STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105966	A. Building B. Wing	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Larsen Health Center	13880 Shell Point Plaza Fort Myers, FL 33908

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of facility policy and procedures, record review and staff interviews, the facility failed to have documentation of a thorough investigation related to alleged violations, including injuries of unknown origin for 2 (Resident #143 and #140) of 3 sampled residents reviewed for accidents. The findings included: 1. The facility policy Fall Management Program origination 3/8/17 (revised 11/22) documented, The Falls Management Program is an interdisciplinary quality improvement program that provides resident fall processes and outcomes. The program utilizes a systemic approach to assessment, individualized intervention and monitoring that will result in injury reduction and minimizing fall risk to our residents. An incident report will be completed for every resident fall within 24 hours. The interdisciplinary team (IDT) will complete a thorough investigation as well as a root cause analysis of all falls by completing the Post Fall Review Form. Review of the clinical record revealed Resident #143 had an admitted [DATE] and a readmitted [DATE] with diagnoses including Alzheimer's, dementia, left hip fracture, frequent falls, and aphasia (loss of ability to express or understand speech). The Admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 1/26/23 documented Resident #143 required limited assistance of one person with bed mobility, transfers, and ambulation. The MDS noted a Brief Interview for Mental Status (assessment of a resident's cognitive function) was 99 indicating the resident was unable to complete the interview. The facility fall assessment dated [DATE] determined the resident was a moderate risk for falls. The facility initiated a care plan on 12/26/22 indicating Resident #143 was at risk for falls due to weakness, low endurance and decreased mobility as a result of acute or chronic health conditions and aphasia. (continued on next page)

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

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan interventions on 12/28/22 included to orient resident to room, call light, and need to call for, and wait for assistance, maintain adequate lighting in resident's room, keep bed in lowest position possible, attempt to keep resident as active in activities during the day as resident will allow. On 1/20/23 at 6:30 a.m., Resident #143 was found on the floor in her room and was unable to state what she was doing at the time of the fall. On 1/21/23 at 3:31 p.m., Unit Manager, Licensed Practical Nurse (LPN) Staff F completed the investigation follow up and documented IDT (interdisciplinary team) meeting regarding found on floor next to bed. Regular mattress in place. Work for grab bars placed. Intervention: Staff to ensure wheelchair to be placed at bedside. On 1/24/23 at 1:00 a.m., Resident #143 was found on the floor in her room. On 1/25/23 at 4:48 p.m., LPN Staff F completed the investigation follow up and documented Visual reminder to use call bell for assistance. On 1/29/23 at 6:25 p.m., Resident #143 was found sitting on the floor. The incident report documented This nurse was notified by neighboring resident family that she heard a big bang. Upon arrival resident was observed sitting, guarding LLE (left lower extremity) and being in distress/teary. Three wheeled walker next to her. The nurse documented the resident reported pain pointing to the left knee. The nurse assessed Resident #143 and documented the left lower extremity appeared shorter and rotated with substantial bruising. The resident was sent to the local hospital emergency room where a left knee x-ray was obtained. The x-ray report documented no acute fracture or dislocation. The resident was transferred back to the facility. On 2/27/23 at 1:03 p.m., LPN Staff F completed the investigation follow up and documented, IDT meeting regarding fall 1/29/23. Resident returned from ER (emergency room) continue B&B (bowel and bladder) observation and set up B&B schedule for resident. On 2/10/23 at 9:00 p.m., a facility incident report documented 2/9/23 resident complained of left hip pain, primary nurse notified, some bruising and edema on left hip. Resident #143 was sent to the local hospital emergency room where an x-ray confirmed acute left hip fracture. The resident was admitted to the hospital and had a surgical repair of the left hip fracture on 2/12/23. On 3/6/23 at 4:16 p.m., LPN Staff F completed the investigation follow up and documented, Left hip fx (fracture). Provider notified supervisor to send to ER for left hip fx, pain management and ortho consult. On 3/16/23 at 11:40 a.m., LPN Staff F said she completed the incident form on 1/29/23 at 6:25 p.m., when Resident #143 was found on the floor. She said she did not find her. The Registered Nurse completed the incident report but did not sign it and, I signed it after I reviewed it. The initial investigation process is the manager or supervisor is notified. The process is to ensure we did contact the house supervisor. In this situation, the supervisor sent her out. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Normally we review the incident and if it was a witnessed fall, we interview staff to see what they observed. If the fall was unwitnessed we do not do interviews but we will now. The root cause of the fall on 1/29/23 was Resident #143 got up to go the bathroom because she does not get up unless she has to go to the bathroom. The resident is nonverbal and took herself to the bathroom. She was found next to the bed with the walker so I figured she was going to the bathroom, it does not say that on the form. The investigation as to why she fell was she was getting up to go to the bathroom it is what she always does. LPN Staff F confirmed she did not have documentation of witness statements, and no documentation of an interview with the family member who reported on 1/29/23 hearing a loud bang from the resident's room. LPN Staff F said there was no documentation of additional falls between 1/29/23 and 2/10/23 when the left hip fracture was identified. The LPN said, the resident was sent to the emergency roiagnom on [DATE] and returned with no fracture, she was propelling herself in the wheelchair with no pain. On 2/9/23 she had pain and we sent her for an x-ray, it showed a fracture, and she was sent to the emergency room . LPN Staff F said I can't say for certain if Resident #143 was ambulating after the fall on 1/29/23 because there was no documentation. I can't say for sure the left hip fracture was related to the fall on 1/29/23 because there was no investigation. On 3/15/23 at 1:38 p.m., the Administrator who is the Risk Manager said she did not investigate or file a report to the required State Agency once the hospital identified an acute left hip fracture with Resident #143, because we did not know what happened to her. On 3/16/23 at 9:40 a.m., in an interview the Administrator said she did an informal investigation with staff but had no documentation of an investigation for the acute left hip fracture. The Administrator confirmed Resident #143 had multiple falls before the left hip fracture was identified on 2/10/23. The Administrator confirmed the follow up and investigation section of the incident reports were completed several weeks after the incident and did not show a complete investigation. On 3/16/23 at 1:31 p.m., the Director of Nursing said they felt the fracture of the left hip was a result of the fall on 1/29/23 but confirmed no investigation was completed. 25618 2. On 3/14/23 at 1:50 p.m., Resident #140 was observed with a purplish-blue bruise under his right eye. On 3/14/23 at 1:52 p.m. , Resident #140's wife said the bruise around her husband's right eye appeared one-day several weeks ago. When she asked what happened they told her they did not know. On 3/15/23 review of Resident #140's medical record revealed he was admitted on [DATE] with a diagnosis of muscle weakness and Parkinson's disease. A nursing progress note dated 2/24/23 at 7:24 a.m. said at 7:15 a.m. they found a new small open area to Resident #140's right temple. They applied pressure to the area and then left it open to the air. The cause of the open area was unknown, and the incident was unwitnessed. Neuro checks were initiated. The daughter was notified, and staff would continue to monitor. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #140's medical record revealed a fall care plan stating Resident #140 was at risk for falls due to weakness, and poor safety awareness related to dementia diagnosis. Some of the approaches listed to keep Resident #140 from falling were to keep the call light within reach, the bed in a low position, reduce stimulus in the room at night, maintain adequate light when the resident was awake and keep personal items within reach. On 3/15/23 at 12:10 p.m., Certified Nursing Assistant (CNA) Staff K, she said when she came to work several weeks ago, she found Resident #140 sitting in a chair. There was a large bruise around his right eye and temple area but due to his dementia, he was unable to tell her what happened. She believed he hit his head on something but did not know what caused the bruise on Resident #140's right temple and eye area. She said no one from the administration interviewed her about the bruise on Resident #140's right temple area. On 3/16/23 at 10:57 a.m., the Director of Nursing (DON), she said Resident #140 was admitted to the facility on [DATE]. She said due to Resident #140's increased confusion and safety concerns he was moved to a secured unit. The DON reviewed Resident #140's medical record and confirmed the nurse wrote a progress note on 2/23/23 at 7:43 a.m. which stated they found a new small open area to Resident #140 right temple. She said when an injury of unknown origin was found an incident report should be created and a full investigation should be started to include resident and staff interviews to assist in determining what could have caused the injury. The DON said after reviewing the 2/24/23 incident report, Resident #140 was found by Staff K in the living area with a bruise on his right temple. She said there was no documentation they had interviewed any of the residents or staff to determine how the injury might have occurred and/or put into place interventions to ensure it didn't happen again. She said the Nurse Manager was responsible to conduct the investigation. On 3/16/23 at 12:55 p.m., Nurse Manager Staff F and Clinical Coordinator Staff L, said they oversee the memory care units. They said on 2/24/23 during the morning meeting they saw the incident report about a bruise of unknown origin on Resident #140's right temple. After the morning meeting, they did an assessment of the bruise of unknown origin on Resident #140's right temple. They said since it was not bleeding, they did not have to get a treatment order. Staff F said they did not document their assessment of the bruise on Resident #140's right temple area and did not investigate to determine how the bruise of unknown origin might have occurred and/or put interventions in place to ensure it did not occur again. On 3/16/23 at 4:26 p.m., the DON said after a full review of Resident #140's medical record, the incident report, and the morning Stand Up meeting notes, she was unable to find the documentation they had completed a full investigation into the bruise of unknown origin to Resident #140's right temple as required.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 41155 Based on review of facility policy and staff interviews, the facility failed to ensure the activities program was directed by a qualified professional who is a qualified therapeutic recreation specialist or an activity professional. This has the potential to affect all current residents residing in the facility. The findings included: The facility policy, Activity Programs - Staffing (revised June 2018) documented, Our activity programs are staffed with personnel who have appropriate training and experience to meet the needs and interests of each resident. Our activity programs are under the direct supervision of a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable by the state in which practicing. On 3/15/23 at 3:14 p.m., Activity Aide Staff H said the facility did not have an Activity Director to oversee the activity programs. Staff H said there were five activity aides to cover six floors of the facility. She said they are each assigned a floor and there are two units on each floor. Staff H said she bounced around a bit to cover her assigned floor and assist with coverage on other floors. On 3/15/23 at 4:21 p.m., the Administrator, said the Activity Director resigned on 10/21/22 and she had tried to replace her. The Administrator said she was overseeing the activity department and was meeting with the activity staff each week. The Administrator confirmed she did not have the credentials to oversee the activity program.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46824 Based on observation, clinical record review, review of the facility's policy and procedure, resident and staff interviews, the facility failed to provide care and services in accordance to professional standards of practice to meet the needs of 2 (Resident #148, and #67) of 5 sampled residents reviewed for skin condition. The findings included: 1. Clinical record review revealed Resident #148 was admitted to the facility on [DATE]. Diagnoses included fracture of the right femur. Resident #148 was non-weight bearing on the right leg. The physician's orders dated 1/27/23 included to apply thigh high TED hose (compression stockings) every morning before rising and remove at bedtime. On shower days, staff was to apply the TED hose after the shower and remove at bedtime. The Admission Minimum data set (MDS) assessment dated [DATE] revealed resident #148 was cognitively intact. The resident required limited physical assistance of one person for dressing (including donning/removing a prosthesis or TED hose), and bathing. Review of the Treatment Administration Record for 3/1/23 through 3/15/23 revealed documentation the TED hose was applied daily at 6:00 a.m., and removed at 9:00 p.m., including on 3/13/23 and 3/14/23. On 3/13/23 at 9:38 a.m., and 3:12 p.m., Resident #148 was observed sitting in a recliner. She was not wearing the TED hose. On 3/13/23 at 3:12 p.m., Resident #148 said she had never had the TED hose put on. On 3/14/23 at 1:31 p.m., Resident #148 was observed in her room. She stated she was just returning from the salon. Resident was not wearing the TED hose. She stated staff had never applied the TED hose to her legs. She said no one asked if she wanted to wear them, and she had never refused to wear them. On 3/15/23 at 2:51 p.m., in a telephone interview Licensed Practical Nurse (LPN) Staff X, stated she works the night shift and took care of Resident #148. She said, I don't have any knowledge of her [Resident #148] wearing the TED hose or refusing them. I do not recall putting them on her. On 3/15/23 at 3:08 p.m., Certified Nursing Assistant (CNA), Staff S said Resident #148 required one person assistance for dressing and transferring. She said, I didn't put the TED hose on her myself. I do not recall seeing them on her. On 3/15/23 at 3:28 p.m., LPN Staff O said she knew Resident #148 had an order to wear TED hose during the day but she could not recall Resident #148 wearing them. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/15/23 at 3:35 p.m., the Physical Therapist assigned to resident #148 stated she never saw the resident with TED hose on. On 3/16/23 at 3:41 p.m., Registered Nurse Staff Z stated she did not recall Resident #148 wearing TED hose, the resident may have refused on occasion. She said the flow sheet showing documentation of the TED hose being put on and taken off may have been documented incorrectly, and she would have to investigate it further. 2. The facility's policy and procedure titled Skin tear protocol with a policy revision date of 1/23 noted skin tears will be treated immediately to expedite rapid healing. The procedure noted to write the order as described. Cleanse with (brand name) wound cleanser . Apply silicone foam dressing. Change every seven days and as needed. The protocol specified, in the presence of a skin tear, the procedure will be written as an order and transcribed to the Treatment Administration Record. The Licensed Nurse will document the procedure and the progress. Review of the clinical record for Resident #67 revealed an admitted [DATE]. The Admission Minimum Data Set (MDS) assessment (tool to measure health status of nursing home residents) with an assessment reference date of 2/12/23 noted the resident's skin was intact. On 3/13/23 at 11:15 a.m., Resident #67 was observed sitting on the edge of her bed. Resident #67 said she had multiple skin tears. A dressing dated 3/2/23 was observed to the right shoulder, and a dressing to the right leg, and left upper arm dated 3/7/23. On 3/15/23 at 8:14 a.m., Resident #67 was observed with the same dressing to the right shoulder dated 3/2/23, the right leg dated, and left upper arm dated 3/7/23. Review of the skin evaluation forms completed on 2/18/23, 2/25/23, 3/3/23, and 3/12/23 did not note skin tears to the right shoulder, the right leg and left upper arm. Review of the Treatment Administration Record (TAR) for 3/23 for Resident #67 failed to reveal treatment orders for the right shoulder the right leg and left upper arm. The TAR had a weekly treatment order for a skin tear starting on 3/3/23 and ending on 3/15/23. The TAR did not specify the location of the skin tear. On 3/15/23 at 8:16 a.m., a joint observation of the dressings to Resident #67's right shoulder, right leg and left upper arm was made with Licensed Practical Nurse (LPN) Staff AA, and the 3rd-floor Unit Manager. Both nurses verified the dressing to the right shoulder was dated 3/2/23 and the dressings to the right leg and left upper arm were dated 3/7/23. LPN Staff AA said the skin tear protocol was to change the dressing every seven days. She confirmed the dressing to the right shoulder was dated 3/2/23 and had not been changed in 13 days. She also confirmed the dressing to the right leg and left upper arm were dated 3/7/23 and had not been changed in eight days. On 3/16/23 at 1:04 p.m., the Unit Manager said she would investigate why the treatment to the right shoulder, the right leg and the left upper arm were not done.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, record review, review of facility's policy and procedure, resident representative and staff interviews, the facility failed to assist with necessary podiatry follow up appointments for 1 (Resident #81) of 5 sampled residents reviewed. The findings included: The facility's policy and procedure for care of the fingernails and toenails reviewed February 2018 noted the purpose included to keep nails trimmed, and to prevent infections. The general guidelines specified unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairment; stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease. Review of the clinical record for Resident #81 revealed an admitted [DATE]. Diagnoses included generalized muscle weakness, dementia, and high blood pressure. Resident #81 resided in the Memory Care Unit of the facility. The Quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 2/20/23 noted the resident was cognitively impaired and dependent on staff for activities of daily living. Resident #81 did not reject care. Review of the physician's progress notes revealed on 9/8/22 Resident #81 saw the podiatrist. The podiatrist documented a diagnosis of atherosclerosis of the arteries of the extremities (thickening of the arteries, causing reduced blood flow to extremities). The podiatrist documented Resident #81 had a painful corn to the left foot; ten mycotic (nail fungus) painful incurvated, inflamed toenails; ingrown toenails; pain in left foot; pain in right toes; pain in left toes. The podiatrist performed a sharp debridement (removal of dead tissue) of the keratotic lesion (corn). The podiatrist documented Resident #81 needed to be seen again in two months. Review of the Social Work Progress Note dated 2/22/23 revealed a care plan meeting was held with the resident's healthcare surrogate (HCS). The HCS said she was worried about Resident #81's toenails. The HCS stated she would check Resident #81's toes and let them know if she needs to be seen. On 3/15/23 at 12:55 p.m., during a telephone interview, Resident #81's Health Care Surrogate (HCS) said the facility was not taking care of Resident #81's toenails. On 3/16/23 at 10:35 a.m., observation of Resident #81's toenails with Clinical Coordinator Registered Nurse (RN) Staff L revealed long, thick, yellow toenails on both feet. RN Staff L said toenail clippers would not be effective for trimming the toenails, and Resident #81 should be seen by the podiatrist. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/16/23 at 12:29 p.m., RN Staff L verified on 9/8/22 the podiatrist requested a two month follow up appointment for Resident #81. She said the facility failed to arrange the two month podiatry follow up appointment, and Resident #81 did not receive the necessary foot care. On 3/16/23 at 2:58 p.m., the Administrator said it has been a problem arranging and transporting Memory Care Residents to and from the podiatrist for a few months.

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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** 41155 Based on observation, review of facility policy and procedures, record review and staff interviews, the facility failed to provide adequate supervision and implement necessary interventions to prevent avoidable accidents for 1 (Resident #143) of 4 residents reviewed who were identified as being at risk for falls and sustained multiple falls at the facility, and a fracture requiring a transfer to a higher level of care. The findings included: The facility policy Fall Management Program origination 3/8/17 (revised 11/22) documented, The Falls Management Program is an interdisciplinary quality improvement program that provides resident fall processes and outcomes. The program utilizes a systemic approach to assessment, individualized intervention and monitoring that will result in injury reduction and minimizing fall risk to our residents . The IDT [interdisciplinary team] will complete a thorough investigation as well as a root cause analysis of all falls by completing a Post Fall Review form. The care plan, and staff assignment sheets will be adjusted as needed to reflect current and appropriate fall interventions. The nursing staff will observe, interview as appropriate and document resident's post fall status as well as effectiveness of identified fall interventions in place on each shift for the next 3 days in the resident record. It is important to recognize that on size does not fit all when considering interventions for residents fall management. Review of the clinical record revealed Resident #143 had an admitted [DATE] with readmissions on 1/20/23 and 2/18/23 with diagnoses including Alzheimer's, dementia, left hip fracture, frequent falls, and aphasia (loss of ability to express or understand speech). The Admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 1/26/23 documented Resident #143 required limited assistance of one person with bed mobility, transfers, and ambulation. Resident #143 was frequently incontinent of urine, and bowel. A urinary and bowel toileting program was not being used to manage the resident's incontinence. The MDS noted a Brief Interview for Mental Status (assessment of a resident's cognitive function) was 99 indicating the resident was unable to complete the interview. The facility initiated a care plan on 12/26/22 indicating Resident #143 was at risk for falls due to weakness, low endurance and decreased mobility as a result of acute or chronic health conditions and aphasia. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The care plan interventions on 12/28/22 included to orient resident to room, call light, and need to call for, and wait for assistance, maintain adequate lighting in resident's room, keep bed in lowest position possible, attempt to keep resident as active in activities during the day as resident will allow. The facility fall assessment dated [DATE] determined the resident was a moderate risk for falls. Review of the incident reports revealed: On 1/20/23 at 6:30 a.m., Resident #143 was found on the floor in her room and was unable to state what she was doing at the time of the fall. Resident #143 sustained a skin tear to the right side of her abdomen. On 1/21/23 at 3:31 p.m., Unit Manager, Licensed Practical Nurse (LPN) Staff F completed the investigation follow up and documented Resident #143 was agitated, had dementia and restlessness. LPN Staff F documented, IDT (interdisciplinary team) meeting regarding found on floor next to bed. Regular mattress in place. Work for grab bars placed. Intervention: Staff to ensure wheelchair to be placed at bedside. The facility lacked documentation of an investigation to determine the root cause of the fall and implement appropriate interventions to prevent further avoidable falls. On 1/24/23 at 1:00 a.m., Resident #143 was found on the floor in her room. After assessment, a bump noted on the back of the head. Resident complained of pain. Tylenol given as ordered and ice pack applied. On 1/25/23 at 4:48 p.m., LPN Staff F completed the investigation follow up and documented Visual reminder to use call bell for assistance. There was no documentation of an investigation to determine the root cause of the fall and implement appropriate interventions to prevent further avoidable falls. On 1/29/23 at 6:25 p.m., Resident #143 was found sitting on the floor. The incident report documented this nurse was notified by neighboring resident family that she heard a big bang. Upon arrival resident was observed sitting, guarding LLE (left lower extremity) and being in distress/teary. Three wheeled walker next to her. The nurse documented the resident reported pain pointing to the left knee. The nurse assessed Resident #143 and documented the left lower extremity appeared shorter and rotated with substantial bruising. The resident was sent to the local hospital emergency room (ER). Review of the ER nursing documentation revealed Resident #143 had left knee swelling and laceration to the left forehead. A left knee x-ray was obtained. The x-ray report documented no acute fracture or dislocation. The clinical impressions were closed head injury, contusion, acute pain of the left knee. Resident #143 was transferred back to the facility. (continued on next page)

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	105966	A. Building B. Wing	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Larsen Health Center	13880 Shell Point Plaza Fort Myers, FL 33908

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/27/23 at 1:03 p.m., (29 days after the fall), LPN Staff F completed the investigation follow up and documented, IDT meeting regarding fall 1/29/23. Resident returned from ER (emergency room) continue B&B (bowel and bladder) observation and set up B&B schedule for resident. The clinical record lacked documentation a bowel and bladder schedule was initiated for the resident. The Admission MDS with a target date of 2/23/23 noted a toileting program was not being used to manage the resident's urinary and bowel continence. On 3/16/23 at 11:40 a.m., Unit Manager LPN Staff F said the root cause of the fall on 1/29/23 was Resident #143 got up to go the bathroom because she does not get up unless she has to go to the bathroom. The resident is nonverbal and took herself to the bathroom. She was found next to the bed with the walker so, I figured she was going to the bathroom. The investigation as to why she fell was she was getting up to go to the bathroom it is what she always does. LPN Staff F confirmed there was no documentation the bowel and bladder schedule was initiated. On 2/10/23 at 9:00 p.m., a facility incident report documented 2/9/23 resident complained of left hip pain, primary nurse notified, some bruising and edema on left hip. Resident #143 was sent to the local hospital emergency room where an x-ray result documented an acute left hip fracture. The resident was admitted to the hospital and had a surgical repair of the left hip fracture on 2/12/23. On 3/14/23 at 12:57 p.m., an observation showed Resident #143's room door was closed and no staff were observed in the hallway. The resident was in her room alone and the call light was on the floor out of her reach. On 3/15/23 at 9:37 a.m., Certified Nursing Assistant (CNA) Staff G said Resident #143 will yell, no words just screams when she wants assistance. She is able to use the call light, but she does not. The CNA said Resident #143 was able to use the toilet and ambulates with the rolling walker and assistance. Staff G said the resident will go to a few activity programs a week and she has family and friends who come to visit her. She does not speak but she understands you. I was not here when she fell and hurt her hip. She could walk with the walker but not by herself, she always needed help. The CNA said, Resident #143 did not like to get out of bed, and she will yell out. On 3/16/23 at 9:40 a.m., the Administrator confirmed the incident report did not specify if the care plan interventions were in place at the time of the fall on 1/29/23. The Administrator confirmed Resident #143 had multiple falls and said, we review the falls and update the care plan. Review of Resident #143's care plan showed the care plan interventions were not updated after the falls on 1/20/23, 1/24/23 and 1/29/23. On 3/16/23 at 1:53 p.m., the Rehab Director said prior to Resident #143 sustaining the left hip fracture she required supervision with bed mobility and stand by assistance. She was ambulating with supervision walking household distance of 100 feet with a three wheeled walker and contact guard. She was not able to toilet herself and was not able to dress her lower body. The Rehab Director said as long as someone was in the general area with eyes on her, she was safe to ambulate. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Rehab Director confirmed Resident #143 had a decline in ambulation and activities of daily living since she sustained the left hip fracture.

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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** 44307 Based on observations, interviews, records review and facility policy review the facility failed to review the risks and benefits of bed rails with the resident/representative or attempt alternative interventions prior to bed rail installation for 5 residents, (#28, #97, #110, #143 and #554) of 5 residents reviewed for bed rails. The findings included: Review of facility policy titled, Grab Bars, revised 1/2023 stated, This program will promote resident mobility with the highest quality of care while maintaining resident safety. These guidelines are to ensure the safe use of grab bars as restraints unless necessary to treat a resident's medical symptoms. 1. Clinical records review for Resident #97 documented an admitted to the facility of11/14/22. A Grab bar data collection form was completed on 11/15/22 at 2:36 p.m. An order was entered on 11/15/22 at 2:34 p.m. for patient to have bilateral grab bars. A verbal consent for side rail device was signed by the Health Care Surrogate on11/15/22. On 3/13/23 at 945 a.m., observed bilateral grab bar / side rails elevated on both sides of Resident #97's bed. Certified Nursing Assistant (CNA) Staff BB said resident had the grab bars for as long as she has worked with her. On 3/14/23 at 10:42 a.m., observed bilateral grab / side rails on both sides of Resident #97 bed. CNA Staff Q said she has had them as long as she has worked with her. 2. Clinical record review for Resident #110 documented an initial admission to the facility of 7/7/22 and current admission of 7/12/22. A Grab bar data collection form was completed on 7/8/22 at 12:24 a.m. An order was entered on 7/13/22 at 5:51 p.m. for the resident to have bilateral grab bars. A consent for side rail device was signed by resident 7/8/22. On 3/13/23 at 1:30 p.m., observed Resident #110 in bed with bilateral grab bar side rails elevated on both sides of bed. On 3/14/23 at 10:07 a.m., Resident #110 observed in bed with bilateral grab bar side rails elevated. Resident said she did not recall signing a consent or having risks reviewed with her before they were installed. On 3/15/23 at 12:00 p.m., CNA Staff CC said resident #110 has had the side rails as long as she has been on their floor. The CNA said, Most of our residents have the grab bars so they can hold on to them when we are doing care. I don't know what is done to decide who gets grab rails or not. That is up to the nurses. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/15/23 at 1:15 p.m., interviewed Registered Nurse (RN) Staff DD about Resident #97 and Resident #110 having grab bars on their bed. RN Staff DD said, we have a grab bar assessment that is done, we get an order and consent. RN Staff DD did not know of any interventions attempted prior to installation of the grab bars side rails. On 3/15/23 at 4:00 p.m., the DON confirmed Resident #97 and Resident #110 had grab bars in place. She said, they are for bed mobility. The DON said she would have to look into interventions attempted prior to the installation of the grab bars. She said she was not sure what was meant by interventions attempted. The DON said, They are screened by therapy and nursing. I will need to look into that. On 3/16/23 at 9:32 a.m., the DON confirmed there were no documented interventions attempted prior to installing the grab bar on residents' beds. She confirmed the grabs bar were started on the day of admission for Resident #97 and #110. 41155 3. Review of the clinical record revealed Resident #28 had a readmitted [DATE] with diagnoses including hypertension, fracture of the right femur and morbid obesity. A Grab Bar Data Collection form dated 2/10/23 documented intervention lower bed to the floor or provide a low bed. There was no documentation in the clinical record of alternate interventions were attempted before the grab bars were applied to the bed. Random observations on 3/14/23 at 12:39 p.m., and 3/15/23 at 8:56 a.m., noted Resident #28 in a regular bed at regular height, with grab bars on both sides in the raised position. 4. Review of the clinical record revealed Resident #143 had a readmitted [DATE] with diagnoses including muscle weakness, fracture of the left femur/left hip and repeated falls. A Grab Bar Data Collection form dated 2/18/23 documented grab bars were not recommended. On 3/14/23 at 12:57 p.m., Resident #143 was observed in a low bed with grab bars in the raised position on both sides of the bed. 5. Review of the clinical record revealed Resident #554 had an admitted [DATE] with diagnoses including muscle weakness and sever protein calorie malnutrition. A Grab Bar Data Collection form dated 2/8/23 documented lower bed to the floor or provide a low bed. There was no documentation in the clinical record of alternate interventions were attempted before the grab bars were applied to the bed. On 3/14/23 at 2:55 p.m., Resident #554 was observed in a regular bed with grabs on both side of the bed in the raised position. On 3/16/23 at 9:03 a.m., in an interview the Administrator confirmed there was no documentation of alternate interventions attempted before the grab bars were applied for Residents #28, #143 and #554.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 41155 Based on observation, record review, and staff interview, the facility failed to conduct regular inspection of all bed frames, mattresses, and grab bars, as part of a regular maintenance program to ensure they remain safe, in good operating condition and to identify areas of possible entrapment for residents with grab bars. This had the potential to cause serious injury to the residents. The findings included: On 3/14/23 random observations on all six floors of the facility revealed multiple residents with grab bars on the beds in the raised position. Review of the facility's list of residents with grab bars revealed 117 residents had grab bars installed on their bed. On 3/16/23 at 10:44 a.m., in an interview the Maintenance Manager said the grab bars are on the beds prior to a resident's admission. He said we order them from the manufacturer and we put them on, that is all we do. We do not assess the grab bars or beds for areas of entrapment. The Maintenance Manager said he receives a work ticket from the staff requesting grab bars and they are placed on the beds. He said the mattress had two positions, wide and narrow but he did not measure for gaps between the mattress and the grab bars. He said a bed check was done quarterly and every movable component is checked. Grab bars are already on the beds and are either up or down, they are called pivoting plastic grab bars. The Maintenance Manager said routine maintenance of 20 beds was conducted monthly. The Maintenance Manager was not able to locate documentation of the routine bed checks for safety of the grab bars. He said he had no policy for use of the grab bars and said he did not check the grab bars and the mattress for entrapment areas. He confirmed he did not measure for gaps that might be present between the mattress and the grab bars. On 3/16/23 at 12:00 p.m., in an interview the Administrator confirmed the maintenance team was not measuring the beds and grab bars for areas of potential entrapment.