

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

PRINTED: 06/14/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/05/2007
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NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF BENTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 ALCOA ROAD BENTON, AR 72015
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F 000	INITIAL COMMENTS	F 000		
F 309 SS=D	<p>Complaint #12623 substantiated (all or in part) with deficiency cited at F309 and F324</p> <p>483.25 QUALITY OF CARE</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #12623 was substantiated (all or in part) with these findings:</p> <p>Based on observation, record review and interview, the facility failed to ensure that neuro assessments were performed per the facility policy and procedures after head injury for 1 (Residents #1) of 2 casemix residents (Residents #1 and #3) who were sustained head injuries. This failed practice had the potential to affect 64 residents who were assessed to be at risk for falls according to a list provided by the Administrator on 6/5/07 at 4:00 p.m. The findings are:</p> <p>Resident #1 had diagnoses of Pulmonary Fibrosis, Congestive Heart Failure and Malignant Breast Neoplasm. The Quarterly Minimum Data Set (MDS) dated 5/21/07 documented the resident had independent cognitive skills for daily decision-making, was continent of bowel and bladder, required supervision with one person assisting for toilet use and fell in the past 30 days.</p>	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 309	<p>Continued From page 1</p> <p>a. A Nurse's Note dated 5/28/07 at 4:45 p.m. and signed by LPN [Licensed Practical Nurse] #1 documented, "This nurse called to resident's room. Resident sitting up on toilet with abrasion to left cheek with bruising and left side of neck. States 'I tried to get up and fell'. Resident redirected to not attempt to get up without assistance. Helped back to bed. V/S [vital signs] 122/54, 98, 79, 20. Wounds cleansed with NS [normal saline] and pressure dressings applied. Bruising noted to left cheek and eye. Resident fell forward hitting cheek on w/c [wheelchair] in front of her. Dr. and [family] notified. Neuro [Neurological] checks done. WNL [within normal limits]. Continue to monitor closely."</p> <p>1) On 6/4/07 at 12:12 p.m., LPN #1 stated in a telephone interview, "I was on the hall with my cart and [CNA (Certified Nursing Assistant) #4] stuck her head out of the door and yelled at me. [Resident #1] was sitting on the toilet, the w/c was directly in front of her in a locked position. She had a scrape with a little blood on her cheek and a skin tear on her neck." LPN #1 was asked how the resident got those injuries. She stated, "I initially thought she hit the floor, but [CNA #4] said she didn't hit the floor. I didn't see any blood on the floor. She must've fell forward and hit the arm rest where it curves down and isn't padded. I just don't know." LPN #1 was asked if the resident said anything to her. She stated, "She said she tried to get up and fell." LPN #1 was asked if she was familiar with the facility's policy on neurological checks. She stated, "No, but I am now."</p> <p>2) On 6/4/07 at 12:38 p.m., CNA #4 stated, "I pushed her in the bathroom, locked the w/c, helped her get her pants down. I walked out of</p>	F 309			

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F 309	<p>Continued From page 2</p> <p>the bathroom, heard a commotion, went back in and she had her head laying down on the w/c, but was still sitting on the toilet. She looked like she had blacked out or something. Her eyes looked different, dazed. She didn't know what was going on. I yelled for the nurse." CNA #4 was asked how Resident #1 sustained an abrasion to the cheek and a skin tear to the neck. She stated, "I have no idea."</p> <p>3) On 6/4/07 at 2:45 p.m., Resident #2 (roommate) stated, "I guess what happened was she blacked out and hit her head on that metal part of the arm rest." Resident #2 was asked if she noticed a change in Resident #1 after the fall. She stated, "She couldn't talk. I thought she had had a stroke. It was jibberish."</p> <p>b. A Nurse's Note dated 5/28/07 on the 11-7 shift and signed by LPN #4 documented, "Resting comfortably. A/O [Alert and oriented] x 3, bruising noted on left cheek and left eye, dressing dry and intact. Will continue to monitor."</p> <p>c. The facility's Fall Checklist policy documented, "All unwitnessed falls are considered suspected head injury unless resident is alert and able to recall event. Neuro assessments are to be done every 15 minutes x 4, every 30 minutes x 2, every hour x 2, every 4 hours x 2, then every shift for the remaining 72 hours."</p> <p>The Neurological Assessment Flow Sheet documented checks were started at 5:00 p.m. on 5/28/07 and performed every 2 hours up to 3:00 a.m. on 5/29/07 with no problems noted. There were no documented 15 minute neuro assessments at 5:15 p.m. and 5:45 p.m.; no documented 30 minute neuro assessments at</p>	F 309			

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F 309	<p>Continued From page 3</p> <p>6:15 p.m. and 6:45 p.m.; and no documented hourly neuro assessment at 8:00 p.m. as per the facility policy.</p> <p>d. A Nurse's Note dated 5/29/07 at 7:15 a.m. and signed by LPN #5 documented, "Resident laying in bed. Speech slurred, pupils pinpoint, decreased LOC [level of consciousness]. Bruising to left side face. Dr. XXX [physician] notified at 7:25 a.m.. Received order to send to [hospital]..."</p> <p>e. A Hospital CT Scan dated 5/29/07 documented, "There is a large left-sided subdural hematoma. This has an acute component along the left lower parietal region which extends posteriorly to the occipital region and anteriorly to the temporal region... The maximum anterior to posterior dimension of this fluid collection is approximately 12 cm [centimeters]... There is shift of the midline structures towards the right with near obliteration of the left lateral ventricles."</p> <p>1) A Hospital History and Physical dated 5/30/07 documented, " The patient ... fell down, striking her face and her arms. She was brought to the Emergency Department. While there, she was noted to have a large subdural fluid collection along much of the left inner table with a large acute component, present more inferiorly, extending at least 12 cm, extending throughout most of the skull... Impression: Large subdural hematoma."</p> <p>2) A Hospital Progress Note dated 5/31/07 documented, "Pronounced dead at 5:47 a.m."</p> <p>f. On 6/4/07 at 12:12 p.m., LPN #1 stated in a telephone interview when asked if she was</p>	F 309		

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F 309	Continued From page 4	F 309			
F 324	familiar with the facility's policy on neurological checks LPN #1 stated, "No, but I am now."				
SS=H	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 #12623 substantiated (all or in part) with these findings: Based on observation, record review and interview, the facility failed to ensure adequate supervision or personal safety devices were provided as recommended to prevent falls for 4 (Residents #1, #3, #4 and #5) of 5 casemix residents (Residents #1 through #5) who were assessed to be at risk for falls. This failed practice resulted in actual harm for Resident #1 who sustained a subdural hematoma as a result of a fall after she was left unattended in the bathroom and Resident #2 who was assessed to require a pressure personal safety alarm which the facility did not have available resulting in another fall and head injury and had the potential to affect 64 residents who were assessed to be at risk for falls according to a list provided by the Administrator on 6/5/07 at 4:00 p.m. The findings are: 1. Resident #1 had diagnoses of Pulmonary Fibrosis, Congestive Heart Failure and Malignant Breast Neoplasm. The Quarterly Minimum Data Set (MDS) dated 2/22/07 documented the resident had independent cognitive skills for daily decision-making, was continent of bowel and	F 324			

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F 324	Continued From page 5 bladder, required limited assistance for toilet use and had no falls in the past 30 - 180 days. The facility's Fall Risk Assessment dated 2/21/07 documented the resident had a score of "9" and had a balance problem. The assessment documented the resident must score a 12 or greater to be considered at high risk for falls. a. A Hospice Nurse's Note dated 3/8/07 documented, "Pt [patient] very fragile, frail and thin. No pain at this time. Pt stated I am just short winded. I just came from the BR [bathroom] and I haven't caught my breath yet... Pt stated that she has no strength to do anything anymore. In bed most of the time, up to BR only..." b. A Hospice Nurse's Note dated 4/2/07 documented, "Pt bed bound, minimal or no activity. Pt has increased SOB [shortness of breath] with chest pain... Pt at risk for falls related to weakness..." c. A Hospice Nurse's Note dated 5/17/07 documented, "Pt c/o [complained of] light headedness and dizziness when moving around. Pt states 'I have to wait and get someone to help me get in the w/c (wheelchair) to go to the BR. I am afraid I am going to fall." d. A Nurse's Note dated 5/19/07 at 10:30 a.m. documented, "Resident found sitting on floor in room beside bed... Resident states my socks slipped. Legs out in front of her, moves all extremities. No c/o [complaint of] pain. No bruising or abrasions noted. Dr. XXX [physician] notified..." e. The Quarterly Minimum Data Set (MDS) dated 5/21/07 documented the resident had	F 324			

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F 324	<p>Continued From page 6</p> <p>independent cognitive skills for daily decision-making, was continent of bowel and bladder, required supervision with one person assisting for toilet use and had fallen in the past 30 days. The facility's Fall Risk Assessment updated on 5/21/07 documented the resident had a score of "11" and had a balance problem.</p> <p>f. A Hospice Nurse's Note dated 5/21/07 documented, "Roommate informed me that patient fell Saturday. Pt stated 'I was trying to get in my w/c and everything happened so fast. I guess I missed my chair or I wasn't on it good and I slid to the floor.' Pt denies any injury. 'My left side of my butt was sore but I didn't hurt myself.' Encouraged pt to use call light for assistance with transfers. Pt stated 'I have to go to the bathroom and they don't come right away'... Pt c/o dizziness when she gets OOB [out of bed] or when she gets her bath. Pt states 'I just feel like I am getting weaker'..."</p> <p>g. The Care Plan dated 5/21/07 documented in the problem section, "Actual fall with no injury related to slipping to floor with only socks on feet due to self attempting transferring on 5/19/07." The approach section documented, "PT [Physical Therapy] to screen; Continue to remind resident not to self transfer; call light within reach and encourage to use call light for assist; Keep living area as clutter free as possible to help reduce risk of significant injury should fall occur in room again." The care plan did not address scheduled toileting to prevent the resident from attempting to get out of be unassisted.</p> <p>h. A Nurse's Note dated 5/22/07 at 10:45 a.m. documented, "Resident assisted to bathroom. C/O feeling nauseated..."</p>	F 324			

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F 324	Continued From page 7 i. A Nurse's Note dated 5/25/07 on 7-3 shift documented, "Pt [patient] c/o SOB [shortness of breath] and numbness. Dr. XXX [physician] notified..." j. A Nurse's Note dated 5/28/07 at 4:45 p.m. and signed by LPN [Licensed Practical Nurse] #1 documented, "This nurse called to resident's room. Resident sitting up on toilet with abrasion to left cheek with bruising and left side of neck. States 'I tried to get up and fell'. Resident redirected to not attempt to get up without assistance. Helped back to bed. V/S [vital signs] 122/54, 98, 79, 20. Wounds cleansed with NS [normal saline] and pressure dressings applied. Bruising noted to left cheek and eye. Resident fell forward hitting cheek on w/c [wheelchair] in front of her. Dr. and [family] notified. Neuro [Neurological] checks done. WNL [within normal limits]. Continue to monitor closely." 1) On 6/4/07 at 12:12 p.m., LPN #1 stated in a telephone interview, "I was on the hall with my cart and [CNA #4] stuck her head out of the door and yelled at me. [Resident #1] was sitting on the toilet, the w/c was directly in front of her in a locked position. She had a scrape with a little blood on her cheek and a skin tear on her neck." LPN #1 was asked how the resident got those injuries. She stated, "I initially thought she hit the floor, but [CNA #4] said she didn't hit the floor. I didn't see any blood on the floor. She must've fell forward and hit the arm rest where it curves down and isn't padded. I just don't know." LPN #1 was asked if the resident said anything to her. She stated, "She said she tried to get up and fell. I asked [CNA #4] why did you leave her. She said I never left her." LPN #1 was asked if Resident	F 324			

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F 324	<p>Continued From page 8</p> <p>#1 was capable of being safely left alone on the toilet. She stated, "She always had to be taken to the bathroom and assisted. She had good days and bad days. I think it was a judgement call on the CNA's part."</p> <p>2) On 6/4/07 at 12:38 p.m., CNA #4 stated, "I pushed her in the bathroom, locked the w/c, helped her get her pants down. I walked out of the bathroom, heard a commotion, went back in and she had her head laying down on the w/c, but was still sitting on the toilet. She looked like she had blacked out or something. Her eyes looked different, dazed. She didn't know what was going on. I yelled for the nurse." CNA #4 was asked if she was familiar with the amount of assistance Resident #1 required. She stated, "I didn't know too much about her but I knew enough... what she needed. [Resident #1] would put on her call light if she needed anything but she basically took care of herself." CNA #4 was asked how far out of the bathroom she went after she assisted Resident #1 to the toilet. She stated, "I closed the bathroom door but left a crack in it so I could hear her when she was ready. I was just right there by her roommate's bed." CNA #4 was asked if it was common practice to leave residents in the bathroom by themselves. She stated, "I'm not sure how other CNAs do it. If they can toilet themselves I step out and give them privacy, but I don't leave the room. To me, she seemed all right when I took her to the bathroom." CNA #4 was asked how Resident #1 sustained an abrasion to the cheek and a skin tear to the neck. She stated, "I have no idea."</p> <p>k. A Nurse's Note dated 5/29/07 at 7:15 a.m. and signed by LPN #5 documented, "Resident laying in bed. Speech slurred, pupils pinpoint,</p>	F 324			

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F 324	<p>Continued From page 9</p> <p>decreased LOC [level of consciousness]. Bruising to left side face. Dr. XXX [physician] notified at 7:25 a.m.. Received order to sent to XXX [hospital]..."</p> <p>I. A Hospital CT Scan dated 5/29/07 documented, "There is a large left-sided subdural hematoma. This has an acute component along the left lower parietal region which extends posteriorly to the occipital region and anteriorly to the temporal region... The maximum anterior to posterior dimension of this fluid collection is approximately 12 cm [centimeters]... There is shift of the midline structures towards the right with near obliteration of the left lateral ventricles."</p> <p>1) A Hospital History and Physical dated 5/30/07 documented, " The patient ... fell down, striking her face and her arms. She was brought to the Emergency Department. While there, she was noted to have a large subdural fluid collection along much of the left inner table with a large acute component, present more inferiorly, extending at least 12 cm, extending throughout most of the skull... Impression: Large subdural hematoma."</p> <p>2) A Hospital Progress Note dated 5/31/07 documented, "Pronounced dead at 5:47 a.m."</p> <p>m. On 6/5/07 at 10:45 a.m., the Administrator was asked what the facility's system was on letting CNAs know which residents can be safely left alone in the bathroom unsupervised and which ones can't. He stated, "If someone is at high risk for falls, they're not to be left alone in the bathroom, but it's actually on a resident by resident basis. There are some residents who are alert and oriented and know to use the call</p>	F 324			

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F 324	<p>Continued From page 10</p> <p>light when they're finished. And if you're talking about [Resident #1], once she was stable in the sitting position, she was fine. She had not had any incidents that would lead anyone to believe she would've been unstable... It's really up to the charge nurse to let their CNAs know."</p> <p>1) On 6/4/07 at 3:40 p.m., CNA #5 was asked if Resident #1 was able to safely sit on the toilet unsupervised. He stated, "They've told us not to not leave them, but there are some who take that as meaning use your own judgement. With her, with that much instability, I would not leave her, knowing that she could fall. I had heard she had problems with blacking out, that's why I didn't leave her." CNA #5 was asked if the resident was weak. He stated, "Yes. She did occasionally tell me she was light headed."</p> <p>2) On 6/4/07 at 1:27 p.m., when asked about Resident #1, the Hospice Registered Nurse (RN #1) stated in a telephone interview, "She was alert and oriented x 3. She was resistant about putting on her call light because she didn't want to bother anybody. I stayed on her a lot about that because she was so weak." RN #1 was asked how much assistance Resident #1 needed for toileting. She stated, "She had been complaining of dizziness. I took her to the bathroom only 1 time and that was a while back." RN #1 was asked if she had taken the resident to the bathroom, would she have left her unsupervised. She stated, "No. I would've stayed in the doorway where I could see her. She was so short of breath."</p> <p>3) On 6/5/07 at 8:30 a.m., CNA #6 was asked how much assistance Resident #1 required. He stated, "She would grab my hands to stand up. She'd pull her own pants down, grab the bar.</p>	F 324			

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F 324	<p>Continued From page 11</p> <p>She'd clean herself." CNA #6 was asked if Resident #1 was able to safely sit on the toilet unsupervised. He stated, "I'd never leave her. She was unsteady and could fall." CNA #6 was asked how he knew which residents could safely be left alone in the bathroom. He stated, "When I started here, an aide told me not to leave anybody, and just because she needed assistance, I wouldn't leave her." At 1:00 p.m., CNA #6 was asked if he would leave a resident, who was assessed to be at risk for falls, alone in the bathroom. He stated, "...No, I would explain why I couldn't leave them and keep the door cracked, anything could happen in a matter of minutes. They could have a seizure, fall off the commode or have a dizzy spell. But I would never really leave them, leave them."</p> <p>4) On 6/5/07 at 8:35 a.m., CNA #7 was asked how she knew which residents could safely be left alone in the bathroom. She stated, "I don't leave no one in the bathroom. Someone like [Resident #1]... She didn't have any patience. She wouldn't wait for ya if you left. She'd get up."</p> <p>5) On 6/5/07 at 3:26 p.m., CNA #8 was asked how she knew which residents could safely be left alone in the bathroom. She stated, "They have a closet care plan. I look at that. I don't leave anyone because they could fall or pass out."</p> <p>6) On 6/5/07 at 1:45 p.m. during an interview, LPN #6 was asked if she would leave a resident, who was assessed to be at risk for falls, alone in the bathroom. She stated, "...No." She was asked but what if the resident was alert and oriented and still requested their privacy. She stated, "I would still stand outside the door where I could see them and keep the door cracked."</p>	F 324			

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F 324	Continued From page 12 7) On 6/5/07 at 1:35 p.m. during an interview, LPN #7 was asked if she would leave a resident, who was assessed to be at risk for falls, alone in the bathroom. She stated, "...No." She was asked but what if the resident was alert and oriented and still requested their privacy. She stated, "I would explain to the resident and stand outside the door with it cracked so I would still see the resident." 2. Resident #3 had diagnoses of Fractured Rib, Muscle Weakness and Alzheimer's Disease. The Medicare 30-day Minimum Data Set (MDS) dated 4/20/07 documented the resident had severely impaired cognitive skills for daily decision making, required limited assistance with one person physical assist for transfers and supervision with one person physical assist for bed mobility, had a history of falls, other fracture in the last 180 days, had problems with balance and required partial physical support for standing and while sitting-position, trunk control. a. The May 2007 Physician's orders documented, "3/9/07-PSA (personal safety alarm) while in bed and up in wheelchair." b. The RAP [Resident Assessment Protocol] Worksheet dated 3/15/07 documented, "has had recent fall resulting in rib fractures. Unsteady gait. has had recent hospital stay for Fx [fracture] ribs and UTI and is weak is at risk for further falls. currently receives PT [Physical Therapy]. Proceed with careplan." c. The Admitting History and Physical dated 3/31/07 documented, "81 year old white female admitted to [nursing home] following	F 324			

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F 324	Continued From page 13 hospitalization for 10th rib fracture following fall at home..." d. The care plan updated 4/30/07 documented the resident was to have a PSA (personal safety alarm) in bed and in wheelchair. The fall risk assessment dated 4/30/07 documented the resident was at risk for falls. e. The sheet entitled, "Resident Status and Care Plan" (no date given), a communication tool for staff caring for resident, located on the inside door of the Resident's closet had a section for listing restraints, bed and chair alarms. The "Resident Status and Care Plan" did not address that the resident was to have a bed alarm, it was left blank. f. The nurse's notes dated 5/30/07 at 2:00 p.m. documented, "...noted bruising to right upper arm, right thigh and right buttock. Denies pain moves all extremity, when asked stated had fallen, didn't tell anyone. could not remember exactly when..." g. The nurse's notes dated 5/30/07 on 3/11 shift documented, "...PSA worn while in bed-resident will unhook PSA and ambulate without assist to BR at times..." h. The Fall Risk Assessment dated 5/31/07 documented a score of 18. The Assessment documented, "If total 12 or greater the resident is considered to be high risk for falls and placed in the fall prevention program immediately." i. The interdisciplinary therapy screening dated 5/31/07 documented, "Resident stated she fell, no injuries noted recommend a Pressure PSA while in bed."	F 324			

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F 324	Continued From page 14 A purchase invoice dated 5/31/07 provided by the facility documented, "Deluxe chair Sentry Monitor" (pressure alarm) ordered 5/31/07. However, the invoice documented the pressure alarm indicated by the facility would not be delivered until 6/8/07, 8 days after the therapist's recommendation to help prevent further falls for the resident. j. An Incident and Accident (I/A) report dated 6/2/07 at 12:20 midnight documented, "...Resident found in floor by nurse while doing census. Had laceration to forehead. Stated she got up and stumbled trying to go to the bathroom, area cleaned and steri-stripped and resident sent to ER [emergency room]. Resident removed her PSA before getting out of the bed." The nurse's notes dated 6/2/07 at 3:05 a.m. after returning from the hospital documented, "...Unable to check pupil response on right eye due to swelling and bruising of eye." k. The nurse's notes dated 6/2/07 at 7:05 a.m. documented, "...resident again took off PSA and attempted to get out of bed unassisted had CNAs get her up and placed her in wheelchair for breakfast." l. On 6/4/07 at 4:15 p.m., during an interview with the Administrator, he was asked what has the facility done to prevent further falls for the resident. He indicated the facility had ordered a new pressure alarm but they were still using the same clip on device at this time. He was asked what was the facility doing to keep the resident safe from further falls until 6/8/07 when the alarm was to be delivered. The Administrator indicated that the facility had changed the mat used on the	F 324		

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F 324	<p>Continued From page 15</p> <p>floor to a thicker one and they would order the pressure alarm from another company and have it delivered tomorrow (6/5/07).</p> <p>m. On 6/4/07 at 3:05 p.m., the DON was asked what the facility was doing for the resident's safety until the Pressure alarm was delivered. She indicated they were transferring the alarm from the chair to the bed. The DON indicated the device had not been changed.</p> <p>n. On 6/4/07 at 2:45 p.m., CNA #2, who was in charge of central supply for the facility, was asked if she had any pressure alarms available that were not being used in the facility. She stated, "No, we have to order those." She was asked if the therapist recommended a pressure alarm for a resident today due to a fall, would the facility have one on hand to provide for that resident. She stated, "No, we have the box devices with clips, but no pressure alarms."</p> <p>o. On 6/4/07 at 2:15 p.m., the Physical Therapist entered the resident's room and looked in the residents bed and closet for a pressure alarm. There was no pressure alarm in the room for the resident.</p> <p>3. Resident #4 had diagnoses of Muscle Weakness and Dementia. The Quarterly MDS dated 5/23/07 documented the resident had moderately impaired cognitive skills for daily decision making, required limited assistance of one person with bed mobility and transfers, had a history of falls and could not balance self while standing without physical help.</p> <p>a. The Incident and Accident (I/A) report dated 3/26/07 at 7:50 a.m. documented, "...Resident</p>	F 324			

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F 324	Continued From page 16 found on floor with large gash to right above eye forehead right shoulder appeared injured stated she tried to get up and hit her head on floor." The resident was sent to the hospital. b. After returning from the hospital, an (I/A) report dated 3/26/07 at 3:00 p.m. documented, "Pt found on floor, transferred self out of bed over siderails and to the floor, Pt did not hit her head ..." c. The May 2007 Physician orders documented, "...3/26/07-Bed alarm every shift." d. The careplan dated 3/27/07 documented, "...Fall x2 [twice] on 3/26/07 with injury to right side of head above eye, with sutures required with bruising to face. Approaches: ...PSA [personal safety alarm] at all times to alert staff of attempting unassisted ambulation..." e. On 6/4/07 at 3:30 p.m., the resident was in her room in bed with the siderails in the up position. There was no bed alarm on the bed and there was not a bed alarm attached to the resident. f. On 6/4/07 at 3:40 p.m., LPN #2, was asked if the resident had an alarm. She stated, "I'm not sure only been here for 3 weeks. " LPN #2 went to the nurse's station and looked at a form entitled, "Restraint/Safety Devices" which listed every resident who had a restraint and/or an safety device such as a low bed, chair or bed alarms, mats or wanderguards. The list did not document the resident had a bed alarm. LPN #2 then looked at the May 2007 physician's order which documented the resident had a bed alarm ordered. LPN #2 entered the resident's room and observed the resident with no bed alarm. She	F 324			

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F 324	<p>Continued From page 17</p> <p>then transferred the alarm from the resident's wheelchair to the bed and then clipped the alarm to the resident.</p> <p>g. On 6/4/07 at 3:50 p.m., CNA #3, was asked if the facility provided anything that informed the CNA what the residents required, such as what type of restraint and if they required a bed or chair alarm. The CNA stated, "...there are sheets on the inside of closet doors of each resident." She was then asked to show the sheets that provided the information that was on the closet door for this resident. The CNA entered Resident #4's room. The sheet entitled "Resident Status and Care Plan" (no date given) had a section for listing restraints, bed and chair alarms. The "Resident Status and Care Plan" did not address the resident was to have a bed alarm.</p> <p>h. On 6/4/07 at 3:50 p.m., the Director of Nursing (DON) was asked when were the "Resident Status and Care Plan" sheets updated. The DON stated, as she was reviewing the form, "these were done on admission, ideally the MDS/Coordinators are to update them. "</p> <p>i. On 6/5/07 at 8:50 a.m., the MDS/Coordinator [LPN #3] was asked when were the "Resident Status and Care Plan" updated for each resident. She stated, "I've not been doing the care plans too long, I was told they are updated only when there is a significant change..."</p> <p>4. Resident #5 had diagnoses of Osteoarthritis, Status/Post Left Hip Endoprosthesis and Dementia. The Significant Change-Medicare 5-day Minimum Data Set (MDS) dated 5/22/07 documented the resident had short and long term memory problems, moderately impaired cognitive</p>	F 324			

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F 324	<p>Continued From page 18</p> <p>status, had a history of falls and required limited assistance of one person with transfers and bed mobility.</p> <p>a. The hospital history and physical dated 4/21/07 documented, "...[Resident] is a 78 y/o [year old] who fell on our Geropsychiatry Unit, sustaining a displaced left femoral neck fracture earlier this morning. ...She was on the Geropsychiatry Unit with history of dementia, behavior disturbances and psychosis. This lady apparently got up and fell last night and she has fractured her left hip."</p> <p>b. The Fall Risk Assessment dated 5/1/07 documented the resident scored a total of 11. The fall risk assessment did not score the resident for balance problems which would have scored the resident a 12 or above and place the resident at risk for falls.</p> <p>c. The Admission orders dated 5/1/07 documented, "...low bed and bed alarm..."</p> <p>d. The MDS dated 5/22/07, under the test for balance section of the MDS, documented the resident was unable to attempt balance while standing without physical assistance. The RAPS dated 5/22/07 documented, "...Falls ...had recent fall in hospital resulting in hip fracture. Due to recent decline in cognitive status does not understand that she is not able to ambulate without assistance and continues to try. Currently receiving PT services will proceed with care plan.</p> <p>e. The careplan dated 5/22/07 documented, "...Risk for continued falls d/t cognitive and physical impairments r/t recent hip fracture, CVA</p>	F 324		

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F 324	Continued From page 19 (Cardiovascular Accident), hx of TIA's (Transient Ischemic Attacks), Macular Deg (Degeneration) and Dementia. ...keep bed in lowest position and place mattress beside bed when in bed. ...PSA [personal safety alarm] on to alert staff when attempting unassisted transfers and or ambulation." f. On 6/4/07 at 2:20 p.m., CNA #1, was asked if the facility provided anything that informed the CNA what the residents required, such as what type of restraint and if they required a bed or chair alarm. The CNA stated, "...in front of every hall's ADL (activity of daily living) book, now whether they're there or not I couldn't tell you, if not then I would go to [CNA #2], the central supply person, she could tell us." She was asked if there were any residents on her hall who had a bed alarm. She stated [Resident #5] and [Resident #3]. The CNA was asked to show the bed alarm. We (surveyor and CNA #1) entered Resident #5's room. The resident was lying in bed. There was no mattress on the floor beside the resident's bed and no alarm on the bed attached to the resident. The CNA immediately transferred the alarm from the wheelchair onto the resident's bed and clipped it to the resident and then stated, "I'm sorry, my bad, write me up." The Social Director was present at the time of the observation and handed the CNA a mattress that was located against the wall across the resident's room to place beside the resident's bed. The DON was in the resident's doorway and observed the event.	F 324			