

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155165	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/07/2016
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00201251.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00197965 completed on April 22,2016.</p> <p>Complaint IN00201251 Substantiated Federal and State deficiencies cited at F 323..</p> <p>Survey dates: June 6, 7, 2016</p> <p>Facility number: 000082 Provider number: 155168 AIM number: 1002899640</p> <p>Census bed type: SNF/NF: 97 Total: 97</p> <p>Census payor type: Medicare: 20 Medicaid: 74 Other: 3 Total: 97</p> <p>Sample: 8</p> <p>These deficiencies reflect State findings</p>	F 0000	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.	
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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 0323 SS=G Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on June 13, 2016.</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 assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents at risk to experience falls received adequate supervision to prevent falls and effective interventions were implemented to prevent injury for 3 of 3 residents who met the criteria for review of accidents in a sample of 8 residents reviewed. This deficient practice resulted in Resident D experiencing a jaw fracture. (Resident D, Resident R, Resident J)</p> <p>Findings include:</p> <p>1. On 6/6/16 at 3:10 P.M., Resident D was observed laying in her bed in no apparent distress. Resident D was observed at that time to have blue and black bruising present around her left eye and forehead and jawline. A mattress was</p>	F 0323	<p>F323-Free of accident hazards/Supervision/Devices Wh at corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> -Residents D, R, and J, affected by the alleged deficient practice, The IDT reviewed fall interventions, careplans and CNA profiles were revised with appropriate interventions and adequate supervision in place regarding fall intervention. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -All residents have potential to be affected by the alleged deficient practice. -100% audit will be completed by DNS/ADNS/Unit Managers/Designee to identify 	06/22/2016

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	<p>observed to be placed on the floor near Resident D's bedside.</p> <p>The clinical record for Resident D was reviewed on 6/6/16 at 10:00 A.M., the diagnoses included, but were not limited to, Jaw fracture (5/27/16), arthritis, failure to thrive, hypertension, dementia and diabetes mellitus.</p> <p>A significant change MDS (Minimum Data Set) assessment dated 5/16/16, indicated Resident D had a BIMS (Brief Interview for Mental Status) score of 3 indicating she was severely cognitively impaired. The MDS further indicated Resident D required extensive assist of 2 for toileting, transfers, and bed mobility.</p> <p>The care plans included, but were not limited to, "Resident is at risk for fall due to impaired mobility and cognition, complicated by use of an assistive device, incontinence, recent fall(s), and high risk medication." initiated 9/24/14. The interventions included, but were not limited to, "...15 min checks [6/6/16], move room closer to nurses station [6/3/16], Roho overlay [A pressure relieving device] on bed, with 1/2 side rails on open side of bed to stabilize mattress [sic] [5/27/16], matt on the floor beside the bed [3/14/16], place bed along wall, in low locked position [9/14/15],</p>		<p>residents currently at risk for fall and ensure interventions on resident careplans are clinically indicated and in place. Interventions, care plans and resident profiles will be updated if indicated. Audit will be completed by 06/22/16.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·All clinical staff will be in serviced on fall prevention and fall management by CEC/Designee by 06/22/16. ·Nursing staff have been instructed to contact DNS and/or designee when a fall occurs to ensure appropriate interventions are discussed and implemented ·Any resident identified as a fall risk on admission, readmission, or with significant change in health status, will be discussed in IDT meeting to ensure care plan and C.N.A profiles are revised with the appropriate interventions and initiated timely. This process will be ongoing. ·Customer care representatives will conduct random audits of fall interventions 5-7 times per week during rounds and report findings during the morning meeting. This process will be ongoing ·ASC Nurse Consultants will provide additional support 3 days per week for 4 weeks and complete fall management tool during these visits as additional 		

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	<p>dysem [an anti-slip device] material to wheel chair [2/23/15]..."</p> <p>Fall #1 A fall event report indicated Resident D had experienced an unwitnessed fall from her bed on 5/27/16. The report further indicated Resident D had hit her head and had experienced a left black eye and "gash" to the left side of her forehead.</p> <p>A Nursing note dated 5/27/16 at 12:54 A.M., included, but was not limited to, "While CNA was doing her hourly round found resident on fall mat on her left side of body. Resident had hit left side of head on bedside dresser, with a large amount of bright red blood on resident's clothing and coming from a gash to left side of forehead. Resident also had bruise forming to left eye, black, and blue in color. Resident's bed was against the wall and in lowest position. Resident had night gown on, PJ [pajama] pants, geri sleeves to BUE [bilateral upper extremities, and gripper socks on. Call light was within reach ...Resident's pupils were sluggish but reactive. Resident is alert and oriented to person only but could answer simple yes and no questions appropriately..."</p> <p>A Nursing note dated 5/27/16 at 9:10 A.M., included, but was not limited to,</p>		<p>monitoring.</p> <p>How the correctiveaction(s) will be maintained to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?</p> <p>·DNS/ADNS/Designee will complete the Fall Management tool weekly times 4 and then monthly times six. The results of these audits will be reviewedby the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>By what date will the systemic changesbe completed?</p> <p>·06/22/2016</p>	

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	<p>"This nurse has placed resident on neuros ...Resident placed on 15 minute checks, resident room rearranged with no furniture around bed..."</p> <p>An IDT [interdisciplinary team] fall note dated 5/27/16 at 3:01 P.M., included, but was not limited to, Res [Resident] was noted to ...have an un-witnessed fall on 5/27 at 12:37 am [sic]. While staff was completing hourly checks, res was found on mat beside bed Res was found lying on left side...Head adjacent to bedside table, Wedge on mat...Res has dementia w [with]/sever [sic] cognitive loss, unable to state details of fall. immediate [sic] intervention Res remained immobile until 911 responded ...Root Cause Res: has dementia w [with]/sever [sic] congntive [sic] impairment, current tx [treatment] for UTI [Urinary Tract Infection], and believe she was unable to feel her bed boundry [sic] and rolled to far towards edge and was unable to prevent rolling of edge of bed on to Mat ...new intervention to DC [discontinue] wedge cushion and hourly checks, replace mattress with scoop mattress [sic] w/roho overlay and 1/2 side rail to open side of bed to stabilize mattress. Careplan [sic] and profile updated.</p> <p>An Emergency Department referral dated 5/27/16 included, but was not limited to,</p>			

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	<p>the following: "Arrival Time 5/27/16 at 00:58 [12:58 A.M.] ...Diagnosis Closed fracture of facial bone; Facial laceration..."</p> <p>Fall #2 A fall event report indicated Resident D had experienced an unwitnessed fall on 6/4/16 at 8:21 P.M. in her room. The fall report included, but was not limited to the following, "...Describe what the resident was doing prior to the fall...Sitting in her wheelchair in her room. CNA was getting ready to lay her down...Describe the position of the resident when first observed after fall...Res was on her right side on the floor. Resident had fallen into floor mat that was propped against the dresser...Resident of witness statement of how fall occurred...CNA had pushed resident in room to lay her down for the night. CNA went to gather supplies to clean resident up, resident was found in floor by another CNA passing by her room...What intervention was put into place to prevent another fall...Placed in bed, Bed rail up, fall mat in place, non-skid seat on w/c [wheel chair]..."</p> <p>A nurses note dated 6/4/16 at 11:52 P.M., included, but was not limited to, "This nurse was called into resident's room. CNA had found resident on the floor.</p>			

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	<p>CNA had pushed resident into her room and went to gather supplies to clean resident up. CNA went to answer another residents cal [call]. While resident [sic] was gone, another aid [sic] walked by and found resident on the floor...15 min checks...in place..."</p> <p>An IDT note for this fall could not be provided.</p> <p>Unit Manager (UM) #10 was interviewed on 6/7/16 at 10:30 A.M. She indicated Resident D had experienced two falls since 5/27/16. UM #10 indicated Fall #1 was an unwitnessed fall that occurred on 5/27/16 at 12:34 A.M. She indicated Resident D had fallen out of bed and hit her head on her bedside table that was located at her bedside above the fall mat that had been placed as an intervention to prevent Resident D from experiencing injuries if she were to fall out of bed. UM #10 indicated Resident D had experienced a laceration to the left side of her forehead that required stitches and a broken left jaw. UM #10 indicated Resident D was sent to the hospital and received 5 stitches to a laceration and x rays that confirmed a fracture of her left jaw. She indicated the intervention added was a side rail to stabilize the roho mattress overlay on Resident D's bed and her nightstand was moved away from her</p>			

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	<p>bed. UM #10 indicated fall #2 occurred on 6/4/16 at 8:25 P.M. She indicated Resident D was pushed into her room by a CNA who what going to assist her into bed. She indicated the CNA left the room and another CNA who was passing observed Resident D lying on the floor with the top half of her body positioned on a fall mat that was propped against the dresser. UM #10 further indicated Resident D had no injuries as a result of Fall #2 and the immediate intervention was to place Resident D in bed.2. On 6/6/16 at 10:00 A.M., Resident R was observed ambulating independently in the hallway of the dementia care unit with an unsteady gait.</p> <p>The clinical record of Resident R was reviewed on 6/7/16 at 9:45 A.M. The record indicated Resident R was admitted to the dementia care unit on 5/17/16 with diagnoses including, but not limited to, dementia with behaviors.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 5/24/16 indicated Resident R experienced severe cognitive impairment, inattention, disorganized thinking, and altered level of consciousness.</p> <p>A CNA Point of Care History indicated Resident R required the limited physical</p>			

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	<p>assistance of one staff for transfers between 5/17/16 and 6/7/16.</p> <p>The June 2016 Physician Order Report included, but was not limited to, an order for, "...Start Date...5/18/16...Activity Level: Up Ad Lib [at liberty]..."</p> <p>An Admission Nursing Assessment dated 5/17/16 indicated Resident R experienced cognitive impairment, unsteady balance and had a history of falls. The Assessment further indicated, "...able to stabilize without human assistance..."</p> <p>A Care Plan dated 5/20/16 for, "...at risk for fall..." indicated safety interventions of, "Call light in reach, Environmental changes: bed aligned along the wall for open floor space, Non skid [sic] footwear [sic] all times, Personal items in reach, Therapy Screen"</p> <p>An Occupational Plan of Care dated 5/18/16 indicated, "...Precautions: Fall risk...Functional Deficits...Balance...unable to accept challenge or move without loss of balance...unable to maintain balance without mod [moderate]/max [maximum] support..."</p>			

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	<p>Fall #1: A Fall Event report dated 5/22/16 at 4:10 A.M. indicated Resident R experienced an unwitnessed fall from bed. The report further indicated immediate interventions implemented after the fall were, "Frequent checks for proper positioning while resident abed [in bed] and request further review by unit mgr [manager]/NP [Nurse Practitioner] r/t [related to] meds [medicines] r/t lethargic state."</p> <p>A Nursing note dated 5/22/16 at 7:00 A.M. indicated, "This nurse was called to residents [sic] room by the nursing assistant to assist with resident on the floor....was fully dressed [sic] shoes on [sic] lying on...left side...speech is mumbled which made for poor communication...was assisted to...bed [sic] assessment was done. Red/purple in color and swelling to the right eye, pupils were non reactive [sic] he was lathargic [sic] the right hand red with swelling. NP was called to send resident to U of L. The note lacked any documentation to indicate adequate supervision was provided or new, immediate, effective interventions were implemented to ensure the safety of Resident R.</p> <p>A Nursing note dated 5/23/16 at 12:51 P.M. indicated, "IDT [Interdisciplinary Team] review of fall...Resident had a</p>				

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	<p>[sic] unwitnessed fall on 5/22/16 at 4:10 am [A.M.] Prior to the fall the resident was sleeping in...bed. Resident was found in...room lying on...left side...was fully dressed with shoes on. A full body assessment was completed...had bilateral weak hand grasp...did hit...head on the right side around eye and eyebrow was red/purple in color...right hand was red and swollen...is on anticoagulant, is not a diabetic and does not have a history of orthostatic hypotension...was continent at the time of fall...Root Cause: [sic] New Intervention...was lethargic R/T [related to] medications and new surroundings. Have psychiatrist review medication and therapy to evaluate...." The note lacked any documentation to indicate adequate supervision was provided or new, immediate, effective interventions were implemented to ensure the safety of Resident R.</p> <p>Fall #2: A Fall Event Report dated 5/23/16 at 10:34 P.M. indicated Resident R experienced an unwitnessed fall from bed. The report further indicated the immediate interventions implemented after the fall were, "Frequent checks for proper positioning while resident abed and request further review by unit mgr/NP r/t meds r/t lethargic state". The note lacked any documentation to</p>						

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	<p>indicate adequate supervision was provided or new, immediate, effective interventions were implemented to ensure the safety of Resident R.</p> <p>A Nursing note dated 5/23/16 at 10:36 P.M. indicated, "Res [resident] was found on floor in room, unwitnessed fall. Res was unable to give statement of incident or event...placed on neuro [neurologic] checks. Redness noted to left cheek area...was assisted to standing position and placed in bed. Will continue to monitor." The note lacked any documentation to indicate adequate supervision was provided or new, immediate, effective interventions were implemented to ensure the safety of Resident R.</p> <p>A Therapy Assessment dated 5/23/16 at 10:56 A.M. indicated Resident R experienced poor balance and required assistance with transfers and walking.</p> <p>A Nursing note dated 5/24/16 at 4:47 P.M. indicated, "IDT fall review...Resident had an unwitnessed fall on 5/23/16 at 10:34 pm [P.M.]...Prior to fall resident was lying in bed. Staff entered room and resident was on floor lying on left side...was wearing shirt, jeans and socks...Redness noted to side of face. After assessment resident was</p>			

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	<p>assisted up per two assist. Assisted resident to change into bed clothes. Root cause: It appeared resident was uncomfortable with jeans on and was getting up to take them Off. Current interventions.: Psych [Psychiatrist] to review meds. Therapy to screen bed mobility and functional transfer. Call light in reach. Bed along wall for open floor space. Non skid footwear. New intervention: Offer to change into bed clothes at HS [hour of sleep] Call placed to [name of physician] to discuss current psych [psychiatric] meds. [name of physician] has worked with resident and...meds for a while [sic] [name of physician] does not wish to change any meds at this time...feels any decrease...would not be beneficial for resident...will review and make note on...next visit." The note lacked any documentation to indicate new, immediate, effective interventions were implemented or adequate supervision was provided to ensure the safety of Resident R.</p> <p>A Care Plan for Falls dated 5/23/16 indicated new interventions of, "psych to review medication regimine [sic]...therapy to screen bed mobility and functional transfers..." were implemented. The plan lacked any documentation to indicate new,</p>			
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	<p>immediate, effective interventions were implemented or adequate supervision was provided to ensure the safety of Resident R.</p> <p>A Care Plan for Falls dated 5/24/16 indicated new interventions of , "...assist to ensure resident wears pajamas or gowns at night...keep night light on from dusk to dawn..." were implemented. The plan lacked any documentation to indicate new, immediate, effective interventions were implemented or adequate supervision was provided to ensure the safety of Resident R.</p> <p>An Occupational Therapist [OT] Progress note dated 5/24/16 indicated, "...Current Level of Function...Standing Balance...demonstrates...able to maintain balance with minimum assistance, mod assist to reach ipsilateral [on the same side of the body] side and unable to weight shift...Fall risk..."</p> <p>Fall #3: A Fall Event Report dated 6/1/16 at 10:10 P.M. indicated Resident R experienced an unwitnessed fall from bed. The report further indicated, the immediate interventions implemented were, "Ensure res is wearing non-slip socks. Assist...with transfers. Ensure call-light [sic] is within reach."</p>			

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	<p>A Nursing note dated 6/1/16 at 10:10 P.M. indicated, "Res had unwitnessed fall this shift at 10:10 pm...found by CNA during bed checks in supine [on back] position on floor next to bed and notified nurse. Small cut to middle of forehead with forehead [sic]...not incontinent at time of fall...lethargic and confused...unable to verbally give statement of event. Neuro check started...wearing [name of facility] provided night gown. Non-slip socks on feet. Call light within reach...assisted back into bed by nurse and two CNA's. Current interventions in place consist of ensuring res wearing non-slip socks, assistance with transfers, call light within reach, and frequent positioning checks when...in bed. New intervention for this current fall includes [sic] 15 min [minute] checks X [times] 24 hours and medication review. Neuro checks continue." The note lacked any documentation to indicate adequate supervision was provided or new, immediate, effective interventions were implemented to ensure the safety of Resident R.</p> <p>A Nursing note dated 6/2/16 at 10:40 A.M. indicated, "IDT fall review...Resident had an unwitnessed fall on 6/1/16 at 10:10 P.M....Prior to fall</p>			
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	<p>resident was lying in bed. When staff entered room resident was on floor lying on back...was dressed in gown and non skid socks...moves all extremities as usual. Fall was not witnessed so neuro checks were started and are WNL [within normal limits]...has small cut to middle of forehead...Light was on in room. Root cause: sleep pattern fragmented. Resident gets up at random times and has unsteady gait. Current interventions: Ensure...is wearing nightclothes, night light in place. psych review of meds. Therapy to screen bed mobility and transfers. Call light in place. Immediate intervention: Resident placed on 15 minute checks times 24 hours. New intervention: Room eval [evaluation] for safety. Bed to be positioned along back wall to allow for change of other furniture. " The note lacked any documentation to indicate adequate supervision was provided or new, immediate, effective interventions were implemented to ensure the safety of Resident R.</p> <p>Fall #4: A Fall Event Report dated 6/4/16 at 11:59 A.M. indicated Resident R experienced a witnessed fall while walking into a crowded dining room area. The report further indicated, the immediate interventions implemented were, "15 minute checks X 24 [sic]</p>			

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	<p>hours. Possible medication review...resident to wear shoes when out of bed. For therapy to evaluate for possible assistive device"</p> <p>The Nursing notes from 6/3/16 at 9:48 P.M. through 6/5/15 at 1:58 A.M. were reviewed and lacked any documentation related to the fall on 6/4/16 at 11:59 A.M.</p> <p>A Nursing note dated 6/6/16 at 4:16 P.M. indicated, "IDT Fall Review...Resident had a witnessed fall on 6/4/26 ...Resident was walking into dining room. Area was crowded room, a family member was blocking the doorway. Resident was required to navigate around...fell on...buttocks and rolled to side...No noted injuries...Root cause...lost balance and fell. Current interventions: Bed along the wall, night light, PJs [sic] [pajamas] at night, gripper socks. Immediate Intervention: 15 minute checks. Resident to wear shoes when out of bed. Therapy to eval for possible assistive device. Upon IDT review due to...shuffling gait...should not wear shoes as they may cause a fall. New intervention: Hipsters [a padded undergarment] to keep resident safe with falls..." The note lacked any documentation to indicate adequate supervision was provided or new, immediate, effective interventions were implemented to ensure the safety of</p>			

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	<p>Resident R.</p> <p>A Care Plan for Falls dated 6/6/16 lacked any documentation to indicate new immediate, effective interventions were implemented or supervision was provided to ensure the safety of Resident R after the fall on 6/4/16.</p> <p>A Therapy Assessment dated 6/7/16 at 11:28 A.M., indicated Resident R required assistance with transfers and walking. The assessment further indicated, "...Pt [patient] currently required CGA [contact guard assist] [staff to provide assistance to steady balance] for ambulation due to balance..."</p> <p>An OT Daily Treatment Note dated 6/7/16 at 12:46 P.M. indicated, "...Nursing education of patient requiring CGA and close supervision while up ambulating..."</p> <p>A Therapy Wheelchair Assessment dated 6/7/16 at 2:28 P.M. indicated, "...Pt [patient] required one on one [supervision] during w/c [wheelchair] use due to decreased safety awareness..[sic] not locking w/c brakes, standing up X 10 [sic] times [sic] in 15 minutes, max verbal and tactile cues for redirection... Recommendation...Physical Therapy [PT] Eval [evaluation]...PT to screen pt</p>			

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	<p>for possible treatment as pt allows related to balance, strength, and endurance impacting falls reduction..."</p> <p>Fall #5</p> <p>During a random observation of the dementia care unit on 6/7/16 at 3:58 P.M., a loud noise was heard. Upon further investigation, at that time, Resident R was observed lying on the floor in the threshold of another resident's room with no staff observed near Resident R.</p> <p>During an interview on 6/7/16 at 4:05 P.M., the Regional DNS [Director of Nursing Services] was made aware Resident R had experienced another unwitnessed fall.</p> <p>During an interview on 6/7/16 at 4:15 P.M., the ADNS [Assistant Director of Nursing Services] indicated one on one supervision would be provided continuously to ensure the safety of Resident R.3. The clinical record of Resident J was reviewed on 6/6/16 at 11:32 A.M. The record indicated the diagnoses of Resident J included, but were not limited to, dementia with behavior disturbance, depressive disorder and osteopenia.</p>			

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	<p>A Quarterly MDS (Minimum Data Set) assessment dated 12/17/16 indicated Resident J was admitted to the facility on 11/5/13, experienced severe cognitive impairment, cognitive skills for daily decision making were moderately impaired (decisions poor, cues/supervision required), did not require an assistive device (wheelchair or walker), required the assistance of one staff for transfers, ambulating, and two staff for toileting.</p> <p>A Care Plan for Falls dated 8/27/14, and updated on 1/27/16 included, but was not limited to, "...Resident is at risk for fall due to: impaired balance, frequent incontinence, and high risk medications...Toilet right after breakfast."</p> <p>A Care Plan for Falls dated 8/27/14, and updated on 2/1/16 included, but was not limited to, "...Resident is at risk for fall due to: impaired balance, frequent incontinence, and high risk medications...Encourage resident to sit in regular chair at table..."</p> <p>Fall #1 An "Event Report" indicated Resident J experienced an unwitnessed fall on 1/27/16 at 8:54 A.M., and it read as follows, "...lying on left side...location of fall...room...pain...difficulty in</p>			

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	<p>movements...yes...limping on left side...Describe injuries...limping on left side...scratch on neck...intervention...toilet after breakfast..."</p> <p>An IDT [Interdisciplinary team] note dated 1/28/16 at 11:20 A.M., read as follows: "...x ray of left hip and left ankle. Both were negative for injury. Resident had an unwitnessed fall in peer's room. Resident had just finished breakfast. Prior to fall was in hallway...Full body assessment was completed per nurse...Resident was moving all extremities without difficulties...scratch with bruising was on right side of neck...After he was up he was up and walking noted to have a limp...x rays were obtained..."</p> <p>An incident report was provided by the Health Care Administrator on 6/6/16 at 1:16 P.M., and it read as follows. "...1/27/16 [name] Resident Q pushed [name] Resident J resulting in [name] Resident J fall to the floor...Raised area to side of neck of [name] Resident J..."</p> <p>An Event Report, "Behavior Events", dated 1/27/16 at 7:45 A.M., read as follows, "...where did behavior occur...A resident room...Resident had just finished his breakfast...Describe</p>			

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	<p>environment...Busy. Staff picking up dishes...Resident urinated in trash can in another resident's room...Resident had a fall during behavior so he was assessed and redirected..."</p> <p>A "PHYSICIAN'S PROGRESS NOTES" dated 1/28/16 [no time documented] read as follows, "...Fell yesterday...c/o [complained of] pain L [left] hip, L ankle, Better now, Pt [patient] ambulating...shuffling gait, unchanged, xray [sic] - [negative]..."</p> <p>Fall #2 An "Event Report" indicated Resident J experienced a witnessed fall on 1/31/16 at 9:51 A.M., and it read as follows: "...Resident was sitting in wheelchair, while pushing on the table...location of fall...dining room area...small ST [skin tear] to right elbow...CNA witnessed fall said resident was pushing at dining table tipping the wheelchair and resident fell...Intervention...Continue to monitor resident, ambulate and reposition resident to prevent further falls..."</p> <p>A Radiology Report dated 1/31/16 read as follows, "...HIP UNILATERAL W [with] PELVIS 1 VIEW, RIGHT...Results: Possible fracture right hip. Additional oblique view recommended. Osteopenia with</p>			

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	<p>degenerative change Question fracture..."</p> <p>A notation on the form dated 1/31/16 at 10:15 P.M. indicated the physician had been notified, new orders had been obtained and that the family had been notified.</p> <p>A "PHYSICIAN'S PROGRESS NOTES" dated 2/1/16 [no time documented] read as follows, "...R [Right] hip pain now...Not willing to walk...Xray R hip..."</p> <p>A Radiology Report dated 2/1/16 read as follows, "...HIP UNILATERAL W PELVIS 2-3 V, RIGHT...Results: There is deformity of right femoral neck consistent with age indeterminate mildly displaced fracture...There is no dislocation...Conclusion: The exam is overall no significantly changed compared with prior dated 1/31/16..." A notation on the form dated 2/1/16, indicated the physician had been notified, new orders had been obtained.</p> <p>An IDT note dated 2/1/16 at 9:34 A.M., read as follows: "...Resident had a witnessed fall on 1/31/16 at 951 am [9:51 A.M.] in the dining room...Dr...notified with new order for xray of right hip... After assessment resident was noted to have right hip pain with bruising noted to the right trochanter area...CNA who witnessed fall was interviewed, She</p>			

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	<p>reports resident tipped his chair backwards and before anyone could reach him he fell onto his right side...xray [sic] of right hip was obtained times two per MD order. Xray [sic] shows fracture and Dr...admitted resident to [hospital name]..."</p> <p>An Physician Examination Report was provided by [Name] hospital on 6/6/16 at 1:17 P.M., and read as follows, "...Multiple areas of bruising on right upper extremity and right lower extremity...There is a slight length inequality on orthopedic exam, right shorter than the left. The patient does respond to...leg roll in the hip...Radiographics of the right hip, 2 views, demonstrate a varus [an inward angulation] alignment at the femoral neck. It is difficult to determine whether or not there is an acute fracture of the hip...ASSESSMENT: Right hip pain after fall, possible acute right hip fracture...If this fractures appears acute and the patient has a history of being ambulatory, recommended prosthetic replacement. If there is some evidence that this is a chronic healed fracture or chronic nonunion, surgery would not be as aggressively pursued given the patient's multiple medical history.</p> <p>During an interview on 6/8/16 at 3:05</p>			

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	<p>P.M., OT #2 indicated Resident J was ambulatory prior to his fall on 1/27/16 at 8:55 A.M. OT #2 indicated OT would ordinarily complete an evaluation and do a trial test with a wheelchair, but due to Resident J's fall occurring on the weekend he was placed in a wheelchair by nursing staff and OT could not complete a trial test with a wheelchair.</p> <p>The policy and procedure for " Fall Management Program" provided by the Health Care Administrator on 6/7/16 at 2:50 P.M. indicated "...It is the policy of [facility name] to ensure residents residing within the facility will maintain physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls."</p> <p>This Federal tag relates to complaint IN00201251.</p> <p>3.1-45(a)(2)</p>			