| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **105354** | A. BUILDING _____ B. WING _____ | **07/17/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **LAKELAND NURSING & REHABILITATION** | **1919 LAKELAND HILLS BLVD LAKELAND, FL 33805** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review and policy review, the facility failed to provide adequate supervision and assistance to prevent falls for one (Resident #2) of 3 residents sampled in regards to the resident sustaining multiple falls, lack of investigation and interventions to prevent further falls and lack of documentation of neurological status after falls. Findings Included: Resident #2 was admitted on [DATE] with a [DIAGNOSES REDACTED]. Review of the nurses notes dated 4/30/20 at 11:10 p.m. reflected the resident alert with confusion, able to make needs known, reasonable to redirection. Requested several times to stand or sit on the side of the bed, advised to wait for these activities with therapy tomorrow in order to ensure precautions were observed. Review of the Social Services Note dated 5/1/20 at 10:33 a.m. reflected an initial admit note. Resident alert with confusion. Residents Brief Interview of Mental Status (BIMS) score of 7 indicating severe impairment. Review of the facility fall log indicated Resident #2 sustained a fall on 5/4/20 at 6:46 a.m. Review of the Nurses notes dated 5/4/2020 showed, Resident #2 yelling help from the room during medication pass. When the nurse approached the room the resident was lying in the bed verbalizing to the nurse that she needed and ambulance. The resident was asked what happened and she stated, I need an ambulance because I fell on the floor and I think I broke my hip. The resident was asked how did you get into the bed? The resident verbalized that after she fell she crawled her way back into the bed from the bathroom about an half hour ago. Complaint of 8/10 left hip pain. 2 staff nurses asses the left hip. No new apparent injury. Sutures observed on the left hip remain in place. No open areas and no bleeding, bandage remains intact. Resident given tylenol for pain. Resident educated on call bell use for assistance. Bed remains in lowest position with call bell within reach. MD contacted. Emergency contact voicemail full. X-ray ordered of the left hip STAT (immediately). Review of the fall risk evaluation completed 5/4/20 at 9:36 a.m. reflected Resident #2 fall risk score of 13 indicating higher risk for falls, above a score of 10. Review of the pain evaluation dated 5/4/20 at 7:07 a.m. indicated pain of 9/10 to the left hip and activity makes the pain worse. Review of the Director of Nursing (DON) nurses notes for Resident #2's (IDT) inter disciplinary team meeting showed the resident fell on [DATE] and verbalized she needed an ambulance because she fell on the floor on her way back to bed from the bathroom about an half hour before the nurse was told by the resident. Resident is cognitively impaired and has a BIMS score of 10 indicating severe impairment. Fall score of 10. Resident is cognitively impaired. Preventative measures in place including prompted voiding program and therapy referral. Review of the Minimum Data Set (MDS) assessment dated [DATE] reflected Resident #2 Section C. BIMS of 7, Section G (functional status) as (B) transfers from bed, chair, wheelchair, standing position required limited physical assistance of two persons, (C) walking in room required extensive physical assistance and one person, (I) toilet use required extensive physical assistance of two plus persons. Review of the radiology report dated 5/4/20 reflected no fracture or dislocation. Requested copies of neurological checks completed after the fall on 5/4/2020. The facility could not provide neurological check documentation. Review of the care plan reflected a focus area at risk for fall and/or fall related injury related to generalized weakness, unsteady gait, requires staff assist with transfers and ambulation, uses wheelchair as primary mode of locomotion, has a history of falls, has poor safety awareness date initiated on 5/4/20. A goal to minimize risk of falls with staff intervention thru the next review target date of 7/29/20. Interventions included Prompted voided program, offer toileting in the am, after meals and at night initiated on 5/4/20, provide hands on assist with transfers dated 5/4/20, observe for use of appropriate footwear and assist as needed dated 5/4/20, educate/remind resident to request assistance prior to ambulation/transfers as needed initiated 5/4/20. Keep bed in lowest position initiated 5/5/20, provide incontinence care/toileting per resident's needs initiated on 5/5/20. Review of the nursing progress notes dated 5/7/20 at 11:20 a.m. reflected the resident with altered mental status. New order for labs obtained. Review of the physician progress notes [REDACTED].#2 receiving a video call visit and noted to have behavior issues earlier which are not her norm. The resident asked for pain medication stronger than tylenol and [MEDICATION NAME] was ordered. Labs ordered. documented [MEDICAL CONDITION], maybe 2/2 pain, rule out metabolic causes. Review of the daily skilled notes dated 5/14/20 at 4:57 a.m. reflected Resident #2 confused. Resident easily agitated and resists care. Resident refused dressing to left hip as the resident believes she is getting discharged on [DATE]. Review of the daily skilled note dated 5/14/20 at 5:54 p.m. reflected the resident receiving skin treatment. Resident #2 displays signs and symptoms of pain to the left hip 9/10. Pain medication given and pain improved. Review of the nurses note dated 5/16/20 at 3:02 p.m. the resident has bruising noted to the right upper extremity and right lower extremity. Review of the record did not reflect documentation or investigation for new areas of bruising. Review of Resident #2's Medication Administration Record [REDACTED]. Resident #2's pain level on 5/14/20 at 8:00 a.m. was a level of 5/10, at 3:51 p.m. the pain level was 9/10. On 5/15/20 at 8:32 a.m. the pain level of 5/10. On 5/16/20 at 12:38 a.m. a pain level of 10/10 and at 6:05 p.m. a pain level of 5/10. On 5/17/20 a pain level of 4/10 at 6:20 p.m. was documented. Review of the nurses note dated 5/17/20 at 6:39 p.m. reflected the resident complaining of increased pain in the left leg. Physician notified and per physician order [REDACTED]. Review of the nurses notes on 5/17/20 at 9:26 p.m. reflected the physician notified of the x-ray results. Orders to send to the ER (emergency room ) for eval and treat. Family notified. Review of the change in condition form dated 5/17/20 at 9:36 p.m. reflected Resident #2 with uncontrolled pain, noting the resident needs more assistance with ADL's (activities of daily living) and general weakness. Pain medication given at 6:00 p.m. and x-ray for new or suspected dislocation. Family and physician notified. Review of the radiology report dated 5/17/20 at 8:30 p.m. reflected AP view of the pelvis and AP view of the left hip demonstrate femoral arthroplasty with superior dislocation with suspected displacement of both the femoral component and acetabular component significantly displaced. Mild [MEDICAL CONDITION] change of the contralateral right hip. Conclusion: left hip arthroplasty with dislocation. Finding is new when compared to imaging of 5/4/20. Review of the IDT notes dated 5/22/20 at 4:03 p.m. the Director of Nursing (DON) documented: IDT follow up related to discharge to the hospital on [DATE]. Resident was originally admitted on [DATE] with a [DIAGNOSES REDACTED]. Resident had a fall on 5/4/20 self reported. BIMS 10. On 5/17/20 resident complained of increased pain in left hip area. Resident stated she wanted to go home. X-ray showed positive dislocation of left femur neck. Information from chart review: resident with history of falls, non compliance with asking for assistance and ambulating without assistance. MD aware and stated dislocation probable from non compliance and osteo ([MEDICAL CONDITION]). Interventions the team has initiated: voiding program for the fall on 5/4/20 and send to ER for further evaluation. During a phone interview on 7/16/20 at 2:51 p.m. with the DON she stated Resident #2 was alert and oriented and complained of pain. The DON stated that the resident did ask to go to the hospital after the 5/4/20 fall but with COVID - 19 were were trying not to hospitalize her to lessen her chance of infection. We did obtain an x-ray of her hip which was negative. The nurse gave the Resident two Tylenol. The DON stated that she did not have any witness statements and did not investigate the fall as to when the resident was last |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>observed or toileted. The DON stated that she was able to communicate with staff. The DON stated she would do an investigation if the resident could not indicate what happened. The DON stated she does not investigate every fall unless the fall does not make sense. The DON stated the resident was non-compliant and ambulates with a walker and was assessed by 2 staff nurses. The DON stated the resident verbalized understanding of her teaching and did not document discussion of the resident agreeing not to go to the hospital. During the phone interview the DON stated the resident was complaining of increased pain on 5/7/20 and the physician added [MEDICATION NAME] and notified the family. The DON then stated the resident was complaining of increased pain on 5/17/20 to her left hip. They called the physician to obtain an x-ray which was positive for dislocation of the left hip. The DON stated that she did not investigate the dislocation of the hip as the resident was non compliant with using the call light. The DON stated the resident was sent out to the hospital and she did not complete an investigation for the dislocation of unknown origin. The DON stated the physician said the dislocation could have been from non compliance or osteo and did not feel she needed to investigate to see if the resident sustained [REDACTED]. Resident #2 was readmitted on [DATE] diagnosed as dislocation of left hip, [MEDICATION NAME] due to [MEDICAL CONDITION], not specified as recurrent, elevated white blood cell count, and presence of left artificial hip joint. Review of the MDS dated [DATE] reflected in Section C a BIMS score of 11 indicating moderate impairment. Section G, functional status reflected bed mobility, and transfer as extensive assistance and two plus person physical assistance. Walking in room reflected the activity did not occur. Locomotion on the unit reflected extensive assistance and one person physical assistance. Review of the nurses notes dated 6/6/20 at 3:36 a.m. reflected the resident found sitting upright next to bed with feet facing window, no injury noted, resident has no complaint of pain at this time, un-witnessed, resident stated she was trying to get to the restroom so she didn't poop in her bed resident assisted back to bed by this nurse and 2 CNAs, resident brief changed, dressing to left hip, neurochecks initiated, pupils equal round and reactive, equal strength bilaterally, right left normal strength, left leg weaker due to wound on left hip, speech clear, Physician aware, no new orders. family aware. Review of the E-interact form dated 6/6/20 at 2:54 a.m. reflected the resident had a fall trying to get to the bathroom. Review of the fall risk evaluation dated 6/6/20 at 3:33 a.m. reflected the resident as a high risk for falls score of 20. Review of the care plan reflected interventions updated to offer toileting assistance/incontinence care upon rising, before and after meals, bedtime and as needed dated 6/5/20. Requested copies of neurological checks that were completed after the fall. The facility was unable to provide the documents. Review of nurses notes dated 6/13/20 at 5:14 a.m. reflected the resident at found at 4:30 a.m. by CNA, resident was found on the floor at the end of the bed lying on her back. Resident stated she went to get a drink of water and go to the bathroom and couldn't make it. Resident had bowel movement on the floor and herself. CNA notified the nurse. CNA and nurse cleaned up the resident, initiated neuro checks. Resident had open area to left hip with yellowish colored drainage and reddened area around wound. Physician notified and wound culture ordered. Review of the referral to therapy dated 6/14/20 at 6:52 p.m. reflected the resident continues to attempt standing and walking unsupervised. Frequent checks, correct slip proof footwear, every 2 hour toileting schedule. Resident currently on therapy for speech, physical and occupational. Review of the change in condition form dated 6/13/20 at 6:39 a.m. reflected the resident had an unwitnessed fall at 4:30 a.m., no injuries noted, resident assisted back to bed via hoyer lift by nurse and CNA, resident has surgical wound to left hip with pus in wound and redness. Physician and family aware and culture ordered. Review of the fall risk evaluation dated 6/13/20 at 7:01 a.m. reflected the resident fall score decreased to 14. Review of the care plan interventions initiated on 6/13/20 reflected elevated toilet chair (3 in 1) to toilet. Review of the nursing IDT notes dated 6/15/20 at 4:25 p.m. from the DON reflected the resident fell on [DATE] at 4:30 a.m. trying to get to the bathroom. Root cause analysis reflected-self toileting care plan updated to add a BSC (bed side commode) raised toilet seat, frequent reminders for resident to ask for assistance and a scheduled toilet plan before and after meals and upon rising. Review of the nursing notes dated 6/17/20 at 4:20 p.m. reflected the resident wound culture returned positive for [MEDICAL CONDITION] (MRSA) physician ordered [MEDICATION NAME] 100 mg twice a day. Review of the nurses notes dated 6/17/20 at 5:14 p.m. reflected the resident found on the floor beside bed. Resident stated that she was trying to transfer back into bed and did not make it. Resident assessed, no injury noted. No complaints of pain. X-ray ordered of left hip to to previous hip surgery. Neurochecks and every 15 minute checks. Family notified. Review of the change of condition evaluation dated 6/17/20 at 11:50 p.m. reflected the resident found lying on the floor by the bed, assisted back into bed. Vitals stable, no complaints of pain. X-ray ordered, resident placed on neuro checks and 15 minute checks. Review of the fall risk evaluation dated 6/17/20 at 6:30 p.m. reflected the resident with 3 or more falls and fall risk score increased to 20 as higher risk for falls. Review of the care plan interventions dated 6/17/20 reflected dycem to wheel chair and 15 minute checks. Review of the nursing notes dated 6/19/20 at 1:58 p.m. reflected the resident went to ortho (orthopedic physician) appointment at 10:30 a.m. and was admitted to the hospital due to left hip wound infection. Review of the DON's IDT notes dated 6/23/20 at 12:54 p.m. reflected the resident discharged to the hospital after follow up appointment with ortho status [REDACTED]. Root cause analysis reflected the resident impulsive, ambulatory and not asking for assistance. Care plan reviewed and interventions were reviewed for accuracy. Will review again when returning from hospital. During the phone interview with the DON on 7/16/20 at 2:51 p.m. the DON stated she did put the resident on 15 minute checks after the 6/17/20 fall and added a dycem cushion to the wheelchair. The DON stated on 6/5 we offered toileting assisting and frequent checks. They added the leaf on the door which meant the resident is a fall risk and needed to be checked more often. The DON stated we try to leave the same CNA and have the same nurse. We don't document on every single resident when they are checked on. We chart by exception. The DON stated that she felt the interventions were appropriate for the falls but could not answer what interventions were in place that were appropriate to the three falls on the 11 to 7 shift. The DON stated the staff are supposed to do frequent checks. The DON stated the resident was alert and oriented enough to use the call light but was confused at times. The DON restated that frequent checks don't have a specific time the staff just know to watch more with the leaf on the door. The DON stated the root cause analysis for most of the falls was toileting related because she was soiled. We always try to put her on the least restrictive interventions and 15 minute checks are invasive. The 15 minute checks can cause more problems. The interventions for toileting were appropriate and stated toileting as needed which covered her getting up in the middle of the night. The DON stated the resident was never put on a bowel and bladder program to monitor her bathroom needs. During an interview with staff member A, RN UM (registered nurse, unit manager) on 7/16/20 at 3:51 p.m., she stated Resident #2 was confused one minute then she would be alert and oriented and then confused. We could have a conversation and assist her to dress then come back and she would ask, why am I here. She was out of it. I made the physician aware and talked to her daughter about it. We would meet for care plan and the IDT team meets to go over the falls and tasks. We would talk about frequent checks on her for incontinence. She would be easily redirected but she was unpredictable and I would go to her first thing in the morning when I arrived around 6:30 a.m. and make sure she had a bath and was changed and would get her breakfast since she would get up early. She would over estimate her ability to get up. She was in a private room near the beginning of the hall but still far a way from the nurses station then they moved her when she came back further down the hall away from the nurses station. During a phone interview on 7/17/20 at 9:10 a.m. with staff member B, CNA she stated she worked with the resident on the 11 p.m. to 7 a.m. shift and the resident was not easily redirected. We would have to stay on the hall and make sure she didn't get up. She was confused at times and fell a few times on my shift. I would try to make sure that I watched her closely since she was unpredictable but then I would go to work with a resident and she would be on the floor. I never assisted her to the bathroom. I would change her brief at night and I would not always document each time but once a shift. The resident scared me one night when I came down the hallway and I found her in her chair. I did not even know she could walk. She was assisted back to her bed. During an interview with staff member D, LPN at 10:59 a.m. on 7/17/20 she reviewed Resident #2's toileting sheet and confirmed the resident was changed once a shift at the end of the shift but her expectation would be to document at the point of care not at the end of shift. Staff member D, LPN reviewed the neurological flow record and confirmed the only document found was from the fall on 6/13/20. Staff member D, LPN stated the document was found in medical records waiting to be filed and confirmed that the fall in May and other falls in June were not found. During an interview with staff member E, LPN on 7/17/20 at 11:44 a.m. she confirmed she could not locate any other neurological flow sheets for Resident #2 other than the one from 6/13/20. During an interview with the Assistant Director of Nursing (ADON) on 12/17/20 at 12:03 p.m. she confirmed neurological checks are to be completed on residents for 3 days after an unwitnessed fall, following the directions on the form. The ADON stated she was aware the resident was nice and pleasantly confused. The ADON stated her expectation would be that if a resident falls we complete nuero checks and we notify the physician and family. We get the orders if an x-ray is needed and call the family back after to let them know the results. The ADON stated if a resident had a new complaint of pain and the resident is found to have a dislocation that |

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| F 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>the facility would start an investigation to find out the cause of the dislocation. Review of the falls and fall risk Policy, managing revised 12/07 pages 58 and 59 reflected Based on previous evaluations and current data, the staff will identify intervention related to the resident's specific risks and causes and try to prevent the resident from falling and try to minimize complications from falling. |