STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065376	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKDALE GREENWOOD VILLAGE	6450 S BOSTON ST GREENWOOD VILLAGE, CO 80111

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to protect one (#1) resident, out of three residents reviewed in a sample of five residents, from neglect. Specifically, the facility failed to assess Resident #1 after she reported a fall to a staff member. Resident #1, was admitted to the facility on [DATE] after falling at home and sustaining multiple fractures. She had a history of [REDACTED]. In the morning of 2/17/2020 the resident reported to her registered nurse (RN) #1 that she fell at night and was picked off the floor by a staff member. RN #1 did not assess resident for injury. In the afternoon of 2/18/2020 (24 hours after the reported fall) when a resident experienced increased pain and swelling of her arm, she was sent to the emergency room where she was diagnosed with [REDACTED]. Findings include: I. Facility policy and procedure A copy of the facility's policy and procedure on Abuse Prevention with revision date 10/2018 was provided by the nursing home administrator (NHA) on 3/9/2020. The policy read in part, Neglect means failure to provide goods and services necessary to avoid physical harm, or mental anguish. II. Resident #1 A. Resident status Resident #1, [AGE], was admitted on [DATE]. According to the January 2020 computerized physician orders [REDACTED]. The 2/6/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident did not display any behaviors, hallucinations, and did not reject the care. She required limited assistance of one person for bed mobility, dressing, and personal hygiene. She required extensive assistance of two people for transfers, locomotion, toilet use, and bathing. Her balance during transition and walking was not steady, she was able to stabilize with staff assistance. She used a walker and wheelchair for mobility. She was occasionally incontinent of bowel and bladder, and she was not on the toileting program. B. Facility record review The care plan (CP) initiated on 1/31/2020, and revised on 2/24/2020, revealed the resident was at risk for falls. Interventions included: to educate the resident/family/caregivers about safety reminders and what to do if a fall occurs and to encourage the resident to wear appropriate footwear when ambulating. The admission assessment dated [DATE] indicated the resident was at risk for falls. There was no documentation found that RN #1 assessed Resident #1 or reported her fall to administration in the clinical record. C. Facility investigation On 3/9/2020 facility investigation was provided by NHA. The summary of the investigation read: On Monday morning 2/17/2020 at 7:00 a.m. (Resident #1) reported to registered nurse (RN #1) that she fell during the night and a tall black man picked her up. No injury was noted at this time. (RN #1) notified (physician assistant PA#1) who saw the resident who had no complaints during her assessment. On Tuesday morning 2/18/2020 swelling was noted in the left upper arm with mild pain. (RN#1) reported to (primary care physician PCP) who at this time suggested resident to be sent to the hospital. (PCP) stated family declined at this time. (PCP) saw resident later in the day and observed left arm very swollen and painful. (PCP) sent resident to the hospital. Resident was found to have a fractured left humerus. There was no conclusion at the end of the investigation. Immediate actions included: resident evaluation and treatment, resident transferred to the hospital, suspension of associated staff members. Certified nurse aide (CNA#1) who found Resident #1 on the floor on 2/17/2020 was suspended from his work until he received corrective action notice on 2/29/2020 prior to returning to work. He was re-educated to notify the nurse about the accident, not to move resident until he or she was assessed by a registered nurse, and to complete appropriate documentation prior to leaving after shift. RN #1 and other clinical staff were re-educated regarding timely assessment after an accident and proper documentation. The investigation was not signed or dated by NHA. D. Staff interviews RN #1 was interviewed on 3/9/2020 around 2:00 p.m. She said on Monday, 2/17/2020 when she came to work in the morning, she noticed that the resident was hallucinating, and around 9:00 a.m. in the morning the resident told her that she fell last night and was picked off the floor by a tall balck male. RN #1 said that she thought that was a part of her hallucination because the resident wouldn't be able to get up by herself, and she did not get any reports about falls. RN #1 said she did not assess resident for injury at that time. -Around 11:00 a.m. when a physician assistant (PA) #1 was in the building, RN #1 asked her to look at the resident because she was hallucinating about people in her room. She said PA #1 spoke with the resident and her daughter who was present in the room and ordered labs and urine tests to rule out infection. -Later during the day, the physical therapist (PT#1) reported to RN #1 that Resident #1 was not able to walk during therapy due to the pain and swelling in her left arm. RN #1 stated that she did not assess resident's arm, but she contacted primary care physician (PCP)to report the pain. PCP told her that the resident previously complained about pain in that arm and it was probably from the last fall. Resident #1 was recently started on the [MEDICATION NAME] for pain that should help. No other orders were given by PCP. RN #1 said during the day when the resident complained of pain, the pain was worse than before and it was in the left arm. She said she gave the resident her pain medication, but did not look at her arm. She said most of the arm was visible because the resident was wearing a nightgown with a short sleeve. She said she did not assess the resident's shoulder. -The next morning, 2/18/2020 when she came back for the next shift, the night nurse called her attention to look at the resident's arm because it was bruised and swollen closer to the elbow area. She said she reported that to assistant director of nursing (ADON) and called PCP. She said she did not do a full body assessment at that time. The PCP told over the phone that he was on his way to the facility and the family agreed to wait for him. When PCP came around noon, he gave an order to send resident to the emergency room for evaluation. RN #1 said because the resident's mental status changed she did not realize that what she was telling about the fall at night was true. She said because the resident could not tell her anything more except that she fell and was picked up by a tall black man off the floor she did not believe her story. She said she should have assessed the resident when the resident told her that she had a fall. PA #1 was interviewed on 3/9/2020 around 3:00 p.m. She said on the late morning of 2/17/2020 she was approached by a nurse and a CNA (certified nurse aide) who told her that Resident #1 was having hallucinations. She said she made a call to the resident's PCP who clarified that the resident had recent changes in medications. She said when she looked at the resident, she was comfortable in bed and her hallucinations cleared. The resident said she saw animals and people in the room and they were pleasant and not harmful and she was comfortable. She said she was not aware that the resident's arm was swollen, or that the resident reported a fall to a nurse. She discussed pain medications with her daughter and they decided to continue current medications. PT #1 was interviewed on 3/9/20 at 3:51 p.m. She said on 2/17/2020 she approached the resident in her room around 3:00 p.m. The resident's daughter was present the entire time during the session. She said at some point during the therapy, resident reported to her that she had a pain in her left wrist. PT#1 said she looked at her wrist but did not see any deformity or injury. A few minutes later the resident stated that pain was in her shoulder and that she fell last night and was picked off the floor by a tall black male. The daughter was present in the room and she told that it was the first time she was hearing about the fall. PT#1 stated she looked at the resident's shoulder that appeared to be swollen and painful with motion. She said she measured the swelling and compared it to the other hand, the

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

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.

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) swelling was significant. She said they continued to do exercise with the resident that did not require the movement of her arms and the resident was guarding her left arm when she was sitting down. PT #1 stated she reported to the nurse her findings (swollen shoulder) and the story that resident shared. The PCP was contacted over the phone on 3/9/2020 at 3:23 p.m. He said he received a call from nursing staff on Monday (2/17/2020) evening regarding increased pain for Resident #1. He said they reported to him that the resident was having hallucinations and was talking about the fall. He said her story about the fall was not collaborative and the resident was confused at baseline. He said the resident had recent falls and was receiving multiple pain medications for pain. -On Tuesday (2/18/2020) morning he received another call from a nurse stating that the resident had a swollen arm and was complaining of pain. He said he told the nurse that he was on his way to the facility and they should send the resident to the emergency room for evaluation. He said the resident's daughter was present at the time and decided to wait for his arrival. Upon his arrival and assessment of the resident's arm he made a decision to send the resident to the hospital because her arm was bruised, swollen and the way it looked was consistent with a fracture. The DON was interviewed on 3/9/2020 around 11:30 a.m. She said she found out about the fall the next day, when the resident was having a lot of pain and the physician sent her to the emergency room . The facility investigated the incident. The findings were that RN #1 did not complete the full body assessment for Resident #1 and did not document her notes timely. She (RN #1) was re-educated regarding change of condition assessment and proper documentation. CNA #1 who was working the night shift and fit the description that the resident provided, was suspended during the investigation and re-educated before he returned to work. CNA #1 communicated to the DON that Resident #1 was found on the floor during the night shift around 5:00 a.m. He said he went looking for the nurse and after he was not able to locate her, he put the resident back to bed. He said he told night shift nurse at the end of the shift that Resident #1 had a fall. The DON said that night shift nurse told her that she was never told about the fall. The NHA was interviewed on 3/9/20 around 2:30 p.m. He said neglect was defined as failure to follow policy and procedures of the facility. He said in above situation policies were not followed when CNA #1 picked the resident off the floor before assessment was completed, and by RN #1, who did not complete a full assessment after the resident reported the fall. He said the incident was investigated and reported to appropriate agencies. He said the allegation of neglect was not substantiated because it did not meet the reporting criteria of being wilful per reporting guidelines.
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#1 and #3) of three residents reviewed for accidents remained free from falls. Resident #1 had a history of [REDACTED]. The resident sustained [REDACTED]. She reported to the nursing team her second fall during the night, her fall was never investigated as nursing staff did not believe the resident. More than 24 hours later, she was sent to the emergency room for increased pain, swelling and bruising of the left arm, where she was diagnosed with [REDACTED]. Resident #3 had a history of [REDACTED]. The resident was not properly assessed for fall risk by nursing staff on admission, and subsequently, due to the lack of proper interventions resident sustained [REDACTED]. Additional failures included the facility failed to ensure the care plan was updated with the residents specific interventions before the resident fell , followed through with new interventions, and failed to complete a thorough investigation after the fall. Cross reference F600: Failed to protect Resident #1 from neglect. Findings include: I. Facility policies and procedures The Fall Prevention Program policy with revision date on 10/2018 was provided on 3/9/2020 at 10:12 a.m., by the nursing home administrator (NHA). The policy revealed all residents would be assessed for a fall risk as part of the nursing assessment on admission and after a change of condition. Those determined to be at risk would receive appropriate interventions to reduce risk and minimize injury. Residents experiencing a fall would receive appropriate care and investigation of the cause. II. Resident #1 A. Resident status Resident #1, [AGE], was admitted on [DATE]. According to the January 2020 computerized physician orders [REDACTED]. The 2/6/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident did not display any behaviors, hallucinations, and did not reject the care. She required limited assistance of one person for bed mobility, dressing, and personal hygiene. She required extensive assistance of two people for transfers, locomotion, toilet use, and bathing. Her balance during transition and walking was not steady, she was able to stabilize with staff assistance. She used a walker and wheelchair for mobility. She was occasionally incontinent of bowel and bladder, and she was not on the toileting program. B. Family interview The resident's daughter was interviewed on [DATE]. She said when her mother was admitted to the facility, staff were aware she was at high risk for falls. She said she saw her mother the day before and she was able to move in bed and work with physical therapy. On the morning of 2/17/2020 around 11:00 a.m. she found her mother hallucinating. She said staff told her that her mother might have a urinary tract infection and they were going to test her urine. Later that morning, a physical therapist came in to work with her mom. She said her mother was not able to work well with therapy and complained of the pain in her left arm. After physical therapy looked at the arm, it was discovered that the resident's left arm was swollen. Resident stated she fell at night and was picked off the floor by black male. Nursing staff stated the resident was hallucinating and arm pain was from the previous fall. She said staff disregarded her mother's statement about the fall and did not assess her condition after the fall. C. Facility record review The care plan (CP) initiated on 1/31/2020, and revised on 2/24/2020, revealed the resident was at risk for falls. Interventions included: to educate the resident/family/caregivers about safety reminders and what to do if a fall occurs and to encourage the resident to wear appropriate footwear when ambulating. The admission assessment dated [DATE] indicated the resident was at risk for falls. D. Fall #1 on 2/5/2020 According to the Situation, Background, Assessment, Recommendation (SBAR) form, the resident had a fall on 2/5/2020 in her room. According to the incident report, the resident had a fall on 2/5/2020 at 10:00 a.m. in the resident's room. She was ambulating with a four wheel walker in the room in the presence of family. She lost her balance and fell . The fall was witnessed by the daughter who was in the room. The resident was complaining of increased pelvic pain after the fall. Interventions included an x-ray of hip and pelvis. No other interventions. According to the physician note on 2/6/2020 With regard to repeated falls the patient has been having episodes of falls and patient reports that it is related to her [MEDICAL CONDITION]. Patient had (an) episode of fall yesterday when she was attempting to go to the bathroom. The incident report did not document any other interventions to address resident's ambulation without staff assistance. E. Fall #2 on 2/17/2020 According to the late entry nurses progress note created on 2/18/2020 at 6:00 p.m., with an effective date of 2/17/2020 at 3:00 p.m Resident reported to (the) writer this morning that she fell at some point in the night and a tall black man picked resident up. Now is complaining of (left) shoulder pain. Some slight swelling noted. [MEDICATION NAME] administered at this time. (Physician) called at this time notifying him of alleged fall. No new orders at this time. Resident was hallucinating seeing people in her room. (Physician assistant) evaluated this morning ordering some blood work in addition to the (urine test). Patient's family by bedside most of the day. Aware of health status. According to the physician assistant (PA) note on 2/17/2020, she was asked to assess the resident on 2/17/2020 due to onset of new hallucinations. Staff noted (the) patient was seeing people this morning and she herself tells me they looked so real. She recently started on [MEDICATION NAME] for pain and [MEDICATION NAME] . Visual hallucinations discussed with (a) primary care physician and daughter who was in the room. Could be adverse reaction to new medications, but need to rule out infection as well. Will order labs and (urine test) without hold of medications for now as pain still considerable. According to the physical therapy (PT) note on 2/17/2020, resident complained of increased left upper extremity pain, limited shoulder mobility and swelling. Attempted passive range of motion on left shoulder all painful and significantly limited. (Resident) unable to rate pain, primary symptoms today left upper extremity pain in the shoulder. Swelling noted, widening of the humerus by 6 centimeters (cm) compared with right circumference. Resident stated she fell out of bed today and was assisted up by staff member. Reported to the nurse. According to the late entry nurses progress note created on [DATE] at 2:00 a.m., with an effective date of 2/18/2020 at 9:30 p.m. Received report from (day nurse) that (resident) may have fallen on a previous shift but not sure per (resident's) report. The resident has had increased confusion and hallucinations. Family member came to (the) nurses station and reported her concerns regarding patients increased confusion and swelling in (her) arm. I noted (resident's) mentation has decreased since I took care of her last Wednesday shift and noted left arm swelling and bruising. (Resident) reports no pain at this time as she takes scheduled pain medication. Left arm elevated on pillow for comfort. When the day nurse came in following (day), I asked her to evaluate (residents') arm

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) alongside with me. There were no further notes in the resident's medical record. All late entry nurses notes regarding the events on 2/17/2020 were documented after the resident was hosptalized on [DATE] around 2:00 p.m. (more than 24 hours after the resident reported her fall to staff). According to hospital admission note on 2/18/2020, the resident was admitted with (left) hand bruising, per x-ray Acute displaced [MEDICAL CONDITION] proximal humerus. Probable elbow joint effusion which may indicate occult fracture in the setting of trauma. The director of nursing (DON) was asked for an incident report regarding this fall on 3/9/2020 at 10:30 a.m. She said they did not have an incident report about the fall on 2/17/2020 because she found out about the fall much later. She said they had an investigation regarding lack of assessment by the nurse after the fall. The investigation dated 2/18/2020 revealed that on 2/17/2020 in the morning, resident reported to RN #1 that she fell during the night and tall black man picked her up. On 2/18/2020 the swelling was noted on the left upper arm, the resident's hand was assessed by a primary care physician, and the resident was sent to the hospital. Resident was found to have a fractured left humerus. -The immediate actions that were documented as following: resident evaluation, transfer to the hospital, suspension of associated staff members. In-service training to staff members. Police, state agency and ombudsman were notified. There was no conclusion written at the end of the investigation. F. Staff interviews RN #1 was interviewed on 3/9/2020 around 2:00 p.m. She said on Monday, 2/17/2020 when she came to work in the morning, she noticed that the resident was hallucinating, and around 9:00 a.m. in the morning she (Resident #1) told her that she fell last night and was picked off the floor by a tall balck male. RN #1 said that she thought that was a part of her hallucination because the resident would not be able to get up by herself, and she did not get any reports about falls. RN #1 said she did not assess the resident for injury at that time. -Around 11:00 a.m. when physician assistant (PA) #1 was in the building, RN #1 asked her to look at the resident because she was hallucinating about people in her room. She said PA #1 spoke with the resident and her daughter who was present in the room and ordered labs and urine tests to rule out infection. -Later during the day, the physical therapist (PT) #1 reported to RN #1 that Resident #1 was not able to walk during therapy due to the pain and swelling in her left arm. RN #1 stated that she contacted primary care physician (PCP)who told her that the resident previously complained about pain in that arm and it was probably from the last fall. Resident #1 was recently started on the [MEDICATION NAME] for pain and that should help. No other orders were given by PCP. RN #1 said when the resident complained of pain, the pain was worse than before and it was in the left arm. She said she gave the resident her pain medication, but did not look at her arm. She said most of the arm was visible because the resident was wearing a nightgown with a short sleeve. She said she did not assess the resident's shoulder. -The next morning, 2/18/2020 when she came back for the next shift, the night nurse called her attention to look at the resident's arm because it was bruised and swollen closer to the elbow area. She said she did not do a full body assessment at that time. She said she reported that to assistant director of nursing (ADON) and called PCP. The PCP was on his way to the facility and the family agreed to wait for him. When PCP came around noon, he gave an order to send resident to the emergency room for evaluation. RN #1 said because the resident's mental status changed she did not realize that what she was telling about the fall at night was true. She said because the resident could not tell her anything more except that she fell and was picked up by a tall black man off the floor she did not believe her story. She said she should have assessed the resident when the resident told her that she had a fall. She said she documented all her notes the next day, on 2/18/2020 because she was too busy to do so earlier. PA #1 was interviewed on 3/9/2020 around 3:00 p.m. She said on the late morning of 2/17/2020 she was approached by a nurse and a CNA (certified nurse aide) who told her that Resident #1 was having hallucinations. She said she made a call to the resident's PCP who clarified that the resident had recent changes in medications. She said when she looked at the resident, she was comfortable in bed and her hallucinations cleared. The resident said she saw animals and people in the room and they were pleasant and not harmful and she was comfortable. She said she was not aware that the resident's arm was swollen. She discussed pain medications with her daughter and they decided to continue current medications. PT #1 was interviewed on 3/9/20 at 3:51 p.m. She said on 2/17/2020 she approached the resident in her room around 3:00 p.m. The resident's daughter was present the entire time during the session. She said at some point during the therapy, resident reported to her that she had a pain in her left wrist. PT#1 said she looked at her wrist but did not see any deformity or injury. A few minutes later the resident stated that pain was in her shoulder and that she fell last night and was picked off the floor by a tall black male. The daughter was present in the room and she said that was the first time she was hearing about the fall. PT#1 stated she looked at the resident's shoulder that appeared to be swollen and painful with motion. She said she measured the swelling and compared it to the other hand, the swelling was significant. She said they continued to do exercise with the resident that did not require the movement of her arms and the resident was guarding her left arm when she was sitting down. PT #1 stated she reported to the nurse her findings (swollen shoulder) and the story that the resident shared. The PCP was contacted over the phone 3/9/2020 at 3:23 p.m. He said he received a call from nursing staff on Monday (2/17/2020) evening regarding increased pain for Resident #1. He said they reported to him that the resident was having hallucinations and was talking about the fall. He said her story about the fall was not collaborative and the resident was confused at baseline. He said the resident had recent falls and was receiving multiple pain medications for pain. -On Tuesday (2/18/2020) morning he received another call from a nurse stating that the resident had a swollen arm and was complaining of pain. He said he told the nurse that he was on his way to the facility and they should send the resident to the emergency room for evaluation. He said the resident's daughter was present at the time and decided to wait for his arrival. Upon his arrival and assessment of the resident's arm he made a decision to send the resident to the hospital because her arm was bruised, swollen and the way it looked was consistent with a fracture. The DON was interviewed on 3/9/2020 around 11:30 a.m. She said she found out about the fall the next day, when the resident was having a lot of pain and the physician sent her to the emergency room . The facility investigated the incident. The findings were that RN #1 did not complete the full body assessment for Resident #1 and did not document her notes timely. She (RN #1) was re-educated regarding change of condition assessment and proper documentation. CNA #1 who was working the night shift and fit the description that resident provided, was suspended during the investigation and re-educated before he returned to work. CNA #1 communicated to the DON that Resident #1was found on the floor during the night shift around 5:00 a.m. He said he went looking for the nurse and after he was not able to locate her, he put the resident back to bed. He said he told night shift nurse at the end of the shift that Resident #1 had a fall. The DON said that night shift nurse told her that she was never told about the fall. III. Resident #3 A. Resident status Resident #3, age 86, was admitted on [DATE]. According to the March 2020 CPO, [DIAGNOSES REDACTED]. According to the 2/15/20 MDS assessment, the resident had mild cognitive impairment with a BIMS score of nine out of 15. He did not exhibit any behaviors of inattention or disorganized thinking. He required extensive assistance of two people with bed mobility, transfers, locomotion on and off the unit, dressing, toileting and personal hygiene. His gait not stable, he was able to stabilize with staff assistance only. He used a walker and wheelchair for ambulation. Resident was frequently incontinent of the bladder, and always continent of bowel, he was not on the toileting program. He had a history of [REDACTED]. B. Record review 1. Failure to accurately assess the resident for fall risk on admission According to the nursing admission data collection completed by licensed practical nurse (LPN) #1 on 2/15/2020, resident had falls in the last 90 days, he required assistance with bowel and bladder, he was ambulating with problems with assistive devices, he was not steady without physical assistance, and he took three or more medications that placed him at risk for falls. The instruction at the end of the assessment read If resident's total score is 10 or more, initiate fall risk interventions and document on the Interim Care Plan. Even though the actual (manual) calculation of total score for the resident was above 10, the resident was marked as no risk for falls. 2. Failure to develop a care plan for falls with resident specific interventions to address his known fall risks and to keep him safe from additional falls and injury. The resident did not have a care plan for falls at the time of the admission on 2/15/2020. The CP for falls was initiated on [DATE] (after the first fall), and revised on [DATE], revealed the resident was at risk for falls. Interventions included to be sure call light was within reach and encourage resident to use it for assistance as needed. Prompt response to all requests for assistance, to educate resident/family/caregivers about safety reminders and what to do if a fall occurs. Encourage the resident to wear appropriate footwear when ambulating or mobilizing in a wheelchair. a. Fall on 2/18/2020 According to the SBAR form, the resident had a fall on 2/18/2020 in the bathroom. Resident was observed sitting on buttocks on the floor next to bed and w/c (wheelchair). Resident stated he was going to the bathroom. 1.5 cm (centimeters) skin tear noted and cleaned and steri strips and dressing applied. Denied pain or discomfort. Range of motion done without pain or discomfort. RN assessed. Two staff members assisted him up and into bed. Message left for doctor and resident responsible for self. Educated importance of using call light. Contributing factors listed as poor safety awareness. The fall investigation did not include any interventions. Resident's bathroom needs were not incorporated into his care plan. The Fall data risk collection completed

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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 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) on 2/19/20 after the fall, revealed the resident was at high risk for falls with a score of 16. b. Staff interviews CNA #2 was interviewed on 3/9/2020 at 12:15 p.m. She said the resident required one person assistance with everything. She said he has not had any falls since he was admitted , and he was not on any fall precautions. LPN #1 was interviewed on 3/9/2020 at 12:23 p.m. He said the resident was mildly confused, required one person assistance with transfers, dressing, and other activities of daily living. He did not know if the resident had any falls, he said he was not on any fall precautions currently. He said the resident was using his call light inconsistently and was at times incontinent of the bladder. He said he did not know if the resident was on the toileting program. LPN #2 was interviewed on 3/9/2020 at 12:55 p.m. She said she was the unit manager. She said all residents were assessed for fall risk on admission, quarterly and with any changes in condition. She said all falls were reviewed by an interdisciplinary team (IDT) that developed interventions and updated the care plans. -She reviewed fall assessment on admission for Resident #3 and stated it was completed incorrectly. She said based on the answers that were given, such as the history of falls, unstable gait and use of medications, the resident should have been marked as at risk for falls. She said she did not know why the nurse marked it the wrong way. She said it was not part of her responsibilities to review assessments. -Regarding the falls, she said she did not review incident reports either, they were completed by staff nurses and sent directly to DON for review. She said care plan updates were also not her responsibility, it was DONs responsibility, because DON reviewed incident reports and was supposed to document interventions in the care plan. She said resident #3 was not on a toileting program and she did not know if he should or should not be on one. LPN #3 was interviewed on 3/9/2020 at 1:01 p.m. She said she completed the fall assessment for Resident #3 on admission. She said the resident answered all the questions she asked him and because he was alert and oriented she marked him as not at risk for falls. She said she worked in the building only for the last two months and had not done any admissions before. She said she did not receive any training on completing admissions and that day she was splitting the care and workload of this resident with another nurse. She said she did not read the instructions on the form and did not know the fall score should be calculated manually. The ADON was interviewed on 3/9/2020 around 4:00 p.m. in the presence of DON. She said all residents were assessed for fall risk on admission and after a fall. She was not aware that the form the facility utilized required manual calculation of the fall risk score. She said they would review all current forms they utilized and make sure staff were familiar with them and used them appropriately. She said the accurate fall assessment would trigger a care plan for falls which did not happen with Resident #3. She said all falls were reviewed during an IDT meeting and care plan updates were a team effort. The DON stated staff would be re-educated on proper documentation of progress notes and care plans. IV. Facility follow-up: Facility provided supporting documents demonstrating that following actions were taken after the incident on 2/17/2020. - [DATE] 12 RNs, including RN #1 and other nurses were educated on proper assessment and documentation on change of condition; -Corrective action for CNA #1 was implemented on 2/29/2020 as a first reminder. The education was provided if a resident was found on the floor to report to a nurse and not move the resident until the resident was assessed by RN; and, -Education on routine clinical documentation for all nurses on 2/13/2020. In addition, on [DATE]20 at 4:07 p.m., the facility submitted by email a Success Plan that included a summary of actions that were taken by the facility. Such as, -2/17/2020 inservice education/training to nurses regarding Change in Condition process and Falls Management; and, -2/24/2020 and [DATE]20 all staff meeting regarding fall management/prevention and reporting. The facility stated they completed education on Change of Condition and Falls prevention and reporting, and have additional education planned with the nurses and CNAs on 3/12/20.