

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155135	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/30/2011
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NAME OF PROVIDER OR SUPPLIER  WESTVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 CLINIC DR BEDFORD, IN47421
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: November 28, 29 and 30, 2011.</p> <p>Facility Number: 000060 Provider Number: 155135 AIM Number: 100266600</p> <p>Survey team: Melinda Lewis RN TC Marla Potts RN</p> <p>Census bed type: SNF/NF: 81 Total: 81</p> <p>Census payor type: Medicare 14 Medicaid 58 Other 9 Total 81</p> <p>Sample: 17</p> <p>These deficiencies also reflect state findings cited in accordance 410 IAC 16.2.</p> <p>Quality review completed 12/1/11 Cathy Emswiller RN</p>	F0000	<p><b>The creation and submission of this 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 of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a post survey review on or after 12/1/11</b></p>	

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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F0221 SS=D	<p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview and record review, the facility failed to ensure a resident who utilized a restraint for safety, had a plan in place to reduce the use of the restraint as much as possible for 1 of 2 residents reviewed with restraints, in the sample of 17.</p> <p>Resident # 54 Findings include: On the initial tour, on 11/28/11 at 8:40 A.M., the Director of Nursing indicated Resident # 54 had cognitive impairment, utilized a lap buddy but could remove it. On 11/28/11 at 9:55 A.M., Resident # 54 was observed to be sitting in a wheelchair with a lap buddy and a foot buddy. Resident # 54 yelled out "my butt hurts". CNA # 1 and CNA # 2 assisted Resident # 54 to her room. Resident # 54 was unable to remove the lap buddy from the</p>	F0221	<p><b>F-221 Right to be free from Physical Restraints Facility failed to ensure a resident who utilized a restraint for safety, had a plan in place to reduce the use of the restraint as much as possible. What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?</b> Resident # 54 has a plan in place to reduce the use of the restraint at meals, during direct care, activities and prn <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents with restraints have the potential to be affected by the alleged deficient practice. All residents with restraints will</p>	12/01/2011

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	<p>wheelchair when asked to do so. CNA # 1 indicated Resident # 54 could remove it sometimes.</p> <p>On 11/29/11 at 5:00 P.M., Resident # 54 was observed to be sitting in her wheelchair at the restorative dining room table. Resident # 54 was observed to have a lap buddy and a foot buddy on her wheelchair. CNA # 3 was observed to be in the restorative dining room with four other residents.</p> <p>On 11/29/11 at 5:15 P.M., CNA # 3 was observed to be seated next to Resident # 54 at the dining room table feeding her supper. Resident # 54 was observed to continue to have both the lap and foot buddies to her wheelchair.</p> <p>In an interview with the Director of Nursing, on 11/29/11 at 6:00 P.M., she indicated the staff knew they were suppose to remove the lap buddy during mealtime.</p> <p>The clinical record for Resident # 54 was reviewed on 11/28/11 at 11:15 A.M. The record indicated Resident # 54 had diagnoses that included but were not limited to dementia Alzheimer's type with behavioral disturbances. The MDS [minimum data set] assessment, dated 11/10/11, indicated Resident # 54 had short and long term memory problems. Resident # 54 required extensive assistance of two with transfers, ambulation and toilet use. Resident # 54</p>		<p>have restraints released at meals, during direct care, activities and prn to reduce as much as possible unless otherwise indicated by resident's physician. Plan of care updated as needed. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> The interdisciplinary team will review restraints every 30 days and complete a monthly review form that includes the rationale for continued use and to ensure care plan includes reduction plan. A restraint assessment will be completed on residents that have a restraint by the DNS- completed on 12/1/11. Nursing staff have been in-serviced on releasing restraints during meals, activities, and direct care by the Staff Development Coordinator on 12/1/11 and 12/13/11 with post tests. DNS/Designee will be responsible to ensure compliance. Non-compliance with these procedures will result in further training including disciplinary action. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> A CQI audit for restraints will be utilized weekly x4, monthly x2 and quarterly thereafter. Findings from the</p>		

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	<p>utilized a trunk restraint daily in chair.</p> <p>The Progress Notes, dated 08/09/2011 10:06 AM, indicated "IDT [intra disciplinary team] met to review fall on 8/8/2011 at 9:10 pm. Residents alarm sounding and when staff found resident she was lying on the floor with her legs on the mat and body on the floor. Bed was in low position. Head to toe assessment was done by nurse. Resident complained of back pain. She could not tell staff how she fell due to dementia. MD notified and order to send to ER [emergency room] for evaluation was given. Family was notified. Neuro checks continued. Will have motion sensor used in room to alert staff when resident starts to sit up. Will have therapy screen. This nurse will discuss with Dr (name) the use of a lap buddy due to residents poor safety awareness. Care plan updated. Resident continues with staff one on one supervision."</p> <p>The Progress Notes, dated 08/09/2011 01:00 PM, indicated "This nurse talked with Dr (name) about residents behaviors and falls. Dr (name) gave orders for a lap buddy while up in a wheel chair to prevent further injury to right hip, give ativan 0.25mg (antianxiety medication) tid [three times daily] and may have bed against wall due to poor safety awareness.</p>		<p>CQI process will be reviewed monthly and an action plan will be implemented if thresholds are not met 95%. <b>This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is: 12/1/11</b></p>		

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	<p>At this time Dr (name) stated we may not prevent her fall but we can try to keep her from having injury. Dr (name) again stated she felt like the behavior unit would not benefit this resident at this time. Staff will continue alarms, low bed and floor mat. Family notified and agreed. Resident continues to try and stand without assistance and staff is unable to redirect. Staff continues one on one with resident."</p> <p>The Progress Notes, dated 08/09/2011 01:09 PM, indicated "Spoke with Dr. (name) regarding residents continual attempts at unassisted transfers. Resident is redirected but will repeat the behaviors in &lt; [less than] 30 seconds. Again, sending Resident to the behavior unit was discussed with the MD and the MD declined and gave new order for lap buddy. Restraint assessment completed. Family gave verbal consent for lap buddy and will be in at 4p to sign consent today."</p> <p>A Physician order, dated 8/9/11, indicated "May have lap buddy while up in wheelchair to prevent further injury to right hip release and reposition every 2 hours and as needed."</p> <p>A Pre-Physical Restraint Assessment Form, dated 8/9/11, indicated "Does the</p>				

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	<p>resident need a restraint such as: Lap buddy. List alternative devices used prior to restraint usage: 1. bed in low position. 2. mat to floor. 3. kept in high traffic areas. 4. alarms...Does the resident exhibit problems with any of the following? If yes, explain reason for problem...Impaired communication- yes- dx [diagnosis] Alzheimer's dementia. Behavior problems- yes- dx behavioral disturbances...History of Falls- yes- hx [history of] non-compliance r/t [related to] dx dementia. Impaired safety/judgement- dx Alzheimer's dementia. Usual footwear- slip on shoes, gripper socks. Method of Locomotion- W/C staff propelled..."</p> <p>A Physical Restraint Notification, dated 8/9/11, indicated " I have been informed that (Resident # 54) has a physician's order dated 8/9/11 for the use of a physical restraint. Type of restraint: lap buddy. Medical symptom/diagnosis supporting the use of the restraint: R [right] hip fx [fracture]..."</p> <p>A Care plan, dated 8/10/11, indicated a problem of "Has restraints (lap buddy): For positioning. Dx: Dementia with very poor safety awareness." The approaches were "Check device every hour. Check skin daily. Evaluate every 30 days for possible reduction. Notify MD prn [as needed]. Observed for s/s [signs and symptoms] of pain. Therapy to screen</p>				

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	<p>prn."</p> <p>The Progress Notes, dated 08/10/2011 11:31 AM, indicated "Resident continues on follow up for incident where she slipped to the floor. Resident continues to be placed constantly in high traffic areas. Resident continues to stand unassisted but is unable to ambulate due to lap buddy. Lap buddy has been released every hour and Resident has been toileted and repositioned. Resident is using lap buddy to place magazines and dolls on. Continues to have alarms in place per MD order..."</p> <p>The Progress Notes, dated 08/11/2011 09:20 PM, indicated "Resident cont [continue] trying to stand up this shift. Lap buddy in place. Resident has been up from chair this shift frequently to be repositioned and toileted. Resident went to bed this shift after evening meal. Has not tried to get up after being put into bed. Resident is adjusting well to room change. In bed at this time, call light in reach."</p> <p>An Occupational Therapy Plan of Treatment, dated 8/18/11, indicated "...Reason for referral: Wheelchair positioning for optimum position and safety. Precautions: Balance precautions include fall risk...Assessment: Patient is currently seated on a regular wheelchair,</p>				

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	<p>with front and rear anti-tippers and anti-rolling mechanism. Nursing applied lap buddy to use, evaluating therapist not recommending this at this time...."</p> <p>The Progress Notes, dated 09/08/2011 01:15 AM, indicated "Resident is alert confusion. Resident requires assist of one with transfers. Resident has lab buddy that is removed at meal times and removed every two hours to reposition resident. Resident is incontinent of bowel and bladder. Alarms in place and functioning."</p> <p>A Physician order, dated 9/8/11, indicated "Clarification: Lap buddy in place at all times while up in wheel chair for positioning, release et [and] reposition frequently while in w/c."</p> <p>The Progress Notes, dated 09/15/2011 08:26 AM, indicated "Resident continues to utilize lap buddy for positioning, lap buddy is removed and resident is toileted and repositioned at least every 2 hours. lap buddy is always removed for meals. Resident continues to lean forward in wheel chair over lap buddy, Resident also is utilizing the lap buddy to place items on. Lap buddy removed while nurse present and Resident continually attempted to transfer unassisted. Resident is able to reposition buttocks while lap buddy is present as evidenced by alarm</p>			

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	<p>sounding when Resident raises buttocks."</p> <p>The Progress Notes, dated 09/18/2011 04:10 AM, indicated "Resident is alert confusion. Resident requires assist of one with transfers. Resident has lab buddy that is removed and resident is repositioned every two hours. Resident is incontinent of bowel and bladder. Alarms in place and functioning."</p> <p>The Progress Notes, dated 10/11/2011 02:30 PM [Recorded as Late Entry on 10/12/2011 08:54 AM], indicated "Lap buddy was removed on this day from 11am until 2p, Resident was trialed with therapy and nursing for reduction in restraint. therapy reports Resident requested lap buddy be replaced, "i feel safe holding onto it". Resident was given a blanket to hold and did not repeat the request. Resident attempted to stand without assistance 3 times and was easily redirected. Resident was kept 1:1 at all times while the lap buddy was removed. Pressure alarms in place at all times."</p> <p>The Progress Notes, dated 10/12/2011 06:30 AM, indicated "Lap buddy removed at 6am while Resident at nurses station prior to breakfast, Resident immediately attempted to climb over foot pedals/foot drop stop. Resident was toileted, repositioned and given sensory activity."</p>			

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	<p>Again, she immediately attempted to climb over the side of the wheel chair. Lap buddy was replaced."</p> <p>A Physician order, dated 10/21/11, indicated "May have lap buddy while up in wheel chair to provide tactile que."</p> <p>The Progress Notes, dated 10/31/2011 06:19 PM, indicated "Resident is up for meals in restorative dining room. Lap buddy in place per resident safety R/T [related to] previous falls. Resident is repositioned, toileted, and walked Q2H [every 2 hours]. Is confused. At times oriented to person. Has no c/o pain/discomfort at this time."</p> <p>The Progress Notes, dated 11/04/2011 03:36 AM, indicated, "Resident alert with confusion. Resident is up for meals in restorative dining room. Lap buddy in place per resident safety. Resident is repositioned and released from lap buddy Q2H. Incontinent of bowel and bladder."</p> <p>The Progress Notes, dated 11/18/2011 05:08 AM, indicated "Resident alert to person. Resident is up for meals in restorative dining room. Lap buddy in place per resident safety. Resident is repositioned and released from lap buddy Q2H. Incontinent of bowel and bladder. Requires assist of two with ADL's and</p>				

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F0323 SS=G	transfers."  3.1-3(w)  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 of and with a history of falls were supervised to ensure their safety from falls, resulting in Resident #54 suffering a second hip fracture and Resident #92 having repeated falls, for 2 of 6 residents reviewed with falls in the sample of 17. Resident # 54 and 92. Findings include: 1. On the initial tour, on 11/28/11 at 8:40 A.M., the Director of Nursing indicated Resident # 54 had cognitive impairment, utilized a lap buddy but could remove it. The clinical record for Resident # 54 was reviewed on 11/28/11 at 11:15 A.M. The record indicated Resident # 54 had diagnoses that included but were not limited to dementia Alzheimer's type with behavioral disturbances. The MDS	F0323	<b>F-323 Free of Accident Hazards/ Supervision/Devices</b> Facility failed to ensure residents at risk of and with a history of falls were supervised to ensure their safety from falls , resulting in Resident #54 suffering a second hip fracture and Resident #92 having repeated falls. <b>What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?</b> · Resident #54's fall interventions are in place and resident has experienced no further injuries. · Resident #92's fall interventions are in place and have had no further falls.  <b>How will you identify other residents having the potential to be affected by the same deficient practice and what</b>	12/01/2011	

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	<p>[minimum data set] assessment, dated 11/10/11, indicated Resident # 54 had short and long term memory problems. Resident # 54 required extensive assistance of two with transfers, ambulation and toilet use. Resident # 54 utilized a trunk restraint daily in chair.</p> <p>An Admission Nursing Care Plan, dated 6/24/11, indicated a problem of "Problem: Fall Risk related to fracture- neck of femur. The interventions were "Observed for fall risk contributors such as medications, hypotension, pain, unsteady gait. Encourage and remind resident to use call light. Refer to therapies for screening. Provide assistance for transfers, bed mobility. Fall risk assessment. Provide appropriate assistive devices such as walker, low bed, mats on floor, alarms on chairs/bed."</p> <p>A Fall Risk Assessment, dated 6/24/11, indicated "...Did the resident have any fracture related to a fall in the 6 months prior to admission? yes...Resident has had a history of falls with in the past 3 months? yes...Resident is noncompliant or had history of noncompliance? yes. Resident is confused and/or disoriented? yes. If any answer above is yes the resident is at risk for experiencing a fall..."</p> <p>The Progress Notes, dated 06/25/2011</p>		<p><b>corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the alleged deficient practice.</li> <li>· All residents are assessed at admission, quarterly and with a significant change for fall risk.</li> <li>· All residents will be re-assessed for falls and appropriate fall interventions with plan of care updated as needed.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· All residents with fall risks were reassessed for appropriate fall interventions and plan of care updated as needed.</li> <li>· An in-service was provided per the therapy on 11/21/11 for nursing staff for fall prevention, and safety. An in-service was also provided from the Staff Development Coordinator on 12/1/11 for all nursing and 12/13 for nurses relating to fall prevention. Post tests were completed.</li> <li>· Charge nurse will contact DNS/designee at the time of the fall to implement appropriate interventions to prevent further falls.</li> <li>· IDT team will review each fall during the clinical meeting to ensure the appropriate intervention's have been implemented. Those residents at risk for falls are reviewed by the</li> </ul>		

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	<p>04:54 PM, indicated "Resident is confused to place and time. Did recognize family member who came in earlier to mark clothing. Refused to have vital signs taken, kept pulling at bp [blood pressure] cuff, chewing on thermometer, and removing pulse ox probe. Grabs at staff and clings to their hands. Has attempted to get up unassisted x 2 this shift. Alarms remain on bed and chair and are functioning appropriately..."</p> <p>The Progress Notes, dated 07/01/2011 11:15 PM, indicated "Resident has attempted to stand several times this shift. Resident ate in restorative dining room. Resident went to bed after meal and has not attempted to get up..."</p> <p>The Progress Notes, dated 07/02/2011 03:21 PM, indicated "Resident has been restless and has attempted to stand multiple times, although she hasn't been able to fully rise from her seat due to weakness. Continues to reach out to staff and visitors and grab on to their hands. Has also been seen pushing along dynamap and grabbing at the clean medication cups on the side of the med cart..."</p> <p>The Progress Notes, dated 07/03/2011 04:54 PM, indicated "Resident became increasingly upset this shift. She refused to stay in bed, sit in wheelchair or lay in recliner. She began hitting staff with her hands and objects. She was kicking at</p>		<p>IDT the first morning (business day) after day of fall for the least restrictive device to prevent injury. The resident's plan of care and c.n.a. assignment sheets are revised as appropriate. The DNS is responsible to monitor the fall prevention program.</p> <ul style="list-style-type: none"> <li>· A CQI audit for falls will be completed weekly</li> <li>· DNS/designee will be responsible for compliance.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· A CQI fall tool will be utilized weekly x 4, monthly x2, and quarterly thereafter.</li> <li>· Findings from the CQI process will be reviewed monthly and an action plan will be implemented for those not meeting threshold of 95%.</li> </ul> <p><b>This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 12/1/11</b></p>		

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	<p>staff. This went on for approx 1 hr. Staff was sitting with resident one on one. At 3pm (doctors name) was called and received an order to give 1mg IM injection of Ativan. Since then resident has been sleeping in recliner. Family was notified and reported, "you have to do what you have to do".</p> <p>The Progress Notes, dated 07/04/2011 09:03 PM, indicated "Resident has not been aggressive this evening. She has tried to get up multiple times and has needed continuous observation this evening. Resident was toileted and repositioned but this didn't seem to alleviate her desire to attempt to stand up repeatedly. Chair alert in place per orders..."</p> <p>The Progress Notes, dated 07/11/2011 06:06 PM, indicated "Resident continues to attempt to get up multiple times per shift. Has been hitting at staff when she is assisted to sit back down. Has been offered activities to do to distract her with little affect."</p> <p>The Progress Notes, dated 07/29/2011 03:30 PM, indicated "Resident was witnessed by aide fell backwards in wheelchair. Alarms were sounding. Resident fell onto floor hitting her right hip and back of head. Resident complained of pain to head and right hip. Neuro checks started. Anti tippers applied to wheelchair front and back."</p>				

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	<p>The Progress Notes, dated 07/29/2011 03:40 PM, indicated "MD was notified of fall and order received to send to ER by Dr. (name) on call for Dr. (name). Order written ambulance called. Called (name) ER and gave report to ER nurse."</p> <p>The Progress Notes, dated 07/29/2011 07:25 PM, indicated "Resident returned to facility with dx of right greater trochanter non displaced hip fracture. Bedrest as tolerated for 2 days. May use walker as tolerated. X-ray of right hip in 1 week then follow-up with ortho of choice after x-ray complete. Reported new orders to (name) for (name). (Name) advised of residents anxiety and behaviors and said if behaviors increased to call for PRN [as needed] order."</p> <p>The Progress Notes, dated 07/29/2011 07:30 PM [Recorded as Late Entry on 08/02/2011 10:23 AM], "Res has been moved to room [room number documented], which is closer to nurses station, as intervention to today's fall..."</p> <p>The fall care plan was updated on 7/29/11 to include the intervention of "W/C anti tip bars front and back and moved to room closer to nurses station."</p> <p>The Progress Notes, dated 07/30/2011 05:41 PM, "Resident remains on bedrest for R [right] hip fx [fracture] r/t [related to] fall. Resident remains on low bed with bed alarm in place and mat next to bed on floor. Neuro checks have been WNL</p>				

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	<p>[within normal limits]. Has been medicated with PRN pain med r/t c/o [complaints of] leg pain."</p> <p>The Progress Notes, dated 07/31/2011 12:30 PM [Recorded as Late Entry on 08/01/2011 06:23 AM], "Resident has set bed alarm off multiple times. Remains in low bed with mat on the floor. Has been medicated for c/o leg pain with good results."</p> <p>The Progress Notes, dated 08/01/2011 09:10 AM, "CNA came to say resident was on the floor. Resident was on the floor in her room at the foot of her bed, Lying on her left side. Resident was asking for help to get up. No blood noted on resident or on the floor. R/T resident's recent fall with hip fracture, resident was left in position on the floor while Dr. (name) and the ambulance was called. Staff stayed with the resident at all times. She was made as comfortable as possible while awaiting the ambulance's arrival..."</p> <p>The Progress Notes, dated 08/01/2011 09:30 AM, "Ambulance staff assisted resident to lie on her back and then lifted her onto the stretcher. Resident was transported to (name) Hospital emergency department for evaluation. There were no obstacles or spills in the floor around the resident's bed. Bed was in the low position with the mat on the floor beside the bed. Resident was off the matt at the end of the bed when she was</p>				

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	<p>found after her fall. The bed alarm had been in place. The resident was barefoot. She had not been incontinent. She had been in bed approximately 1/2 hour when she fell. She had previously been up for breakfast and was toileted prior to laying down. No morning medication had yet been administered. No PRN pain meds had been given. The Resident did have her Fentanyl patch in place per her routine order."</p> <p>The Progress Notes, dated 08/01/2011 10:30 AM [Recorded as Late Entry on 08/03/2011 01:33 PM], "IDT [interdisciplinary team] met to review fall that occurred 7/30/11. Resident was witnessed by aide falling backwards in wheelchair. Wheelchair turned over with resident. Alarms were sounding. Resident fell onto floor hitting her right hip and back of head. Resident complained of pain to head and right hip. Neuro checks started. Resident sent to ER, returned with diagnosis: right hip fracture and bedrest as tolerated times 2 days. New interventions include moving resident to room closer to nurses station and applying anti tippers to front and back of wheelchair."</p> <p>The Progress Notes, dated 08/01/2011 10:50 AM, "Report received from (name) Emergency department that the resident was being returned to the facility. Bilateral hip xrays were done along with a head CT [CAT scan]. These showed no</p>				

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	<p>changes since the ones done on 7/29." The Progress Notes, dated 08/01/2011 04:01 PM, "Resident remains on Q 15 minute monitoring, but has had to stay with a staff member all shift since return to facility, as she has continually tried to stand up. Has set her chair alarm off multiple times this shift. Family has arrived at this time to monitor her for awhile. Cannot be reasoned with. Denies pain."</p> <p>The fall care plan was updated on 8/1/11 to include the interventions of "15 minute checks."</p> <p>The Progress Notes, dated 08/02/2011 10:36 PM [Recorded as Late Entry on 08/03/2011 01:41 PM], indicated "IDT met to review fall that occurred 8/1/11. Resident lying on floor next to her bed. Resident with dementia and is unable to tell staff what happened. Resident assessed for injury. No injuries apparent. Resident was sent to ER due to recent diagnosis of hip fracture. Returned with no new findings and no new orders. Neurochecks initiated. Resident has low bed, mat on floor, bed alarm. Will place scoop mattress on bed."</p> <p>The fall care plan was updated on 8/2/11 to include the intervention of "scoop mattress."</p> <p>The Progress Notes, dated 08/03/2011 01:31 PM, indicated "Resident has continually attempted to transfer</p>			

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	<p>unassisted since after lunch. Resident is easily redirected but will attempt to transfer unassisted with in less than 30 seconds. Writer walked Resident in the hallway per her request with gait belt and peer nurse assistance, resident walked approx 5 feet before asking to sit back down. Re directive ideas have been used through out shift; visits with managers, yarn, magazines, paper and pen, toileting, tape and paper, gentle massage without effectiveness. Resident also received PRN pain medication for s/sx of pain. Alarms in place."</p> <p>The Progress Notes, dated 08/06/2011 05:13 PM, indicated "Resident has been extremely restless today, attempting to stand up continually for 20-30 minutes at a time. Required someone to sit directly with her telling her to sit down over and over. Resident does not follow directions to sit down and continues to try to stand up. Has stood multiple times on her fractured leg. Unable to stop her from standing up even with someone sitting right with her at all times. No obvious further injury, resident has been medicated for pain. No apparent lessening of behaviors noted with Ativan."</p> <p>The Progress Notes, dated 08/08/2011 06:28 PM, indicated "IDT met to review fall on 8/7/2011 at 6:00 am. Staff found resident on floor, left side of bed off of the floor mat. Resident unable to tell staff</p>				

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	<p>how she fell due to dementia. Bed alarm was not sounding and staff had not started alarm checks, nurses was giving report. Last alarm check was at 10:30 pm. Head to toe assessment done by nurse with no injury noted. Resident had regular socks on. Neuro checks initiated. MD notified and order to send to ER was given. This nurse talked with Dr (name) today and order was given for hipsters to prevent injury. Resident is to wear non skid socks at all times. Will continue alarms, low bed and mat on floor next to bed. Care plan updated."</p> <p>The Progress Notes, dated 08/08/2011 09:10 PM [Recorded as Late Entry on 08/09/2011 03:10 AM], "cna called nurse to room res. res laying on floor on her right side to back. res beside bed legs are on matt but rest of body laying on the floor. hipsters are on, bed low and matt on floor alarm on. res has no new injuries noted at this time. res moving arms and legs without difficulty. paged Dr (name)."</p> <p>The Progress Notes, dated 08/08/2011 09:30 PM [Recorded as Late Entry on 08/09/2011 03:19 AM], "Dr (name) called n/o received. 1)send to er for eval post fall xray hips res has non displaced Fx.2) 15 min monitoring. called husband and reported wife's fall and we are going to send her to ER. talked with Don /reported to her sending res to er before i called her husband. family cant come set 1 on 1</p>				

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	<p>with res husband only one who lives here."</p> <p>The fall care plan was updated on 8/8/11 to include the intervention of "Non skid footwear/socks at all times and hipsters." The Progress Notes, dated 08/09/2011 01:45 AM, indicated "res returned from er via amb with paramedics. 15 min monitoring started. called [company initials documented] to come set 1 on 1 with res .nurse will be 1 on 1 till [company initials documented] gets here. res in recliner at this time. alarm on and functioning. res at nurses desk. no new orders from er DX UTI res already started ATB for this. no change in orders. no new fractures. per report from er. neuro checks wnl. hosp remove soft set from abd.called pharmacy to stat one out.iv edk only has one which was used to start and taken out at [name of hospital] er.search for one in med room .none found."</p> <p>The Progress Notes, dated 08/09/2011 10:06 AM, indicated "IDT met to review fall on 8/8/2011 at 9:10 pm. Residents alarm sounding and when staff found resident she was lying on the floor with her legs on the mat and body on the floor. Bed was in low position. Head to toe assessment was done by nurse. Resident complained of back pain. She could not tell staff how she fell due to dementia. MD notified and order to send to ER for evaluation was given. Family was</p>			

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	<p>notified. Neuro checks continued. Will have motion sensor used in room to alert staff when resident starts to sit up. Will have therapy screen. This nurse will discuss with Dr (name) the use of a lap buddy due to residents poor safety awareness. Care plan updated. Resident continues with staff one on one supervision."</p> <p>The fall care plan was updated on 8/9/11 to include the intervention of "Lap buddy when in chair."</p> <p>The fall care plan was updated on 8/10/11 to include the intervention of "motion sensor and pressure alarm mat."</p> <p>2. Resident #92 was identified on the initial tour of the facility locked dementia unit, on 11/28/11 at 9:00 A.M. with the Director of Nursing, as cognitively impaired and having had recent falls. Resident #92 was observed sitting at the nursing station, in a wheelchair at the time of the tour. The resident was observed to stand up from the chair, the alarm ring and fall before staff could get to the resident. The unit manager was heard to tell the director of nursing the resident had refused her lap buddy that morning. Resident #92's clinical record was reviewed on 11/29/11 at 1:00 p.m. Diagnoses include but were not limited to: "Alzheimer dementia." The admission MDS (minimum data set) assessment, dated 10/29/11, indicated the resident was</p>				

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	<p>unable to balance without human assistance during transfers, walking and moving on or off the toilet. The CAAs( care area assessment) for the assessment dated 10/29/11, indicated the resident was at risk of falls related to the balance issues while walking, transferring, moving on and off toilet. A care plan, dated 10/20/11, upon admission, included "fall risk" with interventions of : bed alarm, chair alarm, stationary chair 10/28/11, an update dated 11/9/11, included interventions of "chair and bed alarm, 11/11/11 bed in lowest position, bed against wall and mat to open side of bed." A care plan, dated 11/27/11 indicated "fall risk related to history of falls, dementia," interventions included additional interventions of " 11/28/11 hipsters to wear at all times." An additional problem, dated 11/28/11 for lap buddy restraint.</p> <p>A telephone physician's order, dated 11/25/11 indicated "may utilize lap buddy as tactile cue not to stand without assistance. Remove for meals and activities."</p> <p>Progress notes included: "IDT [interdisciplinary team] met to review fall on 10/20/2011 at 5:20 am. Staff heard alarm coming from residents room. Staff found resident sitting on roommates floor alarm on floor next to roommates bed with multiple layers of</p>			

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	<p>clothes on and her pants down around her legs. Head to toe assessment done by nurse with no injury noted. Neuro checks initiated and...and family notified... and bed alarm applied..."</p> <p>"10/27/2011 09:47 AM Resident was ambulating with a peer in hallway, staff witnessed resident begin to lose balance. Resident caught self on roommate's walker and lowered self to the floor. Peer did not fall or have other injury related to this resident catching self with walker. No injury noted. ROM [range of motion] wnl [within normal limits]. Resident was dressed and had appropriate footwear on. Chair alarm placed on resident to prevent further fall. Therapy to screen. Family and MD (Medical Doctor) notified, order obtained for chair alarm."</p> <p>"10/28/2011 02:50 PM fall witnessed by this nurse, this nurse was standing at the sink in the Cottage dining room, res was sitting in w/c across the dining room, res [resident] stood herself without assist, res attempted to sit back down, w/c wheeled backward away from her, res slid down the front of the w/c landing on the floor on her buttocks, denies discomfort at present... 2 staff assist to bring res to standing position, res bears weight bil without difficulty, no external rotation of BLE (Bilateral lower extremity) noted, no apparent injury noted..."</p> <p>"10/31/2011 09:38 AM</p>				

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	<p>IDT(Interdisciplinary Team) met to review fall on 10/28/11 at 12:50 pm. Resident was sitting in wheelchair in the dining room when staff observed her stand up and try to sit back down when wheel chair rolled backwards and resident slid down to floor on buttocks. Head to toe assessment done by nurse with no injury noted. MD/NP(Nurse Practitioner) and family notified. New orders received for anti roll backs on wheelchair and labs due to unsteady gait. Therapy discussed on 10/28 that resident should be in a stationary chair and staff should ambulate with resident due to poor safety awareness and unsteady gait"</p> <p>"11/11/2011 04:45 PM [Recorded as Late Entry on 11/12/2011 12:19 AM] Staff calls writer into resident's room at this time. Resident was lying on the floor next to her bed with legs extended outward. Resident tried to get up out of bed without assistance and fell to floor. Fall was unwitnessed. Resident denies pain at this time. Family..., and DON [Director of Nursing] notified of fall. ROM done without pain or difficulty. No skin tears, bruising or wounds noted from fall. Resident assisted to her wheelchair per 2 staff without difficulty. Resident alert and able to voice needs et wants. Floor mats placed on both sides of bed and bed put in lowest position..."</p> <p>"11/19/2011 05:20 PM This nurse was</p>				

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	<p>alerted to shower room by CNA. Witnessed resident laying on right side. Was bleeding from laceration above right eye. CNA stated that resident was attempting to sit down onto toilet and fell forward and to the right hitting head on floor. CNA also stated that resident was refusing to let CNA help her. CNA gave resident 2-3 ft of space. Resident was pulling down pants and brief and resident fell forward. CNA was unable to catch resident at time of fall. Resident stated that she had pain to her right hip. APROM was not preformed R/T [related to] resident c/o [complaints of] hip and head pain." "11/19/2011 10:38 PM CNA walking down hall observed this res climb out of bed onto knees on bedside mat. Res stating she wanted to get out of bed et purposefully moved out of bed... " '11/20/2011 12:30 AM Res lying in bed with eyes open. Neurochecks done. Upper and lower extremities strong, equal. Pupils PERRL[pupils equal react to light].. Skin tear above R [right] eye with moderate amount bloody drainage. Area cleansed et [and] steri strips reapplied. Bruise beginning to form around R eyebrow. Res states head "hurts a little but not a lot" c/o back pain also..." "11/24/2011 08:40 AM res chair alarm going off, noted res sitting in h/w(hallway) on buttocks beside w/c, res</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155135		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/30/2011	
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	<p>immediately stated 'I slipped out of that chair get me back in there', res had been attempting to stand, had her slipper shoes on, slippers slid causing res to fall to floor, 2 staff assist to transfer from sitting to standing position, res bears weight bil without difficulty, BLE notably weak, bil grasps =/strong, PERL, denies discomfort at present..."</p> <p>"11/25/11 1115 a.m. Resident was visiting with her (family member) in the sun room. staff heard alarm sound and immediately respond to find resident sitting on her buttocks in front of her wheelchair, legs out in front of her and leaning back against the wheelchair..."</p> <p>"11/28/2011 09:27 AM Resident removed lap buddy and tossed aside. Resident ambulated length of hallway x 2 with staff assist, then began asking for son. Agreed to call son. Refused to allow this writer to put lap buddy back on. Call placed to resident's son and resident given phone. Approx 5 minutes later alarm sounded, this writer responded to find resident sitting on floor in front of wheelchair on buttocks, legs straight out in front. Denied pain/discomfort at this time. ROM WNL. Resident assisted back into wheelchair with assist of 2 staff. Allowed lap buddy to be placed back on. Resident taken to activities as immediate intervention, will ask for therapy screen...."</p>						

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	<p>During interview with the DON on 11/29/11 at 2:00 P.M. she provided a teachable moment dated 11/20/11, for the CNA who had assisted the resident to the bathroom on 11/19/11 which indicated " stay within arms reach of resident when tilting...get assist as needed if residents are combative or high fall risk..." The DON further indicated the residents had 11 falls at home prior to admission to the facility., but did not know this until the first care plan meeting.</p> <p>3.1-45(a)(2)</p>			