STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	10/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00241246. Complaint IN00241246 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F323. Survey dates: October 2 and 3, 2017 Facility number: 000271 Provider number: 155402 AIM number: 100291260 Census bed type: SNF/NF: 80 Total: 80 Census payor type: Medicare: 7 Medicaid: 65 Other: 8 Total: 80 These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on October 10, 2017.	F 0000		

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

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F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is			

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	available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on interview and record review, the facility failed to notify a resident's physician and/or legal representative regarding a change in condition or an accident in a timely manner for 1 of 4 resident's reviewed for accidents (Resident B). Finding includes: The record for Resident B was reviewed on 10/02/17 at 1:55 p.m. Diagnoses included, but were not limited to, Parkinson's disease, chronic pain, restless leg syndrome, flaccid hemiplegia affecting the right dominant side and a history of subdural hematomas. A Quarterly MDS(Minimum Data Set)	F 0157	1. Resident B no longer resides at facility. 2. Other residents have the potential to be affected therefore an in house audit will be conducted of residents with falls for the past 30 days by the DON/Designee by 11.2.17 to assure the MD and responsible party have been notified. Any concerns will be addressed. 3. The DON/Designee will educate licensed nursing staff on the policy and expectations of notification of the doctor and the responsible party in a timely manner by November 2nd, 2017. 4. The DON/Designee will audit the clinical record of residents who have had a fall ongoing to assure compliance of MD and responsible party notification. The results will be present to PI X 6 months. PI will determine the	11/02/2017

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	assessment dated 07/25/17, indicated Resident B was an extensive assist with 2 staff members for transfers and for toileting and was total dependence with 2 staff members for bathing. The MDS also indicated the resident had not had any falls since admission/entry or reentry or prior assessment. A nursing note dated 12/06/16 at 7:13 p.m., indicated "...Resident in shower room with staff and had whirl pool bath. At approx. while seated in chair and pull out of bath, aide assisted resident in drying and dressing. CNA reached out to get another towel and resident then fell forward and to her right then hit head on floor. CNA utilized call light for assistance. An additional aide assisted and came and got nurse. At approx. 11:45am V/S [vital signs] completed...noted to have purple hematoma to right scalp (6cm x 5 cm) [centimeter]...writer called MD [medical doctor] at approx. 12:15pm to notify of accident, orders to send to ER [emergency room]...At approx. 12:45pm writer called POA [power of attorney] (son) and left message on voicemail...picked up by ambulance at approx. 1:30pm...." The nursing notes indicated the POA was notified at least an hour after the resident		need for further audits. 5. Date of compliance 11.2.17.	

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	fell and hit her head. A nursing note dated 12/29/16 at 12:56 a.m., indicated "...Lg [large] bruise to left eye purple, with no c/o [complaint of] pain or discomfort. Bruise r/t [related to] recent fall out of bed...." No nursing note was located to indicate when and how the resident fell and the MD and POA were notified. A nursing note dated 01/22/17 at 2:56 p.m., indicated "...resident continues on fall follow-up with neuro checks...." A nursing note dated 01/22/17 at 7:57 p.m., indicated "...son notified of event...." Addendum dated 01/22/17 at 8:04 p.m., indicated "...discussed with son possible interventions...we will further discuss with DON...he requests that we return call to him on Monday after further interventions discussed...." A nursing note dated 01/23/17 at 12:18 p.m., indicated "...IDT review of incident where resident was found facing on her knees on the floor mat leaning against SR [side rail]. Upon review resident voiced that she turned et [and] rolled out of bed...." A nursing note dated 01/25/17 at 12:18			

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	a.m., indicated "...01/22/2017 11-7 shift 12 midnight, found resident sitting on her knees on the mat next to the low bed...able to state that she repositioned herself and rolled out of bed, wedge was next to her thigh under the bed...." No nursing note was located to indicate the MD and POA were notified at the time of the fall. A nursing note dated 03/11/17 at 3:43 p.m., indicated "...Delayed entry for 4pm 3-10-17. Called to resident room. CNAs x2 stated they sat resident up on side of bed and were putting her shoes on. Resident with poor trunk control and leaned over to right side and hit right cheek on footboard. Resident noted to have red area to right cheek bone...report given to nurse to complete assessments and notification...." No nursing note was located to indicate the MD and POA were notified of the fall. A nursing note dated 07/21/17 at 9:00 a.m., indicated "...Res in bathroom with CNA sitting on toilet, et res slid while sitting on toilet and hit her head on wall...." A nursing note dated 07/21/17 at 11:00			

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	a.m., indicated "...Res son advised of res hitting her head in bathroom on wall...." The nursing notes indicated the POA was notified two hours after the resident fell and hit her head. A social service note dated 07/22/17 at 4:07 p.m., indicated "...Contacted son to inform him of his mother's fall per request of the nurse...I told him that she could be loosing her balance and informed him that we are not able to seat belt them in the chair I told him it could be a progression of her disease she has Parkinson's and this causes an imbalance...I told him that I would go to the hospital to see her...." A social service note dated 07/22/17 at 4:12 p.m., indicated "...Went to hospital to see [name of resident]...was aware that she was in the hospital and that she missed Bingo at 2:00...." A nursing note dated 07/22/17 at 4:28 p.m., indicated "...late entry for 7-3. writer called into room upon entering pt noted on floor in doorway laying on side. blood noted to right side of forehead...911 called...." No documentation was noted to indicated the time of the fall on 07/22/17 and			

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	length of time before POA was notified of the fall. During an interview on 10/03/17 at 10:57 a.m., Resident B's son indicated his mother had received several subdural hematoma's during her falls at the facility and she was supposed to have 2 staff members with her at all times when providing care such as showers, transfers and toileting. He indicated he did not get a clear explanation of how her falls occurred and did not get notified timely after the falls. During an interview on 10/03/17 at 10:15 a.m., Medical Records indicated she was unable to find any additional charting or nursing notes for the resident. During an interview on 10/03/17 at 12:45 p.m., the DON indicated the details of the falls should have been documented in the resident's nursing notes and the time the family and MD were notified. A current facility policy titled "Change in a Resident's Condition" dated 03/10, received from the Executive Director on 10/03/17 at 10:57 a.m., indicated "...1. All changes in the resident's condition will be recorded in the resident's medical record. Such changes or conditions include, but are not limited to: Any			

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	accident/incident involving the resident. Any change in the resident's mental, physical, or emotional status. 2. The attending physician will be notified of any incident, accident, or change in the resident's medical condition. 3. The resident's next of kin or representative will be notified of all changes in the resident's condition or status. 4. Nursing will be responsible for notifying the resident and/or his/her legal representative of all changes in the resident's condition or status...." A current facility policy titled "Falls Management" undated, received from the DON on 10/03/17 at 12:25 p.m., indicated "...2. Management of Falls: ... f. The responsible party and physician are promptly notified of the occurrence and status of the resident...k. Pertinent information regarding the fall will be recorded in the nurses' notes and on the 24-hour shift report...." This Federal tag relates to Complaint IN00241246. 3.1-5(a)(1)			
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES			

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	(d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on interview and record review, the facility failed to complete post fall assessments, implement new post fall interventions and failed to complete post fall interventions and assessments in a timely manner for residents with a history of falls for 3 of 4 residents reviewed for accidents (Resident C, B and E).	F 0323	1. Resident B no longer resides at facility. Resident C and E have had their clinical record reviewed and an updated fall assessment ha been completed, new post fall interventions add, and their care plan and care guides updated to reflect this. 2. Other residents have the potential to be affected therefore residents with falls for the	11/02/2017

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	Findings include: 1. The record for Resident C was reviewed on 10/02/17 at 10:05 a.m. Diagnoses included, but were not limited to, traumatic subdural hemorrhage without loss of consciousness, muscle weakness, abnormal brain scan and difficulty in walking. An annual Minimum Data Set (MDS) assessment dated 08/15/17, was marked as Resident C had not had any falls since admission/entry or reentry or prior assessment. A nursing note dated 07/09/17 at 4:35 a.m., indicated "...LE [late entry] 07/08/17 10:00am: At approx. [approximately] 8:30am writer notified of resident having to have slid from Broda chair. When entered room, Resident seated on foot rest of Broda chair with chair tilted forward...." No neurological checks were located for the unwitnessed fall. A nursing note dated 07/24/2017 at 4:42 p.m., indicated "...IDT [Interdisciplinary team] Review of incident where res [resident] was found on bedside mat. Res was in bed prior to fall...."		previous 30 days have been audited by the DON/Designee for completed post fall assessments, implementation of post fall interventions, 72 hour post fall follow up documentation, and care plan and care guides updated to reflect this by 11.2.17. Any concerns noted will be addressed. 3. Education will be completed with licensed nurses by the DON/Designee by 11.2.17. This education will include the fall policy including notification of fall to MD and family in a timely manner, completing all post fall assessments timely and accurately, completing 72 hour follow post fall documentation, implementation of a new fall intervention and the care plan and care guide updated with the new intervention. The Rehab Director will educate his therapists by 11.2.17 on if recommending a specific transfer technique this will be communicated with the nursing staff and an order written so nursing is aware of the new recommendations and they can educate their staff and update care plan and care guide. 4. DON/Designee will review clinical record of residents with falls X 3 days to ensure MD/Family notification has occurred, post fall assessments are completed timely and accurately, 72 hour charting post fall is completed and care plan	

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	A nursing note dated 07/25/2017 at 12:53 a.m., indicated "...late charting for 7/22/17: pt [patient] found on floor sitting on mat next to bed...." No neurological checks were located for the unwitnessed fall. A nursing note dated 08/11/17 at 12:21 p.m., indicated "...Res found on the floor...outside her room. CNA was in res room placing mechanical lift for res transfer. Res slid out of chair and was noted sitting on chair pedal. Res soiled of urine...." A review of the neurological checks dated 08/11/17, indicated the following: a. The size and reaction to the right and left pupil sections were not completed on 08/11/17 at 11:10 a.m., 11:25 a.m., 11:40 a.m., 12:10 p.m., 12:40 p.m., 1:10 p.m. and 2:10 p.m., on 08/12/17 at 4:00 a.m., 8:00 a.m., 2:00 p.m. and 8:00 p.m., on 08/13/17 for all three shifts and on 08/14/17 for the 11:00 p.m. to 7:00 a.m. shift. b. Movement of the extremities and vital signs were not completed on 08/12/17 at 4:00 a.m. A nursing note dated 08/26/2017 at 2:00 p.m., indicated "...Res returned from [name of hospital] at around 1 pm...Res		and care guides are updated with new intervention and any therapy recommendation for transfers is included ongoing, Results will be presented to PI X 6 months. PI will determine the need for ongoing audits. 5. Date of Compliance November 2nd, 2017.	

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	has an order to push fluids d/t [due to] dehydration...Res remains on fall f/u [follow-up] with neuros [neurological checks] x 3 days...." No nursing note was located to indicate where, when and how the resident fell. A review of the neurological checks dated 08/26/17, indicated the level of consciousness section was not completed for any of the days and times. A nursing note dated 09/03/2017 at 11:30 p.m., indicated "...Resident assessed after found on floor off mat...." A review of the neurological checks dated 09/03/17, indicated an assessment in all the neurological areas were not completed on 09/04/17 at 2:45 p.m. or during the 3:00 p.m. to 11:00 p.m. shift and on 09/06/17 for the 3:00 p.m. to 11:00 p.m. shift. A nursing note dated 09/11/2017 at 7:45 p.m., indicated "...Res was seen by nurse at nurses station standing up and falling out of chair. Res had hit her head on the dresser knob on the way down to the floor. Res was complaining of head and R [right] knee pain...order to send res to hospital...."			

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	A review of the neurological checks dated 09/11/17, indicated the vital section was not completed on 09/13/17 at 4:30 p.m. A nursing note dated 09/30/2017 at 2:56 a.m., indicated "...brought to nurses station for cont [continuous] observation...when she suddenly attempted to stand upon [sic] own and staff unable to reach res before she fell to floor onto buttock. Did not hit head...." A care plan for Resident C addressed the problems she was at risk for a fall related injury due to previous fall with an onset date of 08/17/2016, alteration in mobility and safety due to a history of falls, poor safety awareness, poor cognition and weakness with an onset date of 03/15/17 and the resident intentionally crawls out of bed with an onset date of 09/21/17. Interventions included, but were not limited to, "...07/10/17- Not to leave res in Broda Chair in room unattended, anticipate needs and toilet Q2H [every 2 hours] and PRN [as needed]...09/28/17- Medication review...09/30/17-Psych services referral...." No other interventions were dated for the time period of the falls listed above. During an interview on 10/03/17 and			

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	12:34 p.m., the Director of Nursing (DON) indicated if a fall was unwitnessed neurological checks should have been initiated and completed in all areas and the details of the fall should have been documented in the resident's nursing notes and care plans updated with the new interventions. During an interview on 10/03/17 at 2:45 p.m., Physical Therapy Assistant 1 indicated if a resident was positioned correctly in a Broda chair they typically should not be able to slide out. During an interview on 10/03/17 at 4:20 p.m., the DON indicated she could not locate neurological checks for the unwitnessed falls which occurred on 07/09/17 and 07/22/17. 2. The record for Resident B was reviewed on 10/02/17 at 1:55 p.m. Diagnoses included, but were not limited to, Parkinson's disease, chronic pain, restless leg syndrome, flaccid hemiplegia affecting the right dominant side and a history of subdural hematomas. A Quarterly MDS assessment dated 07/25/17, indicated Resident B was an extensive assist with 2 staff members for transfers and for toileting and was total dependence with 2 staff members for			

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	bathing. The MDS also indicated the resident had not had any falls since admission/entry or reentry or prior assessment. A nursing note dated 12/06/16 at 7:13 p.m., indicated "...Resident in shower room with staff and had whirl pool bath. At approx. while seated in chair and pull out of bath, aide assisted resident in drying and dressing. CNA reached out to get another towel and resident then fell forward and to her right then hit head on floor. CNA utilized call light for assistance. An additional aide assisted and came and got nurse. At approx. 11:45am V/S [vital signs] completed...noted to have purple hematoma to right scalp (6cm x 5 cm) [centimeter]...writer called MD [medical doctor] at approx. 12:15pm to notify of accident, orders to send to ER [emergency room]...At approx. 12:45pm writer called POA [power of attorney] (son) and left message on voicemail...picked up by ambulance at approx. 1:30pm...." A review of the neurological checks dated 12/06/16, indicated how the resident eyes opened, verbal response, motor response and level of consciousness were not completed on 12/08/16 at 8:45 p.m.			

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A nursing note dated 12/29/16 at 12:56 a.m., indicated "...Lg [large] bruise to left eye purple, with no c/o [complaint of] pain or discomfort. Bruise r/t [related to] recent fall out of bed...."

No nursing note was located to indicate when and how the resident fell and the MD and POA were notified.

A review of the neurological checks dated 12/26/16, indicated an assessment in all the neurological areas were not completed on 12/28/16 at 6:15 a.m.

A nursing note dated 01/12/17 at 8:53 p.m., indicated "...resident found beside bed laying on side...stated rolled out of bed over bolster placed back in bed bolster reapplied and secured better with Velcro...upon further questioning with yes no questions resident informed writer that she attempted to put herself to bed...."

A Physician note dated 01/18/17 at 1:45 p.m., indicated "...She is under fall precautions. Her last fall did result in bruising of her right cheek below her eye which is currently resolving...In the past she has fallen due to needing to be toileted. Will review with nursing if she is being scheduled for toileting. She is

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	receiving restorative therapy again at this time..." A nursing note dated 01/22/17 at 2:56 p.m., indicated "...resident continues on fall follow-up with neuro checks...." A nursing note dated 01/22/17 at 7:57 p.m., indicated "...son notified of event...." Addendum dated 01/22/17 at 8:04 p.m., indicated "...discussed with son possible interventions...we will further discuss with DON...he requests that we return call to him on Monday after further interventions discussed...." A nursing note dated 01/23/17 at 12:18 p.m., indicated "...IDT review of incident where resident was found facing on her knees on the floor mat leaning against SR [side rail]. Upon review resident voiced that she turned et [and] rolled out of bed...." A nursing note dated 01/25/17 at 12:18 a.m., indicated "...01/22/2017 11-7 shift 12 midnight, found resident sitting on her knees on the mat next to the low bed...able to state that she repositioned herself and rolled out of bed, wedge was next to her thigh under the bed...." No nursing note was located to indicate the MD and POA were notified at the			

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	time of the fall. A review of the neurological checks dated 01/22/17, indicated an assessment in all the neurological areas were not completed on 01/23/17 at 7:45 a.m. and size and reaction of the left pupil was not completed for any of the days or times. A "Rehabilitation Services Multidisciplinary Screening Tool" dated 02/21/17, indicated "...CNA's to follow care guide to complete transfer wc [wheelchair] to bed, wheelchair to toilet etc. [etcetera] 2 person using pivot disc...." Training was provided to the CNAs on 02/22/17 and 02/24/17 to always use 2 people, use pivot disk and to follow care guide by the therapy department. A nursing note dated 03/11/17 at 3:43 p.m., indicated "...Delayed entry for 4pm 3-10-17. Called to resident room. CNAs x2 stated they sat resident up on side of bed and were putting her shoes on. Resident with poor trunk control and leaned over to right side and hit right cheek on footboard. Resident noted to have red area to right cheek bone...report given to nurse to complete assessments and notification...."			

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	No nursing note was located to indicate the MD and POA were notified of the fall. A "Restorative Administration Record" dated 01/18/17, indicated the resident was on a restorative toileting program and to toilet upon rising, after meals, at bedtime and as needed. The time coding for the documention was for the 7-3 shift and 3-11 shift. The record for January, February, March and April indicated the following: a. January was only documented as completed on the 22nd and the 23rd during the 7-3 shift and was not documented as completed for any of the dates on the 3-11 shift. b. February was not documented as completed on the 7-3 shift for the 4th, 11th, 14th, 18th, 21st, 24th, 25th, 26th, 27th and the 28th. The 3-11 shift was not documented as completed for any of the dates. c. March was not documented as completed on the 7-3 shift for the 5th, 11th, 12th, 18th, 19th, 25th, 26th, 27th and the 30th. The 3-11 shift was not documented as completed for any of the dates. d. April was only documented as completed on the 1st through the 10th during the 7-3 shift and was not documented as completed for any of the			

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	dates on the 3-11 shift. A nursing note dated 07/21/17 at 9:00 a.m., indicated "...Res in bathroom with CNA sitting on toilet, et res slid while sitting on toilet and hit her head on wall...." A nursing note dated 07/21/17 at 11:00 a.m., indicated "...Res son advised of res hitting her head in bathroom on wall...." A social service note dated 07/22/17 at 4:07 p.m., indicated "...Contacted son to inform him of his mother's fall per request of the nurse...I told him that she could be loosing her balance and informed him that we are not able to seat belt them in the chair I told him it could be a progression of her disease she has Parkinson's and this causes an imbalance...I told him that I would go to the hospital to see her...." A social service note dated 07/22/17 at 4:12 p.m., indicated "...Went to hospital to see [name of resident]...was aware that she was in the hospital and that she missed Bingo at 2:00...." A nursing note dated 07/22/17 at 4:28 p.m., indicated "...late entry for 7-3. writer called into room upon entering pt noted on floor in doorway laying on side.			

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	blood noted to right side of forehead...911 called...." No documentation was noted to indicated the time of the fall on 07/22/17 and length of time before POA was notified of the fall. A "Physical Therapy Plan of Treatment" with on onset date of 07/26/17, indicated "...Patient presents with severe weakness in BLE [bilateral lower extremities], stiffness in B [bilateral] knee flexors, difficulty in transfer even with 2 person, poor safety awareness influencing ability to perform all ADL [activities of daily living] and mobility per prior level of function and would benefit from skilled Physical Therapy. Pt had multiple fall last week due to poor safety. Pt also require more and more help to do transfer...Current level of Function: The patient is able to perform all functional transfers requiring maximum assistance x 2 (76-99% assist with 2 people) with pivot disc with unsafe manner and high risk of fall...Education-Caregiver: The caregiver be trained in in[sic] execution of stand lift for transfer...." A "Physical Therapy Plan of Treatment" (end of billing) Progress Report 08/25/17, indicated "...Transfer: General- The patient is able to perform all functional			

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	transfer requiring total assistance (100% assist) using stand lift...Caregiver Education: Caregiver educated in precautions during transfer using pivot disc with 2 person or using standing lift and is able to recount information with 70% accuracy...Discharge Summary: Pt reached max rehab potential at this time and able to do transfer safely using pivot disc or standing lift without any difficulty. There was not a Physician's order for August or September to indicate how the resident was to be transferred. A Physician's note dated 08/25/17 at 12:38 p.m., indicated "...Her last fall resulted in her being sent out for acute care due to developing a laceration. She was again attempting to provide self care...." A nursing note dated 09/13/17 at 7:30 p.m., indicated "...This writer was called to resident shower room by CNA d/t resident falling on floor. CNA et nurse from another hall were in shower room preparing to transfer resident into shower chair. Resident's wheel chair had not been touched yet, CNA moved wheelchair so LPN could help transfer resident et before they could touch her she twitched her whole body forward on			

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	face. Rt [right] front of face hit the floor et lacerated 3 cm in Z shape. Area cleansed et light pressure applied...7:35 p.m. Dr. notified et gave order to send to ER...7:38 p.m. son called two times...voicemail left...." A care plan for Resident B addressed the problems she was at risk for a fall related injury due to a previous fall with an onset date of 08/14/16, an alteration in mobility and safety due to history of falls, poor safety awareness, poor cognition and weakness with an onset date of 08/14/16 and was at risk for falls related to unsteady ambulation, CVA, history of falls, use of a walker, some bowel and bladder incontinence, diagnosis of anxiety, muscle weakness and a history of nightmares with on on set date of 05/14/15. Interventions included, but were not limited to, "...02/27/17- X 2 assist with transfers per pivot disc... 07/24/17- contact guard on toilet. Staff to assist res in sitting position on toilet and keep contact whilst on toilet... 07/26/17 front and back anti tippers to WC...." No other interventions were dated for the time period of the falls listed above. During an interview on 10/03/17 at 10:57 a.m., Resident B's son indicated his mother had received several subdural			

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	hematoma's during her falls at the facility and she was supposed to have 2 staff members with her at all times when providing care such as showers, transfers and toileting. He indicated he did not get a clear explanation of how her falls occurred and did not get notified timely after the falls. During an interview on 10/03/17 at 10:15 a.m., Medical Records indicated she was unable to find any additional charting or nursing notes for the resident. During an interview on 10/03/17 at 12:45 p.m., the DON indicated if there was an order for Restorative Toileting and charting in place then it should have been documented and initialed to show it was completed, neurological assessments should have been completed in all areas, the details of the fall should have been documented in the resident's nursing notes and care plans updated with the new interventions. During an interview on 10/03/17 at 3:52 p.m., the DON indicated after therapy did their evaluation the therapist would write an order. She was an extensive assist with a pivot disc before she went to the hospital, she was evaluated when she returned and a new order was not written.			

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	During an interview on 10/03/17 at 4:04 p.m., the Rehabilitation Director indicated the therapist's discharge summary indicated the resident required total assist using a stand lift or could have continued with the pivot disc. He indicated transfer orders should not be written for both since CNA's can not do assessments and would not have been able to determine which order the resident was capable of performing at the time of transfer. If an order was wrote for two different transfer types then it would have had to been carefully care planned and very specific so the CNA's knew when to use which type of transfer. He indicated "The pivot disc is tricky for those that don't know how to use it." During an interview on 10/03/17 at 4:17 p.m., the Rehabilitation Director indicated the therapist had evaluated the resident to determine if she should have transferred using the pivot disc or the stand lift and after reading the discharge summary it could have indicated "either or" for the type of transfer and was "bad verbiage, bad choice." During an interview on 10/03/17 at 4:47 p.m., the Rehabilitation Director indicated the therapist had thought the residents previous transfer order remained in place after returning from the			

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	hospital and "there should have been an order, you don't know what to do with her without an order."			