

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/30/2012
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NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814
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F0000	<p>This visit was for the Investigation of Complaint IN00113743.</p> <p>Complaint IN00113743-Substantiated. Federal/state deficiencies related to the allegations are cited at F279, F323 and F514.</p> <p>Survey dates: August 29, 30, 2012</p> <p>Facility number: 000215 Provider number: 155322 AIM number: 100267600</p> <p>Survey team: Ann Armey, RN</p> <p>Census bed type: NF: 57 SNF/NF: 24 Total: 81</p> <p>Census payor type: Medicare: 1 Medicaid: 64 Other: 16 Total: 81</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</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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	Quality review 9/06/12 by Suzanne Williams, RN			

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F0279 SS=D	<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 observation, interview and record review, the facility failed to develop, review and revise the fall prevention care plans of 2 of 3 three residents, who had experienced falls, in sample of 4. (Resident #C and Resident #D)</p> <p>Findings include:</p> <p>On 8/29/12 at 10 a.m., during the orientation tour, LPN #10 indicated Resident #C had experienced multiple falls. The resident was observed lying in a low bed with a mat beside the bed and a</p>	F0279	<p><u>Corrective Action for Affected Residents</u> The comprehensive fall care plans for Resident # C and Resident # D were reviewed and revisions implemented by the Interdisciplinary Team.</p> <p><u>Identification/Corrective Action for Potentially Affected Residents</u> All Residents who fall have the potential to require the development, review and/or revision of their fall care plan. The Incident and Accident Report was reviewed and revised (See Attachment # 1). The Unit Supervisor and Nursing Management will review the report, discuss with the IDT</p>	09/21/2012	

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	<p>contoured mattress. An alarm was attached to the bed.</p> <p>The clinical record of Resident #C was reviewed on 8/29/12 at 10:30 a.m.</p> <p>The MDS (Minimum Data Set) Assessment, dated 7/27/12, indicated the resident had severe cognitive impairments and required extensive assistance for transfers, dressing and toileting.</p> <p>The fall prevention care plan, reviewed on 7/2012, effective through 10/2012, included the following interventions: Complete fall assessment quarterly and as needed, Assure call light is within reach and in working order, Assure non-slip footwear is worn for ambulation/transfers; Assure wander guard bracelet is on, Remove furniture from bedside when she is in bed, Assure that she is in a safe position, Observe for steadiness of gait, Keep pathways clear, Needs assistance of 1-2 for transfers and walking, In wheelchair for long distances, Monitor every 15 minutes for location, Low bed with mat at bedside, and Monitor falls at weekly behavior meetings.</p>		<p>(Interdisciplinary Team) any further development and revisions necessary to aide in the prevention of additional falls. The Fall Care Plan will continue to be reviewed and discussed with the IDT quarterly, annually, with a significant change and after each fall in the Behavior Meeting. <u>Measures for Prevention</u> The Director of Nursing and/or Assistant Director of Nursing will review 5 falls weekly times 4 weeks, then monthly to ensure Fall Care Plans are reviewed, revised and developed/ implemented ,as needed, after each Resident fall. A summary of these findings will be forwarded to the Quality Assurance Committee for a review. (See Attachment # 2) <u>Quality Assurance for Prevention</u> Monthly, the Quality Assurance Committee will review the Director of Nursing's monitoring summary from above and make recommendations for continued monitoring. <u>Effective Date</u> These changes will be completed and effective September 21, 2012</p>		

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	<p>The Aide Assignment sheet, in use on 8/29/12, indicated Resident #C was a fall risk and was to have 15 minute checks, pad alarm in bed, personal alarm in wheelchair, low bed with mat and scheduled toileting program.</p> <p>The July and August 2012 TARs (Treatment Administration Records), indicated a bed cushion alarm was to be on when the resident was in bed, and a personal alarm was to be on when the resident was in the wheelchair. The TAR indicated the alarms were to be tested every shift and batteries were to be changed monthly.</p> <p>There was no documentation fall prevention interventions were added to the care plan or that existing interventions were evaluated between 8/1/12 through 8/29/12.</p> <p>Nursing notes indicated the resident had eight falls between 8/2/12 and 8/29/12, as follows: On 8/2/12 at 6:40 p.m., "Res (Resident) found sitting on room floor next to low bed. Res had taken pillow, alarm, and soaker pad off bed. Soaker pad was under resident as if resident was wearing pad as brief..." The note indicated the resident sustained no injuries and stated she was</p>			

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	<p>hungry.</p> <p>The Follow-up and Prevention of Fall Report, dated 8/2/12, was reviewed with the ADON (Assistant Director of Nursing) on 8/30/12 at 3:00 p.m. The ADON indicated the resident had removed her alarm and no new fall prevention interventions were implemented after the fall.</p> <p>On 8/3/12 at 10:30 p.m., (entry for 9:30 p.m.), the resident's bed alarm was sounding and the resident was found sitting on the mat next to her bed. The note indicated the resident sustained no injuries.</p> <p>The Follow-up and Prevention of Fall Report, dated 8/3/12, was reviewed with the ADON on 8/30/12 at 3:00 p.m. No new fall prevention interventions were recommended.</p> <p>On 8/10/12 at 10:45 p.m., "CNA (Certified Nursing Assistant) notified the writer that resident was on floor. Writer observed resident on buttocks scooting across floor to roommates w/c (wheelchair) naked. Bed in low position mat folded et pushed away from bed, gown on floor. pad on bed wet..." The note indicated no injuries were noted. The Follow-up and Prevention of Fall Report, dated 8/10/12, indicated the alarm was not working, was repaired,</p>						

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	<p>replaced, and turned on. There was no documentation the effectiveness of the bed alarm was evaluated.</p> <p>The Behavior Meeting Review indicated the resident was to be seen by the Psychiatrist at the next visit. On 8/30/12 at 3:15 p.m., the ADON indicated the resident was to be seen by the Psychiatrist, on 9/1/12.</p> <p>No new interventions were added to the careplan following the fall.</p> <p>On 8/13/12 at 6:10 a.m., "CNA notified writer that resident was lying on floor. Writer observed resident half way across floor lying on R (Right) side...." The note indicated the alarm was sounding, and a laboratory technician was in the resident's room, five minutes before the fall and observed the resident sitting on the side of her bed.</p> <p>On 8/30/12 at 3:00 p.m., the ADON was interviewed. She indicated staff should accompany the phlebotomist when they are in the facility and a staff person should have been with the phlebotomist to assist Resident #C when she was observed sitting on the side of the bed.</p> <p>The Behavior Meeting Review, of the 8/13/12 fall, indicated staff was to accompany the phlebotomist.</p> <p>On 8/14/12 at 9:05 p.m., the resident was found crawling on the floor with her arm</p>			

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	<p>next to the bathroom door.</p> <p>The Follow-up and Prevention of Fall Report, dated 8/14/12 was reviewed with the ADON on 8/30/12 at 3:00 p.m.</p> <p>The ADON indicated no new intervention to prevent falls were implemented following the fall.</p> <p>On 8/18/12 at 11:45 a.m., Resident #C was found on her hands and knees yelling help me. The bed alarm was sounding. No injuries were noted.</p> <p>The Follow-up and Prevention of Fall Report, dated 8/14/12 was reviewed with the ADON on 8/30/12 at 3:00 p.m.</p> <p>The ADON indicated the resident was given Ativan for anxiety at the time of the incident.</p> <p>The ADON indicated the fall was reviewed at the Behavior Meeting on 8/21/12, but no fall prevention interventions were recommended or added to the careplan.</p> <p>On 8/26/12 at 10:15 p.m., another resident told a CNA to look down the hall and resident was crawling out to the main hall naked. The note indicated the resident was saying she needed help and was incontinent of urine in bed (pads, gown and blankets). The note indicated the resident's alarm was sounding.</p> <p>The Follow-up and Prevention of Fall Report, dated 8/14/12 was reviewed with</p>						

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	<p>the ADON on 8/30/12 at 3:00 p.m., and no new fall prevention interventions were added to the careplan following the fall.</p> <p>On 8/29/12 at 4:00 a.m., nurses' notes indicated, "CNA notified writer that resident had light on et (and) when she went in she was sitting @ (at) edge of bed c/o (complains of) (sic) of bottom burning et (and) her bed was wet. Resident had taken gown et (and) brief off. CNA then went to get clean linen et gown (sic) when she came back to room resident was crawling on floor stating 'help me, I can't walk, I need help'...."</p> <p>2. On 8/29/12 at 10 a.m., during the orientation tour, RN #11 indicated Resident #D had a recent fall. The resident was observed to have a low air loss mattress on her bed.</p> <p>The clinical record of Resident #D was reviewed on 8/29/12 at 3:10 p.m.</p> <p>The MDS (Minimum Data Set) Assessment, dated 6/6/12, indicated the resident had severe cognitive impairments and required extensive assistance for transfer, dressing, eating and toileting.</p> <p>The fall prevention care plan, reviewed on 06/2012 and effective through 9/2012, indicated Resident #D was at risk for falls</p>			

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	<p>due to history of right hip fracture, narcolepsy, atrial fibrillation, poor safety awareness and impaired cognition. The fall prevention care plan, included the following interventions: Complete fall assessment quarterly and as needed, Assure call light is within reach and working, Assure non-slip foot wear is worn, Assure bed alarm is on when in bed and maintain in working order, Assure personal alarm is on and in working order, Remove furniture from bedside when she is in bed, Assure she is in safe position, Keep pathways clear, Locate and reorient checks every 15 minutes, Assure low bed has mats to floor, Do not leave unattended in wheelchair in room, Side rails time two Monitor falls at weekly behavior meeting.</p> <p>The Aide assignment sheet in use on 8/29/12, indicated the resident was to have 15 minute checks, low bed with mat, personal alarm, bed alarm and was to be checked and changed.</p> <p>Nursing notes indicated the following: On 8/11/12 at 7:40 p.m., open areas were</p>						

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	<p>noted on the resident's right and left buttocks.</p> <p>On 8/12/12 at 9:30 p.m., the day shift nurse contacted hospice to arrange for a specialty mattress.</p> <p>On 8/13/12 at 9:30 a.m., the mattress and wheelchair cushion arrived and were placed in the bed and wheelchair.</p> <p>On 8/14/12 at 4:45 a.m., staff heard the alarm sound and found the resident sitting on the mat beside her bed. The resident had no apparent injuries.</p> <p>The Follow-up and Prevention of Fall Report, dated 8/14/12, indicated Resident #D slid off her new bed.</p> <p>There was no documentation on the report that new fall prevention interventions were implemented or recommended. No new interventions were added to the careplan.</p> <p>On 8/30/12 at 10:00 a.m., the ADON (Assistant Director of Nursing) was interviewed. and indicated, after the incident, the safe use of the low air loss mattress was reviewed with the staff, during shift report for 24 hours. The ADON indicated information provided to staff included positioning the resident in the center of the bed, and assuring proper inflation of the resident's mattress.</p> <p>The Fall Prevention Policy, undated,</p>			

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	<p>provided by the DON (Director of Nursing) was reviewed on 8/29/12 at 2:00 p.m., and indicated, in part, "...F. If during a resident's stay, the resident falls or becomes at risk for falls, the plan of care will be reviewed and revised as necessary. See attached list of suggested interventions to decrease falls. G. An Investigation form is to be completed with every fall incident report and actions taken as indicated..."</p> <p>Any fall that occurs will be investigated and interventions put in place to prevent another fall. This is to include consideration for interventions that have already been tried...This is initiated at the time of the fall and reviewed weekly at the behavior meeting..."</p> <p>This Federal tag relates to Complaint IN00113743.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>						

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F0323 SS=D	<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 develop and implement new interventions to prevent falls. This deficiency affected 2 of 3 residents, who had experienced falls, in sample of 4. (Resident #C and Resident #D)</p> <p>Findings include:</p> <p>On 8/29/12 at 10 a.m., during the orientation tour, LPN #10 indicated Resident #C had experienced multiple falls. The resident was observed lying in a low bed with a mat beside the bed and a contoured mattress. An alarm was attached to the bed.</p> <p>The clinical record of Resident #C was reviewed on 8/29/12 at 10:30 a.m. and indicated diagnoses which included, but were not limited to, dementia, seizure disorder, osteoporosis, and depression.</p> <p>The MDS (Minimum Data Set) Assessment, dated 7/27/12, indicated the resident had severe cognitive impairments</p>	F0323	<p><u>Corrective Action for Affected Residents</u> The Follow-up and Prevention Fall Reports for Resident # C and Resident # D were reviewed and interventions added/implemented. _ <u>Identification/Corrective Action for Potentially Affected Residents</u> All Residents who fall have the potential to require the development / implementation of interventions to prevent falls. The Unit Supervisor and Nursing Management will review the report, discuss with the IDT (Interdisciplinary Team) any further development/ Implementation of interventions necessary to aide in the prevention of additional falls. The Incident and Accident Form was reviewed and revised. (See Attachment #1) The Fall Care Plan, Follow-up and Prevention Fall Report (Quality Assurance tool for internal use and not part of the clinical) and the Incident and Accident Report forms will continue to be reviewed and discussed with the IDT quarterly, annually, with a significant change and after each fall in the Behavior Meeting. <u>Measures for Prevention</u> The Director of</p>	09/21/2012	

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	<p>and required extensive assistance for transfers, dressing and toileting.</p> <p>The fall prevention care plan, reviewed on 7/2012, effective through 10/2012, included the following interventions: Complete fall assessment quarterly and as needed, Assure call light is within reach and in working order, Assure non-slip footwear is worn for ambulation/transfers; Assure wander guard bracelet is on, Remove furniture from bedside when she is in bed, Assure that she is in a safe position, Observe for steadiness of gait, Keep pathways clear, Needs assistance of 1-2 for transfers and walking, In wheelchair for long distances, Monitor every 15 minutes for location, Low bed with mat at bedside, and Monitor falls at weekly behavior meetings.</p> <p>The Aide Assignment sheet, in use on 8/29/12, indicated Resident #C was a fall risk and was to have 15 minute checks, pad alarm in bed, personal alarm in wheelchair, low bed with mat and scheduled toileting program.</p> <p>The July and August 2012 TARs</p>		<p>Nursing and/or Assistant Director of Nursing will review 5 falls/incident weekly times 4 weeks, then monthly to ensure interventions are developed/ implemented ,as needed, after each Resident fall. A summary of these findings will be forwarded to the Quality Assurance Committee for a review. (See Attachment # 2) <u>Quality Assurance for Prevention</u> Monthly, the Quality Assurance Committee will review the Director of Nursing's monitoring summary from above and make recommendations for continued monitoring. <u>Effective Date</u> These changes will be completed and effective September 21, 2012</p>	

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	<p>(Treatment Administration Records), indicated a bed cushion alarm was to be on when the resident was in bed, and a personal alarm was to be on when the resident was in the wheelchair.</p> <p>The TAR indicated the alarms were to be tested every shift and batteries were to be changed monthly.</p> <p>There was no documentation fall prevention interventions were added to the care plan or that existing interventions were evaluated between 8/1/12 through 8/29/12.</p> <p>Nursing notes indicated the resident had eight falls between 8/2/12 and 8/29/12, as follows: On 8/2/12 at 6:40 p.m., "Res (Resident) found sitting on room floor next to low bed. Res had taken pillow, alarm, and soaker pad off bed. Soaker pad was under resident as if resident was wearing pad as brief..." The note indicated the resident sustained no injuries and stated she was hungry.</p> <p>The Follow-up and Prevention of Fall Report, dated 8/2/12, was reviewed with the ADON (Assistant Director of Nursing) on 8/30/12 at 3:00 p.m. and was not complete. The sections regarding the last time toileted, change in medications, diagnosis list and physical limitations were blank.</p>						

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	<p>The ADON indicated the resident had removed her alarm and no new fall prevention interventions were implemented after the fall. The Behavior Meeting Review was signed but no fall prevention recommendations were listed.</p> <p>On 8/3/12 at 10:30 p.m., (entry for 9:30 p.m.), the resident's bed alarm was sounding and the resident was found sitting on the mat next to her bed. The note indicated the resident sustained no injuries.</p> <p>The Follow-up and Prevention of Fall Report, dated 8/3/12, was reviewed with the ADON on 8/30/12 at 3:00 p.m. The form was not complete. Sections for continence, last time toileted, if alarm was sounding, changes in medication, medication possible impact on falls, diagnosis and physical limitations were all blank.</p> <p>The Report indicated the alarm was repaired and replaced. The Behavior Meeting Review indicated the facility would continue with alarms, every 15 minute checks, and low bed with mat. No new fall prevention interventions were recommended.</p> <p>On 8/10/12 at 10:45 p.m., "CNA (Certified Nursing Assistant) notified the writer that resident was on floor. Writer observed resident on buttocks scooting</p>			

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	<p>across floor to roommates w/c (wheelchair) naked. Bed in low position mat folded et pushed away from bed, gown on floor. pad on bed wet..." The note indicated no injuries were noted. The Follow-up and Prevention of Fall Report, dated 8/10/12, was not complete and the sections regarding the last time the resident was visualized and toileted were blank.</p> <p>The form indicated the alarm was not working, was repaired, replaced, and turned on. There was no documentation the effectiveness of the bed alarm was evaluated.</p> <p>The Behavior Meeting Review indicated the resident was to be seen by the Psychiatrist at the next visit.</p> <p>On 8/30/12 at 3:15 p.m., the ADON indicated the resident was to be seen by the Psychiatrist, on 9/1/12, to evaluate her medications.</p> <p>On 8/13/12 at 6:10 a.m., "CNA notified writer that resident was lying on floor. Writer observed resident half way across floor lying on R (Right) side...." The note indicated the alarm was sounding, and a laboratory technician was in the resident's room, five minutes before the fall and observed the resident sitting on the side of her bed.</p> <p>On 8/30/12 at 3:00 p.m., the ADON was interviewed. She indicated staff should</p>						

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	<p>accompany the phlebotomist when they are in the facility and a staff person should have been with the phlebotomist to assist Resident #C when she was observed sitting on the side of the bed. The Behavior Meeting Review, of the 8/13/12 fall, indicated staff was to accompany the phlebotomist.</p> <p>On 8/14/12 at 9:05 p.m., the resident was found crawling on the floor with her arm next to the bathroom door. The Follow-up and Prevention of Fall Report, dated 8/14/12 was reviewed with the ADON on 8/30/12 at 3:00 p.m. The ADON indicated no new intervention to prevent falls were implemented following the fall. The sections regarding, the resident's statement, whether the bed was in the low position, whether the alarm was sounding and whether the call light was within reach were all blank. The section for Behavior Meeting Review was also blank. The ADON indicated, the 8/14/12, fall was reviewed on 8/21/12 but no fall prevention interventions were recommended.</p> <p>On 8/18/12 at 11:45 a.m., Resident #C was found on her hands and knees yelling help me. The bed alarm was sounding. No injuries were noted. The Follow-up and Prevention of Fall</p>				

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	<p>Report, dated 8/14/12 was reviewed with the ADON on 8/30/12 at 3:00 p.m. The ADON indicated the resident was given Ativan for anxiety at the time of the incident. The section for Behavior Meeting Review of the fall was blank. The ADON indicated the fall was reviewed at the Behavior Meeting on 8/21/12, but no fall prevention interventions were recommended.</p> <p>On 8/26/12 at 10:15 p.m., another resident told a CNA to look down the hall and resident was crawling out to the main hall naked. The note indicated the resident was saying she needed help and was incontinent of urine in bed (pads, gown and blankets). The note indicated the resident's alarm was sounding. The Follow-up and Prevention of Fall Report, dated 8/14/12 was reviewed with the ADON on 8/30/12 at 3:00 p.m. The ADON indicated the resident was given Tylenol for pain at the time of the incident. The section for the Behavior Meeting Review of the fall was blank. The ADON indicated, the 8/26/12 fall would be reviewed at the next weekly Behavior Meeting.</p> <p>On 8/29/12 at 4:00 a.m., "CNA notified writer that resident had light on et (and) when she went in she was sitting @ (at) edge of bed c/o (complains of) (sic) of</p>			

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	<p>bottom burning et (and) her bed was wet. Resident had taken gown et (and) brief off. CNA then went to get clean linen et gown (sic) when she came back to room resident was crawling on floor stating 'help me, I can't walk, I need help'..."</p> <p>On 8/30/12 at 3:00 p.m., the ADON indicated the 8/29/12, fall would be reviewed at next Tuesday's Behavior Meeting.</p> <p>On 8/30/12 at 11:00 p.m., the DON (Director of Nursing) was interviewed. She indicated she had reviewed Resident #C's Follow-up and Fall Prevention Reports and they were not complete. She indicated she was aware there was a problem with fall incident reviews and she was initiating a new fall protocol starting on 9/1/12. She indicating she had initiated a voiding pattern assessment for Resident #C, on 8/29/12, to determine if her toileting plan needed to be revised.</p> <p>2. On 8/29/12 at 10 a.m., during the orientation tour, RN #11 indicated Resident #D had a recent fall. The resident was observed to have a low air loss mattress on her bed.</p> <p>The clinical record of Resident #D was reviewed on 8/29/12 at 3:10 p.m. The resident was placed in Hospice care on 5/24/11.</p>			

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	<p>The MDS (Minimum Data Set) Assessment, dated 6/6/12, indicated the resident had severe cognitive impairments and required extensive assistance for transfer, dressing, eating and toileting.</p> <p>The fall prevention care plan, reviewed on 06/2012 and effective through 9/2012, indicated Resident #D was at risk for falls due to history of right hip fracture, narcolepsy, atrial fibrillation, poor safety awareness and impaired cognition. The fall prevention care plan, included the following interventions: Complete fall assessment quarterly and as needed, Assure call light is within reach and working, Assure non-slip foot wear is worn, Assure bed alarm is on when in bed and maintain in working order, Assure personal alarm is on and in working order, Remove furniture from bedside when she is in bed, Assure she is in safe position, Keep pathways clear, Locate and reorient checks every 15 minutes, Assure low bed has mats to floor, Do not leave unattended in wheelchair in room, Side rails time two</p>			

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	<p>Monitor falls at weekly behavior meeting.</p> <p>The Aide assignment sheet in use on 8/29/12, indicated the resident was to have 15 minute checks, low bed with mat, personal alarm, bed alarm and was to be checked and changed.</p> <p>Nursing notes indicated the following: On 8/11/12 at 7:40 p.m., open areas were noted on the resident's right and left buttocks. On 8/12/12 at 9:30 p.m., the day shift nurse contacted hospice to arrange for a specialty mattress. On 8/13/12 at 9:30 a.m., the mattress and wheelchair cushion arrived and were placed in the bed and wheelchair. On 8/14/12 at 4:45 a.m., staff heard the alarm sound and found the resident sitting on the mat beside her bed. The resident had no apparent injuries.</p> <p>The Follow-up and Prevention of Fall Report, dated 8/14/12 was not complete and sections on medication and diagnosis were blank. The Report indicated Resident #D slid off her new bed. There was no documentation new fall prevention interventions were implemented or recommended. The section for the Behavior Meeting Review of the fall was signed but there</p>				

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	<p>were no recommendations for interventions to prevention of another fall.</p> <p>On 8/30/12 at 10:00 a.m., the ADON (Assistant Director of Nursing) was interviewed. The ADON indicated the resident had half bolsters on her new mattress that were, soft, small and easy to roll over. She indicated after the incident, the safe use of the low air loss mattress was reviewed with the staff, during shift report for 24 hours. The ADON indicated information provided to staff included positioning the resident in the center of the bed, and assuring proper inflation of the resident's mattress. She indicated full bolsters for the bed were received on 8/30/12 (2 weeks after the incident).</p> <p>The Fall Prevention Policy, undated, provided by the DON (Director of Nursing) was reviewed on 8/29/12 at 2:00 p.m., and indicated, in part, "...F. If during a resident's stay, the resident falls or becomes at risk for falls, the plan of care will be reviewed and revised as necessary. See attached list of suggested interventions to decrease falls. G. An Investigation form is to be completed with every fall incident report and actions taken as indicated..."</p> <p>Any fall that occurs will be investigated and interventions put in place to prevent another fall. This is to include</p>			

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	<p>consideration for interventions that have already been tried...This is initiated at the time of the fall and reviewed weekly at the behavior meeting..."</p> <p>This Federal tag relates to Complaint IN00113743.</p> <p>3.1-45(a)(2)</p>				

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F0514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review, the facility failed to ensure clinical records were complete, related to follow-up fall investigation and fall prevention reports, for 2 of 3 residents, who had experienced falls, in sample of 4. (Resident #C and Resident #D)</p> <p>Findings include:</p> <p>On 8/29/12 at 10 a.m., during the orientation tour, LPN #10 indicated that Resident #C had experienced multiple falls. The resident was observed lying in a low bed with a mat beside the bed and a contoured mattress. An alarm was attached to the bed.</p> <p>The clinical record of Resident #C was reviewed on 8/29/12 at 10:30 a.m.</p>	F0514	<p><u>Corrective Action for Affected Residents</u> The Follow-up and Prevention Fall Report is a Quality Assurance Tool for internal use only and is not part of the clinical record. Resident # C and Resident # D's Follow-up and Prevention Fall Reports were reviewed and the State Surveyor was provided a list of incomplete documentation found prior to the survey visit along with proposed changes to be implemented. The Unit Supervisor and Nursing Management are now responsible to ensure the complete documentation of the reports. - <u>Identification/Corrective Action for Potentially Affected Residents</u> All Residents who fall have the potential to require review of the Follow-up and Prevention Fall Report (a Quality Assurance tool used for internal use only and not part of the clinical record) and the</p>	09/21/2012	

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	<p>Nursing notes indicated the resident had eight falls between 8/2/12 and 8/29/12. The Follow-up and Prevention of Fall Report, dated 8/2/12, was reviewed with the ADON (Assistant Director of Nursing) on 8/30/12 at 3:00 p.m. and was not complete. The sections regarding the last time toileted, change in medications, diagnosis list and physical limitations were blank.</p> <p>The Follow-up and Prevention of Fall Report, dated 8/3/12, was reviewed with the ADON on 8/30/12 at 3:00 p.m. The form was not complete. Sections for continence, last time toileted, if alarm was sounding, changes in medication, medication possible impact on falls, diagnosis and physical limitations were all blank.</p> <p>The Follow-up and Prevention of Fall Report, dated 8/10/12, was not complete and the sections regarding the last time the resident was visualized and toileted were blank.</p> <p>The Follow-up and Prevention of Fall Report, dated 8/14/12 was reviewed with the ADON on 8/30/12 at 3:00 p.m. The sections regarding, the resident's statement, whether the bed was in the low position, whether the alarm was sounding</p>		<p>Incident and Accident Report for completeness of documentation. The Incident and Accident Report Form was reviewed and revised (See Attachment # 1). The Unit Supervisor and Nursing Management will review the reports for completeness of documentation. The reports will continue to be reviewed and discussed with the IDT after each fall in the Behavior Meeting. <u>Measures for Prevention</u> The Director of Nursing and/or Assistant Director of Nursing will review 5 falls weekly times 4 weeks, then monthly to ensure the Follow-up and Prevention Fall Report and Incident and Accident Reports are complete. A summary of these findings will be forwarded to the Quality Assurance Committee for a review. (See Attachment # 2) <u>Quality Assurance for Prevention</u> Monthly, the Quality Assurance Committee will review the Director of Nursing's monitoring summary from above and make recommendations for continued monitoring. <u>Effective Date</u> These changes will be completed and effective September 21, 2012</p>		

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	<p>and whether the call light was within reach were all blank. The section for Behavior Meeting Review of the fall was also blank.</p> <p>The Follow-up and Prevention of Fall Report, dated 8/18/12 was reviewed with the ADON on 8/30/12 at 3:00 p.m. The section for Behavior Meeting Review of the fall was blank.</p> <p>On 8/30/12 at 11:00 p.m., the DON (Director of Nursing) was interviewed. She indicated she had reviewed Resident #C's Follow-up and Fall Prevention Reports and they were not complete. She indicated she was aware there was a problem with fall incident reviews and she was initiating a new fall protocol starting on 9/1/12.</p> <p>2. On 8/29/12 at 10 a.m., during the orientation tour, RN #11 indicated Resident #D had a recent fall. The resident was observed to have a low air loss mattress on her bed.</p> <p>The clinical record of Resident #D was reviewed on 8/29/12 at 3:10 p.m.</p> <p>On 8/14/12 at 4:45 a.m., nursing notes indicated Resident #D was found sitting on the mat beside her bed.</p>			

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	<p>The Follow-up and Prevention of Fall Report, dated 8/14/12 was not complete and sections on medication and diagnosis were blank.</p> <p>The Fall Prevention Policy, undated, provided by the DON (Director of Nursing) was reviewed on 8/29/12 at 2:00 p.m., and indicated, in part, "...G. An Investigation form is to be completed with every fall incident report..."</p> <p>This Federal tag relates to Complaint IN00113743.</p> <p>3.1-50(a)(1)</p>						