

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345516	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/03/2011	
NAME OF PROVIDER OR SUPPLIER CONOVER NURSING AND REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH STREET SOUTH WEST CONOVER, NC 28613		
(X4) ID PREFIX TAG F 221 SS=D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to identify siderails as restraints and determine the medical reason for the use of siderails for two (2) of eight (8) sampled residents. (Residents #7 and #9). The findings are: The facility's policy "Use of Restraints" with the revised date of 12/2008 included "The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint." 1. Resident #7 was admitted to the facility on 08/07/09 with diagnoses including hypertension, dementia, Alzheimer's disease, macular degeneration, and history of cerebral vascular accident. The most recent quarterly Minimum Data Set (MDS) dated 02/07/11 coded Resident #7 with long and short term memory impairment, moderately impaired decision making skills and	ID PREFIX TAG F 221	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F221 1. The siderails for Residents #7 and #9 were immediately lowered upon notification. The Director of Nursing Services, MDS personnel, and all staff involved in the care of Residents #7 and #9 were counseled on 3/3/2011 regarding 3/4-length side rails being restraints, the use of siderails in general as restraints and each resident's right to be free from any physical restraint imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	(X5) COMPLETION DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

3/21/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	<p>Continued From page 1</p> <p>requiring limited assistance with ambulation. The MDS also coded bed rails were used as restraints daily.</p> <p>The Evaluation of Use of Bed Rails dated 02/07/11 stated the resident continued to use half side rails to assist with turning and positioning.</p> <p>On 03/01/11 at 12:50 PM, Resident #7's bed was observed with 3/4 length siderails. Interview with Nurse Aide #6 at this time revealed that when Resident #7 is assisted to bed, both 3/4 length siderails are placed upright. NA #7 was unsure if Resident #7 could put the siderail down when he wanted to get out of bed.</p> <p>On 03/01/11 at 2:33 PM, Resident #7 was observed in bed, on his back with both 3/4 length siderails in the upright position.</p> <p>Interview with the nursing supervisor licensed nurse (LN) #4 on 03/01/11 at 2:40 PM revealed that bedrails are used to help define the perimeter of the bed. She further stated that the length of the siderails was not an issue in determining siderails as restraints. She stated that if a resident can get out of the bed by getting around the siderail, the siderail is not considered a restraint.</p> <p>Interview with the Director of Nursing (DON) on 03/01/11 at 4:52 PM revealed she did not consider the bedrails used for Resident #7 as a restraint because he can ring the call bell to request assistance to get out of bed. She further stated that Resident #7 would not always remember to call for assistance.</p> <p>During interview on 03/03/11 at 10:31 AM, MDS</p>	F 221	<p>2. All facility residents using 3/4 siderails were assessed by a multidisciplinary team on 3/2/11 to determine if the siderails met the definition of a restraint and/or if medical symptoms were evident for the use of the siderails. Restraint reduction interventions (i.e. replacing 3/4 siderails with 1/4 siderails, discontinued use of the siderails except during resident care, etc.) were implemented for those residents in which there was no medical symptom evident to justify the use of the siderails. The Director of Nursing Services immediately counseled nursing staff responsible for the care of all other facility residents regarding each resident's right to be free from any physical restraints, including siderails, imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p>	

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F 221	<p>Continued From page 2</p> <p>coordinator #2 stated that in the bed rail assessment, she referred to the siderails as 1/2 rails because the facility does not consider any difference between the half rails and the 3/4 rails. She further stated that the resident can get out of bed with the siderails upright by scooting to the foot of the bed and going around the siderail. Because Resident #7 can scoot to the end of the bed to get out of bed, the siderails were not considered restraints.</p> <p>2. Resident #9 was admitted to the facility on 04/12/10. Diagnoses included Parkinson's Disease, Alzheimer's dementia and congestive heart failure.</p> <p>A significant change assessment dated 01/09/11 coded him as being severely cognitively impaired, requiring extensive assistance with bed mobility and transfers and being nonambulatory. He was also coded as having no restraints.</p> <p>The Evaluation of Use of Bed Rails dated 01/09/11 stated Resident #9 continues to use half side rails when in bed to assist with turning and positioning.</p> <p>The care plan dated 01/10/11 which addressed his needs for extensive assistance with most activities of daily living skills included the addition on 02/14/11 of 3/4 side rails to allow a feeling of safety per resident's request.</p> <p>On 03/02/11 at 10:55 AM, Resident #9's bed was observed with 3/4 length siderails on each side.</p> <p>Interview with Nurse Aide (NA) #8 on 03/02/11 at 3:19 PM revealed that both siderails were raised whenever Resident #9 was assisted to bed. Per</p>	F 221	<p>3. The Director of Nursing Services and Administrator in-serviced all facility staff on 3/4/2011 and 3/7/2011 on the definition of a restraint and residents having the right to be free from any physical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms with emphasis on how this policy relates specifically to the use of siderails.</p> <p>4. Director of Nursing Services or her designee will monitor all resident rooms weekly for at least 1 month, then randomly inspect resident rooms weekly for at least 2 months to ensure that siderails are not being used as restraints. Data will be reviewed and discussed at quarterly QA meetings. Will randomly inspect 10 rooms for at least 2 months...</p>	<p>TC w/ Todd Roper 3/24/11 1125am</p> <p>3/24/11</p>

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F 221	Continued From page 3 NA #9, Resident #9 ambulated with a walker. Interview with NA #5 on 03/02/11 at 4:27 PM revealed Resident #9 walked with assistance of one person. Interview with NA #7 on 03/03/11 at 10:51 AM revealed Resident #9 was able to transfer himself from his wheelchair to the commode by grabbing the bar in the bathroom. She further stated the resident did not need physical assistance to do so. Interview with the MDS coordinator #2 on 03/03/11 at 10:10 AM revealed stated 3/4 length siderails were not considered a restraint in this facility. She further stated on 03/03/11 at 10:20 AM that Resident #9 had a significant change and was transferring with restorative and can transfer with assistance.	F 221		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family interview and staff interviews, the facility failed to implement and/or change interventions to prevent repeated falls for three (3) of thirteen (13) sampled residents. (Residents #5, #10 and #13).	F 323	F323 1. The tab alarm for Resident #10 was applied immediately upon notification on 3/2/2011. Residents # 10, # 13 and #5 were assessed to determine possible causal factors relative to the repeated falls and new preventative interventions were implemented. New interventions added for Resident #10 included a chair pad alarm, lowered closet rod, & alarm on bathroom door. Interventions for Resident #5 were	

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F 323	<p>Continued From page 4</p> <p>The findings are:</p> <p>1. Resident #10 was readmitted to the facility on 03/31/09. Diagnoses included Alzheimer's Disease, history of a fractured femur, and chronic airway obstruction. Review of physician orders revealed Resident #10 was receiving the anticoagulant medication of Coumadin daily.</p> <p>The annual Minimum Data Set (MDS) dated 09/10/10 coded Resident #10 with short term memory impairment, intact long term memory and difficulty with decision making skills in new situations only. She was coded as being independent with bed mobility, transfers and required limited assistance with ambulation. Resident #10 was coded as having falls in the previous 31 - 180 days. On the Fall Risk Assessment dated 9/10/10, Resident #10 scored a "9" with a score of 10 or above indicating a high risk for falls.</p> <p>The Resident Assessment Protocol Summaries (RAPS) relating to falls dated 9/13/10 assessed her with a history of falls due to getting up unassisted, having episodes of confusion and not always calling for assistance. The RAP stated she needed limited assistance with transfers and walking and was receiving physical therapy for gait training. The RAP stated that the resident was at risk for falls due to decreased mobility and poor safety awareness.</p> <p>The care plan which addressed Resident #10 being at risk for falls was developed on 9/15/10. The goal was that "Resident will be monitored and observed to prevent accidents." Interventions included to monitor for safety,</p>	F 323	<p>to place bed in lowest position with a mat and lower siderails while in bed. Interventions for Resident #13 included placing on a scheduled toileting program, continuing alarm while in bed, and continuing self release seat belt while in wheelchair. The Director of Nursing Services and all nursing staff responsible for the care of Residents #10, #5, & #13 were counseled on 3/3/2011 on assuring that each resident receives adequate supervision and assistance devices to prevent accidents, assuring that interventions are implemented to prevent repeated falls, and the location of information concerning resident-specific fall interventions.</p> <p>2. The Fall Committee met on 3/2/2011. A list of all other facility residents who scored at risk for falls was reviewed and risk factors/possible causal factors were identified. Fall prevention interventions were implemented and added to each resident's care plan.</p>	

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F 323	<p>Continued From page 5</p> <p>encourage her to call for assistance, ensure a clutter free environment, and ensure proper foot wear.</p> <p>Nursing notes dated 12/7/10 at 10:00 PM revealed Resident #10 reported to staff at approximately 9:30 PM that she had lowered herself to the floor from the side of her bed, then rang the call light. Review of the Incident Report revealed this was an unwitnessed fall with no apparent injuries. Per the fall report dated 12/8/10, the resident had a urinary tract infection and was reminded to call for assistance. (note: Nursing notes dated 12/6/10 noted the resident was started on an antibiotic for a dental infection). This nursing note, incident report and fall report were reviewed with the Director of Nursing (DON) on 03/03/11 at 11:57 AM. The DON stated that Resident #10 should have had a bed pad alarm at the time of this fall as one had been added prior to this fall (date unknown). The DON stated that the nursing notes and or incident report should have indicated that the alarm was sounding. The DON further stated that she thought the bed pad alarm was on the bed but not functioning. Per the DON, the alarm was replaced after this unwitnessed fall. The DON gave no explanation as to why the care plan, nursing notes, and incident report did not address a bed pad alarm.</p> <p>A quarterly MDS dated 12/10/10 coded Resident #10 with severely impaired cognition and being independent with bed mobility, transfers, requiring limited assistance with ambulation and having a history of falls. She was coded as needing physical assistance to stabilize herself when walking, turning around and moving on and off the toilet. On her 12/10/10 fall assessment she scored a seventeen with a score of 10 or above</p>	F 323	<p>3. The Director of Nursing Services in-serviced all nursing staff on 3/4/2011 and 3/7/2011 on fall prevention. A new fall tracking log was implemented on 3/4/2011 to assist the DON and fall committee members identify trends related to accidents/incidents. All nursing staff were also in-serviced on 3/18/2011 and 3/23/2011 on accident prevention with emphasis on utilizing care guides provided by the care plan team to alert them on preventative interventions that need to be in place. The interdisciplinary team meets weekly to review and discuss accidents/incidents to assure appropriate interventions are in place, effective and/or if revisions are needed.</p> <p>4. Director of Nursing Services or her designee will randomly monitor residents identified as fall risk to assure compliance with fall prevention interventions at least weekly for 3 months. Data will be reviewed and discussed at quarterly QA meetings. Will monitor 20 residents w/ky for 3 months.</p>	<p>TC w/1 Todd Roper 3/24/11 @11:00am</p> <p>3/24/11</p>
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F 323	<p>Continued From page 6</p> <p>being high risk for falls. No changes were made on the care plan interventions. The care plan did not include any type of alarm for Resident #10.</p> <p>Nursing notes dated 01/04/11 at 8:45 AM revealed Resident #10 was found on the floor in the bathroom face down. She stated she had fallen pulling down her pants. She had a small abrasion and knot on her left eye. The incident report indicated the resident had taken herself to the bathroom. The Fall Report dated 01/05/11 stated she was reminded to call for assistance. Interview with the DON on 03/02/11 at 11:57 AM revealed on this date a tab alarm was initiated. No intervention changes were made on the care plan.</p> <p>Nursing notes dated 01/10/11 at 3:00 PM noted Resident #10 fell and landed on her coccyx when she lost her footing when she attempted to put a pair of pants in her closet. The note stated the nurse would speak to restorative regarding a tab (clip on) alarm. A physician's telephone order was written on 01/10/11 at 3:30 PM for a tab alarm at all times. The Incident Report dated 01/10/11 noted she was "sore" and denied "pain." The falls care plan was updated on 01/11/11 to include a tab alarm at all times. Per the Fall Report dated 01/12/11 the resident removed the tab alarm and got up unassisted. Per this report the tab alarm was replaced and she was reminded to use her call bell. During interview on 03/02/11 at 11:57 AM, the DON stated Resident #10 removed the tab alarm resulting in this fall. The DON stated at this time, a physical therapy referral was made and the tab alarm was replaced.</p> <p>Physical therapy was initiated on 01/06/11 due to</p>	F 323		

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F 323	<p>Continued From page 7</p> <p>a history of falls and discontinued on 02/02/11. Resident #10 was discharged to restorative nursing for transfer assistance and ambulation with one person assistance.</p> <p>There were no nursing notes dated between 01/11/11 and 01/25/11. An Incident Report dated 01/22/11 at 12:15 AM revealed Resident #10 was attempting to remake her bed when she slid to the floor. This report indicated there was no equipment involved (i.e. alarm) and the Fall Report dated 01/23/11 stated she was reminded to call for assistance. During interview on 03/02/11 at 11:57 AM, the DON stated she assumed Resident #10 removed the tab alarm and got up by herself. The DON stated the intervention was to continue to use the tab alarm at all times.</p> <p>Resident #10 was observed on 03/02/11 at 10:56 being assisted out of the bathroom by Nurse Aide (NA) #1. The resident was left in her room in her wheelchair without a tabs alarm. The tab alarm was laying on the bedside table. On 03/02/11 at 11:55 AM, Resident #10 was sitting in her wheelchair in her room, behind the curtain eating a snack. No alarm was attached to her and the tab alarm remained laying on the bedside table. On 03/02/11 at 11:51 AM, Resident #10 was sitting in the doorway of the hall in her wheelchair as NA #1 walked by her. At 11:52 AM, NA #2 started to wheel her up the hall when NA #3 told NA #2 Resident #10 was going to eat in her room. NA #2 took her back to her room and did not connect the tab alarm. At 11:53 AM, NA #3 served Resident #10 her noon meal. She did not apply the tab alarm.</p> <p>Interview with NA #3 on 03/02/11 at 11:55 AM</p>	F 323		

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F 323	<p>Continued From page 8</p> <p>revealed that she was unsure about Resident #10 needing an alarm and would find out. She looked in the ADL book and returned stating the tab alarm was to be attached at all times. Review of the ADL book revealed lists of individual needs and included Resident #10 as needing a tab alarm at all times.</p> <p>Interview on 03/02/11 at 11:53 AM with NA #4, revealed she was responsible for Resident #10. NA #4 stated Resident #10 was supposed to have the tab alarm in bed. She later returned and stated that Resident #10 was to have the alarm on at all times.</p> <p>Interview on 03/02/11 at 12:01 PM with NA #1 revealed she floats on different halls and "heard" that Resident #10 used to have an alarm on when in the wheelchair but it was discontinued.</p> <p>2. Resident #5 was readmitted to the facility from the hospital after experiencing shortness of breath on 11/12/10 with diagnoses including Alzheimer's dementia, mild Parkinson's disease, macular degeneration, weakness, osteoporosis, osteoarthritis, and anxiety.</p> <p>The quarterly Minimum Data Set (MDS) dated 10/15/10 coded Resident #5 with long and short term memory impairment and moderately impaired decision making difficulty. The resident required extensive assistance with bed mobility, transfers, was nonambulatory and had a history of falls. Bed rails were coded as used daily. The Fall Risk assessment dated 10/15/10 scored Resident #5 as an eighteen (18) with a score of ten (10) or above placing Resident #5 at high risk for falls.</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>Nursing notes dated 12/27/10 at 3:40 AM stated that at 3:15 AM, after a nurse aide had heard the resident talking, had gone in to find Resident #5 sitting on the floor at the foot of her bed with her bed rail up. Resident #10 was noted as very confused and talking about a fire in the house. Review of the Incident Report dated 12/27/10 revealed the resident was reminded to call for assist. The Fall Report dated 12/27/10 again stated the intervention was to remind the resident to call for assistance. A urinalysis was also ordered by the physician assistant on 12/27/10 with results being negative for any urinary infection. The licensed nurse (LN) #3, who signed the note of 12/27/10 at 3:40 AM, was interviewed by phone on 03/02/11 at 1:10 PM. LN #3 stated that she did not recall the incident on 12/27/10 during the night shift.</p> <p>Nursing notes dated 12/27/10 at 9:30 PM revealed Resident #5 was confused this shift and as a nurse aide was walking down the hall the nurse aide found the resident lying in the floor on her back at the foot of the bed. Review of the Incident Report dated 12/27/10 revealed the resident had been in bed with the siderails up and was found at the foot of the bed. The Fall Report dated 12/28/10 revealed the intervention of a tab alarm while in bed was initiated. Interview with the licensed nurse (LN) #2 who wrote the nursing note on 12/27/10 at 9:30 PM revealed during interview on 03/01/11 at 3:07 PM that Resident #10 was at the foot of the bed on the floor when she was found. The one side rail was up and the other side of the bed was against the wall. The LN #2 stated that whenever Resident #5 was in bed the right 3/4 length siderail was up and the left side of the bed was against the wall. LN #2 stated there was not and there has not been an</p>	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345516	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/03/2011
NAME OF PROVIDER OR SUPPLIER CONOVER NURSING AND REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH STREET SOUTH WEST CONOVER, NC 28613	
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F 323	<p>Continued From page 10</p> <p>alarm on the bed for Resident #5. She further stated that the Director of Nursing (DON) reviews all incident reports to determine fall risks and any further interventions to be used.</p> <p>The DON was interviewed on 03/03/11 at 11:35 AM regarding the incidents of 12/27/10. The DON stated that the intervention to place a tab alarm on Resident #5 after these falls was not ever done as the DON attributed the falls to the resident having a urinary tract infection.</p> <p>The annual MDS dated 01/13/11 coded Resident #5 with long and short term memory impairment, having moderately impaired decision making skills, having inattention, and disorganized thoughts. The resident exhibited wandering behaviors, nonambulatory, needed extensive assistance with bed mobility, transfers and was not steady when moving from surface to surface, and moving from a seated to standing position. Bed rails were coded as being used daily. The Fall Risk Assessment dated 01/13/11 scored the resident as a sixteen (16) indicating her being at high risk for falling. The Fall Care Area Assessment (CAA) dated 01/24/11 described Resident #5 as having fallen while attempting to get up unassisted. The resident was noted to need one to two person extensive assist while transferring. The CAA further stated the resident was at risk for fall due to inability to transfer self and she tries to get up unassisted.</p> <p>The current care plan dated 01/14/11 addressed the resident's risk for falls with a goal that the resident would be monitored and observed to prevent accidents. Interventions included keeping the call light in reach, provide assistance with all transfers, monitor for safety, remind resident to</p>	F 323		

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F 323	<p>Continued From page 11</p> <p>call when needing assistance, and self release Velcro belt in wheelchair.</p> <p>Nursing notes dated 02/07/11 at 2:45 AM stated that the resident was "climbing out of bed" and was gotten up and placed in her wheelchair so she would not fall. It was also noted that she was receiving an antibiotic for a urinary infection. The licensed nurse (LN) #3, who signed the note of 02/07/11 at 2:45 AM, was interviewed by phone on 03/02/11 at 1:10 PM. LN #3 stated that Resident #5 would not calm down the night of 02/07/11 and she was found at the end of the bed with one leg over the siderail. LN #3 stated that the 3/4 length siderail was always upright on the one side when Resident #5 was in bed with the other side of the bed up against the wall. The DON was interviewed on 03/03/11 at 11:35 AM regarding this incident. She stated she was unaware that Resident #5 had one leg over the siderail.</p> <p>A family member was interviewed on 03/01/11 at 11:02 AM. This family stated that the 3/4 siderail was always up when Resident #5 was in bed with the other side of the bed against the wall. She stated this was necessary because the resident would try to climb out of bed. She recalled around Christmas, Resident #5 crawled out of the end of the bed twice. Family further stated that due to the resident's dementia, Resident #5 could not remember to call for assistance.</p> <p>Interview with NA #6 on 03/01/11 at 11:50 AM revealed when Resident #5 is in bed, one siderails up on the open side of the bed and the bed is pushed against the wall. NA #6 stated she was not aware of any alarms being used in bed for Resident #5</p>	F 323			

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F 323	Continued From page 12 Resident #5 was observed on 03/01/11 at 2:31 PM in bed with a 3/4 length side rail in the upright position on the right side of the bed and the left side of the bed was against the wall. At this time, NA #6 stated she had assisted Resident #5 to bed and no alarm was used for this resident. Interview with Nurse Aide (NA) #5 on 03/01/11 at 3:45 PM revealed she could not recall any tab alarms utilized in bed. Interview with NA #7 on 03/02/11 revealed when Resident #5 is in bed the siderail is always up with the other side of the bed pushed against the wall. She further stated that she has worked with this resident for almost nine months and has never seen an alarm utilized on Resident #5 when she was in bed. 3. Resident #13 was admitted to the facility on 11/23/10 after a left hip fracture. Review of the incident and accident reports during this admission revealed the resident had a fall on 01/15/11. The resident had a TAB alarm in place which he took off and ambulated about the room resulting in a fall. The resident was discharged on 01/19/11 to an assisted living facility. Resident #13 was readmitted to the facility on 01/29/11 with the diagnoses status post right hip fracture (01/25/11), hypertension, depression, and Alzheimer's disease. A Falls Risk Assessment dated 01/29/11 coded Resident #13 with a score of twenty-two (seven or more equals high risk). Minimum Data Set (MDS) dated 02/04/11, assessed the resident as being cognitively intact and needing extensive assistance of two persons with transferring and	F 323		

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F 323	<p>Continued From page 13</p> <p>activities of daily living. The MDS further coded this resident's mobility device as a wheelchair. The resident's Care Area Assessment (CAA) related to the MDS triggered the areas of fall risk and extensive assistance needed with activities of daily living.</p> <p>Review of the incident reports for Resident #13 revealed he had several falls after his admission on 01/29/11. Review of the incident report dated 01/29/11 revealed that the resident was transferring himself unassisted and fell. The resident was reminded to use the call light and to ask for help. Interventions documented on the incident report dated 01/29/11 revealed following this fall a TAB alarm was put into place for use while resident is in bed or in his recliner.</p> <p>Review of the incident reports reveal the resident again had a fall on 01/30/11 at this time the TAB alarm alerted staff to resident's fall. The resident was found in an unoccupied room on the floor. The resident did not sustain an injury during this fall. The TAB alarm was replaced.</p> <p>Review of physician's orders dated 01/31/11 revealed a TAB alarm while in bed and a self release alarming seat belt for the resident's wheel chair was ordered.</p> <p>Review of the incident reports reveal another fall on 02/17/11. The resident had removed his TAB alarm and got up unassisted, walked across room and fell. The resident sustained a skin tear to his left forearm and bumped his head. The resident received first aid for the skin tear. The TAB alarm was replaced. No new interventions were put into place at that time.</p>	F 323		

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F 323	<p>Continued From page 14</p> <p>A review of nurse's notes dated 02/23/11 and 02/25/11 revealed the resident was confused at times and was continuously taking off the TAB alarm and self alarming seat belt.</p> <p>An interview was conducted on 03/02/11 at 12:05 PM with LN #1 who also reported that Resident #13 frequently takes off his TAB alarm and self alarming seat belt. When asked what further interventions were in place for this resident she stated they try to check on him every 30 minutes.</p> <p>An interview was conducted on 03/02/11 at 12:10 PM with NA #5. She reported that Resident #13 frequently takes of his TAB alarm.</p>	F 323		