

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/02/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2016
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NAME OF PROVIDER OR SUPPLIER ALDERSGATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3220 SW ALBRIGHT DRIVE TOPEKA, KS 66614
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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation # 99327. A revised 2567 was sent to the facility on 8/2/16.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 225	<p>Continued From page 1</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 174 residents. The sample included 23 residents. Based on observation, record review and interview, the facility failed to report an unwitnessed fall with injury to the state agency, for 1 of 5 resident's reviewed for accidents (#215).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #215's (POS) Physician Order Sheet, dated 7/20/16, indicated the resident had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). <p>The annual (MDS) Minimum Data Set assessment, dated 5/28/16, indicated the resident had long and short -term memory problems with severely impaired decision-making skills. The assessment revealed the resident required supervision with transfers, ambulation, and extensive assistance of one staff for toileting. The assessment further revealed the resident with a steady balance, wandered daily and one had a non-injury fall.</p> <p>The 7/12/16 care plan stated the resident was at risk for falls due to cognitive loss, poor eyesight, poor safety awareness, and directed staff to increase visual observation, and a complete a</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>medication review. The resident walks and transfers independently with verbal cues for safety.</p> <p>The 7/12/16 and 7/17/16 fall risk assessments indicated the resident was a moderate risk for falls.</p> <p>The, nurse's note on 7/17/16 at 6:22 AM documented staff found the resident sitting on the floor, bleeding from his/her nose. The resident had a cut on the bridge of his/her nose and a cut on his/her inner upper lip. The note further stated the resident was unable to state what happened and it appeared he/she may have fallen out of bed and hit his/her face on the nightstand.</p> <p>The, nurse's note on 7/17/16 at 7:54 PM documented the resident had swelling to the bridge of his/her nose and left eye with discoloration forming to his/her inner eyes and along his/her left check.</p> <p>The 7/17/16 fall investigation and root cause analysis report documented the resident was independent with ambulation and had been last seen lying in bed. The report stated the resident possibly rolled out of bed and hit his/her face on a side stand but the resident was unable to tell staff what had happened.</p> <p>The 7/18/16 physician progress note stated the resident struck his/her face on the bedside table and sustained "raccoon eyes" and a very swollen nose. The note stated the resident's nose was extremely swollen and had a well approximated (clean and in a straight line) laceration inside his/her upper lip. The resident had tenderness with palpation of his/her nose no tenderness to</p>	F 225			

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F 225	Continued From page 3 the orbital bone (the bony cavity containing the eyeball). The note stated the physician felt there was a fracture of the nose but nothing could be done about it and planned to speak to the family regarding diagnostic testing such as X-rays. On 7/25/16 at 1:31 PM, observation revealed the resident independently ambulated with nonskid socks on. Further observation revealed the resident had purple bruising under both of his/her eyes, a swollen nose, and yellowish/purple bruising down the left side of the resident's neck. On 7/26/16 at 10:15 AM, Administrative Nurse D verified the facility did not report the fall with injury on 7/17/16 because staff knew the resident had fallen out of bed and put interventions into place after the fall. The 4/28/14 facility Recognizing Signs and Symptoms of Abuse or Neglect Policy stated and injury of unknown source is defined as an injury that was not observed by any person or the resident could not explain the source of the injury. The policy further stated that all reports of abuse would be reported to state agencies and other entities. The facility failed to report cognitively impaired Resident #215's unwitnessed fall with facial injury to the appropriate state agency.	F 225			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253			

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F 253	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 174 residents. The sample included 23 residents. Based on observation, record review, and interview the facility failed to provide maintenance and housekeeping services necessary to maintain a sanitary and comfortable environment on the facility entrance hall and 4 of 7 halls.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 7/21/2016 at 8:30 AM, during initial tour of the facility's 7 hallways, observation revealed the following: The main entrance to the facility had the two hallways with beige carpet that had numerous areas of various sizes of soiled, brown stains extending the entire length of the hall. <p>One overhead florescent light in the Westminster unit had numerous dead bugs. Continued observation revealed two hallways with beige carpet that had numerous areas of various sizes of soiled, brown stains extending the entire length of the hallways, and the carpet in front of residents recliners across from the nurses station with numerous brown stains and various sizes. Observation revealed the beige carpet in front of the medications cart had numerous brown stains and various sizes.</p> <p>Observation of the nurses's station in the York unit revealed blue carpet with a solid black stained pathway from one side of the room to the other. Resident # 244 room had a urine smell in the carpet.</p>	F 253			

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F 253	Continued From page 5 Resident #59's room the square linoleum tile had a urine smell. On entrance to the Eastminster unit the beige carpet by the nurse's station had a 4"(inch) by 5" area of black melted carpet and a 3" by 2" red stain. The Oakwood dining /kitchenette area had a cabinet below the sink with numerous food particles. On 7/27/2016 at 12:45 PM, Maintenance Staff Z verified the above findings. The facility's 3/2011 scheduled maintenance program indicated the facility and ground maintenance at all times to promote high aesthetic qualities and a safe environment for residents, staff, and visitors. The Director of Plant Operations shall conduct weekly walk through of the facility and identify any areas of concerns such as peeling paint, loose handrails, signaled, lighting, and flooring issues. All the identified issues on any scheduled rounding are to be addressed and corrected as soon as possible and communicated to the client via e-mail or topics of a meeting agenda . The facility failed to provide and maintain housekeeping and maintenance services necessary to maintain a sanitary, comfortable environment in the facility for 4 of the 7 units.	F 253			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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F 281	Continued From page 6 This REQUIREMENT is not met as evidenced by: The facility census included 174 resident. The sample included 23 residents. Based on record review and interview, the facility failed to provide an initial care plan including dialysis interventions for resident #149 admitted with dialysis treatments. Findings included: - The Physician's Order Sheet (POS) dated 7/20/16 for resident #149 revealed a diagnosis of end stage renal disease (a terminal disease because of irreversible damage to vital tissues or organs to the kidneys). The admission Minimum Data Set (MDS) dated 6/25/16 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severely impaired cognition and the resident received dialysis. The electronic record documented an admission date to the facility on 6/16/16. The physician order dated 6/17/16 documented staff where to check blood pressure and weight before and after dialysis on Monday, Wednesday, and Friday. Review of the initial admission care plan, dated 6/28/16, revealed the care plan lacked interventions related to dialysis. On 7/25/16 at 10:26 AM, Licensed Nursing Staff H verified the lack of a dialysis care plan. On 7/27/16 at 11:07 AM, Administrative Nursing Staff A acknowledged the facility failed to develop a dialysis care plan. The facility policy "Temporary Care Plan Development," dated 2/17/11, revealed the care	F 281			

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F 281	Continued From page 7 team developed the comprehensive care plan. The facility failed to develop a dialysis care plan for this cognitively impaired resident who received dialysis.	F 281			
F 323 SS=E	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. This REQUIREMENT is not met as evidenced by: The facility identified a census of 174 residents. The sample included 23 residents with 5 residents sampled for falls. Based on observation, record review, and interview, the facility failed to implement effective interventions to prevent falls for 2 residents (#194 and #215). Resident #215 had 4 falls in 10 days with injury to the face on one of the four falls. Based on observation, record review and interview the facility failed to secure and store toxic chemicals safely for the independently mobile residents on the unit. Findings included: - Resident #215's Physician Order Sheet(POS), dated 7/20/16, indicated the resident had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional	F 323			

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F 323	<p>Continued From page 8</p> <p>reaction characterized by apprehension, uncertainty and irrational fear) and major depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness).</p> <p>The annual Minimum Data Set (MDS) assessment, dated 5/28/16, indicated the resident had long and short term memory problems with severely impaired decision making skills. The assessment revealed the resident required supervision with transfers, ambulation, and extensive assistance of 1 staff for toileting. The assessment further revealed the resident had no upper or lower extremity impairment, steady balance, wandered daily, and 1 non-injury fall.</p> <p>The Care Area Assessment (CAA) for falls documented the resident had significant cognitive losses due to the progression of his/her Alzheimer's disease that placed him/her at risk for falls. The CAA further stated the resident remained able to ambulate independently without any assistive devices.</p> <p>Review of the medical record revealed a change in the resident's condition on 7/5/16, followed by four falls within a 10 day period, on 7/12/16 at 4:04 PM, 7/12/16 at 9:13 PM, 7/17/16 at 6:22 AM and 7/22/16 at 5:00 PM.</p> <p>The care plan documented the resident at risk for falls due to cognitive loss, poor eyesight, and poor safety awareness. The update on 7/12/16 documented to continue current plan of care and directed staff to increase visual observation if the resident had been awake more than 18 hours. The record lacked evidence how staff would monitor for this intervention. The</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>record lacked evidence on the causal factors and reason for the second fall on 7/12/16. The update on 7/17/16 directed staff to place a fall mat beside the bed and make environmental adaptations in his/her room. The care plan updated 7/28/16 (6 days after the fall) with a prompted toileting plan, however lacked an immediate intervention regarding the fall on 7/22/16.</p> <p>The nurse's note, dated 7/5/16 at 12:50 PM documented the resident was very unsteady on his/her feet after getting up in the morning, leaning toward the right side, with pupils pin point and wandering aimlessly. The record lacked evidence of a fall at this time or prior to this event. However, the record also lacked evidence of any cause for the resident's change in condition.</p> <p>The nurse's note on 7/12/16 at 4:04 PM documented the resident was found sitting on his/her bottom with knees up stating " Get me up. "</p> <p>The nurse's note on 7/12/16 at 9:13 PM documented the resident was observed leaning against the wall and lowered him/herself to the floor. Fall precautions were already in place.</p> <p>The nurse's note on 7/17/16 at 6:22 AM, documented staff found the resident sitting on his/her floor, bleeding from his/her nose. The resident had a cut on the bridge of his/her nose and a cut on his/her inner upper lip. The note further stated the resident was unable to state what happened and it appeared he/she may have fallen out of bed and hit his/her face on the night stand.</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>The nurse's note on 7/17/16 at 7:54 PM, documented the resident had swelling to the bridge of his/her nose and left eye and discoloration forming to his/her inner eyes and along his/her left cheek</p> <p>The nurse's note on 7/22/16 at 5:00 PM documented staff heard a loud noise and found the resident lying on his/her back on the floor. The resident was rubbing the back of his/her head and a small know was noted to the left back of his/her head. The residents pupils were very small and sluggish to reaction. The resident had defecated in his/her brief.</p> <p>The 7/12/16 and 7/17/16 fall risk assessments indicated the resident was a moderate risk for falls.</p> <p>The fall investigation and root cause analysis report dated 7/17/16 stated the resident was independent with ambulation and had been last seen lying in bed. The report stated the resident possibly rolled out of bed and hit his/her face on a side stand but the resident was unable to tell staff what had happened. The investigation lacked evidence of a root cause analysis and appropriate intervention for this fall, to prevent further falls.</p> <p>The physician progress note dated 7/18/16 documented the resident struck his/her face on the bedside table and sustained "raccoon eyes" and a very swollen nose. The resident's nose was extremely swollen and had a well approximated (clean and in a straight line) laceration inside his/her upper lip. The resident had tenderness with palpation of his/her nose with no tenderness to the orbital bone (the bony cavity containing the</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>eyeball). The progress note further documented the physician felt there was a fracture of the nose but nothing could be done about it and planned to speak to the family regarding diagnostic testing such as X-rays.</p> <p>The physician's order dated 7/18/16 directed staff to monitor the resident's skin tears to the bridge of the nose and inner lip every evening shift until resolved.</p> <p>The nurse's note on 7/19/16 at 4:18 PM, documented the resident's family had declined any diagnostic testing or x-rays (a photographic or digital image of the internal composition of something, especially a part of the body) of the resident's maxillofacial structures (relating to the jaws and face).</p> <p>The nurse's note on 7/19/16 at 4:23 PM, documented the resident's family rearranged the resident's room so the side table was not beside the bed anymore. (This was done two days after the resident's fall.)</p> <p>The nurse's note on 7/20/16 at 10:55 AM documented due to injuries sustained in the fall on 7/17/16, the resident was provided a mechanical soft diet until his/her mouth healed .</p> <p>On 7/25/16 at 1:31 PM, observation revealed the resident independently ambulated with non-skid socks on. Further observation revealed the resident had purple bruising under both of his/her eyes, a swollen nose, and yellow/purple bruising down the left side of the resident's neck.</p> <p>On 7/26/16 at 1:41 PM, observation revealed the resident entered another resident's room, and shut the door behind him/her. Further observation</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>revealed the resident came out of the room, adjusting his/her pants. The resident turned toward the nurse's station with his/her incontinence brief visibly bunched up and hanging off to the left side under his/her pants. Continued observation revealed a brown stain forming on the back of the resident's pants as he/she held on to the front of his/her sagging pants.</p> <p>On 7/26/16 at 10:15 AM, Administrative Nursing staff D verified the fall with injury had not been reported because staff knew the resident had fallen out of bed and interventions were put into place after the fall (a fall mat at bedside).</p> <p>On 7/26/16 at 10:52 AM, Licensed Nursing staff C stated the resident was receiving therapy and the family had rearranged the resident's room after his/her fall out of bed. Licensed Nurse C stated he/she did not contact the physician on 7/5/16 when the resident was not acting right because the physician was expected at the facility that day. Licensed Nurse C stated he/she was unsure if the physician saw the resident.</p> <p>On 7/26/16 at 3:22 PM, Direct Care Staff Q stated the staff placed a fall mat beside the resident's bed and staff observed the resident more often.</p> <p>On 7/26/16 at 4:02 PM, Licensed Nursing staff E stated since the fall with injury, the furniture had been re-arranged and a fall mat placed beside his/her bed. Licensed Nursing staff E stated the resident had a progression in his/her dementia which caused his/her falls.</p> <p>The facility's policy 'Fall Prevention and Management', dated 3/3/16, documented residents who sustained a fall would be</p>	F 323			

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PRINTED: 08/02/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER ALDRSGATE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 SW ALBRIGHT DRIVE TOPEKA, KS 66614		
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F 323	<p>Continued From page 13</p> <p>thoroughly assessed and care would be provided to reduce further occurrences.</p> <p>The facility failed to implement appropriate interventions to prevent further falls for this cognitively impaired resident with repeated falls and sustained a fall with facial injury on 7/17/16.</p> <p>- On 7/21/16 at 8:00 AM, during the initial tour, observation revealed the north soiled utility room door on a resident hallway was unlocked. The following items were observed in an unlocked cabinet: 2-20 (oz.) ounce cans of Meyer Cream Cleanser 2-32 oz. cans of Spot Fresh Mirror and Glass Cleaner 2-32 oz. cans of Meyers Attack Enzyme Drain Odor and Opener 2-16 oz. cans of Sta-Brite Stainless Steel Polish 1-16 oz. can of Dymon Stainless Steel Polish The labels on each of the above named chemicals read to keep out of the reach of children, flush eyes and skin with water for at least 15 minutes, and call the poison control center if swallowed. On 7/21/16 at 8:08 AM, Direct Care Staff R verified the cabinet containing the chemicals should be locked. On 7/21/16 at 8:14 AM, Licensed Nursing Staff H confirmed the cabinet containing the chemicals should be locked. On 7/21/16 at 8:50 AM, during the initial tour, observation revealed the shower room door on the Elmhurst Neighborhood was unlocked. The following was observed in the corner of shower floor: 1-13 oz. spray bottle of Classic Whirlpool</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>Disinfectant Cleaner</p> <p>The label on the above chemical read to keep out of reach of children, if contact with eyes or skin flush with water for 15 to 20 minutes, and if swallowed call poison control.</p> <p>On 7/21/16 at 8:51 AM, Direct Care Staff R and Licensed Nursing Staff H, both verified the cleaner observed in the shower should be locked in the cabinet.</p> <p>On 7/27/16 at 11:10 AM, Administrative Nursing Staff A confirmed chemicals needed to be behind locked doors and/or stored in a locked cabinet. The facility policy on Chemical Storage, dated 5/1/13, revealed the inventory of cleaning supplies shall be properly stored at all times. The policy further stated all storage areas were to remain locked at all times.</p> <p>The facility failed secure chemicals from independently mobile residents who resided on this unit.</p> <p>- The signed Physician's Order Sheet (POS) dated 7/21/16 for resident #194 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), polymyalgia rheumatic (an inflammatory disorder causing muscle pain and stiffness around the shoulders and hips), anxiety, hereditary and idiopathic neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), and a history of falls.</p> <p>The Annual Minimum Data Set (MDS) dated 2/10/16 noted a Brief Interview for Mental Status (BIMS) of 3 (less than 7 indicated severe cognitive impairment) and required supervision with transfers and walking.</p> <p>The Quarterly MDS dated 5/7/16 noted a BIMS of</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>3 and required supervision with transfers and did not require staff assistance with walking.</p> <p>The Care Area Assessments (CAAs) dated 2/10/16 documented the resident had history of dementia, as well as multiple chronic medical conditions that could place him/her at risk for falls. It documented the resident had gait problems, musculoskeletal problems, impaired balance during transitions, impulsivity/poor safety awareness, incontinence (involuntary loss of urine or bowel), and muscle weakness.</p> <p>The care plan, dated 6/30/16, noted the resident refused to wear the non-slip stockings. Staff ensured the walker was at the bedside with the brakes locked and cleaned up after the cat. Staff reminded the resident to use the call light, with which the resident was not compliant.</p> <p>Fall assessment dated 1/24/16 noted the resident was at a high risk for a fall.</p> <p>Fall investigation report dated 4/17/16 documented the resident left the walker in front of the sink, felt tired, and fell to the floor. The new intervention was for staff to ensure the walker was at the bedside, and to remind the resident to use it. (This intervention was not appropriate for a cognitively impaired resident.)</p> <p>Fall investigation report dated 4/22/16 revealed the resident fell while walking to the bathroom. It also documented the resident was unsteady and cognitively impaired. The new intervention was for staff to encourage the resident to use the call light for assistance to the bathroom. (This intervention was not appropriate for a cognitively impaired resident.)</p>	F 323			

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F 323	<p>Continued From page 16</p> <p>Fall investigation report dated 6/13/16 stated the resident lay on the floor. He/she reported to staff the cat had a bowel movement on the floor, and he/she stooped down to clean it up. The new intervention was for staff to remind the resident to call for assistance to clean up after the cat. (This intervention was not appropriate for a cognitively impaired resident.)</p> <p>Fall investigation report dated 7/2/16 noted the resident laid on the floor. The resident reported he/she lost his/her balance while bending over to clean up after the cat. It lacked new interventions to prevent a future fall.</p> <p>On 7/26/16 at 8:48 AM, the resident reported he/she used the call light for staff assistance for transfers and with walking.</p> <p>On 7/26/16 at 9:00 AM, the resident sat on the side of the bed. He/she used the walker and stood up. The brakes on the walker were not locked.</p> <p>On 7/26/16 at 1:26 PM, direct care staff O stated the resident wore slip resistant socks, and used a walker. Staff O further said staff reminded the resident to use the call light.</p> <p>On 7/26/16 at 9:02 AM licensed staff C stated staff checked on the resident often, and encouraged him/her not to clean up after the cat.</p> <p>On 7/27/16 at 2:20 PM, administrative nursing staff A expected staff to check on the resident every 30 to 60 minutes but we don't document checks unless its post fall or incident.</p>	F 323			

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F 323	Continued From page 17 The facility's policy 'Fall Prevention and Management', dated 3/3/16, revealed residents who sustained a fall would be thoroughly assessed and care would be provided to reduce further occurrences. The facility failed to develop and implement appropriate interventions to prevent further falls for this cognitively impaired resident who experienced multiple falls.	F 323			