STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 09/11/2018

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F 689 SS=G	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, record review, resident interview, and staff interview, the facility failed to prevent a dependent resident from falling out of bed during incontinence care for 1 of 3 residents reviewed for falls. Resident #1 fell face down onto the floor and sustained multiple skin tears to her upper extremities, lacerations to her face requiring sutures, a facial hematoma, and increased pain for a period of 5 days requiring the administration of narcotic medication for pain management. The findings included: Resident #1 was initially admitted to the facility on 9/7/10 and most recently readmitted on 1/4/17 with diagnoses that included muscle weakness, heart failure, pulmonary embolism, long term use of anticoagulants, chronic pain, schizophrenia, and dementia. The quarterly Minimum Data Set (MDS) assessment dated 6/27/18 indicated Resident #1 ' s cognition was intact. She was assessed as dependent on 2 or more staff for transfers and toileting. Resident #1 required the extensive assistance of 1 staff for bed mobility and personal	F 689	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. During the complaint survey ending, 9/11/18, a surveyor reviewed Resident #1□s medical record and interviewed staff and determined Nursing Assistant (NA) #1 did not review the care plan prior to performing nurse aide skills. NA #1 made a personal choice to proceed with providing personal care to Resident #1 unassisted, instead of waiting for an additional staff. On 8/23/18, the MDS (Minimum Data Set) Coordinator reviewed Resident #1□s Care Plan, Care Card, and Bowel and Bladder Guide to assure each was updated to specify that 2 staff physical assistance was required for providing	10/3/18

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

Electronically Signed | 09/27/2018

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F 689	Continued From page 1 hygiene. She was assessed as not steady on her feet and only able to stabilize with staff assistance for surface to surface transfers. Moving from seated to standing, walking, turning around, and moving on and off the toilet had not occurred for Resident #1 during the MDS review period. Resident #1 had impairment on both sides of her upper extremities. Her weight was 220 pounds, she was always incontinent of bladder and bowel, and she no falls since her previous MDS assessment (3/28/18). Resident #1 received scheduled pain medications, no as needed (PRN) pain medication, and no opioid medications during the review period. During the resident interview she indicated she had no pain presence during this MDS review period. The plan of care for Resident #1 included the problem/need of staff assistance for all Activities of Daily Living (ADLs) related, in part, to muscle weakness, impaired mobility, incontinence of bladder/bowel, and dementia with behaviors. This area was initiated on 4/4/18 and most recently reviewed on 6/27/18. The interventions included 2 staff in Resident #1 ' s room while personal care was provided and total dependence for transfers requiring 2 staff and a mechanical lift. The plan of care for Resident #1 also included the problem/need of the risk for falls related, in part, to poor trunk control, poor safety awareness, and muscle weakness. This area was initiated on 4/4/18 and most recently reviewed on 6/27/18. The interventions included incontinence care and transfers as directed. A review of Resident #1 ' s physician ' s order summary for August 2018 included, in part:	F 689	personal care. The Director of Nursing (DON) educated NA #1 on the updated Care Card and DON counseled NA #1 as part of the progressive disciplinary process. Following the fall on 8/23/18, Resident #1 was transferred to the Emergency Department (ED), received medical treatment, and was readmitted to the facility, later that day. Following readmission to the facility, Resident #1 was placed in a bariatric bed for resident safety. On 8/24/18, the Nurse Practitioner reviewed the ED reports and evaluated Resident #1. No new orders were written at that time. MDS Coordinators will conduct a facility-wide review of each resident□s Care Plan, Care Card, and Bowel and Bladder Guide to assure each was updated to specify physical assistance required when providing personal care. The review of care cards, Care Plans, bowel and bladder guides was completed by 9/27/18. New Care Cards were completed on all residents at that time to ensure they were consistent with care plan and the date and initials of the person making revisions was added. Ongoing, the MDS Coordinators will conduct a review of each resident□s Care Plan, Care Card, and Bowel and Bladder Guide during completion of initial, quarterly, and significant change MDS assessments. In addition, each Care Card was updated to now include the date updated and initials.	

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F 689	Continued From page 2 - Tylenol 650 milligrams (mg) every 4 hours PRN for pain or discomforts. This order was initiated on 1/21/17. - Norco (narcotic pain medication) 5-325 mg every 4 hours PRN for pain secondary to rheumatoid arthritis and polyarthritis. This order was initiated on 10/2/17. An incident report dated 8/23/18 completed by Nurse #1 indicated Resident #1 had a witnessed fall on 8/23/18 at 6:30 AM resulting in moderate harm. Nurse #1 indicated she was called to Resident #1 ' s room where the resident was observed face down on the floor. Nursing Assistant (NA) #1 stated she was doing incontinence care and Resident #1 rolled out of bed. Resident #1 had injuries to her face and was sent to the Emergency department (ED) for evaluation and treatment. The post fall investigation dated 8/23/18 at 7:00 AM was also completed by Nurse #1. Nurse #1 indicated she thought the fall happened because Resident #1 had no side rails and she was a "larger resident" in a regular bed. Her recommendation was a bariatric bed (a larger bed frame and mattress). A nursing note dated 8/23/18 at 6:35 AM completed by Nurse #1 indicated she was called to Resident #1 ' s room by the NA (NA #1) who was doing incontinence care when the resident rolled out of bed. Resident #1 was observed by Nurse #1 lying face down with blood coming from her eye. Resident #1 was sent by Emergency Medical Services (EMS) to the ED for evaluation and treatment. The physician and Responsible Party (RP) were notified of the fall. Hospital records dated 8/23/18 indicated Resident #1 presented at the ED at 7:22 AM for	F 689	A new Process Flow was developed to address updating of the Care Card . The Nurse and/or Therapist will determine the level of personal care required for each resident. The Care Card will be updated by the MDS Coordinator if an update is required during the weekday business hours. During off hours and weekends, the Care Card will be updated by the Nursing Leader. Facility Educator will provide inservice on the new Process Flow to Nursing and Therapy. Facility Educator, DON, and Assistant Director of Nursing (ADON) will provide inservices to Registered Nurse (RNs), Licensed Practical Nurse (LPNs), and NAs on protocol to review Care Cards that specify physical assistance required for each resident, prior to providing personal care. All RN's, LPN's, NA's for all Full time (FT, Part Time (PT), as needed (PRN) and Resource Team staff will be educated by 10/3/18. Any RNs, LPNs, and NAs who do not receive the training by the specified date (due to Family Medical Leave Act [FMLA], leave, etc.) will be required to complete training prior to working their next scheduled shift. Orientation for new teammates will include training related to the protocol to review Care Cards that specify physical assistance required for each resident, prior to providing personal care. Administrator, DON, ADON, Facility Educator, and/or Shift Supervisor will	

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F 689	Continued From page 3 evaluation after a fall. Emergency Medical Services (EMS) reported Resident #1 fell out of her bed when staff lost their balance while holding the patient and attempting to change her in bed. Resident #1 reportedly rolled out of bed, striking her head on an oxygen regulator. Resident #1 endorsed head pain that was achy/sore rated at a 6 out of 10 during evaluation in the ED. Resident #1 ' s fall was witnessed by facility staff, she had struck her head, but there was no loss of consciousness. Resident #1 was assessed with multiple skin tears with the most notable on the left elbow, left index finger and right index finger. She had a hematoma (solid swelling of clotted blood within the tissues) to the head, a complex flap laceration approximately 6 centimeters (cm) above the left (L) eyelid, and a subcentimeter (less than a cm) laceration in the midline inferior (lower) of the left eye. Minimal oozing bleeding was noted from both lacerations. The laceration above Resident #1 ' s L eyebrow was assessed as a mixed laceration and skin avulsion (skin avulsion occurs when skin is forcibly detached/torn from the body during an accident or other injury) requiring 4 sutures. The laceration below Resident #1 ' s L eye required 1 suture. A CT (computed tomography) scan was conducted of Resident #1 ' s head and confirmed a L frontal preorbital (situated in front of the eye socket) soft tissue hematoma without fracture. X-rays of Resident #1 ' s left elbow and bilateral hands were completed with the results showing no fractures/dislocations. She was noted with degenerative/rheumatoid changes in the left elbow and both hands. A nursing note dated 8/23/18 indicated Resident #1 returned from the ED at 12:30 PM. Dressings were noted to her L eye due to lacerations above	F 689	conduct weekly observations of Nurse Aides providing personal care to validate continued competency. Observations will be conducted on 3 NAs on day shift per week, 3 NAs on second shift per week, and 3 NA on third shift per week for a period of 90 days. Any identified issues will be corrected at the time they are identified. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with Quality Assurance Process Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be determined by the Quality Assessment & Assurance (QAA) Committee. The DON will have overall responsibility for oversight of this Plan of Correction.	

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and below the eye.

A nursing note dated 8/23/18 at 9:52 PM completed by Nurse #1 indicated the L side of Resident #1 ' s face was swelling and turning purple. The lacerations above and below the L eye were bleeding and required a dressing change. Resident #1 complained of pain all over and PRN Norco was administered.
The plan of care related to Resident #1 ' s risk for falls was updated on 8/23/18 with the interventions of 2 staff assistance with all personal care and a bariatric bed.
A Nurse Practitioner (NP) note dated 8/24/18 indicated the NP reviewed the summary of the medical records for Resident #1. The NP wrote that Resident #1 had a fall from her bed on 8/23/18, she hit her oxygen concentrator, and suffer multiple contusions and lacerations. Due to the facial injuries and the inability to stop the bleeding, Resident #1 was transferred to the ED. Multiple x-rays of Resident #1 ' s elbow, wrist, and hand were indicative of degenerative changes and rheumatoid arthritis with no fracture. A CT of Resident #1 ' s head and neck showed moderate L frontal preorbital facial hematoma. There was no evidence of facial fracture or cervical spine fracture. Sutures were placed on 2 lacerations. The NP indicated Resident #1 had significant difficulty with continued bleeding. She was noted to be on Xarelto (anticoagulant medication) and aspirin related to pulmonary embolism. Resident #1 was assessed by the NP while she was lying in bed. Her left eye was swollen with continued bleeding and she was unable to open the eye.
A nursing note dated 8/25/18 completed by Nurse #4 indicated lacerations continued to Resident #1 ' s L eye and her face was swollen from the

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previous fall (8/23/18). Resident #1 complained of pain all over and PRN Norco was administered.
A review of Resident #1 ' s August 2018 Medication Administration Record (MAR) was conducted. The administration of PRN pain medications indicated Resident #1 had increased pain for a period of 5 days (including the date of the fall) after the fall.
- After Resident #1 ' s fall on 8/23/18 (8/23/18 through 8/31/18): PRN Tylenol was not administered; PRN Norco was administered 9 times (8/23 x2, 8/24, 8/25 x2, 8/26 x2, and 8/27 x2).

An observation and interview were conducted with Resident #1 on 9/11/18 at 1:05 PM. Resident #1 was observed to be in a bariatric bed. Bruising that was brown and yellow in color was noted to her face and steri-strips were observed on the laceration above her L eye. Resident #1 was alert and oriented to self, but she was unable to answer any questions related to her previous fall.

A phone interview was conducted with NA #1 on 9/11/18 at 9:31 AM. She indicated she had worked at the facility for about a year. NA #1 was asked how she knew how much assistance a resident required with their ADLs. She reported that there was hard copy NA care guide in each resident ' s closet. She indicated she was familiar with Resident #1 and had worked with her occasionally. NA #1 was asked how much assistance Resident #1 required with her ADLs based on her care guide. She stated she was not sure off the top of her head. She also stated she had not viewed Resident #1 ' s care plan before.

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This phone interview with NA #1 continued. The incident report related to Resident #1 ' s fall on 8/23/18 at 6:30 AM was reviewed with NA #1. She confirmed she was the NA who was providing incontinent care to Resident #1 at the time of this fall (8/23/18). She stated she had worked the third shift, 11:00 PM to 7:00 AM, on 8/22/18 into 8/23/18. She reported Resident #1 was the last resident she needed to provide incontinence care to that morning prior to the end of her shift. NA #1 stated that she called for a staff member to help her, she waited about 10 minutes, and then she just proceeded to provide care to Resident #1 by herself. She indicated staffing was normal for both the NAs and nurses that morning. She stated she asked Resident #1 to roll onto her side and grab hold of the side of the mattress. She indicated Resident #1 was able to roll, but she rolled too far and was not able to keep herself on the bed. NA #1 indicated she was unable to stop Resident #1 from falling and she proceeded to fall face down onto the floor. NA #1 revealed she should have waited for an additional staff member for the resident ' s safety and for her own safety. She stated that after the incident (8/23/18) the Interim Administrator/previous Director of Nursing (DON) told her to always utilize 2 staff for all personal care for Resident #1. NA #1 reported that since the fall on 8/23/18 she always had another staff member with her when she was providing personal care to Resident #1.

A phone interview was conducted with Nurse #1 on 9/22/18 at 9:38 AM. She stated she was familiar with Resident #1 and confirmed she was the nurse assigned to her at the time of the fall on 8/23/18 at 6:30 AM. She reported she was called to Resident #1 ' s room via a hand held multi-way

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radio. She stated that when she got to the room, Resident #1 was lying on the ground, blood was coming from her face, and lacerations were noted above and below her L eye. She indicated Resident #1 was sent to the ED for evaluation and treatment. Nurse #1 stated she completed the incident report and the post fall investigation, and she believed the fall could have been prevented if Resident #1 had a larger bed. She reported that for several days after the fall, Resident #1 ' s pain was increased, and PRN Norco was administered on several occassions. She revealed this was a change for Resident #1 as PRN Tylenol normally was able to manage her pain.

An interview was conducted with NA #2 on 9/11/8 at 11:23 AM. She stated she had worked at the facility for 4 years. She indicated she was very familiar with Resident #1 as she worked with her regularly. NA #2 was asked how much assistance Resident #1 required with her ADLs. She stated that Resident #1 was dependent for most ADLs other than eating. She indicated 2 staff were required for incontinence care and transfers. She explained that Resident #1 was "heavy" and she was not able to control her trunk. NA #2 reported that any time she performed incontinence care for Resident #1 she always asked for another staff ' s assistance so that 1 staff member could stand on each side of the bed. She indicated she has worked the third shift (11:00 PM to 7:00 AM) and the first shift (7:00 AM to 3:00 PM) and had not found it difficult to find another staff member to assist with care. She stated sometimes you just had to be patient and wait a few minutes for another NA or a nurse to be able to help you out.

A phone interview was conducted with Nurse #3 on 9/11/18 at 11:55 AM. She indicated she was

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aware of Resident #1 ' s fall on 8/23/18 and confirmed she had worked with her after the fall. She stated that Resident #1 had "severe bruising and swelling to her face, bruising to upper extremities, and sutures above one of her eyes". She additionally stated that Resident #1 had, "more pain than usual". Nurse #3 reported that Resident #1 had orders for PRN Tylenol and PRN Norco. She indicated that Resident #1 normally just requested PRN Tylenol when she was having pain, but that for a few days after the fall she was requesting the PRN Norco.

A phone interview was conducted with Nurse #2 on 9/11/18 at 12:20 PM. She indicated she was aware of Resident #1 ' s fall on 8/23/18. She indicated she had not seen Resident #1 after the fall until a several days later. She stated Resident #1 had sutures over the left eye and bruising on her face and arms. Nurse #2 reported she recalled that Resident #1 had increased pain after the fall and that PRN Norco was administered. She explained that PRN Norco was not frequently used for Resident #1 as her PRN Tylenol normally managed her pain.

A phone interview was attempted with Nurse #4 on 9/11/18 at 11:43 AM, but she was unable to be reached.

An interview was conducted with the MDS Coordinator on 9/11/18 at 10:25 AM. The care plans for Resident #1 related to ADLs and the risk for falls were reviewed with MDS Coordinator. She stated that prior to Resident #1 ' s fall on 8/23/18 the care plan, the NA care guide, and the bowel and bladder guide had not been specific about the amount of assistance and/or staff required for Resident #1 ' s incontinence care.

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She explained that prior to the fall (8/23/18) Resident #1 fluctuated between extensive to dependent and 1 to 2 staff for physical assistance with incontinence care. She reported that Resident #1 ' s care plan had an intervention that stated 2 staff members were to be in Resident #1 ' s room during personal care. The MDS Coordinator explained that this intervention was related to behavioral issues for the resident and not intended to specify that 2 staff were required to provide physical assistance. She acknowledged that this intervention on the care plan was not followed on 8/23/18 as NA #1 was the only staff member in Resident #1 ' s room at the time of the fall. The MDS Coordinator verified that after the 8/23/18 fall, the care plan, NA care guide, and bowel and bladder guide were all updated to specify that 2 staff ' s physical assistance was required for all of Resident #1 ' s personal care.

An interview was conducted with the Interim Administrator (former DON) on 9/11/18 at 1:20 PM. The current DON sat in on the interview. Resident #1 ' s 8/23/18 fall was reviewed with the Interim Administrator and the DON. The Interim Administrator verified that as a result of the 8/23/18 fall, Resident #1 sustained multiple skin tears, facial lacerations requiring sutures, a facial hematoma, and increased pain for a period of 5 days (8/23/18 through 8/27/18) requiring narcotic medication for pain management. The Interim Administrator stated she believed the root cause of the fall was that Resident #1 required 2 staff ' s assistance for incontinence care primarily related to Resident #1 ' s size. She acknowledged that Resident #1 additionally had muscle weakness and poor trunk control which limited her ability to assist the staff. The Interim Administrator stated

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F 689	Continued From page 10 that following the 8/23/18 fall Resident #1 ' s care plan, NA care guide, and bowel and bladder guide were updated to specify that 2 staff ' s physical assistance was required for all of Resident #1 ' s personal care needs. She explained that prior to the 8/23/18 fall, these three documents (care plan, care guide, bowel and bladder guide) had not specifically stated that 2 staff were required to provide incontinence care for Resident #1. The Interim Administrator indicated that a bariatric bed was implemented for Resident #1 as a precautionary measure after the 8/23/18 fall, but she had not believed this was the root cause of the fall. She explained that Resident #1 was overweight, but that she adequately fit in a regular bed, there was no indication of her discomfort in the bed, and no recent falls to suggest that a bariatric bed was needed. The current DON confirmed her agreement with the Interim Administrator ' s root cause of the fall and the expectation that 2 staff should have been utilized to provide incontinence care to Resident #1.	F 689		