STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185124	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REDBANKS	**851 KIMSEY LANE HENDERSON, KY 42420**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the Centers for Medicare and Medicaid Services, Resident Assessment Instrument (RAI) Manual 3.0, it was determined the facility failed to ensure the Minimum Data Set (MDS) Assessment accurately reflects the resident's status for two (2) of thirty-four (34) sampled residents (Resident #10 and Resident #141). Resident #10's Quarterly Minimum Data Set (MDS) Assessment, dated 12/11/19, Section I Active Diagnosis, was coded as no infections during the seven (7) day look back period; however, review of the physician's orders [REDACTED]. Resident #141's Quarterly MDS Assessment, dated 11/25/19, Section J Health Conditions, was coded as no falls since prior assessment; however, review of the Fall Incident Reports, revealed the resident sustained [REDACTED]. The findings include: Interview with the MDS Coordinator, on 03/11/2020 at 5:00 PM, revealed the facility utilized the Resident Assessment Instrument (RAI) Manual 3.0, as a guideline for accuracy of assessments. Additionally, the Assessment process included communication with licensed and non-licensed direct care staff members, and review of the medical record. Review of the Centers for Medicare and Medicaid Services, Resident Assessment Instrument (RAI) Manual 3.0, dated October 2017, revealed the primary purpose of the MDS Assessment was to identify resident care problems, address resident problems in individualized care plans, and monitor the quality of care provided to residents. Additional review revealed the Assessment should be an accurate reflection of the resident's status. 1. Review of Resident #10's medical record revealed the facility admitted the resident on 04/30/14 with [DIAGNOSES REDACTED]. Review of Resident #10's Progress Notes, dated 12/02/19 at 2:34 PM, revealed the facility transferred the resident to the emergency room related to behaviors and combativeness. Additionally, a Progress Note, dated 12/02/19 at 9:27 PM, revealed the resident was admitted to the hospital with [REDACTED]. Review of the Progress Note, dated 12/04/19 at 4:20 PM, revealed the resident had a midline to the left upper arm and received intravenous Ertapenem (antibiotic) every twenty-four (24) hours. Further, a Progress Note, dated 12/04/19 at 8:13 PM, revealed the resident returned to the facility from the hospital with a [DIAGNOSES REDACTED]. Review of Resident #10's physician's orders [REDACTED]. Further review of physician's orders [REDACTED].#10's Progress Notes, dated 12/06/19 at 1:21 PM, revealed the resident continued on IV antibiotics for UTI; IV site clean with dry dressing intact. Additionally, a Progress Note, dated 12/07/19 at 8:40 PM, revealed the resident continued in isolation for UTI with IV [MEDICATION NAME] (Ertapenem) daily to midline left upper extremity. Review of the Progress Note, dated 12/09/19 at 2:52 AM, revealed the resident was tolerating IV [MEDICATION NAME] for UTI; midline flushes with some resistance due to positioning. Further, a Progress Note, dated 12/10/19 at 5:06 PM, revealed the resident's IV antibiotics, for UTI, were completed for that shift. Continued review revealed a Progress Note, dated 12/11/19 at 5:53 AM, revealing the resident continued on Antibiotics for UTI with ESBL, with midline to left upper arm and remained in contact isolation. The Progress Note, dated 12/12/19 at 11:09 AM, revealed the resident was taken off isolation precautions due to being asymptotic and completion of IV antibiotics; provider will remove midline. Review of Resident #10's Quarterly MDS Assessment, dated 12/11/19, revealed the facility did assess the resident as receiving six (6) days of antibiotic medication and IV medication, during the seven (7) day look back period for the Assessment. However, Section I Active Diagnosis, revealed the facility assessed the resident as having no Infections present. 2. Review of Resident #141's medical record revealed the facility admitted the resident on 10/12/17 with [DIAGNOSES REDACTED]. Review of Resident #141's Fall Incident Report, dated 10/10/19 at 10:51 AM, revealed the resident reported he/she fell when trying to sit down on the commode and fell to the left side hitting his/her arm on the grab rail in the bathroom. Additionally, the immediate action taken was applying nonskid strips in from of the commode. Per the Report, the resident was alert and oriented to person, place and time and had no obvious injury. Further, there was no predisposing environmental, physiological or situational factors contributing to the fall event. Review of Resident #141's Fall Incident Report, dated 11/05/19 at 5:00 AM, revealed the nurse heard resident yell for help. Per the Report, the nurse entered the resident's room and the upper half of the resident's body was on the bed with his/her legs twisted between the wheelchair and the bed. The resident stated he/she became dizzy and fell over in the bed while making up the bed. Continued review revealed the immediate action taken was assessment of the resident and new orders for [MEDICATION NAME] (antiemetic medication which may be used to treat [MEDICAL CONDITION]) as needed. Further, the resident was alert and oriented to person, place and time and had no obvious injury. Per the Report, there were no environmental or situational factors contributing to the fall event; however, the resident did have a current UTI. However, review of Resident #141's Quarterly MDS Assessment, dated 11/25/19, Section J Health Conditions, revealed the facility assessed the resident as having no falls since the prior assessment. Conversely, review of the medical record revealed since the previous assessment, the resident had fall events on 10/10/19 and 11/05/19. Interview with Licensed Practical Nurse (LPN) #5/MDS Coordinator, on 03/12/2020 at 4:17 PM, revealed she had worked in the building in this role for five (5) years. Additionally, she used the RAI guidelines to ensure accurate MDS Assessments. Per interview, when collecting data to complete MDS Assessments, she interviewed staff and the resident; completed a face-to-face assessment of the resident, and reviewed the medical record to its entirety. Per interview, it was important to ensure MDS Assessments were accurate and reflected the current status of the resident because the MDS Assessment helped develop and revise the Comprehensive Plan of Care. Further interview with LPN #5/MDS Coordinator, revealed after review of Resident #10's physician's orders [REDACTED].#141's Fall Incident Reports, dated 10/10/19 and 11/05/19, falls should have been coded on Resident #141's Quarterly MDS Assessment, dated 11/25/19. Interview with the Director of Nursing (DON), on 03/12/2020 at 5:26 PM, revealed she expected the MDS Assessments to be accurate, as per RAI guidelines. Per interview, LPN #5/MDS Coordinator was responsible for section I Active [DIAGNOSES REDACTED]. After review of Resident #10's medical record, she stated an active [DIAGNOSES REDACTED]. Continued interview revealed after review of Resident # 141's medical record, the Quarterly MDS Assessment, dated 11/25/19, falls should have been coded on the 11/25/19 Quarterly MDS Assessment. Further interview revealed the MDS Assessments guided the development or revision of the Comprehensive Care Plans and therefore the MDS Assessment was to be an accurate reflection of the resident's status in order for residents to receive appropriate services and individualized care. Interview with the Executive Director, on 03/12/2020 at 5:49 PM, revealed the facility was to utilize the RAI Manual as a resource to ensure accuracy of the MDS Assessments. Per interview, it was important for MDS Assessments to accurately reflect a resident's current status in order to ensure the Care Plan was developed or revised to address each resident's individual needs and to ensure resources were provided as necessary to meet resident care needs.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of facility Policy, and review of the Centers for Medicare and

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Medicaid Services (CMS), Resident Assessment Instrument (RAI) Manual 3.0, it was determined the facility failed to ensure the Comprehensive Care Plan (CCP) was reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs for three (3) of thirty-four (34) sampled residents (Resident #87, Resident #109, and Resident #141). Resident #87 was diagnosed and treated for [REDACTED]. Resident #109 was diagnosed and treated for [REDACTED]. Resident #141 had a fall event on 11/05/19; however, the CCP was not revised to related to the actual fall, nor was the CCP updated with a new intervention to prevent further falls of the same nature. The findings include: Review of the facility Comprehensive Care Plans Policy, revised September 2010, revealed the Comprehensive Care Plan is an individualized plan developed to included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs. Additionally, the Interdisciplinary Team identifies problem areas, risk factors, treatment goal, and professional services to prevent or reduce declines in the resident's functional status level and enhance optimal functioning. Per policy, concerns triggered during the resident assessment are added to the care plan. Further, Care Plans are ongoing and revised as information about the resident and the resident's condition changes, at least quarterly. Interview with the MDS Nurse, on 03/12/2020 at 4:17 PM, revealed the facility utilized the Resident Assessment Instrument (RAI) Manual 3.0, as a guideline for Care Plans. Review of the Centers for Medicare and Medicaid Services, Resident Assessment Instrument (RAI) Manual 3.0, dated October 2016, revealed the care plan must be reviewed and revised periodically, and the services provided or arranged should be consistent with each resident's written plan of care. Continued review revealed the care plan was driven not only by identified resident issues and/or conditions, but also by a resident's unique characteristics, strengths, and needs. Furthermore, a care plan based on a thorough assessment and effective clinical decision making, was compatible with current standards of clinical practice that provide a strong basis for optimal approaches to quality of care and quality of life needs of individual residents. A well developed and executed assessment and care plan re-evaluates the resident's status at prescribed intervals (quarterly, annually, or if a significant change in status occurs) using the RAI and then modifies the individualized care plan as appropriate and necessary. 1. Review of Resident #87's medical record revealed the facility admitted the resident on 03/10/17 with [DIAGNOSES REDACTED]. Review of Resident #87's Comprehensive Care Plan (CCP), initiated 02/14/18, revealed the resident had the potential for UTI. The Goal stated the resident would be monitored for signs and symptoms of UTI. The interventions included monitor/document/report as needed signs and symptoms of UTI. Continued review of Resident #87's CCP, revised 06/04/19, revealed the resident had a history of [REDACTED]. The Goal stated the resident's UTI's would resolve without complication. The interventions included check every two (2) hours for incontinence, dated 04/04/18; give antibiotics therapy as ordered, dated 04/04/18; monitor intake and output, dated 02/01/19; and monitor vitals, dated 03/19/2020. Review of Resident #87's Quarterly Minimum Data Set (MDS) Assessment, dated 01/30/2020, revealed the facility assessed the resident as having severe cognitive impairment. Additionally, the resident required total assistance with Activities of Daily Living, had an indwelling catheter and was always incontinent of bowel. Per the Assessment, the resident had the [DIAGNOSES REDACTED]. Review of Resident #87's physician's orders [REDACTED].#87's Medication Administration Record [REDACTED]. Further, the MAR indicated [REDACTED]. Review of Resident #87's Urinalysis, dated 03/04/2020 revealed greater than 100,000 organisms; Citobacter fruendii (anaerobic gram negative bacteria of the family [MEDICATION NAME]). However, further review of the CCP, revealed there was no documented evidence the Care Plan was revised to include the actual UTI, identified on 03/05/2020. 2. Review of Resident #109's medical record revealed the facility admitted the resident on 04/26/19 with [DIAGNOSES REDACTED]. Review of Resident #109's Quarterly Minimum Data Set (MDS) Assessment, dated 02/10/2020, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating intact cognition. Further, the resident had the [DIAGNOSES REDACTED]. Review of Resident #109's Chest X-ray, dated 03/04/2020 revealed a modest infiltrate in the right lower lobe, indicating Pneumonia. Review of Resident # 109's physician's orders [REDACTED].#109's Medication Administration Record [REDACTED]. However, review of Resident #109's Comprehensive Care Plan (CCP), revealed no documented evidence the Care Plan was revised to include the acute Respiratory Infection/Pneumonia, identified on 03/04/2020. Interview with Licensed Practical Nurse (LPN) #3, on 03/12/2020 at 3:42 PM, revealed she had worked at the facility for one (1) month. Per interview, direct care nurses were responsible to revise the CCP with changes in resident conditions, including new acute illnesses. Additionally, Resident # 87 should have had an acute Care Plan revision related to the UTI on 03/05/2020 and Resident #109 should have had an acute Care Plan revision related to Pneumonia on 03/04/2020. Further, the Care Plan was used by direct caregivers as a reference in providing care and should be accurate and up to date. 3. Review of the facility Falls and Fall Risk, Managing Policy, revised March 2018, revealed the facility would identify interventions to prevent the resident from falling and to minimize complications from falling. Additionally, resident-centered approaches to managing falls would be implemented with recurring falls. Further, despite previous interventions, additional or different interventions will be implemented to manage falls. Review of Resident #141's medical record revealed the facility admitted the resident on 10/12/17 with [DIAGNOSES REDACTED]. Review of Resident #141's Quarterly MDS Assessment, dated 08/27/19, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) indicating moderate cognitive impairment. Additionally, the facility assessed the resident as requiring supervision and oversight with Activities of Daily Living and not steady, but could stabilize without assistance during transition. Per the Assessment, the resident had no falls since the previous Assessment. Further, the facility assessed the resident as receiving six (6) days of Restorative Nursing: ambulation and active Range of motion during the seven (7) day look back period. Review of Resident #141's Comprehensive Care Plan, revised on 10/10/19 revealed the resident was a high fall risk related to deconditioning, and gait/balance problems. The Goal stated the resident would be free of minor injury and would not sustain major injury. The interventions included, but were not limited to: anticipate and meet the resident's needs, initiated 10/12/17; non-skid socks when out of bed and no shoes worn, initiated 10/12/17; resident enjoys making the bed, initiated 11/20/17; and wheelchair safety device anti-rollbacks, initiated 12/26/19. Review of Resident #141's Fall Incident Report, dated 11/05/19 at 5:00 AM, revealed the nurse heard the resident yell for help. Per the Report, the nurse entered the resident's room and the upper half of the resident's body was on the bed with his/her legs twisted between the wheelchair and the bed. Additionally, the resident stated he/she fell over in the bed while making up the bed when he/she became dizzy. Continued review revealed the immediate action taken was assessment of the resident and new orders for [MEDICATION NAME] (antiemetic medication used to treat [MEDICAL CONDITION]) as needed. Further, the resident was alert and oriented to person, place and time and had no obvious injury. Per the Report, there were no environmental or situational factors contributing to the fall event; however, the resident did have a current UTI. Review of Resident #141's physician's orders [REDACTED].# 141's Progress Notes: Fall Risk Review, dated 11/07/19 at 1:30 PM, revealed the Root Cause was the resident stated he/she became dizzy and fell over the bed while making it. Further, the current intervention was [MEDICATION NAME] PRN. However, further review of the Comprehensive Care Plan, revealed no documented evidence the Care Plan was revised to indicate the resident had an actual fall on 11/05/19, or to include an additional or different intervention status [REDACTED]. Interview with LPN #2, on 03/12/2020 at 3:42 PM, revealed she had worked at the facility for five (5) years. Additionally, direct care nurses were responsible to revise the CCP with changes in a resident's condition, including acute infections and fall events. Per interview, Resident #87 and Resident #109 should have had revisions to their CCP in March 2020 to reflect their acute illnesses. Continued interview revealed Resident #141's CCP should have been revised to include an intervention status [REDACTED]. Further, the Care Plan was a guide used by all staff to ensure resident care needs were met. Interview with the MDS Coordinator, on 03/12/2020 at 4:17 PM, revealed she had worked at the facility for five (5) months. Per interview, she used the RAI guidelines to ensure the CCP was revised as necessary. Continued interview revealed direct care nurses were responsible to complete revisions to the CCP for acute changes in the residents including new infection [DIAGNOSES REDACTED]. Further, the Nurse Manager reviewed orders each morning and revised the CCP as necessary. Per interview, after review of Resident #87 and Resident #109's physician's orders [REDACTED]. After review of Resident #141's CCP and Fall investigation dated 11/05/19, the MDS Coordinator stated the resident's CCP should have been revised status [REDACTED]. Further, it was important to have a current accurately revised Care Plan to ensure direct care staff knew how to provide care to residents in order to meet their needs. Interview was conducted on 03/12/2020 at 4:45 PM, with the Assistant Director of Nursing (ADON), who was the Interim Manager for the 100 hallway where Resident #87, Resident #109 and Resident #141 resided. She stated direct care nurses were responsible to revise the CCP to indicate new [DIAGNOSES REDACTED]. Further, the CCP was to be revised status [REDACTED]. Continued interview revealed she reviewed all new orders each morning and revised the Care Plans as necessary. However, she stated Resident #87 and Resident #109's CCPs should have been revised to include their acute illness in March 2020 and Resident #141's Care Plan should have been revised to include

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) the fall with a new intervention to prevent falls status [REDACTED]. Additionally, the Care Plan should be accurate and revisions should be made to ensure resident needs were met. Interview with the Director of Nursing (DON), on 03/12/2020 5:26 PM, revealed she expected the CCPs to be revised accurately, as per the facility policies and RAI guidelines. Per interview, direct care nurses were responsible for the revision of the CCP to include acute illness and status [REDACTED]. Per interview, the Unit Managers were to check to ensure the CCPs had been revised as necessary with the morning reviews. Continued interview revealed Resident #87's and Resident #109's CCP should have been revised to include the acute infections, a measurable goal and appropriate interventions related to the identified infections. Further, after review of Resident #141's fall investigation, dated 11/05/19, she stated the CCP should have been revised to indicate the resident sustained [REDACTED]. Interview with the Administrator, on 03/12/2020 at 5:49 PM, revealed the facility was to utilize the RAI Manual and facility policies as resources to ensure the CCP was revised as necessary. Per interview, it was important for the CCP to be revised accurately to reflect a resident's current status and ensure the CCP addressed each resident's individual needs.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility Policy, it was determined the facility failed to ensure position change alarms used as a fall prevention strategy were monitored to ensure efficacy and to ensure the alarms were the least restrictive device prior to implementation and on an on-going basis for three (3) of thirty-four (34) sampled Residents (Resident #10, Resident #96, and Resident #148). Although Resident #10 was Care Planned for the Sensor Alarm to bed and wheelchair on 01/29/19, there was no documented evidence of an Assessment for the Sensor Alarms until 03/16/19, over two (2) weeks later, in order to ensure the Alarms were effective and to ensure the Alarms were the least restrictive device to use as a fall prevention strategy. In addition, there was no documented evidence of ongoing monitoring of the device quarterly as per policy, as the next Assessment for the device was not completed until 01/31/2020, ten (10) months later. Further, Resident #10's Comprehensive Care Plan (CCP) was revised on 05/04/19, to include an intervention for the use of an Alarming Floor Mat; however, there was no documented evidence the facility completed an Assessment for the device in order to ensure the device was effective and the least restrictive device until 01/31/2020, over eight (8) months later. Furthermore, observation of Resident #96 on 03/09/2020, 03/10/2020, and 03/11/2020, revealed a Sensor Alarm to the bed; however, there was no documented evidence the facility completed an Assessment to ensure efficacy and to ensure the Alarm was the least restrictive device to use as a fall prevention strategy. Moreover, Resident #148 was initially assessed for the use of a Sensor Alarm, on 09/19/19; however, there was no documented evidence the facility monitored ongoing to ensure efficacy and to ensure the Alarm was the least restrictive device to use as a fall prevention strategy. The findings include: Review of the facility's Resident Safe Environment Policy, revised December 2017, revealed restraints would be medically justified to treat a medical symptom or condition that endangers the physical and/or psychosocial wellbeing of the resident. Additionally, the Comprehensive Device Assessment would be utilized for the use of protective devices quarterly and as indicated by the occurrences of events within the facility, or as the resident's status changed. Further, the facility would utilize the least restrictive type of restraint/device for the shortest period of time possible. 1. Review of Resident #10's medical record revealed the facility admitted the resident on 04/30/2014 with [DIAGNOSES REDACTED]. Observation of Resident #10, on 03/09/2020 at 2:00 PM; 03/10/2020 at 12:20 PM, and 03/11/2020 at 4:00 PM, revealed the resident was sitting in his/her wheelchair with a Sensor Alarm to the wheelchair. Observation of Resident #10's room, on 03/09/2020 at 2:00 PM; 03/10/2020 at 9:40 AM; 03/11/2020 at 11:00 AM, and on 03/12/2020 at 2:00 PM, revealed an Alarming Mat at bedside. Interview with Resident #10, on 03/11/2020 at 11:00 AM. revealed he/she was not aware of the alarms in use or their purpose. Review of Resident #10's the Comprehensive Care Plan (CCP), revised 10/02/19, revealed the resident was at high risk for falls related to unaware of safety needs, sensory deficits and incontinence. The goal stated the resident would be free from falls. Interventions included, but were not limited to: left side of the bed against wall, initiated 01/27/17; anti-roll back to wheelchair, initiated 09/28/17; Sensor Alarm to bed and wheelchair at all times for safety, initiated 01/29/19; alarming floor mat at bedside due to decreased safety awareness, initiated 05/14/19; and bell placed on bedside table to be used when resident needs to go to the bathroom, initiated 09/16/19. Although the resident was Care Planned for the Sensor Alarm to bed and wheelchair on 01/29/19, there was no documented evidence of a Comprehensive Device Assessment for the Sensor Alarms until 03/16/19, over two (2) weeks later. Review of Resident #10's Comprehensive Device Assessment, dated 03/16/19, related to Sensor Alarms, revealed the resident had poor trunk control and attempted to get up unassisted. Additionally, the resident required limited assistance with mobility. Per the Assessment, the resident was at high risk for falls; had no history of falls; and demonstrated good use of the call light. Further, the least restrictive alternative attempted was modification of personal furniture and personalization of the resident's room. Per the Assessment, the resident's potential benefits for decreased risk for fall/injury and promotion of independent locomotion with the use of the Sensor Alarm outweighed risks associated with the Alarm. Per the Assessment, the Sensor Alarms were the least restrictive device recommended due to poor safety awareness. Review of Resident #10's Monthly March 2020 physician's orders [REDACTED]. Review of Resident #10's Quarterly Minimum Data Set (MDS) Assessment, dated 12/11/19, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of seven (07) out of fifteen (15) indicating severe cognitive impairment. Additionally, the facility assessed the resident to use a bed, chair and floor alarm daily to monitor and alert the staff of the resident's movements. Although facility policy dictated the Comprehensive Device Assessment would be completed at least quarterly, there was no documented evidence the Assessment for the Sensor Alarms for the bed and wheelchair was completed from 03/16/19, until 01/31/2020, ten (10) months later. In addition, although the CCP was revised on 05/04/19, to include an intervention for the use of an Alarming Floor Mat; there was no documented evidence the facility completed an Assessment for the device in order to ensure the device was effective and the least restrictive device until 01/31/2020, over eight (8) months later. Review of Resident #10's Comprehensive Device Assessment, dated 01/31/2020, for the Sensor Alarms, revealed the resident had unsteady gait/falls and attempted to get up unassisted. Additionally, the resident required assistance, up to limited assistance with mobility. Per the Assessment, the resident was at high risk for falls; had no history of falls; and demonstrated good use of the call light. Further, the least restrictive alternative attempted was modification of personal furniture, door buzzer/alarms, and personalization of the resident's room. Per the Assessment, the resident's potential benefits of decrease risk for fall/injury outweighed the resident's risk associated with use of the Alarm. Continued review of the Assessment, revealed the Sensor Alarms to the chair, bed, and floor were the least restrictive devices recommended due to unsafe transfers and history of falls. 2. Review of Resident #96's medical record revealed the facility admitted the resident on 11/04/2016 with [DIAGNOSES REDACTED]. Observation of Resident #96, on 03/09/2020 at 1:35 PM; 03/10/2020 at 9:40 AM and 1:05 AM; and 03/11/2020 at 11:09 AM and 4:00 PM, revealed the resident was lying in bed with a Sensor Alarm at the head of the bed. Interview with Resident #96, on 03/09/2020 at 1:35 PM, revealed the Sensor Alarm to the head of the bed was used to let staff know when he/she was getting out of bed and also to remind him/her to wait for help. Further interview revealed the resident could not recall how long the Sensor Alarm had been on the bed. However, review of Resident #96's Quarterly MDS Assessment, dated 02/04/2020, revealed the facility assessed the resident as having a BIMS score of twelve, (12) out of fifteen (15) indicating moderate cognitive impairment. Further, the facility assessed the resident as not utilizing alarms to monitor and alert the staff of the resident's movements. Additionally, review of Resident #96's current physician's orders [REDACTED]. Furthermore, review of Resident #96's Comprehensive Care Plan, revealed no documented evidence of an intervention for a Sensor Alarm to the bed. Moreover, Resident #96's medical record revealed no documented evidence of a Comprehensive Device Assessment for a Sensor Alarm to the bed. Interview with State Registered Nursing Assistant (SRNA) #1, SRNA #2 and SRNA #3, on 03/11/2020 at 5:00 PM, revealed they were frequently assigned to Resident #96, but were not aware of when the Sensor Alarm was placed to Resident #96's bed. Interview with Licensed Practical Nurse (LPN) #3, on 03/12/2020 at 3:42 PM, who was assigned to Resident #96, revealed she had worked at the facility for one (1) month. Additionally, direct care nurses completed Comprehensive Device Assessments when an alarm was initially implemented. Per interview, the purpose of completing the Assessment was to ensure the device was not a restraint and to ensure the resident's safety. Further, she was not familiar with the facility's Resident Safe Environment policy related to alarms and was uncertain who was responsible to complete ongoing evaluation/assessments of alarms or the frequency in which alarms should be

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) evaluated/assessed. Continued interview revealed she was not aware of the date in which Resident #96's Sensor Alarm was implemented; however, she stated the Comprehensive Device Assessment should have been completed for Resident #96's Sensor Alarm prior to initiation of the Alarm to ensure the Alarm was appropriate for this resident. 3. Review of Resident #148's medical record revealed the facility admitted the resident on 09/19/19 with [DIAGNOSES REDACTED]. Observation of Resident #148, on 03/09/2020 at 2:00 PM, revealed the resident was in the recliner with the Sensor Alarm attached. Additional observations on 03/10/2020 at 11:15 AM; 03/11/2020 at 4:10 PM, and on 03/13/2020 at 3:00 PM, revealed the resident was in his/her bed with a Sensor Alarm attached to the resident's bed. Interview with Resident #148, on 03/13/2020 at 3:00 PM, revealed the Sensor Alarm was used because he/she had a history of [REDACTED].#148's Comprehensive Device Assessment, dated 09/19/19, for the Sensor Alarm, revealed the resident was assessed as having visual and hearing impairment and dementia. Additionally, the resident required extensive assistance with mobility. Per the Assessment, the resident was at moderate risk for falls; had no history of falls; and demonstrated good use of the call light. Further review revealed the least restrictive alternative attempted was modification of personal furniture. Further, the resident's potential benefits of the Sensor Alarm for decreased risk for fall/injury and promotion of safety/security outweighed the resident's risk related to use of the Alarm. Further, the Sensor Alarm was the least restrictive device. Review of the Comprehensive Care Plan (CCP), revised 10/02/19, revealed the resident was at high risk for falls related to incontinence. The goal stated the resident would be free from falls. Interventions included, but were not limited to gait belt with all transfers; ensure frequently used items were in reach; nonskid strips in front of recliner; and Sensor Alarm at all times/ensure the device is in place as needed, initiated 09/20/19. Review of Resident #148's Quarterly Minimum Data Set (MDS) Assessment, dated 02/28/2020, revealed the facility did not assess the resident's cognitive pattern. Further, the facility assessed the resident as using a chair and bed alarm daily to monitor and alert the staff of the resident's movements. Review of Resident #148's physician's orders [REDACTED]. Interview with Licensed Practical Nurse (LPN) #2, on 03/12/2020 at 3:42 PM, revealed the direct care nurses completed Comprehensive Device Assessments when an alarm was initially implemented. Per interview, the purpose of completing the Assessment was to ensure the device was the least restrictive device to maintain the resident's safety. Further, she was familiar with the facility's Resident Safe Environment policy related to alarms and direct care nurses were responsible to complete ongoing evaluation/assessments of alarms quarterly. Continued interview revealed she was not aware the Comprehensive Device Assessments were not being completed upon initiation of the Sensor Alarms and quarterly as per policy. Interview with the MDS Nurse, on 03/12/2020 at 4:17 PM, revealed she had worked at the facility for five (5) months. Per interview, direct care nurses were responsible to complete initial assessments of alarms when a new alarm was implemented and then ongoing quarterly. Continued interview revealed it was important to routinely assess alarms to ensure they were effective interventions, necessary and the least restrictive device for the resident. Additionally, she was unaware Resident #96 used a bed alarm. Per interview, if a direct care nurse implemented an alarm for Resident #96, there should be a physician's orders [REDACTED]. Further, Resident #10 and Resident #148 had a history of [REDACTED]. Interview was conducted on 03/12/2020 at 4:45 PM, with the Assistant Director of Nursing (ADON), who was the Interim Manager for the 100 hallway where Resident #10, Resident #96 and Resident #148 resided. Per interview, she was not aware Resident #96 had a bed alarm until 03/12/2020, and on that date she completed a Comprehensive Device Assessment related to the Sensor Alarm. Per interview, based on the Assessment and interviews with staff, it was identified Resident #96 had increased confusion and a bed alarm was a good idea to reduce his/her risk for falls. However, she stated the Comprehensive Alarm Assessment should have been completed before the alarm was implemented to ensure the device was the least restrictive device and an effective fall intervention. Further, the Physician should have been notified for an order for [REDACTED]. She stated she was unaware Resident #10 and Resident #148 did not have Comprehensive Device Assessments completed quarterly for Sensor Alarms as per policy. Per interview, it was important to complete the Assessments related to the Alarms to ensure the Alarms continued to be beneficial to the residents and were the least restrictive device used in an an attempt to prevent falls. Interview with the Director of Nursing (DON), on 03/12/2020 at 5:26 PM, revealed she expected the facility policy on Resident Safe Environment, to be followed. Per interview, she expected the direct care nurse initiating an alarm to complete a Comprehensive Alarm Assessment to ensure the alarm was effective, the least restrictive device, and the safest device to benefit the resident. Continued interview revealed the MDS nurses were responsible to complete quarterly Comprehensive Alarm Assessments according to the MDS schedule. Further, the Comprehensive Device Assessment should be utilized quarterly and with changes in the resident's status to ensure the least restrictive type of device was used for the shortest period of time. Per interview, the Interdisciplinary Team shared the responsibility to consistently evaluate alarms for their effectiveness and to modify interventions to prevent falls as necessary. Interview with the Administrator, on 03/12/2020 at 5:49 PM, revealed she expected regulations and facility policies to be maintained in order to ensure the necessity of alarms. Per interview, consistent evaluation of alarms, per the facility policy ensured the least restrictive devices were used for residents and their safety and quality of life was maintained. Additionally, she expected an assessment of alarms to be completed prior to implementing an alarm and quarterly thereafter. Further, the facility's Quality Assurance Audits for alarms had not identified concerns related to Assessments not being consistently completed prior to initiation of the alarm and quarterly to ensure effectiveness and to ensure it was the least restrictive device .