

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

PRINTED: 09/27/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185234</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/14/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>CALVERT CITY CONVALESCENT CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1201 FIFTH AVE CALVERT CITY, KY 42029</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>(1.) Resident (#2) expired on June 11, 2010. Therefore, no corrective action could be accomplished for the resident Directly affected by the deficient practice.</p> <p>(2.) All resident have the potential to be affected by the same deficient practice.</p> <p>(3.) All charge nurses have been in-serviced by the DON regarding proper physician notification and follow up care of any received orders with emphasis on clarification of how long a physician wants medications to be held or what date they want a re-valuation completed. Nurses have been instructed to cease writing "for now" when an order is received to hold medications. Nurses much clarify exactly when the medications should be held with the physician. Nurses have been educated to always notify the physician immediately with any</p>		

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

TITLE

ADMINISTRATOR

(X6) DATE

10/5/10

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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews it was determined the facility failed to notify the physician when there was significant change in physical status and the need to significantly alter treatment for one resident (#2) in the selected sample of five. The facility failed to consult with the physician when Resident #2 had an episode of decreased oxygen saturation (O2 sat.) and a decrease in cognition on 06/09/10. Additionally, the facility failed to consult with the physician to determine how long the resident's blood pressure medications should have been withheld. Findings include:</p> <p>A review of the facility's Physician Notification policy and procedure, no date, revealed the facility would notify the physician or his alternate of any changes in the resident's condition, signs and symptoms of any illness and accidents with or without injury.</p> <p>A record review revealed Resident #2 was admitted to the facility 05/06/10 with diagnoses to include Dementia, Muscle Weakness, Hypertension, Atrial Fibrillation and Coronary Artherosclerosis.</p> <p>A review of the nurse's notes, dated 06/02/10 at 9:30 AM and 3:45 PM revealed therapy had made the nurse aware Resident #2 was having increased lethargy. The nurse consulted with the physician and received new orders.</p> <p>A review of a physician's note, dated 06/02/10 at 4:10 PM, revealed the resident's blood pressure was low and the resident was having increased lethargy. A review of a physician's order, dated</p>	F 157	<p>significant change in the resident's physical, mental, or psychosocial status. Nurses have been in-serviced on proper utilization of the facilities' new care alert form to improve internal communication between departments. The form includes signatures for both the person reporting the change and the person receiving notification to ensure caregivers are aware of reported changes in resident's condition. The form is forwarded to the RN department supervisor for review to assure proper action has been taken. All department supervisors were in-serviced on the new care alert form and procedures by the Administrator on September 21, 2010.</p> <p>(4) RN Unit Supervisors will monitor new orders and care alert forms as they are received to ensure that proper physician notification and</p>		

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F 157	<p>Continued From page 2</p> <p>06/02/10, revealed to withhold Resident #2's Prinivil, Imdur, and Lopressor "for now" and obtain an urinalysis (UA). A review of the June 2010 Medication Administration Record (MAR) revealed Resident #2's blood pressure medication was withheld from 06/02/10-06/09/10 (discharge from facility). Further review of the record revealed there was no evidence the facility consulted with the physician to clarify what the physician meant when the order was written to withhold the medications "for now".</p> <p>A review of a Speech Therapy Rehabilitation Addendum Note, dated 06/09/10 at 9:34 AM, revealed the resident was very lethargic and unable to maintain attention. The therapist checked the resident's O2 sat. and it ranged between 77%-84% (normal 90-100 %). The note indicated the resident's heart rate was up and down and the therapist notified nursing. A review of a Occupational Therapist Rehabilitation Addendum Note, dated 06/09/10 at 11:50 AM, revealed the therapist consulted with nursing and made them aware the resident had a decline in cognition, feeding and an inability to stay awake. A review of the nurse's notes, dated 06/09/10, revealed there was no evidence the facility consulted with the physician related to the resident's decreased O2 sats., fluctuating heart rate, or episodes of decreased cognition, inability to feed and inability to stay awake.</p> <p>An interview with the Speech Therapist, on 09/10/10 at 1:00 PM, revealed she made nursing aware of the resident's low O2 sats. and decrease in cognition and nursing came and escorted the resident back to the floor. She was unable to recall who she spoke to in nursing and who escorted the resident back to the floor.</p>	F 157	<p>treatment has been implemented. QI will follow up on a monthly basis by performing random checks of a least ten orders/care alert forms to monitor continued compliance.</p> <p>(5) Completion Date: October 8, 2010</p>	<p>10/08/10 LS/LJS (10/14/10)</p>

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F 157	<p>Continued From page 3</p> <p>An interview with the Occupational Therapy Assistant, on 09/10/10 at 1:10 PM, revealed she made nursing aware of the resident's decreased cognition, inability to feed self and inability to stay awake that day. She was unable to recall who she had spoken to about the resident.</p> <p>An interview with the Licensed Practical Nurse and Unit Supervisor (who worked 06/02/10), on 09/09/10 at 1:20 PM and 3:20 PM, revealed they did not recall therapy making them aware that Resident #2 had low O2 sats, an inability to feed self, decreased cognition and inability to stay awake on 06/09/10.</p> <p>An interview with Resident #2's physician on 09/13/10 at 11:30 AM, revealed she would have expected the facility to contact her to clarify the order relating to withholding the resident's blood pressure medications "for now". She stated she usually writes a time period for nursing to get back in contact with her but had failed to do so on this occasion. She stated the facility should have notified her immediately of the resident's episode of decrease in O2 sats. on 06/09/10 and should have made her aware the resident continued to have episodes of decline in cognition, inability to feed and inability to stay awake.</p> <p>An interview with the Director of Nursing (DON), on 06/10/10 at 4:00 PM, revealed the facility should have clarified the physician's order related to the amount of time Resident #2's blood pressure medication should have been withheld. She stated the facility should have also made the physician aware the day Resident #2's O2 sats. decreased and that the resident continued to have episodes of decline in cognition, inability to</p>	F 157			

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F 157	Continued From page 4 feed and inability to stay awake.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on interviews and record review it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one resident (#2), in the selected sample of five. The facility failed to consult with the physician to clarify a physician's order for withholding medications. In addition, the facility failed to provide ongoing assessments and consult with the physician when the resident's oxygen saturation decreased and the resident continued to have episodes of decreased cognition, inability to feed self and inability to stay awake. Findings include:  A review of Alert Charting Reminders given to licensed staff on 04/16/10 revealed alert charting should be completed on residents with any new type of illness and medication changes. Interview with the Director of Nursing (DON) on 09/10/10 at 4:00 PM revealed there was no policy and procedure to address Alert Charting. She stated	F 309	(1.) Resident (#2) expired in hospital on June 11, 2010. Therefore, no corrective action could be accomplished for the resident directly affected by the deficient practice.  (2.) All resident have the potential to be affected by the same deficient practice.  (3) A policy and procedure has been developed to address Alert Charting. All charge nurses have been in-serviced by the DON on proper procedures related to Alert Charting. In-service content included specific directions for utilization of the Alert	

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F 309	<p>Continued From page 5</p> <p>licensed staff were supposed to place the resident's name and reason for alert charting on the alert charting list when there was a change of condition, medication changes, falls, illness etc. so all shifts would know to assess and chart on the resident.</p> <p>A record review revealed Resident #2 was admitted to the facility 05/06/10 with diagnoses to include Dementia, Muscle Weakness, Hypertension, Atrial Fibrillation and Coronary Artherosclerosis.</p> <p>A review of the initial Minimum Data Set (MDS) assessment, dated 05/17/10, revealed the resident's decisions were poor, required cues and supervision and required set up only for feeding.</p> <p>A review of the Comprehensive Care Plan, dated 05/20/10, revealed care plans were developed for impaired cognitive skills, required assistance with set up of tray for meals and required skilled nursing care for response to therapy (observation, assessment and management).</p> <p>A review of the nurse's notes, dated 06/02/10 at 9:30 AM and 3:45 PM, revealed therapy had made the nurse aware Resident #2 was having increased lethargy. The nurse consulted with the physician and received orders to obtain an urinalysis (UA) and withhold the resident's blood pressure medication "for now". (Prinivil, Imdur and Lopressor). A review of an UA report, dated 06/04/10, revealed no abnormal findings. The results were faxed to the physician. A review of the June 2010 Medication Administration Record (MAR) revealed Resident #2's blood pressure medication was withheld from 06/02-09/10 (discharge from facility). A review of the nurse's</p>	F 309	<p>Charting list/protocol with emphasis regarding proper assessment, documentation, and physician notification for each incident when a resident develops any significant change in their physical, mental, or psychosocial status.</p> <p>(4). RN Unit Supervisors will monitor the alert charting list daily to monitor for compliance and to ensure the proper protocol is being implemented.</p> <p>(5). Completion Date: October 8, 2010</p>	<p>10/08/10 RT/LJ (10/14/10)</p>	

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F 309	<p>Continued From page 6</p> <p>notes and physician's orders, dated 06/02-09/10, revealed there was no evidence the facility consulted with the physician to determine how long the blood pressure medications were supposed to be withheld.</p> <p>A review of the Alert Charting List for 06/02-09/10 revealed Resident #2's name was not placed on the Alert Charting List due to his/her change in condition or medication changes. A review of the record revealed there was no evidence the facility was conducting ongoing assessments to determine if the withholding of the blood pressure medications were improving the resident's cognition and inability to stay awake.</p> <p>A review of a Speech Therapy Rehabilitation Addendum Note, dated 06/09/10 at 9:34 AM, revealed the resident was very lethargic and unable to maintain attention. The therapist checked the resident's O2 sat. and it ranged between 77%-84% (normal 90%-100%). The note indicated the resident's heart rate was up and down and the therapist notified nursing. A review of an Occupational Therapist Rehabilitation Addendum Note, dated 06/09/10 at 11:50 AM, revealed Resident #2 showed a decrease in the ability to feed. The resident was unable to locate the food on the plate and made several attempts with adaptive equipment to eat; however, the resident was unable to feed himself/herself. The note revealed the therapist consulted with nursing and made them aware the resident had a decline in cognition, feeding and inability to stay awake. Further record review revealed there was no evidence the resident was assessed by nursing and no evidence the resident's physician was made aware of the decrease in O2 sats. and the resident's continued</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>decline in cognition and ability to stay awake.</p> <p>An interview with the Speech Therapist, on 09/10/10 at 1:00 PM, revealed she was providing therapy for Resident #2 in the therapy room on 06/09/10 and noticed the resident was unable to follow verbal directions and was unable to stay awake. She stated she checked the resident's O2 sats. and they were low. She revealed she made nursing aware and they came and escorted the resident back to the floor. She was unable to recall who she spoke to in nursing and who escorted the resident back to the floor.</p> <p>An interview with the Occupational Therapy Assistant, on 09/10/10 at 1:10 PM, revealed she was provided therapy for eating for Resident #2 on 06/09/10. The resident was very lethargic, unable to find the food on the plate and was unable to stay awake. She stated she made nursing aware and they told her the resident's laboratory work was normal, medications were being withheld and the physician was aware of the resident's lethargy. She was unable to recall who she had spoken to about the resident.</p> <p>Interviews with the Licensed Practical Nurse (LPN) #3 and Unit Supervisor RN #1 (who worked 06/09/10), on 09/09/10 at 1:20 PM and 3:20 PM, revealed they could not recall Resident #2 ever having a decrease in O2 sats. while receiving therapy. Additionally they could not recall therapy reporting to them on 06/09/10 concerns regarding Resident #2 having a decrease O2 sat., feeding difficulties, change in cognition or the inability to stay awake.</p> <p>Interviews with RN #1, LPN #3, LPN #4, LPN #5 and LPN #6 on 09/08/10 at 4:00 PM, and 4:15 PM</p>	F 309		

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F 309	<p>Continued From page 8</p> <p>and on 09/09/10 at 1:10 PM and 3:20 PM revealed they were not aware Resident #2 had a change in cognition, an inability to stay aware, that his/her blood pressure medications were withheld and/or that the resident was having episodes of not being able to stay awake.</p> <p>An interview with Resident #2's physician on 09/13/10 at 11:30 AM, revealed she would have expected the facility to contact her to clarify the order related to withholding the resident's blood pressure medications "for now". She stated she usually wrote a time period for nursing to get back in contact with her but had failed to do so on this occasion. She stated the facility should have continued to assess the resident for decreased cognition and inability to stay awake to determine if the withholding of the blood pressure medication was having any effect. She stated the facility should have notified her immediately of the resident's decrease in O2 sats. on 06/09/10 and should have made her aware the resident continued to have episodes of decreased cognition, inability to feed and inability to stay awake.</p> <p>An interview with the Director of Nursing on 09/10/10 at 4:00 PM revealed Resident #2's name should have been placed on the alert charting list on 06/02/10 when therapy notified nursing of the change in condition and when the physician wrote the order to withhold the blood pressure medications. She revealed this would have alerted each shift to assess the resident for a decrease in cognition and lethargy and to determine if withholding the blood pressure medications were improving the resident's condition. She stated the facility should have notified the physician for clarification related to</p>	F 309		
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F 309	Continued From page 9 how long the blood pressure medications were to be withheld.	F 309	<p>(1). The fall risk assessment, interventions, care plan, and nurse aide hall sheets have been reviewed and updated as indicated to ensure proper interventions are in place and effective on resident (#1). Hourly alarm, assistive devices, and safety checks have been implemented on resident (#1).</p> <p>(2). All residents have the potential to be affected by the deficient practice.</p> <p>(3). All residents have been re-assessed to ensure effective interventions are in place to provide an environment that is safe with adequate supervision. Fall risk assessments, interventions, care plans, and nurse aide hall sheets are being reviewed and revised as</p>		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review it was determined the facility failed to ensure one resident (#1), in the selected sample of five, received adequate supervision to prevent accidents. Resident #1 fell forward out of his/her wheelchair while reaching for the arm of a chair on 05/29/10 and the facility failed to put an intervention in place to prevent any further falls from the wheelchair. On 06/05/10, Resident #1 was reaching for something on the floor and fell out of the wheelchair sustaining a laceration to the forehead that required sutures. Findings include:  A review of the facility's falls policy and procedure, no date, revealed as soon as possible after a fall a thorough investigation should be conducted to determine contributory causes for the fall and what other actions needed to be implemented to minimize the potential for a future fall.  A record review revealed Resident #1 was	F 323			

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NAME OF PROVIDER OR SUPPLIER  <b>CALVERT CITY CONVALESCENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1201 FIFTH AVE CALVERT CITY, KY 42029</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 323	<p>Continued From page 10</p> <p>admitted to the facility on 05/13/10 with diagnoses to include Unspecified Intracranial Hemorrhage, Senile Dementia, Alzheimer's Disease and Muscle Weakness.</p> <p>Observation on 09/09/10 at 12:20 PM revealed Resident #1 was in a wheelchair with front and back anti-tippers. A clip alarm was attached to the resident. The resident was in a Velcro torso support to keep the resident from leaning forward.</p> <p>A review of the initial Minimum Data Set (MDS) assessment, dated 05/24/10, revealed Resident #1's cognitive skills were severely impaired. The resident required extensive assistance of two staff for transfers and bed mobility and extensive assistance of one staff for locomotion. The resident had a history of falls before admission to the facility. A review of the falls risk assessment, dated 05/14/10, revealed the resident was assessed at high risk for falls.</p> <p>A review of the Comprehensive Care Plan for potential for injury from falls related to decreased safety awareness, unsteady balance, muscle weakness and lack of coordination, dated 05/20/10, revealed Resident #1 had a pressure alarm to the wheelchair.</p> <p>A review of the nurse's notes, dated 05/29/10 at 10:00 AM, revealed Resident #1 was found on the floor on his/her left side in the lobby. The resident's pressure alarm was sounding. The note revealed there were no staff in the lobby area but an alert and oriented resident (Resident #6) had witnessed the fall. The note revealed Resident #6 told the staff that Resident #1 was reaching for the arm of a wicker chair and fell forward out of the wheelchair. The resident</p>	F 323	<p>indicated. Routine two hour alarm checks were scheduled on even hours (0000, 0200, etc.). The form has been revised to include alarm/safety checks with times changed to odd hours on half hours (0130, 0330, etc.) to provide more frequent supervision. A one hour alarm/safety check sheet has also been developed for residents who require more frequent supervision. All charge nurses have been in-serviced on proper fall risk assessment, care planning, writing effective interventions with root cause analysis of a fall and implementation of all interventions, providing adequate supervision as needed and ensuring that an effective intervention is put in place immediately after every fall.</p> <p>(4.) The IDT Team will review each fall to ensure appropriate interventions and supervision has been put in place. The team will update any change in interventions if indicated immediately. QI will</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  <b>CALVERT CITY CONVALESCENT CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1201 FIFTH AVE</b> <b>CALVERT CITY, KY 42029</b>	
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F 323	<p>Continued From page 11</p> <p>sustained a skin tear to the left elbow and left knee.</p> <p>A review of the back of the falls assessment form revealed the resident had sustained a fall from the wheelchair on 05/29/10; but there was no documentation an intervention was put in place to try to prevent any further falls from the wheelchair. A review of the record and comprehensive care plan for falls dated 05/20/10, revealed there were no new intervention initiated after the fall on 05/29/10.</p> <p>A review of the tracking and trending of Resident #1's falls revealed the resident's fall on 05/29/10 was documented but no intervention was put in place because the pressure alarm sounded and staff responded; so the intervention already in place was successful.</p> <p>A review of the nurse's note, dated 06/05/10 at 4:30 PM, revealed Resident #1 was propelling down the hall in the wheelchair when he/she leaned forward as if to pick something off the floor and fell out of the wheelchair. The resident sustained a laceration to the forehead. The resident was sent out to the emergency room and was admitted for sutures to the laceration and hydrocephalus.</p> <p>Interviews with Certified Nurse Aide (CNA) #4, CNA #5, CNA #6 and CNA #7 on 09/09/10 at 10:05 AM, 10:20 AM, 10:28 AM and 10:35 AM revealed Resident #1 would constantly reach for things. They stated at times he/she would lean to far forward trying to reach for something.</p> <p>An interview with the Quality Improvement (QI) Coordinator on 09/10/10 at 8:50 AM revealed no</p>	F 323	<p>do a five day post fall review to re-evaluate the effectiveness of the interventions and supervision. QI will report the findings to the IDT Team for a review to monitor for compliance and to ensure interventions are appropriate.</p> <p>(5.) Completion Date: October 8, 2010</p>	<p>10/08/10 LJ/LJ (10/14/10)</p>

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F 323	<p>Continued From page 12</p> <p>intervention was put in place after the fall on 05/29/10 because staff responded to the chair alarm, so the intervention was effective. She was unable to provide an explanation as to how the facility determined the intervention was effective when the result was the resident still sustaining a fall.</p> <p>An interview with the Director of Nursing on 09/10/10 at 4:00 PM revealed whenever a resident sustains a fall an intervention should be put in place to try to prevent any further falls. She stated an intervention to prevent the resident from falling from the wheelchair should have been put in place immediately after the resident's fall on 05/29/10 because the resident fell even though the alarm sounded.</p> <p>An interview with the Administrator (who conducted the investigation of the fall on 05/29/10), on 09/10/10 at 3:30 PM, revealed when he conducted his investigation he understood Resident #6 to say the resident had stood up prior to falling.</p> <p>An interview with Resident #6 (assessed as alert and oriented with a cognitive status of "0" on the MDS which indicates decisions are consistent and reasonable) on 09/10/10 at 9:45 AM revealed he/she was in the lobby when Resident #1 came into the lobby in his/her wheelchair. He stated Resident #1 began reaching for the arm of the wicker chair and leaned so far forward he/she fell forward out of the wheelchair. He stated the resident never attempted to stand up.</p>	F 323			