

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/02/2016
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NAME OF PROVIDER OR SUPPLIER BROOKDALE OVERLAND PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 12000 LAMAR OVERLAND PARK, KS 66209
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S 000	INITIAL COMMENTS	S 000		
S3026 SS=G	<p>26-41-101 (f) (1) Staff Treatment of Residents ANE</p> <p>(f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation.</p> <p>This REQUIREMENT is not met as evidenced by: 26-41-101 (f) (1)</p> <p>The facility reported a census of 32 residents. Based on observation, interview, and record review the facility failed to implement abuse, neglect, and exploitation policies to ensure 2 of 3 residents sampled (#1, #2) were free from neglect when they failed to thoroughly investigate, develop, and implement interventions to prevent the reoccurrence of falls, which resulted in a head injury and 8 surgical staples for resident #2 and failed to timely intervene, assess, and treat a significant change in condition for resident #1 when he/she went 6 days before staff notified a practitioner of his/her left hip pain diagnosed as a fracture (broken bone).</p> <p>Findings included:</p>	S3026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3026	<p>Continued From page 1</p> <p>- Review of resident #2's signed physician order sheet dated 5/2/2016 documented the following diagnoses: psychotic disorder (a major mental disorder characterized by a gross impairment in reality testing).</p> <p>Review of the Functional Capacity Screen (FCS) dated 1/27/16 documented the resident required physical assistance with bathing, eating, dressing, and toileting, independent with mobility and transfers, and was incontinent of bladder. The resident had falls, unsteadiness, impaired vision and hearing, and had a major difference in activities in daily living in the mornings and evenings.</p> <p>Review of the Negotiated Service Agreement (NSA) dated 1/27/16 documented the family requested the facility not send the resident to the emergency room unless necessary and in the event it was necessary the family preferred to take him/her if available. The resident ambulated with his/her feet pointed outward and he/she had a shuffled gait, which increased his/her fall risk. The care plan directed staff to encourage and guide the resident to sit and rest periodically throughout the day and everyone was aware the resident did not sit for long periods and usually had a rest period of less than 5 minutes. Staff were also directed to encourage the resident to lay down for a nap when observed sleeping, offer early morning get up times, encourage the resident to sit in a larger/deeper chair when in the community for positioning, and the resident's bed was positioned against the wall per family request. The resident was cognitively impaired, not able to use a call light, and the facility offered a pendant, which the family declined. The care plan was revised on the following dates with the following interventions:</p>	S3026		

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S3026	<p>Continued From page 2</p> <p>On 2/7/16 staff were directed to encourage resident/staff to walk at a slower pace with the resident as the resident was jogging.</p> <p>On 4/7/16 the hospice case manager visited and completed a medication review with medication changes.</p> <p>On 4/14/16 the facility documented a decline in the resident's fine motor skills. The facility spoke with a family member who reported he/she believed the resident forgot how to walk.</p> <p>On 5/6/16 the resident fell, hit his/her head, had a laceration (a deep cut or tear in the skin or flesh), went to the emergency room, and received 8 staples to the mid side of his/her head. The hospice nurse visited the resident when he/she returned and facility met with a family member and suggested a soft hat/helmet for added protection of the head, which spouse declined. The resident's staples were removed on 5/16/16.</p> <p>On 5/20/16 hospice provided a rolling shower chair and a wheelchair for unsteady mobility and increased weakness.</p> <p>Review of a nursing progress note dated 1/21/2016 at 5:05 A.M. documented staff called to the 500 Hall and the resident had fallen. Staff observed the resident seated on the floor, leaned to the left, with no injury. Staff lifted him/her to a standing positioning. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls.</p> <p>Review of a nursing progress note dated 2/20/16 at 4:15 P.M. documented a CMA (certified medication aide) observed the resident on his/her knees on the floor. Staff assessed the resident for injuries. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further</p>	S3026		
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S3026	<p>Continued From page 3</p> <p>falls.</p> <p>Review of a nursing progress note dated 4/7/16 at 4:22 P.M. documented a housekeeper went to the wellness office to report the resident was on the floor. When the nurse arrived the resident sat on the floor in front of the public bathroom door and a CNA (certified nursing assistant) stood in front of the resident. The resident was alert and oriented to self and confused. Two staff assisted the resident to a standing positioning. A hospice case manager reviewed the resident's medications and made medication changes. The record lacked a thorough licensed nurse investigation.</p> <p>Review of a nursing progress note dated 4/24/16 at 9:00 A.M. documented staff observed the resident on the floor in front of another resident's door and the CNA could not get out of the resident's room due to the resident fell in front of the door. No injury and staff assisted him/her up and onto the couch in the common area. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls.</p> <p>Review of a nursing progress note dated 5/6/16 at 11:00 A.M. documented at approximately 4:30 A.M. staff checked on the resident and observed the resident on the floor near his/her dresser drawers. The resident was positioned on his/her side near the corner edge of the dresser and bled from the left side of his/her head. Staff reported the resident was last checked at 2:00 A.M. and he/she slept. The resident was transported to the hospital via emergency medical services. The resident returned to the facility within a few hours and received 8 staples to a laceration on the mid left side of his/her head. Staff suggested a soft</p>	S3026		

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S3026	<p>Continued From page 4</p> <p>hat or helmet to the family for additional protection and family refuses, stating "I don't think [he/she] would want that". The record lacked a thorough licensed nurse investigation of the fall and an immediate new intervention to prevent further falls.</p> <p>Review of a nursing progress note dated 5/20/16 at 9:30 A.M. documented staff observed the resident on the floor in the 500 common area, laid on his/her left side, just in front of the couch he had sat on. Direct care staff reported he/she assisted the resident to the couch approximately 20 minutes prior to the fall and the hospice aide reported he/she observed the resident seated in an upright position on the couch approximately 5 minutes before he/she fell. The immediate intervention was for hospice to provide the resident a wheelchair for unsteady mobility/increased weakness and a rolling shower chair. The record lacked a thorough licensed nurse investigation of the fall.</p> <p>During an observation on 5/24/16 at 11:15 A.M. the resident sat in his/her wheelchair in the dining room. The wheelchair foot rests were in place and the resident had his/her right leg positioned behind the foot rest on the carpet. Staff assisted the resident with foot placement at 11:21 A.M. and at 11:22 A.M. the resident removed his/her right foot from the foot rest and positioned his/her right foot behind the foot rest on the carpet. A baking activity occurred in the dining area and the resident showed no interest.</p> <p>During an observation on 5/24/16 at 1:24 P.M. direct care staff R assisted the resident with toileting. Staff R applied a gait belt (belt used for balance) and cued the resident to use the grab bar to stand. Staff R assisted the resident with</p>	S3026		

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S3026	<p>Continued From page 5</p> <p>clothing management and cued the resident to sit down as the resident attempted to stand. The resident wore hip protectors, had a rolling shower in his/her shower, bed positioned against the wall, and a scar to the left side of his/her head.</p> <p>During an observation on 5/24/16 at 4:09 P.M. the resident sat in his/her wheelchair in the dining area with wheelchair foot rest placed and both feet behind the foot rests on the carpet. A music activity occurred in the dining area and the resident showed no interest. The resident kept his/her head down and eyes open.</p> <p>Attempted to interview the resident on 5/24/16 at 1:22 P.M. and the resident made no eye contact and did not respond to interaction.</p> <p>During an interview on 5/24/16 at 10:49 A.M. direct care staff O said he/she knew a resident was a fall risk if the resident wore a red bracelet and also stated fall risk was in the care plan. He/she said the resident was at risk for falls and used a wheelchair to prevent falls. Staff O said the resident walked in his/her sleep, had fallen, was not sure of the cause of the fall, but knew a fall occurred in his/her room.</p> <p>During an interview on 5/24/16 at 1:25 P.M. direct care staff R said the resident used a wheelchair due to falls and adjusted well to the wheelchair. Staff R said current interventions to prevent falls included; wheelchair use, toileted between meals, wore hipsters, and frequent visual observations due he/she attempted to transfer him/herself. Staff R said the resident made no attempts to self transfer since he/she had the wheelchair. Staff R said he/she reviewed the care plan or asked the nurse if he/she had questions regarding fall risk or fall interventions.</p>	S3026		

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S3026	<p>Continued From page 6</p> <p>During an interview on 5/24/2016 at 3:59 P.M. direct care staff P said if he/she noticed a resident had a mattress on the floor in his/her then that meant the resident was a fall risk. Staff P also stated If the resident had a yellow band from the hospital he/she knew they were a fall risk. Staff P said this resident was at risk for falls and the fall interventions were the same as other residents which were bed in a low position.</p> <p>During an interview on 5/24/16 at 4:15 P.M. licensed nursing staff H said if a resident had dementia, or admitted with a history of falls they were considered a fall risk. Staff H said if a resident used a walker, staff observed for stability and went from there. Staff H said this resident was a high fall risk, had a history of falls, and continued to fall. He/she reported fall interventions included, use of a wheelchair and staff were to make sure the resident stayed busy. Staff H said the resident continued to walk at times and walked in his/her sleep, which caused many of his/her falls.</p> <p>During an interview on 5/24/16 at 4:39 P.M. administrative nursing staff D said staff were aware of a resident's fall risk based on the way they walked, if they used a walker/assistive device, medications the resident took, dementia, and the results of a risk identification form completed on admission. Staff D said direct care staff had assignment sheets and falls were discussed during daily meetings. He/she said interventions were determined immediately unless a resident fell on a weekend and it would then take longer to implement an intervention. Staff D said the weekend supervisor was facility wide and could review and implement an immediate intervention following a fall, but felt</p>	S3026		

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S3026	<p>Continued From page 7</p> <p>he/she knew the residents better and did his/her own interventions when he/she returned on Mondays following a weekend fall. Staff D said he/she expected the charge nurse to document all falls thoroughly, make needed family and physician notifications, and document immediate interventions in the medical record. Staff D confirmed the 6 falls reviewed lacked a thorough licensed nurse investigation and 4 of the 6 falls lacked an immediate intervention to prevent further falls. Staff D said the use of a helmet to protect the resident's head if he/she fell again was offered and declined by the family on 1/29/16.</p> <p>Review of the facility's revised abuse, neglect, and exploitation policy dated 6/10/2011 included the failure to provide goods and services, which were reasonably necessary to ensure safety and well being and to avoid physical/mental harm, or illness.</p> <p>The facility failed to ensure this cognitively impaired dependent resident with a known history of falls received the necessary care and services to prevent a fall with a head injury, which required 8 surgical staples.</p> <p>- Review of resident #1's signed physician orders dated March 2016 documented a diagnosis of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).</p> <p>Review of a Functional Capacity Screen (FCS) dated 2/1/16 and 3/2/16 documented the resident required physical assist with dressing, bathing, toileting, transfers, and walking/mobility. The resident was frequently incontinent of urine, had</p>	S3026		

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S3026	<p>Continued From page 8</p> <p>falls/unsteadiness, used an assistive device/wheelchair, had impaired decision making, impaired hearing and vision, and a major difference in ADL (activities of daily living) and/or IADL (instrumental activities of daily living) functioning in the mornings and evenings.</p> <p>Review of a Risk Identification Evaluation dated 2/1/16 documented the resident fell when in assistive living within the past 12 months.</p> <p>Review of the Negotiated Services Agreement (NSA) dated 3/2/16 documented the resident had dementia (a progressive mental disorder characterized by failed memory and confusion) and required staff assistance with dressing and grooming and used a walker as needed. The facility identified the resident as a fall risk due to him/her being greater than 65 years. Staff were directed to familiarize the resident to the environment and routine of the community as needed, educate the resident on the use of the emergency call system, consider reducing environmental clutter, and arrange furniture for adequate walkways. Additionally staff were directed to be alert to placement of personal items, encourage adequate lighting in apartment, prompt the resident to use a night light, encourage properly fitting clothing and shoes, use of grab bars in the bathroom, lock wheelchair, proper use of assistive devices as needed, and encourage participation in the "B-Fit" exercise programs. Staff revised the NSA on 3/23/2106 and documented the resident complained of left hip pain, had a nurse practitioner visit, an order for a left hip x-ray and potassium level in the morning. On 3/24/16 the NSA documented x-ray results showed a left hip fracture and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).</p>	S3026		

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S3026	<p>Continued From page 9</p> <p>Review of a physical therapy assistant (PTA) note dated 3/17/16 at 8:22 P.M. documented the PTA discussed with second shift CNA's (certified nursing assistants) on duty and a charge nurse as well as emailed the physical therapy director, health and wellness director, and home health registered nurse that the resident had increased pain in the left hip area upon going from a supine (lying down with face up) to a sitting position and transfers. Upon palpation (touch) of the hip staff discovered many tight muscles and thought the resident may have had cramps due to dehydration, was currently being treated for a urinary tract infection, and was on potassium per the charge nurse. The resident's family was present and the nurse brought Tylenol (a medication to treat pain) to ease the resident's pain. After the resident transferred to the wheelchair to be taken to the bathroom he/she vomited some of the water the nurse had given him/her with the Tylenol. At 8:38 P.M. on 3/17/16 the PTA documented the resident presented with increase fatigue and pain, was very hard to awaken today and when the resident wanted a drink of water he/she was unable to sit up right away due to increased pain in the left hip every time he/she tried to sit up. PTA documented he/she attempted to massage the left hip area for pain relief when the resident was still lying down. PTA documented he/she suspected muscle cramps due to increased fatigue and dehydration from not drinking enough water, which he/she suspected was the problem with his/her hip pain.</p> <p>Review of nursing progress notes lacked a licensed nurse assessment on 3/17/2016 related to pain as reported by the PTA.</p> <p>Review of a nursing note on 3/21/16 at 10:00</p>	S3026		

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S3026	<p>Continued From page 10</p> <p>P.M. documented a CNA (certified nursing assistant) notified the nurse the resident complained of pain. When the nurse went in to see the resident he/she had no pain. The record lacked documentation of a completed pain assessment.</p> <p>Review of a practitioner progress note dated 3/23/16 documented resident was seen today for follow up on a urinary tract infection, hypokalemia (low blood potassium), and a new report of left hip pain. Nursing reported he/she had not fallen or had any known injury, but began to complain of left hip pain 2 days ago. Physical examination elicited pain with left range of motion. No joint swelling, redness, or warmth. Alert and oriented to person only. An x-ray was ordered to rule out fracture or dislocation and Tylenol (a medication to treat pain) was available for pain.</p> <p>Review of a nursing progress note dated 3/24/16 at 1:00 P.M. documented x-ray results showed a left hip fracture. Staff notified the nurse practitioner who gave orders to send the resident to the emergency room for treatment. Family notified and said okay. Health and Wellness Director also notified. An ambulance was called and the resident was sent to the hospital for treatment.</p> <p>Review of a left hip and unilateral pelvis x-ray dated 3/24/16 documented an acute left femoral neck fracture (broken thigh bone). Moderate Kellgren and Lawrence grade 3 (a method used to classify the severity of osteoarthritis) osteoarthritis involving the hip.</p> <p>Review of a nursing progress note dated 3/25/16 at 10:30 A.M. documented staff called the hospital and spoke with the resident's nurse who</p>	S3026		

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S3026	<p>Continued From page 11</p> <p>reported the resident had surgery this morning and was doing well.</p> <p>During a telephone interview on 5/24/16 at 8:50 A.M. a family member of the resident said he/she was with the resident on 3/17/16, knew the resident had hip pain, and asked the facility to follow up. The following day another family member requested the facility to obtain an x-ray, which he/she said the facility did not do. The family member said 6 days later the facility phoned and informed him/her the resident had a hip fracture and needed surgery. A family member reported while in the hospital the resident reported he/she got up by him/herself, fell in the bathroom, and yelled for help.</p> <p>During an interview on 5/24/16 at 10:49 A.M. direct care staff O said if a resident complained of pain or looked like they were in pain he/she told the nurse. Staff O recalled the resident and said he/she was not at risk for falls and had no falls. Staff O said 2-3 days before the resident left for the hospital he/she complained of pain when staff moved him/her, was less alert, and was not able to stand upright. Staff O said the resident did not normally complain of pain and was usually able to stand without difficulty. Staff O said the day he/she knew the resident had pain he/she told a certified medication aide because the nurse had not arrived yet. Staff O said the nurse usually arrived around 8:00 A.M.</p> <p>During an interview on 5/24/2016 at 3:59 P.M. direct care staff P said if a resident had a mattress on the floor he/she noticed when in the room and that meant the resident was a fall risk. Staff P also stated If the resident had a yellow band from the hospital he/she knew they were a fall risk. He did not recall the resident and said if</p>	S3026		

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S3026	<p>Continued From page 12</p> <p>a resident had a change in condition he/she immediately told the nurse.</p> <p>During an interview on 5/24/16 at 4:08 P.M. direct care staff Q said he/she worked with the resident prior to his/her discharge. Staff Q said the resident needed one staff assist with ADL's and he/she could stand up by him/herself with cueing from staff. Staff Q said 2-3 days prior to discharge the resident was not able to pull him/herself up, could not stand, and required 2 person assist. Staff Q said prior to discharge the resident complained of pain to his/her hip area, he/she told the nurse, and then the nurse would ask the resident and he/she said no. Staff Q said prior to this incident the resident did not complain of pain regularly. Staff Q said the resident's pain occurred when staff moved him/her, but when the resident laid still he/she was not in pain. Staff Q said he/she was not aware of the resident having any falls.</p> <p>During an interview on 5/24/16 at 4:23 P.M. licensed nursing staff H said he/she admitted the resident from assisted living, had a history of falls, and the resident's family members reported the resident tried to do things for him/herself and needed to be supervised with ADL cares. Staff H said the resident required one person assist with ADL's when admitted and when discharged he/she had a change in condition. Staff H said 2 days prior to discharge he/she complained of right hip pain and on the day of discharge he/she went into the room and the resident could not even move. An x-ray was done the day prior which showed he/she had a fracture so the resident was sent out. Staff H said the resident's family member kept saying the resident was in pain, but when asked he/she denied pain. Staff H said the CNA's reported to him/her the resident</p>	S3026		

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S3026	<p>Continued From page 13</p> <p>had pain and once he/she gave the resident Tylenol. Staff H said the resident was a complicated cause because he/she complained of pain when the aides got him/her out of bed, but would deny pain to the nurse. Stated, "it's tricky because you don't know if [he/she] was really in pain". Staff H said staff first informed him/her of the resident's pain on 3/17/16, then on 3/18/16, and then on 3/22/16 and he/she notified the nurse practitioner. Staff H said the resident had no known falls, which would explain the fracture and the resident would not be able to get him/herself off the floor if he/she fell.</p> <p>During an interview on 5/24/2016 at 5:54 P.M. administrative nursing staff D said the resident had a history of falls and no falls since admission to assisted living memory care. Staff D said a PTA notified him/her in an email of the resident's complaints of pain and believed he/she may have assessed the resident, but did not document his/her findings and did not recall a date. Staff D said he/she expected the PTA to notify the physician on 3/17/2016 of his/her left hip pain findings and because the resident was so inconsistent with pain may be the reason staff did not notify the doctor. Staff D said because there was no documented fall and after talking to therapy, and he/she could have gotten him/herself up if he/she fell. Staff D also said the resident may of had a hairline fracture from falls in assisted living, may have fractured further, and osteoarthritis may be a contributing factor. Staff D said he/she was not aware of bruising to the resident's buttocks's as documented by the home health nurse on 3/15/16 and confirmed he/she had not followed on on bruising of unknown origin.</p> <p>Review of the facility's revised change in</p>	S3026		
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S3026	<p>Continued From page 14</p> <p>condition policy dated 1/2015 documented a change in condition was evaluated and documented for residents who exhibited significant deviation in physical or mental status to include a change in a medical condition.</p> <p>Review of the facility's revised abuse, neglect, and exploitation policy dated 6/10/2011 included the failure to provide goods and services, which were reasonably necessary to ensure safety and well being and to avoid physical/mental harm, or illness.</p> <p>The facility failed to ensure this cognitively impaired dependent resident received the necessary licensed health care services in a timely manner following a reported significant change in condition with decreased mobility, pain, and subsequent fracture.</p>	S3026		
S3028 SS=D	<p>26-41-101 (f) (3) Staff Treatment of Residents Reporting</p> <p>(f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met:</p> <p>(A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation.</p> <p>(B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress.</p> <p>(C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator.</p>	S3028		

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S3028	<p>Continued From page 15</p> <p>(D) Appropriate corrective action shall be taken if the alleged violation is verified.</p> <p>(E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report.</p> <p>(F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.</p> <p>This REQUIREMENT is not met as evidenced by: 26-41-101 (f) (3)</p> <p>The facility reported a census of 32 residents. Based on observation, interview, and record review the facility failed to implement the abuse, neglect, and exploitation policy when it failed thoroughly investigate an allegation of abuse for 1 of 3 residents (#3) sampled for accidents.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #3's unsigned physician order sheet dated April 2016 included the following diagnoses: weakness, history of falling, difficulty walking, and dementia (a progressive mental disorder characterized by failed memory and confusion). <p>Review of the Functional Capacity Screen (FCS) dated 2/29/16, 3/31/16, and 5/2/16 documented the resident required physical assistance with dressing, bathing, and walking/mobility. He/she was unable to perform toileting and was occasionally incontinent of urine. The resident required supervised transfers and used an</p>	S3028		

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S3028	<p>Continued From page 16</p> <p>assistive device for mobility. He/she had impaired decision making, impaired vision, had falls/unsteadiness and had a major difference in activities of daily living (ADL) functioning in the mornings and evenings.</p> <p>Review of the Negotiated Service Agreement (NSA) dated 2/29/16 documented the resident admitted with diagnoses of weakness, dementia, and a history of falls. Staff were directed the resident needed physical assistance of one with dressing, bathing, and toileting; used a walker and wheelchair for mobility, and required escort assistance due to memory and physical impairment. The staff were directed to be aware of the resident's environment, functional status, and medical conditions.</p> <p>Review of a nursing progress note dated 4/16/16 at 10:00 A.M. documented the resident yelled in the hallway and staff observed him/her on the floor, on his/her bottom, with his/her back against the wall. Resident stated he/she did not know what happened and then said "maybe someone pushed me". The record lacked a thorough licensed nurse investigation of the fall and lacked follow up of the resident's statement "maybe someone pushed me".</p> <p>During an observation on 5/24/16 at 11:07 A.M. direct care hospice staff S assisted the resident with bathing. The resident held onto the grab bar next to the toilet and sat in his/her wheelchair with cueing and limited assistance from staff S. Staff assisted the resident with putting on his/her eyeglasses. The resident had a dark black moon shaped discoloration under his/her right eye to the inner corner of the right eye. He/she sat in a highback wheelchair, had foot pedals, and both feet were appropriately placed on the pedals. A</p>	S3028		

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S3028	<p>Continued From page 17</p> <p>fall mat laid under the resident's bed.</p> <p>During an observation on 5/24/16 at 11:50 A.M. the resident sat outside the wellness center in his/her wheelchair. The resident was unattended by staff and he/she raised the wheelchair foot pedals and leaned forward. At 12:02 P.M. staff approached the resident and assisted the resident with foot pedal placement and propelled the resident to the commons area.</p> <p>During an observation on 5/24/16 at 1:51 P.M. the resident sat in a recliner next to his/her family's member recliner in the family member's room. His/her eyes were closed. The resident's wheelchair seat had a pummel cushion.</p> <p>During an observation on 5/24/16 at 4:34 P.M. the resident was observed propelling him/herself in a highback wheelchair in the hallway, unattended by staff. Both foot pedals were elevated and the resident leaned forward. At approximately 4:39 P.M. staff D approached the resident and assisted him/her with foot placement.</p> <p>During an interview on 5/24/16 at 11:15 A.M. the resident said he/she got a black eye from losing his/her "balance" and he/she was unsure where or when he/she fell. The resident stated he/she fell several times.</p> <p>During an interview on 5/34/16 at 1:53 P.M. the resident's family member said the resident napped in his/her room every day and he/she was unaware of any falls.</p> <p>During an interview on 5/24/16 at 10:49 A.M. direct care staff O said he/she knew a resident was a fall risk if the resident wore a red bracelet and also stated fall risk was in the care plan.</p>	S3028		

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S3028	<p>Continued From page 18</p> <p>Staff O said the resident was at risk for falls, had falls, and was unaware of the cause of falls. He/she stated the resident used a wheelchair, but tried to toilet him/herself and fell once. Staff O said the resident had so many falls and he/she was unsure of which fall was caused from toileting him/herself. Staff O said fall interventions included checking on the resident every 1-2 hours for toileting so he/she did not attempt to self toilet.</p> <p>During an interview on 5/24/2016 at 3:59 P.M. direct care staff P said he/she noticed if a resident had a mattress on the floor in the room and that meant the resident was a fall risk. Staff P also stated If the resident had a yellow band from the hospital he/she knew they were a fall risk. Staff P said this resident was at risk for falls and the fall interventions were to make sure the resident's bed was lowered, keep his/her wheelchair out of reach when in bed. Staff P said the resident required assistance with toileting and he/she was unsure if the resident had a toileting program.</p> <p>During an interview on 5/24/16 at 4:15 P.M. licensed nursing staff H said if a resident had dementia, or admitted with a history of falls they were considered a fall risk. Staff H said if a resident used a walker, staff observed for stability and went from there. Staff H said this resident was a very high fall risk, had a history of falls, and continued to fall. Staff H said the resident tried to help him/herself and was not oriented so he/she did not know to ask for help. He/she reported fall interventions included, an every one hour toileting schedule, at night his/her door was kept open, and he/she had a special wheelchair cushion to prevent sliding. Staff H said anytime the resident was alone in the hallway he/she was brought to</p>	S3028		

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S3028	<p>Continued From page 19</p> <p>an activity and staff tried to keep the resident out of his/her family's room on the unit. Staff H said the facility did not use bands to identify a resident's fall risk and a stand up meeting was held daily with staff and the aides were informed of fall risks. Staff H said the weekend supervisor or the health and wellness director determined an immediate intervention following a fall and revised the NSA. Staff H said the charge nurse was responsible for completion of incident reports and witness statement at the time of the fall.</p> <p>During an interview on 5/24/16 at 4:39 P.M. administrative nursing staff D said he/she was did not follow up on the resident's statement "maybe someone pushed me". Staff D said he/she expected the resident to know if there were other resident around and to document findings. Staff D said the incident should be investigated and reported if abuse was suspected.</p> <p>Review of the facility's revised Abuse, Neglect, and Exploitation policy dated 6/10/2011 documented and instances or allegations of abuse, neglect, or exploitation were treated seriously and must be reported to the executive director or the supervisor on duty for investigation and appropriate follow up.</p> <p>The facility failed to investigate an allegation of potential abuse made by this resident.</p>	S3028		
S3155 SS=D	<p>26-41-204 (a) Health Care Services</p> <p>. (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health</p>	S3155		

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S3155	<p>Continued From page 20</p> <p>care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.</p> <p>This REQUIREMENT is not met as evidenced by: 26-41-204 (a)</p> <p>The facility reported a census of 32 residents and 3 residents were included in the sample. Based on observation, interview, and record review the facility failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the resident's need for 3 of 3 (#1, #2, #3) resident's sampled for health care services.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #1's signed physician orders dated March 2016 documented a diagnosis of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). <p>Review of a Functional Capacity Screen (FCS) dated 2/1/16 and 3/2/16 documented the resident required physical assist with dressing, bathing, toileting, transfers, and walking/mobility. The resident was frequently incontinent of urine, had falls/unsteadiness, used an assistive device/wheelchair, had impaired decision making, impaired hearing and vision, and a major difference in ADL (activities of daily living) and/or IADL (instrumental activities of daily living) functioning in the mornings and evenings.</p>	S3155		

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S3155	<p>Continued From page 21</p> <p>Review of a Risk Identification Evaluation dated 2/1/16 documented the resident fell when in assistive living within the past 12 months.</p> <p>Review of the Negotiated Services Agreement (NSA) dated 3/2/16 documented the resident had dementia (a progressive mental disorder characterized by failed memory and confusion) and required staff assistance with dressing and grooming and used a walker as needed. The facility identified the resident as a fall risk due to him/her being greater than 65 years. Staff were directed to familiarize the resident to the environment and routine of the community as needed, educate the resident on the use of the emergency call system, consider reducing environmental clutter, and arrange furniture for adequate walkways. Additionally staff were directed to be alert to placement of personal items, encourage adequate lighting in apartment, prompt the resident to use a night light, encourage properly fitting clothing and shoes, use of grab bars in the bathroom, lock wheelchair, proper use of assistive devices as needed, and encourage participation in the "B-Fit" exercise programs. Staff revised the NSA on 3/23/2016 and documented the resident complained of left hip pain, had a nurse practitioner visit, an order for a left hip x-ray and potassium level in the morning. On 3/24/16 the NSA documented x-ray results showed a left hip fracture and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).</p> <p>Review of a home health registered nurse progress note dated 3/15/2016 at 5:25 P.M. documented the nurse visited the resident around 9:00 A.M. and he/she denied pain. The resident had small bruises noted to both buttocks and</p>	S3155		

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S3155	<p>Continued From page 22</p> <p>he/she notified the clinical director. The record lacked documented follow up on bruising of unknown origin.</p> <p>Review of a nursing progress note dated 3/15/16 at 9:00 P.M. documented a CNA (certified nursing assessment) stated the resident complained of pain. The resident denied pain when the nurse went in to talk to her. The record lacked documentation of a completed pain assessment.</p> <p>Review of a physical therapy assistant (PTA) note dated 3/17/16 at 8:22 P.M. documented the PTA discussed with second shift CNA's (certified nursing assistants) on duty and a charge nurse as well as emailed the physical therapy director, health and wellness director, and home health registered nurse that the resident had increased pain in the left hip area upon going from a supine (lying down with face up) to a sitting position and transfers. Upon palpation (touch) of the hip staff discovered many tight muscles and thought the resident may have had cramps due to dehydration, was currently being treated for a urinary tract infection, and was on potassium per the charge nurse. The resident's family was present and the nurse brought Tylenol (a medication to treat pain) to ease the resident's pain. After the resident transferred to the wheelchair to be taken to the bathroom he/she vomited some of the water the nurse had given him/her with the Tylenol. At 8:38 P.M. on 3/17/16 the PTA documented the resident presented with increase fatigue and pain, was very hard to awaken today and when the resident wanted a drink of water he/she was unable to sit up right away due to increased pain in the left hip every time he/she tried to sit up. PTA documented he/she attempted to massage the left hip area for pain relief when the resident was still lying down.</p>	S3155		
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S3155	<p>Continued From page 23</p> <p>PTA documented he/she suspected muscle cramps due to increased fatigue and dehydration from not drinking enough water, which he/she suspected was the problem with his/her hip pain.</p> <p>Review of nursing progress notes lacked a licensed nurse assessment on 3/17/2016 related to pain as reported by the PTA.</p> <p>Review of a nursing note on 3/21/16 at 10:00 P.M. documented a CNA (certified nursing assistant) notified the nurse the resident complained of pain. When the nurse went in to see the resident he/she had no pain. The record lacked documentation of a completed pain assessment.</p> <p>Review of a practitioner progress note dated 3/23/16 documented resident was seen today for follow up on a urinary tract infection, hypokalemia (low blood potassium), and a new report of left hip pain. Nursing reported he/she had not fallen or had any known injury, but began to complain of left hip pain 2 days ago. Physical examination elicited pain with left range of motion. No joint swelling, redness, or warmth. Alert and oriented to person only. An x-ray was ordered to rule out fracture or dislocation and Tylenol (a medication to treat pain) was available for pain.</p> <p>Review of a nursing progress note dated 3/24/16 at 1:00 P.M. documented x-ray results showed a left hip fracture. Staff notified the nurse practitioner who gave orders to send the resident to the emergency room for treatment. Family notified and said okay. Health and Wellness Director also notified. An ambulance was called and the resident was sent to the hospital for treatment.</p>	S3155		

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S3155	<p>Continued From page 24</p> <p>Review of a left hip and unilateral pelvis x-ray dated 3/24/16 documented an acute left femoral neck fracture (broken thigh bone). Moderate Kellgren and Lawrence grade 3 (a method used to classify the severity of osteoarthritis) osteoarthritis involving the hip.</p> <p>Review of a nursing progress note dated 3/25/16 at 10:30 A.M. documented staff called the hospital and spoke with the resident's nurse who reported the resident had surgery this morning and was doing well.</p> <p>During a telephone interview on 5/24/16 at 8:50 A.M. a family member of the resident said he/she was with the resident on 3/17/16, knew the resident had hip pain, and asked the facility to follow up. The following day another family member requested the facility to obtain an x-ray, which he/she said the facility did not do. The family member said 6 days later the facility phoned and informed him/her the resident had a hip fracture and needed surgery. A family member reported while in the hospital the resident reported he/she got up by him/herself, fell in the bathroom, and yelled for help.</p> <p>During an interview on 5/24/16 at 10:49 A.M. direct care staff O said if a resident complained of pain or looked like they were in pain he/she told the nurse. Staff O recalled the resident and said he/she was not at risk for falls and had no falls. Staff O said 2-3 days before the resident left for the hospital he/she complained of pain when staff moved him/her, was less alert, and was not able to stand upright. Staff O said the resident did not normally complain of pain and was usually able to stand without difficulty. Staff O said the day he/she knew the resident had pain he/she told a certified medication aide because the nurse had</p>	S3155		

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S3155	<p>Continued From page 25</p> <p>not arrived yet. Staff O said the nurse usually arrived around 8:00 A.M.</p> <p>During an interview on 5/24/2016 at 3:59 P.M. direct care staff P said if he/she noticed a mattress on the floor when in the room then that meant the resident was a fall risk. Staff P also stated if the resident had a yellow band from the hospital he/she knew they were a fall risk. He/she did not recall the resident and said if a resident had a change in condition he/she immediately told the nurse.</p> <p>During an interview on 5/24/16 at 4:08 P.M. direct care staff Q said he/she worked with the resident prior to his/her discharge. Staff Q said the resident needed one staff assist with ADL's and he/she could stand up by him/herself with cueing from staff. Staff Q said 2-3 days prior to discharge the resident was not able to pull him/herself up, could not stand, and required 2 person assist. Staff Q said prior to discharge the resident complained of pain to his/her hip area, he/she told the nurse, and then the nurse would ask the resident and he/she said no. Staff Q said prior to this incident the resident did not complain of pain regularly. Staff Q said the resident's pain occurred when staff moved him/her, but when the resident laid still he/she was not in pain. Staff Q said he/she was not aware of the resident having any falls.</p> <p>During an interview on 5/24/16 at 4:23 P.M. licensed nursing staff H said he/she admitted the resident from assisted living, had a history of falls, and the resident's family members reported the resident tried to do things for him/herself and needed to be supervised with ADL cares. Staff H said the resident required one person assist with ADL's when admitted and when discharged</p>	S3155		

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S3155	<p>Continued From page 26</p> <p>he/she had a change in condition. Staff H said 2 days prior to discharge he/she complained of right hip pain and on the day of discharge he/she went into the room and the resident could not even move. An x-ray was done the day prior which showed he/she had a fracture so the resident was sent out. Staff H said the resident's family member kept saying the resident was in pain, but when asked he/she denied pain. Staff H said the CNA's reported to him/her the resident had pain and once he/she gave the resident Tylenol. Staff H said the resident was a complicated cause because he/she complained of pain when the aides got him/her out of bed, but would deny pain to the nurse. Stated, "it's tricky because you don't know if [he/she] was really in pain". Staff H said staff first informed him/her of the resident's pain on 3/17/16, then on 3/18/16, and then on 3/22/16 and he/she notified the nurse practitioner. Staff H said the resident had no known falls, which would explain the fracture and the resident would not be able to get him/herself off the floor if he/she fell.</p> <p>During an interview on 5/24/2016 at 5:54 P.M. administrative nursing staff D said the resident had a history of falls and no falls since admission to assisted living memory care. Staff D said a PTA notified him/her in an email of the resident's complaints of pain and believed he/she may have assessed the resident, but did not document his/her findings and did not recall a date. Staff D said he/she expected the PTA to notify the physician on 3/17/2016 of his/her left hip pain findings and because the resident was so inconsistent with pain may be the reason staff did not notify the doctor. Staff D said because there was no documented fall and after talking to therapy, and he/she could have gotten him/herself up if he/she fell. Staff D also said the</p>	S3155		
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S3155	<p>Continued From page 27</p> <p>resident may of had a hairline fracture from falls in assisted living, may have fractured further, and osteoarthritis may be a contributing factor. Staff D said he/she was not aware of bruising to the resident's buttocks's as documented by the home health nurse on 3/15/16 and confirmed he/she had not followed on on bruising of unknown origin.</p> <p>During a telephone interview on 5/26/2016 at 11:17 A.M. administrative nursing staff D reported he/she recalled an email received from the resident's home health nurse on 3/15/2016, which informed him/her of 3 small bruises on the resident's left buttock and one bruise on the right buttock. Staff D said because the message included other information he/she overlooked the bruising and confirmed he/she did not assess or investigation the injury of unknown origin.</p> <p>Review of the facility's revised change in condition policy dated 1/2015 documented a change in condition was evaluated and documented for residents who exhibited significant deviation in physical or mental status to include a change in a medical condition.</p> <p>Review of the facility's revised abuse, neglect, and exploitation policy dated 6/10/2011 included the facility provided goods and services which were reasonably necessary to ensure safety and well being and to avoid physical/mental harm, or illness.</p> <p>The facility failed to ensure this cognitively impaired dependent resident received the necessary licensed health care services in a timely manner following a reported significant change in condition with decreased mobility, pain, and subsequent fracture as well as failed to</p>	S3155		
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S3155	<p>Continued From page 28</p> <p>thoroughly assess and investigate reported bruising of unknown origin.</p> <p>- Review of resident #2's signed physician order sheet dated 5/2/2016 documented the following diagnoses: psychotic disorder (a major mental disorder characterized by a gross impairment in reality testing).</p> <p>Review of the Functional Capacity Screen (FCS) dated 1/27/16 documented the resident required physical assistance with bathing, eating, dressing, and toileting, independent with mobility and transfers, and was incontinent of bladder. The resident had falls, unsteadiness, impaired vision and hearing, and had a major difference in activities in daily living in the mornings and evenings.</p> <p>Review of the Negotiated Service Agreement (NSA) dated 1/27/16 documented the family requested the facility not send the resident to the emergency room unless necessary and in the event it was necessary the family preferred to take him/her if available. The resident ambulated with his/her feet pointed outward and he/she had a shuffled gait, which increased his/her fall risk. The care plan directed staff to encourage and guide the resident to sit and rest periodically throughout the day and everyone was aware the resident did not sit for long periods and usually had a rest period of less than 5 minutes. Staff were also directed to encourage the resident to lay down for a nap when observed sleeping, offer early morning get up times, encourage the resident to sit in a larger/deeper chair when in the community for positioning, and the resident's bed was positioned against the wall per family request. The resident was cognitively impaired, not able to use a call light, and the facility offered</p>	S3155		

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S3155	<p>Continued From page 29</p> <p>a pendant, which the family declined. The care plan was revised on the following dates with the following interventions:</p> <p>On 2/7/16 staff were directed to encourage resident/staff to walk at a slower pace with the resident as the resident was jogging.</p> <p>On 4/7/16 the hospice case manager visited and completed a medication review with medication changes.</p> <p>On 4/14/16 the facility documented a decline in the resident's fine motor skills. The facility spoke with a family member who reported he/she believed the resident forgot how to walk.</p> <p>On 5/6/16 the resident fell, hit his/her head, had a laceration (a deep cut or tear in the skin or flesh), went to the emergency room, and received 8 staples to the mid side of his/her head. The hospice nurse visited the resident when he/she returned and facility met with a family member and suggested a soft hat/helmet for added protection of the head, which spouse declined. The resident's staples were removed on 5/16/16.</p> <p>On 5/20/16 hospice provided a rolling shower chair and a wheelchair for unsteady mobility and increased weakness.</p> <p>Review of a nursing progress note dated 1/21/2016 at 5:05 A.M. documented staff called to the 500 Hall and the resident had fallen. Staff observed the resident seated on the floor, leaned to the left, with no injury. Staff lifted him/her to a standing positioning. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls.</p> <p>Review of a nursing progress note dated 2/20/16 at 4:15 P.M. documented a CMA (certified medication aide) observed the resident on his/her knees on the floor. Staff assessed the</p>	S3155		
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S3155	<p>Continued From page 30</p> <p>resident for injuries. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls.</p> <p>Review of a nursing progress note dated 4/7/16 at 4:22 P.M. documented a housekeeper went to the wellness office to report the resident was on the floor. When the nurse arrived the resident sat on the floor in front of the public bathroom door and a CNA (certified nursing assistant) stood in front of the resident. The resident was alert and oriented to self and confused. Two staff assisted the resident to a standing positioning. A hospice case manager reviewed the resident's medications and made medication changes. The record lacked a thorough licensed nurse investigation of the fall.</p> <p>Review of a nursing progress note dated 4/24/16 at 9:00 A.M. documented staff observed the resident on the floor in front of another resident's door and the CNA could not get out of the resident's room due to the resident fell in front of the door. No injury and staff assisted him/her up and onto the couch in the common area. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls.</p> <p>Review of a nursing progress note dated 5/6/16 at 11:00 A.M. documented at approximately 4:30 A.M. staff checked on the resident and observed the resident on the floor near his/her dresser drawers. The resident was positioned on his/her side near the corner edge of the dresser and bled from the left side of his/her head. Staff reported the resident was last checked at 2:00 A.M. and he/she slept. The resident was transported to the hospital via emergency medical services. The</p>	S3155		

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S3155	<p>Continued From page 31</p> <p>resident returned to the facility within a few hours and received 8 stapes to a laceration on the mid left side of his/her head. Staff suggested a soft hat or helmet to the family for additional protection and family refuses, stating "I don't think [he/she] would want that". The record lacked a thorough licensed nurse investigation of the fall and an immediate new intervention to prevent further falls.</p> <p>Review of a nursing progress note dated 5/20/16 at 9:30 A.M. documented staff observed the resident on the floor in the 500 common area, laid on his/her left side, just in front of the couch he had sat on. Direct care staff reported he/she assisted the resident to the couch approximately 20 minutes prior to the fall and the hospice aide reported he/she observed the resident seated in an upright position on the couch approximately 5 minutes before he/she fell. The immediate intervention was for hospice to provide the resident a wheelchair for unsteady mobility/increased weakness and a rolling shower chair. The record lacked a thorough licensed nurse investigation of the fall.</p> <p>During an observation on 5/24/16 at 11:15 A.M. the resident sat in his/her wheelchair in the dining room. The wheelchair foot rests were in place and the resident had his/her right leg positioned behind the foot rest on the carpet. Staff assisted the resident with foot placement at 11:21 A.M. and at 11:22 A.M. the resident removed his/her right foot from the foot rest and positioned his/her right foot behind the foot rest on the carpet. A baking activity occurred in the dining area and the resident showed no interest.</p> <p>During an observation on 5/24/16 at 1:24 P.M. direct care staff R assisted the resident with</p>	S3155		

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S3155	<p>Continued From page 32</p> <p>toileting. Staff R applied a gait belt (belt used for balance) and cued the resident to use the grab bar to stand. Staff R assisted the resident with clothing management and cued the resident to sit down as the resident attempted to stand. The resident wore hip protectors, had a rolling shower in his/her shower, bed positioned against the wall, and a scar to the left side of his/her head.</p> <p>During an observation on 5/24/16 at 4:09 P.M. the resident sat in his/her wheelchair in the dining area with wheelchair foot rest placed and both feet behind the foot rests on the carpet. A music activity occurred in the dining area and the resident showed no interest. The resident kept his/her head down and eyes open.</p> <p>Attempted to interview the resident on 5/24/16 at 1:22 P.M. and the resident made no eye contact and did not respond to interaction.</p> <p>During an interview on 5/24/16 at 10:49 A.M. direct care staff O said he/she knew a resident was a fall risk if the resident wore a red bracelet and also stated fall risk was in the care plan. He/she said the resident was at risk for falls and used a wheelchair to prevent falls. Staff O said the resident walked in his/her sleep, had fallen, was not sure of the cause of the fall, but knew a fall occurred in his/her room.</p> <p>During an interview on 5/24/16 at 1:25 P.M. direct care staff R said the resident used a wheelchair due to falls and adjusted well to the wheelchair. Staff R said current interventions to prevent falls included; wheelchair use, toileted between meals, wore hipsters, and frequent visual observations due he/she attempted to transfer him/herself. Staff R said the resident made no attempts to self transfer since he/she had the wheelchair. Staff R</p>	S3155		

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S3155	<p>Continued From page 33</p> <p>said he/she reviewed the care plan or asked the nurse if he/she had questions regarding fall risk or fall interventions.</p> <p>During an interview on 5/24/2016 at 3:59 P.M. direct care staff P said if a resident had a mattress on the floor he/she noticed when in the room and that meant the resident was a fall risk. Staff P also stated if the resident had a yellow band from the hospital he/she knew they were a fall risk. Staff P said this resident was at risk for falls and the fall interventions were the same as other residents which were bed in a low position.</p> <p>During an interview on 5/24/16 at 4:15 P.M. licensed nursing staff H said if a resident had dementia, or admitted with a history of falls they were considered a fall risk. Staff H said if a resident used a walker, staff observed for stability and went from there. Staff H said this resident was a high fall risk, had a history of falls, and continued to fall. He/she reported fall interventions included, use of a wheelchair and staff were to make sure the resident stayed busy. Staff H said the resident continued to walk at times and walked in his/her sleep, which caused many of his/her falls.</p> <p>During an interview on 5/24/16 at 4:39 P.M. administrative nursing staff D said staff were aware of a resident's fall risk based on the way they walked, if they used a walker/assistive device, medications the resident took, dementia, and the results of a risk identification form completed on admission. Staff D said direct care staff had assignment sheets and falls were discussed during daily meetings. He/she said interventions were determined immediately unless a resident fell on a weekend and it would then take longer to implement an intervention.</p>	S3155		

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S3155	<p>Continued From page 34</p> <p>Staff D said the weekend supervisor was facility wide and could review and implement an immediate intervention following a fall, but felt he/she knew the residents better and did his/her own interventions when he/she returned on Mondays following a weekend fall. Staff D said he/she expected the charge nurse to document all falls thoroughly, make needed family and physician notifications, and document immediate interventions in the medical record. Staff D confirmed the 6 falls reviewed lacked a thorough licensed nurse investigation and 4 of the 6 falls lacked an immediate intervention to prevent further falls. Staff D said the use of a helmet to protect the resident's head if he/she fell again was offered and declined by the family on 1/29/16.</p> <p>During a telephone interview on 5/26/16 at 11:17 A.M. . administrative nursing staff D confirmed he/she had no fall investigations on this resident to provide for review.</p> <p>Review of the facility's revised Fall Management Policy dated 3/2016 documented a post fall investigation was completed after a resident fall and individualized interventions were included in his/her service plan and staff documented the resident's fall/injuries, resident responses, and interventions taken in the medical record.</p> <p>The facility failed to ensure a licensed nurse thoroughly assessed and investigated 6 falls to include one with injury for this cognitively impaired, dependent resident with a known history of falls.</p> <p>- Review of resident #3's unsigned physician order sheet dated April 2016 included the following diagnoses: weakness, history of falling,</p>	S3155		

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S3155	<p>Continued From page 35</p> <p>difficulty walking, and dementia (a progressive mental disorder characterized by failed memory and confusion).</p> <p>Review of the Functional Capacity Screen (FCS) dated 2/29/16, 3/31/16, and 5/2/16 documented the resident required physical assistance with dressing, bathing, and walking/mobility. He/she was unable to perform toileting and was occasionally incontinent of urine. The resident required supervised transfers and used an assistive device for mobility. He/she had impaired decision making, impaired vision, had falls/unsteadiness and had a major difference in activities of daily living (ADL) functioning in the mornings and evenings.</p> <p>Review of the Negotiated Service Agreement (NSA) dated 2/29/16 documented the resident admitted with diagnoses of weakness, dementia, and a history of falls. Staff were directed the resident needed physical assistance of one with dressing, bathing, and toileting; used a walker and wheelchair for mobility, and required escort assistance due to memory and physical impairment. The staff were directed to be aware of the resident's environment, functional status, and medical conditions. Interventions included consideration for further evaluation by physician, labs, medication reviews, physical and/or occupational consults, and program participation encouragement as a means to increase observations. The NSA documented the resident required staff assistance getting from one place to another and was not able to recognize the need to be at one specific place, at a specific time, for a specific reason. The resident propelled with his/her feet throughout the community as his/her main mode of transportation using his/her wheelchair. The</p>	S3155		

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S3155	<p>Continued From page 36</p> <p>resident had a walker he/she used at times with staff assistance.</p> <p>Revisions to the NSA included the following: On 4/2/16- encourage the resident to always use his/her assistive devices. Therapy to work with him/her on wheelchair safety. On 4/6/16- a room alert placed to the resident's right ankle to prevent him/her from tampering with it. On 4/12/16- nurse practitioner visited and made medication changes related to recent falls. On 4/14/16- obtain a urinalysis with culture and sensitivity related to recent falls. On On 4/16/16- Melatonin (a medication to aide with sleep) was changed from as needed to scheduled at bedtime. An X-ray of the right forearm and right elbow were obtained due to swelling and the results were negative. On 4/17/16- obtain blood pressures every shift for 2 days related to recent falls and low blood pressure. On 4/18/16- obtained new orders for labs, ice pack to elbow, tubigrips, Lasix (a medication to pull excess fluid from the body) for 3 days, Naproxen (medication used to treat pain and inflammation) and an antibiotic for bursitis (inflammation with fluid build up) times 7 days. A meeting was scheduled with the family regarding condition and falls. On 4/18/16 the NSA documented the urinalysis results were negative. On 4/21/16- hospice evaluation and treatment if appropriate due to increased falls and condition. On 4/23/16- admitted to hospice services. On 5/2/16- staff to assist the resident frequently and at least once during the night to the bathroom and very often each shift in an attempt to decrease the behavior of him/her urinating in appropriate places. The NSA recorded despite frequent bathroom assistance and attempted</p>	S3155		

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S3155	<p>Continued From page 37</p> <p>bladder retraining for several weeks the resident continued to urinate in the room, hallways, other rooms, and any corner he/she found. The resident recently started on a medication for overactive bladder and interventions included; physical assistance to dining/activities, staff to be alerted to heightened fall risk, use of a walker and wheelchair, and he/she was on an exercise program.</p> <p>An undated intervention included the use of a pommel wedge (a special cushion designed to stabilize seated posture and promote proper positioning) provided by hospice for prevention/positioning.</p> <p>The NSA lacked a revision for a physician ordered fall mat on 4/23/16.</p> <p>Review of nursing progress note dated 3/2/16 timed 10:00 P.M. documented at around 5:00 P.M. the nurse was called to the hearth room and found the resident laying against the floor next to the wheelchair. Staff said the resident tried to walk and were unable to get to him/her before he/she fell. On this date at 7:30 P.M. an activity staff notified the resident had fallen again while trying to walk while watching videos in the hearth room. The record lacked a thorough licensed nurse investigation of both falls and immediate care plan revisions to prevent further falls.</p> <p>Review of a nursing progress note dated 3/5/16 at 3:00 AM documented staff were called to assess the resident found on the floor by the bedside. The resident reported he/she fell while attempting to ambulate. The resident had an abrasion to the right upper (above) eyebrow with small lacerations next to the abrasion and a small laceration on the nasal bridge. Staff assisted the resident back to bed. The immediate intervention</p>	S3155		

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S3155	<p>Continued From page 38</p> <p>directed staff to encourage the resident to call for assist when needed. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls.</p> <p>Review of an undated nursing progress note documented around 3:00 A.M. staff observed the resident on the floor by his/her bedside. When staff asked the resident what happened the resident said he/she was putting on his/her shoes, seated at the bed, lost his/her balance, and fell. The resident had carpet scrapes to the nose bridge and forehead. When asked what happened the resident said he/she wanted to go to the bathroom. The resident had one shoe on. Documentation provided by the facility on 5/26/16 at 10:14 A.M. recorded a late entry dated 5/26/16 identified the undated progress note occurred on 3/27/16 at 3:00 A.M. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls.</p> <p>Review of a nursing progress note dated 4/2/16 at 11:00 A.M. documented staff observed the resident on the floor in the hallway leaned against the wall. The resident could not state what he/she tried to do. Staff assisted the resident up to a wheelchair and to an activity. The immediate intervention was for therapy to work with the resident on wheelchair safety. The record lacked a thorough licensed nurse investigation and implementation of the immediate care plan revision to prevent further falls.</p> <p>Review of a nursing progress note dated 4/9/16 at 4:30 A.M. documented staff observed the resident on the floor at bedside. The resident stated he/she slid out of bed to the floor. No</p>	S3155		

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S3155	<p>Continued From page 39</p> <p>injury. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls.</p> <p>Review of a nursing progress note dated 4/12/16 at 11:00 A.M. documented maintenance staff observed the resident in another resident's shower room on the floor. The resident got him/herself up by the time staff went and checked on him/her, found the resident naked and sat on the shower chair. Immediate intervention was a nurse practitioner visit and medication changes. The record lacked a thorough licensed nurse investigation of the fall.</p> <p>Review of a nursing progress note dated 4/14/16 at 12:20 A.M. documented a certified medication aide (CMA) notified the nurse the resident was on the floor against the wall in the hallway. When staff asked the resident what happened he/she said "I like sitting down here". No injury and 2 staff assisted the resident to the wheelchair. Immediate intervention was to obtain a urinalysis. The record lacked a thorough licensed nurse investigation of the fall.</p> <p>Review of a nursing progress note dated 4/16/16 at 10:00 A.M. documented the resident yelled in the hallway and staff observed him/her on the floor, on his/her bottom, with his/her back against the wall. Resident stated he/she did not know what happened and in "maybe someone pushed me". No apparent injury. At 1:00 P.M. this date staff observed swelling to the resident's right arm from his/her elbow down. Tenderness to the site and an X-ray was ordered. On this date at 6:00 P.M. the resident appeared fatigued and fell asleep throughout the day in his/her wheelchair. The previous shift reported the resident had not slept much. The immediate intervention was to</p>	S3155		

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S3155	<p>Continued From page 40</p> <p>change the resident's Melatonin for as needed to every bedtime for insomnia. The record lacked a thorough licensed nurse investigation of the fall and lacked follow up of the resident's statement "maybe someone pushed me".</p> <p>Review of a nursing progress note dated 4/19/16 at 4:50 A.M. documented staff observed the resident on the floor in the common area with no injury. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls.</p> <p>An undated nursing progress note documented dietary staff notified the nurse the resident was on the floor. The resident had clothes on the floor and tried to change. Staff had just toileted the resident. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls. Documentation provided by the facility on 5/26/16 at 10:14 A.M. recorded a late entry dated 5/26/16 identified the undated progress note occurred on 4/19/16 at 12:30 P.M. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls.</p> <p>Review of a nursing progress note dated 4/25/16 at 3:00 P.M. documented staff called to the 600 common area outside the dining room and found the resident sat on the floor next to the wheelchair. Staff were unable to make sense out of what the resident tried to say. Continued on antibiotic for cellulitis (a bacterial infection which involved the inner layers of the skin). The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls.</p> <p>Review of a nursing note dated 4/26/16 at 2:18</p>	S3155		

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S3155	<p>Continued From page 41</p> <p>A.M. documented the resident fell in the doorway to his/her room. The resident could not tell what happened when asked. No injury noted. Staff assisted the resident to a wheelchair and back to the room. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls.</p> <p>Review of a nursing progress note dated 5/4/16 at 3:35 P.M. documented staff found the resident on the floor in another resident's room. No injury. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls.</p> <p>Review of a nursing progress note dated 5/16/16 at 9:30 A.M. documented staff observed the resident on the floor in a seated position leaned against the bed. The resident could not remember what happened. The resident was assessed, taken to the bathroom, and then dining room for breakfast. The record lacked a thorough licensed nurse investigation and immediate care plan revision to prevent further falls.</p> <p>Review of a undated and unsigned post fall investigation provided via email by administrative nursing staff D on 5/26/16 documented the resident fell in his/her apartment at bedside on 5/16/16 at 8:30 A.M. The investigation documented vital signs and failed to address other areas listed on the form to include risk factors, date of last fall, interventions, compliance with safety interventions, change in medical/cognitive status, change in medications, change in ability to ambulate, and gait disturbance or decreased mobility. The facility provided a 15 minute resident check form dated 5/16/16 which recorded initials on 9:00 A.M., 9:15</p>	S3155		

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S3155	<p>Continued From page 42</p> <p>A.M., 10:00 A.M., 11:00 A.M., 12:00 P.M., 1:00 P.M., 2:00 P.M., and 3:00 P.M. The NSA lacked an intervention for resident checks.</p> <p>During an observation on 5/24/16 at 11:07 A.M. direct care hospice staff S assisted the resident with bathing. The resident held onto the grab bar next to the toilet and sat in his/her wheelchair with cueing and limited assistance from staff S. Staff assisted the resident with putting on his/her eyeglasses. The resident had a dark black moon shaped discoloration under his/her right eye to the inner corner of the right eye. He/she sat in a highback wheelchair, had foot pedals, and both feet were appropriately placed on the pedals. A fall mat laid under the resident's bed.</p> <p>During an observation on 5/24/16 at 11:50 A.M. the resident sat outside the wellness center in his/her wheelchair. The resident was unattended by staff and he/she raised the wheelchair foot pedals and leaned forward. At 12:02 P.M. staff approached the resident and assisted the resident with foot pedal placement and propelled the resident to the commons area.</p> <p>During an observation on 5/24/16 at 1:51 P.M. the resident sat in a recliner next to his/her family's member recliner in the family member's room. His/her eyes were closed. The resident's wheelchair seat had a pummel cushion.</p> <p>During an observation on 5/24/16 at 4:34 P.M. the resident was observed propelling him/herself in a highback wheelchair in the hallway, unattended by staff. Both foot pedals were elevated and the resident leaned forward. At approximately 4:39 P.M. staff D approached the resident and assisted him/her with foot placement.</p>	S3155		

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S3155	<p>Continued From page 43</p> <p>During an interview on 5/24/16 at 11:15 A.M. the resident said he/she got a black eye from losing his/her "balance" and he/she was unsure where or when he/she fell. The resident stated he/she fell several times.</p> <p>During an interview on 5/34/16 at 1:53 P.M. the resident's family member said the resident napped in his/her room every day and he/she was unaware of any falls.</p> <p>During an interview on 5/24/16 at 10:49 A.M. direct care staff O said he/she knew a resident was a fall risk if the resident wore a red bracelet and also stated fall risk was in the care plan. Staff O said the resident was at risk for falls, had falls, and was unaware of the cause of falls. He/she stated the resident used a wheelchair, but tried to toilet him/herself and fell once. Staff O said the resident had so many falls and he/she was unsure of which fall was caused from toileting him/herself. Staff O said fall interventions included checking on the resident every 1-2 hours for toileting so he/she did not attempt to self toilet.</p> <p>During an interview on 5/24/2016 at 3:59 P.M. direct care staff P said if a resident had a mattress on the floor he/she noticed when in the room and that meant the resident was a fall risk. Staff P also stated If the resident had a yellow band from the hospital he/she knew they were a fall risk. Staff P said this resident was at risk for falls and the fall interventions were to make sure the resident's bed was lowered, keep his/her wheelchair out of reach when in bed. Staff P said the resident required assistance with toileting and he/she was unsure if the resident had a toileting program.</p>	S3155		

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S3155	<p>Continued From page 44</p> <p>During an interview on 5/24/16 at 4:15 P.M. licensed nursing staff H said if a resident had dementia, or admitted with a history of falls they were considered a fall risk. Staff H said if a resident used a walker, staff observed for stability and went from there. Staff H said this resident was a very high fall risk, had a history of falls, and continued to fall. Staff H said the resident tried to help him/herself and was not oriented so he/she did not know to ask for help. He/she reported fall interventions included, an every one hour toileting schedule, at night his/her door was kept open, and he/she had a special wheelchair cushion to prevent sliding. Staff H said anytime the resident was alone in the hallway he/she was brought to an activity and staff tried to keep the resident out of his/her family's room on the unit. Staff H said the facility did not use bands to identify a resident's fall risk and a stand up meeting was held daily with staff and the aides were informed of fall risks. Staff H said the weekend supervisor or the health and wellness director determined an immediate intervention following a fall and revised the NSA. Staff H said the charge nurse was responsible for completion of incident reports and witness statement at the time of the fall.</p> <p>During an interview on 5/24/16 at 3:36 P.M. therapy staff F said the resident was seen by therapy on 4/4/16 and he/she required cues to lock his/her wheelchair brakes. Staff F said the therapy record lacked documented wheelchair safety on 4/2/16 and the resident discharged from therapy on 4/22/16. Staff F said wheelchair safety was not addressed at discharge because wheelchair safety was not a goal.</p> <p>During an interview on 5/24/16 at 4:39 P.M. administrative nursing staff D said staff were aware of a resident's fall risk based on the way</p>	S3155		

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S3155	<p>Continued From page 45</p> <p>they walked, if they used a walker/assistive device, medications the resident took, dementia, and the results of a risk identification form completed on admission. Staff D said direct care staff had assignment sheets and falls were discussed during daily meetings. He/she said interventions were determined immediately unless a resident fell on a weekend and it would then take longer to implement an intervention. Staff D said the weekend supervisor was facility wide and could review and implement an immediate intervention following a fall, but felt he/she knew the residents better and did his/her own interventions when he/she returned on Mondays following a weekend fall. Staff D said he/she expected the charge nurse to document all falls thoroughly and document immediate interventions in the medical record. Staff D stated he/she believed many of the resident's falls occurred due to toileting and the facility directed staff on 5/2/16 to offer toileting more frequently. Staff D said toileting programs are not individualized and the facility does what is workable. Confirmed the resident had no bladder assessment to determine urinary pattern. Staff D confirmed 15 of the 15 falls reviewed lacked a thorough licensed nurse investigation, 11 of the 15 falls lacked an immediate revision to the NSA, and 1 immediate intervention to provide wheelchair safety to the resident was care planned and not implemented.</p> <p>During a telephone interview on 5/26/16 at 11:17 A.M. staff D confirmed the post fall investigation for fall on 5/16/16 was the only investigation he/she had to provide for review.</p> <p>Review of the facility's revised Fall Management Policy dated 3/2016 documented a post fall investigation was completed after a resident fall</p>	S3155		

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S3155	<p>Continued From page 46</p> <p>and individualized interventions were included in his/her service plan and staff documented the resident's fall/injuries, resident responses, and interventions taken in the medical record.</p> <p>The facility failed to ensure a licensed nurse thoroughly assessed and investigated 15 falls for this cognitively impaired, dependent resident with a known history of falls.</p>	S3155		