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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare and Medicaid abbreviated standard survey was conducted 3/7/17 through 3/9/17. Three complaints were investigated during this survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 94 at the time of the survey. The survey sample consisted of 9 resident reviews, 7 current resident reviews (Resident #1, #2, #3, #4, #5, #8 and #9) and 2 closed record reviews (Residents #6 and #7).	F 000		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323	F 323- 483.25 (d) (1) 92) (n) (1) - (3) Free of accident hazards/supervision/devices (d) Accidents, a facility must ensure that (1) the resident environment remains as free from accident hazards as is possible; (2) each resident receives adequate supervision and assistance devices to prevent accidents. (n) Bed rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails. Based on a complaint investigation, The facility failed to ensure the safety of 5 out of 10 residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom Laverse | TITLE: Administrative Director | (X6) DATE: 3/30/17

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 323	Continued From page 1 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, observations, clinical record review, staff interviews and facility documentation review, the facility staff failed to ensure the safety of 5 out of 10 residents (R#1, #4, #5, #8 and #9) in the survey sample, who were identified at risk for falls. 1. Resident #1 was identified at high risk for falls and actively falling in the facility. One of the assistive devices/interventions to alert the staff of the resident's movement in bed was a bed sensory alarm. The resident was found on the floor and the bed sensory alarm was not operational at the time of a second fall. 2. Resident #4 was identified on admission at risk for falls and sustained one fall since admission. The facility did not assure the bed sensory alarm physician orders were in place to monitor placement and function every shift per facility protocol. 3. Resident #5 was identified on admission at risk for falls and sustained one fall since admission. The facility did not assure the bed sensory alarm physician orders were in place to monitor placement and function every shift per facility protocol. 4. Resident #8 was identified on admission at risk for falls and sustained three falls since admission. The facility did not assure the bed sensory alarm	F 323	1. Resident #1, the facility failed to ensure a bed sensory alarm was operational. 2. Resident #4, the facility failed to assure the bed sensory alarm physician orders were in place to monitor placement and function every shift per facility protocol. 3. Resident #5, the facility did not assure the bed sensory alarm physician orders were in place to monitor placement and function every shift per facility protocol. 4. Resident #8, the facility did not assure the bed sensory alarm physicians orders were in place to monitor placement and function every shift per facility protocol. 5. Resident # 9, the facility did not assure the bed sensory alarm physicians orders were in place to monitor placement and function every shift per facility protocol. To ensure compliance for sensory alarms: • Audits completed on all residents to ensure facility protocol compliance regarding sensory alarms and physician orders. • Sensory alarm rounding tool initiated- completed • Daily audits implemented on patients/residents. Placement verified on the EMR dashboard at each shift by nursing. • Daily Interdisciplinary team meetings enhanced to include patients necessitating sensory alarms, and physician orders, alarms and orders obtained by Unit Managers and Unit Secretaries after each meeting. To ensure compliance with Physician orders: • New admission checklist has been enhanced to include an audit component that addresses physician orders and sensory alarm. • Education provided to all Licensed Nursing staff by the Director of Nursing regarding compliance of following facility policy/procedure on following physician's order and initiating fall precautions.	Completed 3/14/2017 Completed 3/10/2017 Completed 3/10/2017 Completed 3/10/2017 Completed 3/15/2017 Completed 3/15/2017

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physician orders were in place to monitor placement and function every shift per facility protocol.

5. Resident #9 was identified on admission at risk for falls and sustained one fall since admission. The facility did not assure the bed sensory alarm physician orders were in place to monitor placement and function every shift per facility protocol.

The findings include:

1. Resident #1 was admitted to the nursing facility on 2/1/17 with diagnoses that included status post operative after care due to a right femur fracture, generalized muscle weakness, hearing loss and dementia.

The Admission Minimum Data Set (MDS) dated 2/8/17 coded the resident with vision problems with corrective lenses and moderate hearing difficulties that required hearing aids. She was assessed to understand people and herself understood. The resident was coded with a score of 5 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was severely impaired in the skills needed for daily decision making. The resident was assessed with fluctuating disorganized and incoherent thinking. She was not assessed with mood or behavioral problems and did not reject care to include activities of daily living assistance. Resident #1 was coded to require extensive assistance of two staff for bed mobility and toilet use, transfers, dressing, personal hygiene and locomotion on and off the unit. She was independent is eating after set up. She was totally dependent on one staff for bathing. She was

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impaired on one side of lower extremity and was not steady without physical assistance to move on and off toilet, move from a seated position to a standing position, walking, any transfers or turning around. The walker and wheelchair were her main mobility devices. The resident was receiving occupational and physical therapy 5 times a week. The resident was coded frequently incontinent of bowel and bladder. Resident #1 was coded to have fallen in the last 6 months prior to admission with injury (fracture) and one time within last month in the facility with injury (i.e., skin tear, superficial lacerations, bruises), but no fracture.

The MDS (30 day) dated 3/1/17 coded the resident with the same BIMS score of 5, same functional status assistance needs. She was coded to have fallen again with same type injury, but no fracture. The resident was receiving occupational and physical therapy 5 days a week.

The Admission Fall Risk Screen completed on 2/1/17 assessed Resident #1 at high risk for falls. The screen identified the resident had periodic confusion, had unsteady gait and ambulated, transferred with assistive devices or assistance. The screen indicated the resident had medication risk factors, call bell was placed in reach (educated about call bell), as well as a clip alarm for the chair and a bed pressure alarm. The resident was coded with a score of 8 (high risk for falls).

The Incident Report indicated the fall occurred 2/2/17 at 11:00 a.m. The resident was observed on the floor in front of wheelchair sitting on buttocks; resident stated she was trying to get out of her chair to the "den". The resident sustained

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skin tears to left arm, treatment performed. The resident did not complain of pain or had any other obvious injuries. The fall prevention protocols in place at the time of the fall were chair and bed alarms and the chair alarm sounded at the time of the fall.

CNA #2 stated she was with the resident and transferred her into the wheelchair on 2/2/17. The CNA stated she placed the resident in the wheelchair, placed the clip chair alarm to the resident's shoulder, left her for about 15-20 minutes when she heard the chair alarm sound. She said when she got to the room the resident was on the floor and the resident told her she tried to put herself in bed. According to the CNA, she went to retrieve the nurse.

On 3/9/17 at 11:30 p.m., an interview was conducted with the Registered Nurse (RN) #3. She said she admitted Resident #1 and found her to be a little confused and have normal anxiousness for a new admission to the facility. The RN stated she assessed the resident with a Fall Risk score of 8, which was considered high risk. RN #3 stated she assessed the resident after the first fall on 2/2/17 and she sustained a 2 skin tears to her left forearm, but no other obvious injuries, swelling or bruising. She said the resident did not complain of pain anywhere. She said the resident said she wanted to go to bed and did not want to bother anyone. She stated CNA #2 stated she heard the chair clip alarm sound and went back to her room and found her on the floor. The pressure alarm to the bed was an added fall intervention after the 2/2/17.

The care plan dated 2/2/17 indicated the resident had an actual unwitnessed fall (2/2/17) in room.

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The care plan indicated the resident said she fell out of wheelchair trying to get into the bed. It was noted the resident did not use the call bell that had been placed within reach and stated she did not want to bother anyone. The resident sustained two skin tears on left forearm. The goal set for the resident by the staff was that she would resume usual activities without further incident. Some of the approaches to accomplish this goal included have bed an chair pressure alarms in place at all times and staff to check function as ordered.

A Fall Risk Screen dated 2/2/17 identified the resident sustained a fall was found on the floor. Clip alarms in place to bed and chair, bed in low position and call bell within reach. The resident was coded with a score of 7 (high risk for falls).

The resident had physician's orders dated 2/2/17 for bed and clip chair alarm to alert staff if resident attempts to get up unassisted, check placement and function every shift for fall precaution, daily and at bedtime.

The care plan dated 2/3/17 identified the resident was admitted with a history of a recent fall with right hip fracture and was at risk for falls in the facility. The goal the staff set for the resident was that the resident would be free of falls. Some of the interventions to accomplish this goal included bed and chair alarms to be in place at all times. Staff to check placement and function every shift for fall prevention. Anticipate and meet the resident's needs. Make sure call light is within reach and encourage resident to use it for assistance as needed. The resident needs

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prompt response to all requests for assistance.

Another incident report for a second fall in the facility indicated Resident #1 fell 2/17/17 at 6:00 a.m. out of the bed on to the floor. The report summary findings indicated the resident's alarm did not sound as resident attempted to transfer self from bed and walk without assistance. The report further noted the pressure alarm was in place on the bed and the Certified Nursing Assistant (CNA) failed to assure the alarm was turned on.

A telephone interview was conducted with CNA #3 on 3/9/17 at 4:21 p.m. She stated she was the CNA who heard the resident hollering out for help on 2/17/17 at around 6:00 a.m. and responded to find the resident on the floor. She said the alarm did not sound. She stated the resident was not her patient so she was not responsible to check if the bed alarm was functioning. Upon checking the Activities of Daily Living (ADL) log and the working schedule, CNA#3 was the assigned CNA for the 11/7 shift 2/16/17 at 11:00 p.m. to 7:00 a.m. on 2/17/17. The Director of Nursing (DON) verified the CNA's working schedule and assignment.

The nurse's note after the second fall dated 2/17/17: "Patient found on floor. Resident stated she was trying to go to the bathroom and couldn't find her walker. Resident found lying supine in the doorway of her bathroom. A skin tear the approximate size of a quarter was noted on the resident's left arm. Area clean and dressed with a dry dressing. Resident's family aware. Physician notified via Fax." The charge nurse who entered this nurse's note was an agency nurse and did

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not work during the dates of the survey, neither could she be reached by telephone. Another nurse's note dated 2/17/17 written by the 11/7 supervisor indicated the resident's representative had arrived before she left her shift and asked "Was the bed alarm on" and was concerned if an X-ray of the right lower extremity was necessary. The 11/7 shift nurse noted there were no visible swelling or bruising and the resident did not complain of any pain.

The care plan dated 2/17/17 indicated the resident fell (2/17/17) attempting to transfer to bathroom without assistance. A perimeter mattress was added to be in place for fall prevention, as well as hipsters. The care plan continued the Bed and chair alarms in place, to be checked every shift for placement and function every shift for fall prevention. Call light within reach and encourage resident to use it for assistance as needed remained in place on the care plan.

Fall risk screen after second fall dated 2/17/17 indicated the pressure mat bed alarm, as well as the clip chair alarm were some of the current interventions at the time of the fall. The report also indicated education was given to the resident regarding use of the call bell. The resident was coded with a score of 7 (high risk for falls).

A perimeter mattress was ordered on 2/22/17 to be applied to the bed for safety and border identification with nurse to check placement every shift.

A telephone interview was conducted with

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Resident #1's Resident Representative (RR) on 3/9/17 at 2:10 p.m. He stated he was concerned that the facility was not implementing the bed and chair alarm to make sure they promptly knew her movement that may lead to trying to get up from the chair or out of the bed. He noted that on several occasions the chair clip alarm was not on the chair and he had to tell the staff to retrieve it and place it on the resident. The RR gave the name of one the the CNAs (CNA #4) that he told the chair alarm was missing. He stated he was also concerned about causing any further damage to the surgical repair of the resident's right leg due to repeated falls. He said he inquired of the licensed nurse if an X-Ray should be taken, especially after the second fall out of bed, at which time one was taken and resulted negative for fracture. He stated at the resident's follow-up appointment with the Orthopedic surgeon on 2/10/17, although there was no new fracture after the first fall, the surgeon told him there was a slight displacement of the right lower extremity fracture and he placed the resident on strict non-weight bearing with physical therapy. The resident had been toe touch weight bearing prior to the surgeons follow-up examination. The surgeon ordered a repeat X-ray and follow-up exam for one week. The repeat X-ray was unchanged on 2/24/17, but the surgeon returned the resident to toe touch weight bearing with physical therapy. The RR stated he wanted to make sure all interventions were in place, especially the alarms so the resident did not experience any further fall incidents. He stated he knew she did not understand or grasp how to use the call bell.

On 3/9/17 at 3:30 p.m., CNA #4 was interviewed via telephone and stated Resident #1 was in the

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dining area when the RR asked her about the missing chair alarm, at which time she went to the resident's room, returned to place it on the chair and clip the string attachment.

The following observations were made of Resident #1:

On 3/7/17 at 10:00 a.m., Resident #1 was out of bed in wheelchair on the unit's dining area at the table. She was very pleasant and appropriate, but some conversation was disconnected as she was asking about visiting family overseas in the near future. The clip alarm was in place resident's sweater and functioning. The perimeter mattress was observed on the resident's bed.

On 3/7/17 at 6:45 p.m., the resident was observed in bed working on word search puzzles. Two upper half rails were raised and the perimeter mattress was in place. The mattress had an egress on each sides at the center to allow for ease of staff to transfer resident in and out of bed. Licensed Practical Nurse (LPN) #2 showed this surveyor the sensitivity of the pressure mat bed alarm. The alarm sounded when the LPN raised and lowered the head of the bed, as well as only slightly shifting the resident's body. The LPN stated, "When the alarm is in place and on (green light flashing), it is very sensitive to any slight movement. We know the sound and she is close enough to the nurse's station for us to hear it and respond." LPN #2 stated the bed was also kept in a low position with mats on the floor anytime she was in bed. The LPN stated even though they instruct her about the use of the call bell, she doesn't understand when to use it, so it was important all other interventions to prevent falls were in place at all

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times.

On 3/7/17 at 7:15 p.m., the resident was in bed with the bed in a high position and no mats on the floor. The pressure mat bed alarm was in place and functioning. A family member was at the bedside and the resident was working on her word search puzzles. The Executive Director told the family member to let staff know when he left so the staff could lower the bed and place mats on the floor. The family member told the Executive director he had not raised the bed and it was in that position when he entered the room.

On 3/8/17 at 3:45 p.m., the resident was in bed for a nap. The bed was in low position with mats on the floor and the pressure mat bed alarm in place and functioning. The alarm sounded at 4:00 p.m. and a CNA (CNA #1) entered the room. The resident had turned to the left, but was well within the perimeter mattress. The CNAs repositioned the resident and reset the alarm. CNA #1 stated, " I know anytime she moves and I am able to catch her well before she tries to get close to coming out of the bed. She is confused and won't use the call bell." This surveyor showed the resident the call bell and asked her what was it used for, the resident did not pick up or understand when to use it or what to do when it was placed in her hand.

On 3/9/17 at 1:30 p.m., Resident #1 was transferred by two CNAs to the bathroom. With instruction and supervision, the resident stood on both feet, pivoted independently to sit on the commode. She was able with the assistance of one CNA to come to a standing position, pivot and sit back in the wheelchair. The resident did not complain of discomfort.

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On 3/7/17 at 5:20 p.m., and interview was conducted with the Director of Nursing (DON). The DON stated after Resident #1 fell out of the bed on 2/17/17 and it was discovered during her investigation of the incident the bed alarm did not sound. She further stated she felt the problem was not having physician orders to check the bed alarms every shift and have the licensed nurses monitor them to assure they were in place and functioning by signing off 7/3, 3/11 and 11/7. The DON had previously given this surveyor a Safety Device Sheet that listed all alarms used by residents in the facility. She said, after Resident #1's fall out of bed with the alarm not sounding, she used the same list and appointed the business office manager, as well as the Nurse Managers to audit 100 % of residents that had bed and chair alarms to determine if there were any residents without orders to check and sign off every shift. The DON stated the audit had long been done and the facility was in 100 % compliance or she would have know about it long before now. This surveyor requested the DON if she could run a Treatment Administration Record (TAR) for the month of March 2017 on every resident with a bed alarm to make sure the orders were in place. The Executive Director entered the interview with the DON on 3/7/17 at approximately 6:00 p.m. and stated they had the education of all staff after the 2/17/17 incident. She further said there was an assurance of 100 % compliance status with the physician's orders and no one was at risk of falls out of bed due to a malfunctioning bed alarm because they were being signed off every shift by the licensed nurse. The Executive Director stated, "The DON has everything in place and we will be able to show you tomorrow with the print out of the TARs."

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On 3/8/17 around 2:00 p.m., the DON stated, "We are not in compliance and I found several residents that did not have proper orders in place to monitor and sign off the functioning status of the bed alarms every shift. I thought the staff were making sure the safety plans and orders were in place. I needed a follow-up plan and my auditors were not doing what I thought they were doing."

The facility's policy and procedures titled "Fall Prevention and Management" dated 6/2009 indicated the facility had a fall prevention and management program actively in place. The program emphasizes identification of fall risk and interventions to minimize falls while utilizing the least restrictive methods possible to keep residents safe within boundaries of resident's rights. Some approaches to fall prevention included assessment and care planning interventions implemented based on resident's evaluation/assessment that could include maintaining low beds, bed alarm and clip alarm to detect resident motion in bed and in chair. Through audits and Quality Assurance designees ensure staff complete steps related to falls per procedures and make any necessary modifications/improvements.

2. Resident #4 was identified on admission at risk for falls and sustained one fall since admission. The facility did not assure the bed sensory alarm physician orders were in place to monitor placement and function every shift per facility protocol.

Resident #4 was admitted to the facility on

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2/24/17 with diagnoses that included after care for acute status post stroke and Subarachnoid hemorrhage and muscle weakness.

The Minimum Data Set (MDS) dated 3/2/17 coded the resident with short and long term memory and severely impaired in the skills needed for daily decision making. The resident required extensive assistance of one staff for all activities of Daily Living and was totally dependent on two staff for transfers. He was not steady without staff assistance during transitions and walking. He was coded impaired on one side in upper extremity.

The care plan dated 2/27/17 identified the resident was at risk for falls and fell on 3/5/17. The goal set by the staff for the resident was that he would be free of falls. Some of the approaches the staff would implement to accomplish this goal included bed pressure alarm.

The resident was assessed on admission to the facility at moderate risk for falls with a score of 6.

On 3/7/17 at 5:20 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated after Resident #1 fell out of the bed on 2/17/17 and it was discovered during her investigation of the incident the bed alarm did not sound. She further stated she felt the problem was not having physician orders to check the bed alarms every shift and have the licensed nurses monitor them to assure they were in place and functioning by signing off 7/3, 3/11 and 11/7. The DON had previously given this surveyor a Safety Device Sheet that listed all alarms used by residents in the facility. She said, after Resident #1's fall out of bed with the alarm not sounding,

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she used the same list and appointed the business office manager, as well as the Nurse Managers to audit 100 % of residents that had bed and chair alarms to determine if there were any residents without orders to check and sign off every shift. The DON stated the audit had long been done and the facility was in 100 % compliance or she would have know about it long before now. This surveyor requested the DON if she could run a Treatment Administration Record (TAR) for the month of March 2017 on every resident with a bed alarm to make sure the orders were in place. The Executive Director entered the interview with the DON on 3/7/17 at approximately 6:00 p.m. and stated they had the education of all staff after the 2/17/17 incident. She further said there was an assurance of 100 % compliance status with the physician's orders and no one was at risk of falls out of bed due to a malfunctioning bed alarm because they were being signed off every shift by the licensed nurse. The Executive Director stated, "The DON has everything in place and we will be able to show you tomorrow with the print out of the TARs."

On 3/8/17 around 2:00 p.m., the DON stated, "We are not in compliance and I found several residents that did not have proper orders in place to monitor and sign off the functioning status of the bed alarms every shift. I thought the staff were making sure the safety plans and orders were in place. I needed a follow-up plan and my auditors were not doing what I thought they were doing."

The Resident Safety Device Sheet indicated the resident had a bed alarm.

Resident #4 was one of the resident's that did not

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have physician's orders in place to check and sign off functioning and placement of the bed alarm every shift.

On 3/5/17, the resident slid out of his wheelchair in the activities area. The post fall risk screening increased the resident's score to an 8 which placed the resident at high risk for falls. A bed alarm was one of the interventions added and put in place, but the resident had no orders in place to check and sign off placement every shift per protocol. Orders were put in place on 3/8/17 at 7:00 a.m. and placed on the Treatment Administration Record (TAR).

3. Resident #5 was identified on admission at risk for falls and sustained one fall since admission. The facility did not assure the bed sensory alarm physician orders were in place to monitor placement and function every shift per facility protocol.

Resident #5 was admitted to the facility on 11/22/16 with diagnoses that included generalized muscle weakness, osteoarthritis, metastatic cancer to the pelvis, reduced mobility and difficulty walking.

The Minimum Data Set (MDS) dated 2/28/17 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had no problems in the skills needed for daily decision making. The resident was assessed to required extensive assistance of one staff for all Activities of Daily Living. She was totally dependent on two staff for bed mobility and transfer. She was coded unsteady without physical assistance for moving from seated to

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standing position, moving on and off the toilet and surface to surface transfer.

The care plan dated 1/19/17 identified the resident was at risk for falls. The care plan was revised to identify an actual fall on 1/24/17 with minor injury. The goals the staff set for the resident were that the resident would have no further falls and she would resume usual activities without further incident. Some of the interventions the staff would implement to accomplish this goal included initiation of a pressure alarm in place to bed.

The resident's most recent Falls Risk Assessment dated 2/21/17 indicated the resident was at high risk for falls with a score of 7.

On 3/7/17 at 5:20 p.m., and interview was conducted with the Director of Nursing (DON). The DON stated after Resident #1 fell out of the bed on 2/17/17 and it was discovered during her investigation of the incident the bed alarm did not sound. She further stated she felt the problem was not having physician orders to check the bed alarms every shift and have the licensed nurses monitor them to assure they were in place and functioning by signing off 7/3, 3/11 and 11/7. The DON had previously given this surveyor a Safety Device Sheet that listed all alarms used by residents in the facility. She said, after Resident #1's fall out of bed with the alarm not sounding, she used the same list and appointed the business office manager, as well as the Nurse Managers to audit 100 % of residents that had bed and chair alarms to determine if there were any residents without orders to check and sign off every shift. The DON stated the audit had long been done and the facility was in 100 %

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compliance or she would have know about it long before now. This surveyor requested the DON if she could run a Treatment Administration Record (TAR) for the month of March 2017 on every resident with a bed alarm to make sure the orders were in place. The Executive Director entered the interview with the DON on 3/7/17 at approximately 6:00 p.m. and stated they had the education of all staff after the 2/17/17 incident. She further said there was an assurance of 100 % compliance status with the physician's orders and no one was at risk of falls out of bed due to a malfunctioning bed alarm because they were being signed off every shift by the licensed nurse. The Executive Director stated, "The DON has everything in place and we will be able to show you tomorrow with the print out of the TARs."

On 3/8/17 around 2:00 p.m., the DON stated, "We are not in compliance and I found several residents that did not have proper orders in place to monitor and sign off the functioning status of the bed alarms every shift. I thought the staff were making sure the safety plans and orders were in place. I needed a follow-up plan and my auditors were not doing what I thought they were doing."

The Resident Safety Device Sheet indicated the resident had a bed alarm.

Resident #5 was one of the resident's that did not have physician's orders in place to check and sign off functioning and placement of the bed alarm every shift.

On 1/24/17, the resident fell from the side of her bed. A bed alarm was one of the interventions added and put in place after this fall, but the

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resident had no orders in place to check and sign off placement every shift per protocol. Orders were put in place on the 3/7/17 at 11:00 p.m. and placed on the Treatment Administration Record (TAR).

4. Resident #8 was identified on admission at risk for falls and sustained three falls since admission. The facility did not assure the bed sensory alarm physician orders were in place to monitor placement and function every shift per facility protocol.

Resident #8 was admitted to the facility on 6/27/14 with diagnoses that included Alzheimer's Disease, generalized muscle weakness and history of stroke.

The Minimum Data Set (MDS) dated 1/23/17 coded the resident with a score of 9 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired in the in the skills needed for daily decision making. The resident was assessed to require limited assistance of one staff for all Activities of Daily Living. The resident was assessed not steady, but was able to stabilize herself without staff assistance. She required staff assistance to steady herself moving on and off the toilet.

The care plan indicated the resident was at risk for falls and had a fall on 5/17/16 (fall in room on floor), 9/5/16 (found on floor in bathroom), 10/31/16 (found on floor, slid out of bed), 11/24/16 (found on floor in sitting position near bathroom-stated had to go to bathroom), and 3/4/17 (going to bathroom without assistance). The goal set by the staff for the resident was that

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she would be free of minor injury. Some of the approaches to accomplish this goal included bed and clip alarm to be applied on 11/24/16 for safety awareness.

The resident's most recent Falls Risk Assessment dated 3/4/17 indicated the resident was at high risk for falls with a score of 8.

On 3/7/17 at 5:20 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated after Resident #1 fell out of the bed on 2/17/17 and it was discovered during her investigation of the incident the bed alarm did not sound. She further stated she felt the problem was not having physician orders to check the bed alarms every shift and have the licensed nurses monitor them to assure they were in place and functioning by signing off 7/3, 3/11 and 11/7. The DON had previously given this surveyor a Safety Device Sheet that listed all alarms used by residents in the facility. She said, after Resident #1's fall out of bed with the alarm not sounding, she used the same list and appointed the business office manager, as well as the Nurse Managers to audit 100 % of residents that had bed and chair alarms to determine if there were any residents without orders to check and sign off every shift. The DON stated the audit had long been done and the facility was in 100 % compliance or she would have know about it long before now. This surveyor requested the DON if she could run a Treatment Administration Record (TAR) for the month of March 2017 on every resident with a bed alarm to make sure the orders were in place. The Executive Director entered the interview with the DON on 3/7/17 at approximately 6:00 p.m. and stated they had the education of all staff after the 2/17/17 incident.

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She further said there was an assurance of 100 % compliance status with the physician's orders and no one was at risk of falls out of bed due to a malfunctioning bed alarm because they were being signed off every shift by the licensed nurse. The Executive Director stated, "The DON has everything in place and we will be able to show you tomorrow with the print out of the TARs."

On 3/8/17 around 2:00 p.m., the DON stated, "We are not in compliance and I found several residents that did not have proper orders in place to monitor and sign off the functioning status of the bed alarms every shift. I thought the staff were making sure the safety plans and orders were in place. I needed a follow-up plan and my auditors were not doing what I thought they were doing."

The Resident Safety Device Sheet indicated the resident had a bed alarm.

Resident #8 was one of the residents that did not have physician's orders in place to check and sign off functioning and placement of the bed alarm every shift.

According to the care plan, the bed alarm was one of the interventions added and put in place after the 11/24/16 fall, but the resident had no orders in place to check and sign off placement every shift per protocol. Orders were put in place on the 3/8/17 at 3:00 p.m. and placed on the Treatment Administration Record (TAR).

5. Resident #9 was identified on admission at risk for falls and sustained one fall since admission. The facility did not assure the bed sensory alarm physician orders were in place to

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monitor placement and function every shift per facility protocol. Resident #8 was admitted to the facility on 6/27/14 with diagnoses that included Alzheimer's Disease, generalized muscle weakness and history of stroke.

Resident #9 was admitted to the nursing facility on 12/1/16 with diagnoses that included Dementia, muscle weakness, repeated falls and Parkinson's disease.

The Minimum Data Set (MDS) dated 2/27/17 coded the resident with a score of 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired in the in the skills needed for daily decision making. The resident was assessed to required extensive assistance of one staff for all Activities of Daily Living accept he needed 2 staff for bed mobility. The resident was assessed not steady and unable to stabilize himself without staff assistance.

The care plan indicated the resident was at risk for falls and had a fall on 1/12/17 (fall on floor beside bed). The goal set by the staff for the resident was that he would be free of minor injury. Some of the approaches to accomplish this goal included bed and clip alarm to be applied on for safety awareness.

On 3/7/17 at 5:20 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated after Resident #1 fell out of the bed on 2/17/17 and it was discovered during her investigation of the incident the bed alarm did not sound. She further stated she felt the problem was not having physician orders to check the bed

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alarms every shift and have the licensed nurses monitor them to assure they were in place and functioning by signing off 7/3, 3/11 and 11/7. The DON had previously given this surveyor a Safety Device Sheet that listed all alarms used by residents in the facility. She said after Resident #1's fall out of bed with the alarm not sounding, she used the same list and appointed the business office manager, as well as the Nurse Managers to audit 100 % of residents that had bed and chair alarms to determine if there were any residents without orders to check and sign off every shift. The DON stated the audit had long been done and the facility was in 100 % compliance or she would have know about it long before now. This surveyor requested the DON if she could run a Treatment Administration Record (TAR) for the month of March 2017 on every resident with a bed alarm to make sure the orders were in place. The Executive Director entered the interview with the DON on 3/7/17 at approximately 6:00 p.m. and stated they had the education of all staff after the 2/17/17 incident. She further said there was an assurance of 100 % compliance status with the physician's orders and no one was at risk of falls out of bed due to a malfunctioning bed alarm because they were being signed off every shift by the licensed nurse. The Executive Director stated, "The DON has everything in place and we will be able to show you tomorrow with the print out of the TARs."

On 3/8/17 around 2:00 p.m., the DON stated, "We are not in compliance and I found several residents that did not have proper orders in place to monitor and sign off the functioning status of the bed alarms every shift. I thought the staff were making sure the safety plans and orders were in place. I needed a follow-up plan and my

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F 323	Continued From page 23 auditors were not doing what I thought they were doing." The Resident Safety Device Sheet indicated the resident had a bed alarm. Resident #9 was one of the residents that did not have physician's orders in place to check and sign off functioning and placement of the bed alarm every shift. According to the care plan, the bed alarm was one of the interventions added and put in place after the 1/12/17 fall, but the resident had no orders in place to check and sign off placement every shift per protocol. Orders were put in place on the 3/7/17 at 11:00 p.m. and placed on the Treatment Administration Record (TAR). COMPLAINT DEFICIENCY	F 323		