

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155121	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/01/2012
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NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE AT LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904
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F0000	<p>This visit was for the Investigation of Complaints IN00101847 and IN00102782.</p> <p>Complaint IN00101847 - Unsubstantiated, due to lack of evidence</p> <p>Complaint IN00102782 - Substantiated. Federal/state deficiencies related to the allegation are cited at F279 and F323.</p> <p>Survey Dates: January 26, 2012 Extended Survey Dates: January 27, 28, 29, 30, 31, and February 1, 2012.</p> <p>Facility Number: 000051 Provider Number: 155121 AIM Number: 100275490</p> <p>Survey Team: Linda Campbell, RN, TC (January 26, 27, 28, 30, and February 1, 2012) Rebecca Lemon, RN (January 29, 31, 2012)</p> <p>Census Bed Type: SNF: 20 SNF/NF: 110 Total: 130</p> <p>Census Payor Type: Medicare: 32</p>	F0000		

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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	<p>Medicaid: 81 Other: 17 Total: 130</p> <p>Sample: 6 Supplemental Sample: 2</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 2/01/12 by Suzanne Williams, RN</p>				

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F0279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure care plans were updated related to fall interventions for 4 of 5 residents reviewed with care plans for falls in a sample of 6 (Residents #B, #C, #E, #G).</p> <p>Findings include:</p> <p>1. Resident #B's clinical record was reviewed on 1/26/12 at 11:30 A.M.</p> <p>An Interdisciplinary Team (IDT) note dated 11/22/11 indicated the resident had fallen on 11/21/11 at 5:15 P.M. Further</p>	F0279	<p><b>Please consider this plan of correction as our credible allegation of compliance to the Complaint survey conducted from January 26 th through the 27 th , 2012. F279 Resident B, C, E, and G have been reviewed and updated and recorded to reflect resident specific interventions and plan of care. All residents are at potential risk for this deficient practice. All care plans relating to falls have been reviewed and updated and reflect resident specific interventions. Staff has been in-serviced, by the SDC, on care plans and there implementation (see attachment</b></p>	02/09/2012	

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	<p>review indicated "...staff will be instructed on not leaving hoyer pad under res in w/c..."</p> <p>A resident care plan dated 9/27/11 indicated documentation was lacking related to the care plan having been updated to address not leaving a hoyer pad under the resident in the wheelchair.</p> <p>2. Resident #C's clinical record was reviewed on 1/26/12 at 1:10 P.M.</p> <p>An "Event Report" dated 1/23/12 indicated the resident had fallen on 1/22/12 at 11:30 P.M. Further review indicated "...bed and chair alarm..."</p> <p>A resident care plan dated 11/30/11 indicated documentation was lacking related to the care plan having been updated to address the use of a bed and chair alarm.</p> <p>3. Resident #E's clinical record was reviewed on 1/26/12 at 12:30 P.M. The clinical record indicated the resident had fallen on 10/16/11 at 8:45 P.M.</p> <p>A "Fall Circumstance Report" dated 10/16/11 indicated "...Alarm was put onto the chair by the door..."</p> <p>Review of a resident care plan dated</p>		<p>#1A, #1B, #1C). In-servicing was completed 2/9/2012. We review all residents at time of Admissions, and with quarterly and annual reviews. DNS will review IDT documents and ensure care plans are updated based on IDT recommendations. Physicians and families will continue to be notified on any and all changes. The CQI tool entitled " Care Plan Review"(see attachment #2) and "Care Plan Update" (see attachment #3) will be implemented by 2/9/2012 and utilized by the Director of Nursing and or designee weekly at the care plan meeting. Threshold of compliance will be 95%, if not met, an action plan will be created. This review will be initiated by 2/9/2012 and done on a weekly basis for the first four weeks, monthly for the next three months and quarterly thereafter. The DNS and or designee will be responsible for this implementation. Completion date: 2/09/2012</p>				

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	<p>7/21/11 indicated documentation was lacking related to the care plan having been updated to address the use of an alarm on the chair by the door.</p> <p>An IDT note dated 10/31/11 indicated the resident had fallen on 10/28/11 at 6:00 P.M. Further review indicated "...Toilet resident q 20 (every two hours) while awake..."</p> <p>Review of a resident care plan dated 7/21/11 indicated documentation was lacking related to the care plan having been updated to address toileting the resident every two hours.</p> <p>An IDT note dated 11/6/11 indicated the resident had fallen on 11/6/11 at 8:15 P.M. Further review indicated "...make sure resident has items in room that she comes to the nurses station for such as iced tea, sugar. Will talk to family about installing a birdfeeder outside of her window...."</p> <p>Review of a resident care plan dated 7/21/11 indicated documentation was lacking related to the care plan having been updated to address making sure items were in her room or installing a birdfeeder outside her window.</p> <p>4. Resident #G's clinical record was</p>			

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	<p>reviewed on 1/27/12 at 12:35 P.M. A "Fall Circumstance Report" dated 10/22/11 indicated the resident had fallen on 10/22/11 at 10:00 A.M. Further review indicated "...Pt (patient) to be out of room while up (indicated by arrow) so we can watch her..."</p> <p>A resident care plan dated 4/20/11 indicated documentation was lacking related to the care plan having been updated to address having the resident out of room when up.</p> <p>An IDT note dated 11/7/11 indicated the resident had fallen on 11/4/11 at 9:15 P.M. Further review indicated "...when res seen coming back from dinner offer to lay down..."</p> <p>A resident care plan dated 4/20/11 indicated documentation was lacking related to the care plan having been updated to address offering to have the resident lay down after dinner.</p> <p>Review on 1/27/12 at 9:00 A.M. of a facility policy and procedure dated 7/01 and revised on 7/04, 9/06, and 3/10, provided by the Executive Director, identified as current, and titled "Fall Management Program" indicated "...The care plan will be reviewed and updated, as necessary."</p>			

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	<p>This federal tag relates to complaint IN00102782.</p> <p>3.1-35(a)</p>			

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F0323 SS=G	<p>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. Based on observation, interview, and record review, the facility failed to ensure residents were assessed for fall risk, effective interventions were implemented and revised, and care plans were updated to prevent falls, resulting in a resident sustaining a fractured nose, a fractured arm and a subarachnoid (brain) hemorrhage and resulting in repeated falls for 5 of 5 residents reviewed with falls in a sample of 6. (Residents #B, #C, #E, #G, #H).</p> <p>Findings include:</p> <p>1. On 1/26/12 at 10:40 A.M., Resident #B was observed sitting in the hallway in a Broda chair. There was a Hoyer lift pad under the resident. He had a sling on his left arm.</p> <p>On 1/27/12 at 8:50 A.M., Resident #B was observed sitting in the Cafe Dining Room in a Broda chair. There was a Hoyer lift pad under the resident. There was dycem (a material to prevent sliding) between the Hoyer lift pad and the</p>	F0323	F323 Resident B, E, H, G Care Plans, intervention's , Fall Risk assessments, and Nursing Aide assignment sheets have been reviewed and updated, to reflect resident specific interventions and plan of care. Resident C was discharge from the facility. All residents have the potential to be affected by this deficient practice. All residents who have experienced a fall within the last 90 days have had their fall assessment and care plan updated. A IDT note has been made and appropriate changes to the c.n.a. assignment sheets completed by DNS and designees. All residents will be reviewed upon admission, significant changes, and on quarterly and annual reviews in order that care plans reflect resident specific interventions. Any resident who experiences a fall will also have their care plan, interventions, fall assessment, and c..n.a. assignment reviewed for accuracy. Families and physicians will be notified of any and all changes. Staff has been in-service on care plans and fall risk management (see attachment #4,#4b, #4c, #4d) by	02/09/2012			

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	<p>wheelchair seat.</p> <p>Resident #B's clinical record was reviewed on 1/26/12 at 11:30 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, dementia with behavioral disturbances, obstructive hydrocephalus (fluid on the brain), osteoarthritis, disorder of the bones/cartilage, and anemia.</p> <p>A Minimum Data Set (MDS) Quarterly Assessment dated 12/7/11, indicated the resident was severely impaired in cognitive decision-making skills, required extensive two-person physical assistance for transfer and toilet use, was non-ambulatory, was not steady during transitions and walking and was able to stabilize with human assistance, and had had a fall with no injury.</p> <p>A Fall Risk Assessment dated 9/9/11, indicated the resident had had a history of falls in the previous 3 months, demonstrated evidence of impaired gait/balance, used a rolling walker, and was confused and/or disoriented. Further review indicated "If any answer above is 'yes', the resident is at risk for experiencing a fall. Proceed to care plan with appropriate interventions based upon the risk factor(s)..."</p>		<p>the SDC as of 2/9/2012. During reviews of falls the IDT team will physically investigate the resident's room to determine root cause of falls. We will also utilize the follow-up tool (see attachment #5) to ensure all corrective action has been implemented. We will also be utilizing the CQI tool entitled "Fall Management" (see attachment #4A, #4b, #4c, #4d) once weekly for four weeks, then monthly for three months and quarterly and or as needed thereafter beginning on 2/9/2012. Again, we will utilize a 95% threshold for compliance, when not met an action plan will be developed. The DNS and or designee will be responsible for the implementation of the CQI tools. Completion date: 2/9/2012</p>				

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	<p>A Physical Therapy "Plan of Treatment" dated 9/12/11 indicated "...Reason for Referral: Recent pattern of falls indicating safety concerns with balance and mobility...Precautions: Fall risk...Current Level of Function...Standing Balance: General - The patient demonstrates standing balance of F (fair) dynamic (able to maintain balance without balance loss or UE (upper extremity) suport (sic) and min (minimal) weight shift ipsilaterally/front, difficulty crossing midline without balance loss) and maintains for 5 minutes requiring 15% stand by assistance (close enough to reach patient if assist needed)..."</p> <p>A resident care plan dated 9/27/11 indicated "Resident is at risk for falls r/t (related to) DX (diagnosis) dementia, arthritis, vitamin defeciency (sic), HX (history) falls, psychotropic use, antihypertensive use, narcotic use, incontinence, impaired mobility, impaired vision, impaired gait and balance, use of assistive device, HX noncompliance, poor safety awareness...Approach...Fall risk assessment...Observe for fall risk contributors such as medications, hypotension, pain, unsteady gait...Provide appropriated assistive devices such as Broda with dycem, hoyer for transfers, romove (sic) hoyer pad from chair after</p>			

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	<p>transfer bed low with mat on floor...Provide assistance for transfers, bed mobility...Refer to therapies for screening.</p> <p>A physician's order dated 9/9/11 indicated "DC (discontinue) bed alarm...DC chair alarm..."</p> <p>Nurses' notes indicated:</p> <p>9/17/11 at 2:00 P.M. "...needs frequent reminders to use walker - gait unsteady..."</p> <p>9/28/11 at 10:15 A.M. "...often forgets to use walker, is reminded to use walker per staff..."</p> <p>9/29/11 at 10:15 A.M. "...has to be reminded to use walker..."</p> <p>10/19/11 at 12:30 P.M. "...has attempted (sic) to get up on own a few times, but decreased from yesterday..."</p> <p>10/20/11 at 1:30 P.M. "...gait unsteady, but does not follow commands easily when trying to direct to walk..."</p> <p>10/21/11 at 1:00 A.M. "...gets up frequently s (without) assistance, gait unsteady..."</p>						

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	<p>11/4/11 at 11:00 A.M. "...extensive assist x ii (two) c (with) ADLs (activities of daily living) toileting et (and) transfers, not ambulatory as well, unable to follow directions..."</p> <p>11/21/11 at 9:39 A.M. "Res (resident) was sittin (sic) in w/c (wheelchair) in dining room. Res had scouted (sic) forward to the edge of his sest (sic) and slipped onto the floor...Fall was witnessed...Res was repositioned in w/c and pulled up to the table where he could be monitored by staff. Res continued to be observed and repositioned in w/c when needed by staff."</p> <p>An IDT (interdisciplinary team) note dated 11/22/11 at 9:24 A.M. indicated "IDT safety review...res was sitting on hoyer pad in w/c...No injuries occurred (sic)...Staff will be instructed on not leaving hoyer pad under res in w/c and therapy will check for w/c positioning..."</p> <p>A "Fall Circumstance Report" dated 11/21/11 indicated "...What intervention(s) was put in to place to prevent another fall?...Res was repositioned in chair, pulled up to a table and placed where he could be monitored by staff..."</p> <p>A physician's order dated 11/26/11</p>				

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	<p>indicated "Broda chair for positioning &amp; safety..."</p> <p>Interview on 1/27/12 at 11:25 A.M. with the Executive Director indicated there were no therapy notes available for review related to the 11/21/11 fall or the use of the Broda chair.</p> <p>A nurses' note dated 12/7/11 at 5:27 P.M. indicated "called into room. Resident was found on floor on his side. No injuries noted...Resident placed in chair, et brought to dinner..."</p> <p>An IDT note dated 12/8/11 at 9:13 A.M. indicated "...Res. noted laying on right side next to bed facing bed room door...Res. unable to explain how they fell...Nurse immediate intervention, replaced O2 per NC (nasal cannula), assisted back to bed...IDT agrees to put bed low with mat on floor. Bed against wall at this time...Care plan updated..."</p> <p>A resident care plan dated 9/27/11 and updated 12/8/11 indicated "...Bed in lowest position...hoyer lift for transfers...Mat on floor..."</p> <p>A nurses' note dated 12/26/11 at 8:32 P.M. indicated "Resident found on floor in room sitting on buttocks on foot rest of broda chair. Appears that resident slid self</p>			

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	<p>to edge of seat and 'slid' down to foot rest. No injury noted..."</p> <p>An IDT note dated 12/27/11 at 10:24 A.M. indicated "...IDT agrees that all interventions were effective at this time and staff awareness prevent fall (sic). Will continue all current interventions. Interventions include broda, bed low position with mat on floor..."</p> <p>An "Event Report" dated 12/26/11 indicated "...Sitting in broda chair in resident room...unable to provide statement due to dementia...What intervention(s) was put in place to prevent another fall...resident will not be left alone in room in broda chair..."</p> <p>A resident care plan dated 9/27/11 indicated documentation was lacking related to any additional interventions being implemented to prevent further falls after the 12/26/11 fall.</p> <p>A nurses' note dated 1/17/12 at 1:41 P.M. indicated "Resident admitted to (hospital name) with dx (diagnosis): nasal fx (fracture), left humerus fx and subarachnoid hemorrhage..."</p> <p>An IDT note dated 1/18/12 at 9:44 A.M. indicated "IDT fall review...Res. lying on bed fully clothed (sic) with hoyer pad</p>						

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NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE AT LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>underneath him. CNA left room to get assistance with hoyer transfer. Nurse called to room d/t (due to) res lying on floor next to mat on floor. Res. c/o (complained of) pain to left shoulder and to nose. Laceration noted to right and left side of bridge of nose...Current interventions in place: bed low with mat on floor and bed against wall...IDT agrees to review room for safety prior to return. Education on staff on hoyer transfers, do not leave res in room with hoyer pad underneath. Upon return from hospital will continue previous interventions of bed low with mat on floor and may have bed against wall, res not to be left in room when not in bed..."</p> <p>An "Event Report" dated 1/17/12 indicated "...What intervention(s) was put into place to prevent another fall...Resident already has low bed with mat on floor..."</p> <p>A hospital consultation report dated 1/17/12 indicated "...he had a fall today, falling forward, striking his nose and his left shoulder. He has a fracture of the left humerus. He is noted to have a nasal fracture and in addition on the CT (computed tomography) scan of his head, had a tiny dot of focal traumatic subarachnoid hemorrhage in a sulcus in the right frontoparietal convexity region</p>			

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	<p>(a bleeding in the brain)."</p> <p>A resident care plan dated 9/27/11 and updated 1/18/12 and 1/20/12 indicated "...Broda chair with dysem...Assess room for safety...resident not to be left alone in room unattended unless in bed...."</p> <p>A "CNA Alert Sheet" dated 1/26/12, provided by the Executive Director and identified as current, indicated "...not to be left alone when out of bed..." Documentation was lacking related to not leaving a hoyer lift pad under the resident.</p> <p>CNA #3's employee file was reviewed on 1/27/12 at 11:05 A.M. A job description signed by the employee on 10/20/11 indicated "...Transfer...Obtains assistance of another staff member if needed before starting to transfer a resident..."</p> <p>Interview on 1/27/12 at 9:40 A.M. with the Executive Director and the Director of Nursing indicated the criteria for discontinuing alarms were they "cause increased agitation and cause more harm." They indicated the alarms had been discontinued on 9/9/11 because it was "the standard then" to apply alarms on admission if at risk for falls and there was no order to apply alarms. The Executive Director indicated after the 1/17/12 fall, the room was checked for safety and the</p>						

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	<p>CNA had been disciplined. He indicated she had been trained on the procedure for the lift and transfers and should have known not to leave the resident on the hoyer pad.</p> <p>2. On 1/26/12 at 1:15 P.M., Resident #C was observed sitting in the dining area of the memory care unit. The resident's rolling walker was next to her. There was no alarm in place on the chair. Staff was present in the dining area.</p> <p>Resident #C's clinical record was reviewed on 1/26/12 at 1:10 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, anemia, hypertension, diabetes mellitus, and dementia. The resident had been a previous resident in the facility and had been readmitted.</p> <p>An MDS Admission Assessment dated 1/5/12, indicated the resident was severely impaired in cognitive decision-making skills, required limited one-person physical assistance for transfer and toilet use, required supervision for ambulation, was not steady but able to stabilize without human assistance for balance, and had had no falls.</p> <p>Interview on 1/27/12 at 11:25 A.M. with the Executive Director indicated a fall</p>				

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	<p>risk assessment for Resident #C could not be located for review.</p> <p>A resident care plan dated 11/30/11 indicated "...Fall risk related to: weakness, DX anemia, Alzheimer's, colon cancer...HX noncompliance with interventions, i.e. res had tendency to remove gripper socks...Approach...Encourage and remind resident to use call light...Fall risk assessment...Observe for fall risk contributors such as medications, hypotension, pain, unsteady gait...Provide assistance for transfers, bed mobility...Refer to therapies for screening..."</p> <p>Nurses' notes indicated:</p> <p>12/30/11 at 1:40 P.M. "...ambulates with walker independently..."</p> <p>1/3/12 at 1:24 A.M. "...Resident displays a very short-term memory, since she has no memory of the conversations, and incidents..."</p> <p>1/15/12 at 8:15 P.M. "Res found in room lying on R (right) side in front of roommate's bed....Res stated that she stubbed her toe on 'that' (res referring to roommate's walker)...Res had removed gripper socks while in bed et (and) was</p>			

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	<p>not wearing them at the time of the fall. Res is often non-compliant et refused to wear gripper socks or shoes. Res often had to be reminded to use walker while ambulating...Will continue to observe..."</p> <p>An "Event Report" dated 1/15/12 indicated "...Res stated that she stubbed her toe on walker (walker belonged to another resident et resident was digging through other resident's belongings inside basket attached to walker)...No injuries...What intervention(s) was put into place to prevent another fall...Gripper socks reapplied, res currently sitting in main area on continuous monitoring..."</p> <p>A resident care plan dated 11/30/11 and updated 1/16/12 indicated "...Resident to wear hipsters except while bathing..." Documentation was lacking related to the resident wearing gripper socks.</p> <p>Nurses' notes indicated:</p> <p>1/17/12 at 5:29 P.M. "...Res removed gripper socks et shoes..."</p> <p>1/18/12 at 9:53 P.M. "Res found on floor sitting on buttocks @ 9:30p. Unwitnessed fall. Res was in other resident's room (uninvited)--had removed shoes et had them sitting beside her. Res had also removed gripper socks. Res has been</p>			

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	<p>non-compliant all shift...Res will not leave gripper socks or shoes on. Res will not amb (ambulate) with walker..."</p> <p>An "Event Report" dated 1/18/12 indicated "...Resident was in other resident's room, without permission...shoes et gripper socks off (res had removed)...What intervention(s) was put into place to prevent another fall...Gripper socks, shoes reapplied..."</p> <p>A resident care plan dated 11/30/11 indicated documentation was lacking related to any additional interventions being implemented after the 1/18/12 fall to prevent further falls.</p> <p>Nurses' notes indicated:</p> <p>1/19/12 at 12:49 A.M. "...non-compliant with using walker and kept taking shoes and socks off prior to bed. Will continue to monitor..."</p> <p>1/20/12 at 3:39 P.M. "...res requiring 1:1 attn (attention) and still getting up and down. Gait is unsteady and resident has nearly fallen several times in the last couple hours..."</p> <p>1/20/12 at 10:55 P.M. "...CNA 1:1 at this time..."</p>			

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	<p>1/20/12 at 11:25 P.M. "Resident found on floor in her room in front of the bathroom door lying flat on her stomach by CNA...last checked less than 5 min (minutes) prior to fall...resident sitting in chair in dining area for close monitoring due to poor safety from sedation and restlessness, gait unsteady..."</p> <p>An "Event Report" dated 1/20/12 indicated "...Resident was in bed resting but tossing and turning, hallucinating (sic) seeing bugs crawling and biting on blanket. Was sent to ER (emergency room) earlier due to increased agitation. Resident sedated...What intervention(s) was put into place to prevent another fall...Resident was brought out to dining area and sat in chair to monitor one on one due to getting out of bed frequently, restlessness, sedation, and visual hallucinations..."</p> <p>A resident care plan dated 11/30/11 indicated documentation was lacking related to any additional interventions being implemented after the 1/20/12 fall to prevent further falls.</p> <p>Nurses' notes indicated:</p> <p>1/21/12 at 12:00 A.M. "...attempted to get up q (every) 2-3 min...Continuing to monitor one on one at this time..."</p>				

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	<p>1/21/12 at 4:08 A.M. "...2 assist as gait unsteady..."</p> <p>1/21/12 at 2:00 P.M. "resident sitting on floor in room next to bed...will continue to observe..."</p> <p>An "Event Report" dated 1/21/12 indicated "...Resident was sitting on her buttock next to her bed...No injuries noted...What intervention(s) was put into place to prevent another fall...Re-educate the use of call light. Resident brought to dining room for observation and safety..."</p> <p>A resident care plan dated 11/30/11 indicated documentation was lacking related to any additional interventions being implemented after the 1/21/12 fall to prevent further falls.</p> <p>Nurses' notes indicated:</p> <p>1/22/12 at 1:00 A.M. "Resident being checked on frequently due to unsteady gait, went to check on resident and was sitting up in bed, states going to the bathroom...will continue to monitor..."</p> <p>1/22/12 at 11:30 P.M. "Resident was sitting in dining room looking at magazines, CNA was sitting with resident as was called away due to noise heard in</p>				

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	<p>another residents room. Resident got up and as writer looked over to check on resident she collapsed down on her right side to the floor, when got to resident her head was under a dining room chair and was lying on right side with her right arm underneath her...resident stated her head hurt and held right side of temporal area...send out to ER at (hospital name) to be evaluated...1 cm (centimeter) bump just above right temporal at scalp and resident complaining of right ankle (sic) pain..."</p> <p>1/23/12 at 1:48 A.M. "Received report form (sic) (hospital name) ER, found no injuries..."</p> <p>1/23/12 at 2:47 A.M. "Resident back from ER, arrived via ambulance on gurney, no new orders received, taken to bathroom...gait unsteady with 2 assist..."</p> <p>An IDT note dated 1/23/12 at 8:00 A.M. indicated "IDT review of falls on 1/21/12 (sic) at 11:25 P.M., 1/21/12 at 2:50 P.M., and 1/22/12 at 11:30 P.M....Interventions include bed and chair alarms, be sure of whereabouts, bed low, assist to transfer, hipsters...IDT agrees have MD review meds for risk vs. benefits, are waiting on a bed in psych unit for eval (evaluation)..."</p>			

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	<p>An IDT note dated 1/23/12 at 9:22 A.M. indicated "...IDT review of falls addendum. Resident had temporary 1:1 monitoring in place on 1/21/12 thru today...Will continue temporary 1:1 monitoring PRN..."</p> <p>An "Event Report" dated 1/23/12 indicated "...CNA had benn (sic) doing one on one w/ (with) resident, CNA heard noise which was another resident up out of bed walking w/o (without) assistance. Nurse saw resident begin to ambulate w/o walker and resident collapsed to floor. Hit floor hard, head under MDR (main dining room) chair...bump on rt (right) temporal area 1 cm...What intervention(s) was put into place to prevent another fall...bed and chair alarm. bed already in low position, hipster in place, observing one on one when needed..."</p> <p>Nurses' notes indicated:</p> <p>1/24/12 at 2:11 A.M. "...She occasionally awakens and attempts to get up from chair..."</p> <p>1/24/12 at 4:25 A.M. "Resident was sitting in her rocker with her clip alarm on. Heard alarm sound and responded in time to see resident sit on her bottom and then lie back...States she was hungry and got up to get something to eat..."</p>				

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	<p>An IDT note dated 1/24/12 at 9:38 A.M. indicated "...continue to wait for bed at (hospital name) for psych stay...Care plan up to date..."</p> <p>An "Event Report" dated 1/24/12 indicated "...Sitting on bottom on floor...Memory Care Dining room...No injuries...Resident stood from chair and before I could get to her sat on her bottom on the floor... intervention(s) was put into place to prevent another fall...Resident already had clip alarm, bed alarm, low bed and gripper socks..."</p> <p>A resident care plan dated 11/30/11 indicated documentation was lacking related to any additional interventions being implemented after the 1/24/12 fall to prevent further falls.</p> <p>A resident care plan dated 11/30/11 and updated 1/23/12 indicated "...attempt 1:1 supervision PRN (as needed)...Be aware of resident's whereabouts...bed and chair alarm...bed in lowest position except when providing care..."</p> <p>A "CNA Alert Sheet" dated 1/26/12, provided by the Executive Director and identified as current, indicated "...hipsters...bed and chair alarms...be sure of res whereabouts...bed low..."</p>			

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	<p>Documentation was lacking related to ensuring the resident had gripper socks/shoes in place.</p> <p>Interview on 1/27/12 at 9:40 A.M. with the Director of Nursing indicated "one on one doesn't mean having someone sit with her. It meant giving her more attention." She indicated the CNA should have stayed with the resident.</p> <p>3. On 1/26/12 at 10:09 A.M., Resident #E was observed sitting on the edge of her bed in her room. The call light was next to her. There was a wheelchair with anti-roll brakes on the opposite wall from the bed. There were no alarms in place.</p> <p>On 1/27/12 at 8:50 A.M., Resident #E was observed sitting in her room in a chair eating breakfast. The call light was lying on the bed across the room. The wheelchair was next to the resident's chair with the back of the chair facing the resident. There was a sign above the bed indicating the "red button" should be pushed for help and a piece of red tape was on the call light.</p> <p>On 1/28/12 at 9:25 A.M., Resident #E was observed sitting in her room in a chair. The call light was lying on the bed across the room. There was a sign above the bed indicating the "red button" should</p>						

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	<p>be pushed for help and a piece of red tape was on the call light.</p> <p>Resident #E's clinical record was reviewed on 1/26/12 at 12:30 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, dementia of Alzheimer's type, transient ischemic attack, bladder cancer, paranoia, multiple sclerosis, anemia, and fibromyalgia.</p> <p>An MDS Quarterly Assessment dated 11/13/11 indicated was severely impaired in cognitive decision-making skills, required limited one-person physical assistance for transfer and ambulation, required extensive one-person physical assistance for toilet use, was not steady but able to stabilize with human assistance for balance, and had had no falls.</p> <p>Fall risk assessments dated 10/6/11, 10/12/11, 10/16/11 and 10/24/11 indicated the resident had had falls in the previous 3 months, demonstrated evidence of impaired gait/balance, had a history of non-compliance and was confused and/or disoriented. Further review indicated "If any answer above is 'Yes', the resident is at risk for experiencing a fall. Proceed to care plan appropriate interventions based upon the</p>			

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	<p>risk factor (s)..."</p> <p>A resident care plan dated 7/21/11, indicated "...Resident is at risk for falls r/t...impaired gait and balance...HX falls...poor safety awareness, HX noncompliance, does not use call light...HX refusing proper fit shoe wear, refusal of helmet, refusal of hipsters...refusal of alarms, and refusal by family to transfer resident to smaller unit in room in common/dining area...Approach...All staff are to assist resident with feeding birds...Encourage and remind resident and staff that resident is NOT to go outside to feed birds unassisted...Fall risk assessment...Observe for fall risk contributors such as medications, hypotension, pain, unsteady gait...Provide assistance for transfers, bed mobility...Refer to therapies for screening...Proper lighting in non clutter environment...Therapy screen quarterly and PRN..." Further review indicated "9/16/11 may have bed against wall for room arrangement...9/25/11 antirollback brakes to promote safety...10/6/11 offer to toilet upon rising, before and after meals, at HS (hour of sleep), et q (every) 2 hours et PRN at NOC (night)..."</p> <p>A Medication Administration Record (MAR) dated November 2011 indicated "9/19/11 Bed pad alarm due to poor safety</p>						

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	<p>awareness to notify staff of unassisted transfers. Check placement every shift...9/19/11 Chair pad alarm due to poor safety awareness to notify staff of unassisted transfers. Check placement and function every shift..."</p> <p>A nurses' note dated 10/16/11 at 10:00 P.M. indicated "...Resident was found on the floor at 8:45 p. Resident sated that she was trying to pull up her brief when she fell...alarm was placed on chair by doorway..."</p> <p>A "Fall Circumstance Report" dated 10/16/11 indicated "...Was trying to pull up brief. No alarm went off because resident was sitting in chair by door with no alarm...What intervention(s) was put in place to prevent another fall? Alarm was put onto the chair by the door. Resident teaching that she needs to have someone in the room if she is going to get up from her chair/bed. Old that if she wants to be out in the halls that she needs to be in her w/c and not walking..."</p> <p>Nurses' notes indicated:</p> <p>10/18/11 at 9:00 P.M. "...non-compliant c (with) attempt to amb (ambulate) unassisted. Attempts to turn off alarms on her own when they sound..."</p>				

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	<p>10/20/11 at 7:00 P.M. "... non-compliant c (with) call light..."</p> <p>10/24/11 at 2:15 P.M. "Res in WC (wheelchair) in hallway. Res stood up et alarms sounded. Staff went in direction of res. Res gait was unsteady. Res went to knees..."</p> <p>A "Fall Circumstance Report" dated 10/24/11 indicated "...Res strolling through hallway...on knees in front of W/C...0 (no) injuries...What intervention(s) was put in place to prevent another fall? Taken to the bathroom/offered snack. Walked c (with) res..."</p> <p>Nurses' notes indicated:</p> <p>10/25/11 at 7:25 P.M. "...Continues to be non-compliant c (with) call light et self transferring. Chair pad et bed pad alarms in place et functioning..."</p> <p>10/26/11 at 2:00 A.M. "...Has made several attempts to transfer s (without) assist this shift...Alarms in place et functioning..."</p> <p>10/28/11 at 12:10 A.M. "...Res has made multiple attempts to transfer s (without) assistance this shift...Alarms in place et functioning..."</p>			

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	<p>10/28/11 at 6:00 P.M. "Res found on floor..."</p> <p>An IDT note dated 10/31/11 indicated "IDT review of fall that occurred on 10-28-11 @ 6pm...Team also agreed to D/C (discontinue) all alarms due to it causes resident to have increased (indicated by arrow) agitation and are not preventing (sic) residents falls. Agreed to toilet resident q20 (every two hours) while awake...resident does not use call light and continues to want to ambulate independently. Resident has unsteady gait and poor balance...careplan updated..."</p> <p>A "Fall Circumstance Report" dated 10/28/11 indicated "...Walking around room...What intervention(s) was put in to place to prevent another fall? (The form was blank)..."</p> <p>A nurses' note dated 11/6/11 at 8:00 P.M. indicated "Res fell in hallway. No injuries..."</p> <p>An IDT note dated 11/6/11 at 8:15 P.M. indicated "...Res was walking independently down hallway and fell, no injuries...IDT agreed to make sure resident has items in room that she comes to nurses station for such as iced tea, sugar. Will talk to family about installing</p>			

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	<p>birdfeeder outside her window..."</p> <p>A "Fall Circumstance Report" dated 11/6/11 indicated "...Walking to nurses station...What intervention(s) was put in to place to prevent another fall? (The form was blank)..."</p> <p>Nurses' notes indicated:</p> <p>11/7/11 at 3:00 A.M. "...Ambulates independently; although encouraged to ask for assist as gait is very unsteady. Res noncompliant...Very forgetful..."</p> <p>11/9/11 at 9:00 P.M. "...Ambulates independently but staff constantly reminds resident to use w/c et call light due to unsteady gait..."</p> <p>11/13/11 at 3:45 P.M. "...Ambulates independently on occasion (sic) et needs constant reminder to use w/c et call light..."</p> <p>11/22/11 at 5:10 P.M. "Called to res room per CNA. Res lying next to bed, head facing toward wardrobe closet with head resting on bed side table. Next to left eye res had a reddened area...Will continue to observe..."</p> <p>An IDT note dated 11/23/11 at 8:52 A.M. indicated "...IDT agrees to do neuro</p>						

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	<p>checks at this time. Alarms are not needed at this time d/t (due to) res non compliance (sic) with alarms...care plan updated..."</p> <p>An "Event Report" dated 11/22/11 indicated "...Describe what the resident was doing prior to the fall...sitting in bed...What intervention(s) was put into place to prevent another fall...Neuro checks started and res returned to bed..."</p> <p>A resident care plan dated 7/21/11 indicated documentation was lacking related to any additional interventions being implemented after the 11/22/11 fall to prevent further falls.</p> <p>A nurses' note dated 11/25/11 at 11:53 P.M. indicated "Called to room by CNA. Resident sitting on floor by bed. Stated that she got up to get something and lost her balance and fell. No injuries seen..."</p> <p>An IDT note dated 11/28/11 at 9:58 A.M. indicated "...Resident had been sitting on edge of bed drinking juice and watching TV prior to fall...IDT team agrees to request orders from MD for labs...care plan updated..."</p> <p>An "Event Report" dated 11/25/11 indicated "...Describe what the resident was doing prior to the fall...sitting on side</p>						

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	<p>of bed watching TV and drinking juice...What intervention(s) was put into place to prevent another fall...Resident reminded to call for assist when getting up..."</p> <p>A resident care plan dated 7/21/11 and updated 11/28/11 indicated "MD to review labs..."</p> <p>Nurses' notes indicated:</p> <p>11/26/11 at 8:30 P.M. "...Ambulating against advise. Encouraged to ask for assistance however resident continue to amb. per self..."</p> <p>12/1/11 at 11:50 A.M. "...Resident came walking out of room by herself. Encouraged to call nurse or CNA to assist with walking or to use WC..."</p> <p>12/12/11 at 10:05 P.M. "Res roommate alerted staff that res had fallen. Res was found lying on right side with head on bottom of TV stand, feet in middle of room....Res educated on use of wheelchair and using call light for assistance..."</p> <p>A nurses' note dated 12/12/11 at 11:30 P.M. indicated "Writer called to res' room by roommate. Res found lying on floor in left side facing bed. No injuries noted...Res assisted into w/c et is one on</p>			

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	<p>one supervision at this time..."</p> <p>An IDT note dated 12/13/11 at 9:28 P.M. indicated "...Met d/t falls on 12/12/11 at 1005pm and 1130pm... Will reattempt hipsters, and helmet. Nurse will assess for s/s (signs/symptoms) of UTI (urinary tract infection)/Resp (respiratory) issues d/t to hx of UTI and pneumonia...careplan updated..."</p> <p>A resident care plan dated 7/21/11 and updated 12/13/11 indicated "...encourage resident to remain out of room...therapy to screen..." Documentation was lacking related to reimplementation of hipsters and helmet or checking for UTI and respiratory problems.</p> <p>A "Transdisciplinary Therapy Screen" dated 12/13/11 indicated - "...falls - res noncompliant with ed (education) to ask for assistance and recommended safety devices such as helmet, hipsters..." Documentation was lacking related to any additional interventions to prevent further falls.</p> <p>Nurses' notes indicated:</p> <p>12/21/11 at 3:04 P.M. "...Res exhibits unsteady gait and is noncompliant with using WC..."</p>						

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	<p>12/22/11 at 7:28 P.M. "Res. (resident) found sitting on buttocks in room on floor in front of chair. States she was moving from chair to w/c and slid to floor..."</p> <p>An "Event Report" dated 12/22/11 indicated documentation was lacking related to any additional interventions implemented to prevent further falls after the 12/22/11 fall.</p> <p>A resident care plan dated 7/21/11 and updated 12/23/11 indicated "...'push red button for help' signs to be in place in room with red tape applied to call light..."</p> <p>A nurses' note dated 1/9/12 at 1:27 P.M. indicated "Resident called writer into room. Resident was sitting on bottom with legs bend at the knees. She was sitting in between bedside table and her wheel chair. Resident stated that she dropped some beads on the floor and 'squated (sic) down to pick them up and could not get back up.'...No injuries noted..."</p> <p>Documentation was lacking related to an "Event Report" or IDT notes having been completed.</p> <p>Interview on 1/27/12 at 11:25 A.M. with</p>			

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	<p>the Executive Director indicated fall investigations had not been completed for the 12/12/11 at 10:05 P.M. and the 1/9/12 falls.</p> <p>Interview on 1/27/12 at 1:30 P.M. with the Director of Nursing indicated the 1/9/12 incident "wasn't a fall. She sat down deliberately."</p> <p>Interview on 1/27/12 at 9:40 A.M. with the Director of Nursing indicated the resident was "a challenge." She indicated several interventions had been attempted but "she refuses them." She indicated the toileting program had not been documented.</p> <p>4. On 1/27/12 at 2:05 P.M., Resident #H was observed sitting at the far end of the hallway from the nurses' station by the exit door. He was in a wheelchair with anti-roll brakes.</p> <p>Resident #H's clinical record was reviewed on 1/27/12 at 1:25 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, failure to thrive, hypertension, insomnia, depression, and dementia.</p> <p>An MDS Admission Assessment dated 9/27/11 indicated the resident was</p>						

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	<p>moderately impaired in cognitive decision-making skills, required extensive one-person physical assistance for transfer, ambulation, and toilet use, was unsteady but able to stabilize without human assistance for balance, and had had one fall with injury.</p> <p>"Fall Risk Assessments" dated 10/16/11 and 10/28/11 indicated the resident had a history of falls in the previous 3 months, demonstrated evidence of impaired gait/balance, was non-compliant, and on 10/28/11 was confused and/or disoriented. Further review indicated "If any answer above is 'Yes', the resident is at risk for experiencing a fall. Proceed to care plan with appropriate interventions based upon the risk factor(s)..."</p> <p>A resident care plan dated 9/15/11 indicated "...Resident is at risk for falls r/t impaired gait and balance...poor safety awareness, HX falls, HX non compliance...tendency (sic) to remove own hipsters against medical advise...Approach...evalute (sic) meds for changes routinely and prn...Provide assistance for transfers, bed mobility, and do not leave unattended in bathroom...Utilize non skid footwear for transfers, hipsters to be on except while bathing, antiroll back brakes to wheelchair..."</p>			
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	<p>Review of IDT notes from 9/19/11 through 10/17/11 indicated the resident had fallen on 9/17/11, 9/24/11, 10/5/11, 10/6/11, and 10/28/11.</p> <p>Nurses' notes indicated:</p> <p>11/24/11 at 5:41 P.M. "...Forgets where room is frequently and requires dierection (sic)..."</p> <p>12/1/11 at 2:04 P.M. "Resident was in the club room enjoying the Christmas tree. He was alone in his wheelchair. He got up to get into the couch. A housekeeper walked by and heard someone yelling help. Resident was laying flat on his back next to the couch..."</p> <p>An IDT note dated 12/2/11 at 9:45 A.M. indicated "...IDT agrees res not to be unattended while up. Current interventions in place monitor meds, assist as needed...care plan updated.</p> <p>An "Event Report" dated 12/1/11 indicated "...No injuries noted...He states he was trying to get on the couch...What intervention(s) was put into place to prevent another fall...To be supervised when he is not in bed laying down. He needs to be out at the nurses station if he</p>			
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	<p>is not in bed..."</p> <p>A resident care plan dated 9/15/11 and updated 12/2/11 indicated "...Encourage resident to remain out of room when out of bed..."</p> <p>A social service progress note dated 12/23/11 at 2:59 P.M. indicated "...has long and short term memory problem and moderately impaired safety awareness. Res needs supervision for safety daily..."</p> <p>A nurses' note dated 1/3/12 at 7:45 P.M. indicated "Writer entered the resident's room to give meds and found the resident lying on his back on the floor. Resident stated he fell while getting out of bed because he wanted to go to the bathroom..."</p> <p>An IDT note dated 1/4/12 at 8:20 A.M. indicated "...Staff education completed r/t notfing (sic) nurse if res refuses to toilet. Res educated to use call light for assist. IDT Agrees to cont (continue) with current interventions..."</p> <p>An "Event Report" dated 1/3/12 indicated "...Resident was trying to get out of bed to go to the bathroom...What intervention(s) was put into place to prevent another fall...Instruct the resident to use the call light when he needs to go</p>						

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	<p>to the bathroom..."</p> <p>A resident care plan dated 9/15/11 and updated 1/18/12 (15 days after fall) indicated "...Leave bathroom light on a NOC (night)...Offer to toilet upon rising, before and after meals, at HS, et q2 hours et PRN at NOC...PT (physical therapy)/OT (occupational therapy) to eval (evaluate) et tx (treat) as needed..."</p> <p>5. On 1/27/12 at 12:35 P.M., Resident #G's room was observed with CNA #4.. There was a motion sensor in place above the door on the inside of the bathroom. CNA #4 indicated the motion sensor was to let staff know when the resident was in the bathroom.</p> <p>On 1/27/12 at 2:00 P.M., Resident #G was observed sitting in her room in a wheelchair. The resident was leaning forward with her head resting on an overbed table sleeping. The resident's wheelchair had anti-roll brakes in place but no anti-tippers in place. There was no staff in the room.</p> <p>Resident #G's clinical record was reviewed on 1/27/12 at 12:30 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, dementia with behavioral disturbance, anemia, Hx of</p>						

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	<p>subdural hematoma with craniotomy, osteoporosis, right hip revision, and arthritis.</p> <p>An MDS Quarterly Assessment dated 10/31/11 indicated the resident was severely impaired in cognitive decision-making skills, required limited one-person physical assistance for transfer, ambulation, and toilet use, had no balance problems, and had no falls.</p> <p>"Fall Risk Assessments" dated 10/28/11, 10/31/11, and 11/11/11 indicated the resident demonstrated evidence of impaired gait/balance, was noncompliant, and on 10/28/11 and 10/31/11 was confused and disoriented. Further review indicated "If any answer above is 'Yes', the resident is at risk for experiencing a fall. Proceed to care plan with appropriate interventions based upon the risk factor(s)..."</p> <p>A resident care plan dated 4/20/11 indicated "...Resident is at risk for falls r/t...impaired gait and balance...HX noncompliance, attempts to self transfer, poor safety awareness, HX falls...likes to sleep slumped over in WC...Refuses hipsters, won't use call light...Approach...May have been against the wall...Low bed with mat on floor...Analyze resident's falls to</p>			

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	<p>determine pattern/trend...Anti-rollback brakes to w/c...Anti-tippers to w/c...Encourage resident to use environmental devices such as hand grips, hand rails, etc...Give resident verbal reminders not to ambulate/transfer without assistance...Keep call light in reach...Keep personal items and frequently used items within reach...Provide proper, well-maintained footwear...Provided resident an environment free of clutter..."</p> <p>A nurses' note dated 10/22/11 at 10:30 A.M. indicated "...Pt (patient) on floor sitting on floor on her pants, naked from waist down...Pt agreed to be out of room during the day et while OOB (out of bed) for safety..."</p> <p>A "Fall Circumstance Report" dated 10/22/11 indicated "Describe what the resident was doing prior to the fall...sitting on bed, resting. CNA (name) stated pt had tx'd (transferred) herself from chair to bed - pads 0 (not) on floor...0 (no) injuries...What intervention (s) was put in to place to prevent another fall? 1) Pt to be out of room while up (indicated by arrow) so we can watch her. 2) Education provided re: placement of mat @ BS (bedside) et toileting/anticipation needs for res...3) Pt on 15 min checks (indicated by</p>			

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NAME OF PROVIDER OR SUPPLIER  ROSEWALK VILLAGE AT LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904
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	<p>checkmark) while in room for safety d/t pt's refusal to stay out of room..."</p> <p>A resident care plan dated 4/20/11 indicated documentation was lacking related to any additional interventions being implemented after the 10/22/11 fall to prevent further falls.</p> <p>A nurses' note dated 10/31/11 at 5:00 P.M. indicated "Resident fell at 4:40p. Resident was found by nurse wedged between her w/c et the wall. Knees were on the floor et head was pressed against the wall...Will continue to monitor for bruising..."</p> <p>A "Fall Circumstance Report" dated 10/31/11 indicated "...Resident stated she woke up from a nap et was still dreaming...What intervention(s) was put in to place to prevent another fall? Teaching to resident to stay in bed until someone can come et help her to get up. Teaching to aid (sic) so that checks will be done whenever resident is laying down..."</p> <p>Documentation was lacking related to the Interdisciplinary Team having reviewed the 10/31/11 fall.</p> <p>A nurses' note dated 11/4/11 at 9:15 P.M. indicated "Resident found on floor next</p>			

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	<p>to bed. Resident stated that she was trying to go to bed unassisted..."</p> <p>A "Fall Circumstance Report" dated 11/4/11 indicated "...Resident stated she was trying to get into bed...mat not on floor...What intervention(s) was put in to place to prevent another fall? Resident teaching - needs to have an aid (sic) or a nurse when getting in et out of bed at all times. Use call light et wait until someone answers her call..."</p> <p>Documentation was lacking related to the Interdisciplinary Team having reviewed the 10/31/11 fall.</p> <p>A resident care plan dated 4/20/11 indicated documentation was lacking related to any additional interventions being implemented after the 11/4/11 fall to prevent further falls.</p> <p>Nurses' notes indicated:</p> <p>11/28/11 at 10:41 A.M. "IDT review of fall...IDT agrees after investigation that his is not considered a fall. Res. had put self to bed earlier in shift then got out of bed by self and then crawled to doorway..."</p> <p>12/18/11 at 7:37 A.M. "Aide called writer into room. Resident was lying</p>			

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	<p>partially on back and half sitting up parallel to bed...No injuries noted...Resident was instructed to use call light and wait for assistance when getting out of bed. Will continue to monitor..."</p> <p>Documentation was lacking related to the Interdisciplinary Team having reviewed the 12/18/11 fall.</p> <p>An "Event Report" dated 12/18/11 indicated "...Getting out of bed...What intervention(s) was put into place to prevent another fall...Vital signs, neuro checks, instructed resident to use call light if assistance is needed..."</p> <p>A resident care plan dated 4/20/11 indicated documentation was lacking related to any additional interventions being implemented after the 12/18/11 fall to prevent further falls.</p> <p>A nurses' note dated 1/4/12 at 6:30 P.M. indicated "Resident lying on floor in front of wheelchair in room...no injuries noted..."</p> <p>An IDT note dated 1/5/12 at 8:49 A.M. indicated "...Res found lying on the floor on her buttocks with wheelchair across her legs in her room...Staff reports that res attempts to self transfer...IDT agrees</p>				

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	<p>to reattempt to try hipsters, and try to serve meal toward end of meal service unless res request tray earlier..."</p> <p>An "Event Report" dated 1/4/12 indicated "...What intervention(s) was put into place to prevent another fall...res. educated per nurse..."</p> <p>A resident care plan dated 4/20/11 and updated on 1/5/12 indicated "attempt to serve resident towards the end of dining service...Offer to assist resident to bed following dinner meal..."</p> <p>A nurses' note dated 1/9/12 at 7:25 P.M. indicated "Res found on bathroom floor. Res states she was transferring self to w/c and 'misjudged distance.'...no injuries noted..."</p> <p>An IDT note dated 1/10/12 at 9:23 A.M. indicated "...IDT agrees to put in room sensor to alert staff when res enters bathroom..."</p> <p>An "Event Report" dated 1/9/12 indicated "...Self transferring on/off toilet...What intervention(s) was put into place to prevent another fall...Re-orientation to call lights-esp in restroom. Teaching that res should put call light on when getting on/off toilet and needs to wait until assistance is</p>			
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	<p>available..."</p> <p>A resident care plan dated 4/20/11 and updated on 1/10/12 indicated "...room sensor to alert staff to res entering bathroom..."</p> <p>A nurses' note dated 1/15/12 at 11:00 A.M. indicated "Aides called writer into resident's room. Resident was sitting on bottom with legs outstretched and back up against bed. Resident stated that she wanted to take a nap...When resident was asked why she did not use call light, she asked is it that thing there, pointed to the yellow string for the over head light. Call light was in place lying across her bed within reach. When family was called, they stated that she does not understand to use her call light..."</p> <p>Documentation was lacking related to the Interdisciplinary Team having reviewed the 1/15/11 fall.</p> <p>An "Event Report" dated 1/15/12 indicated "...Transferring self from wheelchair to bed...What intervention(s) was put into place to prevent another fall...vital signs, neuro checks, educated on call light..."</p> <p>A resident care plan dated 4/20/11 and updated on 1/19/12 indicated "...offer to</p>				

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	<p>toilet upon rising, before and after meals, at HS et q2 hours et PRN at NOC..."</p> <p>A nurses' note dated 1/22/12 at 11:29 A.M. indicated "Writer heard res yelling help from BR. Res found on floor with brief on, pants around thighs, w/c was in front of her, feet were pointing towards door, back was against toliet (sic). Res. stated she was trying to get to the toliet (sic) when she fell..." Documentation was lacking related to the room sensor being in place and functioning.</p> <p>An IDT note dated 1/23/12 at 9:41 A.M. indicated "...wall sensor in bathroom (documentation did not indicate if the sensor was functioning at the time of the fall)...Resident is non compliant with using call light for assistance...IDT agrees to offer assistance with ADLS..."</p> <p>An "Event Report" dated 1/22/12 indicated "Res was trying to transfer unassisted to toliet (sic) from W/C...What intervention(s) was put into place to prevent another fall...Res educated on importance of asking for help with transfers..."</p> <p>A resident care plan dated 4/20/11 and updated on 1/5/12 indicated "attempt to serve resident towards the end of dining service...Offer to assist resident with</p>				

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	<p>ADLs (activities of daily living)..."</p> <p>Documentation was lacking related to toileting the resident as indicated on the care plan.</p> <p>Interview on 1/27/12 at 9:40 A.M. with the Executive Director indicated interventions after a fall should be implemented immediately after the fall and not wait for the Interdisciplinary Team to meet.</p> <p>Review on 1/27/12 at 9:00 A.M. of a facility policy and procedure dated 7/01 and revised on 7/04, 9/06, and 3/10, provided the Executive Director, identified as current, and titled "Fall Management Program" indicated "...A fall risk assessment will be completed upon admission, re-admission, quarterly , annually, and with a significant change...A care plan will be developed at time of admission specific to each resident based upon the results of the fall risk assessment...a fall circumstance report will initiated as soon as the resident has been assessed and cared for... The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions...An entry will be completed in the nurses' notes addressing the fall, any injuries, physician and</p>						

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	<p>family notification, and interventions initiated...All falls will be discussed by the interdisciplinary team the 1st morning after the day of the fall to determine other possible interventions to prevent future falls...The care plan will be reviewed and updated, as necessary..."</p> <p>This federal tag related to complaint IN00102782.</p> <p>3.1-45(a)(2)</p>			
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