STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105736	A. BUILDING _____ B. WING _____	**10/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF SUN CITY	**3850 UPPER CREEK DR SUN CITY CENTER, FL 33573**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that it notified a physician and family representative in a timely manner about a change in condition for 1 (#2) of 4 sampled residents. Resident #2 had fall events and leg pain that were not communicated to the physician and family member on the date of occurrence. Findings include: A review of Resident #2's clinical file, Admission Record, documented admission to the facility on [DATE]. The [DIAGNOSES REDACTED]. The Admission record reflected the resident's daughter's name and phone number as emergency contact #1 and the resident's son's name and phone number as a contact person. A review of Resident #2's Progress notes: 1.A review of an e-interact SBAR, dated 08/21/20, 1600: Nursing observations .: Resident (#2) reaching for something from w/c and slipped to floor. Patient did not use call bell and call for assistance. Neuro checks in place. Reacher /grabber given to patient. X-Ray of right wrist, 2 views for small bruise. Primary Care provider feedback, .recommendations: Neuro checks. X-ray of right wrist for small bruise. No documentation of contacting the resident's family member was reflected in the clinical chart for the latter fall event. 2.08/25/20, 16:09, Spiritual Care: I visited with (Resident #2) in her room. She mentioned several times that her leg was hurting. I mentioned that to the nurse. She had something prepared to give her because she was aware of her pain. I will visit with her again later. No Documentation of contacting the doctor or resident's family member was reflected in the clinical chart in regard to the resident's leg hurting and pain. In addition, no documentation was reflected that would indicate a nursing assessment was conducted for the resident's leg hurting. 3.08/27/20, 12:37: Reported to 7-3 nurse; patient extreme pain to R (right) ankle-foot; unable to touch extremity and unable to attempt to bear weight; significant change of status. No Documentation of contacting the doctor or resident's family member was reflected in the clinical chart regarding extreme pain to R ankle. 08/30/20, 17:56: MD notified of decreased weight bearing and discomfort of right ankle /foot. No swelling or bruising noted. Resident states she cannot move it. New order for x-ray, daughter, (name), called and made aware. 4.09/07/20, 15:07: e-interact SBAR Summary for Providers, situation: The Change in conditions reported . Falls: Nursing observations .: Resident found on floor, states was going to bathroom and slid out of w/c .new intervention: re-educated to use call light for assistance, not to go to BR (bathroom) alone. No documentation was reflected in the clinical chart that would indicate the family was notified of the fall event until 09/08/20 at 8:30 a.m. 09/08/20, 8:30: Spoke at length with the daughter in regard to the resident's fall and care concerns A review of the facility event log for 08/01/20 thru the date of service, listed the following events for Resident #2: 08/20/20, 4:24 p.m., unwitnessed fall incident 08/22/20, 12:02 a.m., unwitnessed fall incident; 09/07/20, 3:12 p.m., unwitnessed fall incident; 09/13/20, 7:50 p.m., unwitnessed fall incident It was noted that the facility falls event documentation occurrence dates did not match the clinical record notes. On 10/19/20 at 4:42 p.m., an interview was conducted with the Director of Nursing (DON) regarding falls for Resident #2. The Risk Manager (RM) also joined. The DON confirmed that she did not have documentation of the family being notified of a fall event that occurred on 08/22/20. And for the 09/07/20 fall event, the family was not called until the next day after the event. A review of the facility Policy and procedure, Nursing-Change in a Residents' condition or Status, effective date October 2014, stated the Policy: The facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/ payments, resident rights, etc.). The Procedure included: 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: .a significant change in the resident's physical/emotional mental condition . 2. . 3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse/designee will notify the resident's family or representative when: The resident is involved in any accident or incident that may or may not have resulted in an injury including injuries of an unknown source; there is a significant change in the resident's physical, mental, or psychosocial status . 4. . 5. The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.
F 0689 **Level of harm** - Minimal harm or potential for 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 interview, the facility failed to ensure that it provided effective supervision to prevent falls for 1 (#2) of 4 residents. Resident #2 had 5 unwitnessed fall events within a 25-day period. Findings include: A review of Resident #2's clinical file, Admission Record, documented admission to the facility on [DATE]. The [DIAGNOSES REDACTED]. A review of Resident #2's Progress Notes, Admission Note, dated 08/14/20, 20:48, documented resident's baseline care plan: Focus: At risk for falls Goal: Will strive to have falls/injuries minimized through mgmt. of fall risk factors while maintaining quality of life and independence. Intervention: Encourage appropriate footwear; Place items used in easy reach, i.e. water, telephone, call lights; keep equipment within reach; observe for unsafe ambulation; observe for unsafe actions and interventions as needed; check toileting needs. 1.08/20/20, 14:04: Resident was heard yelling for help when CNA found her on the side of the bed on stomach on the floor. She was immediately transferred back to bed by writer, CNA, and UM. Resident complained of bilateral knee pain. MD and RP notified. New order for bilateral knee X-Ray given. Will f/u with orders and monitor resident. 2.8/20/20, 16:53: Resident found lying on her left side next to her bed. Resident stated she was sitting on the side of the bed and was trying to reach her iced tea when she slid forward landing on her knees. She then laid herself on her left side. Resident was assisted back into bed. Physician and son notified. New order for bilateral knee x-ray d/t complaints of bilateral knee pain. 3.A review of an e-interact SBAR, dated 08/21/20, 1600: Nursing observations .: Resident (#2) reaching for something from w/c and slipped to floor. Patient did not use call bell and call for assistance. Neuro checks in place. Reacher /grabber given to patient. X-Ray of right wrist, 2 views for small bruise. Primary Care provider feedback, .recommendations: Neuro checks. X-ray of right wrist for small bruise. 4.09/07/20, 15:07: e-interact SBAR Summary for Providers, situation: The Change in conditions reported . Falls: Nursing observations .: Resident found on floor, states was going to bathroom and slid out of w/c .new intervention: re-educated to use call light for assistance, not to go to BR (bathroom) alone. 5.09/13/20, 23:23, Resident seen sitting on floor, stated she was trying to get into the wheelchair to go to the bathroom, helped into bed, no injuries noted, resident denied having pain, MD and family notified, neuro-checks and post fall protocol initiated, resident in bed, redirected to use call light, bed placed in lowest position. A review of Resident #2's Care Plan documented the following: Focus: Cognition: The resident has impaired cognitive function/dementia or impaired thought processes r/t Disease Process ([MEDICAL CONDITION]), Short term

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) memory loss, initiated 09/03/20. Interventions included: Communicate with the resident/family/caregivers regarding resident's capabilities and needs, initiated on 09/03/20. Cue, reorient and supervise as needed, initiated on 09/03/20. Focus: Fall Risk: At risk for falls related to: Impaired safety awareness, fall Hx (history), incontinence, initiated 08/15/20. The goal: will strive to have falls and/or injuries minimized thru management of risk factors while maintaining independence and quality of life through the review date. Interventions included: 30 min checks for safety, initiated 09/15/20. Encourage appropriate footwear, initiated 08/15/20. Encourage resident to use the call and ask for assistance, initiated 08/20/20. Floor mats at bedside while in bed, initiated 08/22/20. Frequent checks, please complete log, initiated 08/24/20. Keep Reacher and call bell close to resident and encourage use, initiated 08/21/20. Place items used in easy reach, i.e. water, telephone, call lights, initiated 08/15/20. PT and OT to scree prn, initiated 08/15/20; revision on 09/07/20 therapy screening for bedside commode. Keep adaptive equipment within reach, initiated 08/15/20. Check for toileting needs, initiated 08/15/20. Medication Review, initiated 08/20/20. Give verbal cues as needed, initiated 08/20/20. Observe for unsafe ambulation, initiated 08/15/20. Observe for unsafe actions and intervene as needed, initiated 08/15/20. A review of the facility event log for 08/01/20 thru the date of service, listed the following events for Resident #2: 08/20/20, 4:24 p.m., unwitnessed fall incident 08/22/20, 12:02 a.m., unwitnessed fall incident; 09/07/20, 3:12 p.m., unwitnessed fall incident; 09/13/20, 7:50 p.m., unwitnessed fall incident It was noted that the facility falls event documentation occurrence dates did not match the clinical record notes. An Interview conducted on 10/19/20 at 3:58 p.m. with the MDS Coordinator. She confirmed that the Care plan was usually updated after a fall; an intervention is added. How do you determine what intervention to add to the care plan? After the resident has a fall, we do an investigation about the fall to see what happened and then we will add an intervention. A lot of times, right after a fall, the nurses will add an intervention and then we will discuss it the next day; we review the existing care plan; what happened; come up with a intervention based on what happened. On 10/19/20 at 4:42 p.m., an interview was conducted with the Director of Nursing (DON) regarding falls for Resident #2. The Risk Manager (RM) also joined. The DON stated, Resident #2's 1st fall was 08/20/20 at around 1:30 p.m., she was found on her left side by her bed. she was found by a CNA. I do not know the name of the CNA, it does not say on the report. Staff A, LPN (Licensed Practical Nurse) completed the report. We asked the resident, if she could tell us what happened; she stated that she was reaching for her iced tea. She slid forward to the floor on her knees. The fall was not witnessed. No injury. What was the proactive measure to prevent a future occurrence? We gave her a reacher; education to use the call light, she did not have the call light on. The DON stated, Resident #2's 2nd fall was 08/22/20 at 12:02 a.m., in her room. She was found by a CNA. Unfortunately, they did not put her name in there. The DON stated that she did not know who completed the report for the event, they did not sign it. The DON confirmed the family notification was not put in the report. The DON stated that per the report, the resident was sitting in her w/c and she stood and fell . There were no witnesses. The resident told them what happened. What was the proactive measure to prevent a future occurrence? We educated the resident about using the call bell light, put floor mats on the floor. A therapy referral for safety awareness, even though she was in therapy already. Did therapy complete the therapy evaluation? I will find out. No documentation was provided during the survey of a therapy evaluation being completed for the 08/22/20 fall. The DON stated, Resident #2's 3rd fall was 09/07/20 at 3:12 p.m., it was unwitnessed, in her room, they found her sitting on the floor by the bathroom door. Who was she found by? The DON stated they do not have that information. The DON stated she did not know the name of the CNA, but the facility document showed a witness statement, dated 09/07/20: Just left rom 107 and sat at nurses' station when (resident room #) screaming (she was asleep when I was in the room as I already toileted her about hour prior to the fall). She was on floor next to bathroom. I asked why she didn't let me know she had to go again, and she said she didn't want to bother me. She also said that she is constipated and and only a little came out earlier. Nurse aware. The DON stated that the resident was assessed by Staff B, LPN, got the resident back to bed, no injury, doctor was notified at 15:00, the resident's family member was notified the following day at 8:00 a.m. What was the proactive measure to prevent a future occurrence? Therapy Screen/bedside commode. The DON stated, Resident #2's 4th fall was 09/13/20 at 19:50, the fall was unwitnessed, in her room, she was found by Staff C, LPN. The resident was seen sitting on the on the floor next to her bed; resident stated that she was trying to transfer to the w/c by herself and go to the bathroom. They did a change of status due to the resident having an abnormal blood sugar. They assessed her, pain, injury, they put the bed in the lowest position; they started neuro checks. Did she hit her head on this fall? No, if we do not see it, we neuro checks. Neuro checks are q 15 x 4; q hour times 4; then q hour times 4; then every hour x 4. Where do you document this? Should be in PCC. Family and Doctor notified. What was the proactive measure to prevent a future occurrence? We started her on 30-minute checks for safety.