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| F 000 | INITIAL COMMENTS<br><br>Complaint #1643145/IL86082 | F 000 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to update Care Plans in a timely manner for 1 of 3 residents (R1) reviewed for Care Plans in the sample of 5.<br><br>Findings include:<br><br>R1's current Care Plan documents a review date of 12/26/15 for Falls, ADL (Activity of Daily Living) | F 280 | | |

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

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Function Rehab, Medical Conditions-Hypertension, Diabetes, Comfort/Pain, Continence, and Psychotropic Drugs. The Care Plan further documents a review date of 9/30/16 for Nutrition, 12/22/15 for Pressure Ulcers, and 12/30/15 for Psychosocial. The following assessments were last reviewed 12/26/15: Abnormal Involuntary Movement Score (AIMS), Braden Scale, Pain, Fall Risk, Hydration, Side Rails, Elopement Risk, and Psychotropic Medication Assessment.

On 6/15/16 at 9:33 AM, E15, Care Plan/Minimum Data Set (MDS) Coordinator, stated Care Plans are updated every 3 months unless a resident has a significant change. E15 stated the Care Plans and MDS are "updated to the best of my knowledge-I do the best I can." E15 stated she "probably reviewed the Care Plan, just didn't put a date down."

On 6/15/16 at 12:05 PM, during a telephone interview, E2, Interim Director of Nursing (DON)/Regional Nurse, stated she would expect the MDS/Care Plan be accurate and updated with any changes.

On 6/15/16 at 10:15 AM, E1, Administrator, stated she expects the Care Plan/MDS to be updated.

The Facility's undated Comprehensive Assessment/Care Planning Policy, documents in part: "It is the policy of this Facility to comprehensively assess, in a timely manner, each resident to this facility. The results of this resident assessment shall serve as the basis for determining resident need, and subsequently how care shall be planned for each resident." It also

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| F 280 | Continued From page 2<br>documents "6. The MDS and Care Plan shall be re-evaluated according to the following schedule." It also documents "c. Key areas of the MDS (as defined by the state) and the care plan shall be re-evaluated every 3 months." | F 280 | | |
| F 309 SS=G | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to properly address the psychosocial needs and follow the plan of care for a resident with Dementia, with known fears of water and increased behaviors while showering for 1 of 5 residents ( R3) reviewed for individualized care in the sample of 5. This failure resulted in R3's increased behaviors during a shower that resulted in R3's left ankle fracture which required hospitalization and surgical intervention.<br><br>Findings include:<br><br>1. R3's June 2016 Physician Order Sheet documents R3 was admitted to the facility on 6/5/14 with a diagnoses, in part, of: Dementia, aggressive behavior, mental status change, severe Dementia with psychosis, and Alzheimer's. R3's Minimum Data Set (MDS), | F 309 | | |

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dated 1/25/16, documents R3 was unable to complete the cognition interview, resident is rarely/never understood. R4's MDS, dated 1/25/16, documents R4 requires extensive assistance with two staff members for toileting and showering. The MDS further documents R3 does not exhibit behavioral symptoms. The MDS also documents R3 rejected care that is necessary to achieve the resident's goals for healing and well-being.

R3's Care Plan, dated 6/5/14, documents: Behavior, with a review date of 1/25/16: "Resident is known/has history of displaying inappropriate behavior and or resisting care/services. Specific behavior exhibited, resists care, physically and verbally aggressive to staff, delusional about food preferences. Related diagnosis/condition, dementia, depression, psychosis unspecified." Cognitive Loss/Dementia, with a start date of 6/20/14: Behavior exhibited.."refusal/fear of water showers." Resident's specific information can be physically/verbally abusive when resisting care. Falls with review date of 1/25/16: "Resident has risk factors that require monitoring and intervention to reduce potential for self injury. A) See also Behavior care plan. minimize fall risk through reducing agitation and impulsive behavior." Behavior: "Use two staff members for showers for safety due to resisting care. Fears water or lotion on skin or hair." Multiple Interventions for Previous Falls noted under the Fall Care Plan. Activity of Daily Living (ADL) Function Rehab, with start date of 6/20/14 and review date of 1/25/16: "Self care deficit-needs supervision and or assist to complete quality care and or poorly motivated to complete ADL. As evidenced by does not like clothes to touch floor

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when dressing and is fearful of anything wet touching hair or skin which results in resisting showers or sponge baths. Resident specific information/preferences will need two staff to bath resident. A) will receive shower. Will need two staff to bath resident due to fear of water."

R3's Bowel Assessment dated 11/2/15 documents: "Staff assist (R3) to bathroom, requires 2 assist frequently with toileting needs related to agitation during care."

R3's Behavior Monitoring Record For March, April, May and June 2016 documents: Agitation at staff. Documentation for 3/17/16 Record states "leaning, twisting with assisted transfer stating 'I'm going to fall'." Documentation for 4/13/16 Record states "being ambulated in hallway, calling out 'Don't hurt me. Don't drop me'." June's Tracking is blank.

R3's SBAR (Situation, Background, Assessment, Recommendation) Communication Form, dated 4/14/16, documents: Resident Evaluation: Mental Status Evaluation: dementia, no changes observed, Functional Status Evaluation: decreased mobility, Behavioral Evaluation: depression, social withdrawal, Respiratory Evaluation: (blank), Cardiovascular Evaluation: (blank), Abdominal/GI Evaluation: date of last bowel movement: 4/14/16, Situation: (entire section-blank), Background: (entire section-blank).

R3's Social Service Progress Notes documents: "7/10/15, IDT(Interdisciplinary Team) met this morning to discuss (R3's) behaviors. (R3) hit CNA (Certified Nurse Assistant) who was assisting her out of bed. Team will continue to

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monitor. 9/11/15 IDT met this morning to discuss behavior tracking. (R3) scratched CNA while attempting to assist her to dinner. Team will continue to redirect and monitor. 9/18/15 IDT met this morning to discuss behavior tracking. (R3) was resistive with CNAs trying to give her a shower and was difficult to calm down. Team will continue to redirect and monitor. 11/13/15 IDT met this morning to discuss behavior tracking. (R3) became agitated with staff during ADL care as well as resistive. team redirected and will continue to monitor. 11/20/15 IDT met this morning to discuss behavior tracking. (R3) became agitated during shower and ADL care and resisting care. Staff redirecting and will continue to monitor. 12/4/15 IDT met this morning to discuss behavior tracking. (R3) was becoming agitated during shower care. Staff redirected and will continue to monitor." The next entry is 4/14/16 documenting the hospital requesting R3's guardianship paperwork.

R3's Nursing Notes dated 4/14/16 documents in part: "7:20 AM, Called to shower room by (E5, CNA). She (R3) lunged, started slipping. (E5) had tried to straighten (R3) prior to impact of extended left leg against commode base. (R3) now lowered to floor into sitting position. Left lower leg/ankle area with a 1 cm (centimeter) whitened area with hard object. Feet beneath this area. Deviation of foot of inner rotation-welling occurring...Stabilized Left lower leg using magazines and ace wrap. no wt (weight) bearing as 4 transfer (R3) to w/c (wheelchair) then to (R3) bed." 0730, "call placed to (Z1, Nurse Practitioner) returning call with orders to send to ER (Emergency Room) for evaluation r/t (related to) left lower leg dislocation, edema, and pain." "835 AM Call received from hospital inquiring to

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how LL (left lower) leg trauma occurred. Told of large loose stool incontinence required shower for cleansing, (R3) lunged and slipped." (Z2, Medical Doctor) "indicates fracture has occurred, surgical intervention being considered." Nursing Notes dated 4/15/16, 9:00 AM, documents "IDT meeting held with review of previous fall. Interventions to educate staff assistance of 2 for showering."

R3's Hospitalist History and Physical dated 4/14/16 documents "Admission: HPI (History of Present Illness); 76 year-old with history of Alzheimer's dementia present to the ED (Emergency Department) from NH (Nursing Home) for left ankle pain and deformity s/p (status post) witnessed fall this morning in the shower. Per NH nurse, (R3) was wearing a gait belt and her leg slipped in the shower and she slid into a commode. The aide reported hearing a pop. Upon exam, unable to obtain any history from (R3) due to confusion. Per nurse, her baseline is A/O (alert and orientated) x 0. History obtained from ED records. Upon arrival to ED, the physical noted purple discoloration of left foot and second and 3rd toes on right foot, which he noted to greatly improve close to normal color. Physical Exam: Musculoskeletal. Extremities; ROM (Range of Motion) grossly intact, Pain with ROM (left ankle), ROM decreased (left ankle), other (left ankle with hourglass posterior splint in place, foot warm DP (dorsalis pedis) pulse 2+, neurovascular intact, slight purple discoloration to 2nd and 3rd toes of right root. Other Test Results: Left ankle x-ray: decreased mineralization, trimalleolar fracture with mild displacement of fracture ligaments. Assessment/Plan: Problem List (1) Trimalleolar Fracture of ankle, closed. Assessment/Plan: X-ray left ankle reveals trimalleolar fracture with

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mild displacement of fracture ligaments. Admit to medical floor. Orthopedic surgeon consulted. Plans for surgery. (3) Alzheimer's dementia: Assessment/Plan Continue home regimen fall precautions."

R3's Orthopedic Consult dated 4/14/16 documents in part: "Assessment/Plan: Problem List (1) Closed trimalleolar fracture of left ankle. Overall the ankle really shows significant displacement and a trimalleolar fracture has an inherent instability. Therefor the recommendation is for an open reduction internal fixation to reposition the alignment and allow for rigid fixation. This would also allow for a little earlier mobilization and weight bearing. However still carry the inherent risk of surgery. Conversely I think to treat this from a close/conservative standpoint is going to leave her with a completely dysfunctional ankle for which she would have difficulty even with limited weightbearing...We'll plan on proceeding to the operating room on 4/15/16 at 1 PM as long as patient is stable for surgery."

On 6/14/16 at 10:30 AM, E1, Administrator, stated E19, Registered Nurse (RN), who was working the day R3 fell is no longer an employee of the facility.

On 6/14/16 at 12:38 PM, E4, Licensed Practical Nurse (LPN), stated she works the 200 hall and dementia unit. On 6/14/16 at 2:21 PM, E4 stated R3 had behaviors. E4 stated R3 would not want to get up, or take medications sometimes. E4 stated R3 was uncooperative with showers or any care. E4 stated R3 would pull away from staff and state she (R3) wants to go back to her room or say "No." E4 stated R3 was never agreeable

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with any care.

On 6/14/16 at 1:00 PM, E5, CNA, stated she was the CNA who assisted R3 in the shower on 4/14/16 when R3 fell. E5 stated R3 had a bowel movement and went to shower R3 to clean her up. E5 stated she was drying R3 off and R3 jumped up and started walking swiftly towards toilet. E5 stated R3's foot slipped and turned and hit ankle on toilet and then R3 sat down on toilet.

On 6/14/16 at 1:20 PM, E3, LPN stated R3 required normally an assist of one staff, sometimes 2 depending on mood. E3 stated they made sure there were 2 people to assist R3 with ADL's. E3 stated R3 like to guide you the way she wanted to go and R3 would try and hurry. On 6/14/16 at 2:26 PM, E3 stated R3 had behaviors at times like pulling away from staff while doing care, and only eating white foods. E3 stated sometimes when staff would change or toilet R3, she would pull away and she (R3) is done with care.

On 6/14/16 at 1:55 PM, Z1, Nurse Practitioner, stated R3 had a fractured ankle and was sent out of the facility and ultimately had surgery. Z1 stated R3's unsteady at times and uncooperative at times as well. Z1 stated getting R3 a shower is "like pulling teeth" because R3 is uncooperative.

On 6/14/15 at 2:15 PM, E8, LPN, stated R3 had behaviors and would get combative. E8 stated R3 didn't want to get up and preferred her room. E8 stated R3 didn't like showers, or to get her hair brushed or get dressed. E8 stated R3 was a "timid physical."

On 6/14/16 at 2:25 PM, E9, RN, stated R3 does

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have behaviors, like asking for food, but is easily redirected. E9 stated he is unsure if R3 has problems with showers and stated no one has reported anything like that to him.

On 6/14/16 at 2:30 PM, E10, CNA, stated R3 does not resist care or have behaviors. E10 stated R3 just repeats herself.

On 6/14/16 at 3:00 PM, E13, CNA, stated R3 had a tendency to pull away from staff. E13 further stated R3 always tried to pull away from you, and R3 could ambulate. E13 stated she thinks R3 requires only one staff member for assistance but stated " I try and get another staff. (R3) is terrified of falling." E13 stated she has never given R3 a shower, but thinks you have to have 2 people because R3 does pull away.

On 6/15/16 at 9:20 AM, E14, CNA, documents she worked with R3 on the dementia unit and R3 does have behavior. E24 stated "You'll have to ask nurse what behaviors there are."

On 6/15/16 at 9:33 AM, E15, Care Plan/MDS Coordinator, stated Care Plans are updated every 3 months unless a resident has a significant change. E15 stated the Care Plans and MDS are "updated to the best of my knowledge-I do the best I can." E15 stated R3 required 1-2 staff assist and R3 was on the dementia unit so it depended on her behaviors. E15 stated R3 had behaviors like hitting, pulling away, throwing fecal matter on the floor and resisting care. E15 stated R3 didn't like water too much and R3's family had told the facility that she didn't like water. E15 stated she "probably reviewed the Care Plan, just didn't put a date down."

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On 6/15/16 at 10:15 AM, E1, Administrator, stated "I encourage staff to look at MDS and Care plan to see resident information." E1 stated she educated staff on using the MDS and Care Plan and that the information is kept behind the nurses station for staff use. E1 stated she expects the Care Plan/MDS to be updated. E1 stated she expects staff to utilize 2 staff members with known behaviors in the shower. E1 stated the facility has bed bath cloths and shower caps for use to bathe residents if unable to shower.

On 6/15/16 at 12:05 PM, during a telephone interview, E2, Interim Director of Nursing (DON)/Regional Nurse, stated she has been the interim since approximately 5/14/16. E2 stated she thinks R3 was on the dementia unit. E2 stated she would expect staff to follow resident Care Plan and MDS. E2 stated if a resident was having behaviors at the time of shower, staff could use bed bath cloths, reapproach later, or have another staff member who has better rapport try. E2 stated she would expect staff to know about individual care and the MDS/Care Plan be accurate and updated with any changes.

On 6/16/16 at 9:40 AM, E1, stated they do not have a special policy for dementia care residents. E1 further stated that all residents have individualized care.

The Facility's undated Comprehensive Assessment/Care Planning Policy documents in part: "It is the policy of this Facility to comprehensively assess, in a timely manner, each resident to this facility. The results of this resident assessment shall serve as the basis for determining resident need, and subsequently how care shall be planned for each resident."

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| F 323 SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to properly transfer, provide a thorough investigation, and implement progressive interventions for falls for 2 of 5 residents (R2, R3) reviewed for falls in the sample of 5. This failure resulted in R2 having multiple Emergency Room visits requiring intervention for lacerations to the head, concussion and compression fracture. The failure resulted in R3's left ankle fracture requiring hospitalization and surgical intervention.<br><br>Findings include:<br><br>1. R3's June 2016 Physician Order Sheet documents R3 was admitted to the facility on 6/5/14 with a diagnoses, in part, of: Dementia, aggressive behavior, mental status change, severe Dementia with psychosis, and Alzheimer's. R3's Minimum Data Set (MDS), dated 1/25/16, documents R3 was unable to complete the cognition interview, resident is rarely/never understood. R4's MDS, dated 1/25/16, documents R4 requires extensive assistance with two staff members for toileting and showering. The MDS further documents R3 does not exhibit behavioral symptoms. The MDS | F 323 | | |

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also documents R3 rejected care that is necessary to achieve the resident's goals for healing and well-being.

R3's Care Plan, dated 6/5/14, documents: Behavior, with a review date of 1/25/16: "Resident is known/has history of displaying inappropriate behavior and or resisting care/services. Specific behavior exhibited, resists care, physically and verbally aggressive to staff, delusional about food preferences. Related diagnosis/condition, dementia, depression, psychosis unspecified." Cognitive Loss/Dementia, with a start date of 6/20/14: Behavior exhibited.."refusal/fear of water showers." Resident's specific information can be physically/verbally abusive when resisting care. Falls with review date of 1/25/16: "Resident has risk factors that require monitoring and intervention to reduce potential for self injury. A) See also Behavior care plan. minimize fall risk through reducing agitation and impulsive behavior." Behavior: "Use two staff members for showers for safety due to resisting care. Fears water or lotion on skin or hair." Multiple Interventions for Previous Falls noted under the Fall Care Plan. Activity of Daily Living (ADL) Function Rehab, with start date of 6/20/14 and review date of 1/25/16: "Self care deficit-needs supervision and or assist to complete quality care and or poorly motivated to complete ADL. As evidenced by does not like clothes to touch floor when dressing and is fearful of anything wet touching hair or skin which results in resisting showers or sponge baths. Resident specific information/preferences will need two staff to bath resident. A) will receive shower. Will need two staff to bath resident due to fear of water."

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R3's Bowel Assessment dated 11/2/15 documents: "Staff assist (R3) to bathroom, requires 2 assist frequently with toileting needs related to agitation during care."

R3's Behavior Monitoring Record For March, April, May and June 2016 documents: Agitation at staff. Documentation for 3/17/16 Record states "leaning, twisting with assisted transfer stating 'I'm going to fall'." Documentation for 4/13/16 Record states "being ambulated in hallway, calling out 'Don't hurt me. Don't drop me'." June's Tracking is blank.

R3's SBAR (Situation, Background, Assessment, Recommendation) Communication Form, dated 4/14/16, documents: Resident Evaluation: Mental Status Evaluation: dementia, no changes observed, Functional Status Evaluation: decreased mobility, Behavioral Evaluation: depression, social withdrawal, Respiratory Evaluation: (blank), Cardiovascular Evaluation: (blank), Abdominal/GI Evaluation: date of last bowel movement: 4/14/16, Situation: (entire section-blank), Background: (entire section-blank).

R3's Social Service Progress Notes documents: "7/10/15, IDT(Interdisciplinary Team) met this morning to discuss (R3's) behaviors. (R3) hit CNA (Certified Nurse Assistant) who was assisting her out of bed. Team will continue to monitor. 9/11/15 IDT met this morning to discuss behavior tracking. (R3) scratched CNA while attempting to assist her to dinner. Team will continue to redirect and monitor. 9/18/15 IDT met this morning to discuss behavior tracking. (R3) was resistive with CNAs trying to give her a shower and was difficult to calm down. Team will

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continue to redirect and monitor. 11/13/15 IDT met this morning to discuss behavior tracking. (R3) became agitated with staff during ADL care as well as resistive. team redirected and will continue to monitor. 11/20/15 IDT met this morning to discuss behavior tracking. (R3) became agitated during shower and ADL care and resisting care. Staff redirecting and will continue to monitor. 12/4/15 IDT met this morning to discuss behavior tracking. (R3) was becoming agitated during shower care. Staff redirected and will continue to monitor." The next entry is 4/14/16 documenting the hospital requesting R3's guardianship paperwork.

R3's Nursing Notes dated 4/14/16 documents in part: "7:20 AM, Called to shower room by (E5, CNA). She (R3) lunged, started slipping. (E5) had tried to straighten (R3) prior to impact of extended left leg against commode base. (R3) now lowered to floor into sitting position. Left lower leg/ankle area with a 1 cm (centimeter) whitened area with hard object. Feet beneath this area. Deviation of foot of inner rotation-welling occurring...Stabilized Left lower leg using magazines and ace wrap. no wt (weight) bearing as 4 transfer (R3) to w/c (wheelchair) then to (R3) bed." 0730, "call placed to (Z1, Nurse Practitioner) returning call with orders to send to ER (Emergency Room) for evaluation r/t (related to) left lower leg dislocation, edema, and pain." "835 AM Call received from hospital inquiring to how LL (left lower) leg trauma occurred. Told of large loose stool incontinence required shower for cleansing, (R3) lunged and slipped." (Z2, Medical Doctor) "indicates fracture has occurred, surgical intervention being considered." Nursing Notes dated 4/15/16, 9:00 AM, documents "IDT meeting held with review of previous fall. Interventions to

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educate staff assistance of 2 for showering."

R3's Hospitalist History and Physical dated 4/14/16 documents "Admission: HPI (History of Present Illness); 76 year-old with history of Alzheimer's dementia present to the ED (Emergency Department) from NH (Nursing Home) for left ankle pain and deformity s/p (status post) witnessed fall this morning in the shower. Per NH nurse, (R3) was wearing a gait belt and her leg slipped in the shower and she slid into a commode. The aide reported hearing a pop. Upon exam, unable to obtain any history from (R3) due to confusion. Per nurse, her baseline is A/O (alert and orientated) x 0. History obtained from ED records. Upon arrival to ED, the physical noted purple discoloration of left foot and second and 3rd toes on right foot, which he noted to greatly improve close to normal color. Physical Exam: Musculoskeletal. Extremities; ROM (Range of Motion) grossly intact, Pain with ROM (left ankle), ROM decreased (left ankle), other (left ankle wit horoglass posterior splint in place, foot warm DP (dorsalis pedis) pulse 2+, neurovascular intact, slight purple discoloration to 2nd and 3rd toes of right root. Other Test Results: Left ankle x-ray: decreased mineralization, trimalleolar fracture with mild displacement of fracture ligaments. Assessment/Plan: Problem List (1) Trimalleolar Fracture of ankle, closed. Assessment/Plan: X-ray left ankle reveals trimalleolar fracture with mild displacement of fracture ligaments. Admit to medical floor. Orthopedic surgeon consulted. Plans for surgery. (3) Alzheimer's dementia: Assessment/Plan Continue home regimen fall precautions."

R3's Orthopedic Consult dated 4/14/16

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documents in part: "Assessment/Plan: Problem List (1) Closed trimalleolar fracture of left ankle. Overall the ankle really shows significant displacement and a trimalleolar fracture has an inherent instability. Therefor the recommendation is for an open reduction internal fixation to reposition the alignment and allow for rigid fixation. This would also allow for a little earlier mobilization and weight bearing. However still carry the inherent risk of surgery. Conversely I think to treat this from a close/conservative standpoint is going to leave her with a completely dysfunctional ankle for which she would have difficulty even with limited weightbearing...We'll plan on proceeding to the operating room on 4/15/16 at 1 PM as long as patient is stable for surgery."

R3's Operative Report, dated 4/15/16, documents in part: "Procedure Performed: open reduction internal fixation left trimalleolar ankle fracture. Open reduction internal fixation to include a lateral place and screw technique for the lateral malleolus fracture. 2 screw fixation for the medical malleolus fracture. No fixation required for the posterior malleolus fracture which reduced after the bimalleolar fixation."

On 6/14/16 at 10:08 AM, E6, CNA, stated she has taken care of R3, but was not working the day R3 fell. E6 stated R3 was in the dementia care unit before her fall and she was walking and required one staff member for assistance for showers. E6 stated she does not know of R3's fall history because she just started at the facility in May.

On 6/14/16 at 10:11 AM, E7, CNA, stated she took care of R3 after surgery and is unsure if she

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had any previous falls. E7 stated she thinks R3 walked around before fall, but doesn't know how fall happened. E7 stated she started at the facility in April.

On 6/14/16 at 10:30 AM, E1, Administrator, stated E19, Registered Nurse (RN), who was working the day R3 fell is no longer an employee of the facility. E1 stated fall investigations are part of the Quality Assurance and the facility does not give them out. E1 stated Care Plans are in the binder and is the most updated and working Care Plan for residents. E1 stated SBAR is in residents' charts and document fall information. E1 stated the facility has been inservicing on filling out the SBAR completely.

On 6/14/16 at 12:38 PM, E4, Licensed Practical Nurse, LPN, stated she works the 200 hall and dementia unit. E4 stated she worked prior to R3's fall in April. E4 stated she was unsure if she was working as a CNA or LPN during this time since she just received LPN license in March/April. E4 stated R3 was dependent on staff for at least most ADLs. E4 stated R3 required at least 2 staff members for showers, and toileting R3 was at least 1 staff member. E4 stated R3 would ambulate, but she wasn't steady and R3 would always say she was going to fall. E4 stated she did not believe R3 had a history of falls. E4 stated she was not working the day R3 fell, but was told R3 pulled away while being toileted. On 6/14/16 at 2:21 PM, E4 stated R3 had behaviors. E4 stated R4 would not want to get up, or take medications sometimes. E4 stated R3 was uncooperative with showers or any care. E4 stated R3 would pull away from staff and state she (R3) wants to go back to her room or say "No." E4 stated R3 was never agreeable

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| F 323 | Continued From page 18<br>with any care.<br><br>On 6/14/16 at 1:00 PM, E5, CNA, stated she was the CNA who assisted R3 in the shower on 4/14/16 when R3 fell. E5 stated R3 had a bowel movement and went to shower R3 to clean her up. E5 stated she was drying R3 off and R3 jumped up and started walking swiftly towards the toilet. E5 stated R3's foot slipped and turned and hit ankle on the toilet and then R3 sat down on the toilet. E5 stated she called for help and E19 came in. E5 stated E19 assessed R3 and called in E3, LPN, Resident Care Coordinator (RCC), and it took 3 staff to get R3 up and put her in wheelchair. E5 stated she didn't know if R3 had any history of falls. E5 stated R3 was unsteady and R3 required one staff member for showering, toileting or ADLs.<br><br>On 6/14/16 at 1:20 PM, E3, LPN, stated she was informed R3 fell on 4/14/16 in the shower room and R3 was complaining of pain to ankle. E3 stated she was not directly involved in assisting R3, and believes it was E20, the Previous Director of Nursing. E3 stated R3 is not someone the facility normally talks about for falls and have not had previous falls that she is aware of. E3 stated R3 required normally an assist of one staff, sometimes 2 depending on mood. E3 stated they made sure there were 2 people to assist R3 with ADLs. E3 stated R3 liked to guide you the way she wanted to go and R3 would try and hurry. On 6/14/16 at 2:26 PM, E3 stated R3 had behaviors at times like pulling away from staff while doing care, and only eating white foods. E3 stated sometimes when staff would change or toilet R3, she would pull away and she (R3) is done with care. | F 323 | | |

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On 6/14/16 at 1:55 PM, Z1, Nurse Practitioner, stated R3 had a fractured ankle and was sent out of the facility and ultimately had surgery. Z1 stated before the fracture, R3 ambulated with assistance or used the rails in the dementia unit. Z1 stated she is only in the facility once a week and has seen R3 ambulate. Z1 stated R3's unsteady at times and uncooperative at times as well. Z1 stated she did not want to speculate if R3's fall could have been prevented if 2 staff members were showering R3. Z1 stated getting R3 a shower is "like pulling teeth" because R3 is uncooperative.

On 6/14/15 at 2:15 PM, E8, LPN, stated R3 was ambulatory and needed 1 assist of staff for any ADLs, including bathing and toileting. E8 stated R3 had behaviors and would get combative. E8 stated R3 didn't want to get up and preferred her room. E8 stated R3 didn't like showers, or to get her hair brushed or get dressed. E8 stated R3 was a "timid physical."

On 6/14/16 at 2:25 PM, E9, RN, stated he has only been employed at the facility for one month and wasn't here when R3 had a fall in April. E9 stated R3 does have behaviors, like asking for food, but is easily redirected. E9 stated he is unsure if R3 has problems with showers and stated no one has reported anything like that to him. E9 stated he is unsure if R3 had a history of falls.

On 6/14/16 at 2:30 PM, E10, CNA, stated R3 does not resist care or have behaviors. E10 stated R3 just repeats herself and does not know of previous falls. E10 stated she has been employed at the facility for 2 weeks.

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On 6/14/16 at 3:00 PM, E13, CNA, stated she recalled R3's fall in the shower room. E13 stated R3 had a tendency to pull away from staff. E13 further stated R3 always tried to pull away from you, and R3 could ambulate. E13 stated she thinks R3 requires only one staff member for assistance, but stated " I try and get another staff. (R3) is terrified of falling." E13 stated she has never given R3 a shower, but thinks you have to have 2 people because R3 does pull away.

On 6/15/16 at 9:20 AM, E14, CNA, stated she worked with R3 on the dementia unit and R3 does have behaviors. E24 stated "you'll have to ask nurse what behaviors there are."

On 6/15/16 at 9:33 AM, E15, Care Plan/MDS Coordinator, stated Care Plans are updated every 3 months unless a resident has a significant change. E15 stated the Care Plans and MDS are "updated to the best of my knowledge-I do the best I can." E15 stated R3 required 1-2 staff assist and R3 was on the dementia unit so it depended on her behaviors. E15 stated R3 had behaviors like hitting, pulling away, throwing fecal matter on the floor and resisting care. E15 stated R3 didn't like water too much and R3's family had told the facility that she didn't like water. E15 stated she "probably reviewed the Care Plan, just didn't put a date down."

On 6/15/16 at 10:15 AM, E1, Administrator, stated "I encourage staff to look at MDS and Care plan to see resident information." E1 stated she educated staff on using the MDS and Care Plan and that the information is kept behind the nurses station for staff use. E1 stated if residents are MDS/Care Planned for 2 staff members then they (staff) should use 2 staff members. E1 stated

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she expects the Care Plan/MDS to be updated. E1 stated she expects staff to utilize 2 staff members with known behaviors in the shower. E1 stated the facility has bed bath cloths and shower caps for use to bathe residents if unable to shower.

On 6/15/16 at 12:05 PM, during a telephone interview, E2, Interim Director of Nursing (DON)/Regional Nurse, stated she has been the interim since approximately 5/14/16 and she does not recall how R3 transfers without reviewing her Care Plan. E2 stated she thinks R3 was on the dementia unit. E2 stated she would expect staff to follow resident Care Plan and MDS. E2 stated if resident having behaviors at the time of shower, staff could use bed bath cloths, reapproach later, or have another staff member who has better rapport try. E2 stated she would expect staff to know about individual care and the MDS/Care Plan be accurate and updated with any changes.

On 6/16/16 at 9:14 AM, E15, LPN and E1 both confirmed R3 had a history of falls since being a resident in the building. E15 stated she should have coded the 4/23/16 MDS for previous falls.

The Facility's Fall Prevention Policy, dated 9/3/15, documents in part: "To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each residents' wishes/desires for maximum independence and mobility. 2. Staff must observe residents for safety. If residents with a high risk code are observed up or getting up, help must be summoned or assistance must be provided to the resident." It also documents "5. The unit nurse will place documentation of the circumstances of the fall in the nurses notes along with any new

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intervention deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA assignment worksheet.
6. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed and comments will be written on the Quality Assurance Fall tracking form and any new interventions will be written on the care plan."

2. R2's Admission Record, undated, documents R2 was admitted 11/14/11. R2's June 2016 Physicians Order Sheet (POS) documents diagnosis in part, Major Depressive Disorder, Psychosis, RT CVA (Right Cerebrovasuclar Accident), Lt (Left) Hemiplegia, Alzheimer's Dementia, and Bilateral AKA (above knee amputation).

R2's MDS dated 5/16/16 and 9/16/15 both document R2 is moderately impaired, is only able to stabilize with staff assistance during surface to surface transfers, has impairment to one side of his upper extremity and has a history of falls.

R2's Care Plan last reviewed 5/16/16 documents in part, "Falls: Potential for falls related to bilateral AKA, has balance issues, CVA with left hemiplegia and is incontinent." Interventions, "9/11/15: (R2) request seat belt on while up in wheelchair related feels weak, able to remove seat belt on own. (R2) does not have any legs. 11/23/15: Physical Therapy/Occupational Therapy (PT/OT) to evaluate and treat related increased weakness. 11/17/16 Educate (R2) to go to bed when tired. 11/29/15: Re-educate (R2) to use reacher when something out of reach. 3/19/16: Sent to Emergency Room and returned with sutures done lip received tetanus at hospital. (R2

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stated he felt dizzy and hit mouth on night stand). Monitor suture site for signs and symptoms of infection, remove as ordered. PRN (as needed) pain meds. 5/18/16: Re-educate staff/(R2) to have help with transfers and wait for assistance. 5/29/16: Frequent reminders for proper wheelchair positioning. 6/6/16: Seat belt repositioned on wheelchair to allow for better trunk control. 6/8/16: Self releasing seat belt alarm was added today. OT to evaluate for positioning."

R2's Fall Risk Assessments, dated 9/16/15, 12/8/15, 2/29/16, 4/29/16 and 5/16/16, document R2 is a high risk for falls.

R2's Physical Therapy Plans of Care, dated 6/13/16 and 12/03/15, both document, "Functional Deficits: Balance, Fall Risk - moderate risk and Balance, Fall Recovery- moderately impaired."

R2's Physical Restraint/Enabler Assessment, dated 9/11/15, documents, "Mental Status: Alert: Yes, Short Attention Span: No, Orientated to: Person and Place, Disorientated: Intermittent. Balance When Sitting: Falls forward: Yes, Falls/Leans sideways: Yes to Right, Slumps: Yes. Recovery of Balance (while sitting): Forward: Yes, Backward: No, Sideways: Yes. Ambulation: Does not ambulate related to both above knee amputations. Describe Risk versus Benefits: able to release seat belt of own/command. (R2) request self release belt for positioning, he is a bilateral AKA, with paralysis on right side, uses left arm/hand for mobility of wheelchair. (R2) states seat belt will keep him in his wheelchair, not a restraint. Reviewed 12/8/15 with no changes. 6/8/16 self releasing seat belt alarm

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was added to alert staff of (R2) leaning over in wheelchair related to no lower extremities, poor trunk control."

R2's Nurse's Note, dated 10/27/15 at 6:20 PM, documents in part, "Called to outside patio, found (R2) laying on ground on his back in front of wheelchair. Other (alert) residents stated he started sliding down and eventually slid out of wheelchair underneath wheelchair... No bruises or apparent injuries." No other documentation found in R2's Clinical Record for this fall.

R2's Nurse's Note, dated 11/17/15 at 7:00 PM, documents in part, "Called to TV room per CNA. Found (R2) laying on floor on his back. (R2) had removed his seat belt and fell asleep causing him to fall face first into the floor. (R2) has a 3.3 x 1.6 cm (centimeter) laceration to midforehead. Complaint of headache... Orders received to send to ER (Emergency Room)."

R2's Nurses Note, dated 11/17/15 at 11:45 PM, documents in part, "(R2) arrived back to facility via stretcher. (R2) has 8 sutures to cent (center) of forehead."

The Facility's Final Report for R2, dated 11/20/15, documents in part, "On 11/17/15 at 7:00 PM (R2) was observed on the floor in the TV room. He was assessed by the nurse and noted to have a laceration to forehead. Physician and family notified with orders to send to ER for evaluation where he received sutures to the laceration. During the investigation (R2) stated that he was watching TV and fell asleep causing him to lean forward resulting in fall. (R2) wears a self releasing seat belt as a reminder which he reports that he had unfastened while watching TV

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prior to the fall. The fall was a result of (R2) falling asleep in his chair while watching TV. The IDT met, reviewed and residents care plan has been updated to reflect current status."

R2's Nurse's Note dated 11/29/15 at 7:45 documents in part, "Heard (R2) yelling, went to see what was going on when nurse walked into room (R2) noted to be sitting in the wheelchair his head was on the floor. (R2) sat up with assistance unable to let us know what happened just motioned to the floor, no item on the floor to be picked up. No red marks or bleeding to forehead. No red mark to abdomen where seat belt was in place attached in place and around waist." No other documentation found in R2's Clinical Record for this fall.

R2's Nurse's Note, dated 3/19/16 at 4:40 PM, documents in part, "This nurses heard resident yelling for help. Upon entering room this nurse found (R2) slumped over in his wheelchair with large amount of blood on floor, beside table and bottom part of bed... Noted (R2) to have a 2 inch deep laceration above upper lip.. (R2) stated he was dizzy and went to his room to lay down and collapsed... New order received to send to Emergency Room."

R2's Nurses's Note, dated 3/20/16 at 2:00 AM, documents in part, "(R2) received 5 stitches to upper lip. (R2) received a tetanus shot."

The Facility's Final Report for R2, dated 3/26/16, documents in part, "On 3/19/16 at approximately 4:10 PM (R2) was observed leaning over on his nightstand while still in his wheelchair and assessed by the nurse with a laceration to his upper lip. Physician and family notified with

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orders to send to the ER where he received sutures. The facility initiated investigation per protocol. Staff reported that (R2) passed the nurse in the hallway stated that he was dizzy and going to his room. The nurse went to (R2's) room where he was noted to be leaning over on his nightstand while still in his wheelchair with laceration to his upper lip. The laceration was a result of (R2) having dizziness and leaning over night stand will still in his wheelchair. The room was assessed with no safety concerns noted. The IDT reviewed and updated care plan reflect current status."

R2's Nurse's Note, dated 5/8/18, untimed, documents in part, "Called to room by nurse, (R2) noted on floor on back, states (I fell from chair.)"

R2's Nurse's Note, dated 5/8/16 at 10:00 PM, documents, "Sent to hospital Emergency Room for evaluation."

R2's Nurse's Note, dated 5/9/16 at 1:30 AM, documents in part, "(R2) returned to facility with DX (diagnosis): of Brain Concussion." On the same day, R2's Nurses' Notes document at 4:00 PM "Neuro checks WNL (within normal limits). See neuro/head trauma assessment form." No other documentation found in R2's Clinical Record for this fall.

R2's Emergency Department (ED) Provider Documentation sheet created 5/9/16 documents in part, "ED Arrival Date: 5/8/16. History of Present Illness, Chief Compliant: Head Injury. 74 year old male nursing home resident who fell while transferring from the wheelchair and struck his head. (R2) is on blood thinners. No LOC (loss of consciousness). No other injuries.

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General Appearance: Mild Distress: Well Developed: Well Nourished.
Diagnosis/Impression: Primary Impression: Brain concussion."

R2's Nurses Note, dated 5/29/16 at 9:55 PM, documents, "See SBAR related to fall."

SBAR Communication Form for R2, dated 5/29/16, documents in part, "Situation: Things that make the condition or symptom worse are (R2) removing seatbelt. Things that make the condition or symptom better are wearing seatbelt. Resident Evaluation: 10. Neurological Evaluation, abnormal speech, dizziness and unsteadiness. Appearance: (R2) was laying on his back on floor. He stated he hit his head. (R2 does have a small goose egg to right forehead) Nursing Notes: (R2) had undone his seatbelt and was leaning forward and toppled out of his chair."

R2's Nurses's Note, dated 6/6/16 at 9:50 AM, documents in part, "(R2) was leaving (R2's) Room, when he fell to the floor hitting his head. This caused a small laceration on his forehead. Sent to hospital. Transferred via ambulance."

R2's Nurse's Note, dated 6/6/16 at 2:30 PM, documents in part, "(R2) returned to facility via ambulance.. Laceration to right forehead measures 2 cm with 3 sutures dry and intact."

R2's ED Provider Documentation sheet created 6/6/16 documents in part, "ED Arrival Date 6/6/16. History of Present Illness, Chief Complaint: Head Injury. 74 year old male from nursing home after a mechanical fall from wheelchair. (R2) at baseline significantly limited in his ability to communicate. Today he is awake, eyes open,

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complaint of facial pain and neck pain, unable to quantify, unable to provide additional descriptors, unsure why he fell or if he is able to tell me (Z4, ED Physician). No loss of consciousness, reportedly witnessed by staff, 911 called. Has a laceration on his forehead with a dressing in place. History of right sided contractures and bilateral AKA's. Normally his is orientated x 1-2, here will tell me (Z4) his name is (R2). Procedures, Laceration Location Description: Right (side of forehead), Laceration Description: Linear, Length: 3 cm, Number of Sutures: 3. Diagnosis/Impression: Primary Impression: Laceration of head, Additional Impression: Traumatic hematoma of forehead."

R2's Radiology Report, dated 6/6/16, documents, "Procedure Description: CT (Cat Scan) Lumbar Spine WO (without contrast), Impression: Mild compression fracture deformity superior endplate of L2 of indeterminate age. Findings: L1-2: Spondylosis, Concern for recent superior endplate mild compression fracture L1."

The Facility's Final Report for R2, dated 6/10/16, documents in part, "On 6/6/16 at approximately 9:50 AM, (R2) was propelling himself in his wheelchair out of his room and fell forward out of the wheelchair. (R2) does wear a seat belt to aid in trunk stability due to his bilateral AKA. At the time of the fall (R2's) seat belt was unbuckled. (R2) is able to undo the seat belt and does at time. When asked if he unbuckled his seat belt, he stated he was not sure. In conclusion, the facility has determined that (R2) fell as a result of trunk instability due to not having his seat belt buckled. It was determined that he unbuckled the seat belt and he has been educated on the importance of keeping it buckled. The IDT met,

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new interventions were discussed and his care plan has been updated to reflect the changes."

R2's Nurse's Note, dated 6/8/16 at 12:30 PM, documents in part, "(R2) in tv room reaching for a magazine. Seat belt was intact but (R2) able to unlock. (R2) fell hitting his posterior head causing 2 cm (centimeter) laceration. Pressure dressing was applied. Bleed stopped. C/O (complaint of) left shoulder and back pain... Ambulance notified for transfer to hospital."

R2's Nurse's Note, dated 6/8/16 at 6:35 PM, documents in part, "Resident returned to facility via stretcher/ambulance, accompanied per 2 attendants with 3 staples dry and intact to posterior scalp."

SBAR dated 6/8/16 documents R2 had a decreased level of consciousness (sleepy lethargic), new pain with complaint of left shoulder pain and back pain.

The Facility's Final Report for R2, dated 6/13/16, documents in part, "On 6/8/16 at approximately 12:30 PM, (R2) was noted to be lying on the floor on his back in the TV area. Noted a laceration to the back of his head and he was complaining of back and shoulder pain. New order received to send to the ER for further evaluation and treatment. While at the ER, sutures were placed to close the laceration. (R2) stated he was reaching to get a magazine off of the shelf and fell out of wheelchair. (R2) does wear a seat belt to aid in trunk stability due to his bilateral AKA. Recently his seat belt was moved from his pelvis area to better fit around his chest area to aid in truck stability. At the time of the fall (R2's) seat belt was unbuckled. The CNA that was assigned

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to (R2) stated earlier in the day (R2) had unbuckled his seat belt and she buckled it and educated him on the importance of keeping it buckled. The facility determined that (R2) fell as a result of trunk instability due to not having his seat belt buckled. The IDT met, new interventions were discussed and his care plan has been updated to reflect the changes."

R2's ED Provider Documentation sheet created 6/8/16 documents in part, "ED Arrival Date 6/8/16. History of Present Illness, Chief Complaint: Head Injury. 75 year old male via EMS (Emergency Medical Services) who I (Z4) am familiar with from earlier this week after a a similar fall. Today (R2) was reportedly reaching for something in the dining room and fell out of his chair striking the back of his head, no LOC (loss of consciousness), denies neck pain, reportedly has a scalp laceration on the back of his head, denies chest pain or dyspnea, no abdominal pain, no other complaints, rates pain (god d***). Procedures, the 3 cm linear scalp laceration was prepped and draped in the sterile fashion. The galea was notable intact and the skin was closed with three staples. Diagnosis/Impression: Primary Impression: Scalp laceration, Additional Impression: Scalp hematoma."

On 6/13/16 at 1:10 PM, R2 was sitting in the hallway with a 1 inch laceration about his right eye. At that time, R2 was wearing a seat belt up under his upper abdomen.

On 6/15/16 at 8:25 AM, E3, LPN, asked R2 to remove his seat belt. R2 then took his left hand grabbed the belt from under his chest and released the Velcro belt.

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On 6/13/16 at 3:00 PM, R2 stated that he has fallen 6 or 7 times lately and he now is wearing a new seat belt that sits higher on his abdomen. He then stated that he likes the new belt and it has an alarm on it. He then stated that he is very scared that he has had all of the falls.

On 6/13/16 at 3:45 PM, E3 stated that R2 repeatedly takes off his seat belt and always forgets to ask for help. E3 also stated that R2 will lean over too far and doesn't realize his seat belt is not latched.

On 6/14/16 at 2:15 PM, E11, CNA, stated that R2's has a history of falls and thinks he needs something on his chest because he seems to go head first.

On 6/14/16 at 2:22 PM, E12, CNA, stated that R2's has a history of falls and he does not always wear his seat belt and frequently takes it off. E12 then stated that R2 refuses and gets aggressive with us when we try to put it on him. E12 then stated that R2 is top heavy and maybe needs a harness or a different chair to help him keep up because he always leans over and has some balance problems. E12 also stated, "The seat belt is helping, but he can take it off so it is useless."

On 6/15/16 at 9:35 AM, E15 stated that R2's seat belt is used as a reminder not to lean over too far and to prevent falls. E15 stated that R2 is supposed to have a reacher to pick up items that he sees on the floor, but he does not always carry that with him. She then stated that the reacher was an intervention because of falls. E15 stated she felt the interventions for R2's falls were progressive at the time implemented for each fall.

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On 6/15/16 at 11:20 AM, E16, Program Director of Therapy Department, stated R2 has a seat belt to help with fall prevention. E16 then stated that R2's previous seat belt was initially effective, but over time became less effective.

On 6/14/16 at 1:45 PM, E1, Administrator, stated that the fall investigations are QA (Quality Assurance) and the facility does not give them out.

On 6/15/16 at 10:15 AM, E21, Regional Nurse, stated that she felt the interventions put into place for R2 after his falls are progressive. E21 also stated that no intervention is going to be 100% effective. E21 stated she was unsure if orthostatic blood pressures were done after the 3/19/16 fall when R2 complained he was dizzy and then fell. No documentation that blood pressure done was provided.

On 6/15/16 at 12:00 PM during a telephone interview, E2, DON, stated that R2's seat belt is is used for trunk stability, bi-lateral seating and positioning. E2 stated she was the interim DON and had been here since 5/14/16 and was only familiar with R2's last two interventions for falls.

On 6/15/16 at 9:15 AM, E1 stated that she has mixed feeling on whether or not re-education on R2 was effective or not.

On 6/15/16 at 4:10 PM, Z4, Medical Doctor, (MD) stated that R2 had a mild compression fracture that was noted on a recent ED visit for falls. Z4 stated he was unsure of R2's prior falls, but that the compression fracture was related to a recent fall. Z4 stated he didn't put the compression

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| F 323 | Continued From page 33<br>fracture on the diagnosis list for the 6/6/16 ED visit for a fall because he felt it was from a previous fall. Z4 further stated he had seen R2 twice in a 2 day period in the ED for falls and felt the facility could be doing more to prevent R2 from falling.<br><br>Facility's Fall Prevention Interventions List dated 9/3/15 documents 42 interventions used by the facility in preventing falls. The interventions included from the list on R2's Care Plan are #4. Personal alarm, #9. Positioning in chair, #34 Physical therapy referral for ambulation, transfer training, strengthening #35. Occupational therapy referral for positioning. No other interventions were documented for R2. | F 323 | | |