

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155379	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2016
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 827 W 13TH ST ROCHESTER, IN 46975
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00200103.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00200103 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F323.</p> <p>Survey dates: May 9, 10, 11, 12, 13 and 16, 2016</p> <p>Facility number: 000325 Provider number: 155379 AIM number: 100274300</p> <p>Census bed type: SNF/NF: 71 Total: 71</p> <p>Census payor type: Medicare: 13 Medicaid: 44 Other: 14 Total: 71</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0157 SS=D Bldg. 00	<p>16.2-3.1.</p> <p>Quality Review completed by 14454 on May 23, 2016.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as</p>				

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	<p>specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure a family member was notified timely of a fall for 1 of 3 residents reviewed for falls. (Resident D)</p> <p>Finding includes:</p> <p>On 5/11/16 at 10:15 A.M., a review of the clinical record for Resident D was conducted. The record indicated the resident was admitted on 4/29/16. The resident's diagnoses included, but were not limited to: pain, unspecified convulsions, insomnia and Alzheimer's disease.</p> <p>An Incident/Accident Data Entry Questionnaire form, dated 5/9/16 at 5:30 A.M., indicated Resident D had an unwitnessed fall and received a laceration to her head with no loss of consciousness. The form indicated the resident was found by QMA (Qualified Medication Aide) #3 lying on her back with her head slightly under her bed. The form indicated the physician was called at 5:40 A.M.; however, a family member</p>	F 0157	<p>The facility is requesting a face to face Informal dispute resolution meeting. The facility does not agree that it failed to notify a family member of a fall. Resident D no longer resides at the facility. The Director of Nursing or designee completed an audit prior to June 16, 2016 of all falls within the past 30 days to ensure that properfamily notification occurred. The licensed nursing staff were re-educated prior to June 16, 2016 regarding timely family notification of a resident who falls. The Director of Nursing or designee will audit 8 incidentsper month for 2 months, then 6 incidents per month for 2 months, then 4incidents per month for 2 months to ensure timely family notification takesplace. Results of these audits will beforwarded to the Quality Assurance Committee for review and additional recommendationsas indicated. The QA committee will recommendongoing monitoring until a 95% threshold is achieved.</p>	06/15/2016

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	<p>wasn't contacted until 8:00 A.M. The resident's head laceration was cleansed, vital signs were taken and neurological assessments were started. The form indicated the interventions in place at the time of the accident was for the resident to have non-skid socks on. There was no new intervention in place due to resident in the emergency room.</p> <p>A Nursing Note, dated 5/9/16 at 6:23 A.M., indicated resident was lying on her backside with head slightly under the bed and the resident's walker was beside her. The note indicated the resident had 2 lacerations to her left side of her hand and to see skin sheets.</p> <p>A Nursing Note, dated 5/9/16 at 8:32 A.M., indicated at approximately, 8:00 A.M., Resident D put her hand to her head and said "my head hurts so bad" then the resident acted very tired. The Nursing Note indicated the Assistant Director of Nursing (ADON) was notified and the ADON and a CNA (Certified Nursing Assistant) (not identified) took the resident to her room to laid her down in her bed, while LPN (Licensed Practical Nurse) #4 called physician, daughter and a ambulance. The Nursing Note indicated the resident became unresponsive and 911 was called again.</p>			

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	<p>During an interview, on 5/11/16 at 3:40 P.M., LPN #4 indicated she was working the day shift on the dementia unit the morning of 5/9/16. She received report a little after 6:00 A.M. and was told Resident D had a fall with a laceration to her head and her vital signs were all ok. LPN #4 indicated the nurse giving her report did not say if the family had been notified of the fall. LPN#4 indicated the resident was observed in the Day room getting her blood drawn and complained of no pain. LPN#4 indicated she started her morning medication pass and gave Resident D her morning medications and took the residents vitals sometime after 7:00 A.M. Resident D's vitals were ok at that time. LPN #4 indicated the resident had no problems with taking her medications. LPN#4 indicated she assisted the resident to her table to eat breakfast sometime near 8:00 A.M. LPN #4 indicated while the resident was eating she put her hand to her head and told LPN #4 "my head hurts so bad." LPN #4 called the ADON over to the unit, so she could call the physician, physician said to send to ER, 911 was called and then a family member was notified. LPN #4 further indicated the resident started to lean so the ADON took the resident to her room to wait for the ambulance to arrive. While the</p>			

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F 0323 SS=G Bldg. 00	<p>resident was in her room the resident became unresponsive, with her pupils fixed and 911 was called again. The ambulance arrived and took the resident to the ER (Emergency Room).</p> <p>On 5/13/16 at 12:05 P.M., the DON provided a policy titled, "Falls Management," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...2. Management of Falls...f. The responsible party and physician are promptly notified of the occurrence and status of the resident...."</p> <p>This Federal tag relates to Complaint IN00200103.</p> <p>3.1-5(a)(1)</p> <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</p>			

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	<p>assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure adequate interventions, including increased supervision, were developed and implement to prevent falls for 1 of 3 who fell resulting in a head injury and subsequant death. (Resident D) The facility also failed to ensure interventions were implemented for 2 of 3 residents reviewed for falls. (Resident's E and F)</p> <p>Findings include:</p> <p>1. On 5/11/16 at 10:15 A.M., a review of the clinical record for Resident D was conducted. The record indicated the resident was admitted on 4/29/16. The resident's diagnoses included, but were not limited to: pain, unspecified convulsions, insomnia and Alzheimer's disease.</p> <p>An Initial Data Collection Tool/Nursing Service form, dated 4/29/16 at 2:00 P.M., indicated resident was unable/unwilling to recognize need to wait for assistance to get out of bed and was unable to wait for assistance before transferring.</p> <p>A Fall Risk Evaluation, dated 4/29/16, indicated the resident scored a 22. The form indicated a score of over 10 or more indicated the resident was at risk for a fall</p>	F 0323	<p>The facility is requesting a face to face informal disputeresolution meeting. The facility doesnot agree that it failed to ensure that increased supervision was implementedto prevent an independently ambulatory resident from falling. Res #D, E, and F were affected. Res #D no longer resides inthe facility. Staffing was reviewed and ensured to meet the requirements forthe residents' needs. Residents E and F were reviewed for fall interventionsand ensured all fall interventions are in place as ordered. The Director of Nursing/designee reviewed staffing andresident needs on the dementia unit. Staff audited falls over the last 30 daysto ensure interventions were implemented for each fall and care plans and caredirectives were updated. Audits to be completed by the DON/designee 3x/week for 8weeks, weekly x 8 weeks for fall interventions, care plans, and directives.Audits to continue as needed thereafter. Nursing will review staffing ondementia unit to ensure adequate staff present to meet needs of the residents. Resultsto be forwarded to the Quality Assurance Committee for review and additional recommendationsas indicated. The QA committee will recommendongoing monitoring until a 95% threshold is achieved.</p>	06/15/2016	

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	<p>and interventions should promptly be put into place.</p> <p>A Minimum Data Set (MDS) Admission Assessment, dated 5/6/16, indicated a Brief Interview Mental Status (BIMS) score of 4, which indicated the resident's cognitive status was severely impaired.</p> <p>An Interim Care Plan, dated 4/29/16, indicated resident was at risk for a physical injury from falls related to fall risk score of 22, unsteady ambulation, unable to understand safety strategies and recent falls. The interventions included to educated resident on call light, independent for transfers/ambulation, monitor & encourage use of proper foot wear and glasses on prior to getting out of bed.</p> <p>A Nursing Note, dated 4/29/16 at 7:30 P.M., indicated the resident was admitted to the secure unit. The Nursing Note indicated the resident was alert, confused, and ambulated with a walker with 1 assist. The note indicated the resident had been taking hydrocodone (opiod pain medication) for the past 2 months for pain.</p> <p>A Progress Note, dated 4/30/16 at 4:24 P.M., indicated the resident required assistance of one with transfers, a</p>			

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	<p>scheduled toileting plan was in place, and resident complained of right knee pain. The note indicated the resident was to have an evaluation by PT (physical therapy) and OT (occupational therapy).</p> <p>A Plan of Treatment for OT, dated 4/30/16, indicated the resident presented with 2 weeks of weight loss (16 pounds), decreased urine output, disorientation, difficulty finding words, falls and a swollen right knee. The plan indicated the resident was admitted due to complex partial seizures with exacerbation, mental status changes and generalized weakness. The Plan of Treatment indicated the resident was able to transfer to toilet requiring contact guard assist (contact with patient due to unsteadiness) and was utilizing a rolling walker.</p> <p>A Plan of Treatment for PT, dated 5/1/16, indicated the resident's current level of function was as follows: The resident demonstrated a balance score of 6/16 and a gait score of 7/12 for a total balance and gait score of 12/28, which relates to a the high risk fall category. The Plan further indicated the resident ambulates 50 feet on level surfaces and required contact guard assist (contact with resident due to unsteadiness) with a rolling walker with 75% (percent) tactile and verbal instruction/cues for safety.</p>			

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	<p>A Nursing Note, dated 5/1/16 at 10:21 A.M., indicated the resident was noted to be leaning sideways on the bathroom sink and told nurse she felt dizzy. The note indicated the resident walked with a rolling walker, from room to dining room, approximately 100 feet with PT.</p> <p>An Activities of Daily Living (ADL's) care plan, dated 5/2/16, indicated resident was self-care deficit. Interventions included but were not limited to: explain all procedures prior to performing task, and provide the amount of assistance/supervision that was needed.</p> <p>A Nursing Note, dated 5/4/16 at 8:49 A.M., indicated resident was incontinent of urine most of the time, wears a pull up, and was ambulating independently with rolling walker.</p> <p>An Incident/Accident Data Entry Questionnaire form, dated 5/5/16 at 1:30 A.M., indicated the resident had an unwitnessed fall while attempting to ambulate to the restroom and received a laceration to the forehead. The form indicated the resident was found in a sitting position on the floor, no head injury was suspected. The the resident's pulse, temperature and respirations were recorded. The area for the resident's</p>			

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	<p>blood pressure was left blank. The questionnaire indicated it was unknown if resident was using an assistive device. The form indicated interventions were in place at time of the fall and resident was to be checked on, routinely throughout the night and the new intervention put into place was to request a medication change. The form noted a family member was notified at 2:00 A.M. and physician was notified at 8:00 A.M.</p> <p>A Nurse's Note, dated 5/5/16 at 1:30 A.M., indicated the resident fell tonight and daughter was notified. The note indicated the daughter wanted resident tapered off the ativan and a fax was sent to the physician.</p> <p>A Non-pressure Skin Condition Record, dated 5/5//16, indicated resident had a non-surgical cut on the left temple area which measured 1.2 x 0.1 centimeters (cm) and a left temple bruise which measured 1.2 x 0.5 cm. Both injuries were first observed on 5/5/16.</p> <p>A Neurological Assessment Flow Sheet was started 5/5/16 at 1:30 A.M. The form was completed every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every hour, then every 4 hours for 16 hours, then every shift until 5/7/16 (night shift). The form indicated with</p>			

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	<p>each observation resident had no neurological problems.</p> <p>A Physician's order, dated 5/5/16 at 4:45 P.M., indicated an order for urinalysis, decrease ativan (an anti-anxiety medication) 0.5 milligrams every morning and to discontinue other atvian orders.</p> <p>A care plan, dated 5/5/16, indicated the resident was at risk for a fall related injury as evidenced by previous fall, functional problem, medication usage, poor safety awareness, poor cognition and weakness. The interventions included by were not limited to: call light within reach, provide/observed use of adaptive devices, referral for PT/OT, educated/remind resident to request assistance prior to ambulation, appropriate footwear, report falls to physician & responsible party, obtain Urine (5/5), request decrease of ativan (5/5) and scheduled toileting (upon rising, before/after meals at bedtime and as needed) (5/9).</p> <p>A Nursing Note, dated 5/5/16 at 9:42 P.M., indicated resident was alert to self with confusion, does not call when she needs help going to the bathroom, the left temple had a small goose egg with cut due to fall earlier, resident using a rolling</p>			

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	<p>walker to ambulate.</p> <p>A urinalysis (U/A) report, dated 5/6/16, indicated the resident had no urine infection.</p> <p>A Nursing Note, dated 5/7/16 at 1:14 P.M., indicated resident continued to be unsteady on her feet, off balance with ambulation, difficulty noted with pivoting as if her feet became crossed, required one assist with transfers/ambulation, having much difficulty with simple conversation and replies with confused words.</p> <p>A Nursing Note, dated 5/8/16 at 8:39 P.M., indicated the neuro checks were completed, resident was confused with disoriented speech, incoherent and had mild anxiety. The Nursing Note indicated the daughter thought the resident might be having little seizures however no involuntary movement was noted by nurse after observing the resident for 15 minutes. The nursing note also indicated she contacted the DON (Director of Nursing) with the above findings and will continue to monitor closely.</p> <p>An Incident/Accident Data Entry Questionnaire form, dated 5/9/16 at 5:30 A.M., indicated Resident D had an unwitnessed fall and received a laceration</p>			

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	<p>to her head with no loss of consciousness. The form indicated the resident was found by QMA (Qualified Medication Aide) #3 lying on her back with her head slightly under her bed. The form indicated the physician was called at 5:40 A.M., however a family member wasn't contacted until 8:00 A.M. The resident's head laceration was cleansed, vital signs were taken and neurological assessments were started. The form indicated the interventions in place at the time of the accident was for the resident to have non-skid socks on and no new interventions were in place due to resident in the Emergency Room. The resident's vital signs were: pulse 69, respirations 18, temperature 96.2 and blood pressure was 120/82</p> <p>A Nursing Note, dated 5/9/16 at 6:23 A.M., indicated resident was lying on her backside with head slightly under the bed and the resident's walker was beside her. The note indicated the resident had 2 lacerations to her left side of her hand and to see skin sheets.</p> <p>A Non-Pressure Skin Condition Record, dated 5/9/16, indicated the resident had two lacerations to left side of her head, one measured 1.0 x 0.1 x <(less than) 0.1 centimeters (cm) and the other measured 1.0 x 0.3 x <0.1 cm.</p>			

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	<p>A Nursing Note, dated 5/9/16 at 8:32 A.M., indicated at approximately 8:00 A.M., Resident D put her hand to her head and said "my head hurts so bad" then the resident acted very tired. The Assistant Director of Nursing (ADON) was notified and the ADON and a CNA (not identified) took the resident to her room and laid her down in her bed, while LPN #4 called physician, daughter and a ambulance. The resident became unresponsive and 911 was called again.</p> <p>An ER (Emergency Room) Report, dated 5/9/16, indicated the resident had arrived to the ER due to a fall at the nursing home and received a minimal laceration to the left temporal area and her right pupil was poorly reactive. The report indicated the resident was in an unresponsive state with a left temporal contusion and huge contrecoup to her right subdural hematoma. (Mosby's Medical Dictionary 4th Edition, 2009, defined the contrecoup injury as follows: an injury, usually involving the brain, in which the tissue damage in on the side opposite the trauma site, as when a blow to the left side of head results in brain damage on the right side.) The Report indicated a head CT (Computerized Tomography) scan showed a massive cerebral subdural hematoma.</p>			

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	<p>Arrangements were made for comfort measures and hospice level care at the hospital.</p> <p>A radiology report, date 5/9/16, indicated the resident had an acute subdural hemorrhage overlying the right cerebral convexity with a right to midline shift. The report indicated brain swelling in the right cerebral hemisphere of the brain.</p> <p>A Patient Progress Note-Nursing Activities & Physical Assessment, dated 5/11/16 at 5:03 A.M., indicated time of death 4:30 A.M., the patient was a Do Not Resuscitate and the family was at the bedside.</p> <p>During an interview, on 5/11/16 at 1:45 P.M., the Director of Nursing (DON) indicated the interventions to prevent a fall for Resident D, after her fall on 5/5/16, were to obtain a U/A and decrease the resident's ativan, staff were to be rounding every 15 minutes and station themselves in the hallway. The DON further indicated the root cause of Resident D's fall were: taking herself to the bathroom, and ativan causing more confusion.</p> <p>During an interview, on 5/11/16 at 3:40 P.M., LPN (Licensed Practical Nurse) #4 indicated she was working the day shift</p>			

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	<p>on the dementia unit the morning of 5/9/16. She received report a little after 6:00 A.M. and was told Resident D had a fall with a laceration to her head and her vital signs were all ok. LPN #4 indicated the nurse giving her report did not say if the family had been notified of the fall. LPN #4 indicated the resident was observed to be in the Day room getting her blood drawn and complained of no pain. LPN #4 indicated she started her morning medication pass and gave the Resident D her morning medications and took the residents vitals sometime after 7:00 A.M. and Resident's vitals were ok. LPN #4 indicated the resident had no problems with taking her medications. LPN #4 indicated she assisted the resident to her table to eat breakfast sometime near 8:00 A.M. LPN #4 indicated while the resident was eating she put her hand to her head and told LPN #4 "my head hurts so bad." LPN #4 called the ADON over to the unit, so she could call the physician, physician said to send to ER, 911 was called and then a family member was notified. LPN #4 indicated the resident started to lean so the ADON took the resident to her room to wait for the ambulance to arrive. While the resident was in her room the resident became unresponsive, with her pupils fixed and 911 was called again. The ambulance arrived and took the</p>			
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	<p>resident to the ER.</p> <p>During an interview, on 5/12/16 at 10:00 A.M., CNA #5 indicated she was working the morning shift of 5/9/16 and when she arrived to the unit Resident D was observed at the nursing station. CNA #5 indicated the resident was smiling, talking and had dried blood on the left side of her head. CNA #5 indicated she had taken care of the resident before 5/9 and resident was a stand by assist with toileting and transfers. She indicated she had caught the resident trying to get out of bed on her own several times. CNA #5 indicated during breakfast the resident complained of nausea and a headache. She remembered the nurse contacting the ADON when the resident complained about her head pain.</p> <p>During an interview, on 5/12/16 at 10:20 A.M., the ADON indicated LPN #4 contacted her on the morning of 5/9/16 regarding concerns with Resident D. The ADON indicated when she arrived on the unit the resident was sitting in the dining area and looked tired. The ADON indicated the resident laid her head on the ADON's shoulder. She then transferred the resident to a wheelchair and took the resident to her room and assisted her to bed while LPN #4 made phone calls.</p>			

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	<p>During an interview, on 5/13/16 at 1:30 P.M., QMA #3 indicated she worked the secure dementia unit from 2:00 A.M. thru 6:00 A.M. on 5/9/16 by herself. QMA #3 indicated she rounded the unit every 15 minutes to check on the residents and at approximately 5:15 A.M., Resident D was observed to be in bed under her covers. QMA #3 indicated the resident had a 6:00 A.M. pain medication and entered the resident's room and found the resident lying on her back, with head at foot of the bed. The QMA #3 indicated the resident's walker was located on the other side of a recliner that sat beside the resident's bed. QMA#3 indicated the resident was crying and trying to sit up on her own. QMA #3 indicated the resident had non-skid socks on and resident's call light was clipped to her bed. The QMA called the manager on duty and she assessed the resident, cleansed her wound and called the doctor. QMA #4 got a wheelchair and assisted the resident to the restroom then resident transferred herself to the toilet with stand by assist and was taken by wheelchair to the nurse's desk to be monitored. The QMA indicated the resident was talking and sitting in the wheelchair when she left the unit.</p> <p>On 5/13/16 at 12:05 P.M., the DON</p>			

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	<p>provided a policy titled, "Falls Management," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Each resident will be assessed throughout the course of treatment for different parameters such as: cognition, safety awareness, fall history, mobility, sensory status, medications, or predisposing health conditions that may contribute to fall risk. An interdisciplinary plan of care will be developed, implemented, reviewed and updated as necessary to reflect each resident's current safety needs and fall reduction interventions...."</p> <p>A Staffing Schedule, dated 5/8/16, and provided by the DON on 5/16/16, indicated a RN (Registered Nurse) worked the night shift till 2:00 A.M. on 5/9/16, then QMA #3 worked from 2:00 A.M. until 6:00 A.M. There were no other staff members to work the secure dementia unit on the morning of 5/9/16.</p> <p>During an interview, on 5/16/16 at 12:45 P.M., the DON indicated on the morning of 5/9/16 there were 13 residents on the secure dementia unit, 10 of those residents required 1 assist for transfers and toileting and one resident was a stand by assist for transfers and toileting. The DON indicated there was one staff member on the unit working the night</p>			

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	<p>shift. When the DON was asked who was supervising the rest of the residents while the one staff member was assisting a resident to the restroom she indicated "no one."</p> <p>2. The clinical record for Resident F was reviewed on 05/12/2016 at 9:07 A.M. Resident F was admitted to the facility, on 12/29/15, with diagnoses, including but not limited to: fracture of the pelvis, chronic obstructive pulmonary disease, enlarged prostate, atherosclerotic heart disease, emphysema, heart failure, hypertension, and history of fracture of the left humerus.</p> <p>The history and physical assessment, completed at an acute care facility prior to the resident's admission to the facility, on 12/25/15, indicated Resident F tripped over his oxygen tubing in his home and fell, fracturing his pelvis and humerus.</p> <p>A fall risk evaluation, completed on 12/29/15, indicated the resident had a history of 1 to 2 falls, required assistance for elimination needs, utilized a wheelchair, had multiple health risk factors and scored an 18 on the evaluation which indicated he was at high risk for falls. The intervention put in place on 12/29/15 to prevent falls was</p>			

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	<p>"call light within reach."</p> <p>The initial admission Minimum Data Set (MDS) assessment, completed on 01/05/16, indicated the resident scored a 14 of 15 on the (Brief Interview of Mental Status) BIMS, required extensive staff assistance for transfers, was non ambulatory, and required extensive staff assistance for wheelchair locomotion and toileting needs. The resident had an indwelling urinary catheter and was frequently incontinent of his bowels.</p> <p>A nursing progress note, dated 03/07/16 at 12:00 A.M., indicated the resident was found on the floor in his room. The resident was confused and had been attempting to ambulate by himself.</p> <p>Another fall risk evaluation, completed on 03/07/16, indicated the resident was still a high risk for falls and the interventions in place were "call light in reach and education provided."</p> <p>An Incident/Accident Data Entry Questionnaire (sic), completed on 03/07/16 at 12:00 A.M., indicated Resident F was found on the floor by a nurse. The resident had been attempting to ambulate without any assistive devices and was alert but confused. The follow up portion of the investigative form</p>			

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	<p>indicated the resident was unable to balance himself independently and had no barriers which might have contributed to his fall. The resident had not utilized his call light and he had a low bed in place. The resident had previously refused hip protectors as an intervention. The interventions implemented were to continue the bed in low position and call light in reach and education regarding the call light was provided to the resident.</p> <p>A Nursing progress note, dated 04/22/16 at 3:54 P.M., indicated the resident slid out of his wheelchair and was found on the floor in front of his wheelchair.</p> <p>The most recent Fall Risk Evaluation, completed on 04/22/16, indicated the resident was still a high risk for falls and the intervention implemented was "dysem [a non slip thin material] to wheelchair."</p> <p>A care plan related to the resident's risk for falls, initiated on 01/04/16 and current through 07/06/16, indicated the resident was at risk for a fall as evidence by previous falls. The interventions included a fall risk assessment, invite and escort to activity programs, provide environmental adaptations- call light in reach and adequate glare free lighting, and area free of clutter, provide resident</p>			

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	<p>teaching for safety measures, provide wheelchair, refer to PT (physical therapy), OT (occupational therapy) and Mental health, remind to lock brakes on bed and chair before transferring, when rising from a lying position sit on side of bed for a few minutes before transferring/standing, educate to request assistance prior to ambulation, report falls to physician and responsible party. "Non-skid strips next to bed" was added as an intervention on 03/07/16 and a "dysom [sic] to wheelchair" was added on 04/22/16.</p> <p>A Nursing progress note, dated 05/02/16 at 3:39 P.M., indicated the resident was attempting to transfer himself and had not utilized the call light or requested assistance.</p> <p>On 05/13/2016 at 10:54 A.M., Resident F's room observed and there were no non-skid strips observed on either side of his bed or in the bathroom.</p> <p>On 05/13/2016 at 10:59 A.M., Resident F was observed in the front lobby seated in his wheelchair. There was a thick cushion visible underneath the resident in the wheelchair seat. The cushion was wider than the wheelchair seat and was slightly creased in the middle and extended past the end of the wheelchair</p>			

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	<p>seat by approximately 1 1/2 inches. There was no dycem material visible underneath the resident. Resident F was queried regarding any thin non slip type material on the chair cushion and he indicated he did not recall any such material being applied, just the cushion.</p> <p>On 05/13/2016 at 2:55 P.M., Resident F was transferred with the assistance of LPN #22 and QMA #23 from his wheelchair to his bed. His wheelchair cushion was noted to be in his wheelchair but there was no dycem type material anywhere in his wheelchair. Both staff confirmed there was no dycem in his wheelchair and no non-skid strips on either side of his bed. QMA #23 looked in his closets and she could not locate any dycem material.</p> <p>On 05/16/2016 at 9:09 A.M., there were still no nonslip strips on either side of Resident F's bed.</p> <p>3. The clinical record for Resident E was reviewed on 05/13/2016 at 8:59 A.M. Resident E was admitted to the facility on 04/28/16, with diagnosis, including but not limited to: dementia with behavioral disturbance, depression, anxiety disorder and shortness of breath.</p> <p>A nursing progress note, dated 04/29/16</p>			

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	<p>at 2:24 A.M., indicated a noise was heard in the resident's room and the resident was found laying on his backside with his feet extended towards the bathroom. Resident E indicated he was trying to go to the bathroom. When the resident was asked why he did not use call light, he indicated because he could not find his call light. The call light was located on the resident's bed. Resident E was reeducated on the use of call light and need for assistance. The resident had incurred skin tears to both his elbows and the top of his left hand and to his left wrist.</p> <p>A nursing progress note, dated 04/29/16 at 7:52 A.M., indicated the IDT (interdisciplinary team) meeting had met in regards to Resident E's fall that occurred early this (04/29/16) A.M. and an appropriate intervention was to place a clip to the resident's call light cord and have staff attach it to the resident's shirt/gown while he was in bed.</p> <p>A fall risk care plan, initiated on 04/29/16, indicated the resident was to be invited and escorted to activities, provided call light in reach and glare free lighting and area free of clutter, provide resident teaching for safety measures, provide walker/cane and wheelchair, remind resident to lock brake on bed,</p>			

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	<p>chair etc before transferring, when rising from lying position to sit on side of bed for a few minute, educated and reminded to request assistance prior to ambulation, report falls to physician and responsible party, report any side effects of medication, and clip to call light cord and keep cord attached to shirt or gown while in bed.</p> <p>A nursing progress note, dated 05/30/16 at 1:47 A.M., indicated the resident required standby by assistance for transfers and ambulation and he utilized a walker.</p> <p>A nursing progress note, dated 05/10/16 at 10:30 A.M., indicated the resident had poor safety awareness.</p> <p>On 05/13/2016 at 10:57 A.M., Resident E was observed sleeping in his bed on his back. His call light was lying on the floor and there was no clip noted on the cord.</p> <p>On 05/16/2016 at 9:38 A.M., Resident E was observed in his room in bed asleep. The resident had a low bed but his call light cord was on the floor and there was no clip on the cord. The resident's call light cord remained on the floor and the resident remained sleeping in his bed from 9:38 A.M. to 11:00 A.M. His shoes</p>			

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	<p>were off and he was wearing non-skid socks on both feet. At 10:37 A.M., two staff members, LPN #25 and CNA #26 had assisted Resident E's roommate but had not noticed the call light on the floor.</p> <p>On 05/16/2016 at 12:45 P.M., Resident E was observed being supervised by an unnamed staff as he ambulated from the dining room back to his room with his walker. He then was noted to be supervised by the staff member while he got into bed. The unnamed staff member left and Resident E was observed, at 1:02 P.M., in his room asleep with his shoes on and his call light cord was on the floor. He was observed again, at 2:07 P.M., in his bed asleep and his call light was on the floor.</p> <p>This Federal tag relates to Complaint IN00200103.</p> <p>3.1-45(a)(2)</p>				