STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105327	A. BUILDING _____ B. WING _____	**07/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASA MORA REHABILITATION AND EXTENDED CARE	**1902 59TH ST W BRADENTON, FL 34209**

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	**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 interview and record review the facility failed to provide supervision to prevent a fall with head injury for one (Resident #5) of two sampled residents. Resident #5 had a documented history of falls prior to his admission at the facility, documented falls throughout his stay at the facility, and fell three times in the span of his final 11 days as a resident there. Two of the falls within those last 11 days required transfer to the hospital. Findings Included: A review of the facility document titled High Risk Fallers dated 05/29/20 revealed that Resident #5 was listed under the category Multi-Fallers in Last 30 Days. A review of the facility report titled Incidents By Incident Type for the three months preceding his last fall, on 06/12/20, revealed that the resident fell eight times in that period on 3/14/20, 3/30/20, 4/5/20, 4/26/20, 5/5/20, 6/2/20, 6/11/20 and 6/12/20. A review of progress notes for the month of June 2020 revealed: Event/Post Event Note dated 06/02/20 written by Staff A, Licensed Practical Nurse (LPN): resident (#5) was sitting in chair in dining room and fell to the floor on his right side. resident did hit his head. resident right scapula (shoulder blade) swollen and resident c/o (complains of) pain at times .resident had just came back from being weighed and was in the dining room. resident had no socks on at the time .called 911 to transport resident to (hospital name) ER (emergency room) for eval (evaluation) and tx (treatment) . Activity Progress Note dated 06/07/20: (Resident #5) is alert and oriented to self. He is up out of bed to wheelchair. He will attempt to ambulate and needs reminders to stay in his chair. he needs encouragement to stay in room or to be safety (safe) when he is (in) hallway . Event/Post Event Note dated 06/11/20 written by Staff B, Registered Nurse (RN) Supervisor: Patient observed lying on the floor, assessed and no visible injury noted .assist resident back in bed, notified MD (medical doctor) and family member. Neuro check initiated and within limits, patient also on 15 minutes check. Care Plan/IDT (interdisciplinary team) Note dated 06/12/20: IDT met to review s/p (status [REDACTED]. Neurochecks and q (every) 15 (minutes) started .Care plan reviewed and updated. Event/Post Event Note dated 06/12/20 at 10:30 am written by Staff B, RN Supervisor: Patient observed sitting on the floor mat, upon assessment, a cut noted to right side of head and forehead, vital sign within limit .MD (medical doctor) ordered to send patient to ER (emergency room) for CT (computed tomography) scan, patient left the building on a stretcher with EMT (emergency medical transport) to (name of hospital). A note written by Staff B, dated 06/13/20 revealed: Called (name of hospital) to check on the resident status, Patient was admitted with Subdural Hematoma (collection of blood under the skull outside of the brain). A review of the medical record for Resident #5 revealed that he was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident had been deemed not competent to make his own decisions and resided in the locked memory care unit of the facility. A review of the most recent completed Minimum Data Sets ((MDS) dated [DATE] and 06/12/20 revealed the following: severely impaired cognitive skills for daily decision making; BIMS (brief inventory of mental status) score of 4 which meant that the resident was severely cognitively impaired; impaired balance while standing, walking, transferring. The MDS dated [DATE] revealed 1 fall with injury since admission/reentry/prior assessment and the MDS dated [DATE] revealed 1 fall without injury since admission/reentry/prior assessment. The care plan revealed the following focus areas: Cognition: (Resident #5) has severely impaired cognition/thought processes r/t (related to) dementia.; .he has a statement of incapacity.; Fall: (Resident #5) falls frequently and is at risk for fall related injury r/t (related to) dx (diagnoses) of [MEDICAL CONDITION], dementia and Alzheimer, poor balance at times; Elopement Risk: (Resident #5) is an elopement risk: he is significantly cognitively impaired and is independently mobile; he is actively exit-seeking. He wanders through the secured unit .Resident is at increased risk for exit seeking behaviors related to the Covid-19 precautions that have been put in place . Staff A, LPN was interviewed on 07/24/20 at 9:37 a.m. She confirmed that she had known Resident #5 well. She described him as alert with confusion, forgetful, ambulatory with physical decline towards the end, and that he was unable to use a walker because of his cognitive impairments. She said, in the end he had a wheelchair but would constantly get up on his own She stated that Resident #5 was combative at times, had no safety awareness or deficit insight, and had no ability to remember redirection from one moment to the next. She said, he was one that if I didn't know where he was, I better find out. Regarding his falls at the facility, Staff A said, last one I was involved in was in the dining room. She confirmed that was the fall that occurred on 06/02/20 and said, he had just gotten back from being weighed and was sitting in his wheelchair in the dining room and got up and fell in an instant. She said, he needed constant eyes on him. The facility Rehabilitation Director was interviewed on 07/24/20 at 12:51 p.m. She confirmed that Resident #5 had received multiple courses of Physical Therapy (PT) and Occupational Therapy (OT) during his time at the facility. She confirmed that he was receiving therapy from PT and OT prior to his last fall on 06/12/20 and the focus had been on strengthening, balance, gait training, and transfers. She stated that the resident had declined in the months leading to his discharge due to frequent hospitalization s and that he had been having more falls. She stated that the resident would constantly get up on his own even though he needed hand-held assistance to safely walk and required supervision for safety. At 10:24 a.m. on 07/24/20 an interview was conducted with the facility Risk Manager. She confirmed that Resident #5 had several falls during his stay here where he hit his head. She confirmed that the resident had a series of falls leading up to his last fall on 06/12/20: a witnessed fall on 06/02/20 and a fall from bed on 06/11/20. She confirmed that he was on the new admission isolation unit at the time of his falls on 06/11/20 and 06/12/20 due to precautions related to COVID-19 with residents readmitted from the hospital. She confirmed that he was in a private room on that unit and that his room door was required to be closed because of infection control precautions in the facility. She confirmed that the falls on 06/11/20 and 06/12/20 were unwitnessed and stated that the fall on 06/12/20 had occurred in the resident's room, that his Certified Nursing Assistant (CNA) had just been in his room, and that after the fall the resident said, I lost my balance but couldn't provide any more details. The Risk Manager confirmed that Resident #5 was on the facility list of residents at high risk for falling and was on 15-minute checks at the time of his fall on 06/12/20. She stated that Resident #5 had been put on 15-minute checks because he was newly readmitted to an unfamiliar unit, had a history of [REDACTED]. Regarding one to one (1:1) supervision, she stated that was only used in the facility in 911 situations which she explained as short term emergency intervention for safety. Regarding fall prevention measures for Resident #5, the Risk Manager said, there was not a lack of supervision .we followed our process and care plan .had him on 15-minute checks. At 11:40 a.m. on 07/24/20 Staff B, RN Supervisor and Staff C, RN Unit Manager were interviewed. Staff C confirmed that she was the unit manager for the isolation unit. She confirmed that Resident #5 had been in a private room on that unit and that he was pretty confused and disoriented .he liked to sit in the chair in his room. Staff B confirmed that he was working in the facility on 06/12/20 and said, I was called to asses (Resident #5) when he was found on the floor .I observed there was a cut on his head so I decided he needed to be sent to the hospital .he was conscious and alert. At 11:59 a.m. Staff D, Certified Nursing Assistant (CNA) was interviewed. She confirmed that she had been assigned

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105327	A. BUILDING _____ B. WING _____	**07/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASA MORA REHABILITATION AND EXTENDED CARE	**1902 59TH ST W BRADENTON, FL 34209**

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 1) to care for Resident #5 at the time of his fall on 06/12/20. She stated the resident had eaten and she had just been in his room to remove his tray and within 15 minutes later when she entered his room to check on him, he was on the floor. Staff D confirmed that Resident #5 was on 15-minute checks. She stated the resident was very confused and impulsive. She confirmed that his door was required to be closed by facility policy and so at times she had brought him to the nurse's station with a mask on so that he could be supervised. A review of medical records from the hospital where Resident #5 was admitted after falling at the facility on 06/02/20 revealed that he was admitted for brain bleed and surgery eval (evaluation). A CT (computerized tomography) scan of the brain was performed on 06/02/20: There is a small subacute subdural hematoma (collection of blood under the skull outside of the brain) measuring 4mm (millimeters) thick along the right fontal and parietal lobe (areas of the brain). A review of the medical records from the hospital when Resident #5 was admitted after falling on 06/12/20 revealed chief complaint of head injury and headache. A CT scan of the brain was performed on 06/12/20: .subdural hematoma .increased to 1.2 cm (centimeters) versus 6mm (millimeters) on the prior study .most consistent with .microhemorrhage (bleeding at the brain). The records revealed that the resident was discharged with a discharge [DIAGNOSES REDACTED]. The facility policy titled, Fall and Injury Reduction Policy dated February 2020 revealed: The facility strives to reduce the risk for falls and injuries by promoting the implementation of the Falls and Injury Reduction Policy. Resident data is collected to identify fall risk factors. The interdisciplinary team works with the resident and family to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. The facility policy titled Frequent Observation dated November 2017 revealed the following: Frequent Observation will be initiated when Resident Behaviors indicate. Frequent observation may include: Continuous, with documentation of observed behaviors every 15 minutes; Observation every 15 minutes with documentation of behaviors observed . The associated procedure revealed: 1. Residents who are placed on continuous one to one are to be in the line of vision of the person assigned to the resident. 2. Residents may be placed on one to one (1:1) by the supervisor in an emergency situation, or by the Risk Manager, Assistant Director of Nursing, the Director of Nursing, or the Administrator after review of the clinical data.