PRINTED: 11/08/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0010	A. BUILDING: _____ B. WING _____	10/25/2013

RECEIVED
WY Dept of Health
NOV 18 2013
Healthcare Licensing and Surveys

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

(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) COMPLETE DATE
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Nursing Care Facilities, Chapter 11, effective 06/26/2000 Rules and Regulations for Licensure of Nursing Care Facilities, Chapter 19, effective 06/26/2000 Licensure Survey: A survey was conducted by the Healthcare Licensing and Surveys on 10/21/13 through 10/25/13. Based upon the findings of the survey team, it was determined that this facility was not in compliance with the state requirements for Section 9. Nursing Services. The facility shall have sufficient nursing staff to meet the needs of the residents. The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide IDON: Interim Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set CAA: Care Area Assessment BIMS: Brief Interview for mental status RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency. Based on observation, review of medical records, nurse staffing schedules and incident documentation related to falls, as well as staff, resident and family interviews, the facility failed to ensure sufficient numbers of qualified nursing staff were available to meet residents' needs and to provide adequate supervision for 11 of 18	S 000	The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. This will be accomplished by: A) On 10/23/2013, the Facility staff initiated an action plan that: a. Provided supervisors on the floor to augment current staffing levels to assist with supervision, care delivery and overall operations. b. Created an interim staffing schedule detailing how care delivery would be maintained until a more permanent solution could be discovered. c. Initiated a newly devised hourly rounding procedure to ensure proper care delivery for all residents. d. Conducted education/training on resident safety and supervision with 100% of scheduled staff at the beginning of each employee's shift. This was initiated in order to ensure effective supervision and interventions to prevent falls for residents #4, #6, #15, #19, #32, #39, #51, #84, #86, #88. B) All facility residents have the potential to be affected by this	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 11/18/13

POC accepted. Call to Michael Speed, NHA on 11/25/13 @ 3:29pm
Janice Cole OHL

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S 000	Continued From page 1 sample residents (#4, #6, #15, #19, #23, #32, #39, #51, #84, #86, #88) identified at risk for falls. Serious injuries related to falls occurred to sample residents #88, #39, #84, and #32. In addition, of 48 residents identified as having falls in the last 6 months, 24 (50%) were noted to have multiple falls. At the time of survey, the facility census was 95. The findings were: 1. Review of the daily nursing staffing schedules for September and October 2013 showed there was not a consistent pattern for staffing. The schedule was divided into 4 units (200, 300, 400 and 500 halls). The number of staff per unit per shift varied from day to day. There were 53 unfilled CNA shifts from 9/1/13 to 10/23/13. In addition, there were 22 shifts when scheduled CNAs failed to show up for work and were not replaced. There were an additional 5 licensed nurse shifts shown as vacant with no replacements. 2. Interview with the IDON on 10/21/13 at 3:50 PM revealed the facility currently had "staffing problems." He further stated he had worked as a floor nurse the previous Friday and would cover shortages again that evening for 7 hours. 3. Interview with 10 alert and oriented residents on 10/22/13 at 2:30 PM revealed not enough staff was present in the facility to accommodate the residents' needs. Residents that required assistance expressed having to wait in excess of 30 minutes to have call lights answered, this occurred on a daily basis during various shifts. The interview further revealed resident's had taken their concerns to administration about a month ago and had not yet received a response. 4. Interview with training aides #1 and #2 on	S 000	deficiency. Facility NHA or designee will evaluate current staffing patterns for effectiveness regarding resident supervision and fall prevention. Any identified changes to staffing patterns will be made immediately. C) DON or designee will provide education to nursing staff on expectations regarding appropriate staffing and resident supervision. The education will include: a. The continued utilization of documented hourly care giver rounds. b. Accident prevention and resident supervision. c. Facility specific fall prevention systems. The Facility DON or designee will conduct daily audits of facility staffing levels and supervision to ensure that the facility is meeting the needs of its residents. Results will be reported daily to the facility NHA. D) The results of the daily audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	12/17/13

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S 000	Continued From page 2 10/22/13 at 8:33 PM revealed it was common to have 1 or 2 CNAs working each shift on the secure dementia unit where 26 residents resided. There were usually 1- 2 non-certified aides also working; however, they had to work directly with a CNA to provide care to residents. 5. Interview with a family member on 10/24/13 at 5:30 PM revealed s/he came to the facility a couple of times weekly. The family member stated residents "definitely need more supervision, if you need someone you usually can't find anyone." S/he stated during this survey was the first time s/he had seen so many staff working. Another family member stated in interview on 10/24/13 at 6:50 PM that s/he was dissatisfied with staffing levels. The family member stated that poor staffing and repeated resident falls caused significant concern for resident safety. The family member stated s/he visited daily to provide care and feared their family member would not be cared for adequately by the facility. The family member stated the concerns were discussed with the administrator; however, the promises of increased staffing had not been accomplished. This family member further stated that since the survey team had come into the building, there was more staff working than usual. 6. Review of the data provided by the facility covering the interval from May through October (10/25/13) 2013, showed residents experienced 197 falls. Of 48 residents identified as having falls, 24 (50%) were noted to have multiple falls within the 6-month time frame; 22 (46%) experienced multiple falls within the past 90 days. During this same 6-month interval, the facility recorded 14 instances of falls resulting in skin tears or abrasions, 16 with swelling or bruising, 3	S 000	This page left blank intentionally	

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S 000	Continued From page 3 with lacerations, and 4 with fractures identified by diagnostic imaging; 2 of the falls with fractures occurred within the past 2 weeks. There were 6 instances of resident falls when facility staff failed to document the presence or absence of injury following the fall. Specific resident examples related to insufficient number of qualified nursing staff related to falls: 1. Review of the medical record face sheet showed resident #88 was admitted to the facility on 4/12/12. The resident's diagnoses included Parkinson's disease and Alzheimer's disease. The resident's medical history included surgical repair of the left hip and placement of orthopedic hardware. The resident lived on the secure dementia unit. Review of incident reports for September and October 2013 showed this resident had 8 falls, one of which occurred on 9/18/13 at 4:39 PM resulting in significant injury to the resident's left hip. The following concerns were identified: a. Review of incident records showed the resident fell in his/her room on 9/1/13 at 6:40 AM and this fall was unwitnessed by staff. The resident fell a second time the same day, this time in the dining room at 2:50 PM, again unwitnessed by staff. Interventions developed after each of these falls instructed staff to "continue to observe." b. Review of incident notes showed the resident fell twice on 9/18/13; the first fall was in the dining room at 4:39 PM and was unwitnessed by staff. This fall resulted in complaints of pain to the left hip, ecchymosis to the left elbow, and erythema noted to the left shoulder. The incident report noted the resident had a tabs alarm placed on his/her wheelchair and staff were instructed to provide "frequent checks to promote safety." At	S 000	This page left blank intentionally	

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S 000	Continued From page 4 9:10 PM that evening (9/18/13) the resident had another fall, this was in the activity room. The incident note showed the resident was self-transferring from the wheelchair to the couch and a staff member witnessed the fall. The resident complained to staff of pain in the left hip following this fall. The physician was notified and the resident was examined that evening; an x-ray was scheduled for the following day. Review of the x-ray report, dated 9/19/13, showed two views revealed damage to the hip and the existing orthopedic hardware: "...there is more collapse of the superior femoral head. The screw now is broken through the collapsing cortex." c. Continued review of incidents in the residents record showed an unwitnessed fall on 9/20/13 at 1 AM which resulted in complaints of pain to the left knee. Resulting documentation instructed staff to educate the resident on "staying in bed and using the call light." d. Incident logs showed the resident continued to fall; on 9/26/13 the resident had an unwitnessed fall at 4:10 AM. The resident was found in his/her room on his/her knees leaning against the bed with his/her incontinence brief off, calling out for help. The note further documented the resident's continued complaint of pain in the left hip. e. Observation on 10/22/13 at 9:40 AM showed the resident wheeled him/herself away from the dining room table without staff assistance. The resident wheeled down the hallway and into another individual's room. The resident opened the closet and looked around the room. The hallway was not in view of the dining area, and there were no staff in the area until 9:51 AM, when non-certified nurse aide (NA) #2 noticed the resident and asked him/her what s/he was doing. The resident stated s/he was looking for the bathroom. The NA wheeled the resident	S 000	This page left blank intentionally	

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S 000	Continued From page 5 out of the room and called to a CNA for assistance. At 10:05 AM CNA #11 and the training aide transferred the resident from the wheelchair to the bed using a full Hoyer mechanical lift. Prior to the transfer the resident repeatedly stated s/he needed the bathroom and to "hurry." The aides transferred the resident into bed where his/her incontinence briefs were changed. As the resident was being laid down, s/he was crying out and ringing his/her hands. The aides stated that movement caused pain to resident's left hip. f. Review of a nurse's note dated 10/22/13 timed at 2:59 PM showed the resident had another fall on 10/22/13 at "approx" 1 PM. The fall was unwitnessed and happened in the dining room. The note showed the resident did not have any injuries, denied pain, and staff were instructed to "continue to monitor." g. Interview with the unit manager, RN #11 on 10/22/13 at 3:33 PM, verified the resident was at risk for falls and stated the resident should be supervised in the main area of the unit and not left in the wheelchair in his/her room alone. 2. Review of the care plan for resident #39 showed s/he was admitted in April 2013. Review of the ADL portion of the care plan showed it was initiated on 4/15/13 and there were new approaches developed on 7/18/13 and 10/8/13. These approaches showed the resident was increasingly unsteady and required assistance to ambulate. The resident was also noted to require extensive assistance for bed mobility, toileting, transferring, locomotion, grooming and dressing. Review of the 4/15/13 care plan showed the resident was at risk for falls based on a history of falls, unsteady gait/balance, and medications that could contribute to loss of balance. There were no approaches for fall prevention shown prior to 7/18/13, even though the resident had a fall and a	S 000	This page left blank intentionally	

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S 000	Continued From page 6 fall-related fracture in May 2013. The care plan instructed staff to promote comfort, provide transfer with assistance, "instruct the resident to call for help (reinforce the use of the call light rather than screaming at staff)", assure good hygiene, assure adequate pain management, place the bed in the lower, locked position, keep personal items in reach, and to anticipate needs. The following concerns were identified: a. Review of the medical record and incident reports showed the resident had an unwitnessed fall on 5/14/13 at 10:50 AM. The fall occurred in the resident's room and was attributed to the resident being "impatient with staff and attempted to transfer self from recliner to bed." The post-fall investigation failed to note if the resident's call light was in reach or had been activated. Accompanying documentation showed the resident had a skin tear to the right elbow. No further injuries or pain were identified at that time. Staff were instructed to "continue to observe" and teach the resident "safe transfer techniques [and] use of call light." b. Review of a radiology report dated 5/15/13 showed the resident was evaluated for complaints of pain to the left hip after the 5/14/13 fall. Diagnostic imaging revealed "...transverse subcapital fracture of the left femur with 50% cranial displacement of the shaft in relation to the head." c. Review of an incident dated 9/13/13 showed the resident was "very argumentative" when found kneeling in front of his/her wheelchair. The incident report alleged the resident to state, "[s/he] needs in [his/her] wheelchair right now, what the f--- is taking so long" and "[s/he] has to go to the bathroom, and no one ever responds to the call bell." There were no complaints of pain or injury attributed to this fall episode.	S 000	This page left blank intentionally	

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S 000	Continued From page 7 d. Review of a 9/17/13 incident report showed the resident had an unwitnessed fall at 5:30 PM in the his/her room. The report stated the resident was "trying to get into [his/her] chair from the bed." As a result of this fall, staff were required to educate the resident to "use of call light, instructed resident on being patient on staff when it comes to [his/her] needs." e. Observation on the evening of 10/22/13 at 8:10 PM showed the resident's call light was on and the resident was yelling loudly for "help." The resident's room was located at the far end of the hallway and was not visible from the main areas of the unit. The call light had an audible tone, but it was low in volume and only audible in the immediate vicinity of the nurses' station. There were no staff readily available in either the nurses' station or the area around the resident's room. Observation and interview with the resident at that time revealed s/he was sitting up in bed with his/her feet on the floor. The resident stated s/he needed help to go to the bathroom, needed his/her incontinence brief changed, needed the bed rearranged, and was cold. The surveyor asked the resident to wait while a staff member was located. The resident expressed concern that help took a "long time." After leaving the resident's room, the surveyor searched for a staff member to assist the resident. The call tone was still sounding from the nurses' station, but there were no staff within hearing distance of the alarm. At 8:15 PM, three staff were on the secure unit; CNA #2 was in the main area assisting another resident, another aide was assisting a resident with a shower, and LPN #10 was passing medications. Interview with the LPN at 8:20 PM verified there were two CNAs assigned to the hall where resident #39 was located, and both were helping other residents; the LPN continued passing medications. At 8:20 PM interview with	S 000	This page left blank intentionally	

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S 000	Continued From page 8 the resident revealed s/he often waited "...a very long time, they don't care about you here. Around here they don't come for a very long time." At 8:30 PM, 20 minutes after the call light had been activated, LPN #10 responded to the resident when she was made aware by the surveyor of the resident's continued need. 3. Review of the medical record face sheet showed resident #84 was admitted on 4/26/13. The resident lived on the secure unit of the facility and had diagnoses that included dementia. Review of the 4/26/13 fall risk assessment revealed the resident's fall risk was influenced by decreased safety awareness, poor recall and judgment, impaired mobility, balance problems when standing, decreased muscular coordination, and a need for assistance with toileting. The risk assessment further showed the resident had a history of falls and had a fall with a fracture prior to admission. Review of the resident's care plan showed fall risks were included on a 5/15/13 update after the resident had a fall. However, there were no interventions dated prior to 8/12/13, when staff were instructed to "proactively promote comfort use assistive devices: wheelchair for locomotion...transfer with assistance...low bed with wheels locked, keep personal items in reach, provide brighter lighting...corrective eyewear..." Supplemental approaches dated 9/12/13 and 9/19/13 required nurse aides to "anticipate needs, locate near staff when out of bed." The following concerns were identified: a. Review of the facility fall log documentation showed the resident fell 6 times on 5/1/13. The log showed two of those falls were unwitnessed, the remaining 4 falls were incompletely documented and failed to include details about the time and location of the falls. There were no injuries attributed related to these falls. The	S 000	This page left blank intentionally	

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S 000	Continued From page 9 resident fell twice on 9/12/13, one fall was witnessed by staff and one was not. There were no injuries documented for these falls. The resident also had another observed fall without injury reported on 9/19/13. b. Review of fall documentation showed the resident had an unwitnessed fall on 10/21/13 at 11 AM. The resident subsequently complained of pain in the right forearm and right thigh. Staff were required to "continue to observe" and the resident was instructed on use of the call light and not to self-ambulate. c. Observation on 10/21/13 at 3:22 PM showed the resident was wheeling him/herself in the hallway closest to the main entrance to the secure unit. The resident was observed to go into room 526 and stand partially up from his/her wheelchair. At that time the resident's tabs alarm monitor was activated. There were no staff in the area at that time and the alarm sound was unnoticed by staff. Continued observation showed the resident sat back down, wheeled around the room, and eventually returned to the hallway. The surveyor asked the resident if s/he heard the sound of the alarm and the resident denied hearing anything. The surveyor observed the resident with the alarm sounding until 3:33 PM (11 minutes), at which time LPN #1 came down the hall and reattached the alarm so it stopped. d. Review of a nursing note dated 10/22/13 at 9:35 AM showed the resident was assessed and medicated for "severe" pain in the right wrist. A 5:29 PM nurse's note that day showed the physician was contacted regarding the wrist pain following the most recent fall and an x-ray order was obtained. Review a nurse's note from 10/23/13 at 8:37 AM revealed x-ray findings showed "an impacted distal radial fracture with a transverse and vertical component." The note showed the physician would be in "ASAP" (as	S 000	This page left blank intentionally	

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S 000	Continued From page 10 soon as possible) to assess the resident and place a splint. 4. Review of the medical record for resident #32 showed the resident was admitted to the facility on 10/2/13 with diagnoses including non-Alzheimer's dementia. Review of the MDS admission assessment dated 10/10/13 showed the resident was cognitively impaired and required extensive assistance with ADL's including ambulation. Review of the CAA dated 10/3/13 showed the resident was getting up frequently unassisted, was unsteady on his/her feet, and was at risk for falls and significant risk for physical illness or injury. Care plans dated 10/14/13 showed the resident required extensive assistance with ADL's; was at risk for falls, and had poor safety awareness related to dementia. Approaches/interventions updated 10/19/13 included instructing the resident to call for help, sensor alarms in the bed and chair, tab alarms and bed in lower, locked position. The following concerns were identified; a. Review of fall documentation showed the resident sustained unwitnessed falls on 10/18/13, and 10/19/13. The resident was observed on the floor in the 400 hallway on 10/18/13 at 10:30 AM and complained of pain in the right buttock. Actions taken included continuing to observe and teaching safe transfer techniques. On 10/19/13 at 1 PM the resident was, "found down" in his/her room and complained of pain in right hip. Actions included "continue to observe." There was no documentation indicating whether alarms were in place and/or functioning or if the bed was in a low, locked position. A fall risk assessment was conducted on 10/19/13 at 2:01 PM, after the second fall, and indicated the resident was at risk of falling related to decreased safety awareness and dementia.	S 000	This page left blank intentionally	

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S 000	Continued From page 11 b. Review of an x-ray dated 10/21/13 showed the reason for the exam was due to 2 falls and severe pain. The MD radiology impression was an "acute fracture new from September 2013 of the superior and inferior pubic raml on the right." c. Observation on 10/21/13 at 3:25 PM revealed the resident was seated in a recliner in his/her room. The sensor alarm was observed lying under the resident's bed, the tab alarm was lying on the resident's dresser in the off position and not attached to the resident's clothing. CNA #22 entered the resident's room stating, "I forgot to put your alarm back on." The CNA placed the tab alarm clip on the resident's clothing, but did not check the alarm and was not aware the alarm was turned off until informed by the surveyor. The sensor alarm remained under the resident's bed. The CNA indicated at the time of the observation that the resident was supposed to have the tab alarm on while sitting up. Observation on 10/22/13 at 7:50 PM revealed the resident's sensor alarm was alarming. LPN #12 was observed in the hallway at the medication cart beside the resident's open door. The LPN walked away from the medication cart into another resident's room and shut the door. CNA #10 responded to the alarm at 7:55 PM. At 7:57 PM the resident's sensor alarm began alarming again and CNA #10 responded to the alarm at 8:01 PM and offered to take the resident to the bathroom, the resident declined. The CNA instructed the resident to use the call light for assistance. Observation on 10/23/13 at 2:10 PM revealed the resident was seated in a recliner in his/her room. The resident's tab alarm was lying on the bedside table turned off and the sensor alarm was lying under the resident's bed, turned off. At 2:18 PM an unidentified staff member walked into the resident's room stating, "I didn't think she hooked you up". The tab alarm was turned on and the clip	S 000	This page left blank intentionally	

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	WY0010	A. BUILDING: _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Continued From page 12 was attached to the resident's clothing. The sensor alarm was left lying under the resident's bed. An interview with RN #5 at 2:18 PM revealed staff were preparing to move the resident to a room closer to the nursing station. d. Interview with CNA #10 on 10/22/13 at 8:05 PM revealed CNAs and nurses were supposed to check resident alarms prior to the end of their shift to ensure alarms were in place and functioning. Interview with CNA #2 on 10/22/13 at 8:35 PM revealed all staff were responsible for checking to see if alarms were in place and maintenance was responsible for ensuring alarms were functioning properly. Interview with the IDON on 10/26/13 at 9:55 AM revealed he expected all staff to respond to alarms. 6. Review of the medical record for resident #19 showed the resident was admitted to the facility on 9/10/13 with diagnoses including dementia and confusion. Review of the preadmission screening and resident review for nursing facility admission (PASSR) level II dated 8/27/13 showed, "Recommendations regarding services that may be needed at the nursing facility include: Close supervision to prevent further falls." The medical record further revealed that prior to admission the resident sustained a fall on 7/24/13 resulting in a right hip fracture and underwent surgical repair with hardware placement. The admission MDS assessment dated 9/20/13 showed the resident was severely cognitively impaired, required extensive assistance with ADL's, used a wheelchair for ambulation, and had fallen prior to admission. Review of the CAA dated 9/20/13 showed the resident was at risk for falling. Review of the care plan dated 9/20/13 showed the resident had the potential for trauma/falls related to gait/balance, history of falls, medications and mental status (poor safety	S 000	This page left blank intentionally	

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S 000	Continued From page 13 awareness). Approaches/interventions included sensor alarm, pull tab alarm in bed and chair, and to instruct the resident to call for help. The care plan was updated on 9/21/13 to include the approach, "transfer with assistance and instruct to call for help." The following concerns were identified: a. Review of fall documentation showed the resident sustained falls on 9/21/13, 10/4/13 and 10/6/13. Review further showed none of the falls were observed by staff. Review of the fall documentation for 10/6/13 showed the resident had sustained a, "large hematoma [bruise] on the right side of forehead". Actions included continue to observe, instruct resident on needing assistance with transfers, anticipate needs and locate near staff when out of bed. The fall on 10/6/13 showed actions which included continue to observe, ice pack applied, vital signs and neurological checks every 15 minutes for 1 hour, then every 30 minutes for 2 hours then every hour for 4 hours, and the resident was instructed on safe transfer techniques. b. Observation on 10/21/13 at 10:20 AM revealed the resident had a yellow, purple tinged bruise on the right side of his/her face surrounding the peri-orbital (eye) area. Continuous observation on 10/22/13 from 7:35 PM until 8:07 PM revealed at 7:35 PM the resident was observed on the 400 hall at the CNA desk seated in a locked recliner that was pushed up to the desk. The resident's wheelchair was observed to the left of the resident with the tab alarm attached to the back of the wheelchair near the right handle. The alarm was turned off and the clip that attaches to the clothing was wrapped around the right handle of the wheelchair. No staff was present. The resident was observed standing up and sitting down repeatedly, there were no alarms in the recliner or attached to the	S 000	This page left blank intentionally	

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	WY0010	A. BUILDING: _____ B. WING _____	10/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Continued From page 14 resident's clothing. At 7:40 PM the resident was observed getting up out of the recliner and attempting to turn around between the desk and the recliner. The resident sat back down in the recliner and put his/her feet upon the side of the desk, and pushed the desk with both feet. At 7:50 PM CNA #10 exited a resident's room and approached the resident who was attempting to stand up. The CNA assisted the resident to transfer to his/her wheelchair and stated, "How would you like to visit [resident name]?" The tab alarm was not turned on or attached to the resident's clothing. The CNA wheeled the resident down the hall into another resident's room where LPN #12 was performing a medication pass. At 7:52 PM an alarm began alarming across the hall, CNA #10 exited the room to respond to the alarm. LPN #12 exited the room leaving the resident unattended in another resident's room. The resident was observed attempting to stand up and was redirected by the other resident, "[resident name] you need to sit back down, you are going to fall." CNA #10 reentered the resident's room at 7:55 PM with a nursing aide student and proceeded to apply lotion to the other resident's legs and assist the other resident with toileting in the presence of resident #19. An interview was conducted with CNA #10 at the time of the observation and s/he was made aware the resident's tab alarm was turned off and not attached to the resident's clothing. The CNA was unaware the resident was supposed to have a sensor alarm in the seat of the wheelchair. Interview further revealed CNAs and nurses were supposed to check resident alarms prior to the end of their shift to ensure alarms were in place and functioning. c. Subsequent observation made on 10/23/13 at 8:50 AM revealed the resident was in a recliner at the 400 hall CNA desk. There was no tab alarm	S 000	This page left blank intentionally	

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S 000	Continued From page 16 attached to the resident's clothing or on the recliner, and there was no sensor alarm in the seat of the recliner. 6. Review of the medical record for resident #88 showed the resident was admitted to the facility on 1/4/05 with diagnoses including non-Alzheimer's dementia. Review of the annual MDS assessment dated 10/15/13 showed the resident was moderately cognitively impaired and had a history of falls. Review of the care plan updated 10/23/13 showed approaches/interventions including instruct to rise slowly, instruct to call for help, encourage asking for assistance, anticipate needs and locate near staff when out of bed. Review of the fall documentation revealed the resident sustained unwitnessed falls on 8/23/13, 9/2/13, 10/14/13, 10/15/13, and 10/23/13. The following concern was identified: Interview with the resident on 10/24/13 at 4:30 PM revealed s/he was able to recall falling in the AM of 10/23/13. The resident stated, "It was early in morning before breakfast and I had to go to the bathroom so I put my call light on and after nobody came, I got up to go to the bathroom, lost my balance and fell." The interview further revealed the resident had to wait, "at least 15 minutes, sometimes longer, before someone comes to answer the call light." The resident was able to recall falling several times in the last month but was unable to recall specific dates, and complained of, "I hurt my right hand, but it is better now." 7. Review of the medical record for resident #4 showed the resident was admitted to the facility on 7/31/13 with diagnoses including non-Alzheimer's dementia. Review of the admission MDS assessment dated 8/7/13	S 000	This page left blank intentionally.	

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S 000	Continued From page 18 showed the resident had wandering behaviors, was moderately cognitively impaired, and required supervision from staff when ambulating with a walker. Review of the CAA dated 8/1/13 showed the resident was at risk for falling and had a fall on 8/1/13 and the resident's, "gait is choppy and [s/he] slides feet at times". Review of the care plan updated 8/15/13 showed the resident had potential for trauma-falls related to impaired balance, unsteady gait, and use of devices for walking and fall in recent past. The care plan approaches were updated on 10/24/13 with interventions including, proactively promote comfort, instruct to rise slowly, increase assistance and surveillance. Review of fall documentation showed the resident sustained unwitnessed falls on 8/1/13, 8/31/13, 9/16/13, 9/21/13, and 9/23/13. The following concerns were identified: a. Further review of fall documentation revealed the resident complained of pain in the left ribs from the fall on 8/31/13, and continued on 9/1/13 to have, "left side pain with a protruding area on left lower ribs." An x-ray of the ribs was done on 9/3/13 and the impression showed no evidence of a displaced rib fracture. The fall on 9/16/13 showed the resident was disoriented and, "found down from sitting in another resident's wheelchair." The resident sustained a hematoma to the back of his/her head. The fall on 9/21/13 showed the resident sustained an abrasion to the right knee. The fall on 9/23/13 showed the resident already had abrasions on both knees and the right knee was bleeding and required a dressing. Actions after falls included continue to observe, monitor vital signs and perform neurological assessments, and the resident was instructed on safe use of assistive devices and using the call light. b. Observation on 10/22/13 at 7:05 PM	S 000	This page left blank intentionally	

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S 000	Continued From page 17 revealed the resident ambulating with the assistance of a rolling walker on the secured unit. The resident was walking in the main dining area behind seated staff and into the hall to the left of the main dining area out of the line of sight of staff. The resident was unsteady with turning the walker and at times picked the walker up and carried it. Observation on 10/25/13 at 9:07 AM revealed the resident was in the main dining area on the secured unit. The resident was standing by a reclining chair, picked up his/her walker and turned it upside down examining the wheels. The resident then turned and sat in the recliner, picked up the walker and placed it in his/her lap. At 9:10 AM the resident was redirected by RN #9. c. Review of the medical record showed there was no assessment of the resident's ability to safely ambulate with the rolling walker. 8. Review of the care plan for resident #51 showed s/he had diagnoses of Alzheimer's disease and was at risk for falls due to impaired balance. Care planning for falls was initiated on 9/2/12 and included approaches dated 7/1/13, 9/7/13, and 10/1/13; these approaches required staff to provide assistance with transfers, instruct the resident to call for help, anticipate the resident's needs, and locate near staff when out of bed. The care plan also addressed the resident's wandering behavior in a note dated 10/3/12. The 10/3/12 approach required staff to record behaviors and maintain the safety of the resident and others around the resident. There were no details explaining how this maintenance of safety would be provided. The 10/1/13 approach further showed when the resident was "acting out" staff were directed to visit with him/her. Observation on 10/21/13 identified the following concern related to fall risks and supervision:	S 000	This page left blank intentionally.	

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S 000	Continued From page 18 a. At 3:25 PM the resident was wandering in the hallway and into other residents' rooms. The resident ambulated without staff assistance and without any assistive devices. During this time there were no staff in the hallway and the hallway was not visible from the main dining and television areas where staff were located. b. At 3:33 PM the tub/shower room door was observed ajar. The room lights were off and the door was noted to have a key pad lock. Two spray bottles of chemical cleaner labeled "Virex" were seen on a counter inside the room. Continued observation showed the tub/shower room remained open and unoccupied until 3:50 PM, when the IDON came into the unit and the surveyor asked about the door being opened. The IDON stated that the door should be closed and, when closed, required a key pad code to unlock and open. c. At 3:43 PM the resident was noticed by the surveyor to be missing from the hallway and the main areas of the unit. When asked at 4 PM nurse aide #1 stated she had not seen the resident and did not know where s/he was. This aide inquired of another CNA who did not know the resident's whereabouts. At 4:30 PM (47 minutes after noticed missing) unit manager, RN #11 went room to room down the hallway looking for the resident. The resident was found in another resident's room asleep in an armchair. 9. Review of fall documentation for resident #23 showed the resident experienced falls on 5/23/13, 6/10/13, 9/18/13 and 10/18/13. Review of the care plan showed the resident was at risk for falls based on impaired balance, an unsteady gait, and falls in the recent past. The care plan was initiated on 10/25/12 and was updated on 7/19/13, 9/18/13 and 10/18/13 after additional falls. The approaches were for staff to ensure the	S 000	This page left blank intentionally	

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S 000	Continued From page 19 call button was within reach, to assist the resident with ambulation, toileting and transferring, to anticipate needs, and to locate the resident near staff when out of bed. These approaches remained the same after each fall. Beginning 10/22/13, resident medical records and facility falls records were reviewed in detail. From these data it was discovered that resident #23 fell 3 times between 8/26/13 and 10/18/13 (8/26/13, 8/27/13, 10/18/13; all without injury); s/he also had 2 falls in April 2013 (noted in Care Plan note dated 6/8/13). From the resident's care plan it was further documented that s/he had poor safety awareness, was not inclined to use her call light or ask for assistance, and continued to show declined cognition and increased confusion. For each of the falls noted, facility staff listed interventions to "...instruct to use call light...teach resident to request assistance...place call button in reach...anticipate needs." Interview with LPN #11 on 10/23/13 at 9:20 AM confirmed the resident's declining mental status and falls history. The LPN acknowledged the resident was not a good candidate for teaching and might not associate the call button with the need to transfer or reposition. Further interview with the MDS/Care Plan coordinator on 10/23/12 at 2:20 PM confirmed the resident had short-term and long-term memory problems and was not always able to retain new information. She acknowledged interventions based on instructing, teaching, and cognitive association would not be consistently effective for this resident. She did not know why fall prevention interventions were not individualized for this resident. 10. Based on facility falls data and medical record review, it was discovered resident #15 had 13 falls since admission on 10/9/13 (4 falls on	S 000	This page left blank intentionally	

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S 000	Continued From page 20 10/9/13, 2 falls each on 10/10/13, 10/12/13, 10/15/13, and a single fall on 10/20/13; all without injury). In each case, post-fall assessment and interventions stated "transfer with assistance, instruct to call for help" and "anticipate needs, locate near staff when out of bed." Observations on 10/23/13 and 10/24/13 revealed the resident was seated in the 200 unit hallway in the vicinity of the nurses' station, but staff were not consistently in the area; 4 observations ranging from 35 to 71 minutes showed staff were not near, nor in line-of-sight, should the resident need assistance or attempt to self-transfer or stand. The resident's care plan further stated s/he exhibited cognitive decline, memory loss, and dementia. There was nothing in the care plan to address the resident's recent admission to the facility or his/her adjustment to the new living environment. Interview with the MDS/Care Plan coordinator on 10/23/13 at 4:05 PM confirmed the resident was a high risk for falls since his/her admission two weeks ago. She acknowledged the planned interventions were unsuccessful and an individualized approach might be helpful in reducing further falls.	S 000	This page left blank intentionally	
	11. Review of the medical record for resident #6 showed s/he had diagnoses of dementia and a history of transient ischemic attack. Review of a fall risk assessment dated 10/13/13 revealed s/he was at risk for falls due to poor recall, judgement, and safety awareness, poor vision, balance problems and decreased muscular coordination. Review of the resident's care plan revealed a plan for falls last reviewed on 8/21/13. Interventions included providing assistance with transfers, to instruct the resident to call for help, to assist the resident with ambulating, transferring and toileting (if s/he would allow), to anticipate needs, and locate near staff when out of bed. The following			

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S 000	Continued From page 21 concerns were identified for the resident related to fall risks and supervision: a. The goal initiated for the falls care plan, dated 5/21/13 was "minimal injury from falls" rather than preventing falls. This goal was then deemed met on 8/21/13, even though the resident had suffered 2 falls in the intervening time with one of those fall resulting in "minor injury." b. Review of facility incident logs revealed the resident had suffered falls most recently on 10/6/13 and 10/21/13. The resident's care plan was updated on both of those occasions with "Transfer with assistance" and "Instruct to call for help." c. Review of the resident's 8/15/13 annual MDS assessment revealed the resident had a BIMS score of 3, indicating severe cognitive impairment. Interview with the MDS coordinator on 10/23/13 at 2:20 PM confirmed that interventions based on instruction and teaching would not be effective for a resident with severe cognitive impairment. d. Observation of the secure unit common area on 10/22/13 at 7:25 PM showed the resident wheeled him/herself over to the kitchen-area gate in his/her wheelchair. S/he then proceeded to unlatch the gate, and wheel him/herself into the kitchen area. At this time, the resident was noted to be in the direct line-of-sight of three aides in the area. The resident was observed to spend 10 minutes propelling him/herself around the kitchen, and pulling him/herself up out of his/her wheelchair to rummage in containers on the counter. At 7:35 PM the resident left the kitchen area without once being engaged by any of the staff present in the area.	S 000	This page left blank intentionally	