STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065150	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Devonshire Care Center	1330 Sidney Ave Sterling, CO 80751

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 48112 Based on record review and interviews, the facility failed to provide a response, action and rationale to residents involved in group grievances. Specifically, the facility failed to follow up with residents' concerns brought up by the resident council during regular meetings. Findings include: I. Facility policy A policy for grievances was requested on 3/7/24 at 8:30 a.m. but was not received. II. Resident group interview Resident #27, Resident #30 and Resident #45 were interviewed on 3/5/24 at 4:13 p.m. Resident #27 said there were not enough sit to stand devices (mechanical lifts) so she had to wait a long time to use the bathroom. She said there were two devices for the facility. One device was too big to use in the bathroom. She told a certified nurse aide (CNA) and it was not resolved. Resident #27 and Resident #30 said they met in the main dining room with the doors opened. They said staff went through the dining room during the meeting. The same residents said they did not have an opportunity to talk without staff present at resident council meetings. III. Frequent visitor interview A frequent visitor, with knowledge of the facility, was interviewed on 3/6/24 at 4:47 p.m. She attended both January and February 2024 resident council meetings. She said the sit to stand lift concern was not resolved. She said the meetings were held in an open space and staff attended resident council meetings. The residents did not have an opportunity to speak without staff present. She said the February 2024 meeting was initially held in an open area but moved to a closed dining room. She said two staff members were present at the meeting. IV. Resident council notes (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident council notes from 1/9/24 documented the residents said there was only one sit to stand lift and the residents always had to wait because another resident used the lift. The facility said they had two sit to stand lifts and three hoyer lifts (a different mechanical lift). The devices required two staff members for safety. Resident council notes from 2/14/24 documented no follow up for the sit to stand lift concerns in January 2024 and the residents again expressed concerns over the wait time for the sit to stand lift. -The resident council notes did not document what the facility did to resolve the issue. The old business section of the minutes was left blank. V. Staff interview The nursing home administrator (NHA) was interviewed on 3/6/24 at 3:30 p.m. She said the staff responsible for running the resident council were not available. The staff was the facility driver and was in the community with a resident. She said the January 2024 resident council meeting was managed by the frequent visitor. No staff were allowed to attend. She said the concerns discussed in the resident council were considered grievances. She resolved a grievance by working on solutions in between monthly resident council meetings. The grievance was brought up at the following meeting to confirm the concern was resolved. She said a closed space was challenging because they had outbreaks. She said the February 2024 meeting was initially in an open space area and then moved to a small closed dining room. The NHA was interviewed on 3/7/24 at 8:22 a.m. She reviewed the grievance for sit to stand lifts that were filed after the February 2024 resident council meeting. She said Resident #27 ate her meals in her room because she had Parkinson's disease and she recently had increased shaking. The facility had a psychotropic review on 3/4/24 to change the medications to reduce her shaking so she could eat in the dining room. Since she ate in her room instead of the dining room, she was ready to use the bathroom sooner. -However, the grievance was not resolved (see interview above).

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F 0574 Level of Harm - Potential for minimal harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. 48112 Based on observations and interviews, the facility failed to ensure residents received notices in a written description of their legal rights. Specifically, the facility failed to post a sign with how to file a complaint to the State Survey Agency. Findings include: I. Resident group interview The group interview was conducted on 3/5/24 at 4:13 p.m. with three residents (#27, #30 and #45) identified by assessment and the facility as interviewable. All three residents said they did not know they could file a complaint with the State Agency and they did not know where the facility posted information in regard to pertinent State Agencies ' contact information. II. Observation and staff interview On 3/5/24 at 11:40 a.m. an observation was conducted throughout the facility. There were no signs in the front lobby of the building and no signs in each of the four units that contained the State Agency contact information. The corporate nurse consultant (CNC) was interviewed on 3/5/24 at 4:40 p.m. She did not know where the sign was located. She said she would find out where the sign was posted in the building. On 3/6/24 at 12:00 p.m. a sign was posted in the entrance of the lobby to the right of the dining room that was next to how to contact the ombudsman. The nursing home administrator (NHA) was interviewed on 3/6/24 at 3:48 p.m. She said there used to be a sign in the lobby but she did not know what happened to the sign.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31229 Based on observations, interviews and record review, the facility failed to provide adequate supervision and assistance devices to prevent accidents for three (#46, #43 and #25) of six residents reviewed for falls out of 33 sample residents. The facility failed to timely and appropriately implement interventions including assistance with all activities of daily living. The facility failed to provide staff education and increase residents' supervision to prevent falls when all three residents could not ask for staff assistance by using the call light due to severely impaired cognition for Residents #46, #25 and #43. Furthermore, the facility failed to ensure adequate supervision and effective interventions were in place to prevent multiple falls for Resident #46, including falls that resulted in injuries requiring transfer to a hospital and one fall which resulted in a right hip fracture requiring surgical repair. Findings include: I. Facility policy The Falls and Fall Risk, Managing policy, undated, was provided by the nursing home administrator (NHA) on 3/7/24 at 10:55 a.m. It read in pertinent part: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident-centered approaches to managing falls and fall risk included: -If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. -Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. -If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. II. Resident #46 A. Resident status (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #46, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included essential hypertension, fracture of unspecified part of neck of right femur, presence of right artificial hip joint, presence of left artificial hip joint, osteoporosis, acute respiratory failure with hypoxia (low blood oxygen) and Alzheimer's disease. The 1/15/24 minimum data set (MDS) assessment revealed the resident required supervision with transfers and walking (with a walker). He had one fall, no injury, since the prior assessment. The most recent MDS assessment dated [DATE] revealed severely impaired cognition with a brief interview for mental status (BIMS) score of two out of 15. He required moderate assistance with transfer sit to stand and bed to chair. He received scheduled pain medication for occasional mild pain. The resident had a fall prior to readmission, with a fracture, surgery and partial hip replacement. Medications included an anticoagulant and diuretic. B. Resident observation and representative interview Resident #46 was observed on 3/6/24 at 10:40 a.m. A large blue color bruise was around his right eye. The resident's representative said the resident fell when he lived at home and fractured his left hip. He said Resident #46 did not remember he was weak and unsteady on his feet and still tried to be independent in his room. C. Record review On 1/4/22 Fall Risk Assessment documented a score of five (at risk 10 or higher), indicating Resident #46 was not considered a high fall risk. -However, he had falls prior to admission with a fracture (see representative interview). On 1/23/24 the resident's Fall Risk Assessment score was 13, considered high risk for falls. A review of the resident's comprehensive care plan revealed: (Resident) has an ADL (activities of daily living) self-care performance deficit r/t hx (related to history) of fractures, weakness, hx (history) of falls, heart disease, tricuspid insufficiency (heart valve insufficiency), Alzheimer disease, spondylosis of cervical region (arthritis of the neck). Date initiated 1/4/22 and revised 3/2/22. Interventions included: Toilet use with limited, one person assistance. Encourage the resident to use call bell for assistance (understands use, does not consistently use). Revised 3/2/22. (Resident) is at risk for falls r/t (related to) unsteady on feet, potential side effects of medication, use of assistive devices, altered cardiac status, hx (history) of fx (fracture), left artificial hip, impaired cognition, impaired communication/hearing, incontinence. Date initiated: 1/4/22. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interventions included: Purposeful rounds. Tab alarm in wheelchair and recliner, pad alarm while in bed (initiated 2/7/24). Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 1/4/22. (Resident) has impaired cognitive function AEB (as evidenced by) BIMS (brief interview for mental status) score r/t (related to) Alzheimer's. Date initiated 1/4/22, revision 3/2/22. Interventions included: Call bell within reach, answer promptly. Assist with decision making by giving simple choices in daily cares. Keep the resident's routine consistent. -The facility failed to appropriately assess Resident #46's call light use ability. -After Resident #46's fall with major injury, hospitalization and surgery (see below), the only intervention added in the care plan to prevent falls was tab alarm in wheelchair and recliner, pad alarm while in bed. 1. Fall #1 On 1/12/24 a nurse documented: CNA (certified nurse aide) reported that resident is on the floor laying on a blanket. RN (registered nurse) assessed resident, H/T (head to toe) assessment with no injury noted. Staff showered resident and no red/bruised or open areas noted. Resident did not say if he fell or not. When asked by this nurse at breakfast he grinned and shrugged his shoulders. Resident resumed normal activities of the day. Denies any c/o (complain of) pain or discomfort. On 1/12/24 an incident description completed by a registered nurse revealed the following: staff reported that resident was laying on the floor on his blanket, saw resident on his right side with his blanket spread out under him, in no distress. No injuries, up and ambulating to the bath without change in gait, with walker. No injury noted in the bath. Call bell on the bed, not activated. On 1/12/24 a nurse documented: Resident complained that his shoulders and right leg are hurting. When LPN (licensed practical nurse) went in to reassess resident and asked about his pain, he denied pain. Family states that he doesn't like to complain. They are taking him to ER (emergency room) to be evaluated. Resident left facility via POV (private vehicle) in stable condition. On 1/14/24 a nurse documented: New complaints of pain and action taken: 7/10 (seven out of ten), given 2 (two) extra strength Tylenol at 12:00 a.m. with + (positive) effect. On 1/15/24 a restorative nurse aide (RNA) documented: Fall intervention: Resident found on floor next to bed. Fall intervention is low bed and fall mat. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/15/24 the interdisciplinary team (IDT) post fall review revealed: (Resident) has not fallen since April of 2023. He currently resides in a room by himself at the end of the hallway. Per his most recent MDS, he scored a 2/15 indicating severe cognitive impairment. He has communication difficulties with minimal difficulty hearing others, he does not use HA (hearing aids), understands others and is understood. He uses a FWW (front wheeled walker) with ambulation and needs some assistance with his ADLs. This fall occurred in his room as he was wrapped up in a blanket. He had gripper socks on at the time of the fall. Per the nursing notes, this fall occurred before 0700 (7:00 a.m.) that morning. No injuries were noted at the time of the fall and post fall. He did not use his call light, but it was within reach prior to the fall. This fall occurred likely due to him getting up for the morning. Staff assist him PRN (as needed) with bed mobility and dressing. Due to his significant cognitive impairment, he is not able to recall the reason for the fall. An electric low bed was implemented, and a fall mat was placed next to his bed for when he is in his bed, to prevent fall related injuries. Care plan reviewed. -However, according to progress notes (see above) the resident had new complaints of pain following the fall. -The resident's care plan was not updated with the new fall interventions. 2. Fall #2 On 1/16/24 RN documented: Date and time of fall 1/16/2024 at 1700 (5:00 p.m.). MD (physician) notified . New complaints of pain and action taken: c/o (complaints of) right hip pain, slight internal rotation noted. Resident roller chair noted in middle of room, appropriate nonskid shoes noted, floor dry free of other hazards, call light not within reach. On 1/16/24 a nurse documented: Contacted (hospital) ER (emergency room) to inquire of res. (resident's) status, res(ident) has been admitted to the hospital with dx (diagnosis) of rt. (right) femur fracture. The 1/16/24 orthopedic consultation report revealed the following: The patient is [AGE] years old. He is assessed through the ER (emergency room) on 1/16/24 with right hip pain following a fall at a nursing facility. He has a subcapital fracture with displacement and is a candidate for surgical management .Right hip procedure will include cemented endoprosthesis to bipolar arthroplasty. Resident #46 was hospitalized for seven days. On 1/18/24 a RNA documented: Fall intervention: resident had a fall on 1/16/23 he was found on floor with roller chair behind him. Fall intervention is room change to more visible room and had family take roller chairs out of room and replaced with regular chairs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/19/24 IDT note revealed: (Resident) was admitted (to hospital) on 1/16/24 for right femur fx (fracture) with scheduled procedure for 1/17/24 and anticipated return within 3-5 days. (Resident's) room is currently located at the end of the 200 hallway and due to the recent falls, his poor safety awareness d/t (due to) progression of dementia it is the recommendation of the committee to relocate (Resident) to a room closer to nurses' station for closer monitoring. We will also ask the family to remove the kitchen roller chairs. (Resident) will be relocated to (room #) a highly visible room that is close proximity to 1/4 wing nurse station. Care plan will be reviewed and updated at time of readmission. Family was in agreement with recommendations and have taken the chairs home. On 1/23/24 a Nursing Admission Assessment revealed Resident #46 had right femoral fracture repaired. On 2/5/24 social worker documented: Following RCC (resident care conference) with daughter, (name) and son (name), a communication board was hung in (Resident) room, WBing (weight bearing) status, reminders of no ice with water and use of tab alarm in chair and pad alarm in bed for tracking patterns of movement and to help protect the integrity of hip frx (fracture) repair. (name) DON (director of nursing) also is performing an in-service with the 100 (unit) nurses. On 2/6/24 a nurse documented: POA (power of attorney) called and asked if any family could come to help with resident. He wanted to go to his room, but he transfers himself and if he falls and breaks his hip, it won't be good. On 2/12/24 a nurse documented: Alarm on wc (wheelchair), recliner, and bed for resident's safety. He forgets he needs assistance with transfers. The alarm does help resident to hesitate before actually continuing to transfer self. 3. Fall #3 On 2/14/24 a nurse documented: Date and time of fall: 2/14/24 at 1715 (5:15 p.m.) No newly observed injuries. -The details of the fall were not indicated. On 2/15/24 a RNA documented: Fall Intervention: Resident found on the floor on 2/14/24. Intervention is staff education on purposeful rounds. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/15/24 IDT post fall review revealed: (Resident) has not fallen this month until this fall. He has poor safety awareness and requires staff assistance with his ADLs due to recent hip fracture. He has been moved to a room closer to the nurses' station within the past month and family has removed his rolling chairs out of his room with his most recent fall. He has severely impaired cognition with a BIMS score of 2/15 per his most recent MDS. He has minimal difficulty hearing, usually is able to make his needs known and to understand others and usually understood by others. His vision is adequate with glasses. He is WBAT (weight bearing as tolerated) and is working with therapy. He was wearing proper footwear at the time of the fall. He does not consistently use his call light. Due to significant cognitive impairment and communication deficits, he does not recall the reason why he was up by his table and the cause of the fall. However, he tested positive for RSV (respiratory synctial virus) and is now under precautions. Deconditioning could also be a potential cause of the fall due to recent surgery and now testing positive for RSV. Restorative has done education with staff for purposeful rounds. He remains in a high traffic hallway where staff are aware to observe him in his room and to monitor for unassisted transfers, and his activity while he is in his room. Continue to work with therapy to maintain strength. Care plan reviewed. 4. Fall #4 On 2/28/24 a nurse documented: (name) in activities came and told this nurse, '(Resident) is on the floor, it looks like it's been awhile because there is dried blood all over the floor.' Grabbed vs (vital signs) equipment while calling (number), asked (name) to send an RN to (Resident #46's) room. Attempted to print paperwork to ship resident out . (name) trying to dress wounds on R (right) head and R (right) arm and hand. Resident c/o (complained of) R (right) hip pain. (name) was helping to hold resident back up, (name) was attempting to keep right leg still. Resident was getting tired of sitting on the floor. I walked EMTs to room while giving report. They left at 1530 (3:30 p.m.). Room is without clutter. Appeared resident walked toward closet and fell then scooted himself back to recliner where he was found. 1455 (2:55 p.m.) (name), CNA and this nurse had redirected resident from another room and since he was going into restroom we took him back to his room and was going to set him on the toilet. Resident refused and wanted in recliner. As I left I reminded (name) to put his alarm on. She said she would and had already picked it up to apply alarm. It appears resident took alarm off and stuck it in his drawer that is beside his recliner. (POA), (name) and (physician) are aware of resident's fall and injuries. ER was given report and EMT's took resident from building at 1530 (3:30 p.m.). The 2/28/24 emergency department report revealed the following: BIBA (brought in by ambulance) from (facility) after fall with head injury over right eye. Does not remember what happened. Skin tear to right elbow. On 2/28/24 a nurse documented: Returned at 1730 (5:30 p.m.). Changed dressing and approximated R (right) elbow. On 2/29/24 a nurse documented: Bruising to eyebrow is now around eye and onto cheek. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/29/24 the IDT review revealed: (Resident) has poor safety awareness and requires staff assistance with his ADLs due to recent hip fracture. He has been moved to a room closer to the nurses' station within the past month and family has removed his rolling chairs out of his room with his most recent fall. He has severely impaired cognition with a BIMS score of 2/15 per his most recent MDS. He has minimal difficulty hearing, usually is able to make his needs known and to understand others and usually understood by others. His vision is adequate with glasses. He is WBAT and is working with therapy. He does not consistently use his call light. Due to significant cognitive impairment and communication deficits, he does not recall the reason why he was up by his table and the cause of the fall. However, he tested positive for RSV within the past two weeks and potential deconditioning due to recent hip fracture, and recent RSV. He was sent to the hospital due to c/o hip pain and abrasion to head. Due to significant cognitive impairment, he is not able to recall the cause of the fall. He is on skilled therapy. Restorative placed hipsters on him to prevent fall related injuries due to hx of fracture and repeated falls due to his poor safety awareness. Staff to continue with purposeful rounds to monitor his in-room activities and to help mitigate falls, as he will wear them. Care plan reviewed. C. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on 3/6/24 at 1:30 p.m. She said the staff were to check on the resident within hour increments. She said to prevent further falls the resident should not be left alone in his room because he would try to get up from his recliner. She said the resident could not use the call light. She said the staff frequently brought Resident #46 by the nurses' office and placed him in his wheelchair in front of the television to keep an eye on him. CNA #2 was interviewed on 3/6/24 at 1:40 p.m. She said before the fall with hip fracture, the resident was independent in his room. The staff interventions were to help him to the bathroom before he tried to go without assistance. She said he should call for staff assistance but he did not remember to use the call bell. She said the resident should be checked by staff more frequently, like every 15 minutes, but this intervention was not in the care plan. She said the purposeful rounds intervention did not have a time attached and when staff was busy they did not check on the resident for a couple of hours. The RNA was interviewed on 3/7/24 at 8:07 a.m. She said after a fall, a registered nurse assessed the resident for injuries and let the RNA know of the accident. She said she reviewed the care plan, added new approaches and wrote a note. She said the IDT reviewed each fall once a week. III. Resident #25 A. Resident status Resident #25, age 86, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), the diagnoses included Parkinson's disease with dyskinesia (involuntary movement of the face, arms, legs or trunk), muscle weakness, right artificial hip joint, restless leg syndrome, hypertension and hyperlipidemia. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 1/15/24 minimum data set (MDS) assessment documented the resident was moderately cognitively intact with a brief interview for mental score (BIMS) of 10 out of 15. He required substantial assistance with showering, dressing, toileting and transfers. The resident fell two or more times since he was admitted and since the last assessment. B. Resident interview Resident #25 was interviewed on 3/4/24 at 4:39 p.m. He said he slipped out of his reclining chair when he transferred himself to or from his wheelchair. He thought he slipped because of the bed sheet on the reclining chair. He slept in his chair instead of a hospital bed. He did not know what the facility was doing to prevent him from slipping or falling. He felt like falling was one of those things in life that would happen. C. Observations On 3/4/24 at 1:11 p.m., the resident transferred himself from the wheelchair to the reclining chair. An unidentified housekeeper entered the room as the resident transferred himself. She did not ask if he needed help and no staff entered the room. The housekeeper was in the room until 1:26 p.m. A continuous observation occurred on 3/6/24 from 9:25 a.m. until 11:01 a.m. The resident was sleeping in his bed with his door open. The resident's room was the second to last room in the hallway and according to previous interventions he was supposed to be moved closer to the nursing station. A staff member looked in the resident's room at 9:33 a.m. The staff member did not walk into the resident's room. An unknown dietary aide walked in and out of the resident's room at 9:47 a.m. At 9:58 a.m. an unidentified nurse walked in the resident's room and closed the door. The nurse left the room at 10:01 a.m. and kept the door open approximately 30 degrees. The resident was not visible with the door opened at 30 degrees. At 10:33 a.m., an unidentified staff member walked from an office at the end of the hallway. The staff member did not enter the resident's room. At 10:36 a.m. the same unidentified nurse walked by all rooms in the hallway. She did not enter Resident #25's room. At 10:54 a.m. laundry entered the resident's room and woke the resident up. She put the resident's clothes away and closed the door at 30 degrees. She did not ask the resident if he needed anything. D. Record review (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The fall care plan, revised 5/10/23, revealed the resident had a care plan for falls. The resident was at risk for falls related to his history of falls, muscle weakness, potential medication side effects, potential vision impairment, cognitive impairment, Parkinson's, psychotropic medication use, potential vision impairment, history of furniture walking, incontinence, increase in tremors, decrease range of motion to bilateral lower extremities (hips), does not consistent call for assistance, refuses the use of slideboard, arthropathy of right hip, benign prostate hyperplasia, right artificial hip, refusal to let staff assist with transfer, potential medication side effects and refusal to use sit to stand lift. Interventions included anti-roll brakes placed on wheelchair (initiated 6/30/21), call do not fall sign placed at bedside (initiated 10/9/19), extra grab bar placed in bathroom to facilitate easier and safer transitions between toilet and wheelchair (initiated 4/12/23), high back wheelchair for proper positioning (initiated 10/20/22), offer and encourage a room closer to the nurse's desk or a high visible room (initiated 11/4/23), purposeful rounds (9/2/18), sign to alert staff of high fall risk on outside of resident's door (initated 10/20/23), extensive two assist and use gait belt (initiated 11/20/23). -The fall risk care plan did not consistently include interventions added after he fell (see below). The 1/19/24 fall risk assessment revealed the resident had intermittent confusion, had one to two falls in the past three months, was chair bound, had a change in medication and had Parkinson's disease. The resident scored a 19 which indicated the resident was a high fall risk. 1. Fall incident on 2/19/24 The 2/19/24 nurse initial fall note revealed the resident was found on the floor between his recliner and his wheelchair. The resident tried to transfer himself from his wheelchair into his recliner to take a nap and slipped between the chairs. The new intervention was resident education on call for staff assistance. -The root cause was not identified. -The physical assessment of the resident was not documented. -The fall care plan did not reveal new interventions. 2. Fall incident on 1/5/24 The 1/5/24 nurse's initial fall note revealed the resident was found on the floor. The resident tried to transfer from his recliner to his wheelchair. The new intervention was staff training to offer toileting after meals. -The root cause was not identified. -The fall care plan did not reveal new interventions. 3. Fall incident on 11/29/23 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 11/29/23 nurse's progress note revealed the resident was found on the floor in front of the recliner. The resident tried to transfer to his wheelchair. The intervention was to call for assistance when toileting. -The root cause was not identified. -The fall care plan did not reveal new interventions. 4. Fall incident on 11/13/23 The 11/13/23 nurse's progress note revealed the resident was found on the floor. The resident tried to transfer to his recliner because he was uncomfortable in his wheelchair for a long period of time. The intervention was to call for assistance when he wanted to transfer to and from his wheelchair. -The root cause was not identified. -The fall care plan revealed there was a call don't fall sign at the bedside initiated on 10/9/19. The care plan revealed to offer and encourage a room closer to the nurse's station or a high visible room initiated on 11/14/23. 5. Fall incident on 9/29/23 The 9/29/23 nurse's fall progress not revealed the resident was found on the floor. The resident had to transfer from his recliner to the wheelchair and slid to the floor. -The root cause was not identified. -There was no intervention documented. -The fall care plan did not reveal new interventions. E. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 3/7/24 at 11:14 a.m. The CNA said she knew a resident was a high fall risk because therapy told her and when she rounded. She said if a resident fell , she would turn the call light on, ensure the resident was safe and notify the charge nurse. She said typical interventions included to check on residents frequently to see if they had to use the bathroom, if they were thirsty or if they were hungry. She said purposeful rounding was walking up and down the hallway and look in the resident's room. She said Resident #25 was a high fall risk. His interventions were to help him to the bathroom before he tried to go without assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Registered nurse (RN) #1 was interviewed on 3/7/24 at 9:52 a.m. She said she knew a resident was a high fall risk based on the resident's cognition and gait. If the resident was restless or their gait was unsteady, she told the CNAs to keep an eye on the resident and keep the resident close to the nurse's station. She said if a resident fell , the registered nurse would do an initial assessment. The assessment included a cognition check and a physical check to see how their gait was and if they had fractures, bruising and skin tears. If the fall was not witnessed, she would monitor for 72 hours with a neurological check. She would notify the provider and the family. She said Resident #25 was a high fall risk because he felt confident to transfer himself. She said CNAs knew he was not compliant with his call light so purposeful rounding was important for his safety. The director of nursing (DON) was interviewed on 3/7/24. The DON said if a resident fell , the nurse responded to do an assessment. The fall assessment was documented in the electronic medical record. After an unwitnessed resident fall, neurological checks started, the provider and family were notified, the care plan was updated to include new interventions and the interdisciplinary team reviewed the fall. She said a nurse knew a resident was a high fall risk based on the fall risk assessment and a CNA knew a resident was a high fall risk based on Kardex (care instructions for CNA). She said one typical intervention was purposeful rounding. She said purposeful rounding was walking into the resident's room to ask if the resident needed something to drink, if the resident was in pain, if the resident needed to go to the bathroom. She said if the resident was asleep, the staff should to go in the room to see if the resident was restless. She said she did not have a frequency for purposeful rounding because the staff were going up and down the hallway to help residents. She said the ideal frequency was an hour. She said Resident #25 was a high fall risk. She said a room closer to the nurse's station opened yesterday and the resident was moving. She said staff that went up and down the hallway should have went into Resident #25's room with the door closed and if he was sleeping. -Resident 25's Kardex did not reveal purposeful rounding to prevent falls. IV. Resident #43 A. Resident status Resident #43, age 99, was admitted on [DATE]. According to March 2024 CPO, diagnoses included nonexudative age-related macular degeneration, bilateral, intermediate dry stage, osteoarthropathy, saddle embolus of pulmonary artery without acute cor pulmonale, history of falling, age-related osteoporosis, insomnia and dementia. The 1/19/24 MDS assessment revealed severely impaired cognition with a BIMS score two out of 15. She required supervision with bed mobility and transfers. She had one fall, no injury. B. Record review The fall risk assessments review revealed: On 10/20/23 Fall Risk Assessment score 14, which indicated high fall risk. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/19/24 Fall Risk Assessment score 14, which indicated high fall risk. The comprehensive care plan revealed: (Resident) has an ADL (activities of daily living) self-care performance deficit r/t (related to) external devices, impaired balance, limited mobility, limited ROM (range of motion), musculoskeletal impairment. Date initiated 7/17/22 Resident) is at high risk for falls r/t (related to) confusion, gait/balance problems, hx (history) of falls, right femur fx (fracture). Date initiated 7/17/22. Interventions included: Apply tape to floor bedside bed to aide in unassisted transfers out of bed. Fall leaf to door frame alerting staff high fall risk. Date initiated 2/10/24. Keep w/c (wheelchair) positioned close to bed with wheels lock for unassisted transfers out of bed. Date initiated 2/10/24. Move to a room where she is more visible. Purposeful rounds. Sign to alert staff of high fall risk placed on outside of resident's door. Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Ensure that the resident is wearing appropriate nonskid footwear when ambulating or mobilizing in w/c (wheelchair). Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT (interdisciplinary team) as to causes. -The facility failed to define a time frame for purposeful rounds. -The facility failed to appropriately assess severely cognitively impaired Resident #43 for the use of a call light. 1. Fall #1 On 12/17/24 a nurse documented: Resident was resting in bed, was trying to get up into w/c (wheelchair) and sustained unwitnessed fall. Resident w/c was at bedside and locked. Resident was sitting on floor with back towards the frame of her bed, feet facing the opposite side of the room. Call light within reach, lying next to resident in bed. 2. Fall #2 On 1/27/24 a nurse documented: CNA reported (Resident) had to be lowered to the floor in her room by her bed. When entering the room this nurse observed (Resident) sitting on her buttock with her back resting against the bed with legs straight and hands at her side. Wheelchair is sitting at bedside with brakes engaged, floor is clean/dry and clutter free. She had her slippers on. C/O (complained of) slight right shoulder pain 1/10. She reports she had just come from the bathroom and was transferring to the bed when she got dizzy. When asked what happened she stated 'I'm keeping the floor warm' and laughed. ROM WNL (range of motion within normal limits), mentation is at baseline. She was assisted up by this nurse and CNA. (Resident) was able to help in getting herself up and into bed. Assisted her to stand and get into bed, notified RN on call, instructed CNA to apply gripper socks due to use of TED hose and ensure pad alarm is on and functioning. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/29/24 RNA documented: Fall Interven[TRUNCATED]

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on interviews and record review, the facility failed to provide trauma informed care in order to eliminate or mitigate triggers for one (#68) of one out four of 33 sample residents. Specifically, the facility failed to identify triggers for Resident #68 ' s trauma, who was a Veteran that served during war time. Findings include: I. Facility policy and procedure The Trauma-Informed and Culturally Competent Care policy, revised 8/22, was provided by the corporate nurse consultant on 3/6/24 at 4:00 p.m. The policy documented in pertinent part: Perform universal screening of residents, which includes a brief, non-specialized identification of possible exposure to traumatic events. Utilize screening tools and methods that are facility-approved, competently delivered, culturally relevant and sensitive. Assessment involves an in-depth process of evaluating the process of symptoms, their relationship to trauma, as well as the identification of triggers. Utilize licensed and trained clinicians who have been designated by the facility to conduct trauma assessments. Use assessment tools that are facility-approved and specific to the resident population. Develop individualized care plans that address past trauma in collaboration with the resident and family. Identify and decrease exposure to triggers that may re-traumatize the resident. Recognize the relationship between past trauma and current health concerns. II. Resident #68 A. Resident status Resident #68, age 76, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO) the diagnoses included Parkinson ' s disease with dyskinesia (involuntary movement of the face, arms, legs or trunk), transient ischemic attack (brief blockage of blood flow to the brain), scoliosis and depression. The 11/27/23 minimum data set (MDS) assessment documented the resident was moderately cognitively impaired with a brief interview for mental status score (BIMS) of 10 out of 15. He required supervision for oral hygiene, substantial assistance with toileting, showering, dressing and personal hygiene. B. Resident interview (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #68 was interviewed on 3/5/24 at 8:57 a.m. He said he had anxiety which caused him to shake. He said he had nightmares. He served in the army during the Vietnam War. He said after the last spinal surgery, he had a nightmare. His nightmare was a flashback of a friend he served with in Vietnam. His friend had abdominal surgery that left a vertical scar from the top of his chest down to his stomach. The surgical site was infected which caused pus and a smell. The resident said he never forgot the smell. When he woke up, a facility nurse said he had a trip. She knew he was having a nightmare because he was full of sweat. C. Record review A life events checklist (LEC) was completed on 9/1/23. It revealed the resident had experienced a transportation accident, serious accident at work, home or recreational activity, physical assault, life threatening illness or injury, severe human suffering, sudden violent death, sudden unexpected death of someone close to you. It documented he was interested in being seen by the mental wellness provider and his pastor. The 11/1/23 mental wellness provider progress note revealed he was seen for psychiatric evaluation. He had increased anxiety, depression and grief over his health decline. He had nightmares or vivid dreams at least four or more times per week. He shared that he had suicidal ideation with a plan six weeks ago. He went to the hospital for an evaluation. The treatment plan was situational depression and nightmares. The trauma informed care plan, revised 10/24/23, documented interventions including refer to life events paper, frequent visits from church/family/community, agree to in-house mental wellness provider, discharge and transportation planning to work on car transfers for transportation needs out of town and to local appointments. The care plan said the resident had insomnia. Interventions included monitoring hours of sleep per order and non-pharmacological interventions. -The care plan did not identify triggers. III. Staff interviews Certified nurse assistant (CNA) #1 was interviewed on 3/7/24 at 11:14 a.m. She said she would know a resident was a trauma survivor either when she was told verbally in report or if she looked in the resident ' s electronic medical record. She knew a resident ' s triggers when another staff member shared the triggers with her. She was familiar with Resident #68 and did not know he was a trauma survivor. Registered nurse (RN) #1 was interviewed on 3/7/24 at 11:06 a.m. She said she knew a resident was a trauma survivor based on her gut feeling. She knew the triggers after she cared for the resident. She tried to document triggers in the progress notes and at shift pass. She said the approach she used was to talk to them about their home and family. She was familiar with Resident #68. She knew he was upset about not being able to walk and he had five back surgeries. She said one surgical incision was a problem because it was infected. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social services director (SSD) and corporate social services quality mentor (CSS) were interviewed on 3/6/24 at 12:08 p.m. The SSD said she knew a resident had a history of trauma at time of admission when the resident or family member completed the life event questionnaire. She documented what services the resident wanted on the questionnaire. It included mental wellness provider services, pastoral visits and family support. The questionnaire was scanned in the electronic record. The SSD was aware the resident was anxious about going out in the community, especially transporting in and out of the car. The SSD and CSS were interviewed again on 3/7/24 at 10:23 a.m. The SSD said she updated the resident ' s care plan. The care plan included a specific care plan for trauma informed care. The SSD said she completed a resident trauma interview. The SSD said the initial life event questionnaire did not identify if the resident had triggers or if any trauma caused nightmares, sleep disturbance and anxiety. The CSS said the resident trauma interview form would be used for all new residents and they would complete the interview for any current residents identified with trauma. IV. Facility follow-up The 3/7/24 resident trauma interview was provided on 3/7/24 at 10:23 a.m. It revealed the resident had military related trauma, back surgery trauma that included a fear of falling, transferring and emergency transport. He sometimes had nightmares related to the military, sleep disturbance related to pain and anxiety. He was concerned about his surgical incision bursting open when they moved him to bed and anxiety related to medical transports and transfers. He had triggers that included the thought of going out of the facility caused him increased anxiety. It revealed anxiety centered around wanting to go home and talking about transfers caused him to shake. The care plan was updated on 3/6/24 to include a trauma informed care plan. It revealed the resident had military service, fear of falling and anxiety with transfers and transports. The interventions included family and friends to visit and take him out in the community, involvement with church community, offer resident activities of his choice, medication management for mental health, offer mental health counseling and staff to inform resident of care to be provided like transfer, repositioning and toileting.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536 Based on observations, interviews and record review, the facility failed to use a person-centered approach when determining the use of bed rails for ten (#2, #22, #26, #36, #43, #58, #59, #62, #68 and #71) residents with bed rails out of 33 sample residents. Specifically, the facility failed to ensure for Residents #2, #22, #26, #36, #43, #58, #59, #62, #68 and #71: -Assess the resident for risk of entrapment prior to installing bed rails; -Obtain consent from the resident and/or the responsible party prior to bed rail installation; and, -Follow guidelines for maintaining bed rails. Findings include: I. Professional reference The U.S. Food and Drug Administration (FDA) Clinical Guidance for the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, updated 2/27/23 and retrieved on 3/5/24 from https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails included bed rail safety guidelines, read in pertinent part: -Any decision regarding bed rail use or removal from use should be made within the framework of an individual patient assessment. -Bed rail use for patient's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan. -The equipment (beds/mattresses/bed rails) should be inspected, evaluated, maintained, and upgraded to identify and remove potential fall and entrapment hazards and appropriately match the equipment to patient needs, considering all relevant risk factors. -The patient's needs should be re-assessed and the equipment re-evaluated if an episode of entrapment or near-entrapment occurred, with or without serious injury; this was done immediately because fatal 'repeat' events could occur within minutes of the first episode. -The bed, mattress and any accessories should be monitored and maintained on an ongoing basis. II. Facility policy and procedure (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Bed Safety and Bed Rails policy, revised August 2022, was received by the nursing home administrator (NHA) on 3/7/24 at 10:55 a.m. read in pertinent part: The use of bed rails or side rails is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation (IDT), resident assessment, and informed consent. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This IDT evaluation includes: -An evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs; -The resident's risk associated with the use of bed rails; -Input from the resident and/or representative; and, -Consultation with the attending physician. The resident assessment to determine the risk of entrapment includes medical diagnoses, conditions, symptoms and/or behavioral symptoms. The resident assessment determines potential risks to the resident associated with the use of bed rails including the following, accident hazards, restricted mobility and psychosocial outcomes. Before using bed rails the staff shall inform the resident or resident representative regarding the benefits and potential hazards associated with bed rails and obtain informed consent. III. Resident #2 Resident #2, over the age of 65, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included arthritis, fracture and asthma with a history of respiratory failure. The 11/28/23 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of ten of 15. The resident was independent with dressing, bed mobility, personal hygiene, transfers, toileting and required partial assistance from staff for showers. -The assessment revealed the resident did not use bed rail physical restraints. On 3/4/24 at 10:20 a.m. and 3/5/24 at 9:35 a.m., Resident #2's bed was observed to have bed rails. -Review of Resident #2's EMR revealed no evidence that Resident #2 was assessed/evaluated by the IDT for the reason for using bed rails and there was no Bed Rail Risk Assessment in the record. Additionally, the EMR revealed no evidence of a CPO for bed rails, consultation from the physician for the use of bed rails, documentation of tried and failed alternatives or informed consent for the use of the bed rail(s). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan for Resident #2, dated 11/14/22, read the resident was independent with bed mobility. -However, the resident had a left side helper rail/bed rail to aid in transfers and bed mobility. The care plan was not updated to include the resident's current need, assessed 11/28/23, for substantial assistance from staff for bed mobility and transfers. IV. Resident # 22 Resident #22, over the age of 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included Alzheimer's disease and anxiety. The 12/23/23 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of three out of 15. The resident required substantial assistance for dressing, bed mobility, personal hygiene and was dependent on staff for transfers, toileting and showers. -The assessment revealed the resident did not use bed rail physical restraints. On 3/4/24 at 10:20 a.m. and 3/5/24 at 9:35 a.m., Resident #22's bed was observed to have bed rails. -Review of Resident #22's EMR revealed no evidence that Resident #22 was assessed/evaluated by the IDT for the reason for using bed rails and there was no Bed Rail Risk Assessment in the record. -The EMR revealed a CPO for a bed rail dated 11/18/18, which read the bed rail was ordered to assist the resident in and out of bed. -However, the date of the order was two years prior to the current admission. Resident #22's care plan, dated 3/4/17, read the resident required total assistance from two staff members for bed mobility and transfers. -The EMR did not reveal evidence of consultation/reevaluation from the physician for the use of bed rails, documentation of tried and failed alternatives or informed consent for the use of the bed rail(s). -Resident #22's care plan failed to include a focus of care, goals and interventions for bed rails. V. Resident #26 Resident #26, over the age of 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included depression, anxiety and spinal cord cancer. The 1/4/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of six out of 15. The resident required substantial assistance for dressing and personal hygiene and was dependent on staff for bed mobility, transfers, toileting and showers. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The assessment revealed the resident did not use bed rail physical restraints. On 3/4/24 at 10:20 a.m. and 3/5/24 at 9:35 a.m., Resident 26's bed was observed to have bed rails. -Review of Resident #26's EMR revealed no evidence Resident #26 was assessed/evaluated by the IDT for the reason for using bed rails and there was no Bed Rail Risk Assessment in the record. Additionally, the EMR revealed no evidence of a CPO for bed rails, consultation from the physician for the use of bed rails, documentation of tried and failed alternatives or informed consent for the use of the bed rail(s). Resident #26's care plan, revised 11/3/23, read the resident had a helper rail/bed rail to assist the resident with positioning and the resident required total assistance from two staff members for bed mobility. VI. Resident #43 Resident #43, over the age of 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included history of falls, dementia and macular eye degeneration. The 1/19/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of two out of 15. The resident required substantial assistance for dressing, bed mobility, personal hygiene, transfers, toileting, and showers. -The assessment revealed the resident did not use bed rail physical restraints. On 3/4/24 at 10:20 a.m. and 3/5/24 at 9:35 a.m., Resident #22's bed was observed to have bed rails. -Review of Resident #43's EMR revealed no evidence that Resident #43 was assessed/evaluated by the IDT for the reason for using bed rails and there was no Bed Rail Risk Assessment in the record. Additionally, the EMR revealed no evidence of a CPO for bed rails, documentation of tried and failed alternatives or informed consent for the use of the bed rail(s). Resident #43's care plan, revised 3/5/24 (after the start of survey), read the resident had bilateral helper rails to assist the resident with bed mobility and the resident required extensive assistance from two staff members for bed mobility. VII. Resident # 59 Resident #59, age 79, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included chronic kidney disease and muscle weakness. The 12/18/23 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of 12 out of 15. The resident required substantial assistance for dressing, bed mobility, personal hygiene, transfers, toileting, and showers. -The assessment revealed the resident did not use restraints or bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/4/24 at 10:20 a.m. and 3/5/24 at 9:35 a.m., Resident #22's bed was observed to have bed rails. Review of Resident #59's EMR revealed an assistive device evaluation for use of a bed rail handle, dated 2/15/24. -The evaluation failed to document Resident #59's cognitive status, pertinent diagnosis, evaluation of gaps between the mattress and the side rail(s), assessment that the mattress will not slide/that it was securely in place and the bed rail was secured to the bed frame. Additionally, the EMR revealed no evidence of a CPO for bed rails, consultation from the physician, documentation of tried and failed alternatives or informed consent for the use of the bed rail. Resident #59's care plan, revised 3/5/24 (after the start of survey), read the resident had bilateral helper rails to assist the resident with bed mobility and the resident required extensive assistance from two staff members for bed mobility. VIII. Resident # 71 Resident #71, age 85, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included spine fracture and need for assistance with personal care. The 2/4/24 MDS assessment revealed the resident was not cognitively impaired with a BIMS score of 14 out of 15. The resident required supervision with oral and personal hygiene, partial assistance for transfers and dressing upper body, substantial assistance for toilet hygiene and was dependent on staff for dressing lower body. The resident refused assessment for bed mobility, showers and transfers for showers. -The assessment revealed the resident did not use restraints or bed rails. On 3/4/24 at 10:20 a.m. and 3/5/24 at 9:35 a.m. Resident #22's bed was observed to have bed rails. -Review of Resident #71's EMR revealed no evidence that Resident #71 was assessed/evaluated by the IDT for the reason for using bed rails and there was no Bed Rail Risk Assessment in the record. Additionally, the EMR revealed no evidence of a CPO for bed rails, consultation from the physician for the use of bed rails, documentation of tried and failed alternatives or informed consent for the use of the bed rail(s). Resident #71's care plan, revised 3/5/24 (after the start of survey), read the resident had a right side helper rail to assist with bed mobility and the resident was independent with bed mobility. IX. Resident #36 Resident #36, age 89, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included heart disease, dementia, behavioral disturbance, psychotic disturbance, mood disturbance, depression, anxiety, osteoporosis (bone disease), pulmonary edema (too much fluid in the lungs), post polio, hypertension (high blood pressure), hyperlipidemia (high cholesterol) and hypokalemia (low potassium). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/14/24 MDS assessment documented the resident was severely cognitively impaired with a BIMS of four out of 15. She required substantial assistance with toileting, showering, dressing, personal hygiene and mobility. On 3/4/24 at 10:36 a.m. and on 3/4/24 at 3:02 p.m. a bed rail was on the left side of the resident's bed. The care plan was reviewed. It revealed the resident had an self care performance deficit related to dementia, impaired balance and limited mobility revised on 11/3/23. One intervention initiated on 2/16/21 revealed the resident had a helper rail to assist with bed mobility. -The resident's electronic medical record revealed Resident #36 was not evaluated to use a bed rail, there was not a physician order for bed rails and there was no documentation about the benefits and risks to use a bed rail was explained to the resident or family. X. Resident #58 Resident #58, age 82, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included Alzheimer's disease, insomnia, chronic kidney disease, prediabetes, anxiety and depression. The 1/4/24 minimum data set (MDS) assessment documented the resident was unable to complete the brief interview for mental status score (BIMS). She was dependent on toileting, showering, dressing, personal hygiene and mobility. She required substantial assistance with oral hygiene and she required moderate assistance with eating. On 3/5/24 at 9:14 a.m., rails were on both sides of the resident's bed. The resident's electronic medical record revealed Resident #58 was not evaluated to use a bed rail, there was not a physician order for bed rails and there was no documentation about the benefits and risks to use a bed rail was explained to the resident or family. XI. Resident #62 A. Resident status Resident #62, age 90, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included emphysema (lung disease), history of falling, atrial fibrillation (irregular heart rhythm), macular degeneration (eye disease that effects vision), anemia (low red blood cells) and hyperglycemia (high blood sugar). The 1/17/24 MDS assessment documented the resident was moderately cognitively intact with a BIMS of 11 out of 15. She required partial assistance with showering and mobility. On 3/4/24 at 3:30 p.m. and on 3/5/24 at 8:57 a.m. rails were on both sides of the resident's bed. -The care plan was reviewed on 3/4/24. It revealed bed rails were not identified on how bed rails would help the resident. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's electronic medical record revealed Resident #68 was not evaluated to use a bed rail, there was not a physician order for bed rails and there was no documentation about the benefits and risks to use a bed rail was explained to the resident or family. XII. Resident #68 A. Resident status Resident #68, age 76, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included Parkinson's disease with dyskinesia (involuntary movement of the face, arms, legs or trunk), transient ischemic attack (brief blockage of blood flow to the brain), scoliosis and depression. The 11/27/23 MDS assessment documented the resident was moderately cognitively impaired with a BIMS of ten out of 15. He required supervision for oral hygiene, substantial assistance with toileting, showering, dressing and personal hygiene. On 3/4/24 at 3:30 p.m. and on 3/5/24 at 8:57 a.m. rails were on both sides of the resident's bed. Resident #68 was interviewed on 3/5/24 at 8:57 a.m. He said the rails were used to help him roll to the left side when the staff changed his briefs. He said the right side rail was used to help him get out of bed in the morning. -The care plan was reviewed on 3/4/24. It revealed bed rails were not identified to help the resident in transfers and mobility. -The resident's electronic medical record revealed Resident #68 was not evaluated to use a bed rail, there was not a physician order for bed rails and there was no documentation about the benefits and risks to use a bed rail was explained to the resident or family. XIII. Staff interviews Registered nurse (RN) #1 was interviewed on 3/7/24 at 9:52 a.m. She said a helper rail was used when a resident was alert and oriented and could help themselves instead of waiting for a staff member to help them. A resident should be evaluated prior to using a helper rail. The evaluation was based on their level of care based on their everyday needs. She said an example was if they required minimal or extensive assistance. She said consent should be obtained by the resident or family member. The consent went over the risk and benefits of using a rail. It should be reviewed with the doctor and an interdisciplinary team conference should be completed. The director of nursing (DON) was interviewed on 3/7/24 at 10:20 a.m. She said beds were received from the vendor with the side and/or helper rails attached. She said the rails were difficult to remove and were subsequently left attached to the bed frames. The DON said the facility had evaluated all residents for bed rails from bed frames where the rails were not used. The DON said of the remaining residents an audit was completed on 3/4/23 for those residents that needed bed rails. The DON said bed rail evaluations and consents were obtained on 3/5/24 and 3/6/24. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Certified nurse aide (CNA) #1 was interviewed on 3/7/24 at 11:14 a.m. She said a helper rail were handles added to the side of the bed. She said rails helped a resident if used appropriately for bed mobility and when the resident went in and out of bed. XIV. Facility follow-up On 3/5/24 the NHA provided additional documentation completed during the survey: Resident #2 signed an informed consent on 3/6/24 for a helper rail. Nursing completed an assistive device evaluation and Resident #2's care plan was revised on 3/5/23 for a left side helper rail. Resident #26 informed consent was obtained from Resident #26's power of attorney for a helper rail. Nursing completed an assistive device evaluation. Resident #43 signed an informed consent on 3/6/24 for bilateral helper rails. Nursing completed an assistive device evaluation and Resident #26's care plan was revised 3/5/24 for the use of bilateral helper rails. Resident #59 signed an informed consent for the use of bilateral helper rails. Resident # 59's care plan was revised on 3/5/24 for the bilateral helper rails to assist with bed mobility. Documentation failed to include trial and outcome of less restrictive measures. Resident #71 signed an informed consent for a helper rail. Nursing completed an assistive device evaluation and Resident #71's care plan was revised on 3/5/24 for the use of a helper rail. -The documentation provided by the NHA on 3/5/24 did not include physician consultation or IDT review for the residents. The assistive device evaluations failed to include evaluations of gaps between the mattresses and the side rail(s), assessments the mattress would not slide, it was secured and the bed rails were secured to the bed frame. For Resident #36 the care plan was updated on 3/6/24 to remove the helper rail intervention. For Resident #58 the care plan was updated on 3/6/24 to remove the helper rail intervention. For Resident #62 a physician order was obtained on 3/5/24 for the resident to have a helper rail. For Resident #68 the care plan was updated on 3/5/24 care plan revealed the resident used bilateral helper bars to maximize independence with transferring and bed mobility. A physical restraint and assistive device evaluation was completed on 3/5/24. It revealed the rail was an assistive device as a helper rail. A physician order was obtained on 3/5/24 for the resident to have a helper rail. 48112

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47536 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection on two of three units. Specifically, the facility failed to ensure staff maintained wore PPE correctly while the facility had an outbreak of the respiratory syncytial virus (RSV). Findings include: I. Professional reference The Centers for Disease Control (CDC) infection prevention tool kit for viral and respiratory pathogens in nursing homes, reviewed 9/28/23, included: Preparing for and responding to nursing home residents or healthcare personnel (HCP) who develop signs or symptoms of a respiratory viral infection, retrieved 3/6/24 from https://www.cdc.gov/longtermcare/prevention/viral-respiratory-toolkit.html. Initial attempts to control limited spread included: -Implement universal masking for source control on affected units or facility-wide, including for residents around others (out of their room) and for HCP when in the facility. II. Facility policies and procedures The Infection Prevention and Control Program policy, revised October 2018, by the nursing home administrator (NHA) on 3/6/24 at 11:27 a.m. It read in pertinent part, An infection prevention and control program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development of transmission of communicable diseases and infections. The program is based on accepted national infection prevention control standards. The program is a facility-wide effort involving all disciplines and individuals. The elements of the infection prevention program includes: coordination/oversight of prevention of infection, outbreak management, prevention of infection and employee health and safety. Important facets of infection prevention include: -Educate staff to ensure they adhere to proper techniques and procedures; and. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Following established general disease-specific guidelines such as those of the Centers for Disease Control (CDC). Outbreak management is a process that consists of: -Determining the presence of an outbreak; -Preventing the spread to other residents; -Reporting the information to appropriate public health authorities; -Educating the staff and the public; and, -Recommending new or revised policies to handle similar events in the future. Prevention of infection: -Instituting measures to avoid complications or disseminations; -Educating staff and ensuring that they adhere to proper techniques and procedures; -Following established general and disease-specific guidelines such as those of the Centers for Disease Control. III. Failures with staff wearing PPE On 3/4/24 at 9:38 a.m. licensed practical nurse (LPN) #1 was wearing her facemask with her nose uncovered. At 11:55 a.m., LPN #1 was in the hallway, at the doorway of a resident with her nose uncovered. She prepared the resident medications and entered the room with her facemask below her nose. At 12:20 p.m. LPN #1 was walking in the hallway with her nose uncovered. While in the hallway and common area seating area, she greeted residents without positioning her mask properly. On 3/5/24 at 9:15 a.m., LPN #2 was in the hallway, working at the medication cart and preparing to administer medications. LPN #2 wore her facemask with her nose uncovered. At 12:03 p.m. office employee (OE) #1 was walking and entered a resident's room in the 200 hallway with her nose uncovered. The assistant director of nursing (ADON) was interviewed on 3/5/24 at 1:45 p.m. She said that staff should wear their facemask properly and cover their nose while the facility was in outbreak status for RSV. She said the facility would educate staff to wear their facemask properly. The ADON was interviewed again on 3/6/24 at 10:35 a.m. She said on 3/6/24 the facility completed facility-wide education for staff to properly wear their facemask. (continued on next page)

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