted out of the bed and was found on the floor with his/her brief off and incontinent of bowel with no injuries noted. The Fall Circumstance Event Form noted antipsychotics to be the contributing factor and no immediate interventions were put in place. Reviewing Resident #5's care plan stated the intervention for the fall event on 08/20/15 was to obtain a urinalysis, culture and sensitivity (UA C&S). However, a UA C&S was obtained the day prior for a previous fall event on 08/19/15.</p> <p>Interview with the MDS Nurse, on 10/08/15 at 10:40 AM, revealed not all falls needed a new intervention; some of the falls for Resident #5 were to educate and re-educate the staff and the resident and monitor the resident more frequently. The MDS Nurse stated, "Frequently" meant watch the resident more. The MDS Nurse stated when the original fall care plan was developed for Resident #5; it had generic fall risk interventions in place. The MDS Nurse stated she would add the individualized interventions after the completion of the fourteen (14) day assessment regardless of the resident's history on admission.</p> <p>Interview with the DHS, on 10/09/15 at 12:20 PM, revealed Resident #5's falls were not reviewed in</p>	F 323			

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

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F 323	<p>Continued From page 110</p> <p>interdisciplinary team meeting, the DHS stated the facility administration staff had identified not all of the Event Forms were correctly completed. The DHS stated repeated falls might not have occurred if the IDT and the MDS Coordinators would have identified the discrepancies in the Fall Circumstance Event Forms.</p> <p>Interview with the Director Clinical Support Registered Nurse (DCS RN), on 10/09/15 at 12:20 PM, revealed revealed the facility was unable to produce any interdisciplinary team discussion notes regarding Resident #5's multiple falls.</p> <p>On 10/02/15 at 2:20 PM, observation of Resident #5's UMP bed alarm pad, 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, on 10/02/15 at 2:20 PM, with CNA #4 revealed she did not know the pad did not have a date on it. Observation revealed CNA #4 removed a black marker from her pocket and wrote 10/02/15 on the pad. She stated all pads used in the building were good for 90 days. She stated the instructions were written on the pad as to how long the pad was good for. She read the pad to the surveyor and stated the pad was actually good for six months not 90 days. She stated she had not received training on the alarms from the manufacturer.</p> <p>Interview on 10/02/15 at 2:30 PM, with LPN #4, revealed 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 she also did not know if the facility had a policy regarding the</p>	F 323			



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

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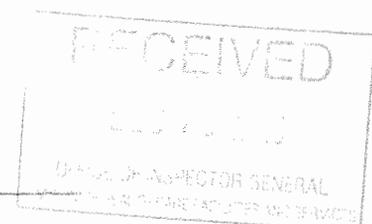
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F 323	<p>Continued From page 111</p> <p>bed/chair alarms. She stated she had not received training on the alarms from the manufacturer.</p> <p>9. Review of the clinical record revealed the facility admitted Resident #2 on 12/16/14, with diagnoses of Depression with Delusions, Dementia, Cerebral Vascular Accident, and Weakness. Review of Resident #2's Quarterly MDS assessment, completed on 09/29/15, revealed the facility assessed the resident to need the 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. The facility assessed Resident #2 with a score of four (4) of fifteen (15) on the BIMS assessment indicating the resident was cognitive impaired.</p> <p>In addition, the facility developed a care plan related to falls with updated goals and target dates for 10/15/15. Problem on the care plan 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 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 goal related to activities of daily living stated the resident would improve current level of self-care. 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</p>	F 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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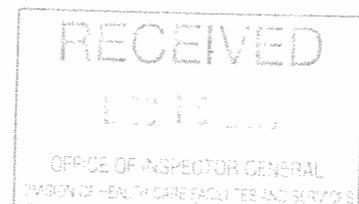
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F 323	<p>Continued From page 112 of the resident.</p> <p>Review of Resident #2's Treatment Administration Record (TAR), dated 07/02/15, revealed an order for the resident to have a bed/chair alarm at all times and for staff to check for placement and functionality every shift. Further review of Resident #2's TAR revealed nursing obtained an order to change the alarm batteries every month on the fifteenth (15th) at 8:59 PM on 10/01/15, after the Surveyor questioned nursing staff, on 10/01/15 at 1:18 PM and 1:25 PM, regarding the process for checking alarm functionality.</p> <p>Observation on, 10/01/15 at 3:00 PM, revealed Resident #2 was sitting in a recliner next to the 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 on 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 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 the pad under the resident was part of an alarm system that alerted staff when a resident attempted to transfer without assistance.</p>	F 323	



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

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OMB NO. 0938-0391

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F 323	<p>Continued From page 113</p> <p>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 the pad had written information on it, detailing in number of days, when it should be disposed of, after opening. She stated if the pads were expired the alarms could malfunction and not alert staff to the fact a resident was attempting to transfer without assistance.</p> <p>Continued interview with CNA #3, on 10/02/15 at 2:35 PM, revealed after investigating Resident #2's alarm malfunction it was determined the alarm needed new batteries and the pad needed to be replaced. She stated there was no way to tell when the pad had been put into use or when it had expired due to no expiration date written on the pad. She stated nursing obtained a new order for Resident #2, on 10/01/15, to start changing the batteries on the fifteenth of every month. She stated it was the responsibility of all staff to ensure the bed/chair alarms were in place and functioning in order to ensure resident's safety needs were met.</p> <p>Interview with LPN #7, on 10/01/15 at 1:25 PM, revealed she had not check Resident #2's bed/chair alarm for functionality only for placement. She stated the Certified Nursing 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>	F 323			



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

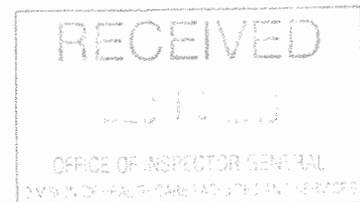
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F 323	Continued From page 114 10. Review of the clinical record revealed the facility admitted Resident #6 on 09/02/15, with diagnoses of Parkinson, Hypertension, Dementia and history of Chronic Deep Vein Thrombosis. Review of Resident #6's Quarterly Minimum Data Set (MDS) assessment, completed on 09/09/15, revealed the facility assessed the resident to need 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 #6 with a score of eight (8) of fifteen (15) on the BIMS assessment indicating mild cognitive impairment. Review of the Comprehensive Care Plan for Resident #6 revealed the facility developed a plan 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 the keep call light within reach. Review of 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. 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 need to be discarded.	F 323		

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

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OMB NO. 0938-0391

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F 323	<p>Continued From page 115</p> <p>Interview, on 10/02/15 at 2:20 PM, with CNA #6 revealed she had forgotten 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 she got busy and forgot. CNA #6 stated due to the pad getting bent, soiled and worn from the resident's sitting on them at times they would malfunction requiring them to be discarded. She stated all the pads were disposable. She stated the pad had written information on it stating how long the pad was good for, after putting it into use. She stated staff would take a marker and write the date the pad was opened not the date it expired. She stated she had not received training on the manufacturer's recommendations for the alarm systems used in the facility. She stated she received training regarding ensuring they were in place and turned on. She stated she did not know the pads were to be marked with the actual date it would need to be discarded.</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 she believed all the pads in the facility were good for ninety (90) days. She stated she was not aware CNA #6 did not mark the pad after opening. She stated she did not know if the facility had a policy regarding the alarms and had not had recent training regarding the manufacturer's recommendations. She stated management reminded staff routinely to check them for placement, but that was about it. She stated she did not know there were three (3) different brands in use and that they were not interchangeable. She stated if the alarms were not interchangeable; they could malfunction and not alert staff the resident had gotten up without</p>	F 323			



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

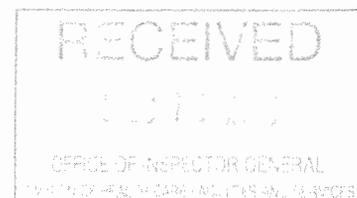
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F 323	<p>Continued From page 116 assistance.</p> <p>Interviews with CNA #1, on 10/02/15 at 8:44 AM, LPN #1, on 10/02/15 at 9:30 AM, CNA #2, on 10/02/15 at 2:05 PM, LPN #7, on 10/01/15 at 1:25 PM, and CNA #3, on 10/02/15 at 2:35 PM, revealed according to their knowledge the facility had two (2) different bed/chair alarms in use not three (3). They all stated the alarm pads and units in use were all interchangeable. Each staff member interviewed stated they had not received training per the manufacturers recommendations for the three (3) types of bed/chair alarm used in the facility. In addition, the interviews revealed each staff member provided a different account of how they would check the alarms for functionality.</p> <p>Interview with the DHS, on 10/05/15 at 11:45 AM and 2:00 PM and on 10/16/15 at 3:00 PM, revealed she did not know the facility had three (3) difference brands of alarms in the building until the Surveyor requested manufacturer recommendations. She stated she had not read the manufacturer's information prior to the survey and the staff had not had training on the information. Per interview, the manufacturer's recommendations were not available for staff reference. She stated the alarms could malfunction if interchanged or not tested according the recommendations. She stated the facility had not determined there might be a problem with the bed/chair alarm process or staff use of them. She stated harm could happen to residents if the alarms were not according to the recommendations.</p> <p>Further interview with the DHS regarding the facility's falls process, on 10/09/15 at 12:20 PM, revealed reportable events were the only events</p>	F 323			

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

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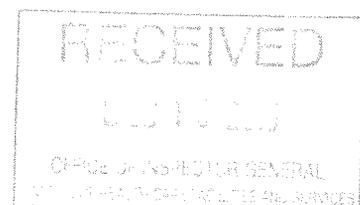
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 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	Continued From page 117 that had completed Post Root Cause Forms. The DHS stated she closed Event Forms when all of the follow-up documentation in the progress notes and reviews, and revisions to the care plans were completed. The DHS stated she was responsible for monitoring the Event Forms for accuracy and completion. The DHS stated the process for fall investigations were to find out first, what the resident was trying to do and why. The next step was interviewing staff, in attempt to determine the root cause. The DHS stated the computer system named root cause as contributing factors. She also stated it was the responsibility of the nurse to perform these actions and document in a progress note. Further interview with the DHS, on 10/16/15 at 3:00 PM, revealed the nursing staff involved in the incident would complete an event form and determine the root cause of the event. She stated the contributing factors listed on the form were the root causes of the event and the interventions developed were based on those factors. She stated the Interdisciplinary Team (IDT) reviewed the forms the next day or on Monday if it occurred over a weekend. She stated the forms had changed over time and used to have a section for documenting the root cause; however, that section was deleted. She stated the IDT did not keep notes or documentation related to the discussion or decisions made during the review of the event. She stated nursing staff should document follow up assessments and the resident's response to treatment for seventy-two hours after the event. She stated she was not aware the event forms were not complete or the follow up assessments had not been completed. She stated in the beginning, the electronic medical record prompted staff to document their	F 323			



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F 323	Continued From page 118 reassessments. However, now nursing had to remember to document a progress note after an event and attach it to the event form. Interview with the Director Clinical Support Registered Nurse (DCS RN), on 10/09/15 at 12:20 PM, revealed follow-up documentation was not consistent with every interdisciplinary team meeting and they had not kept any notes taken during those meetings.	F 323			
	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: 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				



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F 323	<p>Continued From page 119 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 323		

