Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0004	A. BUILDING: _____ B. WING _____	03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEVY CHASE HOUSE	5420 CONNECTICUT AVENUE, NW WASHINGTON, DC 20015

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R 000	Initial Comments An annual survey was conducted from April 27, 2015 through May 8, 2015, to determine compliance with the Assisted Living Law " DC Code § 44-101.01. The Assisted Living Residence (ALR) provides care for one hundred twenty-seven (127) residents and employs ninety-three (93) staff members. The findings of the survey were based on observation, record review and interview. The survey revealed that 88 of the 128 (one resident at the time of survey was deceased) residents had experienced a total of one hundred fifty-three (153) falls from April 2015 to March 2016. Thirty-nine (39) falls resulted in injuries (e.g. fractures, minor head injuries, lacerations, skin tears, and bruises), 23 of which resulted in emergency room visits. Due to the findings, it was determined that conditions found posed a serious and immediate risk to residents' health and safety. Specifically, the findings revealed: (1) The facility failed to ensure residents received sufficient supports to address and prevent recurrent falls; (2) The facility failed to ensure consistent and adequate practices for wound care management; and (3) The facility failed to ensure consistent and adequate practices for Foley care management. On March 23, 2016, at 12:16 p.m., the ALR's administrator was informed of the aforementioned findings. On March 31, 2016, the ALR submitted a plan to correct the immediate concerns, however, it was not sufficient to abate the noted deficiencies. Note: Listed below are abbreviations used throughout the body of the report.	R 000	Status of Resident Sample: #1 On Fall Management Program #2 See All Residents (below) #3 See All Residents (below) #4 On tracking system for appointments /ordered testing #5 Transferred to skilled nursing facility #6 On Fall Management Program #7 Expired (left facility for hospital on 2/13/16) #8 Remains in rehabilitation facility #9 Remains in Collingswood Nursing Center, admission 1/29/16 #10 On Fall Management Program #11 Order for skilled nursing, transferred to skilled nursing #12 On Fall Management Program #13 On Fall Management Program All Residents - #1-13: Housekeeping carts, chemicals, storage closets, windows - under Safety Plan. **(See Citation – R 008 Sec. 102b2 Philosophy of Care)** **R 000 FALLS** All current residents will be reassessed for fall risk. The facility will assure all residents are assessed for fall risk prior to and at admission, at the time of a fall, and during required reassessments (30 days, every six months or with significant change). Residents designated at risk for falls will be referred to their physician for a fall risk examination to include ambulatory assessment, medication assessment, need for physical therapy and any other ordered interventions. Potential fall risk identified in the environment will be reported to housekeeping and maintenance for correction.	5/30/16

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Jackson | TITLE: Exec. Dir. | (X6) DATE: 4/29/16

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R 000	Continued From page 1 ALR --- Assisted Living Residence BPH --- Benign Prostatic Hyperplasia H&P --- History and Physical ISP --- Individualized Service Plan ICFD----Intermediate Care Facilities Division LOC --- Loss of Consciousness PDA --- Private Duty Aide PPD --- Purified Protein Derivative PT --- Physical Therapy MD --- Medical Doctor OT --- Occupational Therapy prn --- As Needed TID --- Three Times a Day TME --- Trained Medication Employee TURP --- Transurethral Resection of the Prostate UTI ---Urinary Tract Infection ALA --- Assisted Living Administrator DON --- Director of Nursing RN --- Registered Nurse ER --- Emergency Room cc --- Cubic Centimeter mg ---milligram po --- by mouth CNA --- Certified Nursing Assistant TB --- tubercle bacillus DVD --- digital versatile disc DC --- District of Columbia	R 000	Staff received training on Fall Management on 4/21, 4/22/16 and 4/28/16. *(Prior to receipt of Statement of Deficiency, CCH was discussing interventions at staff meetings.)* The care planning meeting will include the DON, Resident Care Manager (RCM), other designees, notice to the physician, resident and responsible party. The Individualized Service Plan will be updated. The facility shall implement a falls management system to include: A. Fall Monitoring System (Resident pendants in use 5/6/16) B. Fall Risk Assessment Tool C. Falls Reporting System D. Falls Assessment and Follow-up System E. Environmental assessment, addition of aids (florescent tape/night sensor lights) F. Exercise program G. Staff and Resident Education H. Fall Committee QA Plan: The Fall Reduction Committee (ED, DON, Resident Care Manager, Department Managers and other designated staff) will meet weekly. Review of falls will include analysis of cause of fall, resident and environmental assessments, interventions, response to interventions and recommendations for changes in plan. The Director of Nursing (DON) will review all fall assessments, assure the Individualized Service Plans (ISP) are updated and follow-up is completed. Executive Director (ED) will review charts of residents on fall management, fall reports, fall management documentation, committee minutes weekly for 4 weeks and then monthly.	
R 008	Sec. 102b2 Philosophy of Care (2) The design of services and environment should acknowledge that a significant number of residents may have some form of cognitive impairment. Services and environment should offer a balance between choice and safety in the least restrictive setting. Based on observation and interview, the ALR failed to ensure sufficient safeguards were in	R 008		

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R 008	Continued From page 2 place to prevent potential harm, for thirteen of thirteen residents in the sample. (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13) The finding includes: Observation of the building, on March 8, 2016, starting at 11:00 a.m., revealed the following: - An unlocked and unattended housekeeping cart with three white bottles; - All stairwells were unlocked and did not have an alarm system; and - All windows in residents rooms, common areas, as well as balconies in residents rooms, did not have safety locks. During an interview with the maintenance director on March 8, 2016, at 11:30 a.m., he indicated the three white bottles contained cleaning chemicals used by the housekeeper and should not have been left unattended. Also, the director indicated he was never told he needed to have the alarms on the stairwells doors and safety locks on the windows. It should be noted that interview with staff and review of records from March 8, 2016 through March 28, 2016 revealed 153 incidents of resident falls. Additionally, the records revealed that the residence provides services and support to individuals with multiple diagnosis, including dementia. At the time of the survey, the facility failed to provide evidence of an established mechanism to secure the windows and stairwells to prevent potential harm to residents.	R 008	**R 008 Sec. 102b2 Philosophy of Care** Housekeeping carts were assessed for status for types of cleaning supplies and materials stored on the carts. *Safe supervision requirements of carts, supplies and closets will be reviewed with housekeeping staff by management on 4/27, 28/16 and will be done on a continuous basis using stand up meetings and with weekly staff meetings* . Chemical supplies on carts will be kept in a portable basket which can be taken in the resident's apartment for continuous supervision by housekeeping staff. Safety issues including observing for unsupervised cleaning agents will be discussed at weekly staff meetings. QA: DON, Maintenance Staff Resident Care Manager and ED will make rounds to check for unsupervised cleaning agents and unlocked storage areas daily for three weeks and then monthly. An assessment of doors and windows was done by the Maintenance Supervisor. Door alarms will be in place for all stairwell doors on expected completion 5/6/16. The maintenance supervisor will check and secure each window using safety locks. Maintenance will make weekly round to check doors and windows. Documentation of windows and door checks will be maintained on the safety log. The ED, Maintenance staff and other designated staff will perform tours of the facility to observe for unsecured windows, doors and other hazards on a weekly basis.	5/30/16

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R 008	Continued From page 3 It should be noted that the director removed the cleaning chemicals and instructed the housekeeper to not leave chemicals unattended. Note: Observation of the second, third and fourth floors on March 8, 2016, starting at 1:00 p.m., revealed unlocked and unattended housekeeping carts [three in total, one on each floor] with cleaning chemicals. Interview with the ALA on March 8, 2016, at 1:20 p.m., revealed all the housekeepers had been inserviced earlier in the day to not leave any chemicals unattended on their carts. Also, the ALA indicated that she would have the cleaning chemicals removed immediately.	R 008		5/30/16
R 292	Sec. 504.1 Accommodation Of Needs. (1) To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities and the health or safety of other residents; Based on observation, record review, and interview, the ALR failed to: (1) provide services to reduce and eliminate frequent falls; (2) conduct analysis and reassessments after each fall as indicated in the policy; and (3) provide supportive services as indicated in policy or as recommended, for eight (8) of (8) residents in the sample that sustained multiple falls. (Residents #5, #6, #7, #8, #9, #10, #12 and #13) The findings include: I. The ALR failed to ensure residents received	R 292	**R 292 Sec. 504 1 Accommodation of Needs** **I & II** **See R 000** **292 FALLs** **X R 292 III** Upon receipt of orders for lab testing, specialty tests, medical appointments a log book will be used by nursing to register and track appointments. QA: Resident Care Manager will review the testing and appointment schedule daily to assure orders are completed. Appointment issues will be discussed at weekly staff meetings. DON and ED will check for log for documentation compliance.	

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R 292	Continued From page 4 supportive care to reduce and eliminate frequent falls. Review of the facility's incident reports and resident records beginning from March 8, 2016 through March 28, 2016 revealed that from April 8, 2015 through March 4, 2016 Residents #5, #6, #7,#8, #9, #10, #12 and #13 experienced the following incidents of falling: - Resident #5 sustained five (5) falls. - Resident #6 sustained five (5) falls. - Resident #7 sustained nine (9) falls. - Resident #8 sustained five (5) falls. - Resident #9 sustained four (4) falls. - Resident #10 sustained 10 falls. - Resident #12 sustained three (3) falls. - Resident #13 sustained eight (8) falls. Interview with the DON on March 8, 2016, at 11:45 a.m., revealed that the facility had a "Fall Policy" to address resident falls. Review of the "Fall Policy" dated August 27, 2014, on March 15, 2016, at 10:00 a.m., revealed a section entitled, "Fall Risk Assessment." The section indicated that the resident will be assessed for the presence of fall risk factors and evaluated for any prior history of falls during the pre-admission process. The assessment would provide a score which indicated the level of care the resident required. It additionally documented information regarding assistance a resident may require to aid with fall prevention. The fall policy further	R 292		

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R 292	Continued From page 5 documented the resident's environment was to be reviewed for any fall risk hazards post admission. a. On March 10, 2016, at 9:30 a.m., review of Resident #5's clinical record revealed a "Functional Assessment", dated January 7, 2015 [ten days prior to admission]. In the fall prevention section, the resident received a score of four (4) which indicated that the resident had a history of multiple falls and required total assistance from staff. Further review of the record, revealed that the resident fell five (5) times from March 6, 2015 through June 15, 2015. Four (4) of the five (5) falls, occurred inside of the resident's apartment. The record however, lacked documented evidence that the resident's environment had been assessed for any fall hazards post admission. b. On March 10, 2016, at 1:30 p.m., review of Resident #6's clinical record revealed a "Functional Assessment", dated April 8, 2015 [admission date]. In the fall prevention section, the resident received a score of one (1) which indicated that the resident had no history of falls but due to risk factors [such as medication, vision and/or gait problems] required coaching and reminders from staff. Further review of the record revealed that the resident fell five (5) times from May 26, 2015 through December 21, 2015. Two (2) of the five (5) falls, occurred inside the resident's apartment. The record, however, lacked documented evidence that the resident's environment had been assessed for any fall hazards post admission. c. On March 11, 2016, at 9:45 a.m., review of Resident #7's clinical record revealed a "Functional Assessment", dated May 4, 2015 [fifty days post admission]. In the fall	R 292		

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prevention section, the resident received a score of four (4) which indicated the resident had a history of multiple falls and required total assistance from staff. The resident fell nine (9) times from May 7, 2015 through December 29, 2015. Nine (9) of the nine (9) falls, occurred in the resident's apartment. The record, however, lacked documented evidence that the resident's environment had been assessed for any fall hazards post admission.

d. On March 15, 2016, at 11:00 a.m., review of Resident #8's clinical record lacked documented evidence that a "Functional Assessment" had been conducted. Further review of the record revealed that the resident fell four (4) times from March 27, 2015
through November 14, 2015. Three (3) of the four (4) falls, occurred in the resident's apartment. The record, however, lacked documented evidence that the resident's environment had been assessed for any fall hazards post admission. It should be noted that the resident sustained a fractured left hip following one of the falls [October 12, 2015] in his/her apartment.

e. On March 15, 2016, at 1:30 p.m., review of Resident #9's clinical revealed a "Functional Assessment", dated March 16, 2015 [admission date]. Further review of the record revealed that the resident fell four (4) times from May 6, 2015 through November 15, 2015. Three (3) of the four (4) falls, occurred inside the resident's apartment. It should be noted that the resident sustained a laceration to the back of the head [August 9, 2015] that required nine (9) staples for repair.

f. On March 14, 2016, at 10:10 a.m., review of Resident #10's clinical record lacked documented evidence that a "Functional Assessment" had

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R 292	Continued From page 7 been conducted. Further review of the record revealed that the resident fell ten (10) times from May 6, 2015 through February 7, 2016. Seven (7) of the 10 falls occurred in the resident's apartment. The record, however, lacked documented evidence that the resident's environment had been assessed for any fall hazards post admission. It should be noted that the resident sustained swelling and a laceration to the back of the head on [August 10, 2015] which required staples for repair. g. On March 15, 2016, at 11:45 a.m., review of Resident #12's clinical record revealed a "Functional Assessment", dated March 19, 2015 [admission date]. In the fall prevention section, the resident had a score of one (1) which indicated that the resident had no history of falls but due to risk factors [such as medication, vision and/or gait problems] required coaching and reminders from staff. Further review of the record revealed that the resident fell three (3) times from February 9, 2015 through March 7, 2015. Two (2) of the three (3) falls occurred in the resident's apartment. The record, however, lacked documented evidence that the resident's environment had been assessed for any fall hazards post admission. It should be noted that the resident sustained a left foot injury [March 7, 2016] which required staples for repair. h. On March 15, 2016, at 2:22 p.m., review of Resident #13's clinical record lacked documented evidence that a "functional assessment" had been conducted. Further review of the record revealed that the resident fell eight (8) times from June 18, 2015 through December 14, 2015. Three (3) of the eight (8) falls occurred in the resident's apartment. The record, however,	R 292		

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R 292	Continued From page 8 lacked documented evidence that the resident's environment had been assessed for any fall hazards post admission. It should be noted that the resident sustained multiple lacerations [December 10, 2015] from a fall that shattered a glass lamp. Interview with the Director of Clinical Services on March 15, 2016, at 11:00 a.m., revealed that the pre-admission assessment was entitled "Functional Assessment" and should have been conducted for all residents on admission. She also indicated the resident's environment should have been assessed after every fall. II. The ALR failed to ensure residents received assessments and supportive services to manage falls as identified in the policy for 47 of 47 falls reviewed. On March 15, 2016, at 10:00 a.m., review of the "Fall Policy" dated August 27, 2014, revealed that after each fall the staff was to conduct interventions including the following: - Assess the resident's mental/physical status to identify changes from his/her pre-fall [functional assessment] status then correlate the information for any change in the resident's condition; - Assess the resident for the use of any new medications; - Assess the environment to identify and rectify hazards and potential hazards; - Educate the resident/family on the assessed fall risk and options [intervention] to address the problem; and - The RN was to conduct a critical analysis. Review of resident records beginning on March 8, 2016 through March 28, 2016 revealed that the	R 292		

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R 292	Continued From page 9 facility failed to implement the established fall policy consistently. For example: a. On March 10, 2016, at 1:30 p.m., review of Resident #5's clinical record revealed nursing notes that indicated the resident sustained five (5) falls over a period of 99 days [from March 6, 2015 to June 15, 2015]. Four (4) of Resident #5's five (5) aforementioned falls occurred on March 6, 2015, April 3, 2015, April 6, 2015 and June 15, 2015. The record lacked documented evidence that the staff conducted prompt assessments and treatments of the falls, in accordance with their policy as detailed below: - The record lacked documented evidence that the resident's mental/physical status assessment conducted after aforementioned fall had been correlated with his/her pre-fall status to identify any changes; - The record lacked documented evidence the resident had been assessed for the use of any new medications; - The record lacked documented evidence the environment been assessed to identify any hazards or potential hazards; - The record lacked documented evidence the resident/family had been educated on any identified fall risk; and - The record lacked documented evidence of a critical analysis to determine the root cause of the fall, any interventions needed, or if the resident required a higher level care had been conducted. It should be noted that the resident sustained a right shoulder abrasion with the fall that occurred on April 3, 2015. The remaining fall that Resident #5 experienced occurred on May 6, 2015. Although the record	R 292		

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indicated an intervention had been implemented, it failed to document evidence any of the aforementioned assessments and educational training had been conducted.

b. On March 10, 2016, at 2:30 p.m., review of Resident #6's clinical record revealed nursing notes that indicated the resident sustained five (5) falls over a period of six (6) months [May 26, 2015 to December 21, 2015], as evidenced below:

Four of Resident #6's five (5) aforementioned falls occurred May 26, 2015, October 20, 2015, November 30, 2015 and December 21, 2015. The record lacked documented evidence that the staff conducted prompt assessments and treatments of falls, in accordance with their policy, as detailed below:

- The record lacked documented evidence that the resident's mental/physical status assessment conducted after aforementioned fall had been correlated with the his/her pre-fall status to identify any changes;
- The record lacked documented evidence the resident had been assessed for the use of any new medications;
- The record lacked documented evidence the environment been assessed to identify any hazards or potential hazards;
- The record lacked documented evidence the resident/family had been educated on any identified fall risk; and
- The record lacked documented evidence a critical analysis to determine the root cause of the fall, any interventions needed, or if the resident required a higher level care had been conducted.

The remaining fall that Resident #6 experienced

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R 292	Continued From page 11 occurred on December 21, 2015. Although the record indicated an intervention had been implemented, it failed to document evidence any of the aforementioned assessments and educational training had been conducted. It should be noted that the resident sustained a head injury with no LOC and was transferred to the ER [fall on December 21,2015]. c. On March 14, 2016, at 9:30 a.m., review of Resident #7's clinical record revealed nursing notes that indicated the resident sustained nine (9) falls over a period of nine months [March 31, 2015 to December 29, 2015]. Resident #7's nine (9) aforementioned falls occurred on March 31, 2015, May 31, 2015, June 19, 2015, July 19, 2015, August 24, 2015, November 2, 2015, November 14, 2015, December 20, 2015 and December 29, 2015. - The record lacked documented evidence that the resident's mental/physical status assessment conducted after aforementioned fall had been correlated with his/her pre-fall status to identify any changes; - The record lacked documented evidence the resident had been assessed for the use of any new medications; - The record lacked documented evidence the environment been assessed to identify any hazards or potential hazards; - The record lacked documented evidence the resident/family had been educated on any identified fall risk; and - The record lacked documented evidence of a critical analysis to determine the root cause of the fall, any interventions needed, or if the resident required a higher level care had been conducted.	R 292		

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CHEVY CHASE HOUSE	5420 CONNECTICUT AVENUE, NW WASHINGTON, DC 20015

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R 292	Continued From page 12 It should be noted that Resident #7 sustained several injuries and was transferred to the ER on several occasions following falls, as detailed below: - May 31, 2015, resident transferred to ER for evaluation of a closed head injury without loss of consciousness; - June 19, 2015, resident transferred to ER for evaluation of right shoulder pain, - July 19, 2015, resident transferred to ER for evaluation of closed head injury without loss of consciousness, resident diagnosed with scalp abrasion and compression fracture of thoracic vertebra; - August 24, 2015, resident sustained a laceration to the back of the head; transferred to the ER, and the laceration was repaired with five (5) staples; - November 2, 2015, resident sustained a hematoma to the head; - November 14, 2015, resident sustained a hematoma, transferred to ER for evaluation; - December 20, 2015, resident sustained a hematoma and laceration to occipital area of the head, transferred to the ER for evaluation, laceration repaired with staples; and - December 29, 2015, resident sustained a hematoma and laceration to left side of the head, transferred to the ER, laceration repaired with two (2) staples. It should be noted that Resident #7 sustained a right foot fracture following a fall on January 26, 2015, which was 47 days prior to admission to the ALR. d. On March 15, 2016, at 11:00 a.m., review of Resident #8's clinical record revealed nursing notes that indicated the resident sustained five (5)	R 292		

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R 292	Continued From page 13 falls over a period of four (4) months [March 27, 2015 to November 14, 2015], as evidenced below: - The record lacked documented evidence that the resident's mental/physical status assessment conducted after aforementioned fall had been correlated with his/her pre-fall status to identify any changes; - The record lacked documented evidence the resident had been assessed for the use of any new medications; - The record lacked documented evidence the environment been assessed to identify any hazards or potential hazards; - The record lacked documented evidence the resident/family had been educated on any identified fall risk; and - The record lacked documented evidence of a critical analysis to determine the root cause of the fall, any interventions needed, or if the resident required a higher level care had been conducted. It should be noted that the resident sustained skin tears with the second fall on May 31, 2015 and a left hip fracture which required surgical repair with the third fall on October 12, 2015. Additionally, the resident fell two (2) times within four (4) days after being re-admitted to the ALR following the surgical repair of the left hip fractured sustained falling a fall on October 12, 2015. e. On March 15, 2016, at 1:30 p.m., review of Resident #9's clinical record revealed nursing notes that indicated the resident sustained four (4) falls over a period of seven (7) months [May 6, 2015 to November 15, 2015]. Three (3) of Resident #9's four (4) aforementioned falls occurred on March 3, 2015, April 3, 2015, April 6,	R 292		

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R 292	Continued From page 14	R 292		

2015 and June 15, 2015. The record lacked documented evidence that the staff conducted prompt assessments and treatments of falls, in accordance to their policy as detailed below:

- Assess the resident's mental/physical status to identify changes from his/her pre-fall[functional assessment] status then correlate the information for any change in the resident's condition;
- Assess the resident for the use of any new medications;
- Assess the environment to identify and rectify hazards and potential hazards;
- Educate the resident/family on the assessed fall risk and options [intervention] to address the problem; and
- The RN was to conduct a critical analysis.

It should be noted that the resident sustained a laceration to the back of the head and was transferred to the ER for evaluation and repair of the laceration with nine (9) staples for the fall on August 9, 2015. Additionally, the nurse documented on August 10, 2015, that the resident would be monitored every two (2) hours. The record, however, lacked documented evidence the resident was monitored every two (2) hours.

The remaining fall that Resident #9 experienced occurred on November 15, 2015. Although the record indicated education about fall risk had been provided, it failed to document evidence any of the aforementioned assessments had been conducted or any interventions had been implemented.

f. On March 14, 2016, at 10:10 a.m., review of Resident #10's clinical record revealed nursing

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R 292	Continued From page 15 notes that indicated the resident sustained ten (10) falls over a period of nine months [May 9, 2015 through February 7, 2016].Three (3) of Resident #10's 10 falls occurred on May 9, 2015, June 18, 2015 and December 7, 2015. The record lacked documented evidence that the staff conducted prompt assessments and treatments of falls, in accordance with their policy as detailed below: - The record lacked documented evidence that the resident's mental/physical status assessment conducted after aforementioned fall had been correlated with the his/her pre-fall status to identify any changes; - The record lacked documented evidence the resident had been assessed for the use of any new medications; - The record lacked documented evidence the environment been assessed to identify any hazards or potential hazards; - The record lacked documented evidence the resident/family had been educated on any identified fall risk; and - The record lacked documented evidence a critical analysis to determine the root cause of the fall, any interventions needed, or if the resident required a higher level care had been conducted. It should be noted that the resident sustained a left arm abrasion with the fall that occurred on August 13, 2015. Seven (7) of Resident #10's falls occurred on May 6, 2015, July 13, 2015, July 19, 2015, August 10, 2015, August 13, 2015, December 7, 2015 and February 7, 2016 [2 falls]. The record lacked documented evidence that the staff conducted prompt assessments and treatments of falls, in accordance with their policy as detailed below:	R 292		

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R 292	Continued From page 16 - The record lacked documented evidence the resident had been assessed for the use of any new medications; - The record lacked documented evidence the environment been assessed to identify any hazards or potential hazards; - The record lacked documented evidence the resident/family had been educated on any identified fall risk; and - The record lacked documented evidence a critical analysis to determine the root cause of the fall, if the resident required a higher level care had been conducted. It should be noted that the resident sustained a forehead abrasion with the fall that occurred on July 13, 2015; a laceration to the back of the head that required stitches with the fall that occurred August 10, 2015; and a right arm injury with the fall that occurred on August 13, 2015. Additionally, the nurse documented that Resident #10 was confused following a fall on July 19, 2015, however the record lacked evidence that further assessment was performed. g. On March 15, 2016, at 11:45 a.m., review of Resident #12's clinical record revealed nursing notes that indicated the resident sustained three (3) falls over a period of 26 days [February 9, 2015 through March 7, 2015]. Resident #12's falls occurred on February 9, 2015 [2 falls] and March 7, 2015. The record lacked documented evidence that the staff conducted prompt assessments and treatments of falls, in accordance with their policy as detailed below: - The record lacked documented evidence that the resident's mental status assessment conducted after aforementioned fall had been	R 292		

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R 292	Continued From page 17 correlated with the his/her pre-fall status to identify any changes; - The record lacked documented evidence the resident had been assessed for the use of any new medications; - The record lacked documented evidence the environment been assessed to identify any hazards or potential hazards; - The record lacked documented evidence the resident/family had been educated on any identified fall risk; and - The record lacked documented evidence a critical analysis to determine the root cause of the fall, any interventions needed, or if the resident required a higher level care had been conducted. h. On March 15, 2016, at 2:22 p.m., review of Resident #13's clinical record revealed nursing notes that indicated the resident sustained eight (8) falls over a period of 7 months [June 18, 2015 through January 21, 2016]. Seven (7) of Resident #12's eight (8) falls occurred on June 18, 2015, July 8, 2015, September 15, 2015, October 29, 2015, December 10, 2015, December 11, 2015 and December 14, 2015. The record lacked documented evidence that the staff conducted prompt assessments and treatments of falls, in accordance with their policy as detailed below: - The record lacked documented evidence that the resident's mental status assessment conducted after aforementioned fall had been correlated with the his/her pre-fall status to identify any changes; - The record lacked documented evidence the resident had been assessed for the use of any new medications; - The record lacked documented evidence the environment been assessed to identify any	R 292		

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R 292	Continued From page 18 hazards or potential hazards; - The record lacked documented evidence the resident/family had been educated on any identified fall risk; and - The record lacked documented evidence a critical analysis to determine the root cause of the fall, any interventions needed, or if the resident required a higher level care had been conducted. The eighth fall that Resident #13 experienced occurred on January 21, 2016. The record lacked documented evidence that the staff conducted prompt assessments and treatments of falls, in accordance to their policy as indicated below: - The record lacked documented evidence that the resident's mental status assessment conducted after aforementioned fall had been correlated with the his/her pre-fall status to identify any changes; - The record lacked documented evidence the resident had been assessed for the use of any new medications; - The record lacked documented evidence the resident/family had been educated on any identified fall risk; and - The record lacked documented evidence a critical analysis to determine the root cause of the fall, any interventions needed, or if the resident required a higher level care had been conducted. Interview with the Director of Clinical Services on March 15, 2016, at 1:00 p.m., revealed that the staff had not followed fall policy as outlined. The Director of Clinical Services, however, indicated that they would look into developing a new fall policy that would specifically address the population of residents they serve.	R 292		

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R 292	Continued From page 19 At the time of the survey, the ALR failed to provide evidence that an effective system had been developed and implemented to reduce and/or eliminate falls. III. The ALR failed to ensure medical evaluations and labs were performed as ordered. a. On March 9, 2016, at 12:00 p.m., review of Resident #4's clinical record revealed a H&P dated March 19, 2015. The H&P documented that the resident's primary diagnosis was dementia with paranoia. The resident's secondary diagnoses included chronic obstructive pulmonary disease, hypertension and diabetes mellitus. The attending physician ordered a basic metabolic panel test every three (3) months. Continued review of the record, lacked evidence that the aforementioned lab test had been conducted as prescribed. During an interview with the Director of Clinical Services on March 9, 2016, at 2:00 p.m., it was revealed that Resident #4's lab testing had not been performed as prescribed. b. On March 10, 2016, at 9:45 a.m., review of Resident #6's record revealed a letter from the resident's physician dated October 12, 2015. The letter indicated that the resident would be seen by the gynecologist every three months to have a procedure performed. The record, however, lacked documented evidence the resident had been seen by the gynecologist to have the prescribed procedure performed. On March 10, 2016, at 1:30 p.m., interview with	R 292		

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R 292	Continued From page 20 the Director of Clinical Services revealed she would follow-up with the resident's family to find out if the resident had followed-up with the gynecologist as prescribed. At the time of this survey, there was no documented evidence that Resident #4 and Resident #6 had labs/procedures performed as prescribed.	R 292		
R 293	Sec. 504.2 Accommodation Of Needs. (2) To have access to appropriate health and social services, including social work, home health, nursing, rehabilitative, hospice, medical, dental, dietary, counseling, and psychiatric services in order to attain or maintain the highest practicable physical, mental and psychosocial well-being; Based on record review and interview, it was determined that the ALR nurses failed to directly provide appropriate nursing services for four (4) of four (4) residents in the sample with wounds and/or Foley catheters. (Residents #5, #9, #10 and #11) The finding includes: I. The ALR failed to develop a system to identify residents at risk for the development of altered skin-integrity and implement a system to ensure effective wound care management for residents with pressure ulcers; for example: a. Review of Resident #5's record beginning March 10, 2016 through March 28, 2016, revealed the resident sustained the following altered skin integrity issues:	R 293	**R 293 Section 504.2 Accommodation of Needs** **SEE R 000 WOUNDS** **R 293 II FOLEY CATHETERS** **See X R 000 FOLEY CATHETERS** **R 293 III Access to Immediate Nursing Care Services - PDA** An assessment will be done of residents currently using Private Duty Aides and Companion services. Each resident will have a file containing information as, but not limited to, identifying information of agency employing the PDA, agency service information, agency PDA job description, list of services expected to be provide by the PDA, PDA TB testing, identification, copy of criminal background check, and training certifications	5/30/16

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R 293	Continued From page 21 1. [Right heel wound] The resident was admitted on January 7, 2015. The nurse documented that the resident had a right heel wound that measured 0.1 cm x 10 cm. The record, however, lacked documented evidence that the physician was made aware of the right heel wound and it failed to indicate that the nursing staff continued to monitor the right heel wound after the resident's admission. 2. [Left heel redness] On January 9, 2015, the nurse documented that the resident had left heel redness. The record, however, lacked documented evidence that the left heel redness had healed and/or had been monitored after January 14, 2015. 3. [Stage II- buttocks] On May 19, 2015, the nurse documented, "stage II ulcer noted to bottom, resident already had nystatin cream [used for fungal infection] order in place, treatment done to wound, monitor." The record lacked documented evidence that the wound had been consistently monitored. Continued review of the record revealed that on May 29, 2015, the nurse documented, the physician was called for wound evaluation/treatment orders. Further review of Resident #5's record revealed the following related the aforementioned wound: - On June 16, 2015, the resident was seen at the wound clinic for debridment of the necrotic tissue of the buttocks. The record, however, lacked documented evidence of the decline in status of the wound and that the physician had been made aware of the decline. Additionally, the wound clinic ordered daily wound care, change position	R 293	Private Companions will have a file containing, but not limited to, identifying information, criminal background check, TB testing and information outlining what services will be offered to the resident. The form also will contain information of limitations of services. Each PDA and Companion will be oriented to the facility by facility designated staff. Orientation will include tour of the facility, introduction to facility management, copy of Resident Rights, list of needed phone numbers/extension of facility staff to contact for various needs, medication administration times and procedures, dining times and procedures, laundry procedures, activities, review of expected services and review of emergency procedures in the event of resident accident, health issue, fire or other emergency and how to report a complaint, observed abuse, neglect or exploitation of a resident. An information form will be placed in each resident's chart for the use by staff to list who uses a PDA or Companion, the list will includes the identifying information of the PDA or companion, level of care of the PDA or Companion, contact information and list of services to be provided by the PDA or Companion. QA: The Resident Services Coordinator (RSC) will maintain a current master list of all residents who use PDAs or Companions. The list will contain the name of the resident and the name the PDA or Companion. QA: The RSC and BOM will audit PDA and Companion files monthly to assure all required documentation is present. The ED will monitor files for all new PDA's to ensure compliance monthly.	5/30/16

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R 293	Continued From page 22 every 15 minutes and assist with providing incontinent care frequently [due to the location of the wound]. The record lacked documented evidence that the wound care had been performed daily and that the resident's position had been changed every 15 minutes as prescribed. - On June 25, 2015, the nurse from a licensed homecare agency [who was providing wound care one to two times a week] documented, " wound bed had necrotic tissue 75% with 25% slough, the wound did not have a cover..." The facility's nursing staff failed to ensure the wound was covered as prescribed. - On July 22, 2015, the nurse from a licensed home care agency documented that "the client [resident] buttocks breaking down talked with the DON about leaving depends on the client [resident] all night." The facility's nursing staff failed to ensure frequent incontinent care was provided as prescribed. - The record lacked documented evidence that the nursing staff provided care and/or monitored the wound after August 19, 2015. - According to a nursing note dated September 16, 2015, the noted indicated the resident at the wound clinic and sacral wound had healed. 4. [upper right buttocks-eschar] Review of Resident #5's record revealed the following information related to a wound located on the resident's upper right buttocks: - On January 13, 2016, the physician prescribed a new order for Z-guard ointment to the buttocks	R 293		

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R 293	Continued From page 23 TID and prn for incontinence associated dermatitis. - On January 18, 2016, the physician decreased the Z-guard order to BID and prn. - On January 27, 2016, the nursing note indicated that he/she observed a pressure ulcer with 75% eschar. New orders given for santyl [chemical debrider] daily. On March 8, 2015, interview with the Director of Clinical Services, revealed that the facility did not have a wound care policy and Resident #5's wound care was the responsibility of a licensed home care agency. Note: Interview and record review revealed that wound care was to be provided daily; the licensed home care agency nurse was to provide wound care one (1) to two (2) times a week and the ALR nurse was to provide wound care the days the licensed home agency did not provide wound care and as needed. Additionally, the facility's nursing staff failed to: (1) assess the resident during the admission evaluation to identify if he/she was at risk for developing pressure ulcers; (2) address the resident's decline in his/her functional mobility since admission; (3) ensure wound care was performed daily as prescribed; (4) document daily the description and status of the wound; (5) provide weekly measurements and reassessment of wound; (6) consistently inform the physician of the wound decline/progression; and (7) assess the resident for pain prior/during wound care for the aforementioned wounds. b. Review of Resident #11's record on March 14,	R 293		

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R 293	Continued From page 24 2016, starting at 1:12 p.m. revealed that the resident acquired a pressure ulcer. Nursing notes and physician orders in Resident #11's record documented that the resident was seen periodically by his/her primary physician and a wound care physician for a sacral wound. Further review of the record documented the following physician orders for wound care treatment: - April 6, 2015 - Clean sacral wound with normal saline, pat dry with gauze, apply santyl ointment and cover with bordered gauze for 10 days. - June 1, 2015 - Cleanse wound bed with acetic acid soaks, apply alginate with bordered gauze every other day. - June 12, 2015 - Santyl to sacrococcyx daily and prn, cover with mepilex. - July 7, 2015 - Cleanse sacral wound with normal saline, pat dry, apply hydrogel and cover with bordered gauze daily. - July 21, 2015 - Cleanse wound bed with soap and water or normal saline, apply alginate with bordered gauze every other day. - November 3, 2015 - Cleanse wound bed with soap and water or normal saline, gently pack with nugauze moistened with 0.25% acetic acid and cover with bordered gauze daily. - November 24, 2015 - Cleanse wound bed with soap and water or normal saline, gently pack with nugauze moistened with 1% acetic acid and cover with bordered gauze daily. - December 4, 2015 - Cleanse wound bed with soap and water or normal saline, twirl calgi swab	R 293		

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R 293	Continued From page 25 into depth of wound, then apply alginate and cover with mepilex border Mondays, Tuesdays and Wednesdays. It should be noted that a licensed home care agency was contracted April 21, 2015 to provide skilled nursing wound care 2 - 3 times per week for Resident #11. The facility was to perform wound care for Resident #11 for the remaining days as ordered. Review of the facility's nursing notes starting on March 14, 2016 at 10:10 a.m., however, failed to provide evidence that the ALR completed the remaining wound care treatments (outside the treatments conducted by the contracted agency) as prescribed. Interview with the Director of Clinical Services on March 23, 2016, at 10:41 a.m. revealed that there was no additional treatment documentation because the facility's nurses only document wound care in the nursing notes. The director of clinical services also stated that the facility was working to develop a wound care policy. Note: Interview with the Director of Clinical Services and review of records failed to provide evidence of a policy to manage wounds. II. The ALR failed to develop a system to ensure appropriate and effective Foley catheter care was implemented. a. On March 10, 2016, review of Resident #5's record revealed that on March 28, 2015, the resident complained of anuria (without urine) for 12 hours. The resident was transferred to the ER and received treatment including: The insertion a	R 293		

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R 293	Continued From page 26 Foley catheter with a urinary out put of 1500 cc and the administration of two (2) Fleets enemas. The resident returned to the ALR on the same day with the diagnoses of urinary retention and constipation. Also, the resident returned with an indwelling Foley catheter, orders to follow-up with the urologist in three (3) days and an order to start Colace [stool softeners] 100 mg po TID. Additionally, the record revealed that the resident had a history of BPH. Continued review of the record and interview revealed the following: - On March 31, 2015, the resident followed-up with the urologist and was prescribed Flomax [for the treatment of BPH]. - On April 2, 2015, the resident had a second follow-up visit with the urologist and on that visit the urologist removed the Foley catheter. - On April 7, 2015, the resident complained of constipation for three days. The physician ordered fleets enema. - On April 8, 2015, the resident complained of anuria for one day. The resident also complained of constipation. The resident was transferred to the ER with an admitting diagnoses of urinary retention and constipation. The resident was subsequently hospitalized for 5 days. - On April 13, 2015, the resident returned to the ALR with an indwelling Foley catheter in place. - On May 1, 2015, a nursing noted indicated that the physician ordered skilled nursing services [from a licensed home care agency] for Foley catheter care. - On May 7, 2015, the nurse from the licensed home care agency visited the resident and initiated for [one (1) time a week for eight (8) weeks]. - On June 30, 2015, the skilled nursing services were increased to one (1) to two (2) times a week and to change	R 293		

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R 293	Continued From page 27 the Foley catheter once a month. On March 10, 2016, interview with the Director of Clinical Services, at 2:30 p.m., revealed that the ALR did not have a Catheterization Policy and the licensed home care agency skilled nurse was responsible for providing Foley catheter care. Note: The record revealed the ALR's failed to: (1) monitor the resident for self-medicating of the new aforementioned medication prescribed to treat BPH and constipation; (2) monitor the resident's input; (3) consistently monitored the resident's urinary output; (4) document the characteristics of the of the urine noted in the drainage bag; (5) monitor the resident urinary output post removal of the indwelling catheter on April 2, 2015; and (6) consistently monitor the resident for signs/symptoms of UTI. b. Review of Resident #9's record on March 16, 2016, at 1:00 p.m., revealed that the resident was admitted on March 16, 2015, with indwelling Foley catheter and the resident was to self-empty his/her Foley catheter. The record also revealed that the resident was intermittently incontinent of stool. Further review of the record revealed the resident was admitted to the hospital on April 22, 2015, for a scheduled TURP due to a enlarged prostate. The resident returned to the ALR on April 23, 2015 without the Foley catheter in place. On March 16, 2015, at 2:30 p.m., interview with the Director of Clinical Services revealed the resident was responsible for Foley care. Note: Interview and record review revealed that the ALR's nursing staff failed to : (1) monitor the resident's input; (2) monitor the resident's urinary output with Foley catheter and post TURP ; (3)	R 293		

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R 293	Continued From page 28	R 293		

monitor the characteristics of the of the resident's urine with Foley catheter and post TURP; and (4) monitor the resident for signs/symptoms of UTI.

c. On March 14, 2016, starting at 10:10 a.m., review of a nursing note, dated November 23, 2015, in Resident #10's record revealed that the resident had a Foley catheter. The and indication for insertion however was not noted. Further review of Resident #10's record lacked evidence that the facility's nurse assessed, provided care, nor documented output amount and characteristics of Resident #10's urine from the Foley catheter.

Interview with the Director of Clinical Services on March 14, 2016 starting at 12:02 p.m. confirmed that the resident had a Foley catheter. The Director of Clinical Services stated that the nurses should have documented care provided in the nurses notes.

III. The ALR failed to develop a system to ensure a resident had immediate access to adequate and appropriate nursing services.

Review of Resident #7's record on March 17, 2016, at 11:00 a.m., revealed a nursing note dated November 14, 2015, that indicated the resident fell while in the shower and sustained a hematoma. The resident had a PDA who assisted the resident while he/she was showering. The PDA failed to notify the nurse immediately of the resident's injury [hematoma]. The PDA attempted to provide care for the injury by placing ice to the injured area. The injured area continued to swell and the PDA finally informed the nurse one hour after the injury.

Interview with the Director of Clinical Services, on

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R 293	Continued From page 29 March 17, 2016, at 2:00 p.m., revealed the PDA was to inform the nurse immediatley of the injury. The Director of Clinical Services also revealed that the ALR did not have a PDA or companion policy that outlined the ALRs expectations and rules.	R 293	5/30/16	
R 481	Sec. 604b Individualized Service Plans (b) The ISP shall include the services to be provided, when and how often the services will be provided, and how and by whom all services will be provided and accessed. Based on record review and interview, the ALR failed to ensure ISPs included when, how often, and by whom services will be provided for two (2) of thirteen residents in the sample. (Residents #5 and #6) The findings include: 1. On March 10, 2016, at 11:00 a.m., review of Resident #5's record revealed a physician telephone order dated June 16, 2015, for sacral wound care daily. Further review of the record revealed an ISP update had been completed on June 22, 2015 to reflect the significant change of wound care. The ISP, however, lacked documented evidence of when, how often, and by whom wound care services were to provided. 2. On March 10, 2016, at 12:00 p.m., review of Resident #6's clinical record revealed ISP's dated April 9, 2015, May 19, 2015 and November 22, 2015. The aforementioned ISPs indicated the resident received companion services. The ISPs, however, lacked documented evidence of when and by whom companion services were to be provided.	R 481	**R 481 Sec 604 Individualized Service Plans** All ISPs will be reviewed by nursing staff to assure documentation indicates when, how often and by whom services will be rendered. Any plan not containing this information will be corrected. QA: The DON will review all new or updated ISP's for completeness of required information prior to the form being filed in the resident's chart and initial the form. The ED will audit a random selection of Resident ISD's monthly for completeness	

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R 481	Continued From page 30 On March 10, 2016, at 1:00 p.m., interview with the Director of Clinical Services revealed that going forward they would include the aforementioned information to all significant change ISPs.	R 481	5/30/16	
R 483	Sec. 604d Individualized Service Plans (d) The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each reassessment. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR. Based on record review and interview, it was determined that the ALR failed to ensure ISPs were reviewed by the interdisciplinary team to include the resident's healthcare practitioner, the resident and the resident's surrogate at least every 6 months and more frequently for significant changes for ten (10) of (13) residents in the sample. (Residents #1, #2, #5, #6, #7, #8, #9, #10, #11 and #13) The findings include: Review of residents records on March 9, 2016, beginning at 9:30 a.m., revealed the following regarding the resident's ISPs: 1. Resident #1 had an ISP dated September 7, 2015.	R 483	**X R 483 Sec 604d Individualized Service Plans** All ISP's will be reviewed by Resident Care Manager to assure ISP's have documentation of interdisciplinary team review required every six months and for a significant change. Any omission will be corrected. The DON will review all ISP's for completeness of required information prior to the form being filed in the resident's chart and initial the form. QA: The Care Manager, ED and designated staff will audit at least five ISP's weekly for completeness	

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R 483	Continued From page 31 2. Resident #2 had an ISP dated December 3, 2015. 3. Resident #5 had ISPs dated October 29, 2015, November 25, 2015, and December 29, 2015. The aforementioned ISPs failed to provide documented evidence that they had been reviewed by each resident's healthcare practitioner. Interview with the Director of Clinical Services on March 9, 2016, at 12:15 p.m., revealed that the resident's physician had been faxed a copy of the aforementioned ISP. 4. On March 10, 2016, at 12:00 p.m., review of Resident #6's clinical record revealed two significant change ISPs. The first significant change ISP dated October 21, 2015 lacked documented evidence it had been reviewed by the resident's health practitioner, the resident and/or the resident's surrogate. In addition, the ISP failed to evidence the reason for the significant change. The second significant change ISP dated December 21, 2015, was for multiple falls. The ISP lacked documented evidence it had been reviewed by the resident's healthcare practitioner, the resident and/or the resident's surrogate. On March 10, 2016, at 1:30 p.m., interview with the Director of Clinical Services revealed all aforementioned ISP had been faxed to resident's physician for review. Note: A significant change ISP to address the resident's frequent falls was not developed until after the resident's fifth fall on December 21,	R 483		

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R 483	Continued From page 32 2015. 5. Review of Resident #7's record beginning March 14, 2016 through March 25, 2016, revealed that the resident was admitted to the ALR on March 17, 2015. The review also revealed that the resident had a total of nine (9) falls [from March 31, 2015 through December 29, 2015] with seven (7) ER transfers for evaluation/treatment. The resident sustained multiple injures from the aforementioned falls to include lacerations, closed head injuries without LOC, hematomas, and a compression fracture of the thoracic vertebra. The record, however, lacked documented evidence that a significant change ISP had been developed to address the resident's frequent falls. Further review of the record revealed a six-month ISP updated on October 29, 2015 [which was two months after the resident's fifth fall on August 24, 2015]. The ISP indicated that due the resident's "increasing fall risk" the ALR implemented the following interventions to include: (1) companion services, seven days a week, twenty-four hours a day; (2) staff to monitor and assist the resident for safety; (3) resident was not to be left unattended in apartment; and (4) ensure items needed are within reach. It should be noted that the continued review of the record revealed the resident fell four (4) more times after October 29, 2015. The aforementioned ISP, however, lacked documented evidence it had been updated with any additional interventions to address the resident's continued falls. It should be noted that the record lacked documented evidence that outlined the root cause for the resident's "increasing fall risk". Interview with the Director of Clinical Services, on	R 483		

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R 483	Continued From page 33 March 15, 2016, at 3:00 p.m., revealed that the she had meetings with the resident's family to address the resident's frequent fall. The Director, however, indicated that she failed to include the information in the ISPs. 6. On March 15, 2016, at 12:00 p.m., review of Resident #8's record revealed the last updated ISP was dated September 7, 2015. Further review of the record revealed that the resident sustained a left hip fracture following a fall on October 12, 2015. The resident had hemiarthroplasty surgery to repair the left hip fracture. Physical therapy services were started on November 11, 2015, one day post readmission to assess/treat for safety concerns following hemiarthroplasty surgery. Continued review of the record revealed that the aforementioned ISP had not been updated with significant change information that: (1) addressed any assessed needs that the resident may have required following the hip fracture; and (2) outlining when, how often, and by whom the aforementioned physical therapy services were to be provided/accessed. Further review of the record revealed that the resident fell two (2) times within four (4) days of readmission of the hemiarthroplasty surgery and physical therapy services being provided. The record, however, lacked evidence of an ISP to address any additional interventions the ALR implemented to address the frequent falls. Note: Interview and record review revealed the resident had a history of a right hip fracture with surgical repair 4-5 years prior to his/her admission to the ALR in 2014. 7. On March 15, 2016, at 1:30 p.m., review of	R 483		

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R 483	Continued From page 34 Resident #9's record revealed ISPs dated March 18, 2015, April 17, 2015 , August 18, 2015 and October 18, 2015, that lacked documented evidence they had been reviewed by the resident's healthcare practitioner. Continued review of the ISP dated August 18, 2015, indicated it was a significant change ISP for "falls". The ISP documented the resident fell on May 6, 2015, May 14, 2015 and August 8, 2015. The resident sustained a laceration to the back of the head and required nine staples for repair following the fall on August 8, 2015. The ISP indicated the resident's wife refused night checks. The record, however, revealed that the three aforementioned falls occurred between the hours of 8:00 a.m. and 5:30 p.m. The aforementioned ISP lacked documented evidence of interventions implemented by the ALR to address the resident's frequent falls. On March 15, 2016, at 3:00 p.m., interview with the Director of Clinical Services revealed that she had faxed all of the aforementioned ISPs to the resident's physician for review. Also, the Director indicated the resident's wife refused companion/PDA services. 8a. On March 14, 2016 starting at 10:10 a.m., review of Resident #10's record revealed the resident sustained a head injury that required staples after a fall on August 10, 2015. Further review of the record and the facility's incident reports revealed that the resident had a total of 10 falls from May 6, 2015 through February 7, 2016. On March 14 , 2016, at 10:25 a.m., a review of the ALR's "Fall Risk Assessment, Prevention and Management Protocol" revealed that a resident's	R 483		

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R 483	Continued From page 35 ISP should be updated after a fall as a significant change. At the time of the survey, the ALR failed to update Resident #10's ISP after Resident #10 sustained a fall/injury in accordance with agency policy. 8b. Review of Resident #10's record on March 14, 2016, starting at 10:10 a.m., revealed a nursing note, dated November 23, 2015. The note revealed that the resident had a Foley catheter, however the date of insertion was not noted. Further review of Resident #10's record revealed ISPs dated June 3, 2015 and December 3, 2015. Each of Resident #10's ISPs documented that she/he was continent of bladder and did not mention that Resident #10 had a Foley catheter. Interview with the Director of Clinical Services, on March 14, 2016, during at 12:02 p.m., revealed that the ISP should have been updated with the resident's significant change. 9. On March 14, 2016, starting at 1:12 p.m. review of Resident #11's record revealed that the resident acquired a pressure ulcer that was discovered by the nurse on April 5, 2015. Nursing notes and physician orders in Resident #11's record documented that the resident was subsequently seen by his/her primary physician and a wound care physician. Wound care orders were initiated April 6, 2015. Further review of Resident #11's record on March 14, 2016 revealed ISPs dated November 18, 2014 and May 19, 2015. The record failed to document that the ISP was updated reflect the patient's new wound and wound care orders. (The ISP was updated 43 days after the initiation	R 483		

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R 483	Continued From page 36 of the wound care orders.) 10. On March 15, 2016, starting at 2:22 p.m., review of a nursing note, dated January 8, 2016, in Resident #13's record revealed that the resident underwent pacemaker replacement surgery. The nurse's note documented orders for new activity restrictions for Resident #13. Further review of Resident #13's record on March 15, 2016 revealed ISPs dated August 4, 2015 and January 16, 2016. The record failed to document that the ISP was updated to reflect the resident's surgical procedure and new orders for restricted activities. On March 15, 2016, at 10:00 a.m., the Director of Clinical Services stated during an interview that the facility will start to document significant changes in the residents' ISPs more frequently.	R 483		5/30/16
R 598	Sec. 701d11 Staffing Standards. (11) Maintain personnel records for each employee that include documentation of criminal background checks, statements of health status, and documentation of the employee's communicable disease status; Based on record review and interview, the ALR failed to document one (1) of nine (9) employee's communicable disease status (CNA #1), and failed to document criminal background checks for one (1) of nine (9) employees. (Employee #9) The findings include: 1. On March 11, 2016, beginning at 10:25 a.m., a review of CNA #1's personnel record revealed no documented evidence of his/her communicable	R 598	**R 598 Sec 701d11 Staffing Standards** All personnel records will be reviewed by the Business Office Manager (BOM) to assure the required documentation of statement of health status, documentation of communicable disease status, and criminal background checks are present. Any omission will be corrected. The facility will assure that all employees hired prior to 2012 will be rechecked using the DOH Criminal Background Check program. QA: Audits of personnel records will be done by the ED and BOM monthly to assure required documentation is completed. The facility will use a personnel file index form which will contain all required personnel documents. As required documents are filed in the personnel folder, the items will be checked on the index.	

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R 598	Continued From page 37 disease status. This information was brought to the attention of the ALR's Business Office Manager at 11:15 a.m. The surveyor was informed that the CNA would be instructed to contact his/her doctor to obtain the results. At the time of the survey, the ALR failed to maintain a personnel record for CNA #1 that included the employee's communicable disease status. 2. The ALR failed to maintain documentation of criminal background checks in employee personnel records. (Employee #9) On March 11, 2016, at 1:47 p.m., review of the personnel record for Employee #9 revealed that he/she was hired on December 23, 2008. Further review of the record revealed the results of the employee's criminal background check was documented within an email dated November 25, 2008. The email documented that a background check had been obtained for the employee and that he/she was cleared for hire. Continued review of the criminal results revealed that a Social Security trace was conducted and evidenced that Employee #9 lived in the District of Columbia and lived in the state of Maryland. It should be noted that the criminal information reported was received for Prince Georges County and the City of Suitland only. There was no documented evidence of a clearance for the District of Columbia. At the time of the survey, there was no evidence that a background check had been obtained in all jurisdictions where Employee #9 lived within the	R 598		

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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) COMPLETE DATE
R 598	Continued From page 38 past seven years prior to their date of hire. On March 14, 2016, at 11:52 a.m., the surveyor brought this information to the attention of the Human Resources Director. Further discussion with the HR Director revealed that she/he was not aware that the search should have included all jurisdictions in which the employee worked or resided within the 7 years prior to their date of hire. The surveyor was informed that in the future, as the Human Resources Director, she/he would ensure that all jurisdictions that were applicable for each employee would be included.	R 598		5/30/16
R 602	Sec. 701f Staffing Standards. (f) Employees shall be required on an annual basis to document freedom from tuberculosis in a communicable form. Based on interview and record review, the ALR failed to ensure that an employee was annually tested free from tuberculosis in a communicable form, for one (1) of nine (9) staff in the sample. (CNA #1) The finding includes: On March 11, 2016, beginning at 10:27 a.m., a review of CNA #1's personnel record revealed the employee's date of hire was July 31, 2015. Further review of the record revealed that a PPD skin test had been performed on March 3, 2016. The record, however, lacked documented evidence of the results of PPD [TB] skin test. The ALR's Business Office Manager was informed of the missing information on March 11, 2016 at 11:15 a.m. The Business Office Manager informed the surveyor that CNA #1 would be	R 602	**R 602 Sec 7011 Staffing Standards** All personnel records will be reviewed by the BOM to assure the required documentation is present. Any staff lacking documentation of TB testing will be off work until testing documentation is obtained. QA: The facility will use a personnel file index form which will contain all required personnel requirements. As TB testing reports are received and filed, the TB report will be checked on the index. Audits by ED and BOM will be done monthly to assure testing has been completed and is documented.	

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	ALR-0004	A. BUILDING: _____ B. WING _____	03/28/2016

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R 602	Continued From page 39 instructed to contact he/her doctor to obtain the results. At the time of the survey, CNA #1's personnel record lacked evidence that he/she was from free from tuberculosis in a communicable form.	R 602		
R 659	Sec. 702a4d Staff Training. (D) Procedures for detecting and reporting suspected abuse, neglect, or exploitation of residents; Based on interview, the ALR failed to ensure that staff were properly trained on procedures to report if employees had cause to believe that a resident was subjected to abuse, neglect, or exploitation, would report it to the administrator for two (2) of two (2) CNAs. (CNA #1 and CNA #2) The findings include: On March 9, 2016, beginning at 9:56 a.m., an interview was conducted with CNAs #1 and #2 to ascertain information regarding their knowledge of who to report an allegation of neglect, abuse or exploitation. The interview with both CNA #1 and #2 revealed that they would report such an allegation to the ALR's Charge Nurse. Review of CNA #1's and #2's personnel records on March 11, 2016, beginning at 10:25 a.m., revealed that the CNA's training covered two topics, Resident Rights and Fire Safety. There was no documented evidence that any training was provided on Allegations of Abuse, neglect and exploitation. At the time of the survey, the ALR failed to ensure	R 659	**R 659 Sec. 702a4d Staff Training** A review of all resident files will be done to assure all staff have been trained on the proper procedure to report resident abuse, neglect and exploitation. An in-service will be provided to all staff by the Ombudsman on reporting abuse, neglect and exploitation of residents prior to 5/15/16. QA: Audits by ED and BOM will be done monthly to assure training on the proper procedure for reporting abuse, neglect and exploitation of residents has been completed and is documented	5/30/16

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R 659	Continued From page 40 CNAs #1 and #2 were educated to report an allegation of abuse, neglect, or exploitation to the ALR's administrator.	R 659		
R 669	Sec. 702b Staff Training. (b) Within 7 days of employment, an ALR shall train a new member of its staff as to the following: Based on record review and interview, ALR failed to ensure that two (2) of two (2) newly hired staff received the required orientation within 7 days of employment. (CNA #1 and #2) The findings include: 1. On March 11, 2016, at 10:27 a.m., review of CNA #1's personnel record revealed s/he was hired on July 31, 2015. The record revealed that orientation had been provided, however, there was no documented evidence of the date that the training was provided. 2. On March 11, 2016, at 10:57 a.m., review of CNA #2's personnel record revealed s/he was hired on July 22, 2015. Further review of the record revealed a document entitled "Certificate of Completion of First Hire Orientation DVDs." Continued review of the document, revealed that CNA #2 had received two of the nine required trainings (Resident Rights and Fire Safety). It should be noted that the aforementioned document lacked evidence of CNA #2's name and the date of training. During the exit conference on March 28, 2016, beginning at 11:15 a.m., the surveyor reported the aforementioned findings. It should be noted that the Human Resources Director was present for the exit conference and did thank the surveyor for	R 669	**R 669 Sec. 702b Staff Training** 5/30/16 A review of training practices will be done by the ED and BOM. The BOM will develop an efficient documentation system to track employee training. QA: The ED and BOM will audit personnel records monthly to assure staff training has been completed and documentation is accurate.	

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R 669	Continued From page 41 providing the aforementioned information. At the time of the survey, CNA #2's record lacked documented evidence that the required training was provided within seven days of employment. Additionally, CNA #2's record lacked documented evidence that the facility provided all nine required trainings ("their specific duties and assignments; the purpose and philosophy of the ALR; the CNA's daily routines; elementary body mechanics, including proper lifting and in place transfer; choking precautions and airway obstruction, including the Heimlich Maneuver; and infection control.")	R 669		5/30/16
R 812	Sec. 904c Medication Storage (c) The storage area shall be used only for storage of medications and medical supplies. Based on observation and interview it was revealed that the ALR failed to stored delivered medication in a space only used for medications and medical supplies for one (1) of thirteen resident's in the sample. The finding includes: On March 16, 2016, at 11:00 a.m., observation revealed the receptionist receiving a delivery of medications. The receptionist put the delivered medication in the resident's open and unsecured mailbox. The receptionist then gave the delivered medications to the resident. On March 16, 2016, at 11:05 a.m., interview with the receptionist revealed that when that only resident's medication is dropped off at the front desk. Once the medications are dropped off, the receptionist will place the medication in the	R 812	**R 812 Sec 904c Medication Storage** All medication deliveries will be taken directly to Nurse in Charge by the pharmacy transport personnel. Medication will be signed in and processed by the Nurse in Charge. The facility will develop a written policy covering delivery practices for medication. A copy of the policy will be sent to all pharmacy providers. Staff will be educated to direct pharmacy deliveries to the medication room. QA: The DON will audit for correct receipt of medications on a monthly basis.	

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R 812	Continued From page 42 resident's mailbox. The nurse/resident will pick-up the medications and take them to the nurses station. Additionally, it was revealed the receptionist was not a licensed nurse or TME. On March 16, 2016, at 11:20 a.m., interview with the Director of Clinical Services, revealed that all medications should only be delivered to the nurses station. She then indicated she would educated the receptionist she is to direct all medication deliveries to the nurse station.	R 812		5/30/16
R 960	Subheading Fire Safety. Sec. 1002. Fire safety. An ALR shall comply with the Life Safety Code of the National Fire Protection Association, NFPA 101, 1997 edition as follows: Based on record review and interview, the ALR failed to conduct fire drills at least quarterly for three (3) of the three (3) shifts. The findings include: Interview with the Director of Maintenance on March 14, 2016, at 10:24 a.m. revealed that he/she conducts fire drills for the ALR. Further interview revealed the ALR had three shifts, 7:00 a.m. - 3:00 p.m., 3:00 p.m. -11:00 and 11:00 p.m. to 7:00 a.m. Continued discussion with the Director of Maintenance revealed that he was not aware of how often fire drills should be conducted. The surveyor informed the Director of Maintenance that the ALR regulations require that fire drills be conducted quarterly on each shift. On March 14, 2016, at 3:08 p.m., review of the Fire Drill records failed to evidence that the ALR	R 960	**R 960 Subheading Fire Safety Sec. 1002 Fire Safety** The ED met with the Maintenance Director to review requirements of fire drills on 4/18/16. Fire drill procedures have been discussed at weekly staff meetings in March and April, 2016. Fire drill schedules and reports will be given to the ED by the Maintenance supervisor for review. All Fire drill schedules and Fire Safety Training schedule is complete for 2016. Any cancellation of drills will be reported immediately. Maintenance will give ED the date for the rescheduled drill. QA: The facility will invite the Fire Department to observe a fire drill. The ED will audit all fire drill documentation for completion monthly. The ED will attend at least 1 fire drill monthly to assure requirements are met	

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R 960	Continued From page 43 had conducted fire drills in accordance with the regulation as evidenced below: 1. [Second Quarter -April 2015 - June 2015] Two fire drills were conducted on the evening shift; (April 30, 2015, at 3:30 p.m., and June 1, 2015, at 4:15 p.m.) There was no documented evidence that fire drills had been conducted on the day or overnight shift during the second quarter. 2. [The Third quarter (July 2015 - September 2015) There was no documented evidence that any fire drills had been conducted during the third quarter. 3. [The 4th quarter October 2015 - December 2015] There was no documented evidence that any fire drills had been conducted on any shift.	R 960		5/30/16
R 981	Sec. 1004a General Building Interior (a) An ALR shall ensure that the interior of its facility including walls, ceilings, doors, windows, equipment, and fixtures are maintained structurally sound, sanitary, and in good repair. Based on observations and interviews, the ALR failed to ensure the kitchen's equipment was sanitary and in good repair for one (1) of one (1) kitchens in the ALR. The findings include: During an environmental inspection on March 8, 2016, the surveying team notified the Supervisory Health Services Program Specialist from the ICFD of potential environmental concerns. It should be noted that a Sanitarian from the Food	R 981	**R 981 Sec. 1004a General Building Interior** The ED and Kitchen Manager will review all equipment to assure proper functioning, cleanliness of the kitchen and assure equipment is in sanitary condition. Equipment not meeting standards will be repaired or replaced. Daily kitchen inspections for cleanliness and sanitary practices will be documented. An in-service was held for dietary staff regarding sanitary requirements for thawing meat and proper guidelines for storing food in refrigerators and freezers on 4/25/16. The ED and designated staff will audits of the kitchen, sanitary requirements and condition of equipment will be done on weekly basis.	

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R 981	Continued From page 44 Safety and Hygiene Inspection Services Division was referred to conduct an inspection of the ALR's kitchen on the aforementioned date. At 11:55 a.m., the inspector met with the surveying team at the ALR. At 12:10 p.m., the inspector proceeded to conduct an environmental walk-through and the following concerns were identified: 1. A residential grade refrigerator was observed with rust on the exterior that was not holding foods, (milk, juice and yogurt) at 41 degrees Fahrenheit or below. The ALR's chef chose to discard foods inside the refrigerator and cease using the unit. It should be noted that the facility had a commercial grade refrigerator that was available and had adequate space for the storage of these items at the time of the survey. 2. There was mold on the ice machine drip panel. 3. A preparation sink holding chicken for thawing was observed with a garden hose directly connected to a faucet of the facility's three (3) compartment sink. The three compartment sink was used to provide water for the preparation sink. The garden hose did not provide a means to prevent the water coming from the preparation sink from contaminating the supplied water. At the time of the survey, the garden hose was removed. 4. An open top refrigerator was being used improperly. Food in small pans were stacked inside of larger pans. The railings for the refrigerator to allow the unit to be used as intended were located and installed. The ALR's chef stated the unit will be used as designed moving forward.	R 981		

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R 981	Continued From page 45 5. Some fixed sinks had discolored or missing caulking where they were affixed to the wall. At the time of the survey, the facility's Administrator stated the repair could be completed on the day of survey. 6. The dish machine had lime/calcium build-up on the interior. The ALR's chef stated he would use a delimer to remove the build-up. 7. There was some food debris on the wall above the three (3) compartment sink. It should be noted that the ALR had a DC certified food protection manager on site and a written plan posted to prevent the spread of norovirus.	R 981		

Health Regulation & Licensing Administration

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R 000	INITIAL COMMENTS An annual survey was conducted from April 27, 2016 through May 8, 2016, to determine compliance with the Assisted Living Law " DC Code § 44-101.01. The Assisted Living Residence (ALR) provides care for one hundred twenty-seven (127) residents and employs ninety-three (93) staff members. The findings of the survey were based on observation, record review and interview. The survey revealed that 88 of the 128 (one resident at the time of survey was deceased) residents had experienced a total of one hundred fifty-three (153) falls from April 2015 to March 2016. Thirty-nine (39) falls resulted in injuries (e.g. fractures, minor head injuries, lacerations, skin tears, and bruises), 23 of which resulted in emergency room visits. Due to the findings, it was determined that conditions found posed a serious and immediate risk to residents' health and safety. Specifically, the findings revealed: (1) The facility failed to ensure residents received sufficient supports to address and prevent recurrent falls; (2) The facility failed to ensure consistent and adequate practices for wound care management; and (3) The facility failed to ensure consistent and adequate practices for Foley care management. On March 23, 2016, at 12:16 p.m., the ALR's administrator was informed of the aforementioned findings. On March 31, 2016, the ALR submitted a plan to correct the immediate concerns, however, it was not sufficient to abate the noted deficiencies.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the	R 125		

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R 125	Continued From page 1 criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and review of personnel records, ALR failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the 7 years prior to the check, for one (1) of nine (9) staff. (Employee #9) The finding includes: On March 11, 2016, at 1:47 p.m., review of the personnel record for the Employee #9 revealed that he/she was hired on December 23, 2008. Further review of the record revealed the results of the employee's criminal background check was documented within an email dated November 25, 2008. The email documented that a background check had been obtained for the employee and that he/she was cleared for hire. Continued review of the criminal results revealed that a Social Security trace was conducted and evidenced that Employee #9 lived in the District of Columbia and lived in the state of Maryland. It should be noted that the criminal information reported was received for Prince Georges County and the City of Suitland only. There was no documented evidence of a clearance for the District of Columbia. At the time of the survey, there was no evidence that a background check had been obtained in all jurisdictions where Employee #9 lived within the	R 125	**R 125 401.5 Background Checks** The BOM will check all personnel files to assure back ground checks are complete. The facility will assure that all employees hired prior to 2012 will be rechecked using the DOH Criminal Background Check program. QA: Audits of personnel records will be done by the ED and BOM monthly to assure required documentation is completed. The facility will use a personnel file index form which will contain all required personnel documents. As required documents are filed in the personnel folder, the items will be checked on the index. **Corporate Quality Assurance** The Corporate Quality Assurance Registered Nurse will make quarterly visits for the first year and then as needed. In addition, an Interdisciplinary Team (Nursing, Human Resources, Business Associate and Facility Management) will visit the facility annually.	5/30/16 5/30/16

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R 125	Continued From page 2 past seven years prior to their date of hire. On March 14, 2016, at 11:52 a.m., the surveyor brought this information to the attention of the Human Resources Director. Further discussion with the Human Resources Director revealed that she/he was not aware that the search should have included all jurisdictions in which the employee worked or resided within the 7 years prior to their date of hire. The surveyor was informed that in the future, as the Human Resources Director, she/he would ensure that all jurisdictions that were applicable for each employee would be included.	R 125		

CHEVY CHASE HOUSE

WOUND CARE PROGRAM

(APRIL, 2016)

BULLET POINTS FOR WOUND MANAGEMENT PROGRAM

SKIN ASSESSMENTS ARE DONE AT PREADMISSION, ADMISSION, AT 30 DAYS, EVERY SIX MONTHS, AND WHENEVER A SKIN ISSUE OCCURS

CARE AIDES ASSESS SKIN DURING PERSONAL CARE AND REPORT TO NURSING

NURSING PERFORMS A SKIN ASSESSMENT IMMEDIATELY WITH REPORT OF SKIN ISSUE

NURSING NOTIFIES THE MEDICAL PROVIDER AND RESPONSIBLE PERSON (SURROGATE) IS NOTIFIED

NJRSING ASSURES ALL ORDERS ARE FOLLOWED.

NURSING ASSURES WOUND REDUCTION MEASURES ARE IN PLACE

NURING INSTITUTES THE WOUND TRACKING FORM

NURSING ASSURES THE ISP IS UPDATED

NURSING ASSURES CARE PLANNING MEETING IS DONE

NURSING ASSURES REQUIRED REPORTS ARE COMPLETED

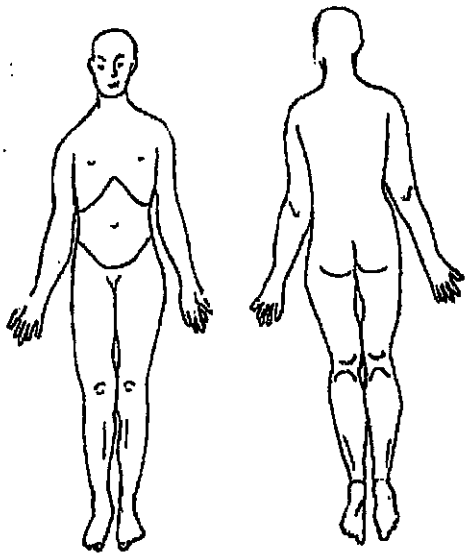
DON REVIEWS ALL DOCUMENTATION AND CHECKS STATUS OF WOUNDS

FOR WOUNDS GREATER THAN A STAGE II, HOME HEALTH IS ENGAGED IN CARE

NURSING ASSURE THE WOUND MANAGEMENT COMMITTEE REVIEWS EACH WOUND AND FOLLOWS THE STATUS OF THE WOUND

Body/Skin Check

Individual_____ Date_____



Mark an X on diagram for any red, open rash area. Look closely at pressure points for start of pressure sores.

Details:_____

_____

_____

_____

_____

Refusals: Offer skin check. Explain skin check. If refuses: Educate resident of signs and symptoms to report regarding skin.

Check areas identified in the Individual Body/Shin Check Protocol

D Head- o Normal o Dry o Scabbed areas o Red Patches o Missing Hair D

D Ears- D Normal o Red/Dry Areas o Excess Ear Wax o Scaly Patches

D Eyes- D Normal D Drainage D Puffy - D Crust Like material

D Nose - D Normal - D Discharge(note color).____ D Swollen

D Mouth- o Chapped Lips D Canker Sores D Bad Breath D Dry Tongue

D Arms- D Dry patchy areas D Bruises D Scabs D Red/Rash areas

D Abdomen/Breasts- D Swelling D Red/Rash Areas D Odor D Rigid Belly

D Peri Area- Male: - D Discharge D Odor D Red/Rash Scrotum
Female: - D Discharge D Menstruating D Red/Rash Area D Odor

D Leg D Red/Rash areas D Bruising D Scabs D Swelling

D Feet- D Swelling D Open areas D Dry/Cracked areas between toes D red areas
D Heels (soft? Discolored?)

D Back D Red/Rash areas D Bruises D Open areas

D Buttocks- D Red/ Rash areas D Open areas

D Full Body Check

ody Check Performed By_____Date: _____
urse Review _____ Date: _____

Resident Declined at this time: ----------
Staff:---------- Date: ----------

QA Pressure Ulcer Monitoring Form

RESIDENT NAME_____ Date of Birth: _____

Key Location of Ulcer(s): Identify where ulcer is on body: i.e. coccyx, left hip, right shoulder, left heel, etc.
Ht/Wt: Resident's current height and weight
Mobility: N = Non-ambulatory, S = Semi-ambulatory, or A = ambulatory
Continence: C = Continent for bladder and bowel, I/Blad = Incontinent Bladder only, I/Bow = Inc Bowel only, or I/B&B = Inc Bladder and bowel
Meal Intake: M-Good Fair Poor Fluid Intake: F - Good Fair Poor
Pain Status: Less Severe to More Severe 1 - 5
Treatment: orders from Medical Provider for care of pressure ulcer. Note who provides: HH – Home Health S - Staff

DATE	Location of Ulcer(s)	Ht/Wt	Mobility	Continence	Meal/Fluid Intake	Pain	Treatment Note by HH or Staff

DATE	Location of Ulcer(s)	Ht/Wt	Mobility	Continence	Meal/Fluid Intake	Pain	Treatment HH or Staff

STAGES:

Stage I Skin is red/discolored, but not broken. May show changes of hardness or temperature. If you press on it, it stays red but does not stay white, remains red after 30 minutes.

Stage II Top layer of skin (epidermis) is broken with shallow open sore. Second layer may be broken, Drainage of pus/fluid may or may not be present.

Stage III Wound extends through dermis (2^{nd} skin layer) into fatty tissue. Bone, tendon or muscle are not seen. May see pus, green drainage, black/dead tissue (necrosis). Odor may be present.

Stage IV Wound can extend to bone. Dead tissue and drainage present. Infection highly possible.

Facility: _____

Wound Management Team Meeting **Confidential Quality Assurance Review**

Team meets regularly to analyze falls.
Team should consist of ED, DON, Resident Care Manager,
Other _____
Team is to review reports and resident charts.

RESIDENT: _____

Reporting Wound History and Status Documentation:

Does the resident have a history of wounds? If so when? Where were wounds located?	
Was resident's wound(s) present on admission? When did the wound occur? Describe treatments received for the wound.	
Is there a history of any other skin issues?	
When was the current wound observed? Who reported the wound? What is the current wound status?	
What treatments have been prescribed?	
Is home health currently involved? Wound Care Clinic?	
What pressure relieving interventions are present?	
What other health issues are present that may interfere with healing?	
Does the resident need to be upgraded to skilled?	
Has the ISP been updated?	

RESIDENT: _____

Has there been a care planning meeting?
Is there sufficient documentation in the resident's chart to support ongoing assessments, interventions, treatment and wound status?

(MINUTES) TEAM COMMENTS & RECOMMENDATIONS:

TEAM MEMBERS	DATE

Minutes should be filed with ED .

CHEVY CHASE HOUSE

FALL REDUCTION PROGRAM

(APRIL, 2016)

BULLET POINTS FOR FALL MANAGEMENT PROGRAM

FALL ASSESSMENTS ARE DONE AT PREADMISSION, ADMISSION, AT 30 DAYS, EVERY SIX MONTHS, WHEN A FALL OCCURS AND FOR A SIGNIFICANT CHANGE

ANY RESIDENT IDENTIFIED AT RISK FOR FALLS IS PLACED ON THE FALL REDUCTION PROGRAM

NURSING ASSURES ALL RESIDENTS AT RISK ARE EVALUATED BY MEDICAL PROVIDER FOR ISSUES CONTRIBUTING TO FALL RISK

WHEN A FALL OCCURS, NURSING INSTITUES EMERGENCY PROCEDURES, ASSESSES THE RESIDENT AND NOTIFIES THE MEDICAL PROVIDER AND RESPONSIBLE PARTY (SURROGATE)

NURSING ASSURES ALL ORDERS ARE FOLLOWED

NURSING ASSURES A COMPLETE FALL ASSESSMENT IS DONE, INCLUDING ASSESSING FOR CAUSE OF THE FALL AND ASSESSING THE ENVIRONMENT FOR RISKS

NURSING ASSURES REQUIRED DOCUMENTATION AND REPORTS ARE COMPLETED

NURSING ASSURES ALL FALL REDUCTION MEASURES ARE IN PLACE

NURSING ASSURES THE ISP IS UPDATED

NURSING ASSURES CARE PLANNING MEETING IS DONE

DON REVIEWS ALL DOCUMENTATION, ASSURES REPORTS ARE DONE AND FALL REDUCTION IS IN PLACE

NURSING ASSURES THE FALL MANAGEMENT COMMITTEE REVIEWS EACH FALL AND FOLLOWS THE STATUS OF RESIDENT

FALLS MANAGEMENT PROGRAM

Policy: It is the policy of **Chevy Chase House** to assess all residents for risk of falls. Recognizing that there are many causes of falls, the facility utilizes the team approach to manage and reduce falls while allowing each individual as much freedom and independence as possible.

Procedure:

A-Fall Risk Assessment Tool:

1. To be completed for all new admissions and current Residents to identify factors that may contribute to possible falls.

B-Staff Education:

1. Staff will receive formal training on Fall Prevention Awareness during orientation and a minimum of once annually by a qualified Professional.

C – Falls Reporting:

1. Staff to contact family/responsible party. The medical provider is contacted by phone, and fax.
2. Nursing staff should institute any immediate nursing interventions, doctor's orders, and assure appropriate required documentation is completed (72 Hour Follow Up form to be used)
3. DON is to review the 72 hour form and documentation for completeness. If the 72 hour form is completed, it is then placed in resident's chart under the Nurse Tab.

D-72 Hour Follow Up:

1. Staff will institute 72 Hour Follow Up to investigate possible circumstances contributing to the fall and document observations for the period of 72 hours after the fall.
2. 72 Hours after incident documentation includes:
    a. Vitals initially & every shift x 72 hours, additional vitals may be taken as necessary
    b. Assessment of possible risk /contribution factors for falls:

- Area where resident fell-Was it properly lit?
  If No (complete maintenance work order)
- Was the area cluttered? Clothes on floor?
  If Yes (aide to tidy area and maintain clear pathways)

- Is resident capable of calling for assistance?

- Was call system used?
- Did resident have an assistive device? Was assistive used?
- If resident does not have an assistive device, would resident benefit from having an assistive device?
  If Yes (consider order for PT assessment)
- Is the furniture stable and out of pathway(s) where resident fell?
- If resident's fall was in the bathroom-did fall involve bath mats?
  If Yes (recommend that staff remove mat)
- Does the height of the toilet seat need to be raised or lowered?
  If Yes (consider order for OT assessment)
- Does resident have unsteady gait or improper fitting shoes?

  If Yes (consider order for PT assessment)
- Was resident wearing glasses?
- Did resident receive any psychotropic or new medications 24 hours prior to fall?
- If resident is a diabetic; was FSBS within normal range?
- Would resident benefit from an assisted device?
  If Yes (recommend PT assessment)

E. If a resident is evaluated in ER after a fall, assure that any follow-up orders are completed.

F- Hot Box Charting:

For any fall, the resident must be placed on ***HOT BOX/ALERT CHARTING*** for 72 hours for follow up and monitoring.

G-Falls Committee:

Team will consists of the Executive Director, Director of Nursing, Lead LPN, and any other discipline as determined by Team.

a. Team will review all resident falls from the previous month (or past week if weekly meetings occur). Meeting frequency will be determined by the ED as the need arises.
b. **Committee will review the Resident's 72 hour form for trends, any issues and actions to be taken.**
c. Possible Trends:
    - Are falls occurring on the same shift?
    - Are there repeat falls of the same resident?
    - Are falls due to environment?
    - Are falls due to medication changes?
    - Complaints of chronic pain
    - Incontinence of Bowel or Bladder

Facility: _____

FALL ASSESSMENT

(To be completed by Nurse to determine if there may a medical or physical factor that could possibly contribute to falls)

Resident:_____ **DOB:** _____

				Date	**Date**	**Date**	**Date**
Gait	Steady = 0	Cane or Walker = 2	Shuffling = 3				
Level of Consciousness	Alert = 0	Lethargic =2	Confused = 3				
Mobility	Independent = 0	Limited = 1	Immobile or Amputation = 2				
Diagnosis	Arthritis or Age > 80=1	Transient Ischemic Attack, Dementia, Alzheimer's or Parkinsons = 2	Orthostatic Hypotension= 3 (decreased blood pressure upon standing)				
Medications	Diuretics or laxatives (medications that increase fluid removal from the body or laxatives) = 1	Antihypertensive = 2 (medications to lower blood pressure)	Benzodiazepines, Sedatives or Hypnotics = 3 (generally used for sleep and behavior modifications)				
History of Falls	None = 0		Any previous falls = 5				

Initial Assessment:	**Points:**	**Assessor:**
2nd Assessment:		
3rd Assessment:		
4th Assessment:		

Add the points, <u>any score of 5 or above indicates a high risk for falls.</u>

Resident is to be monitored for 72 hours after a fall including immediate evaluation for reason for fall.

Facility: _____ 72 Hour Follow Up on Resident Fall (First 24 hrs-1st Day)

Resident: _____ **Date:** _____

Fall occurred on 1st, 2nd, 3rd Shift (Circle One)	7am-3pm Date: _____	3pm-11pm Date: _____	11pm-7am Date: _____
Staff on shift to complete following fall: A. Assess are where resident fell -Well lighted? ( ) Yes ( ) No -Cluttered? ( ) Yes ( ) No -Furniture stable/bed in good condition? ( ) Yes ( ) No If fall was in bathroom: -Toilet seat need to be raised /lowered? ( ) Yes ( ) No -Bath mats ( ) Yes ( ) No Document steps taken to correct: _____ _____ _____ B. Assess Resident: - Vital signs within normal range? ( ) Yes ( )No -If diabetic check BS. Report abnormal BS. -Was resident wearing proper shoes? ( )yes ( ) No -Was resident using assisted device? ( ) yes ( ) No -Was resident wearing eye glasses? ( ) yes ( ) No -Has resident received any psychotropic medications with the last 24 hours? ( ) Yes ( ) No *Document steps taken in chart! **Additional Vitals taken Initially: Time: _____** **BP:_____ P:_____T:_____ Pain:_____**	Vitals: BP: _____ Pulse: _____ Temp: _____ Unwitnessed fall or resident hit head-complete neuro check form 1-Signs of bruising around injured area ( ) yes ( ) no 2-Increased difficulty walking due to injury? ( ) yes ( ) no 3-Soreness around injured area? ( ) yes ( ) no 4.) C/O pain _____ 5-Behavior changes? ( ) yes ( ) no 6-Has resident needed/received Tylenol? ( ) yes ( ) no **Must notify MD if you answer yes to any of these questions. Might be cause for an appointment.** Staff: _____	Vitals: BP: _____ Pulse: _____ Temp: _____ Unwitnessed fall or resident hit head –complete neuro check form 1-Signs of bruising around injured area ( ) yes ( ) no 2-Increased difficulty walking due to injury? ( ) yes ( ) no 3-Soreness around injured area? ( ) yes ( ) no 4.) C/O pain ( ) yes ( ) no 5-Behavior changes? ( ) yes ( ) no 6-Has resident needed/received Tylenol? ( ) yes ( ) no **Must notify MD if you answer yes to any of these questions. Might be cause for an appointment.** Staff: _____	Vitals: BP: _____ Pulse: _____ Temp: _____ Unwitnessed fall or resident hit Head-complete neuro check form 1-Signs of bruising around injured area ( ) yes ( ) no 2-Increased difficulty walking due to injury? ( ) yes ( ) no 3-Soreness around injured area? ( ) yes ( ) no 4 (C/O) pain ( )yes ( ) no 5-Behavior changes? ( ) yes ( ) no 6-Has resident needed/received Tylenol? ( ) yes ( ) no **Must notify MD if you answer yes to any of these questions. Might be cause for an appointment.** Staff: _____

Note: This is page 1 of 3. You must complete pages 2 & 3 to equal the 72 Follow Up as required

Form must be submitted to the DON

Facility: _____

Pg 2 of 3

72 Hour Follow Up on Resident Fall (2nd Day) **Resident:** _____

7am-3pm Date: _____	3pm-11pm Date: _____	11pm-7am Date: _____
Vitals: BP: _____ Pulse: _____ Temp: _____ 1-Signs of bruising around injured area ( ) yes ( ) no 2-Increased difficulty walking due to injury? ( ) yes ( ) no 3-Soreness around injured area? ( ) yes ( ) no 4-Behavior changes? ( ) yes ( ) no 5-Has resident needed/received Tylenol? ( ) yes ( ) no **Must notify MD if you answer yes to any of these questions. Might be cause for an appointment.** Staff: _____	Vitals: BP: _____ Pulse: _____ Temp: _____ 1-Signs of bruising around injured area ( ) yes ( ) no 2-Increased difficulty walking due to injury? ( ) yes ( ) no 3-Soreness around injured area? ( ) yes ( ) no 4-Behavior changes? ( ) yes ( ) no 5-Has resident needed/received Tylenol? ( ) yes ( ) no **Must notify MD if you answer yes to any of these questions. Might be cause for an appointment.** Staff: _____	Vitals: BP: _____ Pulse: _____ Temp: _____ 1-Signs of bruising around injured area ( ) yes ( ) no 2-Increased difficulty walking due to injury? ( ) yes ( ) no 3-Soreness around injured area? ( ) yes ( ) no 4-Behavior changes? ( ) yes ( ) no 5-Has resident needed/received Tylenol? ( ) yes ( ) no **Must notify MD if you answer yes to any of these questions. Might be cause for an appointment.** Staff: _____
Additional Comments:: _____ _____ _____ _____ _____ _____ _____ Staff: _____	Additional Comments: _____ _____ _____ _____ _____ _____ _____ Staff: _____	Additional Comments: _____ _____ _____ _____ _____ _____ _____ Staff: _____

Form must be submitted to the DON

Facility: _____

Pg 3 of 3

72 Hour Follow Up on Resident Fall (3rd Day)

Resident: _____

7am-3pm Date: _____	3pm-11pm Date: _____	11pm-7am Date: _____
Vitals: BP: _____ Pulse: _____ Temp: _____ 1-Signs of bruising around injured area ( ) yes ( ) no 2-Increased difficulty walking due to injury? ( ) yes ( ) no 3-Soreness around injured area? ( ) yes ( ) no 4-Behavior changes? ( ) yes ( ) no 5-Has resident needed/received Tylenol? ( ) yes ( ) no **Must notify MD if you answer yes to any of these questions. Might be cause for an appointment.** Staff: _____	Vitals: BP: _____ Pulse: _____ Temp: _____ 1-Signs of bruising around injured area ( ) yes ( ) no 2-Increased difficulty walking due to injury? ( ) yes ( ) no 3-Soreness around injured area? ( ) yes ( ) no 4-Behavior changes? ( ) yes ( ) no 5-Has resident needed/received Tylenol? ( ) yes ( ) no **Must notify MD if you answer yes to any of these questions. Might be cause for an appointment.** Staff: _____	Vitals: BP: _____ Pulse: _____ Temp: _____ 1-Signs of bruising around injured area ( ) yes ( ) no 2-Increased difficulty walking due to injury? ( ) yes ( ) no 3-Soreness around injured area? ( ) yes ( ) no 4-Behavior changes? ( ) yes ( ) no 5-Has resident needed/received Tylenol? ( ) yes ( ) no **Must notify MD if you answer yes to any of these questions. Might be cause for an appointment.** Staff: _____
Additional Comments::	Additional Comments:	Additional Comments:
Staff: _____	Staff: _____	Staff: _____

Form must be submitted to the DON

Neurological Flow Sheet

Vital Signs and Neuro Checks:
- q 15 mins. X (1) hour
- q 30 mins. X (1) hour
- q 1 hour X (4) hours, then
- q 4 hours X (24)hours

(Progress along this time schedule ONLY if signs are stable)

Date:																					
Time:																					
Level of Conciousness:																					
Movement:																					
Hand Grasps:																					
Pupil Size: Rt.																					
Pupil Size: Lt.																					
Pupil Reaction: Rt.																					
Pupil Reaction: Lt.																					
Speech:																					
B/P:																					
Pulse:																					
Respiration:																					
Temperature:																					
See Nurse's Notes: *																					
Initials:																					

KEY:

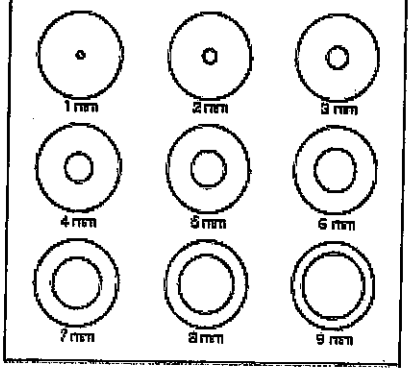
Level of Conciousness

1. Fully Concious - awake, aware, oriented
2. Lethargic - responds slowly to verbal stimuli
3. Obtund - very drowsy, responds to touch stimuli
4. Stupor - responds only to painful stimuli
5. Coma - absent response to stimuli

Movement

1. All 4 extremities
2. Arms only
3. R arm only
4. L arm only
5. R leg only
6. L leg only
7. No movement/unusual movement

Pupil Size Chart



Hand Grasp

1. Equal and strong
2. R weakness
3. L weakness
4. None

Speech

1. Clear
2. Slurred
3. Rambling
4. Aphasic

Pupil Reaction

1. Brisk
2. Sluggish
3. Fixed

Notify MD IMMEDIATELY of signs and symptoms of Intracranial Pressure!!!

Resident Name:	Room #	Physician:	Medical Rec. #

Facility: _____

Fall Management Team Meeting **Confidential Quality Assurance Review**

Team meets regularly to analyze falls.
Team should consist of ED, DON, Other_____
Team is to review reports and resident charts.

Resident:	Resident:	Resident:
Fall Date:	Fall Date:	Fall Date:
Shift:	Shift:	Shift:
Injured Area:	Injured Area:	Injured Area:
Did staff complete 72 Hour Report? Did staff complete IR Report?	Did staff complete 72 Hour Report? Did staff complete IR Report?	Did staff complete 72 Hour Report? Did staff complete IR Report?
Could this fall have been prevented?	Could this fall have been prevented?	Could this fall have been prevented?
-How?	-How?	-How?
Were they any recent medication changes previous to fall?	Were they any recent medication changes previous to fall?	Were they any recent medication changes previous to fall?
Other suspected causes?	Other suspected causes?	Other suspected causes?
Steps team will implement to assist in preventing this type of fall again.	Steps team will implement to assist in preventing this type of fall again.	Steps team will implement to assist in preventing this type of fall again.

Facility:_____

Guidelines:

1-Are falls occurring on the same shift 2-Repeat falls on the same resident 3-Preventable falls due to environment 4-Preventable falls due to medication changes 5-72 hour follow up completed 6-RCC/MCC intervention needed/documented	**Aggression towards each other: (Resident to Resident)** In the event of resident incident of aggression towards each other; team is to consider the following: 1-Factors precipitating aggressive behaviors. Documentation in chart of notification to families and MD intervention. 2-Review meds. To prevent over-sedation proper use of PRN meds intended to assist with behavior 3-Notification to family member/responsible party of possibility of discharge if aggressive behavior towards other residents continue.

Did staff place chart in the "Hot Box/Alert" and document for 72 hours after the incident? ( ) Yes ( ) No (If no, explain)

Notes:

Team Members Present: (Signature & Title)	

Minutes should be filed with Administrator.

CHEVY CHASE HOUSE

FALL CARE INFORMATION

HANDOUTS

Facts About Falls

1

Facts About Falls

- **General Population**
  - 34.9 million people ≥ 65 years of age
  - One in three elderly persons living in the community fall each year
  - Of deaths caused by a fall, 60% involve people who are ≥ 75 years of age
  - Falls account for 87% of all fractures in people ≥ 65 years

2

Facts About Falls

- **Nursing Facilities**
  - The average age at admission to a nursing facility is 82.6 years
  - Over 50% of those admitted to a nursing facility have three or more admitting diagnoses
  - One in two patients in nursing facilities fall every year
  - Of those patients who fall, 30-40% will fall again
  - People ≥ 85 years are 10-15 times more likely to experience hip fractures than those people who are 60-65 years

3

Intrinsic Fall Risk Factors

- **Effects of normal aging**
  - **Vision**- decreased acuity, decreased contrast sensitivity, increased sensitivity to glare, decreased peripheral vision, decreased night vision
  - **Hearing**- decreased hearing sensitivity
  - **Changes in gait and balance**- reduced arm swing, decreased step length, slowed reaction time, slower movements
  - **Urological**- feelings of urgent need to urinate and having to urinate frequently

4

Intrinsic Fall Risk Factors (cont.)

- **Acute and chronic diseases** (Parkinson's, Alzheimer's, stroke, arthritis, depression, cancer, osteoporosis)
  - Confusion, disorientation, agitation, impaired judgment
  - Weakness, dizziness, fainting
  - Paralysis, tremors
  - Loss of joint mobility, contractures
  - Lower extremity weakness
  - Drop in blood pressure upon standing, after meals or after voiding
  - Incontinence

5

Intrinsic Fall Risk Factors (cont.)

- **Side Effects of Medications** (antidepressants, sedatives/hypnotics, and antipsychotics)
  - Dizziness
  - Confusion, impaired judgment
  - Weakness, impaired gait
  - Sedation, slowed reaction time
- **Drug interaction and or polypharmacy**

6

Extrinsic Fall Risk Factors

- **Environment**
  - Clutter
  - Inadequate lighting, glare
  - Uneven or wet floors, raised thresholds, missing tiles or linoleum
  - Unstable or lightweight furniture
  - Insecure toilet seat or handrail
  - Hard-to-reach personal items
  - Unstable wheels
  - Low toilet seat
  - Lack of handrail support in bathroom

7

Extrinsic Fall Risk Factors (cont.)

- **Personal Safety**
  - Unsafe shoes or slippers
  - Hard-to-manage clothing

8

Extrinsic Fall Risk Factors (cont.)

- **Equipment**
  - Missing wheelchair parts
  - Incorrect wheelchair fit
  - Inadequate wheelchair seating
  - Broken parts

9

Physical Restraints

Physical restraints **INCREASE** the likelihood of serious injury resulting from a fall.

Not a method of fall prevention

10

Consequences of Falls

- Serious injury such as hip fracture
- Increased risk of death associated with hospitalization and complications
- Loss of independence and decreased ability to function
- Loss of self-confidence and fear of falling
- Reduced quality of life
- Increased need for care

11

Staff Strategies to Reduce Fall Risk

- Falls Assessment to determine problems with medications, behavior, vision, gait and mobility, or presence of postural hypotension
- Medical evaluation
- Medication review
- Gait and balance training

12a

Staff Strategies to Reduce Fall Risk (cont.)

- Hip protectors
- Individualized wheelchair seating
- Low beds, Mats
- 1/2 or 1/4 side rails
- Toileting
- Alarms / sensors
- Activities and exercise programs
- Behavioral strategies

12b

How You Can Help

- Remove clutter from room and bathroom
- Provide safe shoes and slippers
- Promote safety during transfer and bathroom use
- Use low blood pressure precautions when needed

13

Remove Clutter

- Help keep pathways around bed and to bathroom clear
- Provide only stable furniture from home
- Remove items no longer needed

14

Provide Safe Footwear

- Shoes and slippers should have tread, fit well, have a firm shape and have low even heels.

Examples: tennis shoes with Velcro fasteners, oxford style shoes, canvas or leather slip-on shoes, fitted, soft slippers with tread

15

Promote Safety During Transfer

- Call for help when unsure about safety
- Provide easy-to-manage clothing with elastic waist and Velcro fasteners
- Lock wheelchair brakes before transfer
- Keep all seating items in wheelchair

16

Use Low Blood Pressure Precautions

For resident's with low blood pressure:

- Sit on edge of bed and dangle feet before rising
- Flex feet backwards several times before rising
- Do not tilt head backwards
- Get up slowly and use assistance
- Report dizziness

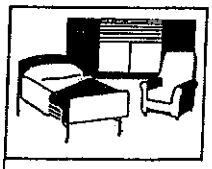
17

FALL PREVENTION CONSIDERATIONS

Successful fall prevention is based upon comprehensive assessment and identification of risk factors and implementation/carryover of a plan of care based upon potential related causes. Listed below are some considerations for preventive interventions; to discuss with the resident's doctor. This is not an exclusive listing.

Risk/Causative Factors	Suggestions for Prevention
Unsteady Gait	♦ Rehab therapy assessment/training ♦ Evaluation for appropriate assistive device ♦ Education on using assistive device [i.e. walker, cane, etc.] ♦ Assessment/treatment by Restorative Nursing ♦ Evaluate and provide appropriate footwear ♦ Encourage participation in exercise activities
Hyper/Hypoglycemia	♦ More frequent AccuChecks ♦ Dietary evaluation for better blood sugar control
Hypotension Dizziness	♦ Check blood pressure lying, sitting, standing in AM and PM ♦ Evaluate medication schedule and review meds for possible side effects of unstable/fluctuating blood pressure ♦ Encourage resident to slowly rise and sit on bed before attempting to stand/walk ♦ Consider evaluation by medical specialist for dizziness [i.e. ENT for possible inner ear or Neurologist, etc.]; treat condition as prescribed by physician ♦ Encourage/educate resident to use appropriate assistive device [i.e. ½ rail to assist in standing, etc.]
Short-Term Memory Loss	♦ Use bed/chair alarm ♦ Frequently remind resident to ask for assistance ♦ Encourage resident to participate in diversional activity program ♦ Encourage resident to participate in activities in supervised areas; limit amount of time spent unsupervised in room ♦ Frequently remind/demonstrate how to use call bell
Incontinence Dependence on Staff for ADLs	♦ Evaluate and establish scheduled toileting program ♦ Keep objects within easy reach [i.e. water, call bell, phone, tissues, etc.] ♦ Turn and reposition resident more frequently; offer water, toileting, snack when turning/repositioning
Non-compliance Resident Refusal	♦ Educate resident on risks of falling ♦ Verbally remind resident to ask for assistance or use assistive device ♦ Provide opportunity for resident to be busy and involved within the facility
Pain	♦ Review schedule of medication administration; administer prior to daily care ♦ Consider ROM exercises early in day ♦ Evaluate need for analgesic crème/ointment or hot/warm packs ♦ Evaluate for restorative nursing ♦ Educate in relaxation techniques
Sensory Impairment Vision/Hearing	♦ Keep eyeglasses clean and encourage resident to use them ♦ Keep hearing aids in working order; encourage resident to use ♦ Minimize background noise when talking with resident ♦ Keep room well lighted and free of shadows ♦ Evaluate for changes in vision or hearing by medical specialists ♦ Encourage participation in activities that are considerate of visual or hearing limitations ♦ Provide adaptive call bells as appropriate
Paralysis/Paresis Poor Trunk Control Kyphosis; scoliosis Contractures	♦ Provide appropriate seating devices [i.e. custom wheelchair, recliner, wedges, lateral supports, etc.] ♦ OT evaluation for positioning devices and adaptive equipment to facilitate independence in ADLs [i.e. reachers, etc.] ♦ Evaluate for need of assistive devices to assist in bed mobility ♦ Restorative nursing for ROM
Unstable Health Condition Anemia Terminal Illness	♦ Encourage resident to ask for assistance ♦ Evaluate for need of rest times ♦ Monitor health condition for acute and chronic changes ♦ Obtain and evaluate lab work with physician [i.e. low Hgb/Hct] ♦ Monitor for signs/symptoms of infection [i.e. UTI, respiratory, etc.] ♦ Offer snacks and fluids frequently
Agitated Behavior Confusion	♦ Re-direct resident; encourage to participate in diversional activty ♦ Offer fluids, snack, or to toilet resident ♦ Remove to quiet location ♦ Quietly remind resident to ask for assistance

RESTRAINTS should only be used if all other means for providing safety have been exhausted and there are no other alternatives for providing safety. If it is necessary to use restraints, they are to be used according to the State restraint regulations.



How to Reduce Falls in Nursing Facilities

Residents' Living Space and Personal Safety

- Remove clutter. Keep a clear path 2 to 3 feet wide around the bed, from the bed to the hall, from the bed to the bathroom, and from the bed to the lounge chair.
- Keep the bed wheels locked at all times. Report beds with broken wheel locks.
- Remove lightweight furniture. Keep the overbed table across the bed when it is not in use.
- Report loose handrails and toilet seats.
- Report torn linoleum and loose carpet edges. Wipe up wet spots when you see them.
- Report burned out light bulbs.
- Keep the call light, water pitcher, glass, and any personal items within arm's length of the resident.
- Use footwear which has tread on the bottom, a firm shape, and a low, even heel. Use gripper socks when the resident cannot wear safe shoes.
- Give proper foot care.

Residents' Transfer and Mobility

- Know which residents need assistance during transfer and walking. Give help when needed.
- Watch all residents closely during the first 2 to 3 weeks after admission and after a health decline or acute illness. Increase assistance during these times.
- For most residents, keep bed in the lowest position at all times. Use a raised toilet seat when ordered.
- Dress the resident in easy-to-manage clothing such as those with elastic bands and Velcro fasteners.
- Provide toileting, food, drink and activity based on the resident's individual schedule.
- Check the resident often. Ask volunteers and family to help.

Equipment Use

- Check the wheelchair brakes often. Report ones that do not hold the chair firmly in place.
- Report all broken or lost parts of wheelchairs, walkers and canes.
- Use all of the seating items which are ordered for the resident.
- Report any resident who leans over, slides down, or leans to one side while seated in a wheelchair.
- Do not share wheelchairs among residents.
- Make sure all equipment is labeled with the resident's name.

Psychotropic Drugs

- Know which residents take a benzodiazepine or an antipsychotic.
- Watch residents who are on these drugs for side effects such as confusion, drowsiness, dizziness, changes in gait, loss of balance, and changes in mental status.
- Use behavior management skills to lessen the need for these drugs.

Falls Assessment Cue Sheet

Medications

Review the resident's drugs in the MAR and PRN records. Consider all drugs in each of the classes listed below when completing the medications section of the Falls Assessment.

Antipsychotic

Trade Names	*Generic Names*
Abilify	aripiprazole
Clozaril	clozapine
Etrafon	perphenazine
Haldol	haloperidol
Loxitane	loxapine
Mellaril	thioridazine
Moban	molindone
Navane	thiothixene
Orap	pimozide
Permitil	fluphenazine
Prolixin	fluphenazine
Risperdal	risperidone
Serentil	mesoridazine
Seroquel	quetiapine
Stelazine	trifluoperazine
Taractan	chlorprothixene
Thorazine	chlorpromazine
Tindal	acetophenazine
Trilafon	perphenazine
Triavil	perhenazine
Vesprin	triflurpromazine
Zyprexa	olanzapine
Geodon	ziprasidone

Benzodiazepines

Trade Names	*Generic Names*
Ativan	lorazepam
Centrax	prazepam
Dalmane	flurazepam
Doral	quazepam
Halcion	triazolam
Klonopin	clonazepam
Librium	chlordiazepoxide
Paxipam	halazepam
ProSom	estrazolam
Restoril	temazepam
Serax	oxazepam
Tranxene	chlorazepate
Valium	diazepam
Xanax	alprazolam

Antidepressant

Trade Names	*Generic Names*
Anafranil	clomipramine
Asendin	amoxapine
Aventyl, Pamelor	nortriptyline
Celexa	citalopram
Desyrel	trazadone
Effexor	venlafaxine
Elavil	amitriptyline
Lexapro	escitalopram
Nardil	phenelzine
Norpramin	desipramine
Paxil	fluoxetine
Parnate	tranylcypromine
Prozac	paroxetine
Remeron	mirtazapine
Serzone	nefazodone
Sinequan	doxepin
Surmontil	trimipramine
Tofranil	imipramine
Wellbutrin	bupropin
Zoloft	sertraline

Digoxin

Trade Names	*Generic Names*
Digoxin	digoxin
Lanoxicaps	
Lanoxin	
Novo-digoxin	

Sedatives/hypnotics

Trade Names	*Generic Names*
Ambien	zolpidem
Atarax, vistaril	hydroxyzine
Buspar	buspirone
Aquachloral	chloral hydrate
Equanil, Miltown	meprobamate
Seconal	secobarbital
Sonata	zaleplon
Versed	midazolam

Orthostatic Hypotension

Equipment needed: stethoscope, sphygmomanometer, watch with a second hand

Take the resident's blood pressure in the right arm unless otherwise indicated and take an apical heart rate for 60 seconds. Encourage the resident not to smoke and to remain calm for at least 10 minutes before the test.

For ambulatory residents, take BP readings in the sitting position and then 1 minute after standing. Ensure that the resident has been sitting for at least 5 minutes before taking the first measurement. Use staff assistance when necessary for resident safety.

Subtract the values obtained while resident is standing from the values obtained while the resident was sitting. Determine if there is a reduction of $\geq$ 20 mm Hg in systolic pressure for postural hypotension.

Vision

Observe the resident during her activities of daily living and while she moves about in her room, bathroom, hallway and dining room. Determine if the resident stumbles, trips, has difficulty finding objects or detecting changes in floor surfaces, or shows other signs of poor vision.

Mobility

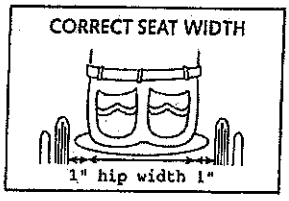
Complete a Mobility and Transfer Assessment for all residents who ambulate or transfer without human assistance. Include residents who use a cane, walker or wheelchair and those residents who should be assisted but get up unsafely without assistance.

Get Up and Go Test: Ask the resident to sit in a standard armchair, rise, walk 10 feet, turn, walk back to the chair and sit down. The resident should wear her normal footwear and use her customary walking aid. Look for unsteadiness, difficulty rising or lowering and any gait problems. Determine level of staff assistance required for safety.

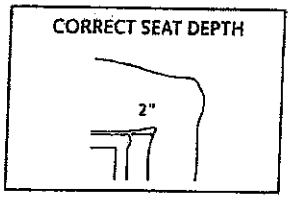
Transfer Test: Ask the resident to transfer in and out of the bed, on and off the toilet and in and out the lounge chair. Determine if the resident is safe, if the height of the bed, toilet or lounge chair needs adjustment; if existing handrails need adjustment; and if the resident's assistive device needs further evaluation.

Wheelchair Screen: For all residents who use a wheelchair or sit in a wheelchair for reasons other than transport only, collect the following measurements and assess the resident's position while seated. Based on your evaluation, determine if the resident is unsafe while seated in the wheelchair.

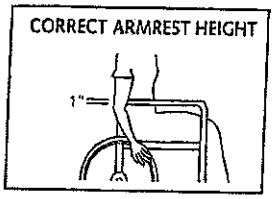
Use the following measurements to determine if the wheelchair seat and armrests are the correct size for the resident.



Hip width + 2 in = ____

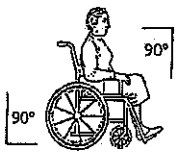


Thigh length – 2 in = ____



1 in higher than elbow = ____

After the resident has been seated in the wheelchair for at least 1 hour, compare her position with the pictures to determine if she is seated correctly.



correct position with two 90° angles

sliding down

leaning over

leaning to one side

Unsafe Behavior

Review the chart and MAR, obtain a history from the family and talk with staff about the resident's behavior. Complete the Unsafe Behavior Worksheet if necessary to determine the following:

- location
- time of day
- frequency
- potential triggers
- resident's agenda
- motivation
- people involved
- unsuccessful staff approaches
- new interventions

The Falls Management Program

Falls Assessment

Resident: _____ **Room:** _____

Directions: Use the instructions on the Falls Assessment Cue Sheet to assess the resident in the five areas listed in the first column. Put a check beside each risk factor present for this resident. If the resident does not have a risk factor, put a check beside N/A. In the second column, check when the primary care provider report is faxed and orders are received and when the resident is discussed in the interdisciplinary team meeting. Check all appropriate evaluations and referrals. Once the assessment is complete, proceed to the Fall Interventions Plan and select specific individualized interventions for each risk category identified for this resident.

RISK FACTORS	INTERDISCIPLINARY ASSESSMENTS
	☐ Primary Care Provider Report faxed ☐ Primary Care Provider Orders received ☐ Discussed in falls team meeting
Medications ☐ Antipsychotics ☐ Antidepressants ☐ Benzodiazepines ☐ Sedative/hypnotics ☐ Digoxin ☐ N/A	☐ Medication review by consultant pharmacist ☐ Psychiatric evaluation
Orthostatic Hypotension ☐ Reduction of ≥ 20 mm Hg in systolic pressure 1 minute after change in position from sitting to standing Sitting BP: ___/___ Standing BP: ___/___ ☐ N/A	☐ Review cardiovascular medications
Vision ☐ Stumbles and trips ☐ Difficulty finding objects or detecting changes in floor surfaces ☐ N/A	☐ Optometrist evaluation ☐ Ophthalmologist referral
Mobility ☐ Unsafe during the Get Up and Go Test ☐ Unable to transfer on and off toilet, bed or chair safely ☐ Unsafe wheelchair seating ☐ N/A	☐ OT consultation ☐ PT consultation
Unsafe Behaviors ☐ Tries to stand, transfer or walk alone unsafely ☐ Tries to climb over bed rails or get out of bed alone unsafely ☐ Walks or paces alone when too tired to be safe ☐ Propels or walks alone in unsafe areas ☐ N/A	☐ Behavioral assessment ☐ Evaluation of restraint use

Signature: _____ Date Completed: _____