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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435078	A. BUILDING _____ B. WING _____	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE EUREKA, SD 57437

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 8/29/22 through 9/1/22. Avera Eureka Health Care Center was found not in compliance with the following requirement: F689.	F 000		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to implement a system of fall risk assessments and individualized interventions for: *One of three sampled residents (2) with a history of falls. *Three of three sampled residents (21, 26, and 38) with a history of falls and use of position change alarms. Findings include: 1. Observation and interview on 8/30/22 at 4:42 p.m. with resident 2 while she sat in her lounge chair in her room revealed: *A large bruise on the left side of her face. *She was not able to explain what happened and did not remember falling.	F 689	Mobility alarms for residents 2, 26 and 38 have been removed as of 9/23/22 and frequent hourly checks for safety have been implemented. Preliminary education was completed by Director of Nursing through 1:1 verbal discussion with nursing staff and via written education on 9/20/22 regarding the reduction of mobility alarms and implementation of hourly rounding; education also included information on the appropriate consent process for mobility alarms with required order, documentation and ongoing reassessment/evaluation for mobility alarms. Formal training for all RN's, LPN's and CNA's will occur through mandatory meetings on 9/28/22 and 9/29/22 to educate on the process and benefit of hourly rounding as a strategy to reduce falls, anticipate resident needs and improve resident outcomes. Education includes addressing the 5 P's (pain, potty, possessions, pump (IV pump if applicable), and position) The formal education will reinforce the shift to phase out mobility alarms at this facility and to use mobility alarms only when needed to identify fall risk patterns and then to discontinue the fall alarms. Facility will use silent floor mat alarms for identification of fall risk patterns whenever possible to promote a quiet, home-like environment and minimize disruptions to residents. Occupational Therapy has been notified and consulted to perform positioning assessments as needed. continued.....	9/29/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carmen Weber
TITLE: Administrator
(X6) DATE: 9/23/22

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 689	Continued From page 1 Observation and interview on 9/1/22 at 1:23 p.m. resident 2's revealed answers after the surveyor asked about: *What help she needed from staff, she said, "Maybe sometimes I need help." *How she got staff attention when she needed help, she reported she did not know. *The call light button clipped to her bed within reach from the lounge chair she was sitting on, she said, "That's the call light." *Using the call light in the bathroom if she was on the toilet, she replied, "I don't think there is a call light in the bathroom." *How she would get staff attention to help her get off the toilet, she would "turn on the light" and pointed to the call light clipped to her bed. Interview on 9/1/22 at 1:37 p.m. with licensed practical nurse (LPN) F regarding resident 2's fall risks revealed: *She is "fairly independent." *The staff "remind her to use the call light." *They "keep her walker in reach." *She needs "visual checks," which meant opening the door since she "likes her door partly closed." *"Once per hour" was a "good frequency" for visual checks. *"Before her fall, she was very trustworthy with using the call light, now she needs more frequent reminders." Interview on 9/1/22 at 1:44 p.m. with certified nursing assistant (CNA) L regarding resident 2's fall risks revealed: *She "walks too fast or gets up too fast." "She "wants to be independent" but CNA L goes into her room "more to provide supervision." "After asking about resident 2's use of the call	F 689	Director of Nursing or other delegated nurse will complete weekly audits of 100% of falls for 3 months to monitor that appropriate fall prevention interventions were in place and to ensure that the care team has huddled to imlement any new and appropriate fall prevention interventions (including adequate hourly rounding.) After 3 monhts of weekly auditing 100% of all falls, audit will shift to 3 months of weekly auditing 50% of all falls for a total of six months of auditing to aid in establishing appropriate hourly rounding, appropriate fall prevention interventions, and a process for assessing each resident's individual needs to prevent falls with reduction of mobility alarms to promote a home-like environment. Director of Nursing.will report findings of audits to the Quality Assurance Performance Improvement Committee quarterly for 6 months.	

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F 689	Continued From page 2 light, CNA L responded, "I haven't seen her use the call light." Comparative review of the 3/31/22 admission Minimum Data Set (MDS) assessment and the 6/13/22 significant change MDS revealed resident 2 was coded as: *Having severely impaired cognition during the cognitive function interviews conducted for both assessments due to: -Incorrect orientation to current year and month. -No recall of three previously repeated items. *Having improved activities of daily living (ADL) self-performance and assistance for: -Transfer, dressing, and toilet use from weight bearing with two persons to independent with no set-up or physical help. -Walking from no walking to independent with no set-up or physical help. *Not steady with balance and needing assistance to stabilize when moving from a seated to a standing position and moving on and off the toilet that improved to being able to stabilize herself. Comparative review of resident 2's care plan "last reviewed: 6/13/22" that was printed by the provider from their previous electronic health record (EHR) system and the care plan in the current EHR system revealed: *She was admitted on 3/25/22. *Fall risk factors included history of falls with a hip fracture (3/22/22), impaired balance, hypertension [blood pressure pill] and diuretic [water pill] medications, impaired mobility and cognition. *There were no fall prevention interventions related to: -The frequency of visual checks. -Supervision of her independent performance of	F 689		

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F 689	Continued From page 3 ADLs. -The resident's cognitive ability to remember to use the call light. -Ensuring she was keeping her walker within reach. *The problem for ADL status was related to the same factors listed under fall risk except impaired mobility was not included. Additional factors included thirteen diagnoses. *The ADL interventions noted she was "independent with most of her ADL's" but did not address staff supervision or visual checks during her independent performance of ADLs related to her impaired balance or cognition. *The care plan had not been reviewed or revised following resident 2's recent fall. Review of the fall investigation report entered by registered nurse (RN) M on 8/17/22 at 7:36 a.m. revealed: *The unwitnessed fall occurred on 8/16/22 at 11:40 p.m. *Resident 2's roommate "came to the nurse station to inform staff that resident is on the floor in the bathroom." *"Found resident sitting on the floor in front of the toilet, blood noted on the floor and on her night gown, noted 1 cm [centimeter] laceration to the left eyebrow." *"As resident explained, she voided and got up and fell, bumped her head, she was using her walker and have a gripper slippers on [sic]." *"Advised resident to call for assistance to go to bathroom and pull string." *"Alarm was put on resident tonight as precautionary intervention in case she will forget to call for assistance." *The documentation fields were blank for the fall review areas regarding:	F 689		

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F 689	Continued From page 4 -Details for "previous fall risk score" and "post fall risk score." -If the call light was sounding at the time of the fall. -The time of the "last purposeful hourly rounding" for resident 2. -Why the resident thought the fall occurred. -Staff involved in the "Post Fall Huddle." Interview on 9/1/22 at 10:30 a.m. with director of nursing services (DNS) B after copies of fall risk assessment and position change alarm documentation had been requested revealed: *The alarm during the night of 8/16/22 after resident 2's fall was "trialed and discontinued." *Fall risk assessments were completed only at admission but she did not provide one for resident 2. Review of the provider's Falls and Accidents policy last revised on 11/2021 revealed: *The policy statement was to "provide a systematic approach to fall and accident prevention and monitoring, include identifying and evaluating hazards and risk, individualized approaches to reduce the risk of falls and accidents, and monitoring for effectiveness of interventions when necessary." *The definition for "supervision/adequate supervision" was "based on the individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident. " *The policy for "resident assessment and intervention" stated: -"Upon admission/readmission, quarterly, and with status changes, staff will assess each resident's individual risk factors."	F 689		

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F 689	Continued From page 5 -"Based on assessment of fall risk...staff will implement appropriate individualized, resident-centered interventions to reduce the likelihood of falls...and communicate the risk and intervention to the staff through the plan of care." "After a fall occurs, it "must be investigated for cause." *"Review of individualized, resident-centered interventions, including adequate supervision and assistive devices...must occur. The plan of care must be updated/modified accordingly." 2. Observation and interview on 8/30/22 at 2:55 p.m. with resident 26 revealed: *She was lying on her right side facing the wall in her bed that was positioned low to floor. *A soft cushion mat was on the floor on the left side of the bed and the same length of the bed. *Her eyes were open, and when the surveyor spoke to her, she turned her head slightly, smiled, and responded with unclear words and continued talking as the surveyor withdrew from her line of vision. *She was wiggling her feet and a pillow was positioned between her legs. *The lights in the room were not on, the curtains were closed, and the television was on with a low volume. Observation and interview on 8/30/22 at 4:35 p.m. in the hallway outside resident 26's room revealed: *CNA G had just opened the door from inside resident 26's room. *Resident 26 was seated in a reclining four wheeled chair with pillow behind head, leaning her head and upper torso slightly to the right. *CNA G stated she and another CNA had just transferred her out of bed into the chair and they	F 689		

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F 689	Continued From page 6 "try to get her hips square so she doesn't lean to the right." *She explained resident 26 had been using the reclining chair for "about one week." Interview on 9/1/22 at 1:37 p.m. with LPN F regarding resident 26's fall risks revealed: *She liked to do "more frequent visual checks" than hourly. *Resident 26 gets "squirrelly." She did not explain what that meant. Comparative review of the 12/6/21 annual MDS and the 7/25/22 quarterly MDS revealed resident 26 was coded as: *Having severely impaired cognition during the cognitive function interviews conducted for both assessments due to: -Incorrect responses to time orientation questions. -Inability to repeat and recall three items *Having continuous inattention or easily distracted and fluctuating disorganized thinking. *Needing weight bearing support with one person for ADL performance for transfer and toilet use, and having a decline in walking performance to not walking. *Having balance that was not steady and needing assistance to stabilize when moving from a seated to a standing position and moving on and off the toilet. *Having fallen one time with no injury prior to each MDS, two separate falls. *Use of two "other" alarms daily on 12/6/21 MDS but use of bed and chair alarms daily on the 7/25/22 MDS. Comparative review of resident 26's care plan "last reviewed: 7/26/22" printed from the previous	F 689		

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F 689	Continued From page 7 EHR and in the current EHR revealed: *She was admitted on 4/15/19. *Fall risk factors included history of falls (last on 7/17/22), impaired balance with Parkinson's, hypertension medication, and impaired cognition. *There was no intervention related to frequency of visual checks related to her "squirrelly" behavior. *The fall prevention interventions included safety equipment of: -Call light in reach, and encourage and remind resident to use. -Walker for ambulation with one person assistance and gait belt with wheelchair following close behind as needed. -"Pressure pad alarm" in bed, wheelchair, or recliner to "alert staff when resident is up and out of bed/chair to prevent falls/injury." -"Bed in low position when she is in it" and "keep floor mat at bedside on her left side." -"Geri chair to prevent falls" and "aid with positioning." -"Toilet as needed in ADL Status section." *The ADL status interventions noted: -"DO NOT LEAVE ALONE IN THE W/C [wheelchair] OR TOILET. SHE TRIES TO STAND UP ON HER OWN. STAY WITH [resident] UNTIL SHE IS TRANSFERRED INTO A RECLINER. BE SURE SHE HAS THE PRESSURE ALARM UNDER HER AT ALL TIMES." -"Assist with toileting upon rising, before and after meals, at HS [hour of sleep] and during rounds at night as needed. Review of the fall investigation report entered by RN N on 7/17/22 at 6:43 p.m. revealed: *The unwitnessed fall occurred on 7/17/22 at 4:15 p.m. *Resident 26 was "found by staff by bed lying on	F 689		

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F 689	Continued From page 8	F 689		

her right side."
*"When asked, resident stated that she hit her head when she fell."
*"Pressure alarm was on bed, but was not sounding."
*The call light questions revealed the call light was not on at the time of the fall but was within reach. *The resident was "unable to state why" she had not attempted to use the call light. She "has dementia and history of trying to get up per self."
*The last time staff had contact with the resident was at 4:10 p.m. There was no explanation about what service was provided at that time.
*There was no documentation under the "contributing information" section to indicate potential causes for the fall.
*The "outcomes" section noted:
-"Pressure pad was in place, but did not sound. Checked after fall and it was working correctly."
-"Continue to keep bed in low positions, [head of bed] down and pad on floor."
*The "reviewing manager's comments" section noted DNS B commented on 8/3/22 that the "care plan reviewed and appropriate."

Review of care activity for resident 26 on 7/17/22 revealed CNA L had documented:
*At 2:34 p.m., she was incontinent of bowel a small amount and continent of bladder.
*At 2:41 p.m., the bed alarm was in place and working.

Interview on 9/1/22 at 10:08 a.m. with DNS B revealed:
*She was unable provide copies of fall risk assessments and position change alarm documentation including an assessment of the medical symptom that warranted the use of the

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F 689	Continued From page 9 alarms and a physician order. *The nurses today "agreed to remove the alarm" from use for resident 26. *Resident 26 had recently moved from using the wheelchair to the "Geri chair" but occupational therapy had not been involved to help with the positioning assessment. Review of the provider's "LTC [Long Term Care] - Physical Restraint/Bed Rails Policy" last revised on 12/2021, provided by DNS B when the survey team requested a policy regarding alarm use, revealed: *The purpose of the policy was to "standardize guidelines for the appropriate use of physical restraints, bed rails/bed mobility devices." *The "Policy Statement" included the philosophy to "keep residents unrestrained and as independent as possible. If the results of a comprehensive, interdisciplinary assessment determine that there are no alternative to provide resident safety, or that the alternative methods have been unsuccessful," a restraint/bed rail may be recommended. *Physical restraint was defined as "any manual method, physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." *The "Definitions" section also defined: -"Freedom of movement" as "any change in place or position for the body or any part of the body that the person is physically able to control." -"Removes easily" as "can be removed intentionally by the resident in the same manner as it was applied by staff." *"Policy Implementation" included: -"The "interdisciplinary team (IDT) will evaluate	F 689		

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F 689	Continued From page 10 the resident's safety needs." -"The use of restraints shall require clinical justification....must not be used to limit mobility, for convenience of staff...or as a substitute for supervision." -*"If a restraint is found to be necessary, appropriate health professional will complete the appropriate documentation in the electronic health record (EHR). The assessment will include medical condition requiring the need for restraint and will be documented in the intervention." -"Physician notification is required for all restraints initiated and a physician's order must be obtained prior to implementation." -"Resident and family will be educated on restraint use, reasons for use, assessment results, and risks and benefits associated with restraint use." -"Resident or resident's family must sign a consent form for restraint use." -"Interdisciplinary team and physician will evaluate restraint usage monthly at minimum and will be reviewed at quarterly care conference by care planning team, resident and resident's family." -"Staff will check the resident's restraint every 30 minutes....provide exercise and therapeutic interventions...provide an opportunity for motion, exercise, and elimination for not less than ten minutes during each two-hour period..." 3. Observation on 8/30/22 at 1:39 p.m. of resident 38 revealed: *She was lying on the bed sleeping under a blanket. *A pull tab alarm was attached to her wheelchair at the bedside. *A thin mat was on the floor next to the bed.	F 689		

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F 689	Continued From page 11 Review of resident 38's medical record revealed: *She was admitted on 5/25/16. *Diagnoses included Alzheimer's, Parkinson's, anxiety, and dementia. *The 6/6/22 quarterly MDS assessment listed: -A Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impact. -Walking/locomotion required 1 to 2 person assist. -A bed alarm was used daily. -A chair alarm was not used. -She had two falls without injury and one fall with injury. *The care plan had dementia with behaviors and falls listed with the following interventions: -History of enjoying walks/assist for walks with 1 person and assistive device. -Take for wheelchair rides. -If she is walking, go to her and offer assistance. -May use wheelchair pushed by another. -Handwritten on the care plan and dated 7/12/22 was "pressure pad alarm in bed @ [at] all times" and "pull string alarm while in wheelchair or chair." *An 8/8/22 fall investigation report revealed: -The incident occurred on 8/8/22 at 3:55 p.m. -"Staff were notified from the pull tab alarm sounding and staff went to investigate and found the resident on the floor in the day room laying on her right side in front of her chair sideways one foot pedal was up pushed aside." -"It looked as if resident had tried to get up and walk, she is very weak and does not understand her limitations." -"Injury, not major/laceration to right ear with first aid provided." -"Contributing factors to fall: unexpected movement." -"No call light within reach (pull tab alarm on, she	F 689		

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F 689	Continued From page 12 was in day room)." -"Bed/chair alarm used and sounding at time of fall." -"Assessment: Resident liked to walk independently, she is now too weak to walk safely and is cognitively unable to understand her limitations." -"Time of last purposeful hourly rounding on resident was 15:30 [3:30 p.m.]." -"Staffing level at or above matrix and properly trained for situation." -"Family notified 8/8/22 at 16:24 [4:24 p.m.]." Interview and review of previously requested records on 9/1/22 at 10:30 a.m. with DNS B about resident 38 revealed: *The facility did not: -Complete a fall risk assessment. -Complete a bed/chair alarm assessment. -Document education with the resident's family or representative for the bed or chair alarm. -Obtain consent from the family or representative for the bed or chair alarm. -Obtain a physician order for the bed or chair alarm. *Following a nurses meeting on 8/31/22 at 7:00 p.m., the bed and chair alarm had been discontinued. Interview on 9/1/22 at 1:25 p.m. with CNA H regarding resident 38 revealed: *She started working at the facility in 2018. *She was assigned to the hallway where resident 38 resided. *The resident was "full cares" and "I just observe her." *The resident's most recent fall was approximately one month ago. *The resident had a history of a fall resulting in a	F 689		

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	435078	A. BUILDING _____ B. WING _____	09/01/2022

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F 689	Continued From page 13 hip fracture and surgery. *Interventions in place to prevent falls were: -A bed and chair alarm had been in place for "a long time, since 2018 when I came here." -A mat on the floor next to her bed. -"We usually lay her down facing the wall so she does not get out of bed, if you put her in bed not facing the wall, she will get out of bed and fall." -We monitor her often every 30 minutes. -Encourage water. -Check to see if she was incontinent. "If she is messy she gets restless, so we make sure she is clean. "She does not sit on the toilet anymore, she is incontinent all the time now." -"Sometimes she liked to go for walks but not anymore. She is not walking now, sometimes she stands up and takes maybe three steps." -"These things are in place because she has had a lot of falls." Interview on 9/1/22 at 1:45 p.m. with RN I regarding resident 38 revealed: *She had worked at the facility for one and a half years. *The resident was a fall risk due to weakness and confusion. *Falls had occurred when the resident was trying to stand up from her wheelchair or bed. *Her last fall was approximately one month ago. *The resident had sustained injuries from her falls such as bruises, skin tears, and history of a fracture related to a fall. *Mobility alarms were in place to prevent falls. *The bed was in the lowest position. *Regular checks were completed every hour or more between the nurse and the CNAs. *Nursing was always assessing the resident. *She had not documented a fall risk assessment. *Staff knew what interventions or assistance the	F 689		

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F 689	Continued From page 14 resident needed from experience, shift reports and checking the chart to see if there had been a change in condition. *Staff identified interventions were suitable for this resident "just the day by day assessment and change in her status." *Her son was involved and here almost every day. *Staff were monitored to ensure they were implementing care-planned interventions by "just making sure it is done and going to check the residents to make sure things are in place the way they should be and if they are not making sure they get done and follow up." Interview on 9/1/22 at 2:05 p.m. with activity assistant J regarding resident 38 revealed: *She completed restorative therapy with residents weekly on Tuesdays. *The nurse completed the restorative plan and the schedule. *The resident did not currently participate in restorative therapy. *The nurse had not implemented a restorative therapy plan for this resident since she fell approximately 6 months ago. *She assumed restorative therapy stopped because she had a fall and was in bed and then she started using the wheelchair. *Prior to six months ago, the resident would use the NuStep machine, pulleys, and did range of motion exercises. *Interventions in place to prevent falls were: -Bed in the low position. -A pull tab alarm when she was in the wheelchair or bed. *She never fell during restorative therapy. 4. Observation on 8/30/22 at 1:21 p.m. of resident	F 689		

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F 689	Continued From page 15 21 revealed: *She had sat up at the end of her bed, causing her bed alarm to be activated with an audible alarm. *CNA K came in and turned off the bed alarm and resettled resident 21 in bed, then left. *While the surveyor was still in the room, resident 21 moved herself to the foot end of the bed and sat up, causing the bed alarm to sound again. CNA K responded and stated, "[Resident name] let's go out of here," and assisted her out of the room. Observation on 8/30/22 at 2:02 p.m. revealed resident 21: *In her wheelchair in the hallway, during which time she stated, "I want to go home." *She self-propelled her wheelchair with a clip attached to the back of her shirt at the top right shoulder, to which a string was fastened leading to an alarm that was attached to her wheelchair. Observation on 8/31/22 at 3:10 p.m. revealed resident 21 in her wheelchair in the hallway by the facility's front entrance with the alarm again attached to her wheelchair and clipped to the back of her shirt. Interview on 8/31/22 at 3:13 p.m. with CNA E revealed: *Resident 21 had the alarm mostly for bed due to her unsafe transfers, but staff also transfer the alarm to her wheelchair during the day. *She demonstrated how staff documented the alarm use in the provider's electronic charting. *The electronic charting stated the pull string alarm was to be used "...in bed at night." *She stated, "during the morning, she's usually walking with her walker and tires by late	F 689		

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F 689	Continued From page 16 afternoon/evening, but she will attempt to stand so we use the alarm on the chair as well." Interview on 8/31/22 at 3:38 p.m. with DNS B regarding resident 21 confirmed: *The pull string alarm was to be used when the resident was in bed at night. *When the surveyor asked if the noise from the pull string alarm may have been a bother to resident 21, she was not aware of any concern. *She revealed they had a pressure pad floor alarm that connected to the call light system and activated the bedside call light when pressure was placed on the floor pad. Interview on 9/01/22 at 1:11 p.m. with CNA D regarding resident 21 revealed: *During the daytime, the alarm would sound "once or twice" when the resident was in bed. *She did not recall hearing it "go off" when the resident was in her wheelchair. *When asked if the alarm noise seemed to bother the resident, she stated, "Yeah it does, she would look around to see where the noise is coming from." *She stated the alarm was used to prevents falls. Interview on 9/01/22 at 1:30 p.m. with social worker C revealed: *Resident 21's alarm was "so she doesn't get up" and the alarm was used in both the wheelchair and bed. *She stated resident 21 "doesn't seem to be bothered by them." Review of resident 21's medical record revealed: *She had been admitted on 12/3/21. *Her diagnosis included: unspecified dementia without behavioral disturbance, history of falling,	F 689		

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F 689	Continued From page 17 other specified anxiety disorders, and weakness. *She had a BIMS assessment score of double zero indicating severe cognitive impairment. *She required extensive assistance of staff with her bed mobility, transfers, dressing, toilet use, and personal care. *Her initial care plan developed on 12/3/21 identified she was a fall risk and had "PULL STRING alarm" handwritten on her care plan. *A 12/4/21 Fall Risk Assessment identified: -Three or more falls during the last 90 days. -Safety devices of a pull string alarm on her chair and bed. *A 12/13/21 nurse note at 2:13 p.m. stated, " ...Daughter requesting we discontinue use of pull string alarm, concerned it is restricting resident's freedom of movement, concerned it is affecting resident's mood and adjustment. Informed daughter that staff placed alarm out of abundance of caution due to recent falls at assisted living prior to coming. Daughter agreed res [resident] is a fall risk but would like to trial no alarms. Will alert all staff and encourage res to use call light, practice close supervision of resident when ambulating." *A 12/13/21 progress note at 2:42 p.m. documented the bed and chair alarm were in place and working. *Her 12/13/21 admission MDS identified no bed alarm or chair alarm was used in the previous seven days. *A 12/22/21 progress note documented the bed and chair alarm were in place and working. *Resident falls were documented on the following dates: -1/16/22 at 7:50 p.m. in the resident's room. -5/10/22 at 2:30 p.m. in the dining room. -5/27/22 at 4:40 a.m. in the resident's room. -6/9/22 at 6:41 p.m. in the resident's room.	F 689		

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F 689	Continued From page 18 -7/28/22 at 1:30 p.m. in the resident's room. -8/12/22 at 3:42 p.m. in the resident's room. *Her 2/14/22 quarterly review MDS assessment identified no bed alarm or chair alarm used in the previous seven days. *Her 5/2/22 quarterly review MDS assessment identified no bed alarm or chair alarm used in the previous seven days. *Her 7/18/22 quarterly review MDS assessment identified a bed alarm was used daily in the previous seven days, but no chair alarm was used. *An eight page MDS summary form completed on 7/18/22 included the fall prevention interventions used in the last 90 days noted, "See Care Plan. Pull string Alarm used @ NOC [night], while elder is in bed." *Her care plan dated 7/19/22 identified her problem of fall risk with a goal to prevent falls and fall related injury through the next target date identified as 10/16/22. This problem included the intervention initiated on 12/10/21 of safety equipment, "Attach the pull string alarm to [resident's first name] when she is in bed at noc [night], to alert staff when she attempts to get out of bed." This intervention's status was active. *A physician order dated 8/31/22 for a "pressure pad floor alarm connected to call light system at bedside. Pull string alarm when resident up in wheelchair." *A nurse note dated 8/31/22 stated, "Family update re [regarding] pressure pad alarm at night and pull string alarm during the day." Interview on 9/01/22 at 9:43 a.m. with DNS B regarding resident 21's daughter's concern with the alarm and request for a trial with no alarms revealed: *She stated they had conducted a trial period with	F 689		

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F 689	Continued From page 19	F 689		

no alarms, however, there was no clear trial period identified in the resident's record.
*Review with DNS B of the initial care plan, fall risk assessment, four MDS assessments, and current care plan regarding alarm use failed to reveal a timeline on when the alarm use was broadened to be used in both the bed and wheelchair and/or when the trial with no alarms was completed.
*DNS B did reveal a note in resident 21's record that stated the alarm was "D/C [discontinued]12/13/21 per daughter."
*She confirmed that resident 21 was currently using a chair alarm and a bed alarm.

Further interview with DNS B on 9/1/22 at 9:43 a.m. regarding the use of position change alarms or "pull string alarms" revealed:
*Assessment of these alarms for individual resident use were not documented.
*She had verbal discussion with staff on the need for the position change alarms.
*The fall risk assessments for residents were completed only once, upon admission.

Interview on 9/1/22 at 10:20 a.m. with DNS B revealed:
*The provider had a "Physical Restraint/Bed Rails Policy" last revised on 12/2021.
*The provider did not have a policy specifically addressing "position change alarms" by name.
*There was no procedure or process in place for the use of resident position change alarms.
*There were no consent forms signed by family/representative for use of alarms prior to use.
*The provider had not obtained physician orders for mobility alarms prior to use.