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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045140	A. BUILDING ______ B. WING ______	C **01/29/2007**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEARCY HEALTHCARE CENTER	**1205 SKYLINE DRIVE SEARCY, AR 72143**

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F 000	INITIAL COMMENTS Complaint #12273 substantiated (all or in part) with deficiencies cited at F324, F490 and F520	F 000		
F 324 SS=J	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #12273 substantiated (all or in part) with these findings: Based on observation, record review and interview, the facility failed to ensure that causative factors for falls were identified and evaluated, interventions were developed based on the causative factors, that interventions were consistently implemented or effectiveness assessed/reassessed in order to prevent falls and to reduce the risk of injuries from falls for all 5 case-mix residents (Residents # 1-5) who was identified to be at risk for falls. The failed practices resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury or death for Resident #1who sustained repeated falls which resulted in a subdural hematoma, and had the potential to affect 33 residents in the facility who had fallen in the past 30 days according to a list provided by the Director of Nursing (DON) on 1/29/07 at 3:30 p.m.. The facility was informed of the Immediate Jeopardy condition on 1/29/07 at 12:40 p.m. The findings are: 1. Resident #1 had diagnoses of Impulse Control Disorder, Mental Retardation, and Deaf-Mute.	F 324		

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.

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F 324	Continued From page 1 The Quarterly Minimum Data Set (MDS)dated 11/8/06 documented the resident had moderately impaired cognitive skills for daily decision making, required limited assistance of one person with transfers and walking in his room and had a fall in the past 31-180 days. a. The resident's care plan (problem onset 12/3/04) was updated 12/28/06 and documented, "Problem: Resident at risk for falls related to vertigo, wandering, staggery and unsteady gait with history of multiple falls. Lasts falls were 8/11/04, 9/2/04, 9/30/04, and 10/27/04. Interventions: ...1/17/05 - helmet provided to resident to protect head due to falls. Res. removed helmet and threw it into the floor on several occasions. ...1/18/05 - Locked lap tray to w/c when up - Dc'd 1/19/05 causing agitation and aggression..." b. The Occupational Therapy Screen Form dated 4/12/06 documented, "...fell going to B.R. (bathroom) has all the fall precautions system in place." c. The Occupational Therapy Screen Form dated 4/24/06 documented, "...Pt (patient) turned off w/c alarm got up and tripped over w/c ..." d. A Fall Risk Assessment dated 5/16/06 documented a score of 15. The assessment documented, "... If the total score is 10 or greater, the resident should be considered at High Risk for potential falls ... " e. The Psychiatric Evaluation dated 7/23/06 documented, "... (Resident #1) is evidently deaf and mute; however, he can make sounds. He has mental retardation and poor coping skills. He	F 324		

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F 324	Continued From page 2 is not able to write and primarily our only communication with him is via gesturing at this time. ..." f. The Bowel and Bladder Assessment dated 7/28/06 documented the resident was not a candidate for the Bowel and Bladder Program. There was no further documentation that a Bowel and Bladder Assessment was conducted after 7/28/06. g. The August 2006 Physician's Order documented, "... 8/4/06 - Releaseable Seatbelt with Alarm while up in w/c (wheelchair) due to resident attempting to ambulate and being unable to do so check every 30 minutes and release every 2 hours and PRN (as necessary) for ADLs (activities of daily living) , grooming, repositioning. ... Bed Alarm to bed to remind resident to call for assist prior to transfers. Check placement and function every shift." h. The Incident and Accident (I/A) Report dated 9/6/06 at 03:45 a.m. documented, "...resident got OOB (out of bed) alarm was functioning attempted to walk to bathroom unassisted fell to the floor knocking items off chest of drawers by bathroom door and fell on his bottom possible bruise ..." The diagram indicated the possible bruise was located in the middle lower back section and the left posterior arm. "Past Interventions: Bed alarm - Recommendations/New Interventions: Cont (continue) POC (plan of care)." i. The Occupational Therapy Screen Form dated 9/12/06 documented, "...Pt found in floor of room. Alarm turned off (pt has been known to turn alarm off) Nsg (Nursing) to monitor this closely."	F 324		

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j. The nurse's notes dated 9/27/06 at 8:20 p.m. documented, "... resident observed in floor on his hands and knees. no witness present. ...no s/s (signs and symptoms) of injury ..."

k. The I/A report dated 10/7/06 at 9:00 a.m. documented, "... found resident sitting in floor on buttock in bathroom with sink beside him ... no injuries noted assisted back to bed ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, skid strips, bed alarm, chair alarm and dysum (non-skid cushion) in chair - Recommendations/New Interventions: floor in BR (bathroom) dried Bed alarm replaced."

l. On 1/26/07 at 10:40 a.m., the Social Director was asked if Resident #1 was transferred to a different room within the facility for any reason. She provided information that the resident was moved out of Room #42 into Room 70 on 10/7/06 for housekeeping and maintenance to strip and wax the floors and paint his room. The resident returned to Room #42 on 10/9/06.

m. On 1/29/07 at 9:45 a.m., during an interview with the Housekeeping Supervisor, she stated, "During the morning meetings, we discuss falls and we're told who (residents) to put the non-skid strips down for." She stated that maintenance puts the strips down on the floor. She stated the strips would have to come up off the floor in order to strip and wax a room and then they're replaced. She acknowledged nothing had been done to the resident's room (Room #42) since October 2006. The strips were never replaced [after the resident returned to the room on 10/9/06].

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n. The I/A report dated 11/5/06 at 21:45 p.m. (9:45 p.m.) documented, "... Found sitting in floor in D/R (dining room) with w/c over on him. Attempting to get another meal tray. ... no injuries noted ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips beside bed and in bathroom, and dysum (non-skid cushion) in chair - Recommendations/New Interventions: given extra food on plate."

o. The I/A report dated 11/7/06 at 8:00 a.m. documented, "... Resident was in room and fell hitting head on door - Hematoma to Left side of head ...Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips, bed alarm, chair alarm and dysum in chair - Recommendations/New Interventions: Resident has a bed alarm and chair alarm - non-skid socks on at all times - Dry floor when through in restroom."

p. The I/A report dated 11/13/06 at 5:00 a.m. documented, "...CNA (certified nursing assistant) responded to bed alarm found resident on floor trying to get up. Resident noted to have a small abrasion to left side of forehead above eyebrow. Abrasion from previous fall 11/7/06. ... Past interventions: see CP (care plan) - Recommendations/New Interventions: Therapy Screen - keep urinal beside bed at all times while resident in bed."

The Occupational Therapy Screen Form dated 11/13/06 documented, "...Alarm devices in place and working - Pt tried to get up out of bed. Hx (history) of falls secondary to inner ear problem. Nursing care planning falls as all interventions

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has been tried."

q. The I/A report dated 11/14/06 at 4:10 a.m. documented, "... resident got OOB (out of bed) unassisted and was standing at bathroom door when CNA responded to bed alarm resident then let go of door lost his balance and fell on his bottom continued onto back and bumped his occipital region of head on dresser. ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips beside bed and in bathroom, bed alarm, chair alarm and dysum in chair - Recommendations/New Interventions: continue current POC (plan of care)."

r. The I/A report dated 11/30/06 at 11:50 p.m. documented, "... Bed alarm sounding, CNA responded saw resident standing by BR (bathroom) door - blood noted on face. Resident pointed to BR door. ... Past Interventions: Bed alarm seatbelt with alarm, non-skid socks - Recommendations/New Interventions: Sent to ER (emergency room) for eval. (evaluation) - cont. (continue) w/c with SB (seatbelt) and cont. (continue) bed alarm while up in bed."

1) The Nurse's Notes dated 12/1/06 at (no time given) documented, "...CNA responded to bed alarm, Resident was standing by BR door upon entering room, blood noted to face and floor. Resident examined, approximately 1 inch laceration to top of head, ... PEARL (pupil equal, asymmetrical and react to light) order rec (received) to send to ER ... transported at 12:15 midnight V/S (vital signs) 144/82, 100, 24, 96.9"

2) The CT (Computerized Tomography) Scan of the Head without Contrast dated 12/1/06

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F 324	Continued From page 6 documented, "... Findings: There is a thin low attenuation subdural hematoma along the right frontal lobe, 4 mm (millimeters) average thickness. Only a small posterior portion of this collection is dense, suggesting either a very early subdural hematoma, current anticoagulation, or an early chronic hematoma. ... Impression: Thin right frontal subdural hematoma, age uncertain as discussed above, with mild mass effect but no shift". The resident's CT Head without Contrast dated 12/4/06 documented, "... Findings: ... No areas of acute hemorrhage are found. Impression: Stable CT head as described". 3) The nurse's notes dated 12/4/06 at 4:30 p.m. documented the resident returned to the facility. "... No redness or edema to laceration to the upper part of his head ..." s. The I/A report dated 12/10/06 at 3:40 a.m. documented, "... observed resident sitting in the floor in his room. ... Past interventions: bed alarm, bed in lowest position, belt restraint when up in w/c. Recommendations/New Interventions: Cont POC." t. The I/A report dated 12/14/06 at 5:00 a.m. documented, "...CNA responded to bed alarm, observed resident sitting in floor beside bed, no apparent injuries noted. ... no wet areas noted on floor, resident was barefoot. [The documentation did not indicate the resident was wearing non-skid socks.] ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips beside bed and in bathroom, bed alarm, chair alarm and dysum in chair - Recommendations/New Interventions: possibly	F 324		

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make appt. (appointment) with ENT (ears, nose and throat) and eye MD (medical doctor) about increase in poor eyesight".

u. The I/A report dated 12/20/06 at 8:30 a.m. documented, "... 3 cm (centimeter) laceration noted on back of head, when I pointed at resident's head, he gestured toward bathroom door and mumbled - blood noted on BR door frame. ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips beside bed and in bathroom, bed alarm, chair alarm and dysum in chair - Recommendations/New Interventions: Cont POC - waiting for ENT appt. to see if any new procedures can assist resident."

v. As of 1/26/07 at 10:40 a.m., there was no documentation the ENT appointment had been made. During an interview with the Social Director on 1/26/07 at 10:40 a.m., she was asked when was the resident's last ENT and eye doctor appointments. She indicated the last ENT exam was on 1/11/00 and last eye exam was in 6/2005.

w. The Nurse's Notes dated 12/21/06 at 10:00 a.m. documented, "...resident reported to be leaning to left side this am. Resident unable to sit upright. Unable to amb. (ambulate) to bathroom as usually does with assist of one. Very unsteady left sided weakness. Following signed directions/gestures. ... Laceration to left crown of head without s/s of infection. Edges approximated. Called doctor and order received send to ER ... At 4:00 p.m., ... resident admitted to hospital diagnosis of Subdural Hematoma".

1) The resident's CT of the Head without Contrast dated 12/21/06 documented,

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"...Impression: Acute re-hemorrhage into the right subdural hematoma which has increased in size and is causing mass effect upon the right cerebral hemisphere with approximately 8 to 9 millimeters of midline shift to the left ..."

2) The Emergency Room History and Physical dated 12/21/06 documented, "... Plan: I've discussed the case at length with his sister, who is the only local family. She did not want to be aggressive, and our feelings is that he probably would not survive an operation to evacuate the subdural right now ..."

3) The nurse's notes dated 12/22/06 at 1:00 p.m., documented the resident returned to the facility. A physician's order dated 12/22/06 documented, "Lowbed with red mat d/t (due to) frequent falls. ... The nurse's notes documented, "... needs assistance with dressing, ... with all ADLs, ... with walking - Resident has order for low bed with red mat, ... Levaquin 500mg 1 by mouth times 7 days URI (Upper Respiratory Infection) ...".

x. The nurse's notes dated 12/27/06 at 11:00 a.m., documented, "...resident is now DNR (do not resuscitate). Resident in bed with eyes open, left eye appears to be drooping ...".

y. On 1/27/07, during record review, the Significant Change Medicare 5-day MDS dated 12/28/06 documented the resident had a severely impaired cognitive status with periods of lethargy requiring extensive to total care with all ADLs. Overall changes in care needs: deteriorated receives more support.

z. The Nurse's notes dated 12/30/06 (no time given) documented, "Resident requiring

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increased assistance with all ADLs d/t (due to) decline in functional ability. Incont. (incontinent) care PRN (as needed). Requires assistance with turning and repositioning. Resident has made no attempt to get up out of bed in several days ...".

aa. The nurse's notes dated 1/5/07 at 3:00 a.m., documented, "... resident temp (temperature) 100.5 ax (axillary) ... resident displayed mottling and coolness to touch on bilateral LE (lower extremities) and UE (upper extremities). Medicated with Tylenol ... at 10:00 a.m. ... unable to obtain BP (blood pressure) - pule weak - SpO2 (Oxygen Saturation) 86 - ... fingertips blue ... doctor spoke with resident sister ... At 11:30 p.m. ...V/S 72/46, 92, 26, 103.6 ...".

bb. The nurse's notes dated 1/6/07 at 12:57 MN (midnight) documented, " ... unable to obtain any vital signs, doctor notified at this time. Coroner notified also ...".

cc. On 1/26/07 at 10:30 a.m., during an interview with CNA #2 (employed for 4.5 months), she stated, "[Resident #1] was a fun loving gentleman, he like everybody and everybody liked him. ... He didn't want nothing out of its place, very particular, most of the time he wanted to go to the bathroom, ... he had a bed alarm, chair alarm in his w/c and a seat belt". She was asked if she had ever seen non-skid strips on the floor beside his bed and in his bathroom. She stated, "I worked that room all the time, I've never seen non-skid strips in that room". She was asked if the resident had been on a scheduled toileting plan. She stated, "No, he was not on a toileting schedule." She was asked if she thought he should've been. She stated, "He should've been on toileting schedule, but they never did because

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F 324	Continued From page 10 we always took him. After his first fall when he hit his head (in December) they asked us to make sure we watched him closely and make sure he had all his restraints and alarms." She also indicated the resident did not receive a red mat next to his bed until after his second visit to the hospital on 12/22/06. She stated, "...It seems like he fell mostly at night, the night shift CNAs could've done a better job." dd. On 1/26/07 at 10:50 a.m., during an interview with CNA #3, she stated, "[Resident #1] was fine, playful couldn't speak, communicated by gestures, problem keeping him in bed, easy to care for though, always had to have someone to help with him. His bed had to be lowered all the way to the ground". She was asked, when did he receive the low bed. She stated, "... after his head injury." When asked if non-slid strips were ever placed on his floor beside the bed and in his bathroom. She stated, "No, none on the floor in his room or in his bathroom." She was asked if the facility had inserviced them on anything particular regarding the resident. She stated, "No, but our LPN spoke with us and told us to keep an eye on him as much as possible to keep him from falling again." She was asked, if she thought he could've done a toileting schedule. She stated, "Yes." ee. On 1/29/07 at 10:05 a.m., during an interview with the Director of Nursing (DON), she was asked if the facility had inserviced staff regarding the resident and if the facility had attempted any new interventions or tried past interventions since December 2006. She stated, "No". She stated the facility had conducted an inservice prior to 12/1/06, (before the resident's first head injury). She added they knew he had been falling on night	F 324		

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F 324	Continued From page 11 shift so she decided to get staff to get him up earlier before breakfast and she had inserviced that on 11/16/06. She then stated, "... But the resident started falling all different times during the day and night". She stated she had not tried other interventions again such as the helmet, "... I know not the helmet, he would throw it across the room". She indicated after the resident's room had been stripped and waxed, the non-skid strips, I didn't know they had not been replaced. She stated, "... He was not put on any formal scheduled toileting plan and had never had a red mat until 12/22/06, but staff was to make sure the bed was in its lowest position". She stated they had just initiated a new toileting schedule on 12/21/06. ff. The facility's "Falls and Fall Risk, Managing" implemented March 2005 documented, "... If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified..." 2. Resident #2 had diagnoses of Anxiety State and Congestive Heart Failure (CHF). The Annual Minimum Data Set (MDS) dated 1/7/07 documented the resident had moderately impaired cognitive skills for daily decision-making, had an unsteady gait, had fallen in the past 30 days, past 31-180 days and sustained a fracture in the last 180 days. a. A Fall Risk Assessment dated 4/20/06, 7/20/06 and 10/12/06 documented the resident was at high risk for falls.	F 324		

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b. A Change of Condition Report dated 7/26/06 at 9:00 p.m., documented, "Res (Resident) sitting on floor, states my feet slipped and I slid down. AROM (Active Range of Motion) to all ext (extremities). Denies pain. No visible signs of injury. Recommendations/New Interventions: Bed alarm replaced and moved to end of bed d/t (due to) R (Resident) sleeping close to end of bed."

c. An Incident/Accident Report dated 8/16/06 at 11:30 p.m. documented, "Resident observed in floor lying in left lateral recumbent position on floor. Denied pain...Stated I fell down. Recommendations/New Interventions: Apply non-skid strips to area in front of bed."

d. A Physician Order dated 8/31/06 documented, "Bed alarm to remind R (resident) to call for assist prior to transfers. Check placement and function every shift."

e. An Incident/Accident Report dated 10/31/06 at 11:25 a.m., documented, "Found lying on left side in floor next to bed with walker next to her ... Bed alarm was off. Resident will mess with it ever so often daughter stated. Recommendation/New Interventions: Continue bed alarm. Check function and placement of bed alarm."

f. A Change of Condition Report dated 12/2/06 at 1:00 a.m., documented, "Resident attempted to amb (ambulate) to BR without assist ... lac (laceration) to right 5th digit, c/o (complains of) back pain. First aid administered to 5th digit. Family notified at 8:00 a.m. Recommendations/New Interventions: 7:00 a.m. ... Placed call to MD at 8:00 a.m.. Received orders to send Resident to ER for x-rays. Came

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back with hairline fx (fracture) to wrist. Have therapy to screen. Keep splint in place x 4 weeks. Continue toileting."

g. A Temporary Problem List dated 12/2/06 documented, "Got up in room and fell going to BR. Therapy to screen d/t fx wrist."

h. A Change of Condition Report dated 12/15/06 at 10:50 p.m., documented, "Observed in floor in supine position with walker lying over her. Denied pain ... Recommendations/New Interventions: Always wear socks when in bed. Low bed placed."

i. On 1/26/07 at 11:40 a.m., the Assistant Director of Nursing (ADON) was asked how therapy was informed of needed therapy screens for residents. She stated, "We don't give therapy anything in writing. We talk about it in stand-up and they write it down."

j. As of 1/26/07 at 12:15 p.m., there was no documentation the resident was screened by therapy after the fall on 12/2/06. On 1/26/07 at 12:15 p.m., the Occupational Therapist was asked if a screen was done on Resident #2 after the fall on 12/2/06. She stated no and that they were unaware of the resident sustaining a fracture. "Usually for a fracture they will call us and tell us we need to screen and give us a doctor's order. They need to tell us."

k. On 1/29/07 at 12:10 p.m., the Director of Nursing was asked how the therapy screen for Resident #2 was omitted. She stated, "I have no idea."

l. The Resident Assessment Protocol Summary

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(RAPS) dated 1/7/07 documented in the Cognitive Loss/Dementia section, "PT (Physician Therapy) services were initiated on 10/23/06 for thera-ex (therapeutic exercise) and gait training and was d/c'd on 11/21/06. Resident has experienced 3 falls during the last review period, on 10/31, 12/7, and 12/15. The 12/7 fall resulted in a hairline fx ([fracture) to the R (right) wrist, for which resident wore an immobilizer for 1 month ... Deficits continue to be noted ... very poor safety awareness, for which she has a bed alarm to remind her to use the call light for assistance (which she rarely does)."

m. The Care Plan dated 1/9/07 documented in the problem section, "At risk for falls due to history of the problem." The approach section documented, "Bed alarm to bed to remind resident to call for assist prior to transfers. Check placement and function every shift. Respond to alarm activation promptly."

n. On 1/25/07 at 12:25 p.m., the resident's daughter was present in the room. She was asked about the resident's falls. She stated that the falls had not resulted in significant injury, but at times staff would help her mother to the bathroom then forget to turn the bed alarm back on.

o. On 1/25/07 at 2:50 p.m., and 4:05 p.m., on 1/26/07 at 8:45 a.m., and on 1/29/07 at 9:25 a.m., the resident was observed in bed with the bed alarm switch in the "off" position.

p. On 1/26/07 at 10:30 a.m., LPN #1 stated, "There should never be a reason for the bed alarm to be off if she's in bed. I've told the girls and told them to leave it on but when they take

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her to the bathroom or shower, they turn it off."

q. On 1/29/07 at 9:25 a.m., the resident's son was present in the room and stated that the bed alarm was left off a lot and that the staff had just taken [Resident] to the bathroom.

3. Resident #3 had diagnoses of Anxiety Disorder and Arthropathy. The Medicare MDS dated 12/24/06 documented the resident had moderately impaired cognitive skills for daily decision-making, had an unsteady gait and had fallen in the past 31-180 days.

a. A Change of Condition Report dated 11/13/06 at 6:15 a.m., documented, "Resident observed sitting in floor leaned up against bathroom door. When asked what happened, stated I fell ... c/o pain to left shoulder ... Additional comments and/or steps taken to prevent recurrence: Therapy to screen. Place bed alarm to bed while resident in bed to alert staff resident is up without assist".

b. A Fall Risk Assessment dated 7/10/06 and 11/20/06 documented the resident was at high risk for falls.

c. The Care Plan dated 11/20/06 documented, "Fall - 11/13/06. New dx (diagnosis) UTI (Urinary Tract Infection) and sprain left wrist ... Will place bed alarm..."

d. On 1/25/07 at 2:33 p.m., the resident was receiving a shower in his bathroom. There was no bed alarm on the resident's bed. CNA #1, who was in the resident's room, was asked if the resident normally had a bed alarm on his bed. She stated she had not seen one on his bed at

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all.

e. On 1/26/07 at 8:41 a.m. and on 1/29/07 at 9:23 a.m., the resident was in bed with side rails up x 2. There was no bed alarm on the bed.

f. On 1/29/07 at 9:51 a.m., the ADON (Assistant Director of Nursing)was asked how the facility ensured fall interventions such as bed alarms were implemented. She stated, "I do it myself [ensure interventions are implemented]".

4. Resident #4 had diagnoses of Senile Dementia and Parkinson's Disease. The Quarterly MDS dated 12/5/06 documented the resident had moderately impaired cognitive skills for daily decision-making, had an unsteady gait, had fallen in the past 31-180 days and had a hip fracture in the last 180 days.

a. A Fall Risk Assessment dated 6/12/06, 9/19/06 and 12/6/06 documented the resident was at high risk for falls.

b. A Physician Order dated 8/25/06 documented, "Body alarm to w/c (wheelchair) to alert staff, check every shift for function."

c. A Change of Condition Report dated 12/28/06 at 10:20 a.m., documented, "Resident states she took seat belt off w/c, sat down in floor after becoming weak, attempting to ambulate to bathroom. Recommendations/New Interventions: ... Continue to remind to call staff for assist, continue personal alarm, refer to therapy for w/c placement."

d. A Temporary Problem List dated 12/28/06 documented, "Refer to therapy for w/c

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placement."

e. On 1/26/07 at 10:25 a.m. and on 1/29/07 at 9:35 a.m., the resident was in the wheelchair with no chair alarm in place.

f. On 1/26/07 at 12:15 p.m., the Occupational Therapist provided a screen form for Resident #4 dated 1/12/07. She was asked why the screen had not been done sooner right after the resident's fall. She stated they [Occupational Therapy] did not become aware of the need for a screen until 1/12/07.

5. Resident #5 had diagnoses of Paralysis Agitans and Dementia. The Annual MDS dated 12/7/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, had an unsteady gait and had not had any falls.

a. A Change of Condition Report dated 7/18/06 at 5:00 p.m., documented, "CNA found resident in floor with feet under w/c. Chair alarm was on w/c, turned off ... but don't know if resident turned off ... Recommendations/New Interventions: Replaced chair alarm, alarm malfunctioned."

b. The RAPS dated 12/7/06 documented, "Falls: Resident is at risk for injury d/t unsteady gait, trunk restraint and the use of psychotropic drugs, will address in cp (care plan)."

c. The Care Plan dated 12/8/06 documented, "... self releasable seat belt with alarm to w/c to remind resident to call for assist prior to transfers."

d. A Fall Risk Assessment dated 12/8/06

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documented the resident was at high risk for falls.

e. A Change of Condition Report dated 1/22/07 at 7:45 p.m., documented, "Resident slid to the floor from w/c ... Recommendations/New Interventions: Will leave door to room open, call light in reach, encourage resident to call for assist. Will continue self release seat belt while up in w/c."

f. On 1/29/07 at 9:47 a.m., the ADON was asked about Resident #5 having a chair alarm on his wheelchair. She stated, "I don't see an order for one. I don't think he's ever had one. I don't know how it got on the care plan without an order."

g. On 1/29/07 at 12:10 p.m., the Director of Nursing was asked how fall interventions were developed. She stated, "We talk about the I/As in stand-up and come up with interventions then." She was then asked how those interventions were implemented. She stated, "The RCCs (Resident Care Coordinators) actually go out and do it, then it's communicated to the LPNs and CNAs." She was asked whose responsibility it was to ensure those interventions had been implemented. She stated, "Me and [ADON's name] do that. Every new order is tracked for 72 hours, and a fall is tracked anyway for 72 hours no matter what."

6. On 1/29/07 at 3:20 p.m., the Immediate Jeopardy was removed and the Scope/Severity reduced to an "G", when the following plan of removal was implemented:

a. On 1/29/07 Beginning at 1:00 p.m., 1/29/07, every in-house resident with physician order for restraint or assistive device was checked for

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function; and placement was verified by staff, completed by 2:30 p.m. on 1/29/07.

b. Also, beginning at 1:00 p.m., all staff including Licensed Nurses, Certified Nursing Assistants, Housekeeping, Dietary, Laundry, Maintenance, Office Staff, Social Workers, Activity Directors will be in-serviced on Fall Prevention before they return to work. Staff on duty will be inserviced this shift.

c. Preventive measures and monitoring to include:
1. I & A's will be made out on every fall
2. The doctor and family will be notified
3. Therapy will do a screen after each fall
4. The care plan will be revised after each fall
5. The aide's kardex will be updated after each fall and all new interventions will be transferred to the kardex.
6. Each fall will be recorded on the 24 hours nursing communication report
7. Internal investigation will be completed within 5 days
8. Each fall will be charted on for 72 hours to observe for delayed complications
9. Restraints and devices to be checked every shift by licensed staff, daily

d. The Charge Nurse will notify the Director of Nursing when each fall occurs. The Interdisciplinary Care Plan Team will meet and determine further preventive measures regarding preventing future falls for the residents, and verification of previous interventions in place and appropriate. The DON/Designee will monitor the resident daily for 4 weeks, then weekly for 1

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F 324	Continued From page 20 month, and monthly thereafter. The DON/Designee will also ensure planned interventions are implemented. e. The Administrator will sign off on every Incident and Accident Report regarding Falls and determine with the DON that fall preventions are in place from his point forward. Any negative findings will be corrected immediately. f. DON will conduct a weekly "Fall Prevention" meeting with Therapy representative, Restorative aide, Social, Activity and Dietary in attendance.	F 324		
F 490 SS=J	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint #12273 substantiated (all or in part) with these findings: Based on observation, record review and interview, Nursing Administration failed to ensure that causative factors for falls were identified and evaluated, interventions were developed based on the causative factors, that interventions were consistently implemented or effectiveness assessed/reassessed in order to prevent falls and to reduce the risk of injuries from falls for all 5 case-mix residents (Residents # 1-5) who was identified to be at risk for falls. The failed practices resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury	F 490		

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F 490	Continued From page 21 or death for Resident #1who sustained repeated falls which resulted in a subdural hematoma, and had the potential to affect 33 residents in the facility who had fallen in the past 30 days according to a list provided by the Director of Nursing (DON) on 1/29/07 at 3:30 p.m.. The facility was informed of the Immediate Jeopardy condition on 1/29/07 at 12:40 p.m. The findings are: 1. From 9/6/06 - 12/20/06, Resident #1 experienced 11 falls : a. The August 2006 Physician's Order documented, "... 8/4/06 - Releaseable Seatbelt with Alarm while up in w/c (wheelchair) due to resident attempting to ambulate and being unable to do so check every 30 minutes and release every 2 hours and PRN (as necessary) for ADLs (activities of daily living) , grooming, repositioning. ... Bed Alarm to bed to remind resident to call for assist prior to transfers. Check placement and function every shift." b. The Incident and Accident (I/A) Report dated 9/6/06 at 03:45 a.m. documented, "...resident got OOB (out of bed) alarm was functioning attempted to walk to bathroom unassisted fell to the floor knocking items off chest of drawers by bathroom door and fell on his bottom possible bruise ..." The diagram indicated the possible bruise was located in the middle lower back section and the left posterior arm. "Past Interventions: Bed alarm - Recommendations/New Interventions: Cont (continue) POC (plan of care)." The Occupational Therapy Screen Form dated 9/12/06 documented, "...Pt found in floor of room.	F 490		

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F 490	Continued From page 22 Alarm turned off (pt has been known to turn alarm off) Nsg (Nursing) to monitor this closely." c. The nurse's notes dated 9/27/06 at 8:20 p.m. documented, "... resident observed in floor on his hands and knees. no witness present. ...no s/s (signs and symptoms) of injury ..." d. The I/A report dated 10/7/06 at 9:00 a.m. documented, "... found resident sitting in floor on buttock in bathroom with sink beside him ... no injuries noted assisted back to bed ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, skid strips, bed alarm, chair alarm and dysum (non-skid cushion) in chair - Recommendations/New Interventions: floor in BR (bathroom) dried Bed alarm replaced." e. On 1/26/07 at 10:40 a.m., the Social Director was asked if Resident #1 was transferred to a different room within the facility for any reason. She provided information that the resident was moved out of Room #42 into Room 70 on 10/7/06 for housekeeping and maintenance to strip and wax the floors and paint his room. The resident returned to Room #42 on 10/9/06. f. On 1/29/07 at 9:45 a.m., during an interview with the Housekeeping Supervisor, she stated, "During the morning meetings, we discuss falls and we're told who (residents) to put the non-skid strips down for." She stated that maintenance puts the strips down on the floor. She stated the strips would have to come up off the floor in order to strip and wax a room and then they're replaced. She acknowledged nothing had been done to the resident's room (Room #42) since October 2006. The strips were never replaced	F 490		

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[after the resident returned to the room on 10/9/06].

g. The I/A report dated 11/5/06 at 21:45 p.m. (9:45 p.m.) documented, "... Found sitting in floor in D/R (dining room) with w/c over on him. Attempting to get another meal tray. ... no injuries noted ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips beside bed and in bathroom, and dysum (non-skid cushion) in chair - Recommendations/New Interventions: given extra food on plate."

h. The I/A report dated 11/7/06 at 8:00 a.m. documented, "... Resident was in room and fell hitting head on door - Hematoma to Left side of head ...Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips, bed alarm, chair alarm and dysum in chair - Recommendations/New Interventions: Resident has a bed alarm and chair alarm - non-skid socks on at all times - Dry floor when through in restroom."

i. The I/A report dated 11/13/06 at 5:00 a.m. documented, "...CNA (certified nursing assistant) responded to bed alarm found resident on floor trying to get up. Resident noted to have a small abrasion to left side of forehead above eyebrow. Abrasion from previous fall 11/7/06. ... Past interventions: see CP (care plan) - Recommendations/New Interventions: Therapy Screen - keep urinal beside bed at all times while resident in bed."

The Occupational Therapy Screen Form dated 11/13/06 documented, "...Alarm devices in place and working - Pt tried to get up out of bed. Hx

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(history) of falls secondary to inner ear problem. Nursing care planning falls as all interventions has been tried."

j. The I/A report dated 11/14/06 at 4:10 a.m. documented, "... resident got OOB (out of bed) unassisted and was standing at bathroom door when CNA responded to bed alarm resident then let go of door lost his balance and fell on his bottom continued onto back and bumped his occipital region of head on dresser. ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips beside bed and in bathroom, bed alarm, chair alarm and dysum in chair - Recommendations/New Interventions: continue current POC (plan of care)."

k. The I/A report dated 11/30/06 at 11:50 p.m. documented, "... Bed alarm sounding, CNA responded saw resident standing by BR (bathroom) door - blood noted on face. Resident pointed to BR door. ... Past Interventions: Bed alarm seatbelt with alarm, non-skid socks - Recommendations/New Interventions: Sent to ER (emergency room) for eval. (evaluation) - cont. (continue) w/c with SB (seatbelt) and cont. (continue) bed alarm while up in bed."

1) The Nurse's Notes dated 12/1/06 at (no time given) documented, "...CNA responded to bed alarm, Resident was standing by BR door upon entering room, blood noted to face and floor. Resident examined, approximately 1 inch laceration to top of head, ... PEARL (pupil equal, asymmetrical and react to light) order rec (received) to send to ER ... transported at 12:15 midnight V/S (vital signs) 144/82, 100, 24, 96.9"

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F 490	Continued From page 25 2) The CT (Computerized Tomography) Scan of the Head without Contrast dated 12/1/06 documented, "... Findings: There is a thin low attenuation subdural hematoma along the right frontal lobe, 4 mm (millimeters) average thickness. Only a small posterior portion of this collection is dense, suggesting either a very early subdural hematoma, current anticoagulation, or an early chronic hematoma. ... Impression: Thin right frontal subdural hematoma, age uncertain as discussed above, with mild mass effect but no shift". The resident's CT Head without Contrast dated 12/4/06 documented, "... Findings: ... No areas of acute hemorrhage are found. Impression: Stable CT head as described". 3) The nurse's notes dated 12/4/06 at 4:30 p.m. documented the resident returned to the facility. "... No redness or edema to laceration to the upper part of his head ..." l. The I/A report dated 12/10/06 at 3:40 a.m. documented, "... observed resident sitting in the floor in his room. ... Past interventions: bed alarm, bed in lowest position, belt restraint when up in w/c. Recommendations/New Interventions: Cont POC." m. The I/A report dated 12/14/06 at 5:00 a.m. documented, "...CNA responded to bed alarm, observed resident sitting in floor beside bed, no apparent injuries noted. ... no wet areas noted on floor, resident was barefoot. [The documentation did not indicate the resident was wearing non-skid socks.] ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips beside bed and in bathroom, bed	F 490		

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alarm, chair alarm and dysum in chair - Recommendations/New Interventions: possibly make appt. (appointment) with ENT (ears, nose and throat) and eye MD (medical doctor) about increase in poor eyesight".

n. The I/A report dated 12/20/06 at 8:30 a.m. documented, "... 3 cm (centimeter) laceration noted on back of head, when I pointed at resident's head, he gestured toward bathroom door and mumbled - blood noted on BR door frame. ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips beside bed and in bathroom, bed alarm, chair alarm and dysum in chair - Recommendations/New Interventions: Cont POC - waiting for ENT appt. to see if any new procedures can assist resident."

o. As of 1/26/07 at 10:40 a.m., there was no documentation the ENT appointment had been made. During an interview with the Social Director on 1/26/07 at 10:40 a.m., she was asked when was the resident's last ENT and eye doctor appointments. She indicated the last ENT exam was on 1/11/00 and last eye exam was in 6/2005.

p. The Nurse's Notes dated 12/21/06 at 10:00 a.m. documented, "...resident reported to be leaning to left side this am. Resident unable to sit upright. Unable to amb. (ambulate) to bathroom as usually does with assist of one. Very unsteady left sided weakness. Following signed directions/gestures. ... Laceration to left crown of head without s/s of infection. Edges approximated. Called doctor and order received send to ER ... At 4:00 p.m., ... resident admitted to hospital diagnosis of Subdural Hematoma".

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F 490	Continued From page 27 1) The resident's CT of the Head without Contrast dated 12/21/06 documented, "...Impression: Acute re-hemorrhage into the right subdural hematoma which has increased in size and is causing mass effect upon the right cerebral hemisphere with approximately 8 to 9 millimeters of midline shift to the left ..." 2) The Emergency Room History and Physical dated 12/21/06 documented, "... Plan: I've discussed the case at length with his sister, who is the only local family. She did not want to be aggressive, and our feelings is that he probably would not survive an operation to evacuate the subdural right now ..." 3) The nurse's notes dated 12/22/06 at 1:00 p.m., documented the resident returned to the facility. A physician's order dated 12/22/06 documented, "Lowbed with red mat d/t (due to) frequent falls. ... The nurse's notes documented, "... needs assistance with dressing, ... with all ADLs, ... with walking - Resident has order for low bed with red mat, ... Levaquin 500mg 1 by mouth times 7 days URI (Upper Respiratory Infection) ...". q. The nurse's notes dated 12/27/06 at 11:00 a.m., documented, "...resident is now DNR (do not resuscitate). Resident in bed with eyes open, left eye appears to be drooping ...". r. The Nurse's notes dated 12/30/06 (no time given) documented, "Resident requiring increased assistance with all ADLs d/t (due to) decline in functional ability. Incont. (incontinent) care PRN (as needed). Requires assistance with turning and repositioning. Resident has made no attempt to get up out of bed in several days ...".	F 490		

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s. The nurse's notes dated 1/5/07 at 3:00 a.m., documented, "... resident temp (temperature) 100.5 ax (axillary) ... resident displayed mottling and coolness to touch on bilateral LE (lower extremities) and UE (upper extremities). Medicated with Tylenol ... at 10:00 a.m. ... unable to obtain BP (blood pressure) - pule weak - SpO2 (Oxygen Saturation) 86 - ... fingertips blue ... doctor spoke with resident sister ... At 11:30 p.m. ...V/S 72/46, 92, 26, 103.6 ...".

t. The nurse's notes dated 1/6/07 at 12:57 MN (midnight) documented, " ... unable to obtain any vital signs, doctor notified at this time. Coroner notified also ...".

u. On 1/26/07 at 10:30 a.m., during an interview with CNA #2 (employed for 4.5 months), she stated, "[Resident #1] was a fun loving gentleman, he like everybody and everybody liked him. ... He didn't want nothing out of its place, very particular, most of the time he wanted to go to the bathroom, ... he had a bed alarm, chair alarm in his w/c and a seat belt". She was asked if she had ever seen non-skid strips on the floor beside his bed and in his bathroom. She stated, "I worked that room all the time, I've never seen non-skid strips in that room". She was asked if the resident had been on a scheduled toileting plan. She stated, "No, he was not on a toileting schedule." She was asked if she thought he should've been. She stated, "He should've been on toileting schedule, but they never did because we always took him. After his first fall when he hit his head (in December) they asked us to make sure we watched him closely and make sure he had all his restraints and alarms." She also indicated the resident did not receive a red mat next to his bed until after his second visit to the

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F 490	Continued From page 29 hospital on 12/22/06. She stated, "...It seems like he fell mostly at night, the night shift CNAs could've done a better job." v. On 1/26/07 at 10:50 a.m., during an interview with CNA #3, she stated, "[Resident #1] was fine, playful couldn't speak, communicated by gestures, problem keeping him in bed, easy to care for though, always had to have someone to help with him. His bed had to be lowered all the way to the ground". She was asked, when did he receive the low bed. She stated, "... after his head injury." When asked if non-slid strips were ever placed on his floor beside the bed and in his bathroom. She stated, "No, none on the floor in his room or in his bathroom." She was asked if the facility had inserviced them on anything particular regarding the resident. She stated, "No, but our LPN spoke with us and told us to keep an eye on him as much as possible to keep him from falling again." She was asked, if she thought he could've done a toileting schedule. She stated, "Yes." w. On 1/29/07 at 10:05 a.m., during an interview with the Director of Nursing (DON), she was asked if the facility had inserviced staff regarding the resident and if the facility had attempted any new interventions or tried past interventions since December 2006. She stated, "No". She stated the facility had conducted an inservice prior to 12/1/06, (before the resident's first head injury). She added they knew he had been falling on night shift so she decided to get staff to get him up earlier before breakfast and she had inserviced that on 11/16/06. She then stated, "... But the resident started falling all different times during the day and night". She stated she had not tried other interventions again such as the helmet, "... I	F 490		

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F 490	Continued From page 30 know not the helmet, he would throw it across the room". She indicated after the resident's room had been stripped and waxed, the non-skid strips, I didn't know they had not been replaced. She stated, "... He was not put on any formal scheduled toileting plan and had never had a red mat until 12/22/06, but staff was to make sure the bed was in its lowest position". She stated they had just initiated a new toileting schedule on 12/21/06. x. The facility's "Falls and Fall Risk, Managing" implemented March 2005 documented, "... If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified..." 2. From 7/26/06 to 12/15/06 Resident #2 experienced 5 falls: a. A Fall Risk Assessment dated 4/20/06, 7/20/06 and 10/12/06 documented the resident was at high risk for falls. b. A Change of Condition Report dated 7/26/06 at 9:00 p.m., documented, "Res (Resident) sitting on floor, states my feet slipped and I slid down. AROM (Active Range of Motion) to all ext (extremities). Denies pain. No visible signs of injury. Recommendations/New Interventions: Bed alarm replaced and moved to end of bed d/t (due to) R (Resident) sleeping close to end of bed." c. An Incident/Accident Report dated 8/16/06 at 11:30 p.m. documented, "Resident observed in	F 490		

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floor lying in left lateral recumbent position on floor. Denied pain...Stated I fell down. Recommendations/New Interventions: Apply non-skid strips to area in front of bed."

d. A Physician Order dated 8/31/06 documented, "Bed alarm to remind R (resident) to call for assist prior to transfers. Check placement and function every shift."

e. An Incident/Accident Report dated 10/31/06 at 11:25 a.m., documented, "Found lying on left side in floor next to bed with walker next to her ... Bed alarm was off. Resident will mess with it ever so often daughter stated. Recommendation/New Interventions: Continue bed alarm. Check function and placement of bed alarm."

f. A Change of Condition Report dated 12/2/06 at 1:00 a.m., documented, "Resident attempted to amb (ambulate) to BR without assist ... lac (laceration) to right 5th digit, c/o (complains of) back pain. First aid administered to 5th digit. Family notified at 8:00 a.m. Recommendations/New Interventions: 7:00 a.m. ... Placed call to MD at 8:00 a.m.. Received orders to send Resident to ER for x-rays. Came back with hairline fx (fracture) to wrist. Have therapy to screen. Keep splint in place x 4 weeks. Continue toileting."

1) A Temporary Problem List dated 12/2/06 documented, "Got up in room and fell going to BR. Therapy to screen d/t fx wrist."

2) On 1/26/07 at 11:40 a.m., the Assistant Director of Nursing (ADON) was asked how therapy was informed of needed therapy screens for residents. She stated, "We don't give therapy

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anything in writing. We talk about it in stand-up and they write it down."

g. A Change of Condition Report dated 12/15/06 at 10:50 p.m., documented, "Observed in floor in supine position with walker lying over her. Denied pain ... Recommendations/New Interventions: Always wear socks when in bed. Low bed placed."

h. As of 1/26/07 at 12:15 p.m., there was no documentation the resident was screened by therapy after the fall on 12/2/06. On 1/26/07 at 12:15 p.m., the Occupational Therapist was asked if a screen was done on Resident #2 after the fall on 12/2/06. She stated no and that they were unaware of the resident sustaining a fracture. "Usually for a fracture they will call us and tell us we need to screen and give us a doctor's order. They need to tell us."

i. On 1/29/07 at 12:10 p.m., the Director of Nursing was asked how the therapy screen for Resident #2 was omitted. She stated, "I have no idea."

j. The Resident Assessment Protocol Summary (RAPS) dated 1/7/07 documented in the Cognitive Loss/Dementia section, "PT (Physician Therapy) services were initiated on 10/23/06 for thera-ex (therapeutic exercise) and gait training and was d/c'd on 11/21/06. Resident has experienced 3 falls during the last review period, on 10/31, 12/7, and 12/15. The 12/7 fall resulted in a hairline fx ([fracture) to the R (right) wrist, for which resident wore an immobilizer for 1 month ... Deficits continue to be noted ... very poor safety awareness, for which she has a bed alarm to remind her to use the call light for assistance

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(which she rarely does)."

1) The Care Plan dated 1/9/07 documented in the problem section, "At risk for falls due to history of the problem." The approach section documented, "Bed alarm to bed to remind resident to call for assist prior to transfers. Check placement and function every shift. Respond to alarm activation promptly."

2) On 1/25/07 at 12:25 p.m., the resident's daughter was present in the room. She was asked about the resident's falls. She stated that the falls had not resulted in significant injury, but at times staff would help her mother to the bathroom then forget to turn the bed alarm back on.

3) On 1/25/07 at 2:50 p.m., and 4:05 p.m., on 1/26/07 at 8:45 a.m., and on 1/29/07 at 9:25 a.m., the resident was observed in bed with the bed alarm switch in the "off" position.

4) On 1/26/07 at 10:30 a.m., LPN #1 stated, "There should never be a reason for the bed alarm to be off if she's in bed. I've told the girls and told them to leave it on but when they take her to the bathroom or shower, they turn it off."

5) On 1/29/07 at 9:25 a.m., the resident's son was present in the room and stated that the bed alarm was left off a lot and that the staff had just taken [Resident] to the bathroom.

3. Resident #3 sustained an injured wrist after a fall on 11/13/06:

a. A Change of Condition Report dated 11/13/06 at 6:15 a.m., documented, "Resident observed

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sitting in floor leaned up against bathroom door. When asked what happened, stated I fell ... c/o pain to left shoulder ... Additional comments and/or steps taken to prevent recurrence: Therapy to screen. Place bed alarm to bed while resident in bed to alert staff resident is up without assist."

b. A Fall Risk Assessment dated 7/10/06 and 11/20/06 documented the resident was at high risk for falls.

c. The Care Plan dated 11/20/06 documented, "Fall - 11/13/06. New dx (diagnosis) UTI (Urinary Tract Infection) and sprain left wrist ... Will place bed alarm..."

d. On 1/25/07 at 2:33 p.m., the resident was receiving a shower in his bathroom. There was no bed alarm on the resident's bed. CNA #1, who was in the resident's room, was asked if the resident normally had a bed alarm on his bed. She stated she had not seen one on his bed at all.

e. On 1/26/07 at 8:41 a.m. and on 1/29/07 at 9:23 a.m., the resident was in bed with side rails up x 2. There was no bed alarm on the bed.

f. On 1/29/07 at 9:51 a.m., the ADON (Assistant Director of Nursing)was asked how the facility ensured fall interventions such as bed alarms were implemented. She stated, "I do it myself [ensure interventions are implemented]."

4. Resident #4 experienced a fall on 12/28/06:

a. A Fall Risk Assessment dated 6/12/06, 9/19/06 and 12/6/06 documented the resident

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F 490	Continued From page 35 was at high risk for falls. b. A Physician Order dated 8/25/06 documented, "Body alarm to w/c (wheelchair) to alert staff, check every shift for function." c. A Change of Condition Report dated 12/28/06 at 10:20 a.m., documented, "Resident states she took seat belt off w/c, sat down in floor after becoming weak, attempting to ambulate to bathroom. Recommendations/New Interventions: ... Continue to remind to call staff for assist, continue personal alarm, refer to therapy for w/c placement." d. A Temporary Problem List dated 12/28/06 documented, "Refer to therapy for w/c placement." e. On 1/26/07 at 10:25 a.m. and on 1/29/07 at 9:35 a.m., the resident was in the wheelchair with no chair alarm in place. f. On 1/26/07 at 12:15 p.m., the Occupational Therapist provided a screen form for Resident #4 dated 1/12/07. She was asked why the screen had not been done sooner right after the resident's fall. She stated they [Occupational Therapy] did not become aware of the need for a screen until 1/12/07. 5. Resident #5 experienced falls on 7/18/06 and 01/22/07: a. A Change of Condition Report dated 7/18/06 at 5:00 p.m., documented, "CNA found resident in floor with feet under w/c. Chair alarm was on w/c, turned off ... but don't know if resident turned off ... Recommendations/New Interventions:	F 490		

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F 490	Continued From page 36 Replaced chair alarm, alarm malfunctioned." b. The RAPS dated 12/7/06 documented, "Falls: Resident is at risk for injury d/t unsteady gait, trunk restraint and the use of psychotropic drugs, will address in cp (care plan)." c. The Care Plan dated 12/8/06 documented, "... self releasable seat belt with alarm to w/c to remind resident to call for assist prior to transfers." d. A Fall Risk Assessment dated 12/8/06 documented the resident was at high risk for falls. e. A Change of Condition Report dated 1/22/07 at 7:45 p.m., documented, "Resident slid to the floor from w/c ... Recommendations/New Interventions: Will leave door to room open, call light in reach, encourage resident to call for assist. Will continue self release seat belt while up in w/c." f. On 1/29/07 at 9:47 a.m., the ADON was asked about Resident #5 having a chair alarm on his wheelchair. She stated, "I don't see an order for one. I don't think he's ever had one. I don't know how it got on the care plan without an order." g. On 1/29/07 at 12:10 p.m., the Director of Nursing was asked how fall interventions were developed. She stated, "We talk about the I/As in stand-up and come up with interventions then." She was then asked how those interventions were implemented. She stated, "The RCCs (Resident Care Coordinators) actually go out and do it, then it's communicated to the LPNs and CNAs." She was asked whose responsibility it was to ensure those interventions had been	F 490		

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implemented. She stated, "Me and [ADON's name] do that. Every new order is tracked for 72 hours, and a fall is tracked anyway for 72 hours no matter what."

6. On 1/29/07 at 3:20 p.m., the Immediate Jeopardy was removed and the Scope/Severity reduced to an "G", when the following plan of removal was implemented:

a. On 1/29/07 Beginning at 1:00 p.m., 1/29/07, every in-house resident with physician order for restraint or assistive device was checked for function; and placement was verified by staff, completed by 2:30 p.m. on 1/29/07.

b. Also, beginning at 1:00 p.m., all staff including Licensed Nurses, Certified Nursing Assistants, Housekeeping, Dietary, Laundry, Maintenance, Office Staff, Social Workers, Activity Directors will be in-serviced on Fall Prevention before they return to work. Staff on duty will be inserviced this shift.

c. Preventive measures and monitoring to include:
1. I & A's will be made out on every fall
2. The doctor and family will be notified
3. Therapy will do a screen after each fall
4. The care plan will be revised after each fall
5. The aide's kardex will be updated after each fall and all new interventions will be transferred to the kardex.
6. Each fall will be recorded on the 24 hours nursing communication report
7. Internal investigation will be completed within 5 days
8. Each fall will be charted on for 72 hours to

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F 490	Continued From page 38 observe for delayed complications 9. Restraints and devices to be checked every shift by licensed staff, daily d. The Charge Nurse will notify the Director of Nursing when each fall occurs. The Interdisciplinary Care Plan Team will meet and determine further preventive measures regarding preventing future falls for the residents, and verification of previous interventions in place and appropriate. The DON/Designee will monitor the resident daily for 4 weeks, then weekly for 1 month, and monthly thereafter. The DON/Designee will also ensure planned interventions are implemented. e. The Administrator will sign off on every Incident and Accident Report regarding Falls and determine with the DON that fall preventions are in place from his point forward. Any negative findings will be corrected immediately. f. DON will conduct a weekly "Fall Prevention" meeting with Therapy representative, Restorative aide, Social, Activity and Dietary in attendance.	F 490		
F 520 SS=J	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment	F 520		

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and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Complaint #12273 substantiated (all or in part) with these findings:

Based on observation, interview and record review, the facility's Quality Assessment and Assurance Committee (QA&A) failed to identify and take corrective actions to ensure that causative factors for falls were identified and evaluated, interventions were developed based on the causative factors, that interventions were consistently implemented or effectiveness assessed/reassessed in order to prevent falls and to reduce the risk of injuries from falls for all 5 case-mix residents (Residents # 1-5) who was identified to be at risk for falls. The failed practices resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury or death for Resident #1who sustained repeated falls which resulted in a subdural hematoma, and had the potential to affect 33 residents in the facility who had fallen in the past 30 days according to a list provided by the Director of

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F 520	Continued From page 40 Nursing (DON) on 1/29/07 at 3:30 p.m.. The facility was informed of the Immediate Jeopardy condition on 1/29/07 at 12:40 p.m. The findings are: 1. On 1/29/07 at 1:03 p.m., the facility's Administrator was asked to provide documentation that the QA&A Committee had intervened with the history of falls and/or potential for falls. a. The facility's "August 2006 Facility QA&A Agenda/Minutes documented, "Purpose of Meeting: Analyze and identify opportunities for quality improvement, Provide oversight of quality and compliance preformance, and Identify and communicate best practices and lessons learned." "Topic discussed: Clinical Indicators - Falls - Issues/Discussion: 38 falls for July, 9-falls were on the units. Residents identified with repeat falls: listed 5 casemix resident which included Resident #1." b. As of 01/29/07 the "Facility's QA&A" documentation provided did not address a plan of action for this topic discussed. 2. Five case-mix residents experienced falls in which the facility failed to to ensure that causative factors for falls were identified and evaluated, interventions were developed based on the causative factors, that interventions were consistently implemented or effectiveness assessed/reassessed in order to prevent falls and to reduce the risk of injuries from falls: a. From 9/6/06 - 12/20/06, Resident #1 experienced 11 falls :	F 520		

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1) The Incident and Accident (I/A) Report dated 9/6/06 at 03:45 a.m. documented, "...resident got OOB (out of bed) alarm was functioning attempted to walk to bathroom unassisted fell to the floor knocking items off chest of drawers by bathroom door and fell on his bottom possible bruise ..." The diagram indicated the possible bruise was located in the middle lower back section and the left posterior arm. "Past Interventions: Bed alarm - Recommendations/New Interventions: Cont (continue) POC (plan of care)."

The Occupational Therapy Screen Form dated 9/12/06 documented, "...Pt found in floor of room. Alarm turned off (pt has been known to turn alarm off) Nsg (Nursing) to monitor this closely."

2) The nurse's notes dated 9/27/06 at 8:20 p.m. documented, "... resident observed in floor on his hands and knees. no witness present. ...no s/s (signs and symptoms) of injury ..."

3) The I/A report dated 10/7/06 at 9:00 a.m. documented, "... found resident sitting in floor on buttock in bathroom with sink beside him ... no injuries noted assisted back to bed ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, skid strips, bed alarm, chair alarm and dysum (non-skid cushion) in chair - Recommendations/New Interventions: floor in BR (bathroom) dried Bed alarm replaced."

On 1/26/07 at 10:40 a.m., the Social Director was asked if Resident #1 was transferred to a different room within the facility for any reason. She provided information that the resident was moved out of Room #42 into Room 70 on 10/7/06 for

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housekeeping and maintenance to strip and wax the floors and paint his room. The resident returned to Room #42 on 10/9/06.

On 1/29/07 at 9:45 a.m., during an interview with the Housekeeping Supervisor, she stated, "During the morning meetings, we discuss falls and we're told who (residents) to put the non-skid strips down for." She stated that maintenance puts the strips down on the floor. She stated the strips would have to come up off the floor in order to strip and wax a room and then they're replaced. She acknowledged nothing had been done to the resident's room (Room #42) since October 2006. The strips were never replaced [after the resident returned to the room on 10/9/06].

4) The I/A report dated 11/5/06 at 21:45 p.m. (9:45 p.m.) documented, "... Found sitting in floor in D/R (dining room) with w/c over on him. Attempting to get another meal tray. ... no injuries noted ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips beside bed and in bathroom, and dysum (non-skid cushion) in chair - Recommendations/New Interventions: given extra food on plate."

5) The I/A report dated 11/7/06 at 8:00 a.m. documented, "... Resident was in room and fell hitting head on door - Hematoma to Left side of head ...Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips, bed alarm, chair alarm and dysum in chair - Recommendations/New Interventions: Resident has a bed alarm and chair alarm - non-skid socks on at all times - Dry floor when through in restroom."

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F 520	Continued From page 43 6) The I/A report dated 11/13/06 at 5:00 a.m. documented, "...CNA (certified nursing assistant) responded to bed alarm found resident on floor trying to get up. Resident noted to have a small abrasion to left side of forehead above eyebrow. Abrasion from previous fall 11/7/06. ... Past interventions: see CP (care plan) - Recommendations/New Interventions: Therapy Screen - keep urinal beside bed at all times while resident in bed." The Occupational Therapy Screen Form dated 11/13/06 documented, "...Alarm devices in place and working - Pt tried to get up out of bed. Hx (history) of falls secondary to inner ear problem. Nursing care planning falls as all interventions has been tried." 7) The I/A report dated 11/14/06 at 4:10 a.m. documented, "... resident got OOB (out of bed) unassisted and was standing at bathroom door when CNA responded to bed alarm resident then let go of door lost his balance and fell on his bottom continued onto back and bumped his occipital region of head on dresser. ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips beside bed and in bathroom, bed alarm, chair alarm and dysum in chair - Recommendations/New Interventions: continue current POC (plan of care)." 8) The I/A report dated 11/30/06 at 11:50 p.m. documented, "... Bed alarm sounding, CNA responded saw resident standing by BR (bathroom) door - blood noted on face. Resident pointed to BR door. ... Past Interventions: Bed alarm seatbelt with alarm, non-skid socks -	F 520		

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F 520	Continued From page 44 Recommendations/New Interventions: Sent to ER (emergency room) for eval. (evaluation) - cont. (continue) w/c with SB (seatbelt) and cont. (continue) bed alarm while up in bed." The Nurse's Notes dated 12/1/06 at (no time given) documented, "...CNA responded to bed alarm, Resident was standing by BR door upon entering room, blood noted to face and floor. Resident examined, approximately 1 inch laceration to top of head, ... PEARL (pupil equal, asymmetrical and react to light) order rec (received) to send to ER ... transported at 12:15 midnight V/S (vital signs) 144/82, 100, 24, 96.9" The nurse's notes dated 12/4/06 at 4:30 p.m. documented the resident returned to the facility. "... No redness or edema to laceration to the upper part of his head ..." 9) The I/A report dated 12/10/06 at 3:40 a.m. documented, "... observed resident sitting in the floor in his room. ... Past interventions: bed alarm, bed in lowest position, belt restraint when up in w/c. Recommendations/New Interventions: Cont POC." 10) The I/A report dated 12/14/06 at 5:00 a.m. documented, "...CNA responded to bed alarm, observed resident sitting in floor beside bed, no apparent injuries noted. ... no wet areas noted on floor, resident was barefoot. [The documentation did not indicate the resident was wearing non-skid socks.] ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips beside bed and in bathroom, bed alarm, chair alarm and dysum in chair - Recommendations/New Interventions: possibly make appt. (appointment) with ENT (ears, nose and throat) and eye MD (medical doctor) about	F 520		

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increase in poor eyesight".

12) The I/A report dated 12/20/06 at 8:30 a.m. documented, "... 3 cm (centimeter) laceration noted on back of head, when I pointed at resident's head, he gestured toward bathroom door and mumbled - blood noted on BR door frame. ... Past Interventions: Self locking w/c, orthostatic hypotension checks, helmet, lap tray, non-skid strips beside bed and in bathroom, bed alarm, chair alarm and dysum in chair - Recommendations/New Interventions: Cont POC - waiting for ENT appt. to see if any new procedures can assist resident."

As of 1/26/07 at 10:40 a.m., there was no documentation the ENT appointment had been made. During an interview with the Social Director on 1/26/07 at 10:40 a.m., she was asked when was the resident's last ENT and eye doctor appointments. She indicated the last ENT exam was on 1/11/00 and last eye exam was in 6/2005.

The Nurse's Notes dated 12/21/06 at 10:00 a.m. documented, "...resident reported to be leaning to left side this am. Resident unable to sit upright. Unable to amb. (ambulate) to bathroom as usually does with assist of one. Very unsteady left sided weakness. Following signed directions/gestures. ... Laceration to left crown of head without s/s of infection. Edges approximated. Called doctor and order received send to ER ... At 4:00 p.m., ... resident admitted to hospital diagnosis of Subdural Hematoma".

13) On 1/26/07 at 10:30 a.m., during an interview with CNA #2 (employed for 4.5 months), she stated, "[Resident #1] was a fun loving gentleman, he like everybody and everybody liked

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F 520	Continued From page 46 him. ... He didn't want nothing out of its place, very particular, most of the time he wanted to go to the bathroom, ... he had a bed alarm, chair alarm in his w/c and a seat belt". She was asked if she had ever seen non-skid strips on the floor beside his bed and in his bathroom. She stated, "I worked that room all the time, I've never seen non-skid strips in that room". She was asked if the resident had been on a scheduled toileting plan. She stated, "No, he was not on a toileting schedule." She was asked if she thought he should've been. She stated, "He should've been on toileting schedule, but they never did because we always took him. After his first fall when he hit his head (in December) they asked us to make sure we watched him closely and make sure he had all his restraints and alarms." She also indicated the resident did not receive a red mat next to his bed until after his second visit to the hospital on 12/22/06. She stated, "...It seems like he fell mostly at night, the night shift CNAs could've done a better job." 14) On 1/26/07 at 10:50 a.m., during an interview with CNA #3, she stated, "[Resident #1] was fine, playful couldn't speak, communicated by gestures, problem keeping him in bed, easy to care for though, always had to have someone to help with him. His bed had to be lowered all the way to the ground". She was asked, when did he receive the low bed. She stated, "... after his head injury." When asked if non-slid strips were ever placed on his floor beside the bed and in his bathroom. She stated, "No, none on the floor in his room or in his bathroom." She was asked if the facility had inserviced them on anything particular regarding the resident. She stated, "No, but our LPN spoke with us and told us to keep an eye on him as much as possible to keep	F 520		

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him from falling again." She was asked, if she thought he could've done a toileting schedule. She stated, "Yes."

15) On 1/29/07 at 10:05 a.m., during an interview with the Director of Nursing (DON), she was asked if the facility had inserviced staff regarding the resident and if the facility had attempted any new interventions or tried past interventions since December 2006. She stated, "No". She stated the facility had conducted an inservice prior to 12/1/06, (before the resident's first head injury). She added they knew he had been falling on night shift so she decided to get staff to get him up earlier before breakfast and she had inserviced that on 11/16/06. She then stated, "... But the resident started falling all different times during the day and night". She stated she had not tried other interventions again such as the helmet, "... I know not the helmet, he would throw it across the room". She indicated after the resident's room had been stripped and waxed, the non-skid strips, I didn't know they had not been replaced. She stated, "... He was not put on any formal scheduled toileting plan and had never had a red mat until 12/22/06, but staff was to make sure the bed was in its lowest position". She stated they had just initiated a new toileting schedule on 12/21/06.

16) The facility's "Falls and Fall Risk, Managing" implemented March 2005 documented, "... If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified..."

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b. From 7/26/06 to 12/15/06 Resident #2 experienced 5 falls:

1) A Fall Risk Assessment dated 4/20/06, 7/20/06 and 10/12/06 documented the resident was at high risk for falls.

2) A Change of Condition Report dated 7/26/06 at 9:00 p.m., documented, "Res (Resident) sitting on floor, states my feet slipped and I slid down. AROM (Active Range of Motion) to all ext (extremities). Denies pain. No visible signs of injury. Recommendations/New Interventions: Bed alarm replaced and moved to end of bed d/t (due to) R (Resident) sleeping close to end of bed."

3) An Incident/Accident Report dated 8/16/06 at 11:30 p.m. documented, "Resident observed in floor lying in left lateral recumbent position on floor. Denied pain...Stated I fell down. Recommendations/New Interventions: Apply non-skid strips to area in front of bed."

A Physician Order dated 8/31/06 documented, "Bed alarm to remind R (resident) to call for assist prior to transfers. Check placement and function every shift."

4) An Incident/Accident Report dated 10/31/06 at 11:25 a.m., documented, "Found lying on left side in floor next to bed with walker next to her ... Bed alarm was off. Resident will mess with it ever so often daughter stated. Recommendation/New Interventions: Continue bed alarm. Check function and placement of bed alarm."

5) A Change of Condition Report dated 12/2/06 at 1:00 a.m., documented, "Resident attempted to

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SEARCY HEALTHCARE CENTER	1205 SKYLINE DRIVE SEARCY, AR 72143

(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 520	Continued From page 49 amb (ambulate) to BR without assist ... lac (laceration) to right 5th digit, c/o (complains of) back pain. First aid administered to 5th digit. Family notified at 8:00 a.m. Recommendations/New Interventions: 7:00 a.m. ... Placed call to MD at 8:00 a.m.. Received orders to send Resident to ER for x-rays. Came back with hairline fx (fracture) to wrist. Have therapy to screen. Keep splint in place x 4 weeks. Continue toileting." A Temporary Problem List dated 12/2/06 documented, "Got up in room and fell going to BR. Therapy to screen d/t fx wrist." 6) On 1/26/07 at 11:40 a.m., the Assistant Director of Nursing (ADON) was asked how therapy was informed of needed therapy screens for residents. She stated, "We don't give therapy anything in writing. We talk about it in stand-up and they write it down." 7) A Change of Condition Report dated 12/15/06 at 10:50 p.m., documented, "Observed in floor in supine position with walker lying over her. Denied pain ... Recommendations/New Interventions: Always wear socks when in bed. Low bed placed." 8) As of 1/26/07 at 12:15 p.m., there was no documentation the resident was screened by therapy after the fall on 12/2/06. On 1/26/07 at 12:15 p.m., the Occupational Therapist was asked if a screen was done on Resident #2 after the fall on 12/2/06. She stated no and that they were unaware of the resident sustaining a fracture. "Usually for a fracture they will call us and tell us we need to screen and give us a doctor's order. They need to tell us."	F 520		

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F 520	Continued From page 50 On 1/29/07 at 12:10 p.m., the Director of Nursing was asked how the therapy screen for Resident #2 was omitted. She stated, "I have no idea." 9) The Care Plan dated 1/9/07 documented in the problem section, "At risk for falls due to history of the problem." The approach section documented, "Bed alarm to bed to remind resident to call for assist prior to transfers. Check placement and function every shift. Respond to alarm activation promptly." 10) On 1/25/07 at 12:25 p.m., the resident's daughter was present in the room. She was asked about the resident's falls. She stated that the falls had not resulted in significant injury, but at times staff would help her mother to the bathroom then forget to turn the bed alarm back on. On 1/25/07 at 2:50 p.m., and 4:05 p.m., on 1/26/07 at 8:45 a.m., and on 1/29/07 at 9:25 a.m., the resident was observed in bed with the bed alarm switch in the "off" position. On 1/26/07 at 10:30 a.m., LPN #1 stated, "There should never be a reason for the bed alarm to be off if she's in bed. I've told the girls and told them to leave it on but when they take her to the bathroom or shower, they turn it off." On 1/29/07 at 9:25 a.m., the resident's son was present in the room and stated that the bed alarm was left off a lot and that the staff had just taken [Resident] to the bathroom. c. Resident #3 sustained an injured wrist after a fall on 11/13/06:	F 520		

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F 520	Continued From page 51 1) A Change of Condition Report dated 11/13/06 at 6:15 a.m., documented, "Resident observed sitting in floor leaned up against bathroom door. When asked what happened, stated I fell ... c/o pain to left shoulder ... Additional comments and/or steps taken to prevent recurrence: Therapy to screen. Place bed alarm to bed while resident in bed to alert staff resident is up without assist." A Fall Risk Assessment dated 7/10/06 and 11/20/06 documented the resident was at high risk for falls. The Care Plan dated 11/20/06 documented, "Fall - 11/13/06. New dx (diagnosis) UTI (Urinary Tract Infection) and sprain left wrist ... Will place bed alarm..." 2) On 1/25/07 at 2:33 p.m., the resident was receiving a shower in his bathroom. There was no bed alarm on the resident's bed. CNA #1, who was in the resident's room, was asked if the resident normally had a bed alarm on his bed. She stated she had not seen one on his bed at all. On 1/26/07 at 8:41 a.m. and on 1/29/07 at 9:23 a.m., the resident was in bed with side rails up x 2. There was no bed alarm on the bed. 3) On 1/29/07 at 9:51 a.m., the ADON (Assistant Director of Nursing)was asked how the facility ensured fall interventions such as bed alarms were implemented. She stated, "I do it myself [ensure interventions are implemented]." d. Resident #4 experienced a fall on 12/28/06:	F 520		

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1) A Fall Risk Assessment dated 6/12/06, 9/19/06 and 12/6/06 documented the resident was at high risk for falls. A Physician Order dated 8/25/06 documented, "Body alarm to w/c (wheelchair) to alert staff, check every shift for function."

2) A Change of Condition Report dated 12/28/06 at 10:20 a.m., documented, "Resident states she took seat belt off w/c, sat down in floor after becoming weak, attempting to ambulate to bathroom. Recommendations/New Interventions: ... Continue to remind to call staff for assist, continue personal alarm, refer to therapy for w/c placement."

A Temporary Problem List dated 12/28/06 documented, "Refer to therapy for w/c placement."

3) On 1/26/07 at 10:25 a.m. and on 1/29/07 at 9:35 a.m., the resident was in the wheelchair with no chair alarm in place.

4) On 1/26/07 at 12:15 p.m., the Occupational Therapist provided a screen form for Resident #4 dated 1/12/07. She was asked why the screen had not been done sooner right after the resident's fall. She stated they [Occupational Therapy] did not become aware of the need for a screen until 1/12/07.

e. Resident #5 experienced falls on 7/18/06 and 01/22/07:

1) A Change of Condition Report dated 7/18/06 at 5:00 p.m., documented, "CNA found resident in floor with feet under w/c. Chair alarm was on w/c, turned off ... but don't know if resident turned off

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... Recommendations/New Interventions: Replaced chair alarm, alarm malfunctioned."

2) The RAPS dated 12/7/06 documented, "Falls: Resident is at risk for injury d/t unsteady gait, trunk restraint and the use of psychotropic drugs, will address in cp (care plan)." The Care Plan dated 12/8/06 documented, "... self releasable seat belt with alarm to w/c to remind resident to call for assist prior to transfers." A Fall Risk Assessment dated 12/8/06 documented the resident was at high risk for falls.

3) A Change of Condition Report dated 1/22/07 at 7:45 p.m., documented, "Resident slid to the floor from w/c ... Recommendations/New Interventions: Will leave door to room open, call light in reach, encourage resident to call for assist. Will continue self release seat belt while up in w/c."

4) On 1/29/07 at 9:47 a.m., the ADON was asked about Resident #5 having a chair alarm on his wheelchair. She stated, "I don't see an order for one. I don't think he's ever had one. I don't know how it got on the care plan without an order."

5) On 1/29/07 at 12:10 p.m., the Director of Nursing was asked how fall interventions were developed. She stated, "We talk about the I/As in stand-up and come up with interventions then." She was then asked how those interventions were implemented. She stated, "The RCCs (Resident Care Coordinators) actually go out and do it, then it's communicated to the LPNs and CNAs." She was asked whose responsibility it was to ensure those interventions had been implemented. She stated, "Me and [ADON's name] do that. Every new order is tracked for 72 hours, and a fall is tracked anyway for 72 hours

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F 520	Continued From page 54 no matter what." 3. On 1/29/07 at 3:20 p.m., the Immediate Jeopardy was removed and the Scope/Severity reduced to an "G", when the following plan of removal was implemented: a. On 1/29/07 Beginning at 1:00 p.m., 1/29/07, every in-house resident with physician order for restraint or assistive device was checked for function; and placement was verified by staff, completed by 2:30 p.m. on 1/29/07. b. Also, beginning at 1:00 p.m., all staff including Licensed Nurses, Certified Nursing Assistants, Housekeeping, Dietary, Laundry, Maintenance, Office Staff, Social Workers, Activity Directors will be in-serviced on Fall Prevention before they return to work. Staff on duty will be inserviced this shift. c. Preventive measures and monitoring to include: 1. I & A's will be made out on every fall 2. The doctor and family will be notified 3. Therapy will do a screen after each fall 4. The care plan will be revised after each fall 5. The aide's kardex will be updated after each fall and all new interventions will be transferred to the kardex. 6. Each fall will be recorded on the 24 hours nursing communication report 7. Internal investigation will be completed within 5 days 8. Each fall will be charted on for 72 hours to observe for delayed complications 9. Restraints and devices to be checked every	F 520		

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F 520	Continued From page 55 shift by licensed staff, daily d. The Charge Nurse will notify the Director of Nursing when each fall occurs. The Interdisciplinary Care Plan Team will meet and determine further preventive measures regarding preventing future falls for the residents, and verification of previous interventions in place and appropriate. The DON/Designee will monitor the resident daily for 4 weeks, then weekly for 1 month, and monthly thereafter. The DON/Designee will also ensure planned interventions are implemented. e. The Administrator will sign off on every Incident and Accident Report regarding Falls and determine with the DON that fall preventions are in place from his point forward. Any negative findings will be corrected immediately. f. DON will conduct a weekly "Fall Prevention" meeting with Therapy representative, Restorative aide, Social, Activity and Dietary in attendance.	F 520		