

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

PRINTED: 07/08/2013  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/21/2013
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NAME OF PROVIDER OR SUPPLIER  TWIN RIVERS NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301
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F 000	INITIAL COMMENTS  An abbreviated survey (#KY #20272) was conducted on 06/18/13 through 06/21/13 to determine the facility's compliance with Federal regulations. KY #20272 was substantiated with deficiencies cited at a scope and severity of a "G".	F 000	Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator, or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of receipt of the statement of deficiencies as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review it was determined the facility failed to ensure care was provided in accordance with the resident plan of care for one (1) of three sampled residents (Resident #1). The facility assessed and care planned Resident #1 as requiring the assistance of two (2) staff for bed mobility and incontinent care. On 06/01/13 at 2:30 AM, one Certified Nursing Assistant (CNA #1) initiated care by removing a foot bolster from the resident's feet and a positioning wedge from behind Resident #1's back. The CNA turned her back on Resident #1 to obtain a brief and the resident rolled off the bed onto the floor. Resident #1 was transported to the hospital for further evaluation and was diagnosed with a fracture of the right femur shaft which required surgery.	F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shelly Moffa TITLE: NHA (X6) DATE: 7/15/13

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 282	<p>Continued From page 1</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Comprehensive Care Plans", last revised 10/2010, revealed each resident's comprehensive care plan was designed to incorporate identified problem areas; incorporate risk factors associated with identified problems; build on resident's strengths; aid in preventing or reducing declines in the resident's functional status and/or functional level; and reflect currently recognized standards of practice for problem areas and conditions. The Care Plan interventions were designed after careful consideration of the relationship between the resident's problem area and their causes.</p> <p>Record review revealed the facility admitted Resident #1 on 10/05/06 with diagnoses which included Anxiety Disorder, Mental Retardation, Schizophrenia, Alzheimer's Disease, Bipolar Disorder, Tremors and Convulsions. Review of the Minimum Data Set (MDS) assessment, dated 05/09/13, revealed the facility assessed Resident #1's cognition as severely impaired and the resident required the extensive assistance of two (2) staff for bed mobility and toilet use.</p> <p>Review of the Comprehensive Care Plan, last revised 05/09/13, revealed two (2) staff should assist Resident #1 with bed mobility. Review of the Activities of Daily Living (ADL) Plan of Care Skilled Sheet, dated 06/18/13, revealed Resident #1 was totally dependent on two staff for positioning and for incontinent care. Interview with MDS Coordinator, on 06/20/13 at 2:30 PM, revealed Resident #1 was assessed and care planned for total assist of two (2) staff for all of</p>	F 282	<p>F282</p> <p>1. On 06/24/2013, the Director of Nursing and Unit Manager reviewed Resident #1's plan of care to ensure that it is appropriate, meets the needs of the resident and to ensure that care is being provided in accordance with the resident's plan of care. No concerns were identified, activities of daily living were being provided as care planned.</p> <p>2. On 07/11/2013, the Director of Nursing and Nursing managers completed an audit of all current resident care plans to ensure they are appropriate, meet the needs of the resident, and that care is provided in accordance with the plan of care. Any identified concerns were immediately corrected.</p> <p>3. On 07/11/13, the Director of Education and Training and/or Nurse Mangers complete re-educated of all licensed nurses and certified nursing assistants on the requirement that care must be provided in accordance with the plan of care and that care can not be initiated until the appropriate level of staff is present in accordance with the plan of care. No licensed nurse or certified nursing assistant will work past 07/11/13 without receiving this education.</p>		

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F 282	<p>Continued From page 2 his/her Activity's of Daily living.</p> <p>Review of the Nurse's Note, dated 06/01/13 at 2:30 AM, revealed the Certified Nurse Assistant (CNA#1) entered Resident #1's room to provide incontinent care. The CNA removed the foot bolster and positioning wedge from the resident. Continued review revealed the CNA went to the closet to get a brief for the resident, and the resident was shaking his/her arms and legs in bed. The CNA heard a thud, turned around and saw the resident lying on the right side of the bed on the floor. The CNA yelled for assistance to lift the resident from the floor to the bed. The resident was assessed by Licensed Practical Nurse (LPN) #1, who identified a two (2) centimeter (cm) abrasion to the resident's left thigh. The resident's right upper leg was swollen with deformity noted to the right femur. Further review revealed the physician was notified at 2:45 AM and an order was received to send the resident to the emergency room for evaluation. The resident was transferred to the emergency room per ambulance at 3:10 AM. At 7:30 AM, the facility called the emergency room and received information the resident was being admitted with a fracture to the right femur.</p> <p>An interview with CNA#1, on 06/19/13 at 10:15 AM and 3:30 PM, revealed she entered Resident #1's room to provide routine check and change care for Resident #1. She stated CNA #2 was answering a call light and was coming to assist her with Resident #1. CNA #1 revealed she removed the foot bolsters from the resident's feet and the positioning wedge from behind the resident's back to prepare the resident for incontinent care. When she removed the wedge,</p>	F 282	<p>4. The Director of Nursing and/or Nurse Manager will perform observations and care plan reviews of care being provided on five (5) residents per shift daily five (5) times per week for one (1) week, followed by five (5) times per week on random shifts for four (4) weeks and then weekly for seven (7) weeks to ensure that care is provided in accordance with the resident plan of care and care plan interventions are being followed. The results of the audits will be reviewed with the Quality Assurance Committee, at a minimum, monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Administrator, the Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly.</p>	07/12/2013	

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F 282	<p>Continued From page 3</p> <p>Resident #1 began shaking his/her hands as he/she always does when staff begin to provide care. CNA #1 revealed she turned her back to the resident to get a brief from the resident's closet and heard a thump and when she turned around the resident had fallen to the floor. CNA #1 stated when she removed the wedge from behind the resident's back, the resident may have been too close to the edge of the bed, so when the resident started shaking his/her hands it caused him/her to fall out of the bed. Further interview with CNA #1 revealed she really did not think the resident was near the edge of the bed, but she didn't really know what happened because her back was to the resident and she did not see the resident fall. The CNA revealed the resident was care planned for the assistance of two (2) and she would never change the resident by herself. The CNA stated she was waiting on CNA #2 to change the resident.</p> <p>Interview with CNA #2, on 06/19/13 and 06/20/13 at 10:10 AM and 11:10 AM respectively, revealed she was on the way to assist CNA #1 with the checking and changing of Resident #1 but had to answer a call light before getting there. CNA #2 revealed she heard CNA #1 yell for help and when she entered the room, CNA #1 was holding Resident #1's head up, the feeding tube was tucked under the resident very tightly, and they were afraid the tubing was going to pull out of the resident. CNA #2 revealed she observed CNA #1 pick Resident #1 up and place the resident back in bed. CNA #2 stated Resident #1 was care planned for two (2) person assist with all care except for feeding.</p> <p>Interview with Licensed Practical Nurse (LPN) #1,</p>	F 282		

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F 282	<p>Continued From page 4</p> <p>on 06/19/13 at 8:30 AM, revealed she was called to Resident #1's room by CNA #1. The CNA told her she was preparing Resident #1 for incontinent care by removing the wedge from behind the resident's back and the foot bolster. The CNA stated she turned around to get a brief out of the closet and heard a thud and when the CNA turned back around she saw Resident #1 had fallen out of the bed. CNA #1 further reported to the LPN the resident's feeding tube and oxygen tubing were still attached to the resident and were stretching. The CNAs were afraid the feeding tube would pull out, so CNA #1 and CNA #2 lifted the resident back to the bed. LPN #1 stated Resident #1 had a diagnosis of Tremors, and she thought the resident was a one assist for changing and a two assist for transfers. LPN #1 stated she notified the on call nursing supervisor (Registered Nurse #1), the physician and the State Guardian and then she called the ambulance. LPN #1 stated she conducted a head to toe assessment of Resident #1 and checked the resident's vital signs.</p> <p>Interview with Registered Nurse (RN) #1, on 06/19/13 at 1:05 PM, revealed she received a phone call from LPN #1 in the middle of the night that Resident #1 had fallen out of bed and LPN #1 thought the resident had a leg fracture. RN #1 stated Resident #1 was a two (2) person assist with incontinent care and turning, had tremors and would shake at times. The RN revealed the resident's tremors were worse in the evening and sometimes she would shake so hard it could have caused the resident to fall out of the bed. The RN stated the resident's tremors are mostly in the upper body, but sometimes it's in his/her legs too.</p>	F 282			

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F 282	Continued From page 5  Interviews with CNA #3, CNA #4, CNA #5, CNA #6 on 06/19/13 at 9:15 AM, 9:25 AM and 9:30 AM; and, on 06/20/13 at 8:20 AM revealed Resident #1 was care planned for two (2) assist with all care. The CNAs revealed they would not attempt to provide care for Resident #1 without the assistance of another staff because the resident was too heavy and the resident had tremors, mainly his/her hands, when they would start to provide care to the resident.  Interview with the Assistant Director of Nursing (ADON), on 06/19/13 at 1:55 PM, revealed the root cause of the fall was Resident #1's shaking which caused the resident to fall out of the bed. The ADON stated this was typical behavior for Resident #1 when staff was getting the resident ready to be changed or bathed. Further interview revealed Resident #1 was a two (1) assist with all his/her care, except for feeding.  Interview with the Administrator, on 06/21/13 at 9:58 AM, revealed Resident #1's fall took place on 06/01/13 and the DON informed the Administrator the resident had fallen out of bed with an injury, but the plan of care was followed and the resident did not have a history of falls. The Administrator stated she reviewed the resident's record and spoke to the DON asking her if care was being provided by one staff. The Administrator stated the DON said "no", the staff was waiting for the other staff member to get there and CNA #1 was doing her preparation for care when the resident fell from the bed.	F 282		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	<p>Continued From page 6</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review and review of the facility's investigation it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #1) received adequate supervision to prevent accidents. On 06/01/13 at 2:30 AM, Certified Nursing Assistant (CNA) #1 initiated care for Resident #1 by removing the foot bolsters from the resident's feet and a positioning wedge from behind the resident's back. The CNA then turned her back away from the resident to obtain a brief from the closet and the resident rolled off the bed onto the floor. Resident #1 was transported to the hospital for further evaluation and was diagnosed with a fracture of the right femur shaft and required surgery.</p> <p>The findings include: Review of the facility's policy titled, "Assessing Falls and Their Causes", revised 10/2010, revealed the staff will identify significant potential complications of falling for each resident at risk of falling.</p>	F 323	<p>F323</p> <ol style="list-style-type: none"> <li>On 06/24/2013, the Director of Nursing observed care being provided to resident # 1 and noted that care was being provided with the appropriate level of supervision.</li> <li>On 07/11/2013, the Director of Nursing and Unit Managers reviewed all current residents to assure that they were receiving the appropriate level of supervision to include supervision during activities of daily living. Any requiring changes to level of supervision were noted on the resident's plan of care.</li> <li>On 07/11/13, the Director of Education and Training and/or Nurse Manager completed re-educated of all licensed nurses and certified nursing assistants on the requirement that care must be provided in accordance with the plan of care to include supervision and supervision with activities of daily living and that care can not be initiated until the appropriate level of staff is present to supervise resident in accordance with the plan of care. No licensed nurse or certified nursing assistant will work past 07/11/13 without receiving this education.</li> </ol>		

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F 323	<p>Continued From page 7</p> <p>Record review revealed the facility admitted Resident #1 on 10/05/06 with diagnoses which included Anxiety Disorder, Mental Retardation, Schizophrenia, Alzheimer's Disease, Bipolar Disorder, Tremors and Convulsions. Review of the Minimum Data Set (MDS) assessment, dated 05/09/13, revealed the facility assessed Resident #1's cognition as severely impaired and the resident required extensive assistance of two (2) staff for bed mobility, dressing, toilet use and personal hygiene. Review of a Fall Risk Assessment, dated 02/19/13, revealed the facility assessed Resident #1 at high risk for falls.</p> <p>Review of the Comprehensive Care Plan, dated 01/23/12, revealed two (2) staff should assist Resident #1 with bed mobility. Review of the Activities of Daily Living (ADL) Plan of Care Skilled Sheet, dated 06/18/13, revealed Resident #1 was totally dependent on two (2) staff for positioning and incontinent care.</p> <p>Review of the Nurse's Note, dated 06/01/13 at 2:30 AM, revealed the Certified Nurse Assistant (CNA) #1 had entered Resident #1's room to provide incontinent care. The CNA removed the foot bolster and positioning wedge from the resident. The CNA went to the closet to get a brief for the resident, and the resident was shaking his/her arms and legs in bed. Further review revealed the CNA heard a thud, turned around and saw the resident lying on the right side of the bed on the floor. The CNA yelled for assistance to pick the resident up from the floor. The resident was assessed by Licensed Practical Nurse (LPN)#1, and was noted to have a two (2) centimeter (cm) abrasion to the left thigh. The resident's right upper leg was swollen with a</p>	F 323	<p>4. The Director of Nursing and/or Nurse Manager will perform observations and care plan review of care being provided on five (5) residents per shift daily five(5) times per week for one (1) week, followed by five (5) times per week on random shifts for four (4) weeks, then weekly for seven (7) weeks to ensure that care is provided in accordance with the resident plan of care to include supervision and supervision with activities of daily living and that care plan interventions are being followed. The results of the audits will be reviewed with the Quality Assurance Committee, at a minimum, monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Administrator, the Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly.</p>	7/12/13	

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F 323	<p>Continued From page 8</p> <p>deformity noted to the right femur. The physician was notified at 2:45 AM and an order was received to send the resident to the emergency room for evaluation. The resident was transferred to the emergency room per ambulance at 3:10 AM. At 7:30 AM, the facility called the emergency room and received information the resident was being admitted with a fracture to the right femur.</p> <p>Interview with CNA#1, on 06/19/13 at 10:15 AM and 3:30 PM, revealed she entered Resident #1's room to provide routine check and change care for Resident #1, but was waiting for CNA #2 to finish answering a call light. CNA #1 stated while waiting for CNA #2 she removed the wedge from behind the resident's back, and removed the foot bolsters from the resident's feet. The CNA stated she then turned and walked over to the closet and bent down to obtain a brief when she heard a thump. When she turned around the resident had fallen out of the bed. The CNA stated when she pulled the wedge from behind the resident, he/she began shaking his/her hands. CNA #1 stated Resident #1 always moved his/her upper body when people touched him/her. Further interview revealed the CNA stated she thought that maybe when she removed the wedge, the resident was too close to the edge of the bed, but she really didn't know because her back was to the resident and she did not see the resident fall. The CNA stated Resident #1 was a two (2) assist for bed mobility and incontinent care and she would never change him/her by herself. CNA #1 stated Resident #1 did not have side rails and never had as far as she could remember. Further interview revealed the wedge was used to support and position the resident off his/her back</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>because the resident was large and was unable to turn and reposition without assistance. The CNA stated without the wedge, the resident would lie flat on his/her back all the time.</p> <p>Interview with CNA #2, on 06/19/13 at 11:10 AM, and on 06/20/13 at 10:10 AM, revealed she was going to assist CNA #1 with a check and change of Resident #1 but she had to answer a call light first. CNA #2 stated she heard CNA #1 yelling for help and when she got to the room she saw CNA #1 holding the resident's head up, and the resident's feeding tube was tucked under the resident very tightly. The CNA stated they were afraid the tubing was going to pull out, so CNA #2 picked up Resident #1 and placed the resident back in the bed. CNA #2 further stated Resident #1 was a two (2) person assist with all care except for feeding and the resident sometimes jiggled his/her arms and hands when staff started to provide care, but the resident stops soon after the care begins. The CNA stated staff used the wedge to turn and reposition the resident so the resident could lay on his/her side and not on his/her back all the time.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/19/13 at 8:30 AM, revealed she was called to Resident #1's room by CNA #1. The LPN stated CNA #1 told her she prepared Resident #1 for incontinent care by first removing the wedge from behind the resident's back and removed the foot bolster. The CNA then turned and walked to the closet and bent down to obtain a brief out of the closet when she heard a thud and turned back around and saw Resident #1 had fallen out of the bed. CNA #1 picked the resident up and placed him/her back in the bed before the LPN</p>	F 323			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/21/2013
NAME OF PROVIDER OR SUPPLIER  TWIN RIVERS NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 W. 3RD ST. OWENSBORO, KY 42301		
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F 323	<p>Continued From page 10</p> <p>arrived because the resident had fallen on top of his/her feeding tube and oxygen tubing and they were afraid the feeding tube would pull out. LPN #1 stated she assessed the resident and notified the on call supervisor (Registered Nurse #1), the physician, the state guardian and then she called the ambulance.</p> <p>Interview with Registered Nurse (RN) #1, on 06/19/13 at 1:05 PM, revealed she received a phone call from LPN #1 in the middle of the night that Resident #1 had fallen out of bed and LPN #1 thought the resident had a leg fracture. The RN stated Resident #1 required the assist of two (2) with incontinent care and turning, and had tremors and shakes at times. The RN stated the resident's tremors were mostly of the upper body, but they were worse in the evenings and the resident shakes pretty hard at times. The RN stated this possible could have caused the resident to fall from the bed.</p> <p>Interview with CNA #3, on 06/19/13 at 9:15 AM; and, on 06/20/13 at 2:18 PM, revealed Resident #1 was a two (2) person assist with all care and she would not attempt any care by herself because the resident was heavy and hard to handle. CNA #3 further stated the resident has little tremors, mainly his/her hands, but she just stops and waits till the resident calmed down. The CNA stated the staff used a wedge for turning and positioning for residents who couldn't keep themselves on one side or the other. The wedge kept them in a certain position. The CNA stated Resident #1 couldn't support himself/herself on his/her side, so they used the wedge.</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>Interview with CNA #4, on 06/19/13 at 9:25 AM, revealed Resident #1 was total care of two (2) persons for assistance. The CNA stated the resident's hands and arms jiggled. The CNA revealed the wedge behind the resident's back was used for positioning to help keep the resident off of his/her back.</p> <p>Interview with CNA #5, on 06/19/13 at 9:30 AM, revealed Resident #1 was a two (2) person assist and was total care. CNA #5 stated she would never attempt to provide care for the resident by herself, because the resident was just too heavy. The CNA stated the resident was incontinent and required check and change every two (2) hours. Further interview revealed Resident #1 did shake his/her arms at times, but not very much.</p> <p>Interview with CNA #6 on 06/19/13 at 8:22 AM and 3:55 PM, revealed when staff turn Resident #1 on his/her side to provide incontinent care, he/she would sometimes start to jerk his/her upper arms and hands and there should always be two (2) staff to ensure the resident's safety. The CNA stated Resident #1 was care planned for the total assist of two (2) and the wedge was used to keep the resident off his/her back. The CNA stated Resident #1 never moved unless care was being provided.</p> <p>Interview with CNA #8 on 6/20/13 at 1:45 PM, revealed staff used wedges to keep residents off their backs and for positioning. The CNA stated it kept them from rolling over on their backs, when they have no back support. Further interview revealed some residents can't stay on their side without a wedge.</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>Interview with the Physical Therapy Assistant, on 06/20/13 at 1:31 PM, revealed Resident #1 couldn't stay over on his/her side because he/she has no trunk control or body alignment.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 06/19/13 at 1:55 PM and 06/20/13 at 3:30 PM, revealed they determined the root cause of the fall was Resident #1 was shaking and this caused Resident #1 to fall out of the bed. The ADON stated this was the resident's typical behavior when staff was starting to change or bathe the resident. The ADON revealed Resident #1 had always had these shaking episodes but only when someone gets ready to provide care. A wedge was used for positioning and foot bolsters to prevent foot drop. Further interview revealed Resident #1 was a two (2) person assist with all his/her care, except for feeding.</p> <p>Interview with the Administrator on 06/21/13 at 9:58 AM, revealed Resident #1's fall took place on 06/01/13 and the DON called and informed him of what had taken place. The Administrator stated the DON told him the resident had fallen out of bed with an injury, but the plan of care was followed and the resident did not have a history of falls. The Administrator further stated that on 06/02/13, he reviewed Resident #1's record, spoke to the DON and asked her if the care was being provided by one staff and the DON said, "no" that the CNA was waiting for another CNA to get there to provide incontinent care. The Administrator stated the DON told him the CNA was prepping for the incontinent care while the other CNA answered a call light. The Administrator stated that there was nothing that could have been foreseen or predicted that would</p>	F 323			

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F 323	Continued From page 13 have caused the resident to fall out of his/her bed. The Administrator stated the CNA did not leave the resident in an unsafe position, the resident was lying midline in the bed and the resident had no history of falls.  Review of the facility's investigation of Resident #1's fall sustained on 06/01/13, dated 06/03/13, revealed "CNA #1 was preparing supplies to give incontinent care. While the CNA was at the closet getting supplies, she heard a noise and the resident was falling out of the bed onto the floor. CNA stated when she removed the wedge pillow from behind the resident's back, the resident began shaking (tremors) which is very usual for the resident to do when he/she knows he/she is getting ready to be changed or bathed. Resident also has a seizure disorder. Apparently, had rolled out of the bed onto the floor during this time. Cannot rule out that resident had a seizure to cause the fall." A review of the Fall Investigation worksheet, dated 06/01/13, revealed that based on the fall investigation the immediate intervention to prevent further falls was to ensure the resident was positioned properly in the middle of the bed.	F 323			