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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185141		C 06/07/2013

NAME OF PROVIDER OR SUPPLIER: SIGNATURE HEALTHCARE OF GEORGETOWN

STREET ADDRESS, CITY, STATE, ZIP CODE: 102 POCAHONTAS TRAIL, GEORGETOWN, KY 40324

(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		
	An Abbreviated Survey investigating KY#00020258 was initiated on 06/05/13 and concluded on 06/07/13. KY#00020258 was unsubstantiated with related deficiencies cited.			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		
	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.			
	A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.			
	This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to revise the Comprehensive Plan of Care for one (1) out of five (5) sampled residents			

RECEIVED JUL - 8 2013 BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: DON (X6) DATE: 7/8/13

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 280	Continued From page 1 (Resident #1). The facility failed to revise Resident #1's care plan after the resident had falls on 04/24/13 and 04/30/13. There was no documented evidence the facility added interventions to reduce the risk of falls after the fall incidents as per the facility's policy. The findings include: Review of the facility's policy: Incident Reporting, effective date 12/2010, revealed the Charge Nurse/designee was to add interventions to the care plan as needed. Review of the facility's reference: Educational Guidelines / Incident Reporting, dated October 2009, revealed under Section 5 Fall: staff were to document new interventions put in place to prevent further falls. Interview, on 06/07/13 at 11:30 AM, with the Minimal Data Set (MDS) Coordinator revealed the purpose of the care plan was to identify care needs of the residents and the interventions to meet those needs. She further stated by knowing the interventions in place they could monitor their effectiveness in meeting the resident's needs. Record review revealed Resident #1 was admitted to the facility on 04/12/13, with diagnosis which included Cerebral Vascular Accident (Stroke), Muscle Weakness, Osteoporosis, Seizure Disorder, Diabetes, and History of Pituitary Tumor with Panhypopituitarism. Review of the Fall Risk Evaluation, completed 04/12/13, revealed the resident was assessed as a high fall risk. Review of the initial MDS	F 280	F 280 SS = D 1. Resident #1 was reassessed by the Minimum Data set coordinator (MDS coordinator) and by therapy for adequate assistive device, by 6/7/13. Resident #1 comprehensive Plan of Care was reviewed and revised on 6/10/13 by the Interdisciplinary team which includes the following: rehab service manager, director of nursing, assistant director of nursing, dietary manager, social service director, minimum data set coordinator, quality of life director, chaplain, and the administrator (IDT) to include individualized interventions based on resident #1 assessment to be measurable objectives and timetables to meet resident #1 medical nursing and mental and psychosocial needs. The Brief Interview of Mental Status (BIMS) was reassessed by the social service director on 6/10/13 accurately capture the cognition status of resident #1. The State Registered Nursing Assistant (SRNA) care plan was reviewed and revised by the Interdisciplinary team IDT on 6/10/13. The resident chair alarm was replaced by the director of nursing on 6-7-13.	

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F 280	Continued From page 2 Assessment, dated 04/23/13, revealed Resident #1 had moderate cognitive impairment. The resident was assessed, under the Functional Status section, to require staff assistance with transfers and was not steady with walking, and surface to surface transfers. Review of the Resident #1's Comprehensive Plan of Care, initiated 04/23/13, revealed the resident was at risk for fall related injury due to self care deficits, stroke, seizures, and weakness. The goal of the plan of care was for Resident #1 to sustain no fall related injuries. Interventions listed to prevent falls on the Comprehensive Plan of Care for Resident #1 included educate / remind resident to request assistance prior to ambulation and / or transfers, staff assistance with ambulation, and monitor use of assistive devices. Review of the facility's 04/24/13 investigative report, revealed Resident #1 was found on the bathroom floor on his/her buttocks at 9:45 AM. The resident stated he/she walked into the bathroom and took a spill. Continued review of the report revealed staff reported the resident's chair alarm was not sounding. Review of the Comprehensive Care Plan and the Certified Nursing Assistant (CNA) Care Plan for Resident #1 at the time of the fall on 04/24/13 revealed the care plans did not include an intervention for a chair alarm. Further review of the Comprehensive Care Plan revealed it was not updated to include the 04/24/13 fall or a new intervention to try and reduce the risk of falls. Interview, on 06/05/13 at 4:10 PM, with Registered Nurse (RN) #1 revealed the resident	F 280	2. All residents will receive a brief interview of mental status (BIMS) by the Interdisciplinary team (IDT) by 7/12/13 Any resident that has a Brief Interview of Mental Status (BIMS) of eight or less will be reported to the director of nursing for follow up to the administrator and the Interdisciplinary team (IDT). Any resident who has a Brief Interview of Mental Status (BIMS) score of eight or less will receive a comprehensive review of their minimum data set (MDS) assessment by the Interdisciplinary team (IDT) to be completed by 7/19/13 to ensure the assessment results are used to develop the care plan and the care plan reflects specific interventions and deficits of the resident with individualized interventions based on the residents current Minimum Data set (MDS) assessment. The Minimum Data set coordinator (MDS) coordinator will ensure resident assessments, to include the falls risk evaluation and the care planning are accurately reflected for each resident identified by 7/19/13. All residents with alarms will be checked by 6-7-13 by the unit supervisor for battery strength, placement and function.	

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F 280	Continued From page 3 had a chair alarm, but the intervention was not listed on the Comprehensive Care Plan. She further stated she did not know when the chair alarm was placed. Interview, on 06/07/13 at 10:00 AM, with RN #1/Transitional Care Unit (TCU) Manager about the fall on 04/24/13 revealed after the fall the CNA checked on the resident more frequently, but it was not put on the care plan and was not sure if it was passed on in report. RN #1 stated after a fall they were supposed to add interventions to the care plan to try and reduce the risk of a fall, but no interventions were added. In addition, RN #1 stated the alarm was not listed on the CNA care plan but should have been so the CNA's knew to check and monitor the alarm. Continued review of Investigative reports revealed Resident #1 had a fall on 04/30/13 at 8:00 AM when the resident got up out of his/her wheelchair to use the bathroom. He/She was found on the floor and the chair alarm was sounding. Under the section of interventions already in place it was reported the resident had a bed and chair alarm. Review of the interventions added revealed they had the resident demonstrate use of the call light while in the wheelchair three (3) times and speech therapy was to continue cognitive therapy. Review of Resident #1's Comprehensive Plan of Care revealed the care plan was not updated to include the 04/30/13 fall or any added interventions. Further review revealed no documentation the resident had an intervention of a bed alarm. Review of Resident #1's CNA Care Plan revealed no bed alarms were listed.	F 280	3. The Interdisciplinary team (IDT) will receive education from the Regional Clinical Reimbursement Consultant by 7/12/13 on developing a care plan utilizing assessments results and reflection of the specific abilities and deficits of a resident with individualized interventions. The director of nursing and the MDS coordinator will educate and train the licensed staff on the care planning process policy/procedure, and clinical meeting compliance by 7/12/13. The facility Interdisciplinary team (IDT) will review each comprehensive care plan, the falls risk evaluation, and alarm audit compliance with any resident admission, incident and or change of condition during the daily clinical meeting which is directed by the director of nursing. Identified non- compliance of the care plan process, falls risk evaluation and or the alarm audit will be reported to the director of nursing and administrator immediately, and forwarded to the weekly at risk meeting for review and follow up.	

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F 280	Continued From page 4 Interview, on 06/06/13 at 3:40 PM and on 06/07/13 at 9:40 AM, with RN #2, who completed the investigative report of the 04/30/13 fall, revealed she took care of Resident #1 and he/she had bed and chair alarms. After review of the Care Plan RN #2 stated if the resident had alarms it should have been listed on the care plan so everyone was on the same page. She further stated she could not believe it was not on the care plan. Continued interview with RN #2, revealed after the fall she discussed possible interventions with the DON, who instructed her to have the resident demonstrate call light use while up in the wheelchair. She stated they were aware the resident could already use his/her call light, but the DON told her to put down this intervention on the investigative report. Interview, on 06/06/13 at 1:15 PM and on 06/07/13 at 10:00 AM, with RN #1/TCU Manager about the fall on 04/30/13 revealed there were no new documented interventions put in place after the fall that they were not already doing. She stated the resident could use his/her call light, but thought he/she could do anything on his/her own. Interview with the Interim Director of Nursing (DON), on 06/07/13 at 12:15 PM, revealed there was no new interventions added to the care plan after the falls on 04/24/13 and 04/30/13. She stated the Incident Report on 04/24/13 noted they would inform therapy about the fall, but letting therapy know was a notification not an intervention. She further stated falls were brought to the clinical meetings and interventions were reviewed to determine if they needed to be revised, in both cases it appeared the care plan	F 280	4. The director of nursing/ assistant director of nursing /minimum data set coordinators (MDS) and the interdisciplinary team (IDT) will audit quarterly, times two quarters, and or until 100% compliance is met for all resident care plans to ensure compliance with the care plan process policy and procedure along with process to include individualized interventions based on resident assessment to be measurable objectives and timetables to meet resident's medical nursing and mental and psychosocial needs. The resident care plans audit results will be forward quarterly to the director of nursing and administratnr for follow up and review. Care Plan audit results will be reported to the quarterly quality assurance committee to include the administrator and the facility medical director for review and follow up for further recommendations. 7/21/13	

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F 280	Continued From page 5	F 280		

was not revised and interventions should have been added. The DON stated both falls occurred when the resident was trying to use the bathroom, they could have used the data collection for baseline elimination as an intervention.

Review of Resident #1's medical record revealed the resident was transferred to the skilled side of the facility on 05/14/13.

Interview, on 06/06/13 at at 11:05 AM and 12:00 PM, with Licensed Practical Nurse (LPN) #2, who cared for Resident #1 on the skilled side revealed the resident had a chair alarm, but was not sure if he/she had a bed alarm. She stated she should have known if he/she had a bed alarm and she did not see alarms on the resident's care plans which was used to communicate to staff. She further stated she was unaware if the bed alarm was discontinued.

Review of the facility's investigative reports revealed on 05/20/13 Resident #1 was found on the floor at 5:30 AM at reported he/she was going downstairs to the bathroom. Under interventions they had initiated a 72 hour tracking for pattern.

Further review of the resident's Care Plan revealed, the fall care plan was not updated with new interventions until 05/30/13 when the following interventions were added: Continue to remind the resident to ask for assistance prior to transfer; Continue alarms to chair; Assist of one with tilting as needed, and 1/2 side rails.

Continued interview, on 06/06/13 at 11:05 AM and 12:00 PM, with LPN # 2, revealed the resident had fallen after getting up out of bed to

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F 280	Continued From page 6 use the bathroom. The LPN stated after the fall the DON had her initiate a data collection for bowel and bladder as an intervention. After reviewing Resident #1's medical chart the LPN stated she did not see the completed document in the chart. Interview with the DON, on 06/07//13 at 12:15 PM revealed the fall on 05/20/13 occurred when the resident got out of his/her bed to use the bathroom and the incident report did not indicate an alarm was sounding. She further stated she did not know why Resident #1 did not have a bed alarm which could have alerted staff the resident was trying to get out of the bed. The DON stated the Intervention was to initiate the Data Collection Baseline Elimination, but it did not appear the document was completed. Continued interview with the MDS Coordinator, on 06/07//13 at 11:30 AM, revealed she did not recall if she had been made aware of the falls on 04/24/13, 04/30/13, and 05/20/13. The MDS Coordinator stated the fall should have been added to the care plan to track the effectiveness of the goal. She stated it was her responsibility to ensure the care plan was updated with a new intervention after a fall. The MDS Coordinator further stated the care plan was not updated with interventions after the falls on 04/24/13, 04/30/13 and was unaware of the results of the toileting tracking data from the 05/20/13 fall to determine if an intervention should have be added. She further stated she should have been notified of the alarms so they could have been added to the care plan and if the alarm was discontinued she would note it on the care plan. The MDS Coordinator added, she did not know how to	F 280		

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F 280	Continued From page 7 monitor the effectiveness of the interventions if they were not all listed on the care plan and she was not made aware of the falls. Continued interview with the DON, on 06/07/13 at 12:15 PM, revealed staff was made aware of the interventions, to meet the resident needs, via the care plan and CNA care plan. She stated all interventions should have been listed on the care plan and should be dated when the intervention was put in place or removed. The DON stated when they had clinical meetings it was the MDS Coordinator who updated the Comprehensive Care Plan and CNA care plan with changes/new interventions. She further stated it was a breakdown in their process for not putting all the interventions that were in place on the care plan and by not having all the falls and interventions listed it would impact the facility's ability to monitor the effectiveness of the interventions in trying to prevent falls.	F 280		
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, interview, record review,	F 323		

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F 323	Continued From page 8 and review of the facility's policy, it was determined the facility failed to ensure one (1) of five (5) sampled residents received adequate supervision and assistive devices to remain as free from accidents as was possible. Resident #1 had three (3) falls while at the facility and investigation of the falls revealed the facility failed to enure fall prevention alarms were routinely checked for function/placement and failed to implement new interventions after the falls to reduce risks. The findings include: Review of the facility's policy: Incident Reporting, effective date 12/2010, revealed under Guideline - the facility was to ensure the resident's environment was as free of accident hazards as was possible and each resident was to receive adequate supervision and assistive devices to reduce accidents. Further review of the policy revealed the Charge Nurse/designee was to add intervention to the care plan as needed. Review of the facility's reference: Educational Guidelines/Incident Reporting, dated October 2009, revealed under Section 5 Fall: staff was to document new interventions put in place to prevent further falls. Review of the facility's policy: Resident Alarms, effective date 12/2010, revealed resident alarms were to be monitored by the restorative nurse each week. Function and changing of the battery were checked weekly. The restorative nurse was to check the strength and function of each alarm weekly and the battery was to be changed when the battery tester indicated a change was needed.	F 323	F 323 SS = D 1. Resident #1 was reassessed by the Minimum Data set coordinator (MDS) 6/7/13. Resident #1 comprehensive Plan of Care and nursing care plan was reviewed and revised on 6/10/13 by the Interdisciplinary team which includes the following: rehab service manager, director of nursing, assistant director of nursing, dietary manager, social service director, minimum data set coordinator, quality of life director, chaplain, and the administrator, (IDT) to reflect adequate supervision required and assistive devices to prevent accidents for resident #1. Brief Interview of mental Status (BIMS) was reassessed by the social service director on 7/12/13 to accurately capture the cognition status of resident #1. On 7/19/13 the Minimum Data set coordinator (MDS) completed a falls risk assessment to capture the current fall risk of resident #1. Education was completed by the director of nursing on 6/14/13 to the clinical nursing staff caring for resident #1 to include the fall risk level and the supervision required to ensure the safety of resident #1. The alarm of resident #1 was immediately checked and replaced by the director of nursing. 6/7/13	

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F 323	Continued From page 9 Record review revealed the facility admitted Resident #1 on 04/12/13, with diagnosis which included Cerebral Vascular Accident (Stroke), Muscle Weakness, Osteoporosis, Seizure Disorder, and History of Pituitary Tumor with Panhypopituitarism. Review of the Fall Risk Evaluation, completed 04/12/13, revealed the resident was assessed as a high fall risk. Review of a Initial Minimum Data Set (MDS) Assessment, dated 04/23/13, revealed Resident #1 had moderate cognitive impairment. The Initial MDS indicated, under Functional Status, the resident required staff assistance with transfers and was not steady with walking, and surface to surface transfers. Review of Resident #1's medication orders revealed the resident was on Plavix, (anticoagulant/blood thinner medication) 75 milligrams given daily. Review of the Resident #1's Comprehensive Plan of Care, initiated 04/23/13, revealed the resident was at risk for fall related injury due to self care deficits, stroke, seizures, and weakness. The goal of the plan of care was for Resident #1 to sustain no fall related injuries. Interventions listed to prevent falls on the Comprehensive Plan of Care for Resident #1 included educate / remind resident to request assistance prior to ambulation and / or transfers, staff assistance with ambulation, and monitor use of assistive devices. Further review of the resident's care plan revealed, the fall care plan was not updated with new interventions until 05/30/13 when the following interventions were added: Continue to	F 323	2. All residents will receive a Fall Risk Evaluation, a check of any alarm the resident may have, a Brief Interview of Mental Status (BIMS) by the interdisciplinary team by 7/12/13. The comprehensive care plans and the state registered nursing assistant (SRNA) care plans will be reviewed and revised by the Minimum Data set coordinator (MDS) assistant director of nursing (ADON) director of nursing (DON) by 7/19/13 according to the completed evaluations to ensure adequate supervision and assistive devices are checked for compliance, logged for strength, placement and function, to prevent accidents weekly by the unit manager.	

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F 323	Continued From page 10 remind the resident to ask for assistance prior to transfer; Continue alarms to chair; Assist of one with toilting as needed, and 1/2 side rails. Further review of the Comprehensive Plan of Care revealed the resident was also care planned for abnormal bleeding and bruising related to the anticoagulant medication. Further review of Resident #1's medical record revealed no orders for alarms or documentation in the Treatment Administration Record (TAR) of any alarms in place for the resident. Review of the facility's 04/24/13 Investigative report revealed Resident #1 was found on the bathroom floor on his/her buttocks at 9:45 AM. The resident stated he/she walked into the bathroom and took a spill. Continued review of the report revealed staff reported the resident's chair alarm was not sounding. Interview with Registered Nurse (RN) #3, on 06/05/13 at 4:10 PM, revealed Resident #1 was found sitting on the bathroom floor and reported he/she took a little spill. The resident's wheelchair was not near the resident and the chair alarm was not sounding. The RN reported the alarm was plugged in and was unable to determine why the alarm was not working, but it had sounded earlier in the morning. The RN further stated she checked to see if the device was working, but did not check the alarm itself and only checked to see if it beeped when the resident sat back down in the wheelchair. Interview with Licensed Practical Nurse (LPN)/Restorative Nurse #1, on 06/06/13 at 12:45	F 323	3. The Interdisciplinary team (IDT) will receive education from the Regional Clinical Reimbursement Consultant by 7/12/13 on developing a care plan utilizing assessment results to ensure adequate supervision is assessed, care planned and assistive devices are part of the plan provided to ensure a safe environment to prevent accidents for residents. The director of nursing will educate and train the licensed staff on the care planning process policy/procedure, and the utilization of the (SRNA) care plan for specific assistance, supervision, placement strength and function, for the use of the required assistive device (alarms) for each resident. The facility Interdisciplinary team (IDT) will review each comprehensive care plan with any resident admission, incident and or change of condition in the daily clinical meeting, which is directed by the director of nursing, to determine the supervision and or assistive device required for each resident. Any resident assessed to have a (BIMS) of less than eight will be provided supervision and assistive devices to prevent accidents. The director of nursing and unit manager will continue to educate and monitor staff for non-compliance of placement and function of the alarms and supervision of any resident with a (BIMS) less than eight.	

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	

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F 323	Continued From page 11 PM, revealed if a resident had alarms they were put on the TAR and staff was to make sure the resident had the alarm and the alarms were functioning each shift. LPN #1 stated it was a performance improvement tool. Further interview with LPN #1 revealed she was responsible for monitoring resident alarms on the skilled side each week and did not test the alarms on the Transitional Care Unit (TCU) side, where Resident #1 resided. She stated she took out the alarm battery each week and tested it to make sure it was still good. Interview with RN #1/TCU Manager, on 06/06/13 at 1:15 PM and 06/07/13 at 10:00 AM, revealed she was under the impression the person on the skilled side was supposed to check the resident alarms throughout the building. She was not aware they were not checking the alarms on the TCU side. The RN further stated she thought they were supposed to get an order for alarms, but upon review of Resident #1's chart could find no order. In addition, she stated she was not aware of documenting alarms on the TAR. Further interview, on 06/07/13 at 10:00 AM, with RN #1/TCU Manager about the fall on 04/24/13 revealed the nurse should have checked the batteries and replaced the alarm if there was a problem with the device. The RN stated after a fall they were supposed to add interventions to the care plan, but no new interventions were added. In addition, the RN stated the alarm was not listed on the Certified Nursing Assistant (CNA) care plan and should have been so the CNAs would know to check and monitor the alarm.	F 323	4. The director of nursing/ assistant director of nursing /minimum data set coordinators (MDS) will monitor weekly 20% of the facility residents and staff to ensure supervision is provided to each resident per the comprehensive assessment and plan of care. All non-compliance for supervision to a resident will be reported immediately to the director of nursing and administrator. The staff member responsible for non-compliance will be coached and disciplined accordingly by the director nursing. Supervision results, alarm checks f will be reported to the quarterly quality assurance committee to include the administrator and the facility medical director for review and follow up for further recommendations. 7/21/13	

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F 323	Continued From page 12 Interview with the Interim Director of Nursing (DON), on 06/07/13 at 12:15 PM, revealed there was no new interventions added to the care plan after the fall on 04/24/13. She stated if the alarm was not working they should have addressed the reason why it had not sounded and would have expected them to replace the alarm. The DON stated staff should have listed the alarms on the resident's TAR so staff could monitor to make sure they were functioning. The DON also added, the facility did not follow the Alarm Policy on the TCU side, because they were not checking the alarm function and battery weekly. Continued review of Investigative reports revealed Resident #1 fell on 04/30/13 at 8:00 AM when the resident got up out of his/her wheelchair to use the bathroom. He/She was found on the floor and the chair alarm was sounding. Review of the Interventions listed revealed they had the resident demonstrate use of the call light while in the wheelchair three (3) times and speech therapy was to continue cognitive therapy. Review of the Resident #1's record revealed the Daily Skilled Nurse note on 05/06/13 at 5:00 PM, noted the resident had large bruising to the right flank and left flank from previous falls. The bruise to the right flank was observed today by the CNA. Interview, on 06/06/13 at 1:15 PM, with CNA #4 revealed on 04/30/13 the resident got up to try and use the bathroom without using his/her call light. The CNA stated he heard the chair alarm sounding and went to check on the resident. He stated the resident had redness to his hand and left hip but no bruising. The CNA further stated	F 323		

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F 323	Continued From page 13 he was unaware of any revision to the CNA plan of care after the fall. Interview, on 06/06/13 at 3:40 PM and on 06/07/13 at 9:40 AM, with RN #2 revealed on 04/30/13 she completed the Investigative report related to Resident #1's fall. She stated after the fall she discussed Interventions with the DON, they were aware the resident could not use his/her call light, but that was what the DON told her to put down as an intervention. She further stated this was no different then the interventions already in place. The RN stated the resident had some bruising to their right side a couple of days after the fall. Interview, on 06/07/13 at 10:00 AM, with RN #1/TCU manager about the fall on 04/30/13 revealed there were no new documented Interventions put in place after the fall that they were not already doing. Continued Interview with the DON, on 06/07/13 at 12:15 PM, revealed after the 04/30/13 fall no new interventions were put in place. She stated falls were brought to the clinical meetings and interventions were reviewed to determine if they needed to be revised. She further stated after review of the falls on 04/24/13 and 04/30/13 no new Interventions were added and they should have been. The DON stated both falls occurred when the resident was trying to use the bathroom, they could have used the data collection for baseline elimination as an Intervention. Further review of the 04/30/13 Investigative report revealed, under the section Interventions already in place, the resident had a bed and chair alarm.	F 323		

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F 323	Continued From page 14 Review of Resident #1's Comprehensive Plan of Care for Falls revealed no bed alarm listed and only an added Intervention on 05/30/13 to continue chair alarm. Review of Resident #1's CNA care plan revealed no bed alarms were listed. Further Interview, on 06/06/13 at 1:15 PM, with CNA #4 revealed he took care of Resident #1 routinely on the TCU side and when the resident came in he/she had both a bed and chair alarm. He stated the resident would take off his/her bed alarm at times and throw it on the floor because the resident did not like it going off when he/she moved in bed. Interview, on 06/07/13 at 12:00 PM, with CNA #3 revealed she took care of Resident #1 on the TCU side and the resident had both a bed and chair alarm. She stated the alarms let them know when the resident was attempting to get up and they were able to get to the resident and assist him/her. Interview, on 06/06/13 at 2:10 PM and 06/07/13 at 12:05 PM, with CNA #1 revealed she took care of Resident #1 on the TCU side and the purpose of putting the alarms on the CNA care plan was to let them know of the Interventions. She further stated she was unaware the resident had a bed alarm. Continued interview, on 06/06/13 at 3:40 PM and on 06/07/13 at 9:40 AM, with RN #2 revealed Resident #1 had a bed and chair alarm. The RN reported the resident would pull out the bed alarm at times because it would go off when he/she	F 323		

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F 323	Continued From page 15 moved in bed. RN #2 further stated the alarms should have been listed on the care plan so everyone could be on the same page. In addition, she stated if alarms were discontinued you were supposed to note this on the care plan so the CNA's were aware. Continued Interview, on 06/07/13 at 10:00 AM, with RN #1/TCU Manager revealed they should have put the alarms on the CNA care plan because it allowed the CNA's to know to check and monitor. If an alarm was discontinued they were to assess why it was okay to discontinue. Review of Resident #1's medical record revealed the resident was transferred to the skilled side of the facility on 05/14/13. Interview, on 06/06/13 at 10:30 AM, with CNA #5 revealed she took care of Resident #1 on the skilled side and he/she had a bed and chair alarm in the past. She stated she was aware the resident had a chair alarm, it was listed on the current CNA care plan on the skilled side. Interview, on 06/06/13 at 3:15 PM, with CNA #2 revealed he took care of Resident #1 on the skilled side and the resident had a chair alarm, but no bed alarm. Interview, on 06/06/13 at at 11:05 AM and 12:00 PM, with LPN #2, who cared for Resident #1 on the skilled side revealed the resident had a chair alarm, but not sure if he/she had a bed alarm. She stated she should have known if he/she had a bed alarm and she did not see alarms on the resident's care plan which was used to communicate to staff. She further stated she was	F 323		

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F 323	Continued From page 16 unaware if the bed alarm was discontinued. The LPN stated she did not put alarms on the TAR. Review of the facility's Investigative reports revealed on 05/30/13 Resident #1 was found on the floor at 5:30 AM and reported he/she was going downstairs to the bathroom. Interview, on 06/06/13 at 11:05 AM and 12:00 PM, with LPN #2, revealed the resident had fallen, on 05/20/13, after getting up out of bed to use the bathroom. She stated the incident report did not identify a bed alarm. The LPN stated after the fall the DON had her initiated a data collection for bowel and bladder as an intervention, but she did not see the completed document in the chart. The LPN further stated after the fall the resident developed bruising to the chest area, but did not complain of pain. Record review revealed Resident #1 was sent out to the hospital on 05/23/13 after the resident complained of chest pain. Review of the Diagnostic Imaging Report of the resident's ribs, dated 05/23/13, revealed numerous rib fractures of uncertain age, although it was suspected there was an acute rib fracture bilaterally of the left fifth rib and a possible acute fracture of the tenth or eleventh right rib. Interview with the DON, on 06/07/13 at 12:15 PM, revealed the 04/30/13 incident report listed Resident #1 had a bed and chair alarm. The DON stated she did not know what happened to the bed alarm, when Resident #1 was transferred to the skilled side. She stated the fall on 05/20/13 occurred when the resident got out of his/her bed to use the bathroom and the incident report did	F 323		

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F 323	Continued From page 17 not indicate an alarm was sounding. She further stated she did not know why the resident did not have a bed alarm which could have alerted staff the resident was trying to get out of the bed. The DON stated the Intervention was to initiate the Data Collection Baseline Elimination, but it did not appear the document was completed. She stated it was the DON's responsibility to follow-up, but the DON at that time was no longer at the facility and it appeared the Intervention was not followed through. Continued Interview with the DON revealed it appeared the facility did not follow their fall prevention policy for putting new Interventions in place to reduce the risk of falls or their policy on checking alarms.	F 323		