

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

PRINTED: 05/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2015	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHABILITATION, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 LAGRANGE RD PEWEE VALLEY, KY 40056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey was initiated 05/05/15 and concluded on 05/06/15 to investigate KY23201. The Division of Health Care substantiated the allegation and past noncompliance was determined to exist on 05/05/15 in 42 CFR 483.25 (F323 S/S "G") for failure to provide adequate supervision and assistive devices to prevent accidents. Also cited for past noncompliance in 42 CFR 483.20 (F282 S/S "G") for failure to provide qualified persons in accordance with each resident's written plan of care. All corrective actions were completed on 04/27/15 prior to the entrance of the State Survey Agency's investigation making the deficiency Past Non-compliance.	F 000		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to implement the interventions outlined on a Falls care plan for one (1) of four (4) sampled residents (Resident #1). The facility assessed Resident #1 as requiring a tab alarm applied while in bed and when up in the wheelchair. However, on 04/23/15 at approximately 1:00 AM, Certified Nursing Assistant (CNA) #1 failed to follow the care plan when he failed to attach the alarm to the resident	F 282	Past noncompliance: no plan of correction required.	

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

TITLE

(X6) DATE

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

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F 282	<p>Continued From page 1</p> <p>after finishing care. At 3:00 AM the staff found Resident #1 on the floor by the bed with a laceration to the right forehead and a fracture to the wrist, orbital, and maxillary sinus that required evaluation and treatment at a local hospital.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Falls, not dated, revealed when a resident was identified as a high risk for falls then a plan of care would be implemented based on identified risk factors.</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on July 24, 2014 with diagnoses of a history of a Fractured Femur, Aphasia, Difficulty in Walking, Dementia, Depression, Heart Disease, Congestive Heart Failure, Muscle Weakness, Hypothyroidism, Anemia, Hypertension, Atrial Fib, and Normal Pressure Hydrocephalus.</p> <p>Review of a quarterly Minimum Data Set (MDS) Assessment, dated 02/24/15, revealed the facility assessed the resident as an extensive assist for transfers. The facility further assessed the resident's balance during transitions and walking was not steady and the resident needed staff assistance to balance. In addition, there was an impairment of range of motion (ROM) on one side. The facility conducted a Brief Interview for Mental Status (BIMS) with a score of a seven (7), which indicated severe cognitive impairment and the resident was not interviewable. Review of the Morse Fall Scale, dated 04/24/15, revealed the resident was at high risk for falls due to an impaired gait. The facility determined the resident's mental status was a factor in the resident's overestimating or forgetting his/her</p>	F 282		
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F 282	<p>Continued From page 2 limits.</p> <p>Review of Resident #1's care plan, dated 03/25/15, revealed the facility determined the resident was at risk for falls related to impaired balance and required assist with transfers. Interventions included safety devices, such as a tab alarm to the chair and a sensor alarm to the bed and the recliner. The care plan was revised on 04/24/15 to include the sensor alarm to the bed and the chair. A revision of the care plan on 04/27/15 indicated therapy was to evaluate and treat. Review of the Certified Nursing Assistant (CNA) Kardex care plan included the need for safety devices. The resident was to have a tab alarm to the chair and a sensor alarm to the bed and the recliner.</p> <p>Observation of Resident #1, on 05/05/15 at 2:06 PM, revealed the resident was lying in bed on his/her back with the head of the bed up. The right forearm had a black brace on it. The grab bars were up on each side of the bed. There was a fading purplish green area on the right cheek. There were fall mats on the side of the bed. A bed sensor pad was under the resident and the wheelchair was at the bedside with two alarms (one green Cordiless and one purple Horizon) on it.</p> <p>Interview with Resident #1, on 05/05/15 at 2:06 PM, revealed the staff took care of him/her okay. The resident stated he/she had fallen before, but then his/her word content was difficult to understand. The resident did not answer other questions appropriately.</p> <p>Review of the 04/23/15 investigation completed by the facility revealed CNA #1, on 04/23/15 at</p>	F 282		

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F 282	<p>Continued From page 3</p> <p>approximately 1:00 AM, did not re-apply Resident #1's alarm device before he (CNA) had exited the room after providing care. The staff found the resident lying at the foot of the bed after the resident exited the bed by themselves. The resident sustained a laceration to the forehead. The resident was sent to the hospital for sutures and was subsequently admitted with fractures and an intracranial bleed. The resident returned to the facility on 04/24/15.</p> <p>Interview with CNA #1 via telephone, on 05/07/15 at 4:00 PM, revealed he had provided care to the resident around 1:00 AM and had inadvertently forgot to put the tab alarm back on the resident when he walked out of the room. He stated it was on the CNA Kardex care plan to apply the tab alarm, but he just forgot to replace it. CNA #1 stated he thought that not putting the tab alarm back on the resident contributed to the resident falling, but only if a person was in close proximity to the resident because he/she was quick and if the staff were far away the staff would not be able to get to him/her quick enough.</p> <p>Interview with the Director of Nursing (DON), on 05/06/15 at 2:00 PM, revealed CNA #1 did not put the alarm back on Resident #1 as outlined in the resident's care plan. When the care plan was completed it triggered the CNA Kardex to have the same information. CNA #1 was terminated for failure to follow the care plan.</p> <p>Prior to exit of the survey, the State Survey Agency verified the facility conducted house wide training by the Staff Development Coordinator and the Director of Nursing (DON) on 04/24/15 which included following all care plan instructions</p>	F 282			

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F 282 Continued From page 4
and to seek clarification if the staff had questions. All staff was to respond when alarms sounded. A sample of residents was interviewed by the DON on 04/23/15 to determine if they felt their needs were being met. An audit of a sample of residents was conducted by the Assistant Director of Nursing (ADON) on 04/27/15 to determine if the care plan was followed. A house wide audit of all falls incidents were conducted the Interdisciplinary Team (IDT) on 04/24/15 to ensure appropriate interventions were applicable and care planned and in place to prevent future reoccurrence. The Office of the Inspector General was notified on 04/24/15 and a five day follow up was faxed on 04/27/15. Adult Protective Services, the physician and the family were also notified by the DON on 04/24/15.

Observation of Resident #2, on 05/05/15 at 5:05 PM, revealed the resident was not in their room, but in the dining room. The resident was sitting up in a chair waiting for supper. The resident was awake, alert, and oriented, dressed appropriately, hair combed, clean, and neat. The resident had a walker by the table within reach. The resident stated he/she lived at home alone, fell and broke the hip and shoulder. The resident further stated a fall had occurred not too long ago, but there was no injury. Continued observation of Resident #2's bathroom revealed tape was applied to the floor in front of the sink and the commode as outlined in the falls care plan.

Review of Resident #2's Falls risk assessment, completed on 03/25/15, revealed the resident was at risk for falls. Review of the quarterly MDS, dated 03/20/15, revealed the resident was able to ambulate with the use of a walker and assist given as needed. Review of the care plan, dated

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F 282	<p>Continued From page 5</p> <p>03/25/15, revealed a care plan had been developed for falls.</p> <p>Observation of Unsampled Resident B, on 05/05/15 at 2:06 PM, revealed the resident was laying in bed on his/her back with an alarm attached. Fall mats were noted on each side of the bed.</p> <p>Observation of Unsampled Resident A, on 05/05/15 at 3:00 PM, revealed the resident was sitting in a wheelchair with a sensor alarm attached and the green light was blinking. Review of the Falls care plan and Kardex revealed the resident was to have a sensor alarm when up in the wheelchair.</p> <p>Interview with the Staff Development Nurse, on 05/06/15 at 4:40 PM, revealed she was part of the Quality Assurance team and they discussed the root causes of falls. The team did audits to track and trend any concerns. She educated the staff on safety and alarms at the end of April 2015. They covered how to know who had alarms and how to use the Kardex and care plans. They required post tests to make sure staff understood what they had gone over. Review of the safety in-service conducted on 04/23/15 and 04/24/15 revealed staff was educated on the care plan which drives the care provided to residents. Every nurse and CNA was responsible to ensure the care plan was followed. They were to make sure that all alarming devices were in place and functioning properly. Review of the program plan attendance record revealed the staff development nurse reviewed safety; alarms; charting; falls; call light audits; and the Kardex.</p> <p>Interview with Nurse #9, on 05/06/15 at 4:15 PM,</p>	F 282		
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F 282	<p>Continued From page 6</p> <p>revealed she had been inserviced on alarms on 04/23/15. They discussed who got an alarm and how to refer to the care plans for the correct alarm. Review of the Safety, Alarms, Kardex and Falls Inservice completed on 04/23/15 revealed the nurse was in attendance.</p> <p>Interview, on 05/06/15 at 3:30 PM, with CNA #4 revealed she had been in-serviced on personal alarms. They were to make sure the alarms were on. She stated the Kardex would say if the resident needed an alarm or not and if they did the staff needed to make sure it was on them. If the staff heard an alarm sound they were to check on it.</p> <p>Review of the CNA care plan compliance audit, completed on 04/27/15, revealed five residents had audits completed on multiple areas that included appropriate seating; assistive device use; wheel chair devices properly placed; bed devices properly placed; and, bed and or chair alarms functioning properly.</p> <p>Interview, on 05/06/15 at 4:30 PM, with Nurse #11 revealed the audits were completed by the Interdisciplinary Team (IDT) weekly and quarterly; however, could be completed at any time, and taken to the IDT meetings in the morning and discussed. The IDT morning meetings were part of the Quality Assurance (QA) program. They meet weekly and then Quarterly.</p> <p>Interview with the Administrator, on 05/06/15 at 4:40 PM, revealed he was the Director of the QA Committee and responsible for the audits completed for QA. The QA team was responsible for putting interventions in place and doing audits to make sure there was compliance with those</p>	F 282		

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F 282 F 323 SS=G	Continued From page 7 interventions. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to reapply a personal alarm on one (1) of four (4) sampled residents (Resident #1) that resulted in a fall with injury. The facility identified Resident #1 to be at risk for falls and required a tab alarm on while in bed; however, Certified Nursing Assistant (CNA) #1 failed to reapply the alarm after care was completed. The resident sustained a fracture of the right maxillary sinus, the right orbital, and a right wrist fracture. He/She also sustained a subdural hematoma all of which required transfer to a hospital for evaluation and subsequently admitted for treatment. The findings include: The facility did not provide a policy regarding supervision of residents to prevent accidents. Review of the facility's policy regarding Falls, not dated, revealed when a resident was identified as	F 282 F 323	Past noncompliance: no plan of correction required.	

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F 323	<p>Continued From page 8</p> <p>a high risk for falls then a plan of care would be implemented based on identified risk factors. In the event of a fall a post fall analysis would be done to aid in identifying contributing factors and the care plan would be revised as appropriate.</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on July 24, 2014 with diagnoses of a history of a Fractured Femur, Aphasia, Difficulty in Walking, Dementia, Depression, Heart Disease, Congestive Heart Failure, Muscle Weakness, Hypothyroidism, Anemia, Hypertension, Atrial Fib, and Normal Pressure Hydrocephalus.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/24/15, revealed the facility assessed the resident with impaired cognition and a score of three (3) of fifteen (15) on the Brief Interview for Mental Status (BIMS). Further, the resident required extensive assist for transfers and bed mobility. The facility determined the resident's balance during transitions and walking was not steady and needed staff assistance to balance. There was an impairment of Range of Motion on one side due to a history of a stroke and a previous fractured femur, which happened prior to admission. A wheelchair was used for mobility. Review of the Morse Fall Scale, dated 04/24/15, revealed the resident was at high risk for falling due to an impaired gait.</p> <p>Review of the care plan, dated 03/25/15, revealed the resident was at risk for falls related to impaired balance and required assistance with transfers. Interventions included safety devices, such as a tab alarm to the chair and a sensor alarm to the bed and recliner. The care plan was revised, on 04/24/15, to include the sensor alarm</p>	F 323		

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F 323 Continued From page 9

to the bed and chair. The revision on 04/27/15 included therapy to evaluate and treat as ordered. Review of the CNA Kardex care plan included the need for safety devices as indicated, a tab alarm to chair and sensor alarm to the bed and the recliner.

Review of the facility's investigation, dated 04/23/15, revealed CNA #1 did not reapply a personal alarm to Resident #1 after providing care. On 04/23/15 at 3:00 AM, the staff found the resident on the floor at the foot of the bed. A laceration was noted to the right forehead. The facility sent the resident to the hospital and was subsequently admitted overnight with a laceration to the forehead that required sutures, fractures, and an intracranial bleed. The resident returned to the facility on 04/24/15. The facility concluded the CNA did not apply the alarm and his employment was terminated.

To prevent recurrence the facility conducted house wide training by the Staff Development Coordinator and the Director of Nursing (DON) on 04/24/15 which included following all care plan instructions and to seek clarification if the staff had questions. All staff was to respond when alarms sounded. A sample of residents was interviewed by the DON on 04/23/15 to determine if they felt their needs were being met. An audit of a sample of residents was conducted by the Assistant Director of Nursing (ADON) on 04/27/15 to determine if the care plan was followed. A house wide audit of all falls incidents were conducted the Interdisciplinary Team (IDT) on 04/24/15 to ensure appropriate interventions were applicable and care planned and in place to prevent future reoccurrence. The Office of the Inspector General was notified on 04/24/15 and a

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F 323	Continued From page 10 five day follow up was faxed on 04/27/15. Adult Protective Services, the physician and the family were also notified by the DON on 04/24/15. Review of the hospital History and Physical, dated 04/24/15, revealed Resident #1 had a history of a stroke in 2014. On 04/23/15 the resident fell out of bed and sustained a laceration above the right eye. The resident was sent to the emergency room. A computerized axial tomography (CT) scan of the spine and head was completed which revealed no fracture of the spine; however, a right closed facial bone fracture of the maxillary sinus, a right orbital floor fracture, and a right radius and non-displaced ulna fracture were noted. The facial fractures were stable and no interventions were needed. The CT of the head revealed an acute, but stable, subdural hematoma to the right side and an old stroke. A Ventriculoperitoneal Shunt (VP) shunt was noted on the CT and it was not functioning correctly. The resident would need the fluid volume to be decreased. The resident was to follow up with an Orthopedic physician for the fracture of the right wrist. The resident was sent back to the nursing home on 04/24/15. The physician orders, dated 04/23/15, revealed the tab alarm was discontinued for the bed and a sensor pad instead was to be used. The tab alarm was to be used on the chair. Orders for Physical Therapy, Speech Therapy, and Occupational Therapy were obtained on 04/27/15. A follow up visit to the physician was completed on 04/29/15. A new order for pain medication to be given every four (4) hours, while awake was received. The resident received the pain medication as needed. Review of the April and May 2015 Medication Administration Record (MAR) revealed Resident	F 323			

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F 323	<p>Continued From page 11</p> <p>#1 had received the pain medication, Norco, as ordered by the physician.</p> <p>Observation of Resident #1, on 05/05/15 at 2:06 PM, revealed the resident was lying on the bed with the head of the bed raised. The right forearm had a black brace. The grab bars were up on each side. A fading purplish green area on the resident's right cheek was observed. A mat was on the right side of the bed. There was a bed sensor pad under the resident and the wheelchair had two alarms.</p> <p>Interview with the resident at this time revealed the staff took care of him/her okay. The resident stated he/she had fallen before, but then the verbalizations were hard to understand and the resident did not answer other questions appropriately.</p> <p>A telephone interview with CNA #1, on 05/07/15 at 4:00 PM, revealed he was providing care to Resident #1 around 1:00 AM on 04/23/15. The resident had a bowel movement and it was all over the sheets and he had to go get more supplies. He thought he took the tab alarm off at that point, but after thinking about it he was not sure it was already off. He stated he cleaned the resident up and was just finishing when another alarm had sounded. He exited the room and inadvertently did not put the tab alarm back on the resident. He stated he just forgot. He stated around 3:00 AM or 3:30 AM he heard an alarm go off and went to Resident #1's room and found the resident on the floor with two (2) staff members assisting him/her. The resident had a laceration to his/her right forehead. He stated the failure to reapply the alarm may have contributed to his/her fall. He stated the alarm used at that time was</p>	F 323		

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the one with a magnet on it. One end of the alarm was attached to him/her and the other end had a magnet on it that was attached to the device which laid in the bed. If the resident tried to get up the alarm would sound. He stated the resident did not have the sensor alarm at the time of the fall. He said he had been trained on personal alarms and knew they should be attached at all times if the Kardex stated that. He indicated the staff was to check the alarms on every round to make sure they were working.

Interview with CNA #3, on 05/05/15 at 2:15 PM, revealed the resident required assistance with transfers and mobility. The CNA stated she had just laid the resident down to rest because he/she would be going to therapy later. The CNA stated the resident had fallen before and a sensor alarm was utilized while in bed that was in synchronized with the green alarm on the chair.

Observation of Resident #1, on 05/06/15 at 12:55 PM, revealed the resident was up in a wheelchair in the dining room waiting for lunch to be served. The personal alarms were attached to the wheelchair and functional. The resident was observed to be awake, alert, and calm. There was no grimacing or crying out of pain noted.

Observation of Resident #1, on 05/06/15 at 2:15 PM, revealed the resident was lying in bed on his/her back with the grab bars up and his/her eyes were closed. The sensor alarms were under the resident and the green light was flashing indicating it was working.

Interview with the Administrator, on 05/06/15 at 11:40 AM, revealed there was a process in place to put alarms on residents that needed them.

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F 323	<p>Continued From page 13</p> <p>Resident #1's fall on 04/23/14, as all falls, was brought to the attention of the Interdisciplinary Team (IDT) at the morning meeting and the decision was made to further investigate the root cause of the fall. CNA #1 was suspended and later terminated. It was during the investigation that it was discovered the tab alarm had not been placed back on the resident after the CNA had provided care. The Administrator stated the CNA was in error by not putting the alarm back on the resident.</p> <p>Further interview with the Administrator on 05/06/15 at 4:40 PM, revealed they had a Quality Assurance (QA) meeting after the resident's fall. The QA committee consisted of the Medical Director, Director of Nursing, Assistant Director of Nursing, Staff Development, Administrator, and other department heads who implemented interventions to help prevent further problems. The normal QA meetings were done quarterly. The IDT meetings were done weekly and there were morning meetings every morning. When there was an incident report on a resident fall it was put into the point computer system and the Administrator would get an alert. The team would discuss the fall at the morning meeting. They reviewed the interventions, discussed the appropriateness of the interventions and determine if there were other interventions needed. The team tried to determine the root cause of the fall. The team would track the falls and interventions weekly at the IDT meetings. The quarterly QA reviews the trends of what they had tracked. The Administrator stated it was an unfortunate accident, but the facility followed the process appropriately and self-reported the incident.</p>
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F 323	<p>Continued From page 14</p> <p>Interview with the Staff Development Nurse, on 05/06/15 at 4:40 PM, revealed she was part of the Quality Assurance team and they discussed the root causes of falls. The team did audits to track and trend any concerns. She educated the staff on safety and alarms at the end of April 2015. They covered how to know who had alarms and how to use the Kardex and care plans. They required post tests to make sure staff understood what they had gone over. Review of the safety in-service conducted on 04/23/15 and 04/24/15 revealed staff was educated on the care plan which drives the care provided to residents. Every nurse and CNA was responsible to ensure the care plan was followed. They were to make sure that all alarming devices were in place and functioning properly. Review of the program plan attendance record revealed the staff development nurse reviewed safety; alarms; charting; falls; call light audits; and the Kardex.</p> <p>Interview, on 05/06/15 at 3:30 PM, with CNA #4 revealed she had been in-serviced on personal alarms. They were to make sure the alarms were on. She stated the Kardex would say if the resident needed an alarm or not and if they do the staff needed to make sure it was on them. If the staff heard an alarm go off they were to go check on it.</p> <p>Interview with CNA #2, on 05/06/15 at 1:50 PM, revealed Resident #1 used a body alarm when up in the wheelchair and at all times. The pad alarm was used in the bed and on the recliner. She stated they had been instructed on what type of alarms to use, when to put them on a resident and where to look to find that information. She stated the information was placed on the Kardex that was in the computer.</p>	F 323		

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F 323	<p>Continued From page 15</p> <p>Interview with Nurse #9, on 05/06/15 at 4:15 PM, revealed she had been inserviced on alarms on 04/23/15. They discussed who got an alarm and how to refer to the care plans for the correct alarm. Review of the Safety, Alarms, Kardex and Falls Inservice completed on 04/23/15 revealed the nurse had attended the inservice.</p> <p>Observation of Resident #2, on 05/05/15 at 5:05 PM, revealed the resident was not in their room, but in the dining room. The resident was sitting up in a chair waiting for supper. The resident was awake, alert, and oriented, dressed appropriately, hair combed, clean, and neat. The resident had a walker by the table within reach. The resident stated he/she lived at home alone, fell and broke the hip and shoulder. The resident further stated a fall had occurred not too long ago, but there was no injury. Continued observation of Resident #2's bathroom revealed tape was applied to the floor in front of the sink and the commode as outlined in the falls care plan.</p> <p>Review of Resident #2's Falls risk assessment, completed on 03/25/15, revealed the resident was at risk for falls. Review of the quarterly MDS, dated 03/20/15, revealed the resident was able to ambulate with the use of a walker and assist given as needed. Review of the care plan, dated 03/25/15, revealed a care plan had been developed for falls.</p> <p>Observation of Unsampled Resident B, on 05/05/15 at 2:06 PM, revealed the resident was laying in bed on his/her back with an alarm attached. Fall mats were noted on each side of the bed.</p>	F 323		

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F 323	<p>Continued From page 16</p> <p>Observation of Unsampled Resident A, on 05/05/15 at 3:00 PM, revealed the resident was sitting in a wheelchair with a sensor alarm attached and the green light was blinking. Review of the Falls care plan and Kardex revealed the resident was to have a sensor alarm when up in the wheelchair.</p> <p>Review of the CNA care plan compliance audit, completed on 04/27/15, revealed five residents had audits completed on multiple areas that included appropriate seating; assistive device use; wheel chair devices properly placed; bed devices properly placed; and, bed and or chair alarms functioning properly.</p> <p>Interview, on 05/06/15 at 4:30 PM, with Nurse #11 revealed the audits were taken to the IDT meetings in the morning and discussed. The IDT morning meetings were part of the Quality Assurance (QA) program that meet weekly and then Quarterly.</p> <p>Interview with the Administrator, on 05/06/15 at 11:40 AM, revealed members of the Interdisciplinary Team (IDT) talked to other residents to make sure they felt safe and their needs were met. All staff were re-trained to respond when an alarm sounded. Audits were conducted by the IDT to see if the CNA care plans were followed and a house wide audit were completed for all falls. Interview with the Administrator on 05/06/15 at 4:40 PM revealed he was the Director of the QA Committee and the QA team was responsible for putting interventions in place and doing audits to make sure there was compliance with those interventions.</p>
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