STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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/Medicaid abbreviated standard survey was conducted on 9/15/20. Two complaints were investigated during the survey. Complaint VA00045906 was substantiated with a deficiency. Complaint VA00046855 was unsubstantiated. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 168 certified bed facility was 75 at the time of the survey. The survey sample consisted of two current resident reviews (Residents #1, #4) and two closed record reviews (Residents #2, #3).	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to ensure a safe transfer for one of four residents in the survey sample (Resident #2) and failed to ensure safety devices were in use for one of four residents (Resident #4). Resident #2's right arm was fractured and shoulder dislocated after staff attempted to lift the	F 689	Resident #2 1) The resident that was affected by the deficient practice was discharged from the facility on March 13, 2019. An in-service was held on September 17, 2020, to re-educate nursing staff on the sit-to-stand lift. 2) The Therapy Department will evaluate	10/30/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/27/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 689	Continued From page 1 resident with a stand up (sit-to-stand) lift when she required a total mechanical (Hoyer) lift for all transfers. Resident #4 was observed in bed without physician ordered floor mats and a bed alarm in use as required by her plan of care for fall/injury prevention. The findings include: 1. Resident #2 was admitted to the facility on 6/21/11 and was discharged on 3/13/19. Diagnoses for Resident #2 included Alzheimer's, aphasia, chronic pain, peripheral vascular disease, anemia, hypertension, psychosis, urinary tract infection and hyperlipidemia. The minimum data set (MDS) dated 1/8/19 assessed Resident #2 with short and long-term memory problems and moderately impaired cognitive skills. This MDS documented the resident had impaired range of motion of both upper and lower extremities and was totally dependent upon two staff members for bed mobility and transfers. Resident #2's closed clinical record documented the resident was sent to the emergency room on 3/7/19 at 10:10 p.m. for evaluation/treatment of pain in the right arm/shoulder. A nursing note dated 3/8/19 at 12:45 a.m. documented, "...ER [emergency room] called...Stated resident had a R [right] arm fx [fracture] and dislocation and would be coming back [with] a R arm sling..." The hospital emergency room (ER) record dated 3/7/19 documented the resident presented with pain localized over the right shoulder. The ER assessment stated, "...There is pain noted over the right shoulder... The patient is bedridden and	F 689	current residents who use the sit-to-stand lift to ensure it is safe for them to use. 3) The Nurse Manager, Team Leader, and DON will instruct staff not to use the sit-to-stand lift unless the resident has been identified as being appropriate for use with the lift. 4) The Nurse Manager, Team Leader or designee will make rounds weekly to monitor for the safe use of the sit-to-stand lift. Logs will be kept of the findings and will be reported to the QAPI Committee on a monthly basis. The Committee will review the findings and determine the duration of these audits. Resident #4 1) The bed alarm was put on the bed, and fall mats were placed on each side of the bed at the time of the finding. The Nurse Manager re-evaluated the resident for risk of falling and the bed alarm and fall mats were discontinued on 9/15/2020. 2) The Nurse Manager, Team Leader, or DON will review all residents in the facility that use bed/chair alarms and fall mats for placement. 3) The Nurse Manager, Team Leader or designee will make rounds daily to ensure bed alarms and fall mats are in place and working properly. 4) Audit information will be reported and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 689	Continued From page 2 is essentially nonmobile...Patient complains of pain affecting right shoulder. Nature of the pain cannot be described due to the patient's condition. Pain is constant...Pts [patient's] daughter notes the nursing home called her and reported the pt was grimacing in pain and her right shoulder 'looked different' than her left..." Resident #2's x-ray report dated 3/7/19 diagnosed a "comminuted fracture and dislocation of the right humeral head" due to trauma and/or injury. The resident returned to the facility on 3/8/19. Treatments included a sling for immobilization, ice to the injured area, pain medication and referral to orthopedics. Resident #2's clinical record, including nursing notes, made no mention of any incident, accident or possible source of the fracture/dislocation. A skin condition report dated 3/7/19 documented a skin tear on the resident left lower forearm but documented no source of this injury. A facility reported incident form to the state agency dated 3/8/19 documented an investigation of Resident #2's fractured arm and dislocated shoulder. This report documented, "...Daughter stated resident c/o [complained of] R arm pain. Sent to ER for evaluation. Fx of right Humerus [upper arm]." The investigation report dated 3/8/19 documented, "CNA [certified nurses' aide] attempted to transfer resident using inappropriate mechanical lift. CNA put resident in lift to stand her up to get her dressed and harness slid up resident's back causing her arms to extend abruptly over her head...Resident sent to ER...Returned with dx [diagnosis]: R humerus fracture...CNA used a sit to stand lift and resident was not a canidate [candidate] for that lift. Resident was to be transferred [with] Hoyer lift	F 689	reviewed at the QAPI Committee meeting monthly. The Committee will review the findings, make recommendations as needed and determine the duration of the audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 689	Continued From page 3	F 689		

only..." This report documented the circumstances of the incident as, "[CNA #3] and [CNA#2] used inappropriate lift to stand resident to get her dressed after bath. Lift harness slipped up resident's back causing her arms to suspend over her head. Another CNA was called in to help to keep resident from falling but incident was not reported to nurse..."

The facility's investigation documented staff interviews stating, "[CNA #3 and CNA #2] both reported they were trying to figure out the best way to stand resident to get her dressed and the harness slipped (wasn't secure) up resident's back causing bilateral arms to be extended abruptly over resident's head..." The interviews documented during the evening of 3/7/19, CNA #1 got the resident ready for bed and "noted resident grimmacing [grimacing] when arm was moved and upon investigation noted bruising to the RUE [right upper extremity]. Nurse made aware and resident was assessed...Sent to ER...and returned with dx R humerus fracture..." This report documented, "Investigation with dayshift staff confirmed incident with inappropiate [inappropriate] mechanical lift happened at approx. [approximately] 7:30 AM and was never reported to nurse on duty..." (Sic)

The facility's investigation documented statements from staff members including CNA's caring for Resident #2 at the time the resident's arms slipped in the sit-to-stand lift. A written statement by CNA #2 dated 3/8/19 documented, "... [CNA #3] and I gave [Resident #2] a whirlpool. We did a 2 person transfer from her geri chair to the spa chair. We bathed her and dressed her in the spa chair except for her brief. We could not lift her to put her bref [brief] on so [CNA #3] said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 689	Continued From page 4	F 689		

to get the standup [sit-to-stand] lift. She [Resident #2] started to slip from the lift so we grabbed her and put her back in the spa chair. I went and got [CNA #4] to help. [CNA #3 and CNA#4] lifted her from the spa chair while I put her brief on and then the three of us put her in the geri chair." (Sic)

CNA #4's written statement dated 3/8/19 documented, "...was ask to assist with a transfer. From the whirlpool chair...I then proceed to walk into the spa to assist [CNA #3 and CNA#2] to hold [Resident #2] as [CNA #2] put on the brief... [CNA #3] stated thank you cause we almost lost her when we [CNA #3 and CNA #2] were trying to transfer her [Resident #2] with the stand-up lift..." (Sic)

Resident #2's plan of care in place at the time of the incident (revised 1/17/19) documented the resident required total care by staff related to dementia and contractures of upper and lower extremities. This care plan documented the resident was at risk of falls/injury due to extremity contractures and listed the resident as "unable to hold body in correct position..." Interventions to prevent falls/injury and to meet activities of daily living needs included, "mechanical lift all transfers...Mechanical lift as needed for all transfers as of 4-1-18 no longer able to use sit to stand lift..."

On 9/15/20 at 11:30 a.m., CNA #2 that was with Resident #2 at the time of the lift incident was interviewed. CNA #2 described Resident #2 as requiring "total" assistance with all activities of daily living that included dressing, bathing, eating and transfers/mobility. CNA #2 stated on 3/7/19 she and CNA #3 used the Hoyer lift to transfer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 689	Continued From page 5	F 689		

Resident #2 from bed to a reclining "geri-chair" and then took her to the spa for a whirlpool bath. CNA #2 stated when the bath was finished, she and CNA #3 performed a "two-person" transfer of the resident to the bath chair. CNA #2 stated they dressed the resident and could not get her raised enough to get her incontinence brief back in place. CNA #2 stated CNA #3 suggested using the sit-to-stand lift to raise the resident in order to put on the brief. CNA #2 stated when they raised Resident #2 in the stand-up lift, the resident slipped with both of her arms going straight up through the harness. CNA #2 stated she and CNA #3 then lowered her back into the chair. CNA #2 stated they got CNA #4 to come help them lift the resident so they could get the brief applied. CNA #2 stated she was aware the resident required a Hoyer lift but she was still in orientation and was following the suggestion of CNA #3. When asked about the differences in the lifts, CNA #2 stated the sit-to-stand lift required a resident to hold and assist with standing and the Hoyer lift was a "total" lift." CNA #2 stated she did not report the incident when it happened because she did not think the resident was hurt.

On 9/15/20 at 11:40 a.m., the licensed practical nurse unit manager (LPN #1) that cared for Resident #2 was interviewed. LPN #2 stated Resident #2 required a Hoyer lift for all transfers, as she was totally dependent upon staff for mobility. LPN #2 stated their investigation revealed CNA #2 and CNA #3 attempted to use the sit-to-stand lift on 3/7/19 to raise the resident from the bath chair to put on an incontinence brief. LPN #1 stated the CNA's reported as she was raised, the resident's arms suddenly went up through the harness because the resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 689	Continued From page 6	F 689		

unable to hold and stand. LPN #1 stated later that evening, CNA #1 reported the resident had a discolored right shoulder and was grimacing when her right arm was moved. LPN #1 stated the resident was then sent to the emergency room and diagnosed with an arm fracture. LPN #1 stated the resident should have been transferred from the whirlpool using the Hoyer lift to the geri-chair then returned to bed for dressing and application of the incontinence brief. LPN #1 stated a mesh Hoyer lift pad designed for use in the shower room was available but was not used by CNA #2 or #3 when transferring the resident on 3/7/19. LPN #1 described Resident #2 as non-verbal and totally dependent upon staff for all care needs.

On 9/15/20 at 11:55 a.m., CNA #1 that routinely cared for Resident #2 was interviewed. CNA #1 stated Resident #2 required "total care" and was not able to move her arms. CNA #1 stated the resident could partially open one hand with the other hand and both arms contracted. CNA #1 stated she cared for Resident #2 on the evening of 3/7/19 and noticed the resident grimacing when she moved her right arm while dressing the resident for bed. CNA #1 stated she also saw that the right shoulder was "bluish" and had discoloration that was not there previously. CNA #1 stated when she attempted to raise the resident's right arm the resident "hollered out" and she immediately got the nurse. When asked about transfers for Resident #2, CNA #1 stated the resident was always a Hoyer lift.

CNA #2 and CNA #4 with Resident #2 at the time of the lift incident on 3/7/19 were not working at the time of the survey and not available for interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 689	Continued From page 7	F 689		

The facility's policy titled Mechanical Lift (revised 1/19/10) documented the stand up (sit-to-stand) lift was used with residents able to weight-bear and hold lift grips with both hands. This policy documented concerning use of a stand up lift, "The stand up lift may be operated by one (1) healthcare professional for ALL lifting preparation, transferring from and transferring to procedures with a cooperative, weight-bearing individual able to support the majority of his/her own weight..." Lifting procedures for the stand up lift included, "...Instruct the resident to do the following...Hold onto the hand grips on both sides of the stand up lift...Lean back into the standing or transport sling...Before lifting the resident, make sure...the resident's arms are outside the transport sling..."

The administrator was out of the facility during the survey. These findings were reviewed with the director of nursing on 9/15/20 at 3:40 p.m.

This was a complaint deficiency.

2. Resident #4 was admitted to the facility on 7/10/19 with diagnoses that included dementia with agitation, hypertension, vitamin deficiencies, constipation and hyperlipidemia. The minimum data set (MDS) dated 6/25/20 assessed Resident #4 with short and long-term memory problems and moderately impaired cognitive skills.

On 9/15/20 at 1:50 p.m., Resident #4 was observed in bed. There was one protective floor mat beside the bed near the center of the room. There was no floor mat on the opposite side of the bed near the door and no bed alarm in use. Resident #2 was observed again on 9/15/20 at 2:10 p.m. in bed with one floor mat in place and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 689	Continued From page 8	F 689		

no bed alarm.

Resident #4's clinical record documented the resident ambulated independently with use of a walker and had a history of falls and recent fractures from a fall. Nursing notes documented the following recent falls/injuries.

6/2/20 - found in floor beside bed, no injuries
6/18/20 - fell in television room while ambulating with walker, fractured clavicle and left rib fracture
7/2/20 - found in floor at foot of bed, skin tear to left forehead
7/21/20 - resident "sat herself in floor," no injuries
8/13/20 - found in floor in hallway, no injuries

The clinical record documented a physician's order dated 8/27/20 for a fall alarm to bed and "fall mats to bed X 2." Resident #4's plan of care (revised 9/1/20) documented the resident was at risk of complications from fracture due to falls and was at risk of further falls due to Alzheimer's dementia, medications, wandering with use of walker, impaired vision, history of falls/fracture, restlessness and agitation. Interventions to prevent falls/injuries included, "Fall alarm to bed...Fall mats times two bedside each side..."

On 9/15/20 at 2:15 p.m., accompanied by licensed practical nurse (LPN #4), Resident #4 was observed in bed with only one floor mat by the bed and no bed alarm. LPN #4 was interviewed about this time about the mats and alarm. Concerning the mats, LPN #4 stated the resident was supposed to have two mats in use, one on each side of the bed. LPN #4 stated, "She [Resident #4] had them [mats] the other day." Certified nurses' aide (CNA) #2 entered Resident #4's room and stated she did not know

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. BUILDING _____ B. WING _____	C 09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSVILLE HEALTH & REHAB CENTER	184 BUFFALO ROAD CLARKSVILLE, VA 23927

(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 689	Continued From page 9 where the second floor mat was located and that two mats had been in the room earlier. CNA #2 stated the resident at times removed the bed alarm. LPN #4 stated she did not know if housekeeping removed the other floor mat. CNA #2 and LPN #4 searched the resident's room including around/under the bed, closets, dresser drawers and restroom and did not locate an alarm. CNA #2 located the second floor mat folded inside the resident's closet. LPN #4 stated she did not know where the alarm was located or if the resident had removed it from use. These findings were reviewed with the director of nursing on 9/15/20 at 3:45 p.m.	F 689		