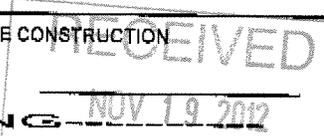


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/02/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185194</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. <b>WING</b>	(X3) DATE SURVEY COMPLETED  <b>10/19/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE FORUM AT BROOKSIDE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 BROOKSIDE DRIVE LOUISVILLE, KY 40243</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 000 INITIAL COMMENTS

F 000

A standard survey was initiated on 10/16/12 and concluded on 10/19/12. A Life Safety Code survey was conducted on 10/16/12. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct before remedies would be recommended for imposition.

F 252 483.15(h)(1)  
SS-D SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

F 252

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, it was determined the facility failed to provide a homelike environment for four (4) of forty (40) resident rooms as evidenced by torn wall paper and gouged/damaged dry wall in visible areas behind and to the sides of the residents' beds. In addition, room #1 had multiple medical supplies placed throughout the room.

The findings include:

Observation, on 10/16/12 at 9:30AM, during initial tour revealed peeling wall paper behind the beds in rooms #1 bed B, #12 bed A, #26, and #29 bed A. In addition, gouged areas of dry wall were observed in rooms #1 bed B, #12 bed A, and #29 bed A.

F252 483.15(h)(1)

Safe/Clean/Comfortable/Homelike Environment

11/09/12

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and state law.

**Corrective Action for Residents Cited by Deficient Practice**

With respect to the residents rooms cited, Room #1 peeling wallpaper has been repaired and room painted, gouged areas of drywall were filled and painted, multiple personal and medical supplies were consolidated and stored in stackable storage containers, to provide a comfortable and homelike environment, to the extent possible. Rooms #12, 26, and 29, the gouged areas of drywall were filled and painted, wallpaper was repaired. All corrective actions were completed by 11/06/12.

**Identification of Other Facility Residents that may be affected by the deficient practice**

With respect to how the facility will

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Karen J. ... RN, BSN, WHA, DON</i>	TITLE <i>Dir. of Nsg</i>	(X6) DATE <i>11/19/12</i>
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A 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 252 Continued From page 1

Observation, on 10/16/12 at 10:00 AM, during initial tour revealed room #1 bed B, with multiple medical supplies stacked on top of the counter along the window that was visible from the door.

Observation, on 10/17/12 at 8:10AM, found the following medical supplies stored in room #1: On the left counter area and below on shelves were 10 blue chucks; 3 tracheostomy tubing packages; multiple bath supplies; a humidifier; and 1 opened gallon of distilled water. On the floor was 2 gallon jugs of distilled water, and a large package of blue briefs. On the right counter visible from the door was a pack of 12 briefs; 8 chucks; 8 bottles of 1000 ml sterile water; 2 boxes with different items for tracheostomy care/needs; 13 suction catheter sets; 8 tracheostomy care sets; 1 suction canister kit; 1 nebulizer kit; 5 nebulizer adapter kits; and 1 partial box of 25 split trach sponges.

Interview with Unsampled Resident C, on 10/19/12 at 9:45AM, revealed a request to pull the privacy curtain further down because the resident did not like to look at all the clutter on the other side of the room.

Interview, on 10/19/12 at 10:00 AM, with the Director of Plant Operations revealed he was aware of the damaged wall and torn wallpaper in room #12, and he provided a copy of a work order #5793, dated 10/16/12, for the scheduled repair. The Plant operations manager stated he was not aware of the damage in rooms #1, #26, and #29. He stated he made monthly room rounds to identify potential safety hazards and necessary repair work, but he was not aware of the wall damage in rooms #1, #26, and #29. He

F 252

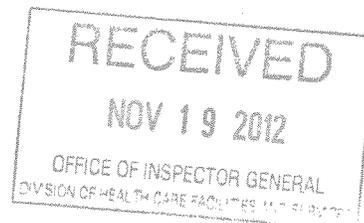
identify residents with the potential for the identified concern and take corrective action, The Director of Plant Operations conducted a full facility room audit to identify and improve any rooms that appear to not be safe, clean, comfortable and provide a homelike environment, on 11/06/12.

**Implementation of Systemic Measures**

With respect to what systemic measures have been put in place to address that stated concern, The Director of Plant Operations and Director of Nursing conducted in-service training for nursing, maintenance and housekeeping staff on the proper procedures for identifying and reporting resident room repairs, safety hazards, minimizing clutter, cleanliness, and how to place work orders was completed 11/08/12. The Maintenance department will conduct bi-weekly audits of resident rooms to ensure all rooms are safe, clean, comfortable and a homelike environment.

**Monitoring of Corrective Action**

With respect to how the plan of corrective measures will be monitored, The Director of Plant Operations will conduct monthly life safety inspections



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F 252 Continued From page 2  
could not provide a log that documented his monthly rounds, but he stated as soon as problems were identified he assigned the repair work to his maintenance staff.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  
SS=E  
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 observation, interview, record review and review of facility policy, it was determined the facility failed to follow the care plan for three (3) of ten (10) sampled residents (#5, #7 and #8). The facility assessed Residents #5, #7, and #8 as a high falls risk and implemented interventions for bed and chair alarms at all times.

The findings include:  
Review of the facility's policy regarding Fall Management and Investigation Program, revised 10/15/11, under the section interventions and care plan process revealed facility staff, residents and family members will be made aware of the different interventions used with the resident through the care plan process.

1. Review of the medical record for Resident #5 revealed the facility admitted the resident on 09/17/09 with diagnoses including Bladder

F 252 of all resident rooms to review the completion of any concerns noted in the bi-weekly audits. All findings of the audits will be reported at the Quarterly Quality Assurance Committee Meeting quarterly for one year then as needed for any issues or concerns.

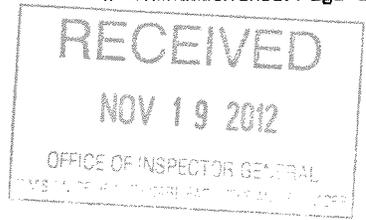
F 282 483.20(k)(3)(ii) Services by Qualified Persons/per Care Plan

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and state law.

**Corrective Action for Residents Cited by Deficient Practice**

With respect to the residents cited, Residents #5, 7, 8, audits of the resident care plans were completed by the Assistant Director of Nursing on 10/18/12, to determine that all alarm interventions were in place. A new falls assessment was completed by the Assistant Director of Nursing on 10/24/12 for each resident. All alarms were checked for functioning, correct placement and all batteries were replaced by the night shift charge

11/09/12



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F 282 Continued From page 3

Cancer, Esophageal Stricture, Memory Loss, and Depression. Review of the Comprehensive Care Plan revealed the facility had initiated a care plan for high falls risk on 09/30/09. The resident did not have a fall from 09/17/11 until 04/23/12. The next fall was documented on 06/21/12. From 07/14/12 until 10/10/12 the resident had 20 falls without significant injury. On 07/22/12 the facility put an intervention in place for a floor mat alarm after a fall. On 08/12/12 the facility put in an intervention for a chair/bed alarm. The interventions for floor mat alarm and chair/bed alarms were included on the Certified Nursing Assistants (CNA) plan report as well.

Observations, on 10/16/12 at 3:50PM, 10/17/12 at 8:15AM, 9:45AM, and 10:50 AM, and 10/18/12 at 7:50AM, found Resident #5 sitting up in the wheelchair or recliner with no alarm in place. Continued observations, on 10/18/12 at 10:45 AM, revealed the resident in the recliner dressing self. The floor mat was stepped on but did not alarm. Observation, on 10/18/12 at 1:15 PM, revealed the resident sitting up in the wheelchair, dressing self. There was no chair alarm on the wheelchair, and when the floor mat was stepped on it did not alarm. Observation of the alarm box revealed the switch was in the off position.

Interview, on 10/17/12 at 10:45 AM, with CNA#2 revealed she was assigned to provide care for Resident #5. She stated the resident did not have alarms on the wheelchair and had not since she had been here from July of this year.

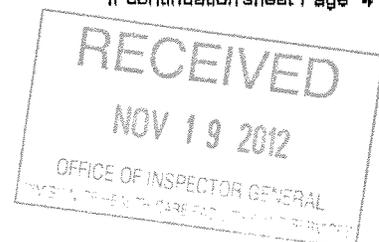
Interview with CNA#2, on 10/18/12 at 10:45 AM, revealed Resident #5 had a floor mat alarm and it

F 282

nurse. Health Care staff received in-service training regarding proper placement of resident alarms, checking resident alarms every two hours as residents are toileted and provided ADL care, timely response to activated resident alarms, and review of resident care plans on a continual basis. Staff were in serviced on location to view resident care plans, within the Care Tracker system and in resident's rooms by the Director of Nursing and Assistant Director of Nursing with completion on 11/08/12.

**Identification of Other Facility Residents that may be affected by the deficient practice**

With respect to how the facility will identify residents with the potential for the identified concern and take corrective action, an audit of all care plans was completed by the Assistant Director of Nursing to ensure all alarm interventions were in place, on 11/08/12. All resident alarms were checked for functioning and correct placement. New batteries were installed on all alarms on 10/18/12 by the night shift charge nurse. Fall assessments were conducted on all residents by the Assistant Director of Nursing and completed on 11/08/12. Health Care staff received in-service training regarding proper placement of resident alarms, checking resident alarms every two hours as residents are toileted and providing ADL care, timely



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F 282 Continued From page 4

should be on when the resident was in the room. She proceeded to check the box and stated she thought it needed a battery.

Interview with Registered Nurse #1, on 10/18/12 at 1:15 PM, revealed Resident #5 should have a floor mat in use when the resident was in the room.

Interview with RN #1, on 10/18/12 at 1:55PM, revealed Resident #5 should have had a floor mat, alarm and chair alarms. She stated she found the chair alarm in the resident drawer. She stated the nurse was responsible to check alarms every shift to ensure they are on and functioning. She stated we are all responsible to ensure residents have assistive devices to prevent falls. She stated the resident will take off alarms and turn them off.

2. Review of the medical record for Resident #7 revealed the facility admitted the resident on 07/13/11 after a fall at home. The Resident's diagnoses included Alzheimer Dementia, Epilepsy, Macular Degeneration, Glaucoma, and Right Hip Replacement.

Review of the comprehensive care plan revealed a care plan for high risk of falls was developed on 07/21/11 with an intervention of a floor mat alarm, and a pad alarm to bed and chair dated 07/21/11. An intervention to observe frequently and place in supervised area when out of bed, was dated 10/17/11.

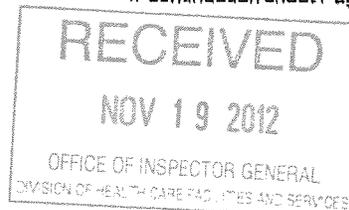
Observation, on 10/16/12 at 11:45 AM, revealed Resident #7 in the dining room with three other residents. There was no staff monitoring in the dining room. The residents chair alarm was

F 282

response to activated resident alarms, and review of resident care plans on a continual basis. Staff were in serviced on location to view resident care plans, within the care tracker system and in resident's rooms by the Director of Nursing and Assistant Director of Nursing with completion on 11/08/12.

**Implementation of Systemic Measures**

With respect to what systemic measures have been put in place to address that stated concern, The Assistant Director of Nursing will maintain an up-to-date master list of all residents with alarms and proper placement of the alarms. The Central Supply staff member will change the batteries of all alarms on a monthly basis and will keep a list of the date the batteries are changed. Health Care staff received in-service training regarding checking resident alarms are placed correctly, proper placement of resident alarms every two hours as residents are toileted and providing ADL care, timely response to activated resident alarms, and review of resident care plans on a continual basis. Staff were in serviced on location to view resident care plans, within the care tracker system and in resident's rooms. Director of Nursing and Assistant Director of Nursing conducted in-service training with Health Care staff by 11/08/12.



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F 282 Continued From page 5

sounding and the resident was found by two surveyors standing up beside the wheelchair trying to put it under the table.

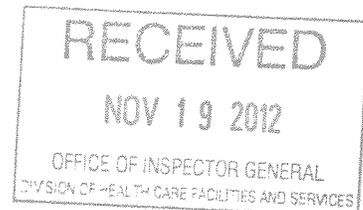
Interview with CNA#1, on 10/18/12 at 2:15PM, revealed Resident #7 should not have been in the dining room without supervision and, they should have responded to the alarms immediately.

Interview with Licensed Practical Nurse #1, on 10/18/12 at 2:45 PM, revealed staff were trained on accidents /supervision with the most recent inservice last month. She stated last months training on accidents including alarms and they should be checking them every 2 hours for chair alarms, pad alarm and tab alarm. She stated the nurses are responsible to check that the alarms are in place. She stated if an alarm sounds, staff should respond immediately. She stated Resident #7 should have never been left in the dining room unsupervised and it was unacceptable when they did not respond immediately to the alarm. LPN #1 stated she believed the problem was the facility couldn't get the staff to keep current and read the care tracker for updates, and no one was assigned to monitor the CNA's and nurses to ensure they are providing the care as indicated on the care plan.

Review of the medical record for Resident #8 revealed the facility admitted the resident on 07/03/12 with diagnoses including, Interstitial Lung Disease, Respiratory Insufficiency, Severe Mitral Valve Regurgitation, and Paroxysmal Atrial Fibrillation. Review of the comprehensive care plan for Resident #8 revealed the facility implemented interventions on 07/11/12 for falls prevention including a floor pad alarm when in

F 282 **Monitoring of Corrective Action**

With respect to how the plan of corrective measures will be monitored, The Assistant Director of Nursing will update care plans daily with new physician orders, maintain daily the master list of residents with alarms, which will be accessible to all staff. Bi-weekly room rounds will be conducted by Executive Director, Director of Nursing, Director of Admissions, Food & Beverage Director, Assistant Food & Beverage Director, and Central Supply staff member, to ensure proper placement of resident alarms and functioning of alarms. All findings of the audits will be reported at the Quarterly Quality Assurance Committee Meeting quarterly for an ongoing basis. The Director of Nursing will review all audits on a monthly basis for an ongoing basis.



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F 282 Continued From page 6

F 282

bed, and bed/chair alarms at all times. This was also included on the CNA care record.

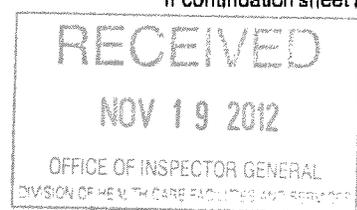
Observation, on 10/18/12 at 9:30AM, revealed Resident #8 seated in a recliner in his/her room with no chair alarm in place, nor were floor mats in place by the recliner.

Observation, on 10/18/12 at 1:05 PM and at 1:20 PM, at the health care dining room, revealed Resident #8 did not have a chair alarm in place.

Interview, on 10/18/12 at 2:25 PM, with CNA#1 revealed she was not aware that Resident #8 was to have a chair alarm in place at all times, and she had not read the section in the CNA care tracker where this information was recorded.

Interview, on 10/18/12 at 1:45 PM, with RN #1 revealed she was aware that Resident #8 had a history of falls and that bed and chair alarms were ordered to be in place at all times. All direct care staff was responsible for knowing which residents were care planned for alarms, and for checking the placement and functionality of the alarms.

Interview with the Director of Nursing, on 10/18/12 at 3:15 PM, revealed when a resident had a fall, staff meet as a team to determine changes in interventions, labs, and/or diet. She stated the nurses should be checking the alarms every shift and documenting this action on the Medication/Treatment record. She stated if the resident had an alarm it should be checked every two hours by the CNA. She stated everyone was to respond to alarms immediately. The DON went on to say if staff are not doing the interventions put in place to prevent falls the



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F 282 Continued From page 7  
interventions are not effective. She stated someone did random room rounds and random checks on residents to ensure alarms and intervention are in place but no documentation of this action was given to the surveyor.

F 323 SS=E 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  
  
The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure bed and chair alarms were in place to alert staff of potential falls for three (3) of ten (10) Residents (#3 and #8) and failed to supervise and respond to alarms for Resident #7.

The findings include:

Review of the facility's policy regarding Falls Management and Restraint Reduction Strategies, dated 10/30/01, revealed under section 1.1 alternatives for residents with unsafe mobility included: do not leave the resident alone while transported to activities, meals, therapy and bathroom; and provide fall prevention devices

F 282

F 323

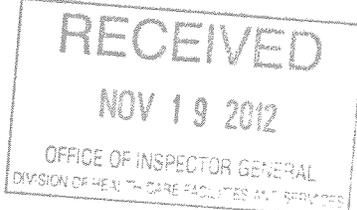
**F323 483.25(h) Free of Accident Hazards/Supervision/Devices**

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and state law.

**Corrective Action for Residents Cited by Deficient Practice**

With respect to the residents cited, Residents #3, 5, 7, 8, audits of the resident care plans were completed by the Assistant Director of Nursing on 10/18/12, to determine that all alarm interventions were in place. A new falls assessment was completed by the Assistant Director of Nursing on 10/24/12 for each resident. All alarms were checked for functioning, correct placement and all batteries were replaced. Health Care staff received in-service training regarding proper placement of resident alarms, checking resident alarms every two hours as residents are toileted and providing ADL

11/09/12



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NAME OF PROVIDER OR SUPPLIER  THE FORUM AT BROOKSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 BROOKSIDE DRIVE LOUISVILLE, KY 40243
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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 Continued From page 8  
and ensure they are functioning properly.

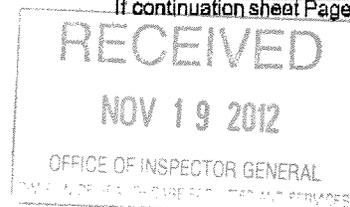
1. Review of the medical record for Resident #5 revealed the facility admitted the resident on 09/17/09 with diagnoses including Bladder Cancer, Esophageal Stricture, Memory Loss, and Depression. Review of the Minimum Data Set (MDS) Assessment revealed the facility completed a significant change comprehensive assessment on 06/14/12 related to decline in mental status, mobility, and weight. The facility assessed the resident with a Brief Interview for Mental Status (SIMS) at a 12, moderately impaired; and mobility, transfer, ambulation and dressing with supervision with assist of one staff. The facility completed a quarterly assessment for Resident #5 on 09/10/12 and assessed Cognition with a SIMS score of 3, severely impaired and mobility, transfer, ambulation, and dressing as limited assistance with assist of one.

Review of the comprehensive care plan for Resident #5 revealed the facility had initiated a care plan for high falls risk on 09/30/09. On 07/22/12 the facility added an intervention in place for floor mat alarms after a fall. On 08/12/12 the facility put in an intervention for a chair, and bed alarms. The interventions for floor mat alarm and chair/bed alarms were included on the Certified Nursing Assistants (CNA) plan report as well. The resident had falls on 08/20/12, 08/24/12, 08/25/12, 08/28/12, 08/31/12, 09/02/12, 09/03/12, 09/04/12, 09/08/12, 09/29/12, 10/06/12, and 10/10/12 with no injury. There were no new interventions put into place following these falls. On 10/06/12 the facility documented refusal of therapy and after the fall on 10/10/12, refusal of

F 323 care, timely response to activated resident alarms, and review of resident care plans on a continual basis. Staff were in serviced on location to view resident care plans, within the Care Tracker system and in resident's rooms by the Director of Nursing and Assistant Director of Nursing with completion on 11/08/12.

**Identification of Other Facility Residents that may be affected by the deficient practice**

With respect to how the facility will identify residents with the potential for the identified concern and take corrective action, an audit of all care plans was completed by the Assistant Director of Nursing on 11/08/12 to ensure all alarm interventions were in place on all residents. A master list for all alarms systems has been placed at the nurse's station and accessible to all staff. This list will be updated daily, with new physician orders, by the Assistant Director of Nursing. Health Care staff received in-service training regarding proper placement of resident alarms, checking resident alarms every two hours as residents are toileted and providing ADL care, timely response to activated resident alarms, review of resident care plans on a continual basis. Staff members were in serviced on location



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NAME OF PROVIDER OR SUPPLIER  THE FORUM AT BROOKSIDE		STREET ADDRESS, CITY, STATE, ZIP CODE 200 BROOKSIDE DRIVE LOUISVILLE, KY 40243	
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			(X5) COMPLETION DATE

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therapy and removes alarms. A care plan was developed on 10/12/12 for refusal of care related to taking alarms off and refusal to use the call light.

Review of the accident investigations for Resident #5 from 08/20/12 to 10/10/12 revealed no indication if alarms were sounding or if the resident removed the alarms.

Observation, on 10/16/12 at 3:50PM, 10/17/12 at 8:15AM, 9:45AM, and 10:50 AM, and 10/18/12 at 7:50AM, found Resident #5 sitting up in the wheelchair or recline with no alarm in place. Continued observation, on 10/18/12 at 10:45 AM, revealed the resident in the recliner dressing self. The floor mat was stepped on but did not alarm. Observation, on 10/18/12 at 1:15 PM, revealed the resident sitting up in the wheelchair dressing self. There was no chair alarm on the wheelchair, and when the floor mat was stepped on it did not alarm. Observation of the alarm box revealed the switch was in the off position.

Interview, on 10/17/12 at 10:45 AM, with CNA#2 revealed she was assigned to provide care for Resident #5. She stated she was not aware the resident had an intervention for chair alarms.

Interview with CNA#2, on 10/18/12 at 10:45 AM, revealed Resident #5 had a floor mat alarm and it should be on when the resident was in the room. She proceed to check the floor mat alarm and when it did not sound she checked the box and stated she thought it needed a battery.

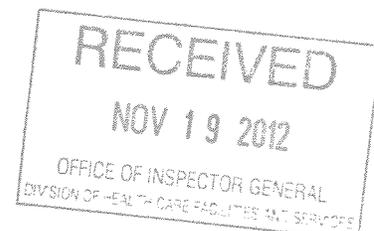
Interview with Registered Nurse #1, on 10/18/12 at 1:15 PM, revealed Resident #5 should have a

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to view resident care plans, within the Care Tracker system and in resident's rooms. Staff members were in-serviced on not leaving residents that are at high risk for falls, unattended in the dining room or during activities. Director of Nursing and Assistant Director of Nursing conducted in-service training by 11/08/12.

**Implementation of Systemic Measures**

With respect to what systemic measures have been put in place to address that stated concern, a master list for all alarms systems has been placed at the nurse's station and accessible to all staff. This list will be updated daily, with new physician orders, by the Assistant Director of Nursing. Health Care staff received in-service training regarding proper placement of resident alarms, checking resident alarms every two hours as residents are toileted and providing ADL care, timely response to activated resident alarms, review of resident care plans on a continual basis. Staff members were in serviced on location to view resident care plans, within the Care Tracker system and in resident's rooms. Staff members were in-serviced on not leaving residents that are high risk for falls unattended in the dining room or during activities. Director of Nursing and Assistant Director of



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NAME OF PROVIDER OR SUPPLIER  THE FORUM AT BROOKSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 BROOKSIDE DRIVE LOUISVILLE, KY 40243
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F 323 Continued From page 10  
 floor mat in use when the resident was in the room. Continued interview with RN #1, on 10/18/12 at 1:55 PM, revealed Resident #5 should have had a floor mat alarm and chair alarms. She stated she found the chair alarm in the resident drawer. She stated the nurse was responsible to check alarms every shift to ensure they are on and functioning. She stated they are all responsible to ensure residents have assistive devices to prevent falls. She stated the resident will take off alarms and turn them off.

2. Review of the medical record for Resident #7 revealed the facility admitted the resident on 07/13/11 after a fall at home. The Residents diagnoses included, Alzheimer Dementia, Epilepsy, Macular Degeneration, Glaucoma, and Right Hip Replacement. Review of the Minimum Data Set Assessment (MDS), dated 10/08/12 and 07/17/12, revealed the facility assessed the resident as zero (0), unable to complete the BIMS assessment, as moderately impaired with assist of one (1) with transfer, mobility, hygiene and bathing.

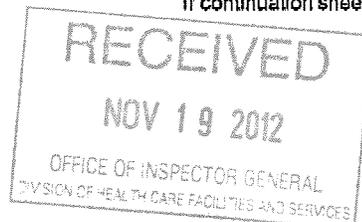
Review of the comprehensive care plan revealed a care plan for high risk of falls was developed on 07/21/11 with interventions including floor mat alarm, pad alarm to bed and chair. On 10/17/11 an intervention to observe frequently and place in supervised area when out of bed was added.

Observation, on 10/16/12 at 11:45 AM, revealed Resident #7 in the dining room with three other residents. There was no staff in the dining room. The residents chair alarm was sounding and the resident was found by two surveyors standing up beside the wheelchair trying to put it under the

F 323 Nursing conducted in-service training by 11/08/12.

**Monitoring of Corrective Action**

With respect to how the plan of corrective measures will be monitored, the Interdisciplinary Care Plan team will review care plans for proper usage and placement of alarms, on a quarterly basis. The Assistant Director of Nursing will update care plans daily with new physician orders, maintain daily the master list of residents with alarms, which will be accessible to all staff. Weekly room rounds will be conducted by Executive Director, Director of Nursing, Director of Admissions, Food & Beverage Director, Assistant Food & Beverage Director, and Central Supply staff member, to ensure proper placement of resident alarms and functioning of alarms. All findings of the audits will be reported at the Quarterly Quality Assurance Committee quarterly for and ongoing basis. The Director of Nursing will review all audits on a monthly basis for an ongoing basis.



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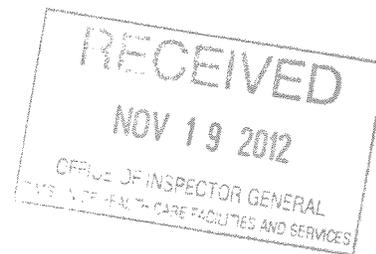
F 323

table. Two staff were outside the medication room door directly across from the dining room tending to an oxygen cylinder and did not respond to the audible alarm. One surveyor retrieved a staff member to assist the resident.

Interview with CNA#1, on 10/18/12 at 2:15PM, revealed Resident #7 should not have been in the dining room without supervision and, they should have responded to the alarms immediately.

Interview with Licensed Practical Nurse #1, on 10/18/12 at 2:45 PM, revealed staff was trained on accidents/supervision with the most recent inservice last month. She stated last months training on accidents, including alarms instructed staff to check them every 2 hours for chair alarms, pad alarm and tab alarm. She stated the nurses are responsible to check that the alarms are in place. She stated if an alarm sounds, staff should respond immediately. She stated Resident #7 should have never been left in the dining room unsupervised and it was unacceptable when they did not respond immediately to the alarm. LPN #1 stated she believed the problem was the facility cant get the staff to keep current and read the care tracker for updates, and no one was assigned to ensure the CNA's and nurses were doing what they should be doing.

3. Review of the medical record for Resident #8, revealed the facility admitted the resident on 07/03/12 with diagnoses including: Interstitial Lung Disease, Respiratory Insufficiency, Severe Mitral Valve Regurgitation, and Paroxysmal Atrial Fibrillation. Review of the MDS Assessment, dated 08/20/12, revealed the facility assessed the



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resident with a cognition of four (4) on the BIMS as severely impaired; and transfer, dressing and bathing as moderately impaired with one assist. Review of the MDS Assessment, dated 07/10/12, revealed the facility assessed the resident with a cognition 14 out of 15 on the SIMS score, with transfer, dressing and bathing as moderately impaired with one assist.

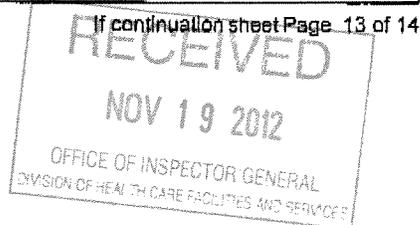
Review of the comprehensive care plan for Resident #8 revealed the facility initiated interventions, on 07/11/12, for falls prevention including a floor pad alarm when in bed, and bed/chair alarms at all times. The facility documented on the care plan the resident had falls on 07/21/12, 07/24/12, 08/03/12, 08/04/12, and 08/14/12 with no injury. There were no new interventions put into place after these falls.

Review of the CNA care tracker for Resident #8 revealed documentation of bed and chair alarms in place at all times.

Observation, on 10/18/12 at 9:30AM, revealed Resident #8 seated in a recliner in his/her room, no chair alarm was not in place, nor were floor mats in place by the recliner.

Observation, on 10/18/12 at 1:05 PM and 1:20 PM, at the health care side dining room, revealed Resident #8 did not have a chair alarm in place.

Interview, on 10/18/12 at 2:25PM, with CNA#1 revealed she was not aware Resident #8 was to have a chair alarm in place at all times, and she had not read the section in the CNA care tracker where this information was recorded.



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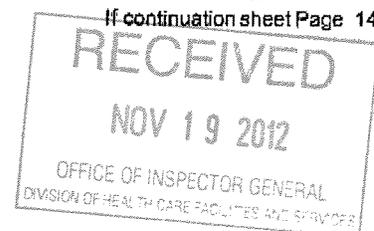
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Interview, on 10/18/12 at 1:45 PM, with RN #1 revealed she was aware that Resident #8 had a history of falls and that bed and chair alarms were ordered to be in place at all times. All direct care staff was responsible for knowing which residents were care planned for alarms, and for checking the placement and functionality of the alarms.

Interview with the Director of Nursing, on 10/18/12 at 3:15 PM, revealed when a resident had a fall, staff meet as a team to determine changes in interventions, labs, and/or diet. She stated the nurses should be checking the alarms every shift and documenting this action on the Medication/Treatment record. She stated if the resident had an alarm it should be checked every two hours by the CNA. She stated everyone was to respond to alarms immediately. The DON went on to say if staff are not doing the interventions put in place to prevent falls the interventions are not effective. She stated someone did random room rounds and random checks on residents to ensure alarms and intervention are in place but no documentation of this action was provided.



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NAME OF PROVIDER OR SUPPLIER  <b>THE FORUM AT BROOKSIDE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 BROOKSIDE DRIVE LOUISVILLE, KY 40243</b>		
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1991</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III Protected.</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors, upgraded in 2001.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet and dry) sprinkler system, upgraded in 2001.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 10/16/12. The Forum at Brookside was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.