| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385228 | A. Building<br>B. Wing | 10/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Portland Health & Rehabilitation Center | 12441 SE Stark Street<br>Portland, OR 97233 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>38140<br><br>Based on interview, and record review it was determined the facility failed to ensure a resident was treated in a dignified manner and free from a derogatory slur for 1 of 4 sampled residents (#110) reviewed for dignity. This placed residents at risk for being treated in a disrespectful manner. Findings include:<br><br>Resident 110 was admitted to the facility in 6/2023 with diagnoses including after care for surgical amputation and was assessed as cognitively intact.<br><br>Review of the 6/15/23 FRI and facility investigation revealed on 6/14/23 Staff 20 (LPN) called Staff 18 (Former DNS) at 6:00 PM to report during the dinner service, Resident 110 overheard Staff 19 (Former Hospitality Aide) use the homophobic slur of faggot in conversation and Staff 21 (Former CNA) observed the comments. Staff 20 reported he interviewed Resident 110 who reported feeling afraid to be at the facility. Resident 110 did not want to be a whistle blower as she/he had experienced similar incidents in the past and she/he was later retaliated against.<br><br>Staff 18 also interviewed Resident 110 who stated she/he overheard Staff 19 complaining to several other CNAs about work bonuses and she used the f word several times. Resident 110 stated she/he did not want to get anyone in trouble, experienced homophobic issues at another facility and she/he felt retaliated against when she/he reported to management.<br><br>Staff 18 also interviewed Staff 21 who observed the event. Staff 21 confirmed she heard Staff 19 loudly use the word faggot several times in conversation with other staff and Resident 110 overheard. Staff 21 stated she noticed Resident 110 was upset and she spoke to her/him. Staff 21 confirmed Resident 110 said she/he overheard the slur of faggot. The resident appeared uncomfortable, talked about how she/he took it in a negative manner and stated she/he was afraid.<br><br>Staff 18 also interviewed Staff 20 who confirmed when Resident 110 spoke to him the evening prior, the resident stated she/he overheard the term of faggot, interpreted it as a homophobic slur, felt uncomfortable about being at the facility, did not feel safe and feared retaliation for talking about it.<br><br>The 6/15/23 investigation revealed Staff 18 also interviewed Staff 19 whom did not recall using the word faggot and confirmed she was upset when she talked to staff and used swear words in conversation.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 110's Progress Notes form 6/15/23 through 6/28/23 revealed she/he was placed on alert monitoring for psychosocial well-being with no negative outcomes to the resident reported.<br><br>In an interview on 10/23/24 at 11:44 AM Resident 110 recalled her/his stay at the facility and would not comment about overhearing homophobic language.<br><br>On 10/24/24 at 12:30 PM Staff 1 (Administrator) stated he expected all residents to be treated with dignity and respect and to live in an environment free from homophobic slurs. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41458<br><br>Based on observation, interview and record review it was determined the facility failed to ensure residents' bed mattresses were in good repair for 1 of 1 sampled resident (#5) reviewed for restraints and a comfortable environment free from offensive odors for 1 of 1 facility observed for environment. This placed residents at risk for an uncomfortable environment. Findings include:<br><br>1. Resident 5 was admitted to the facility in 8/2010 with diagnoses including abnormal posture, cognitive deficits and depression.<br><br>Observations from 10/23/24 through 10/25/24 between the hours of 7:39 AM and 3:30 PM revealed Resident 5's bed mattress had a large divot in the center, covering approximately 3/4's of the entire mattress and was several inches deep.<br><br>On 10/25/24 at 9:49 AM Staff 5 (CNA) reported Resident 5's bed mattress had a large divot in the center for at least the last year.<br><br>On 10/25/24 at 10:23 AM Staff 23 (CNA) stated Resident 5's bed mattress was played out, old and needed to be replaced. Staff 23 stated Resident 5 had to fight the divot to roll over.<br><br>On 10/25/24 at 11:24 AM Staff 20 (Maintenance Director) looked at Resident 5's bed mattress and stated the mattress had a big divot, was old and broken down. Staff 20 confirmed Resident 5's mattress needed to be replaced.<br><br>38140<br><br>2. On 9/5/23 the State agency received a public complaint which alleged residents' bathrooms in the facility were not clean and smelled of urine.<br><br>On 9/13/23 the State agency received a public complaint which alleged the facility had offensive odors in all three halls during multiple visits to the facility.<br><br>On 10/23/24 at 11:17 AM Room eight's shared bathroom smelled of urine, the toilet base had old caulking which was dark in color, and the flooring tiles were cracked.<br><br>On 10/24/24 at 4:41 PM Witness 2 (Family) confirmed the public complaint. He worked in long term care facilities previously and the facility smelled rancid from urine and fecal matter on multiple visits to the facility.<br><br>On 10/24/24 at 11:19 AM there was a very strong smell of urine in the south hallway near room nine.<br><br>On 10/25/24 at 12:11 PM Room eight's shared bathroom smelled of urine, the toilet base had old caulking which was dark in color, and the flooring tiles were cracked.<br><br>On 10/25/24 at 2:37 PM the south hallway near room two had a strong smell of urine.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/28/24 at 10:53 AM room [ROOM NUMBER]'s shared bathroom had a strong smell of urine.<br><br>On 10/28/24 at 11:01 AM the hallway near rooms three and four smelled of urine.<br><br>Multiple housekeeping staff were observed multiple times from 10/23/24 though 10/28/24 between 7:30 AM to 4:30 PM to clean hallways, resident rooms and resident bathrooms with appropriate cleaning products and procedures.<br><br>On 10/28/24 at 12:33 PM Staff 20 (Maintenance Director) during a facility walkthrough, acknowledged the floor of the toilet in room nine appeared clean but cracked tiles and the lack of a seal around the base of the toilet could contribute to the odor and the cracks in the hallway between rooms one and two needed to be sealed.<br><br>On 10/28/24 at 12:47 PM Staff 1 (Administrator) confirmed the smell of urine in room eight's bathroom and the cracked tiles in the hallway between room one and two where odors were observed. |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>47000<br><br>Based on observation, interview and record review it was determined the facility failed to ensure residents' change of condition was assessed timely for 2 of 2 residents (#s 8 and 22) reviewed for skin conditions. This failure resulted in Resident 8 experiencing untreated and significant pain, sustaining multiple fractures and receiving treatment at the hospital. Findings include:<br><br>1. Resident 8 was readmitted to the facility in 10/2018 with diagnoses including hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild or partial loss of strength on one side of the body) following a stroke.<br><br>a. Resident 8's 1/7/24 Quarterly MDS Assessment revealed the resident was usually able to make her/himself understood and understand others, experienced upper and lower extremity impairment on one side of her/his body and required substantial-to-maximal assistance with transfers.<br><br>A review of Resident 8's clinical record revealed the following:<br><br>-On 2/25/24 at 6:59 AM a Progress Note written by Staff 34 (Former LPN) indicated the resident experienced increased pain to her/his right knee, the knee was painful to the touch and the resident refused to move it. Staff 34 contacted the resident's provider to request an order for PRN Tylenol (pain reliever used to treat minor aches and pains). The note indicated Staff 34 would pass this information on to the day shift nurse to follow up.<br><br>-On 2/25/24 at 11:16 AM a Progress Note indicated an X-ray was to be completed stat due to symptoms and per the provider's verbal orders.<br><br>-On 2/25/24 at 11:20 AM the resident received her/his first dose of PRN Tylenol for ankle pain rated as a four out of 10.<br><br>-On 2/25/24 at 2:21 PM X-ray results were reported to the resident's provider which indicated the resident had fractures involving the distal fibula (the lower end of the fibula bone in the leg) and the medial malleolus (the bony prominence on the inner side of the ankle).<br><br>-On 2/26/24 at 1:21 AM a Progress Note written by Staff 34 stated the resident possibly hit her/his right ankle and the facility was waiting for the provider to review the X-ray results.<br><br>-On 2/26/24 at 3:09 PM a Progress Note written by Staff 35 (LPN) indicated a call was placed to the resident's provider as Staff 35 was concerned about the resident's right ankle and leg pain and noted the resident was unable to move her/his right leg. Non-emergency transportation was called as the resident agreed to go to the emergency department for evaluation.<br><br>-On 2/26/24 at 3:20 PM the resident received PRN Tylenol for ankle pain rated as a nine out of 10.<br><br>-On 2/26/24 at 3:42 PM a Progress Note indicated the resident was transported to the hospital.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 2/26/24 to 2/27/24 Emergency Department Provider Notes indicated the resident experienced significant pain in the right ankle and her/his ankle required splinting (a medical procedure that involves immobilizing the ankle joint with a rigid device to treat injuries or other conditions) in the emergency department.<br><br>A 3/1/24 Injury of Unknown Origin Investigation of Resident 8's distal fibula and medial melleolus fractures revealed the following:<br><br>-On 2/25/24 the resident complained her/his right ankle hurt.<br><br>-An unidentified nurse assessed the resident's ankle on 2/25/24 and noted it to be swollen and tender to the touch.<br><br>-The resident confirmed her/his ankle was injured and indicated the injury occurred in the last couple days.<br><br>-Immediate actions included: an X-ray was completed, the resident's provider was notified of the X-ray results, the resident was placed on alert charting and the facility waited for further orders from the provider. The investigation did not indicate any times for these action items.<br><br>-The resident declined to go to the hospital at this time. The investigation did not indicate what time the resident was offered to go to the hospital, if the resident was informed she/he had fractured multiple bones or if the resident was re-offered the opportunity to go to the hospital.<br><br>No evidence was found in Resident 8's clinical record to indicate any pain relief alternatives were offered or provided to the resident following the resident's first documented report of pain on 2/25/24 at 6:59 AM until she/he received Tylenol at 11:20 AM on 2/25/24 or any action was taken by the facility between 2/25/24 at 2:21 PM through 2/26/24 at 3:09 PM following the receipt of the X-ray that confirmed the resident experienced multiple fractures.<br><br>On 10/23/24 at 2:53 PM Resident 8 was observed in her/his room in her/his wheelchair. Resident 8 was able to answer yes or no questions and confirmed she/he broke her/his ankle during a transfer from her/his wheelchair to bed when she/he was assisted by an unidentified staff person in 2/2024. Resident 8 further confirmed she/he experienced a great deal of pain during this time period, indicated she/he reported her/his pain to multiple staff and it took a long time until any one at the facility realized she/he was hurt.<br><br>On 10/28/24 at 3:31 PM Staff 37 (CNA) stated she assisted Resident 8 with restorative exercises on Friday, 2/23/24, and at this time, the resident was great. Staff 37 stated she worked as a CNA on Saturday, 2/24/24, and recalled Resident 8 did not get out of bed for either breakfast or lunch on this day, which was unusual for the resident as she/he was usually always up and in her/his wheelchair by 5:00 AM. Staff 37 stated she asked Staff 5 (CNA), the resident's assigned day shift CNA on 2/24/24, about Resident 8 and was told the resident did not feel well.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 10/28/24 at 3:51 PM Staff 5 stated she recalled Resident 8 was totally fine on 2/23/24. Staff 5 stated she was the resident's assigned day shift CNA on 2/24/24, and when she started her shift, the resident complained her/his foot hurt and she/he would not let me do anything with [her/his] leg. Staff 5 stated the resident would yell no, no, no any time she tried to touch her/his leg know and she let the nurse know immediately. Staff 5 stated Resident 8 was normally a a very active resident and on 2/24/24 she/he refused to be touched or do anything. Staff 5 stated she reported this change of condition to multiple nurses on 2/24/24 many, many times.<br><br>On 10/29/24 at 10:08 AM Staff 35 (LPN) stated she worked evening shift on 2/25/24. Staff 35 stated she asked CNAs how long Resident 8 had been in pain and nobody gave me answers. Staff 35 stated she had worked with Resident 8 for years and knew she/he was not her/himself and she/he just seemed like she/he was in pain. Staff 35 stated she was not told much about what happened and she did not know when Resident 8's injury occurred. Staff 35 stated she recalled asking the resident if she/he wanted to go to the emergency room to which she/he was agreeable.<br><br>On 10/29/24 at 11:00 AM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the findings and confirmed Resident 8's change of condition was not addressed timely.<br><br>b. Resident 8's 8/11/23 Care Plan revealed the following:<br><br>-Staff were to ask the resident yes or no questions in order to determine her/his needs.<br><br>-The resident required extensive assistance from one staff with dressing and personal hygiene and extensive assistance from one-to-two staff with showers.<br><br>-CNAs were to monitor for changes in skin integrity during dressing, personal care and showers and alert the licensed nurse immediately of any changes.<br><br>An 8/14/23 Progress Note revealed the following:<br><br>-Staff 36 (CNA) reported to the nurse Resident 8's right fifth toe was black.<br><br>-The nurse assessed Resident 8's fifth toe and noted the black area covered the entire bottom of her/his toe and the wound measured approximately 1.5 cm long and 1 cm wide.<br><br>-Staff 36 observed a red blister on Resident 8's fifth toe last week and didn't tell anyone then.<br><br>-Staff 36 was educated on the importance of reporting abnormal skin impairments right away.<br><br>An 8/14/23 Incident and Investigation determined the facility failed to ensure identification of a skin issue and provide needed care and services in a timely manner.<br><br>On 10/23/24 at 2:50 PM Resident 8 was observed in her/his room and sat in her/his wheelchair. The resident was able to indicate through yes or no questions her/his toe was black months ago but was unable to provide any additional details about this skin impairment.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 10/28/24 at 7:43 AM Staff 36 stated she recalled she assisted Resident 8 with range of motion in 2/2024 when she noticed the resident's right fifth toe was a different color. Staff 36 stated the toe really looked different and was black the second time she observed it a few days later. Staff 36 stated she thought she informed a nurse of the resident's toe discoloration after her initial observation but could not recall for sure but stated she did report it to Staff 18 (Former DNS) after her second observation.<br><br>On 10/29/24 at 11:00 AM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the findings and did not provide any additional information.<br><br>2. Resident 22 was admitted to the facility in 11/2022 with diagnoses including stroke.<br><br>Resident 22's 9/2024 and 10/2024 Physician's Orders revealed the following:<br><br>-All wounds must be evaluated by the physician or NP at first opportunity.<br><br>-The resident was to receive a weekly skin evaluation and each skin impairment was to be evaluated.<br><br>Resident 22's 9/24/24 Weekly Skin Evaluation identified the resident to have self-inflicted scratches and dry scabs all over her/his bilateral upper extremities. The evaluation did not indicate if the resident's physician or NP was notified of the wounds or if a treatment was to be implemented.<br><br>Resident 22's Weekly Skin Evaluations from 9/30/24 through 10/22/24 made no mention of the resident's bilateral upper extremity wounds, including any measurements, number of wounds or whether or not they had improved, worsened or stayed the same.<br><br>Resident 22's 10/3/24 Potential/Actual Impairment to Skin Integrity Care Plan indicated weekly treatment documentation of skin breakdown was to include the width, length and depth of the skin impairment as well as any other notable changes or observations.<br><br>Resident 22's 10/10/24 Annual MDS Assessment revealed the resident was able to make her/himself understood and understood others without difficulty and received application of nonsurgical dressings and ointments/medications other than to her/his feet. The CAAs revealed the resident recently had open skin on her/his left shin area which was partially due to her/his scratching, a wound culture was completed that indicated the wound was positive for Methicillin-resistant Staphylococcus aureus (MRSA, a type of bacteria that is resistant to certain antibiotics and an infection that can be serious and difficult to treat, especially if left untreated), the resident was treated with antibiotics and she/he refused several doses.<br><br>On 10/23/24 at 11:33 AM Resident 22 was observed in her/his room in bed. The resident's arms were observed to have numerous scattered scabs, some of which were opened and revealed streaks of blood. Resident 22 stated she/he was recently treated with antibiotics for a staph infection related to the wounds on her/his legs. Resident 22 stated the scabs on her/his arms had been there for weeks, the scabbing on her/his arms looked like the wounds on her/his legs, her/his arms itched regularly and the facility was not doing anything to treat the scabs on her/his arms.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 10/24/24 at 12:28 PM Witness 8 (Family Member) stated he discussed Resident 22's leg and arm wounds with Staff 4 (LPN Resident Care Manager) in 9/2024 but thought only the leg wounds were addressed. Witness 8 wondered if the continued itching and scabbing of the resident's arms was a result of an allergic reaction but never got a resolution.<br><br>On 10/25/24 at 10:11 AM Staff 5 (CNA) stated the scabs on Resident 22's arms had been there for at least a month and the resident complained about and scratched them. Staff 5 stated she reported these scabs to the nurse and was not sure if anything was done.<br><br>On 10/25/24 at 10:34 AM Staff 23 (CNA) stated she noticed the resident's arms were scratched up really bad about a week or two ago and stated she reported this to the nurse.<br><br>On 10/25/24 at 11:07 AM Staff 31 (LPN) observed Resident 22's arms and confirmed the resident had scattered scabbing throughout her/his bilateral upper extremities. Staff 31 stated the resident did not have these scabs the last time she worked with the resident last month and the scabbing had not been reported to her. Staff 31 stated a resident's physician or NP was to be notified in the case of any new skin issue in order to obtain a treatment. Staff 31 reviewed the resident's electronic record and stated it did not look like the doctor had been notified of the resident's arm wounds.<br><br>On 10/25/24 at 2:52 PM Staff 4 observed Resident 22's arms. Staff 4 stated she was not aware of the resident's arm wounds and neither was the resident's physician.<br><br>On 10/25/24 at 3:28 PM Staff 33 (NP) stated she was not aware of any new skin issues for Resident 22, including any wounds or scabs on her/his arms.<br><br>On 10/25/24 at 3:42 PM Staff 2 (DNS) confirmed the wounds on Resident 22's arms had not been reported to the resident's physician or NP and were not being monitored or treated and should have been. |

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|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>38140<br><br>Based on observation, interview and record review it was determined the facility failed to assess for care plan effectiveness, identify and implement new fall interventions or provide adequate supervision needed to prevent falls for 3 of 3 sampled residents (#s 40, 48 and 108) reviewed for falls. This failure resulted in Resident 108's hospitalization and placed residents at risk for falls and injury. Findings include:<br><br>1. Resident 108 was admitted to the facility in 9/2023 with diagnoses including cancer, severe protein-calorie malnutrition, abnormal weight loss, chronic fatigue, and weakness.<br><br>Resident 108's 9/9/23 Admission MDS indicated she/he was cognitively intact and while she/he moved about her/his room and facility, she/he required supervision with the assistance of one other person. The MDS indicated Resident 108 experienced falls prior to admission to the facility.<br><br>Review of Resident 108's 9/2/23 care plan indicated she/he was a high risk for falls. The care plan directed staff to provide a safe environment free from clutter or spills, adequate and glare-free light, a reachable call light which worked, encouragement to participate in activities, physical therapy, and have her/his bed in a low position.<br><br>The 9/2/23 Visual Bedside Individual Service Plan (bedside care plan) indicated Resident 108 was independent with ambulation, used a wheelchair and mobility was with a wheelchair which required one person to assist with mobility.<br><br>A 10/4/23 at 1:25 PM Progress Note revealed Resident 108 walked independently in the hallway and fell face-forward. The resident was transported to the hospital.<br><br>A 10/4/23 at 8:59 PM Progress Note revealed Resident 108 returned from the hospital with a fractured orbital wall (break in one or more of the eye socket bones), which was swollen, bruised with a small laceration (cut).<br><br>Review of Resident 108's 10/4/23 fall investigation provided was not a thorough investigation or assessment of the fall. The investigation was not completed until 10/13/23 (three days after discharge). No fall care plan revisions were found as completed or implemented.<br><br>A 10/5/23 at 8:57 PM Progress Note revealed Resident 108 tripped and fell walking in the hallway. The resident acquired 1 cm bilateral scrapes on both knees.<br><br>Review of Resident 108's 10/5/23 fall investigation provided was not a thorough investigation or assessment of the fall. The investigation was not completed until 10/15/23 (five days after discharge). No fall care plan revisions were found as completed or implemented.<br><br>(continued on next page) |

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| | 385228 | A. Building<br>B. Wing | 10/29/2024 |

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| Portland Health & Rehabilitation Center | 12441 SE Stark Street<br>Portland, OR 97233 |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of a 10/6/23 fall investigation revealed Resident 108 fell in her/his room and was found on the floor. The resident believed the wheelchair brakes did not work and the facility found one of the brakes was loose and the facility repaired the wheelchair brake. No evidence of the 10/6/23 fall was found in the resident's electronic health record, progress notes or alert charting, no revision of care plan interventions, the investigation was not a thorough investigation or assessment of the fall. The investigation was completed 10/15/23 (five days after discharge).<br><br>A 10/10/23 at 3:02 AM Progress Note revealed Resident 108 was found on the floor next to her/his bed face-forward and bled from her/his nose and mouth. Resident 108 was sent to the hospital.<br><br>On 10/11/23 at 12:59 AM Staff 4 (LPN) received a phone call from the hospital to inform the facility Resident 108 passed away in the hospital.<br><br>No evidence was found to reflect Resident 108's care plan interventions were revised prior to her/his discharge. The fall investigations were not timely, did not identify all known, foreseeable and unforeseeable accident hazards in her/his environment. No evidence was found of a plan for attempts to reduce fall risks or identify possible assistance to prevent an avoidable accident.<br><br>On 10/29/24 at 9:51 AM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the lack of care plan revisions for Resident 108's falls. Staff 1 and Staff 2 acknowledged the fall investigations were not comprehensive and were completed after the resident's discharge to the hospital. Staff 1 and Staff 2 would expect thorough fall investigations and care plan revisions for falls to be completed and implemented timely. No additional information was provided.<br><br>41458<br><br>2. Resident 40 was readmitted to the facility in 5/2024 with diabetes, pneumonia and metabolic encephalopathy (brain dysfunction caused by an underlying illness or organs not working well).<br><br>From 5/30/24 through 10/16/24, 10 fall risk assessments were completed. Resident 40 was identified to be at high risk for falling on all assessments.<br><br>Resident 40's 5/30/24 Fall Care Plan, with revisions on 6/10/24, 9/17/24, 9/30/24, 10/14/24, 10/22/24 and 10/23/24, indicated the resident was a high fall risk due to gait/balance problems and impaired cognition. The following fall precautions were in place:<br><br>-Anticipate and meet the resident's needs. Initiated 5/30/24.<br><br>-Be sure the resident's call light was within reach and encourage the resident to use it for assistance. Initiated 5/30/24. Revised 9/30/24.<br><br>-Ensure the resident was wearing appropriate footwear such as rubber soled shoes or non-skid socks when ambulating or mobilizing in her/his wheelchair. Initiated 5/30/24. Revised 6/10/24.<br><br>-Follow facility fall protocol. Initiated 5/30/24.<br><br>-PT evaluation and treatment as ordered or PRN. Initiated 5/30/24.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter or remove any potential causes, if possible. Provide education to the resident/family/caregivers/IDT (interdisciplinary team) as to causes. Initiated 5/30/24.<br><br>-The resident needed a safe environment with even floors free from spills and/or clutter, adequate glare free light, a working and reachable call light and personal items within reach. Initiated 5/30/24. Revised 6/10/24.<br><br>-For no apparent acute injury, determine and address causative factors of the fall. Initiated 9/17/24.<br><br>-Provide one-to-one activities that promote exercise and strength building where possible. Provide one-to-one activities if bed bound. Initiated 9/17/24.<br><br>-PT consultation for strength and mobility. Initiated 9/17/24.<br><br>-The resident had frequent falls due to self-transferring. Initiated 9/30/24.<br><br>-Place a full sized mattress on the floor by Resident 40's bed when she/he was in bed. The bed was to be in the lowest position. Initiated 10/14/24. Revised 10/23/24.<br><br>-Keep Resident 40's wheelchair out of her/his view. Initiated 10/14/24.<br><br>-Enhanced activities for fall prevention. Initiated 10/22/24.<br><br>Resident 40's 8/4/24 Significant Change MDS indicated Resident 40 had moderately impaired cognition and the resident required substantial to maximal assistance for bed mobility and standing.<br><br>Resident 40's 10/10/24 Discharge with Return Anticipated MDS indicated Resident 40 had short term memory deficits, severe impairment making decisions regarding tasks of daily life and required substantial to maximal assistance for bed mobility and partial to moderate assistance for standing.<br><br>From 7/12/24 through 10/16/24, Resident 40 sustained 12 non-injury falls in the facility. Fall investigations revealed the following:<br><br>-7/12/24 at 4:50 AM: Resident 40's fall investigation revealed Resident 40 was found kneeling on the floor in front of her/his bed. The report indicated Resident 40 tried to pick something up off the floor. According to the report, at the time of the fall, the resident required one person assistance for standing, had a fall mat, high/low bed and the bed was against the wall. The resident was reminded that staff needed to pick up items if she/he dropped them.<br><br>No new fall care plan interventions were put into place.<br><br>-9/17/24 at 4:00 AM: Resident 40's fall investigation revealed Resident 40 was found on the floor in her/his room, next to her/his bed. The resident's bed was in the lowest position, she/he had on non-skid socks and the call light was by the resident but not activated. The resident was educated regarding the importance of using the call light.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -9/26/24 at 7:00 AM: Resident 40's fall investigation revealed the resident was found sitting on the floor in her/his room leaning on the right side of her/his bed. Resident 40 was alert with confusion and exhibited impulsivity with poor safety judgement.<br><br>No new fall care plan interventions were put into place.<br><br>-9/26/24 at 9:55 PM: Resident 40's fall investigation revealed the resident was found on the floor in her/his room on the right side of her/his bed. The resident was wearing non-skid socks.<br><br>No new fall care plan interventions were put into place.<br><br>-9/29/24 at 12:40 PM: Resident 40's fall investigation revealed the resident was found on her/his floor. The resident's bed was in the lowest position and the resident was wearing non-skid socks. Resident 40 tried to transfer herself/himself to the wheelchair. Resident 40's call light was within reach and the area was free from clutter. The resident was very confused.<br><br>No new fall care plan interventions were put into place.<br><br>-10/5/24 at 7:35 AM: Resident 40's fall investigation revealed the resident was found down on her/his room floor. The resident was wearing non-skid socks and the lights were on in her/his room. The resident had impaired memory, gait and balance. Resident 40 had a history of self-transferring.<br><br>No new fall care plan interventions were put into place.<br><br>-10/7/24 at 8:30 PM. Resident 40's fall investigation revealed the resident was found on the floor in her/his room very close to the bed. The resident's bed was in the lowest position and she/her wore non-skid socks. The resident had impaired memory and a history of self-transferring.<br><br>No new fall care plan interventions were put into place.<br><br>-10/10/24 at 7:00 AM: Resident 40's fall investigation revealed the resident was found on the floor in her/his room leaning against the bed. The resident had on non-skid socks and the lights were on in her/his room. The call light was within reach and the area was free of clutter. Resident 40 had a history of self-transferring and impaired gait/balance.<br><br>No new fall care plan interventions were put into place.<br><br>-10/14/24 at 11:00 AM: Resident 40's fall investigation revealed the resident was found on the floor in her/his room by the bed after attempting to self-transfer. Resident had on non-skid socks and the floor was dry. A new intervention was identified to have Resident 40's wheelchair put away and out-of-sight to prevent the resident from self-transferring.<br><br>-10/14/24 at 2:48 PM: Resident 40's fall investigation revealed the resident was found on the floor in her/his room. The resident wore non-skid socks, the fall mat was in place, the resident's bed was in the lowest position and the call light was within reach and not activated. Resident 40 indicated via pointing that she/he was attempting to reach her/his wheelchair. A new intervention was care planned to have a full sized mattress next to Resident 40's bed while she/he was in bed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident 40's care plan was not followed as her/his wheelchair was supposed to be put away and out-of-sight to prevent the resident from self-transferring.<br><br>-10/14/24 at 11:26 PM: Resident 40's fall investigation revealed the resident was found sitting on the floor mat by her/his bed. The resident had on non-skid socks, the room was free of clutter and Resident 40's call light was within reach. A new intervention was care planned for Activities to develop a structured activities plan for the resident.<br><br>-10/16/24 at 12:05 PM: Resident 40's fall investigation revealed the resident was found on the floor in her/his room, attempting to get to her/his wheelchair which was located on the other side of the room. The resident had multiple falls due to attempts to self-transfer in her/his room.<br><br>Resident 40's care plan was not followed as her/his wheelchair was supposed to be put away and out-of-sight to prevent the resident from self-transferring. No new fall care plan interventions were put into place.<br><br>Random observations from 10/23/24 through 10/29/24 between the hours of 7:30 AM and 3:30 PM revealed the following concerns:<br><br>-Resident 40 was in her/his wheelchair in her/his room being interviewed by the State surveyor and attempted to get up from the wheelchair without assistance.<br><br>-Resident 40 was observed multiple times resting in her/his bed, at times appearing to be asleep and other times awake, with the curtains drawn which resulted in staff being unable to visualize the resident from the hallway.<br><br>-On two separate observations, Resident 40 was observed in her/his bed with her/his wheelchair parked next to the end of the bed, visible to the resident.<br><br>-Resident 40 was not observed engaged in one-to-one or group activities during any observations.<br><br>On 10/25/24 at 9:30 AM Staff 22 (CNA) stated Resident 40 fell a lot so he tried to keep the resident up. He stated if the resident was in bed then he put the full sized mattress next to the bed. Staff 22 stated he did not see Resident 22 engaged in group or one-to-one activities.<br><br>On 10/25/24 at 9:41 AM and 10:44 AM Staff 5 (CNA) reported Resident 40 liked to have meals in the dining room and then get back into bed. Staff 5 stated Resident 40 had many falls and her/his fall precautions included having a full sized mattress at the resident's bedside and ensuring the resident's bed was in the lowest position. At 10:44 AM, Staff 5 entered Resident 40's room and the resident was sitting on the edge of the bed with her/his wheelchair parked at the end of the bed, in full view. Staff 5 acknowledged that Resident 40's wheelchair was supposed to be put away, out-of-sight.<br><br>On 10/25/24 at 10:13 AM Staff 23 (CNA) stated Resident 40's falls always occurred in her/his room. Staff 23 stated she had not seen any one-to-one activities occurring with Resident 40 and thought the resident liked activities such as playing volleyball and painting. Staff 23 stated the resident was supposed to have a fall mat at the bedside and the wheelchair should be out-of-sight but sometimes co-workers aren't doing things right which resulted in Resident 40 falling. Staff 23 stated Resident 40 did not use the call light to summon assistance.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 10/28/24 at 8:05 AM Staff 25 (RN) stated Resident 40 was at risk for falling and had many falls because the resident attempted to get to her/his wheelchair and fell . Staff 25 stated Resident 40's wheelchair was supposed to be put away and out-of sight. Staff 25 entered Resident 40's room and confirmed the resident's wheelchair was parked at the end of the resident's bed, in full view, and the wheelchair was not supposed to be in her/his sight.<br><br>On 10/28/24 at 9:31 AM Staff 14 (Activities Director) stated Resident 40 rarely went to group activities and doing one-to-one activities with the resident was not a frequent thing.<br><br>On 10/28/24 at 10:40 AM Staff 4 (LPN Care Manager) stated Resident 40 was a frequent faller and will try to stand-up and go right down. Staff 4 stated Resident 40 was supposed to be engaged in group or one-to-one activities and have her/his wheelchair out-of-sight. Staff 4 stated Resident 40 did not use her/his call light. Staff 4 reviewed Resident 40's falls and acknowledged staff did not consistently follow the resident's care plan including providing group and one-to-one activities and ensuring the resident's wheelchair was out-of-sight when she/he was in bed. Staff 4 confirmed there were multiple falls where no new fall care plan interventions were identified or implemented. Staff 4 stated she expected other care plan interventions to be attempted and put into place.<br><br>On 10/28/24 at 2:34 PM Staff 1 (Administrator) stated he was aware Resident 40 experienced frequent falls. Staff 1 stated they needed to do more root cause analysis regarding the resident's falls and look into what else we can do to prevent the falls.<br><br>Refer to F679.<br><br>47000<br><br>3. Resident 48 was admitted to the facility in 5/2024 with diagnoses including traumatic subdural hemorrhage (condition that occurs when blood pools between the skull and the brain after a head injury).<br><br>Resident 48's 9/24/24 Significant Change in Status MDS Assessment revealed the resident was cognitively intact and had not experienced any falls since her/his prior assessment.<br><br>Resident 48's 10/18/24 Fall Investigation revealed the resident experienced a non-injury fall out of bed on 10/18/24. The investigation concluded a perimeter mattress (a mattress with raised edges used to help prevent residents from rolling out of bed) to define bed perimeter would be implemented to reduce the risk of the resident rolling out of bed.<br><br>Resident 48's 10/21/24 At Risk for Falls Care Plan indicated the following:<br><br>-The resident was considered a high risk to fall related to a history of falls.<br><br>-The resident's bed was to be kept at an appropriate height.<br><br>-A perimeter mattress was to be placed on the resident's bed when it became available.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Random observations of Resident 48 from 10/23/24 at 12:35 PM through 10/25/24 at 9:26 AM revealed the resident to be in her/his room in bed. The resident laid on a regular mattress and her/his bed was at approximately waist height and no fall mats were observed on the ground. The resident was unable to answer any questions about her/his care.<br><br>On 10/25/24 at 10:05 AM Staff 5 (CNA) stated she was unsure if Resident 48 was considered at risk to fall or if the resident had experienced any recent falls.<br><br>On 10/25/24 at 10:34 AM Staff 23 (CNA) stated she thought Resident 48 was considered at risk to fall but was not aware of any recent falls or interventions.<br><br>On 10/28/24 at 11:48 AM Staff 4 (LPN Care Manger) stated Resident 48 fell out of bed on 10/18/24, following which she ordered a perimeter mattress for the resident's bed to help with safety. Staff 4 stated staff were supposed to use wedges to help keep the resident safe until the perimeter mattress arrived at the facility but she did not care plan the use of wedges.<br><br>On 10/28/24 at 12:14 PM Staff 2 (DNS) stated the facility's interdisciplinary team determined a perimeter mattress was the best intervention to implement following the resident's fall on 10/18/24. Staff 2 stated the resident's bed was to be kept in a low position when occupied with a fall mat in place until the perimeter mattress was put in place. Staff 2 confirmed these temporary safety interventions should have been care planned and were not. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>47000<br><br>Based on interview and record review it was determined the facility failed to ensure the correct POLST was readily available and accessible to enable staff to provide the appropriate interventions for 1 of 5 residents (#42) reviewed for choices. This placed residents at risk for not receiving care per their current wishes. Findings include:<br><br>Resident 42 admitted to facility in 10/2023 with a diagnosis of chronic obstructive pulmonary disease.<br><br>Resident 42's 10/5/23 admission MDS indicated she/he was cognitively intact.<br><br>A public complaint received on 6/4/24 alleged Resident 42 wanted to be full code (all life saaving measures provided). The 6/4/24 public complaint alleged the resident's POLST was filled out incorrectly.<br><br>Resident 42's clinical record revealed two signed POLST documents.<br><br>The 10/4/23 POLST for Resident 42 indicated she/he wished to be full code.<br><br>The 10/27/23 POLST for Resident 42 indicated she/he wished to be Do not resuscitate (DNR).<br><br>On 10/28/24 Staff 4 (LPN care manager) interviewed resident 42, at which time Resident 42 indicated she/he was to be full code. Staff 4 confirmed Resident 42's code status was currently documented DNR which was not accurate.<br><br>On 10/29/24 at 7:31 AM Resident 42's code status was still DNR.<br><br>On 10/29/24 at 7:38 AM and 7:42 AM Staff 27(LPN) and Staff 25(RN) indicated where to locate Resident 42's code status. The code status at the designated location was DNR.<br><br>On 10/29/24 at 10:13 AM Staff 2 (DNS) confirmed Resident 42's Code status should reflect her/his desired status. |