| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395324 | A. Building<br>B. Wing | 05/17/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Allied Services Meade Street Skilled Nursing | 200 S. Meade Street<br>Wilkes Barre, PA 18702 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235<br><br>Based on a review of clinical records and select facility policy and staff interview, it was determined that the facility failed to provide nursing services consistent with professional standards of practice by failing to conduct ongoing and thorough nursing assessments of residents' status and condition after unwitnessed falls for three residents out of eight sampled (Residents 18, 33 and 61).<br><br>Findings include:<br><br>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care:<br><br>Assessments<br><br>Clinical problems<br><br>Communications with other health care professionals regarding<br><br>the patient<br><br>Communication with and education of the patient, family, and the patient ' s designated support person and other third parties.<br><br>A review of facility policy entitled Fall Assessment Prevention/Review last revised January 2019, and Neurological Assessment, dated March 2020, indicated the facility will ensure safety for the residents by implementing appropriate fall interventions to decrease risk of falls and injury. Question of head injury: bruising, swelling, observed striking of head with fall or unwitnessed fall, or change in level of consciousness: Neurological checks per policy and procedure. Initiate Neurological Assessment Flow Sheet for 48 hours and complete at the following intervals:<br><br>Every 15 minutes for one (1) hour<br><br>Every hour for four (4) hours; then<br><br>(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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Every four (4) hours for the remainder of the 24-hour period post incident; then<br><br>Every eight (8) hours for the next 24 hours for a total of a 48 hours observation period.<br><br>A review of Resident 18's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to have included abnormal gait (walking pattern) and mobility, lack of coordination, and heart failure.<br><br>Review of a facility Risk Management Fall Report for Resident 18 and dated January 11, 2022, at 4:30 AM, revealed that the resident had an unwitnessed fall and was found lying on his right side on the floor of his room. The resident reported that he was standing to try to use his urinal and lost his balance and fell and sustained skin tears. Interventions noted post fall were to place a call nurse sign in his room, every 15-minute checks, a therapy screen. physician and responsible party (RP) aware.<br><br>Review of Physician's Orders dated January 11, 2022, at 5:25 AM, revealed an order for every 15-minute checks for 72-hours.<br><br>Review of Resident 18's clinical record failed to reveal that physician ordered every 15-minute checks of the resident were completed for 72 hours post-fall as ordered.<br><br>Interview with the Assistant Director of Nursing (ADON), on May 17, 2022, at 12:00 PM, confirmed that the facility was unable to demonstrate that staff had conducted the physician ordered every 15-minute checks of the resident for three days after the fall.<br><br>A review of Resident 33's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to have included unspecified dementia without behavioral disturbances, history of falling, and chronic kidney disease.<br><br>Review of a facility Risk Management Fall Report for Resident 33 dated January 9, 2022, at 1:30 PM, revealed that the resident was found in her bathroom, lying on the floor, slightly turned to her left side, facing the bathtub. Interventions planned post fall were to conduct a therapy screen, every 15-minute checks for 72-hours, and neuro checks. Physician and responsible party (RP) aware.<br><br>Review of the facility provided Q 15 Minute Check - Resident Safety Checks for Resident 33 dated January 9, 2022, revealed that the safety checks were completed only from 2:00 AM through 5:00 AM. The facility failed to consistently carry out physician orders for post fall monitoring of the resident.<br><br>Review of a facility Risk Management Fall Report for Resident 33 dated February 25, 2022, at 11:15 PM, revealed that a nurse aide (NA) was assisting the resident to the bathroom and the resident pulled off toilet paper and began to wipe off toilet seat. The resident asked the nurse aide to turn off the heat and before the nurse aide could prevent it, the resident fell . Interventions planned post fall included every 15-minute checks, neuro checks, and bowel and bladder tracking. Physician and RP were made aware.<br><br>Review of Physician's Orders dated February 26, 2022, at 5:59 AM, revealed an order for every 15-minute checks of the resident for 72-hours after the fall.<br><br>(continued on next page) |

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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 33's clinical record failed to reveal that physician ordered every 15-minute checks were completed. There was also no documented evidence that nursing had conducted the neurochecks as planned after the resident's fall and in accordance with facility policy.<br><br>A facility Risk Management Fall Report for Resident 33 dated May 4, 2022, at 4:10 PM, revealed that the resident was yelling out oh God help and a nurse and nurse aide found the resident on floor lying on her back between her bed and window. At time of fall, the resident's walker was observed on the right side of bed and her Broda chair was observed in the resident's bathroom. The nurse assessed the resident and noted that the resident had complaints of mild pain on the occipital area of head and was observed with a silver dollar sized bump on her head in occipital area. New interventions planned post fall included every 15-minute checks for 72 hours and re-eval, neuro checks, therapy screen, and to remind the resident to ask for assistance when needed.<br><br>A Physician's Order dated May 4, 2022, at 6:07 PM, was noted for every 15-minute checks of the resident for 72-hours until May 7, 2022, at 11:59 PM.<br><br>Review of the facility provided Q 15 Minute Check - Resident Safety Checks for Resident 33 dated May 4, 2022, revealed that the safety checks were only conducted at 4:00 PM and at 4:15 PM. The facility failed to consistently conduct the every 15 minute checks of the resident after the fall as ordered by the physician and planned after the resident's fall. Nursing staff failed to conduct the neurochecks of the resident as planned after the fall and according to facility policy.<br><br>At the time of survey ending May 17, 2022, the facility was not able to provide documented evidence to demonstrate that physician orders, planned post-fall interventions and facility policy were consistently followed and implemented by failing to consistently conduct every 15 minute checks and complete neurochecks of the residents after the above noted falls.<br><br>During an interview with the Assistant Director or Nursing (ADON) on May 17, 2022, at 12:15 PM, the ADON confirmed that the facility failed to ensure that post fall interventions, facility policy and physician orders were consistently carried out and implemented.<br><br>A review of the clinical record revealed that Resident 61 was admitted to the facility on [DATE], with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), diabetes, chronic kidney disease, major depression, malignant neoplasm of the large intestine and seizures.<br><br>A review of an Annual Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated October 14, 2021, indicated that the resident was moderately cognitively impaired with a BIMS (brief interview to assess cognitive status) score of 12 (8 - 12 represents moderate cognitive impairment) and required extensive assist of staff for bed mobility, transfers, dressing, toileting, and personal hygiene (combing hair, brushing teeth) and with physical help in part with bathing.<br><br>A nursing progress note, dated January 5, 2022, at 1:36 AM, indicated Resident 61 was found lying in a prone position (face down) with his right arm under him causing a discoloration to top of right hand. A nursing progress note, dated January 5, 2022, at 2:20 AM noted that Neuro checks, 15 - minute safety checks were initiated.<br><br>(continued on next page) |

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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | According to the Neuro Check sheet dated January 5, 2022, revealed that the checks were completed at 1:30 AM, 1:45 AM, 2:00 AM, and 2:15 AM. There was no documented evidence at the time of the survey ending May 17, 2022, that the neurochecks had been completed at the frequency and duration noted in facility policy.<br><br>A nursing progress note dated March 17, 2022, at 4:30 PM, indicated Resident 61 had activated his bathroom call light and was found lying on the bathroom floor on his right side. His W/C was in the bathroom doorway with his brakes unlocked. Resident 61 stated he attempted to put himself on the toilet and his feet slid out from underneath him and he slid onto the floor. Denied hitting his head, and denied pain, however a small abrasion was found on his right lateral forearm. Neuro checks, 15 - minute safety checks initiated, and therapy evaluation sent. Physician and resident representative (RP) made aware.<br><br>A nursing progress note dated March 17, 2022, at 9:07 PM, indicated, called to assess resident at 4:30 PM. Resident awake and alert lying on right side in front of the toilet. W/C observed behind him in doorway of bathroom. Resident is oriented x 3. Respirations easy and nonlabored on room air (RA). Lung sounds clear. Skin warm, dry and color flesh tone. Denies bumping head. Speech clear. Neuro checks within normal limits (WNL). Resident stated, my feet slid out from underneath me New interventions planned were Neuro checks, 15 - minute safety checks, therapy eval, resident education on importance of asking for assistance and using call bell.<br><br>A review of the Neuro Check sheet dated March 17, 2022, revealed that checks were conducted only at 4:30 PM, 4:45 PM, 5:00 PM, 5:15 PM, 5:30 PM and 6:00 PM. There was no documented evidence at the time of the survey ending May 17, 2022, that the neurochecks had been completed at the frequency and duration noted in facility policy.<br><br>A nursing progress note dated April 9, 2022, at 4:30 PM, indicated Resident 61 was found sitting on his buttocks on the floor with his wheelchair behind him as his dinner tray was delivered to him. Resident 61 stated he slid from his chair when he attempted to stand up to go to the bathroom, resident did not ring call bell or ask for assistance to go into restroom, call bell was within reach. Resident denied pain, denied hitting his head, assisted resident back to W/C with assist x 2 staff members, neuro checks initiated and WNL. Therapy eval sent, physician group made aware of fall and no new orders at this time. Resident was last observed by this nurse at 4:10 PM in room sitting in his W/C reading a book.<br><br>A nursing progress note, dated April 9, 2022, at 4:35 PM, indicated that the resident was observed sitting on his buttocks with the W/C directly behind him stating I just slid out of my chair when I went to stand, was trying to transfer to bathroom. Call bell within reach and not activated. Education on utilizing call bell for assistance, verbalized understanding. Denied hitting his head, nor having pain. Neuro checks initiated as per facility policy. RP made aware.<br><br>There was no documented evidence at the time of the survey ending May 17, 2022, that the neurochecks had been initiated and completed according to facility policy after the resident's fall on April 9, 2022.<br><br>(continued on next page) |

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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on May 17, 2022, at approximately 3:00 PM, with the Nursing Home Administrator (NHA), confirmed that the facility was unable to demonstrate, at the time the survey ended on May 17, 2022, that the facility had conducted Neurologic Assessments - Neuro Checks and or every 15 - minute safety checks as prescribed, planned and in accordance with facility policy after the above falls.<br><br>Refer to F 689<br><br>28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing Services<br><br>28 Pa. Code 211.5 (f)(g)(h) Clinical Records<br><br>28 Pa. Code 211.10(a)(c) Resident care policies |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235<br><br>Based on a review of clinical records and select incident investigations, observations and staff interviews, it was determined that the facility failed to consistently provide necessary staff supervision and implement individualized planned safety interventions to prevent repeated falls for three residents out of eight sampled (Residents 18, 33, and 61).<br><br>Findings include:<br><br>A review of Resident 18's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to have included abnormal gait (walking pattern) and mobility, lack of coordination, and heart failure.<br><br>Review of Resident 18's Admission/5-Day Minimum Data Set [(MDS) is a federally mandated standardized assessment process completed periodically to plan resident care), dated November 4, 2021, revealed that the resident was moderately cognitively impaired according to the resident's Brief Interview for Mental Status [(BIMS) section of the MDS which assesses cognition, a tool to assess the resident's attention, orientation, and ability to register and recall new information]. The MDS also indicated that the resident required extensive assistance with support of two plus-persons physical assistance with transfers (from bed, chair, wheelchair, standing position), dressing, toileting, and performance of personal hygiene.<br><br>A Risk Management Fall Report for Resident 18 dated January 11, 2022, at 4:30 AM, revealed that the resident had an unwitnessed fall and was found lying on his right side on the floor of his room. The resident reported that he was standing to try to use his urinal and lost his balance and fell . The resident sustained skin tears as a result of the fall. Interventions planned after the fall were to place a call nurse sign in his room, every 15-minute checks, and a therapy screen. Physician and responsible party (RP) aware.<br><br>A physician order dated January 11, 2022, at 5:25 AM, was noted for every 15-minnute checks for 72-hours. Review of Resident 18's clinical record failed to reveal that physician ordered every 15-minute checks were completed as ordered.<br><br>Interview with the Assistant Director of Nursing (ADON), on May 17, 2022, at 12:00 PM, confirmed that the facility failed to ensure that physician ordered every 15-minute checks were completed by staff after this fall.<br><br>A review of Resident 33's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to have included unspecified dementia without behavioral disturbances, history of falling, and chronic kidney disease.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 33's quarterly Minimum Data Set, dated dated dated [DATE], revealed that the resident had severe cognitive impairment. The MDS also indicated that the resident required extensive assistance with support of one-person physical assistance with transfers (from bed, chair, wheelchair, standing position), walking in her room, locomotion on the unit, dressing, toileting, and performance of personal hygiene.<br><br>Resident 33's care plan initiated on December 5, 2020, and revised on January 12, 2022, revealed that the resident was at high risk for falls related to cognitive loss, impaired balance, history of falls with injury, poor safety awareness, non-compliant asking for assistance with transfers, and use of medications that may increase risk of falls. The resident's goal was that safety interventions would be in place to decrease the risk of falls and that the resident would not experience injury related to falling. Fall prevention interventions included to remind the resident to ask for assistance and to keep walker at bed side.<br><br>Review of a facility Risk Management Fall Report for Resident 33 and dated January 9, 2022, at 1:30 PM, revealed that the resident was found in her bathroom lying on the floor slightly turned to her left side facing the bathtub. Interventions planned after this fall were to conduct a therapy screen, every 15-minute checks for 72-hours, and neuro checks. Physician and responsible party (RP) aware.<br><br>Review of the facility provided Q 15 Minute Check - Resident Safety Checks for Resident 33 that was dated January 9, 2022, revealed that the safety checks were only completed from 2:00 AM through 5:00 AM. The facility failed to ensure that post fall interventions were completed as planned.<br><br>Review of a facility Risk Management Fall Report for Resident 33 and dated February 25, 2022, at 11:15 PM, revealed that a nurse aide was assisting the resident to the bathroom and the resident pulled off toilet paper and began to wipe off toilet seat. The resident asked the nurse aide to turn off the heat and before the nurse aide could prevent it, the resident fell . Interventions planned after this fall were to conduct every 15-minute checks, neuro checks, and bowel and bladder tracking. Physician and RP were made aware.<br><br>A physician order was noted February 26, 2022, at 5:59 AM, to conduct every 15-minnute checks for 72-hours after the fall. A review of Resident 33's clinical record failed to reveal that physician ordered every 15-minute checks were completed as ordered after this fall.<br><br>A Risk Management Fall Report for Resident 33 dated May 4, 2022, at 4:10 PM, revealed that the resident was yelling out oh God, help and a nurse and nurse aide found the resident on the floor of the resident's room, lying on her back, between her bed and the window. At time of fall, the resident's walker was observed on the right side of bed and her Broda chair was observed in the resident's bathroom. The nurse assessed and noted that the resident had complaints of mild pain on the occipital area of head and was observed with a silver dollar sized bump on her head in occipital area. New interventions that were added post fall included every 15-minute checks for 72 hours and re-eval, neuro checks, therapy screen, and to remind the resident to ask for assistance when needed.<br><br>A physician order dated May 4, 2022, at 6:07 PM, was noted to conduct every 15-minnute checks for 72-hours until May 7, 2022, at 11:59 PM.<br><br>(continued on next page) |

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|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility provided Q 15 Minute Check - Resident Safety Checks for Resident 33, dated May 4, 2022, revealed that the safety checks were only completed 4:00 PM and at 4:15 PM. The facility failed to demonstate that the ordered 15-minute checks were completed.<br><br>At the time of survey ending May 17, 2022, the facility was not able to provide documented evidence that post fall interventions of 15-minute checks safety checks were completed as planned and ordered by the physician.<br><br>The facility also failed to demonstrate that the facility had evaluated the residents' toileting needs as related to these falls, which occurred related to self-toileting attempts and planned person-centered measures to address this specific fall risk factor to prevent further falls of a similar nature.<br><br>During an interview with the Assistant Director or Nursing (ADON) on May 17, 2022, at 12:15 PM, confirmed that the facility failed to ensure that post fall interventions were carried out and planned and prescribed. The ADON was also unable to show that the facility had identified and addressed the residents' individual risk factors, toileting needs, and developed and implemented approaches to meet these needs and prevent additional falls.<br><br>A review of the clinical record revealed that Resident 61 was admitted to the facility on [DATE], with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), diabetes, chronic kidney disease, major depression, malignant neoplasm of the large intestine and seizures.<br><br>A review of an Annual Minimum Data Set assessment dated [DATE], indicated that the resident was moderately cognitively impaired with a BIMS (brief interview to assess cognitive status) score of 12 (8 - 12 represents moderate cognitive impairment) and required extensive assist of staff for bed mobility, transfers, dressing, toileting, and personal hygiene (combing hair, brushing teeth) and with physical help in part with bathing.<br><br>A quarterly Fall Risk Assessment (documentation tool used to predict falls), dated December 24, 2021, revealed that the resident was at moderate risk for falls.<br><br>A nursing progress note dated January 5, 2022, at 1:36 AM, indicated Resident 61 was found lying in a prone position (face down) with his right arm under him causing a discoloration to top of right hand. Able to demonstrate full range of motion (FROM) to all extremities without indication of pain or discomfort noted. Stated he had to have a bowel movement and slid out of his wheelchair (W/C). Observation noted the W/C brakes were not engaged. Supervisor on unit to assess.<br><br>A nursing progress note dated January 5, 2022, at 2:20 AM, indicated that when asked why he thought he fell the resident stated that he slid from his W/C. He was able to demonstrate FROM without pain/discomfort. He stated he had to have a bowel movement and was assisted to the bathroom. Neuro checks, 15 - minute safety checks and Dycem (non -slip material which grips on both sides, used to stabilize objects, to provide a better grip) above and below W/C cushion were initiated as well as therapy screen.<br><br>(continued on next page) |

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|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A facility provided investigation - Risk Management Fall Report dated January 5, 2022, at 1:30 AM indicated the resident had an unwitnessed fall in his room, while attempting to toilet himself. He was found on the floor calling for help, prone position (face down) with his right arm under him causing a discoloration to top of right hand. He stated, he needed to have a bowel movement, slipped out of W/C (brakes not engaged). The interventions added after the fall to prevent further recurrence included every 15 - minute safety checks x 72 hours, education (reminded to call for assistance with toileting as needed), therapy screen, and Dycem above and below W/C cushion.<br><br>A review of facility was unable to provide evidence that every 15 - minute safety checks x 72 hours had been completed as planned.<br><br>A review of physician orders dated January 5, 2022, indicated that non - skid material be placed above and below the resident's wheelchair cushion.<br><br>A nursing progress note dated March 17, 2022, at 4:30 PM, indicated Resident 61 had activated his bathroom call light. Staff found the resident lying on the bathroom floor on his right side. His W/C was in the bathroom doorway with his brakes unlocked. Resident 61 stated he attempted to put himself on the toilet and his feet slid out from underneath him and he slid onto the floor. Denied hitting his head, and denied pain, however a small abrasion was found on his right lateral forearm. Neuro checks, 15 - minute safety checks initiated, and therapy evaluation sent. Physician and resident representative (RP) made aware.<br><br>A nursing progress note dated March 17, 2022, at 9:07 PM, noted called to assess resident at 4:30 PM. Resident awake and alert lying on right side in front of the toilet. W/C observed behind him in doorway of bathroom. Resident is oriented x 3. Respirations easy and nonlabored on room air (RA). Lung sounds clear. Skin warm, dry and color flesh tone. Denies bumping head. Speech clear. Neuro checks within normal limits (WNL). Resident stated, my feet slid out from underneath me. Able to move all extremities without difficulty. Hips appear in proper alignment. NO internal or external rotation of extremities. Hand grasps strong and equal. Footwear- slippers with rubber sole. All safety measures in place per care plan. Alarm ringing in bathroom. Resident stated he pulled it after he fell . Resident assisted from floor. New interventions: Neuro checks, 15 - minute safety checks, therapy eval, resident education on importance of asking for assistance and using call bell. 97.8-68-18-130/74 96% 02 Call bell in reach. Safety measures in place.<br><br>A facility provided investigation Risk Management Fall Report dated March 17, 2022, at 4:30 PM, indicated that the resident had an unwitnessed fall in his bathroom. The resident attempted to self - transfer onto the toilet and his feet slid out from underneath him and he slid onto the floor, sustaining right arm abrasion. The interventions added after the fall to prevent further recurrence included neuro checks, every 15 - minute safety checks x 72 hours, education to ask for assistance, and therapy screen.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395324 | A. Building<br>B. Wing | 05/17/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Allied Services Meade Street Skilled Nursing | 200 S. Meade Street<br>Wilkes Barre, PA 18702 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Nursing progress note dated April 9, 2022, at 4:30 PM, indicated Resident 61 was found sitting on his buttocks on the floor with his wheelchair behind him as his dinner tray was delivered to him in his room. Resident 61 stated he slid from his chair when he attempted to stand up to go to the bathroom, resident did not ring call bell or ask for assistance to go into restroom, call bell was within reach. Resident denied pain, denied hitting his head, assisted resident back to W/C with assist x 2 staff, neuro checks initiated and WNL. Therapy eval sent, physician group made aware of fall and no new orders at this time. Resident was last observed by this nurse at 4:10 PM in room sitting in his W/C reading a book.<br><br>A review of the clinical record, nursing progress note, dated April 9, 2022, at 4:35 PM, indicated the resident was observed sitting on his buttocks with the W/C directly behind him stating I just slid out of my chair when I went to stand, was trying to transfer to bathroom. Call bell within reach and not activated. Education on utilizing call bell for assistance, verbalized understanding. Denied hitting his head, nor having pain. Neuro checks initiated as per facility policy. RP made aware.<br><br>A Risk Management Fall Report dated April 9, 2022, at 4:30 PM, indicated the resident had an unwitnessed fall in his room, while attempting to toilet himself. The resident was found sitting on his buttocks on the floor with his wheelchair behind him as his dinner tray was delivered to him. The interventions added after the fall to prevent further recurrence included therapy evaluation and every 15 - minute safety checks x 72 hours.<br><br>A review of the resident's current care plan for at risk for falls initially dated April 21, 2020, revealed that the facility failed to review the effectiveness of existing care planned interventions to prevent falls, to decrease the resident's risk of similar incidents, attempts at toileting - bathroom use, after the falls on January 5, March 17, and April 9, 2022.<br><br>Observation of Resident 61 on May 17, 2022, at approximately 3:21 PM, in the presence of Employee 1, Licensed Practical Nurse (LPN), revealed that the resident did not have a non - skid material above and or below his wheel - chair cushion as ordered and or care planned. In addition, the resident was observed seated on several electric cords, appearing to be similar to phone charging cords, and a larger, thicker cord such as an electric shaving cord. This obseravation was confirmed by Employee 1 at the time.<br><br>During an interview with Assistant Director of Nursing (ADON) on May 17, 2022, at approximately 2:20 PM, confirmed that the facility failed to demonstrate the development and implementation of individualized and effective safety interventions to prevent repeated falls for Resident 61.<br><br>During an interview on May 17, 2022, at approximately 3:00 PM, with the Nursing Home Administrator (NHA) verified the events of the incident and was unable to provide any additional information. She further confirmed that the facility failed to demonstrate individualized and or effective safety interventions to prevent repeated falls for Resident 61 and that there was no evidence that the facility and addressed the resident's toileting needs in relationship to the resident's repeated falls and timely developed and implemented person-centered approaches to manage this risk factor and prevent repeated falls while attempting to self-toilet.<br><br>Refer to F 684<br><br>28 Pa. Code 211.12 (a)(d)(1)(5) Nursing services<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395324 | A. Building<br>B. Wing | 05/17/2022 |

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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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 28 Pa. Code 211.11(d) Resident care plan |