STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185244	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STANFORD CARE AND REHAB, LLC	**105 HARMON HEIGHTS STANFORD, KY 40484**

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 -** Immediate jeopardy **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 interview, record review, and review of the facility policy it was determined the facility failed to immediately inform the physician when a significant change in condition occurred for one (1) of thirty-nine (39) sampled residents (Resident #259). Resident #259 was admitted to the facility on [DATE] and had experienced frequent falls since admission. On [DATE] at approximately 7:15 PM, Resident #259 attempted to get out of bed unassisted and was exhibiting symptoms of increased confusion and agitation. Staff assisted the resident out of bed and into his/her wheelchair where staff observed the resident attempt to get up from the wheelchair unassisted multiple times on [DATE] and into the morning of [DATE]. Resident #259 was restless/anxious, and would not calm down and was hallucinating by reaching in the air and leaning forward to touch the floor in front of his/her wheelchair, trying to retrieve objects that were not there. Even though staff informed Licensed Practical Nurse (LPN) #3 that Resident #259's anxiety and confusion, had been worse the past few days, the physician was not notified of the resident's change in condition. Resident #259 continued to be unable to sleep, exhibit signs of anxiety and restlessness, and attempt unsafe transfers from the wheelchair, into the morning of [DATE]. At approximately 1:02 AM on [DATE], Resident #259 was still up in the wheelchair (almost six (6) hours since getting up at 7:15 PM) and continued to be restless, fidgety, and wiggly. On [DATE] at 1:05 AM, Resident #259 was observed on the floor, lying on his/her left side in the hallway of the facility. The resident was transferred to a local hospital on [DATE] and was diagnosed with [REDACTED]. Resident #259 expired on [DATE] as a result of [MEDICAL CONDITION] due to the fall to the floor. The facility's failure to ensure resident physicians were notified of changes in a resident's condition has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE] at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656), 42 CFR 483.25 Quality of Care (F689), and 42 CFR 483.45 Pharmacy Services (F756). The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Allegation of Compliance was received on [DATE], which alleged removal of the Immediate Jeopardy on [DATE]. The State Survey Agency determined the Immediate Jeopardy was removed as alleged on [DATE] prior to exit on [DATE], which lowered the scope and severity to D level at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656), 42 CFR 483.25 Quality of Care (F689), and 42 CFR 483.45 Pharmacy Services (F756) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility policy titled Notification of Change, dated 2016, revealed the facility must immediately inform and consult with the resident's physician and notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status, which included a deterioration in health, mental status, or clinical complications. Review of Resident #259's record revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Resident #259's admission Minimum Data Set Assessment ((MDS) dated [DATE] revealed the resident was interviewable with a Brief Interview for Mental Status (BIMS) score of nine (9), and had no behaviors or signs of difficulty sleeping during the assessment period. The MDS also indicated Resident #259 required extensive assistance of two (2) staff members for transfers, bed mobility, and toileting; and had sustained one (1) fall since admission, with no injury. Review of Resident #259's physician orders and his/her Medication Administration Record [REDACTED]. Continued review of the physician orders and Resident #259's MAR indicated [REDACTED]. Review of the physician orders also indicated staff were directed to administer [MEDICATION NAME] 5 mg, every twelve (12) hours as needed for sleep. Further review of Resident #259's MAR indicated [REDACTED]. Interview with State Registered Nurse Aide (SRNA) #8 on [DATE] at 6:00 PM revealed she frequently cared for Resident #259 and was also assigned to care for the resident on [DATE], during the 6:30 PM to 6:30 AM shift. SRNA #8 stated Resident #259 was attempting to get out of bed unassisted on [DATE] at the beginning of the shift at approximately 7:15 PM and staff assisted the resident out of bed, and into his/her wheelchair. SRNA #8 stated Resident #259 was very confused, wild, and wiggly more than normal and she reported the change in the resident's condition to Licensed Practical Nurse (LPN) #3. SRNA #8 stated Resident #259 was going up and down the hallways of the facility, pulling medication carts, and attempting to stand without assistance from his/her wheelchair. The SRNA stated Resident #259 was also reaching in the air for things that were not there, and reaching to the floor in front of his/her wheelchair. She also stated she informed LPN #3 that Resident #259 was having a bad night and reported the resident's behaviors. The SRNA stated that the LPN instructed her to leave the resident where we could see the resident as much as possible. SRNA #8 stated attempts were made to toilet the resident, and a diversional activity was also provided; however, SRNA #8 stated the activities were not effective in addressing the resident's behavior. SRNA #8 stated at approximately 1:02 AM, after the resident had been up in the wheelchair for hours, she observed the resident in his/her wheelchair and the resident continued to be wiggly and fidgety. The SRNA stated she observed the resident approximately three minutes later, and the resident was lying on the floor in front of his/her wheelchair, at approximately 1:05 AM. Interview with Kentucky Medication Aide (KMA) #1 at 6:15 PM on [DATE] revealed she administered medicine on the unit that Resident #259 resided on during the 6:30 PM to 6:30 AM shift that began on [DATE]. KMA #1 stated the resident was up in his/her wheelchair and was fidgety and would not relax enough to go to sleep. The KMA stated she also observed Resident #259 leaning forward, to reach the floor in front of his/her chair in attempts to pick up things that were not there. KMA #1 stated the resident also attempted to move the medication cart and attempted unsafe transfers a few times from the wheelchair during that shift. The KMA administered the resident's 9:00 PM medications and thought the medications would help relax the resident; however, she stated the medications were not effective and the resident continued to be fidgety. According to the KMA, she was not aware that the resident had medication ordered as needed for sleep, and stated she would have administered the medication if she had known. Interview with SRNA #9 on [DATE] at 6:55 PM revealed she assisted in the care provided to Resident #259 during the 6:30 PM to 6:30 AM shift, which began on [DATE]. She stated she assisted SRNA #8 with getting the resident out of bed because the resident was trying to climb out of bed unassisted. SRNA #9 stated Resident #259 was confused and was observed to propel his/her wheelchair up and down the hallways and attempted to stand from the wheelchair. She reported the resident's behaviors to the nurse and had witnessed SRNA #8 inform the nurse that the resident was more confused than usual, and staff was instructed to keep the resident at the nurses' station. SRNA #9 stated she was in a room with another resident and when she came out, Resident #259 was on the floor, in front of his/her wheelchair at the nurses' station and blood was coming nonstop out of the resident's head. Interview with Licensed Practical Nurse (LPN) #3 on [DATE] at 7:10 PM revealed he was pulled to work the unit where Resident #259 resided on [DATE]. He stated that at approximately 7:30 PM on [DATE], he observed the resident in his/her wheelchair. LPN #3 stated the resident was disoriented, saying off the wall stuff, and was yelling out for people that wasn't there. He also stated that a SRNA informed him of the resident's history of falls and that the resident was more confused than normal. Further

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

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F 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) interview revealed LPN #3 was aware the resident remained up in a wheelchair for many hours into his shift because he/she was confused, disoriented, experienced unrelieved anxiety and restlessness, and couldn't sleep. The LPN also stated he was trained to notify the resident's physician when changes in the resident's condition occurred; however, he did not call the physician with the change in the resident's condition because the SRNA reported that the resident had been different for days. The LPN acknowledged he should have called the resident's physician. Further interview with LPN #3 revealed he was not aware that Resident #259 had as needed medication ordered if he/she was unable to sleep, or I would have given it. The LPN stated he left the unit to get something to drink and returned to the unit at approximately 1:05 AM on [DATE]. He stated he observed Resident #259 on the floor, in front of the nurses' station and blood was everywhere. The LPN transferred the resident to a local hospital for further evaluation and treatment. Review of Resident #259's nurse's notes, completed by LPN #3, revealed at 1:05 AM on [DATE], the resident was found lying on the floor on his/her left side, in the hallway in front of the nurses' station/dining room of the facility. The nurse's notes indicated Resident #259 had a large hematoma to the left temporal area and copious amount of bleeding also present from area; however, staff was unable to determine the exact origin of bleed. According to the nurse's notes, staff contacted Emergency Medical Services (EMS) and a pressure dressing was applied to the resident's left temporal area. Resident #259 was transferred to the local hospital for further evaluation and treatment. Review of Resident #259's hospital record revealed the resident was triaged on [DATE] at 1:50 AM at a local hospital with a complaint of a [MEDICAL CONDITION] to the left temporal area. Review of Resident #259's ED General Exam dictated by the emergency room (ER) Physician at 2:42 AM on [DATE] revealed the resident resided at a nursing home and had trouble sleeping lately. The physician's documentation also revealed Resident #259 was sitting in his/her wheelchair when he/she leaned forward and fell out and hit his/her head on the floor. The physician documentation indicated Resident #259 had a 2 centimeter (cm) laceration to the left forehead that went to the skull, with a small arterial bleed, that was bleeding briskly. The physician also documented he had Nursing put pressure on the area; however, there was already a large hematoma forming. Further review of the record revealed the physician stated, because of the brisk arterial bleeding, smooth pickups were used to grasp the bleeder using high temperature electrocautery, the arterial bleeding was cauterized. The record indicated three (3) sutures were placed to close the wound. Further review of the hospital record revealed a CT was performed on [DATE] and review of the Preliminary Radiology Report dated [DATE] at 2:45 AM indicated Resident #259 had an acute-appearing left frontotemporal subdural hemorrhage, largest component along the left temporal lobe measuring approximately 9 millimeters (mm) in maximal thickness. Continued review of the report revealed Resident #259 also had an acute-appearing left parietal, left posterior temporal, and right posterior temporal subarachnoid hemorrhage. According to the record, Resident #259 was transferred to a larger hospital, under the care of the trauma team on [DATE] at 3:55 AM. Review of a Coroner's Report revealed Resident #259 was pronounced deceased at 6:38 AM on [DATE], due to [MEDICAL CONDITION] due to a fall to the floor as a cause of death. Interview with the Director of Nursing (DON) on [DATE] at 12:45 PM revealed staff were expected to notify a resident's physician when a change in his/her condition was identified. She also acknowledged that approximately six (6) hours was too long for a resident to have exhibited unrelieved anxiety/restlessness without the resident's physician being notified and interventions implemented to assist the resident with the identified concerns. Interview with Administrator #1 on [DATE] at 2:20 PM revealed she expected staff to notify the resident's physician immediately when changes in their condition occur. The Administrator also acknowledged that approximately six (6) hours was too long for a resident to be up in a wheelchair when he/she was unable to sleep, exhibiting restlessness/agitation, confusion, and seeing things that were not there, without an intervention being implemented to assist the resident with their identified concerns. Interview with Physician #1 on [DATE] at 3:25 PM revealed she expected staff to notify her when changes in a resident's condition occurred and when residents experienced bad anxiety that was unrelieved.

***The facility alleged the following was implemented to remove Immediate Jeopardy effective [DATE]: 1. Resident #259 no longer resides at the facility. 2. By [DATE], the Pharmacist will complete a Medication Regimen Review for current residents, which will include psychoactive medications, to ensure there is a supporting diagnosis, and will review for necessity/indication for the medication. The Pharmacist will also review for psychoactive medications that may be contributing to falls. One hundred eleven (111) residents were reviewed. Recommendations to the Medical Director was made for sixty-three (63) residents, six (6) of which were recommendations for a gradual dose reduction of psychoactive medications. 3. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) assessed current residents for potential side effects from psychoactive medication on [DATE], and ensured resident's Medication Administration Records (MAR) reflected the need to monitor for potential side effects of psychoactive medication. 4. The facility held a meeting on [DATE] to evaluate residents receiving psychoactive medications, residents with new orders for psychoactive medications, residents that had a medication dose adjustment, and any pharmacy recommendations. The IDT (Director of Nursing, Social Service Director, Social Service Assistant, Activity Director, Assistant Director of Nursing, Registered Dietitian/Dietary Service Manager) was in attendance and the Medical Director attended by phone to review appropriate utilization of psychoactive medications, which includes antipsychotic medications, hypnotic medications, antianxiety medications, and mood altering medications to ensure side effects, medication changes, and overall adjustment to psychoactive is achieved. 5. The DON/ADON/Wound Nurse completed Falls Risk Assessments (utilizing the MORSE Fall Scale tool) and Pain Evaluations for current residents on [DATE]. The Nurse Consultant/DON/ADON/ Wound Nurse will also review resident falls for the past 30 days to ensure a root cause analysis has been conducted and appropriate interventions are in place. This will include a review of the care plan to ensure updates have been entered. 6. The Social Service Director, Social Service Assistant, and the Clinical Liaison will interview residents with a BIMS of eight (8) and above to identify residents with concerns related to change of condition, including but not limited to: pain, concerns related to sleep changes, requiring increased help from staff, or concerns related to increased fall risks. The interviews were completed by [DATE] and any concerns identified will be reported to the Director of Nursing (DON) and/or Executive Director immediately and addressed by the appropriate department. 7. The Wound Nurse (LPN) and Clinical Liaison (LPN) will complete resident observations by [DATE] for residents with a BIMS score of seven (7) and below to identify residents with concerns related to change of condition, including but not limited to: pain, concerns related to sleep changes, needing increased help from staff, or concerns related to increased fall risks. Concerns identified will be reported to the DON and/or Executive Director immediately and addressed by the appropriate department. 8. The Human Resource Director, ADON, Medical Records, Registered Dietician, Scheduler, Environmental Service Director, and/or the Director of Rehab will interview current staff related to any knowledge of residents with concerns related to change of condition, including but not limited to: pain, concerns related to sleep changes, needing increased help from staff, or concerns related to increased fall risks. The interviews will be completed by [DATE] and any concerns will be reported to the DON and/or Executive Director immediately and addressed by the appropriate department. 9. The DON/ADON and/or designee will review resident interviews, staff interviews, and resident observations by [DATE] to ensure the physician is notified of any change in condition. The DON/ADON/ MDS nurse will review current resident and staff interviews to ensure that appropriate interventions were placed based on falls root cause analysis. 10. On [DATE], the DON/ADON and/or designee will review fall risk evaluations and pain assessments to determine if a change of condition is indicated and will notify the resident's physician if needed. 11. By [DATE], the MDS Coordinator will review nursing notes for the past 30 days to ensure physician notification and care plan revision to reflect any change, including falls and behaviors. One resident was identified to not have a care plan related to a skin tear; however, the physician had been notified with orders for treatment. 12. By [DATE], the DON and/or the ADON will review the Twenty-Four hour reports to ensure any change in a resident's condition has been addressed appropriately to include physician notification and care plan revision. No concerns were identified. 13. The Nurse Consultant/DON/ADON/SDC/RN Charge Nurse will review care plans on current residents to ensure appropriate documentation related to change in conditions, including but not limited to: pain, concerns related to sleep, changes in behavior, fall interventions, and fall risk. The reviews were completed by [DATE]. Five resident care plans were revised. 14. By [DATE], the Nurse Consultant educated the ED/DON/ADON/SDC on utilizing Stop and Watch forms, a communication form developed by CMS to communicate changes related to change of condition. Education will include giving the completed Stop and Watch to the nurse and making a copy and leaving for the DON/ADON. The DON/ADON will review Stop and Watches and follow up on possible change of condition during the daily clinical meeting and was completed as appropriate. By [DATE], the ED/DON/ADON/SDC will educate current staff regarding utilizing Stop and Watch forms for any change in condition, giving the completed form to the nurse, and making a copy for the DON. 15. The Nurse Consultant educated the ED/DON/ADON/SDC the DON/ADON on [DATE] to |

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F 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) review Stop and Watches forms to ensure they were acted upon appropriately to include physician notification for changes in condition, They were also educated to ensure appropriate interventions were implemented for falls based on root cause analysis of the fall, which includes the 5 Why's (a tool approved by CMS for identifying root cause analysis), to assist in determining an appropriate intervention at time of fall. The education also included the need for licensed nurses to submit the 5 Why's form for each fall to DON/ADON for review in clinical meeting. The Nurse Consultant will also re-educated the staff regarding the facility's Falls Management Policy that requires the completion of a Falls Risk Evaluation (utilizing the MORSE fall Scale tool developed for assistance in identifying fall risk residents) after each fall. The SDC/DON/ADON/ED then educated licensed staff by [DATE] regarding the utilization of the 5 Why's tool to determine the root cause of a fall to assist in determining the most appropriate intervention. In addition, current licensed nurses will be educated to notify the on-call Nurse Manager after a fall to review the root cause and the intervention for appropriateness. 16. By [DATE], the ED/DON/ADON/SDC will educate current licensed staff on appropriate documentation including, but not limited to: changes in condition, pain, concerns related to sleep changes, effectiveness of medication, notification of residents' physicians, or needing increased help from staff. 17. By [DATE], the Nurse Consultant will educate the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), and the Wound Care Nurse (LPN) on assuring that residents are assessed for potential medication side effects; to ensure a monitoring order is placed on the MAR indicated [REDACTED]. Education included reviewing residents who was newly admitted /readmitted to ensure the resident had an appropriate [DIAGNOSES REDACTED]. The review will be conducted during the daily clinical meeting and will be followed-up by the Pharmacy Consultant. Any new medication orders will be reviewed by the DON/ADON/SDC for necessity to include appropriate [DIAGNOSES REDACTED]. 18. The Nurse Consultant will educate the DON/ADON/SDC on ensuring pharmacy reviews have occurred monthly and ensuring timely follow up of recommendations per facility policy, which states the recommendations will be received by the DON within 3 days of completion of review. The recommendations will be sent to the physician and the DON will verify the physician and Medical Director has received the review within 3 days. The DON should receive a response from the physician within 7 days. If a response is not received in 7 days, the DON/ADON will notify the physician for acceptance and/or a response to the recommendations that require action. If no response is received in 14 days, the DON/ADON will notify the Medical Director for further action. The DON/ADON will also notify the Executive Director and the Nurse Consultant. This education will occur on [DATE]. The DON, ADON, or Staff Development Coordinator will then will educate current licensed staff by [DATE] on assuring that residents are assessed for potential side effects of medications, ensuring a monitoring order is placed on the MAR indicated [REDACTED]. 19. The Pharmacy Director will re-educate the Registered Pharmacist by [DATE] on accurately completing a Medication Regimen Review, which will include a supporting [DIAGNOSES REDACTED]. The Pharmacist assigned to the facility at the time of the IJ has been removed as the Pharmacy Consultant. The current Pharmacy Consultant has been educated on the concerns related to regimen reviews, appropriate [DIAGNOSES REDACTED]. 20. For all education, a post education test will be administered by the Nurse Consultant/DON/ADON/SDC following education. If a score of 100% is not obtained, re-education will be completed until proficiency is obtained and their score is 100%. Five tests will be administered daily by ED/Assistant Administrator/ DON/ADON/SDC to ensure retention of education, until IJ is removed and approved through QAPI process. Current staff who have not received education by [DATE] will be mailed a certified letter informing them to contact the Executive Director/DON/SDC prior to working the floor. Staffing Agencies currently being utilized will be mailed a certified letter on [DATE] of the need to contact the ED/DON/SDC for education prior to working. The Executive Director/SDC or designee will ensure all newly hired staff and agency staff will receive education during New Hire Orientation or prior to working the floor. 21. The IDT will review in the daily clinical meeting (Monday through Friday) each fall and nursing shift reports to ensure the following is completed for any resident who sustained a fall: Falls Risk evaluation, to include the 5 Why's; physician notification; and care plan revision. In addition, the IDT will review Stop and Watch forms, progress notes, and physician orders to ensure care plans have been updated appropriately and physicians have been notified. 22. The Executive Director/Assistant Administrator/DON will conduct daily post clinical IDT meetings Monday-Friday for two weeks to review all identified Change of Condition and the effectiveness of medication to ensure notification of residents' physician as required. In addition, the Executive Director/Assistant Administrator/DON will review five (5) random resident records to ensure proper documentation has been completed related to any change in condition, physician notification, and the care plans are appropriate. Any issues identified will be corrected immediately and reported to the QAPI Committee for 3 months for further review and recommendations. 23. The facility will conduct weekly monitoring to evaluate psychoactive medication on residents, residents new prescribed psychoactive medications, and residents that have had medication dose adjustment. This psychoactive meeting will be conducted weekly by the facility IDT, (Director of Nursing, Social Service Director, Social Service Assistant, Activity Director, Assistant Director of Nursing, Registered Dietitian or Dietary Service Manager), residents physician, facility medical director, and Pharmacist to review appropriate utilization of psychoactive medications which includes antipsychotic medications, hypnotic medications, antianxiety medications, and mood altering medications to ensure side effects, medication changes and overall adjustment to psychoactive is achieved. 24. Beginning [DATE], the Nursing Consultant/ED/DON/ADON/Assistant Administrator will be on sight at facility to monitor processes related to supervision to prevent accidents, care plan development/revision, and physician notification until IJ is removed and pending QAPI Committee review. Any concerns identified will be addressed immediately and reported to QAPI weekly for review and further recommendations. An AD-HOC QAPI meeting is held at least bi-weekly and as needed to discuss issues with the Medical Director. The IDT team meets daily to discuss findings and progress. 25. Beginning [DATE], The Director of Nursing, Assistant Director of Nursing, or the Staff Development Nurse will review MAR's daily (Monday through Friday), during the Clinical Meeting, for two weeks, for documentation of side effect monitoring of [MEDICAL CONDITION] medication and appropriate [DIAGNOSES REDACTED]. The Director of Nursing will also review falls to ensure the Medication Regimen Review has been sent to the consultant pharmacist daily (Monday through Friday) during the clinical meeting. The Director of Nursing will contact the Pharmacy Director, in 72 hours, if no communication from the review is received from the consultant pharmacist. Any concerns identified will be corrected immediately, and reported to QAPI committee for further review and recommendations. 26. The Executive Director will ensure the facility has conducted weekly monitoring, month over month, for 3 months to evaluate psychoactive medication on residents newly prescribed psychoactive medications, and residents that have had medication dose adjustments. This psychoactive meeting will be conducted weekly, by the facility IDT (Director of Nursing, Social Service Director, Social Service Assistant, Activity Director, Assistant Director of Nursing, Registered Dietitian or Dietary Service Manager), residents physician, facility medical director, and the Pharmacist to review appropriate utilization of psychoactive medications, which includes; antipsychotic medications, hypnotic medications, antianxiety medications, and mood altering medications to ensure side effects, medication changes and overall adjustment to psychoactive is achieved. 27. The Nurse Consultant or Director of Nursing will be in the center daily to monitor residents with new [MEDICAL CONDITION] medication orders to ensure side effect monitoring is completed. 28. Beginning [DATE], Nursing Consultant/ED/DON/ADON/Assistant Administrator will be on sight at the facility to monitor process, related to [MEDICAL CONDITION] medications, until IJ is removed and pending QAPI Committee review. Any concerns identified will be addressed immediately and reported to QAPI weekly for review and further recommendations. AD-HOC QAPI meeting is held at least bi-weekly, and as needed, to discuss issues with the Medical Director. The IDT team meets daily to discuss findings and progress. 29. The Executive Director will review 5 random Admissions/Readmissions/Falls/New Medication Orders/ Monthly Pharmacy Reviews for timeliness, and to ensure proper documentation has occurred daily. Any issues identified will be corrected immediately, and reported to QAPI Committee for 3 months for further review and recommendations. ***The State Survey Agency determined that the facility implemented the following to remove Immediate Jeopardy on [DATE], as alleged: 1. Review of documentation revealed Resident #259 no longer resided at the facility. 2. Interview with the Administrator on [DATE] at 5:15 PM and review of documentation revealed by [DATE], the Pharmacist completed a Medication Regimen Review for current residents on psychoactive medications, to ensure there was supporting diagnosis, and necessity and indication for the use of the medication. The Pharmacist also reviewed psychoactive medications that could have contributed to falls. Further review of documentation and interview with the Administrator confirmed one-hundred and eleven (111) residents were reviewed by the Pharmacist. Review of facility documentation revealed the Pharmacist made recommendations to the Medical Director on 63 residents reviewed and six (6) of those recommendations were for gradual dose reductions of psychoactive medications. 3. Interview with the Director of Nursing (DON) on [DATE] at 3:30 PM and review of documentation revealed she and Assistant Director of Nursing (ADON) #1 assessed current residents for potential side effe

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F 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3)
F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, it was determined the facility failed to maintain a clean, comfortable, and homelike environment with comfortable sound levels for residents on Hall 100 and Hall 200. On 02/17/2020 and 02/18/2020, observations of the breezeway door on Hall 200 and the copy room door on Hall 100 revealed a loud slamming noise when the doors closed. On 02/17/2020 and 02/18/2020, observations in Resident #83's room revealed a dried residue-type substance on top of the oxygen concentrator that resembled food and/or a partial pill/medication tablet. The findings include: 1. Review of the facility policy, Environment and Safety, undated, revealed the resident's bedroom should be homelike. The policy further revealed the goal of any dementia care setting was to create an environment that was simple, safe, secure, and supportive. Observation of Resident #83's room on 02/17/2020 at 9:32 AM, revealed small dried substances on top of the oxygen concentrator. The appearance of the residue was indicative of food and possible pill fragments. Further observations on 02/17/2020 at 10:42 AM, 11:48 AM, 1:16 PM, and 3:47 PM, and on 02/18/2020 at 8:33 AM revealed the residue remained on the oxygen concentrator. Review of the medical record of Resident #83 revealed the facility admitted the resident on 05/11/2018 with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment, dated 01/21/2020, revealed the resident had a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated the resident had moderate cognitive impairment. Review of the progress notes for Resident #83, a nurse's note dated 02/16/2020 at 2:48 PM, revealed the resident was displaying behaviors of yelling and throwing items into the hallway. Interview with Licensed Practical Nurse (LPN) #1 on 02/18/2020 at 9:00 AM, revealed she had noticed the residue on top of the resident's oxygen concentrator that morning. She stated the residue was from the resident spitting or throwing food over the side of the bed. She further stated that due to the resident's medications being crushed, the residue was probably not medication. Per the LPN, the resident had orders to have his/her oxygen status to be assessed every four (4) hours, which would have included observing the concentrator to ensure the resident was receiving oxygen at the correct rate. However, the LPN also stated she had been assigned to provide care for the resident on 02/17/2020 and had not noticed the debris on that date. Interview with Assistant Director of Nursing (ADON) #1 on 02/21/2020 at 9:48 AM, revealed nursing staff should have noticed or been notified of the residue on the concentrator. She further stated the resident had a habit of spitting out food, which was probably what was on the concentrator. She stated the concentrator should have been cleaned immediately upon discovery of the debris. Interview with the Director of Nursing (DON) on 02/21/2020 at 12:07 PM, revealed when a nurse signed off on a Treatment Administration Record (TAR), regarding oxygen delivery, she expected the residue to have been identified and cleaned immediately. 2. Review of the facility policy titled, Environment and Safety, not dated, revealed Staff should conduct noise observations to determine which noise may be causing resident outburst and work toward eliminating them. 2. a. Record review revealed the facility admitted Resident #87 to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #87's Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #87 had a Brief Interview for Mental Status (BIMS) score of 15, indicating little to no cognitive impairment. Interview with Resident #87 on 02/16/2020 at 2:32 PM, revealed that staff go in and out to the smoke porch a lot and let the door slam. The resident further stated that the door slamming had awakened him/her at times. Observation on 02/18/2020 at 3:51 PM revealed while the surveyor was coming down the hallway a loud slamming noise was heard. Upon investigation, the slamming noise was from the breezeway door leading to the employee smoking area. Interview on 02/17/2020 at 1:14 PM with the resident council revealed that five (5) of the ten (10) residents (Residents #7, #11, #39, #87, and #102) attending stated that they had been awakened or startled by doors slamming. 2. b. Observation on 02/17/2020 at 9:16 AM and 02/18/2020 at 9:59 AM revealed the copy room door slammed loudly when staff entered and exited the copy room on the 100 hallway, where residents resided. Interview with the Administrator on 03/05/2020 at 11:35 AM revealed the Administrator was not aware that slamming doors were an issue, nor was she aware of staff monitoring to ensure a homelike environment was provided.

F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy it was determined the facility failed to provide five (5) of thirty-nine (39) sampled residents (Residents #18, #19, #52, #60, and #82) with written notification of bed hold policy upon transfer from the facility or within 24 hours if the resident's transfer was an emergency. The findings include: Review of the facility policy, Bed Hold and Return to Center Policy, dated 04/20/2018, revealed a copy of the facility Bed Hold Policy Review and Notice would be provided to the resident and/or resident representative at the time of transfer or, in cases of emergency, within twenty-four (24) hours. 1. Review of the medical record revealed Resident #19 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) significant change assessment, dated 02/11/2020, revealed a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident had severe cognitive impairment. Review of the record progress note, dated 11/05/2019, revealed Resident #19 was transported to the emergency room at a local hospital on [DATE], for medical clearance for admission to a behavioral health unit. Further review of the record did not reveal any evidence of a notification of bed hold provided to the resident/resident representative. 2. Review of the medical record revealed Resident #60 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a Change of Condition progress note dated 12/26/2019 revealed Resident #60 had changes in neurological status and a decreased level of consciousness. Review of a progress note dated 12/26/2019 revealed Resident #60 was transported to the emergency room at a local hospital on [DATE]. Further review of the record revealed no evidence that a notification of bed hold was provided to the resident or resident representative. Further review of the medical record revealed Resident #60 was readmitted to the facility on [DATE]. Review of the progress note dated 12/31/2019 revealed Resident #60 was transported to the emergency room again on 12/31/2019 for medical treatment. Further review of the record did not reveal any evidence of a notification of bed hold provided to the resident or the resident's representative. 3. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #18's Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment. Review of Resident #18's progress note dated 11/06/2019 revealed the resident had a change of condition with signs and symptoms of shaking, diaphoretic, not responsive, and labored respirations. The physician was notified and a new order was received to send to the local hospital emergency room . Further review of the record did not reveal any evidence of a notification of bed hold provided to the resident or the resident's representative. 4. Review of the medical record revealed Resident #52 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #52's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating little to no cognitive impairment. Review of Resident #52's progress note, dated 12/16/2019, revealed the resident was sent to the local hospital emergency room for evaluation due to a change of condition. Further review of the record revealed no documented evidence that a notification of bed hold was provided to the resident or the resident's representative. 5. Review of the medical record revealed that Resident #82 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #82's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment. Review of Resident #8's progress note dated 01/07/2020 revealed the resident was sent to the local hospital emergency room for evaluation due to a change of

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F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) condition. Further review of the record revealed no evidence of a notification of bed hold provided to the resident or the resident's representative. Interview with Assistant Director of Nursing (ADON) #1 on 02/21/2020 at 9:52 AM revealed when a resident was transferred out of the facility the facility sent a face sheet, the transfer form, a medication list, physician orders, and occasionally laboratory results with the resident. She stated she was not sure who provided the bed hold notifications. Interview with the Nurse Consultant on 02/18/2020 at 3:39 PM, revealed she was not able to find evidence of the notification of bed hold for any resident. She stated it was routinely sent with the transfer packet, but the business office manager did not follow up on it. Interview with the Business Office Manager on 02/02/2020 at 11:06 AM, revealed she had been in the position for approximately one (1) year. She stated she did not know she was responsible for issuing/following up on bed hold notifications until the past few days. Interview with the Administrator on 02/18/2020 at approximately 12:00 PM, revealed the facility had no proof of bed hold notifications being provided to the resident or resident representative. She further stated, I inherited this problem.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy, it was determined the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for one (1) of thirty-nine (39) sampled residents (Resident #66). Review of Resident #66's medical record revealed the resident sustained [REDACTED]. However, the facility completed MDS assessments on 11/08/2019 and 11/22/2019, and documented that the resident had sustained no falls. The findings include: Review of the policy, Resident Assessment Instrument, with an implementation date of 2001 and revised date of September 2010, revealed, The Interdisciplinary Assessment Team must use the Minimum Data Set (MDS) form currently mandated by Federal and State regulations to conduct the resident assessment. Review of the MDS Manual, mandated by Federal and State regulation, Section J1800, revealed the facility must answer the question, Has the resident had any falls since admission/entry or reentry or the prior assessment, whichever is more recent? when completing a resident's MDS assessment. Review of Resident #66's medical record revealed a fall on 11/08/2019. A review of the MDS quarterly assessment completed on 11/08/2019 for Resident #66 revealed Section J1800 stated that the resident had sustained no falls. Continued review of Resident #66's medical record revealed the resident sustained [REDACTED]. However, a review of Resident #66's MDS quarterly assessment completed on 11/22/2019 revealed the facility documented in Section J1800 that the resident had sustained no falls. Interview on 02/21/2020 at 10:18 AM with the Director of Nursing (DON), who was formerly the MDS Coordinator, revealed that she had verified that the 11/08/2019 and 11/22/2019 quarterly assessments were completed. However, she confirmed that both quarterly assessments were inaccurately coded for Section J1800, Falls.
F 0656 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and a review of the facility policy, it was determined the facility failed to develop a person-centered care plan to ensure services were furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for two (2) of thirty-nine (39) sampled residents (Resident #259 and Resident #84). Interviews with staff revealed Resident #259 experienced [MEDICAL CONDITION] (unable to sleep), attempted to get up from the wheelchair unassisted, and leaned forward in his/her wheelchair in attempts to retrieve objects that were not there. Review of the resident's care plan revealed no evidence the facility developed a care plan that addressed the resident's inability to sleep at times, or that addressed the identified safety concerns when he/she was up in a wheelchair. On [DATE] at approximately 7:00 PM, staff assisted the resident to a wheelchair and the resident remained in the wheelchair for approximately six (6) hours, even though the resident was restless, fidgeting, attempting to get up from the wheelchair, and leaning forward to touch the floor. At approximately 1:05 AM on [DATE], staff found the resident on the floor in a common area of the facility with a large hematoma and bleeding. The resident was transferred to a local hospital on [DATE] and was diagnosed with [REDACTED]. Resident #259 was pronounced deceased at 6:38 AM on [DATE], due to a [MEDICAL CONDITION] as a result of the fall. On [DATE], staff failed to utilize a mechanical lift when transferring Resident #84, and the resident had to be lowered to the floor. The facility's failure to ensure residents' care plans were implemented has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE] at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656), 42 CFR 483.25 Quality of Care (F689), and 42 CFR 483.45 Pharmacy Services (F756). The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Allegation of Compliance was received on [DATE], which alleged removal of the Immediate Jeopardy on [DATE]. The State Survey Agency determined the Immediate Jeopardy was removed as alleged on [DATE] prior to exit on [DATE], which lowered the scope and severity to D level at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656), 42 CFR 483.25 Quality of Care (F689), and 42 CFR 483.45 Pharmacy Services (F756) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility policy titled Comprehensive Care Plan, dated [DATE], revealed staff were to ensure the resident or his/her representative was included in all aspects of the person-centered care plan and the planning was to include the provision of services to enable the resident to live with dignity and support the resident's goals, choices, and preferences which included, but were not limited to, goals related to the resident's daily routines. The policy stated care plans must be prepared with input from the Interdisciplinary Team (IDT), which included, but was not limited to the physician, a Registered Nurse (RN), and a nurse aide with responsibility for the resident. The policy also stated staff should include input from the resident and his/her representative to the extent practicable. Per the policy, the care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. Review of Resident #259's record revealed he/she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #259's admission Minimum Data Set Assessment ((MDS) dated [DATE] revealed he/she had no signs of difficulty sleeping and had not exhibited behaviors during the assessment period. The assessment indicated Resident #259 required extensive assistance of two (2) staff members for bed mobility, transfers, and toileting. The MDS also revealed the resident had one (1) fall since admission, with no injury, and was interviewable with a Brief Interview for Mental Status (BIMS) score of nine (9). Review of Resident #259's comprehensive care plan initiated [DATE] revealed staff identified that the resident was at risk for falls. Interventions implemented since admission included for staff to anticipate and meet the resident's needs, his/her bed was placed against the wall per resident/family preference, non-slip footwear when ambulating or mobilizing in the wheelchair, offer snack and fluids, and offer the resident to sit in a wheelchair when he/she is restless or cannot sleep. Interview with Resident #259's daughter on [DATE] at 7:30 PM revealed she visited the resident daily; however, she did not recall being included in the development of the resident's care plan. According to the daughter, Resident #259 attempted to get up from the wheelchair unassisted a lot, especially when the resident was anxious/restless; however, no one did anything to keep the resident from doing that. She also stated Resident #259 had fallen so many times in the facility and, Why would they leave, the resident alone up in a chair at that time of night? The resident's daughter stated she admitted the resident to the facility because the resident was unable to sleep and would stay up for two (2) or three (3) days at a time, and she was unable to care for the resident at home. The daughter stated she informed facility staff of the resident's inability to sleep when the resident was admitted to the facility. Interview with LPN #2 on [DATE] at 9:10 PM revealed she was not sure if Resident #259 had sundowners or what but the resident was very fidgety and didn't sleep much. LPN #2 also stated the resident attempted unsafe transfers from the wheelchair and was unable to be redirected. The LPN stated the only way to keep the resident from falling was to keep your eyes on the resident when he/she was in the wheelchair. The LPN stated no interventions had been implemented to prevent the resident from falling when he/she was up in a wheelchair. Interview with LPN #6 on [DATE] at 11:35 AM revealed Resident #259 attempted unsafe transfers from his/her wheelchair and required redirection. The LPN also stated that was normal for the resident. Per LPN #6, she was not aware of any interventions that had been implemented to prevent Resident #259 from falling when he/she was up in a wheelchair. Interview with Occupational Therapist (OT) #1 on [DATE] at 12:30 PM revealed Resident #259 was confused/restless and would attempt unsafe transfers from the wheelchair. Per the OT, she had observed him/her grab hold of the hand rails in attempts to stand by his/herself while up in the wheelchair. The OT was not aware of any fall interventions that had been implemented related to these identified safety concerns. The OT stated she had not discussed the identified concerns with nursing staff because the

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F 0656 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) resident's attempts to stand happened next to the nurses' station and they were there. Interview with the facility Social Worker (SW) on [DATE] at 1:35 PM revealed the resident's daughter informed her on admission that the resident had trouble sleeping and got his/her days and nights mixed up. Further interview revealed the SW completed sections of the resident's MDS that indicated the resident had no difficulty sleeping. However, she stated she had not spoken with the resident's daughter or any direct care staff during the assessment period, and was unaware that the resident had trouble sleeping since admission to the facility. The SW acknowledged she failed to develop a care plan that addressed the resident's sleep pattern disturbances, stating it should have been addressed. Interview with MDS Nurse #1 on [DATE] at 2:05 PM revealed she assisted in the development of Resident #259's care plan; however, she did not recall speaking to the resident's daughter or direct care staff when Resident #259's care plan was developed. The MDS Nurse further stated she was not aware that Resident #259 attempted unsafe transfers from the wheelchair, or that he/she had trouble sleeping. She stated she had not discussed the resident with direct care staff; however, she stated staff should have informed her of the resident's identified concerns so a care plan could have been developed and interventions implemented that addressed the resident's unsafe transfer attempts from the wheelchair and difficulty sleeping. Interviews with State Registered Nurse Aide (SRNA) #8 on [DATE] at 6:00 PM and SRNA #9 on [DATE] at 6:55 PM revealed they cared for Resident #259 during the 6:30 PM - 6:30 AM shift on ,[DATE]-,[DATE]. They stated they assisted Resident #259 out of bed at approximately 7:15 PM on [DATE] because the resident was trying to get out of bed. According to the SRNAs, the resident remained in the wheelchair for approximately six (6) hours. SRNA #9 stated once the resident was in a wheelchair, he/she was confused, looking for car keys and keys to his/her house, rolling up and down the hallways of the facility, and kept trying to stand up from the wheelchair. SRNA #8 stated the resident attempted to stand from the wheelchair, went up and down the hallways, pulled medication carts around, and was hallucinating (reaching in the air and reaching for the floor, attempting to retrieve objects that were not there), and was fidgety and wiggly. SRNA #8 stated she attempted toileting the resident and gave him/her something to look at, a magazine I think, but stated, no matter what we did he/she would not calm down. The SRNAs stated they reported the resident's behaviors to the nurse and the nurse instructed them to leave the resident where they could see the resident as much as possible. According to the SRNAs, they found the resident on the floor in front of the wheelchair at approximately 1:05 AM on [DATE]. Further review of Resident #259's comprehensive care plan initiated on [DATE] revealed no evidence that staff developed a care plan that addressed the resident's unsafe transfer attempts from the wheelchair, or that he/she leaned forward reaching for objects on the floor in front of the wheelchair. Continued review of the care plan revealed no evidence the facility identified or implemented interventions related to the resident's inability to sleep at times. Interview with Licensed Practical Nurse (LPN) #3 on [DATE] at 7:10 PM revealed staff informed him on [DATE] that Resident #259 had a history of [REDACTED]. He stated he was not aware that the resident was attempting to stand from the wheelchair unassisted, but acknowledged that the resident remained up in a wheelchair for many hours due to unrelieved anxiety, restlessness and couldn't sleep. Continued interview with the LPN revealed no interventions were implemented on ,[DATE]-,[DATE] to address the resident's fall risk. He stated that at approximately 1:05 AM on [DATE] the resident was found on the floor in front of the nurses' station and blood was everywhere. He stated he transferred the resident to a local hospital for further evaluation and treatment. Resident #259's hospital record revealed the resident had a 2 centimeter (cm) laceration to the left forehead that extended to the skull, with small arterial bleed that was bleeding briskly. Further review of the hospital record revealed the resident also sustained an acute-appearing left frontotemporal subdural hemorrhage (brain bleed) and an acute-appearing left parietal, left posterior temporal, and right posterior temporal subarachnoid hemorrhage (brain bleeds in three other areas of the brain). Continued review of the hospital record revealed Resident #259 was transferred to a larger hospital, under the care of the trauma team, on [DATE] at 3:55 AM. According to a Coroner's Report, Resident #259 was pronounced deceased at 6:38 AM on [DATE], and his/her cause of death was a [MEDICAL CONDITION] due to a fall to the floor. Interview with the DON on [DATE] at 12:45 PM revealed she was not aware that Resident #259 attempted unsafe transfers from the wheelchair or that he/she had difficulty sleeping. The DON stated a care plan should have been developed and interventions implemented related to the identified concerns for Resident #259. Interview with Administrator #1 on [DATE] at 2:20 PM revealed she attended the Monday-Friday IDT meetings where falls were discussed daily; however, the only fall for Resident #259 that she recalled discussing was the fall that occurred on [DATE]. The Administrator stated she was not aware that Resident #259 had trouble sleeping or that he/she attempted unsafe transfers while up in the wheelchair. She also stated if staff identified these behaviors, a care plan should have been developed and interventions implemented for the resident's identified concerns. The Administrator also stated that being in a wheelchair for approximately six (6) hours was a long time for a resident to be up in a wheelchair and in hind sight an increased level of supervision would have helped him/her. 2. Review of the medical record revealed Resident #84 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) quarterly assessment, dated [DATE], revealed Resident #84 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident had severe cognitive impairment. The MDS also revealed the resident required extensive assistance of two (2) or more persons for the activity of transfers and the resident was non-ambulatory. Observation of Resident #84 on [DATE] at 3:49 PM, revealed the resident was lying on the left side and the bed was in low position. The resident was lying on a perimeter mattress with eyes closed. Review of a fall investigation dated [DATE] revealed Resident #84 sustained a fall on [DATE] at 2:10 PM when he/she was lowered to the floor by the shower aide, while being transferred from the wheelchair to the shower chair. The report stated the resident suffered no injury. The root cause of the fall was determined to be the resident's weakness and requiring more assistance. The investigation revealed a mechanical lift assessment would be completed. Review of Resident #84's care plan revealed the resident was identified to be at risk for falls on [DATE]. Further review revealed the care plan was revised on [DATE], to include an intervention for the use of a Maxi lift (an electronic, hydraulic lift for transferring persons from one point to another) for transfers. Review of the nurse aide Kardex (care guide for direct care staff), undated, revealed the facility also revised the Kardex to include the requirement for a Maxi lift for transfers. Review of a fall investigation dated [DATE] revealed Resident #84 suffered a fall at 9:10 PM when staff were assisting the resident to bed from the wheelchair. The investigation stated the resident grabbed the wheelchair and would not let go. The staff were not able to convince the resident to let go and had to lower the resident to the floor. The resident suffered no injury as a result of the fall. The investigation revealed the root cause of the fall to be the resident's inability to follow commands and the intervention was education to the staff regarding transfers. The investigation did not address whether staff were utilizing the Maxi Lift during the transfer as required by the resident's care plan. Interview with State Registered Nurse Aide (SRNA) #1 on [DATE] at 1:53 PM revealed at the beginning of each shift, the facility provides a Kardex that defines what level of assistance and support a resident needs to safely perform tasks. Interview with SRNA #2 on [DATE] at 3:48 PM, revealed the Kardex provided the needed information regarding the amount of assistance and support a resident needs. Review of the facility staffing roster, dated [DATE], revealed SRNA #3 and SRNA #17 and Licensed Practical Nurse (LPN) #2 were assigned to the area of the facility where Resident #84 resided on [DATE]. Interview with SRNA #3 on [DATE] at 3:22 PM, revealed she worked on [DATE] and was familiar with Resident #84, but did not recall the resident having any falls or any incidents. Three attempts were made to contact and speak with SRNA #17 but were unsuccessful. The Nurse Consultant stated on [DATE] at 1:28 PM, that the SRNA had left under unpleasant circumstances. Interview with Licensed Practical Nurse (LPN) #2 on [DATE] at 3:52 PM, revealed on [DATE] two SRNAs were attempting to transfer Resident #259, and the resident grabbed onto the wheelchair. The LPN stated the resident did not fall, but was lowered to the floor. She stated she was not aware the resident's care plan had been updated to include a requirement for the extensive assistance of two (2) staff persons and the Maxi lift for transfers. The LPN stated Kardexes are provided to SRNAs at the beginning of their shift and the information regarding how much assistance a resident needs is on the Kardex. Interview with the Director of Nursing on [DATE] at 11:58 AM, revealed the Maxi lift should have been used to transfer Resident #84 on [DATE], as the intervention had been placed on the care plan on [DATE]. ***The facility alleged the following was implemented to remove Immediate Jeopardy effective [DATE]: 1. Resident #259 no longer resides at the facility. 2. By [DATE], the Pharmacist will complete a Medication Regimen Review for current residents, which will include psychoactive medications, to ensure there is a supporting diagnosis, and will review for necessity/indication for the medication. The Pharmacist will also review for psychoactive medications that may be contributing to falls. One hundred eleven (111) residents were reviewed. Recommendations to the Medical Director was made

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F 0656 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) for sixty-three (63) residents, six (6) of which were recommendations for a gradual dose reduction of psychoactive medications. 3. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) assessed current residents for potential side effects from psychoactive medication on [DATE], and ensured resident's Medication Administration Records (MAR) reflected the need to monitor for potential side effects of psychoactive medication. 4. The facility held a meeting on [DATE] to evaluate residents receiving psychoactive medications, residents with new orders for psychoactive medications, residents that had a medication dose adjustment, and any pharmacy recommendations. The IDT (Director of Nursing, Social Service Director, Social Service Assistant, Activity Director, Assistant Director of Nursing, Registered Dietitian/Dietary Service Manager) was in attendance and the Medical Director attended by phone to review appropriate utilization of psychoactive medications, which includes antipsychotic medications, hypnotic medications, antianxiety medications, and mood altering medications to ensure side effects, medication changes, and overall adjustment to psychoactive is achieved. 5. The DON/ADON/Wound Nurse completed Falls Risk Assessments (utilizing the MORSE Fall Scale tool) and Pain Evaluations for current residents on [DATE]. The Nurse Consultant/DON/ADON/ Wound Nurse will also review resident falls for the past 30 days to ensure a root cause analysis has been conducted and appropriate interventions are in place. This will include a review of the care plan to ensure updates have been entered. 6. The Social Service Director, Social Service Assistant, and the Clinical Liaison will interview residents with a BIMS of eight (8) and above to identify residents with concerns related to change of condition, including but not limited to: pain, concerns related to sleep changes, requiring increased help from staff, or concerns related to increased fall risks. The interviews were completed by [DATE] and any concerns identified will be reported to the Director of Nursing (DON) and/or Executive Director immediately and addressed by the appropriate department. 7. The Wound Nurse (LPN) and Clinical Liaison (LPN) will complete resident observations by [DATE] for residents with a BIMS score of seven (7) and below to identify residents with concerns related to change of condition, including but not limited to: pain, concerns related to sleep changes, needing increased help from staff, or concerns related to increased fall risks. Concerns identified will be reported to the DON and/or Executive Director immediately and addressed by the appropriate department. 8. The Human Resource Director, ADON, Medical Records, Registered Dietician, Scheduler, Environmental Service Director, and/or the Director of Rehab will interview current staff related to any knowledge of residents with concerns related to change of condition, including but not limited to: pain, concerns related to sleep changes, needing increased help from staff, or concerns related to increased fall risks. The interviews will be completed by [DATE] and any concerns will be reported to the DON and/or Executive Director immediately and addressed by the appropriate department. 9. The DON/ADON and/or designee will review resident interviews, staff interviews, and resident observations by [DATE] to ensure the physician is notified of any change in condition. The DON/ADON/ MDS nurse will review current resident and staff interviews to ensure that appropriate interventions were placed based on falls root cause analysis. 10. On [DATE], the DON/ADON and/or designee will review fall risk evaluations and pain assessments to determine if a change of condition is indicated and will notify the resident's physician if needed. 11. By [DATE], the MDS Coordinator will review nursing notes for the past 30 days to ensure physician notification and care plan revision to reflect any change, including falls and behaviors. One resident was identified to not have a care plan related to a skin tear; however, the physician had been notified with orders for treatment. 12. By [DATE], the DON and/or the ADON will review the Twenty-Four hour reports to ensure any change in a resident's condition has been addressed appropriately to include physician notification and care plan revision. No concerns were identified. 13. The Nurse Consultant/DON/ADON/SDC/RN Charge Nurse will review care plans on current residents to ensure appropriate documentation related to change in conditions, including but not limited to: pain, concerns related to sleep, changes in behavior, fall interventions, and fall risk. The reviews were completed by [DATE]. Five resident care plans were revised. 14. By [DATE], the Nurse Consultant educated the ED/DON/ADON/SDC on utilizing Stop and Watch forms, a communication form developed by CMS to communicate changes related to change of condition. Education will include giving the completed Stop and Watch to the nurse and making a copy and leaving for the DON/ADON. The DON/ADON will review Stop and Watches and follow up on possible change of condition during the daily clinical meeting and was completed as appropriate. By [DATE], the ED/DON/ADON/SDC will educate current staff regarding utilizing Stop and Watch forms for any change in condition, giving the completed form to the nurse, and making a copy for the DON. 15. The Nurse Consultant educated the ED/DON/ADON/SDC the DON/ADON on [DATE] to review Stop and Watches forms to ensure they were acted upon appropriately to include physician notification for changes in condition, They were also educated to ensure appropriate interventions were implemented for falls based on root cause analysis of the fall, which includes the 5 Why's (a tool approved by CMS for identifying root cause analysis), to assist in determining an appropriate intervention at time of fall. The education also included the need for licensed nurses to submit the 5 Why's form for each fall to DON/ADON for review in clinical meeting. The Nurse Consultant will also re-educated the staff regarding the facility's Falls Management Policy that requires the completion of a Falls Risk Evaluation (utilizing the MORSE fall Scale tool developed for assistance in identifying fall risk residents) after each fall. The SDC/DON/ADON/ED then educated licensed staff by [DATE] regarding the utilization of the 5 Why's tool to determine the root cause of a fall to assist in determining the most appropriate intervention. In addition, current licensed nurses will be educated to notify the on-call Nurse Manager after a fall to review the root cause and the intervention for appropriateness. 16. By [DATE], the ED/DON/ADON/SDC will educate current licensed staff on appropriate documentation including, but not limited to: changes in condition, pain, concerns related to sleep changes, effectiveness of medication, notification of residents' physicians, or needing increased help from staff. 17. By [DATE], the Nurse Consultant will educate the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), and the Wound Care Nurse (LPN) on assuring that residents are assessed for potential medication side effects; to ensure a monitoring order is placed on the MAR indicated [REDACTED]. Education included reviewing residents who was newly admitted /readmitted to ensure the resident had an appropriate [DIAGNOSES REDACTED]. The review will be conducted during the daily clinical meeting and will be followed-up by the Pharmacy Consultant. Any new medication orders will be reviewed by the DON/ADON/SDC for necessity to include appropriate [DIAGNOSES REDACTED]. 18. The Nurse Consultant will educate the DON/ADON/SDC on ensuring pharmacy reviews have occurred monthly and ensuring timely follow up of recommendations per facility policy, which states the recommendations will be received by the DON within 3 days of completion of review. The recommendations will be sent to the physician and the DON will verify the physician and Medical Director has received the review within 3 days. The DON should receive a response from the physician within 7 days. If a response is not received in 7 days, the DON/ADON will notify the physician for acceptance and/or a response to the recommendations that require action. If no response is received in 14 days, the DON/ADON will notify the Medical Director for further action. The DON/ADON will also notify the Executive Director and the Nurse Consultant. This education will occur on [DATE]. The DON, ADON, or Staff Development Coordinator will then will educate current licensed staff by [DATE] on assuring that residents are assessed for potential side effects of medications, ensuring a monitoring order is placed on the MAR indicated [REDACTED]. 19. The Pharmacy Director will re-educate the Registered Pharmacist by [DATE] on accurately completing a Medication Regimen Review, which will include a supporting [DIAGNOSES REDACTED]. The Pharmacist assigned to the facility at the time of the IJ has been removed as the Pharmacy Consultant. The current Pharmacy Consultant has been educated on the concerns related to regimen reviews, appropriate [DIAGNOSES REDACTED]. 20. For all education, a post education test will be administered by the Nurse Consultant/DON/ADON/SDC following education. If a score of 100% is not obtained, re-education will be completed until proficiency is obtained and their score is 100%. Five tests will be administered daily by ED/Assistant Administrator/ DON/ADON/SDC to ensure retention of education, until IJ is removed and approved through QAPI process. Current staff who have not received education by [DATE] will be mailed a certified letter informing them to contact the Executive Director/DON/SDC prior to working the floor. Staffing Agencies currently being utilized will be mailed a certified letter on [DATE] of the need to contact the ED/DON/SDC for education prior to working. The Executive Director/SDC or designee will ensure all newly hired staff and agency staff will receive education during New Hire Orientation or prior to working the floor. 21. The IDT will review in the daily clinical meeting (Monday through Friday) each fall and nursing shift reports to ensure the following is completed for any resident who sustained a fall: Falls Risk evaluation, to include the 5 Why's; physician notification; and care plan revision. In addition, the IDT will review Stop and Watch forms, progress notes, and physician orders to ensure care plans have been updated appropriately and physicians have been notified. 22. The Executive Director/Assistant Administrator/DON will conduct daily post clinical IDT meetings Monday-Friday for two weeks to review all identified Change of Condition and the effectiveness of medication to ensure notification of residents' physician as required. In addition, the Executive Director/Assistant Administrator/DON will review five (5) random resident records to ensure proper documentation has been completed related to any change in condition, physician notification, and the care

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F 0656 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) plans are appropriate. Any issues identified will be corrected immediately and reported to the QAPI Committee for 3 months for further review and recommendations. 23. The facility will conduct weekly monitoring to evaluate psychoactive medication on residents, residents new prescribed psychoactive medications, and residents that have had medication dose adjustment. This psychoactive meeting will be conducted weekly by the facility IDT, (Director of Nursing, Social Service Director, Social Service Assistant, Activity Director, Assistant Director of Nursing, Registered Dietitian or Dietary Service Manager), residents physician, facility medical director, and Pharmacist to review appropriate utilization of psychoactive medications which includes antipsychotic medications, hypnotic medications, antianxiety medications, and mood altering medications to ensure side effects, medication changes and overall adjustment to psychoactive is achieved. 24. Beginning [DATE], the Nursing Consultant/ED/DON/ADON/Assistant Administrator will be on sight at facility to monitor processes related to supervision to prevent accidents, care plan development/revision, and physician notification until IJ is removed and pending QAPI Committee review. Any concerns identified will be addressed immediately and reported to QAPI weekly for review and further recommendations. An AD-HOC QAPI meeting is held at least bi-weekly and as needed to discuss issues with the Medical Director. The IDT team meets daily to discuss findings and progress. 25. Beginning [DATE], The Director of Nursing, Assistant Director of Nursing, or the Staff Development Nurse will review MAR's daily (Monday through Friday), during the Clinical Meeting, for two week
F 0657 **Level of harm -** Actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, it was determined the facility failed to revise the comprehensive care plan for three (3) of thirty-nine (39) sampled residents (Residents #35, #24, and #84). Resident #35 had a history of [REDACTED]. The facility investigated the fall and determined the resident required a supervised area when up in a wheelchair. However, the facility failed to revise Resident #35's care plan and include the resident's need for supervision. The resident sustained [REDACTED]. Resident #24 sustained two (2) unwitnessed falls at 12:30 AM and 4:33 AM, and was found to have been incontinent of urine with each fall. The facility failed to consider that the need for toileting may have been the cause of the falls and failed to implement interventions to address toileting needs/incontinence, particularly at night. In addition, the facility failed to revise Resident #84's care plan to address the resident's election for Hospice care. The findings include: Review of the facility policy, Comprehensive Care Plan, dated 01/13/2018, revealed a comprehensive care plan will be developed for each resident within twenty-one (21) days and no more than seven (7) days after the completion of the comprehensive MDS assessment. The policy further stated the Care Planning/Interdisciplinary Team was responsible for the review and updating of care plans when there has been a significant change in the resident's condition, when the desired outcome is not met, etc. 1. A review of Resident #35's medical record revealed the facility admitted the resident on 04/06/2019 with [DIAGNOSES REDACTED]. A review of the most recent quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #35 was severely impaired for cognition, utilized a wheelchair for mobility, and required the extensive assistance of two staff members for transfers. A review of the plan of care developed for Resident #35 dated 04/01/2019 revealed Resident #35 was at risk from falls due to balance problems and weakness. Per the care plan, the resident had a history of [REDACTED]. Resident #35 was in the hospital during the survey and was not observed. A review of fall investigations for Resident #35 revealed on 10/13/2019 at 6:02 AM, the resident sustained [REDACTED]. Resident #35 was transferred to the hospital for evaluation and treatment. A review of the fall investigation revealed no evidence of a root cause analysis conducted to identify the reason for Resident #35's fall. The facility's plan to prevent further falls was for Resident #35 to be in a supervised area when up in the wheelchair. However, a review of the resident's plan of care revealed this intervention was not added to the plan of care. Continued review of Resident #35's medical record/fall investigations revealed the resident sustained [REDACTED]. Review of a fall investigation dated 02/13/2020 for Resident #35 revealed the resident sustained [REDACTED]. Resident #35 was sitting in a wheelchair in the doorway of his/her room. Resident #35 attempted to stand, fell , and landed on the right side before staff could intervene. Resident #35 complained of right hip pain, was transferred to the hospital, and diagnosed with [REDACTED]. Interview with Registered Nurse (RN) #2 on 02/18/2020 at 4:30 PM revealed the RN had witnessed Resident #35 fall on 02/13/2020. The RN stated she was in the hallway with her medication cart administering resident medications. The RN stated the resident was in a wheelchair, attempted to stand, and fell before she could get to the resident. According to RN #2, she assessed the resident after the fall. The resident complained of right hip pain. She stated she transferred the resident to the hospital where he/she was diagnosed with [REDACTED]. RN #2 stated she could not remember what the resident was doing prior to the fall, but stated that the resident had dementia and a history of falls, and often tried to get up unassisted. Interview with the Director of Nursing (DON) on 03/04/2020 at 3:18 PM revealed the DON was the Minimum Data Set (MDS) Nurse in October 2019 when Resident #35 sustained a fall and was responsible for revising the resident's plan of care. According to the DON, she was unaware why the intervention for the resident to be in a supervised area when up in the wheelchair was not added to the plan of care. 2. A review of the medical record for Resident #24 revealed the facility admitted the resident on 06/12/2019 with [DIAGNOSES REDACTED]. A review of the most recent significant change MDS assessment completed for Resident #24 dated 02/06/2020 revealed the resident had severely impaired cognition with a BIMS score of two (2), and was assessed to require the extensive assistance of two staff members for transfers. In addition, the resident was assessed to be a fall risk with a history of falls. A review of the plan of care initiated on 07/05/2019 revealed Resident #24 was at risk for falls with interventions to have a call light in his/her room, educate the resident to call for assistance before transferring, encourage non-skid foot wear, give [MEDICAL CONDITION] medication as ordered, and to keep the environment well lit and free of clutter. A review of a fall investigation completed for Resident #24 revealed the resident had sustained a fall on 11/30/2019 at 4:33 AM. The resident was found sitting on the floor beside the bed and had an incontinence episode. Further review of fall investigations revealed the resident sustained [REDACTED]. The resident was observed lying on the floor by his/her bed and the resident was incontinent. A review of the root cause analysis revealed the cause of the fall was weakness, impaired safety awareness. According to the investigation, the intervention implemented was to move the resident closer to the nurses' station. There was no evidence the facility considered that the resident might have been attempting to toilet when he/she fell and developed care plan interventions to address toileting needs at night. Observations on 02/16/2020 at 9:30 AM, 2:35 PM, and 3:21 PM, and on 02/17/2020 at 10:45 AM revealed the resident had a low bed with an air mattress and fall mats to the floor. Interview with Licensed Practical Nurse (LPN) #12 on 03/05/2020 at 1:45 PM revealed the LPN could not remember the resident falling on 11/30/2019 and 12/01/2019, and was unsure why she did not consider the resident's incontinence or consider including interventions for the resident to be checked and changed more often to possibly prevent further falls. Interview with the Minimum Data Set (MDS) Nurse on 02/21/2020 at 11:17 AM revealed after a resident sustained [REDACTED]. She stated the facility tried to develop interventions to prevent further falls, but was not aware why toileting or checking and changing the resident was not considered as possible interventions for Resident #24 to prevent further falls. 3. Observation of Resident #84 on 02/17/2020 at 3:49 PM, revealed the resident was lying on his/her left side in bed with his/her eyes closed. Review of the medical record revealed Resident #84 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #84's quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident had severe cognitive impairment. Continued review revealed an incomplete significant change assessment dated [DATE]. Continued review of Resident #84's medical record revealed the resident elected for Hospice care on 01/28/2020. Continued review revealed an incomplete significant change assessment dated [DATE]. Subsequently, review of the comprehensive care plan for Resident #84 revealed no evidence that the resident was receiving Hospice care. Interview with the MDS Coordinator on 02/19/2020 at 3:49 PM, revealed she had been in the position since 01/20/2020, and had prior MDS experience. The Coordinator stated she had calculated that Resident #84's care plan should have been completed by 03/03/2020. However, upon review of the date of Hospice election, 01/28/2020, she agreed the significant change comprehensive assessment should have been completed by 02/11/2020 and the care plan updated by 02/18/2020.
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy it was determined the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for five (5) of thirty-nine (39) sampled residents (Residents #259, #35, #24, #84, and #60). Interviews with staff and Resident #259's daughter revealed the resident had [MEDICAL CONDITION] and attempted unsafe transfers from the wheelchair. However, the facility failed to develop care plan interventions to address the resident's behavior. On [DATE] at 7:15 PM, staff assisted Resident #259 out of bed to a wheelchair because the resident was restless and attempting to get out of bed unassisted. While up in the wheelchair, Resident #259 was also observed leaning forward, attempting to stand, and hallucinating (reaching into the air and leaning forward to touch the floor for objects that were not there). However, the facility failed to develop/implement interventions to prevent falls from the wheelchair and failed to administer as needed medication to help the resident rest/sleep. At 1:05 AM on [DATE], after the resident had been in the wheelchair for approximately six (6) hours, Resident #259 was found on the floor, lying on his/her left side in the hallway of the facility, bleeding from the head. The resident was transferred to a local hospital on [DATE] and was diagnosed with [REDACTED]. Review of a Coroner's Report revealed Resident #259 was pronounced deceased at 6:38 AM on [DATE], and his/her cause of death was a [MEDICAL CONDITION] due to a fall to the floor. Resident #35 sustained a fall on [DATE], and the facility documented that the resident would be supervised when up in a wheelchair; however, the facility failed to add the intervention to the resident's care plan and the intervention was never implemented. Subsequently, Resident #35 continued attempts to get up from his/her wheelchair unassisted and sustained six (6) more falls. However, the facility failed to implement interventions addressing the resident's attempts to get out of the wheelchair unassisted. On [DATE] at 6:00 PM, Resident #35 attempted to stand from his/her wheelchair and fell . The resident was transferred to the hospital due to right hip pain and was diagnosed with [REDACTED].#24 was found on the floor by the bed, incontinent of urine. The facility investigated the falls and determined the cause of the falls was weakness/not calling for assistance/impaired safety awareness. The facility failed to consider that the need for toileting might have been the cause of the falls and failed to implement interventions to address toileting needs/incontinence. On [DATE], the facility failed to utilize a mechanical lift when transferring Resident #84 as required by the resident's care plan. Staff had to lower the resident to the floor. The facility investigated the resident's fall, but failed to identify that the cause of the fall was the failure to follow the resident's care plan. Resident #60 was admitted to the facility on [DATE] after a fall at home that resulted in a Retropharyngeal (throat area) hematoma, Right Traumatic Subdural Hematoma (brain bleed), and a Compression [MEDICAL CONDITION] spine. The resident sustained [REDACTED]. Interviews with staff revealed the only way to keep the resident safe and prevent falls was to provide one-on-one supervision for the resident; however, the facility failed to implement increased supervision to prevent the resident from falling. The facility's failure to ensure each resident received adequate supervision and assistive devices to prevent accidents has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE] at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656), 42 CFR 483.25 Quality of Care (F689), and 42 CFR 483.45 Pharmacy Services (F756). The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Allegation of Compliance was received on [DATE], which alleged removal of the Immediate Jeopardy on [DATE]. The State Survey Agency determined the Immediate Jeopardy was removed as alleged on [DATE] prior to exit on [DATE], which lowered the scope and severity to D level at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656), 42 CFR 483.25 Quality of Care (F689), and 42 CFR 483.45 Pharmacy Services (F756) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility policy titled Fall Management, dated [DATE], revealed a fall was an unintentional change in position coming to rest on the ground, floor, or onto the next lower surface, which included onto a bed, chair, or bedside mat. The policy stated injury related to a fall was any documented injury that occurred as a result of, or was recognized within a short period of time (hours or to a few days) after the fall and attributed to the fall. According to the policy, a major injury included bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematomas. Review of the policy also revealed a fall risk observation was completed on admission, quarterly, annually, with any significant change in condition, and with any fall, and was utilized to identify individuals who were at high risk for falls, as well as those individuals who have any risk factors for falls. Further review of the policy revealed fall prevention was achieved through an interdisciplinary approach of managing risk factors and implementing appropriate interventions to reduce risk for falls. The policy directed staff to develop a plan of care, which included general and specific interventions to reduce fall risk. The policy also directed staff to investigate falls and complete a root cause analysis and determine an intervention based on that information. The policy also stated the investigation and root cause analysis of a fall may include medications that place a resident at risk for falls, [MEDICATION NAME]/extrinsic fall risk factors, time of day, and devices used at the time of the fall. 1. Review of Resident #259's record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #259's admission Minimum Data Set Assessment ((MDS) dated [DATE] revealed he/she had no signs of difficulty sleeping and had not exhibited behaviors during the assessment period. The assessment also indicated the resident required extensive assistance of two (2) staff members for bed mobility, transfers, and toileting. The MDS also indicated Resident #259 had experienced one (1) fall since admission, with no injury, and was interviewable with a Brief Interview for Mental Status (BIMS) score of nine (9). Review of Resident #259's comprehensive care plan initiated [DATE] revealed staff identified that the resident was at risk for falls. Interventions implemented since admission included to anticipate and meet the resident's needs, place the resident's bed against the wall per resident/family preference, non-slip footwear when ambulating or mobilizing in the wheelchair, offer snack and fluids, and offer the resident to sit in a wheelchair when he/she was restless or could not sleep. Review of Resident #259's physician orders for [DATE] revealed staff were directed to administer [MEDICATION NAME] 5 mg, every twelve (12) hours as needed for sleep. Review of Resident #259's Incident Reports and Nurse's Notes revealed the resident sustained [REDACTED]. On each occasion, staff found the resident on the floor by his/her bed. On [DATE], staff observed the resident's call light on, and found the resident on his/her knees by the bed. The nurse's notes also revealed staff asked the resident why he/she was getting out of bed and the resident stated he/she did not know. Continued review of Resident #259's nurse's notes revealed on [DATE] the resident hit the back of his/her head, reddened discoloration to the resident's forehead, redness to the left hip, and a skin tear to his/her left arm. According to the incident report for Resident #259's fall on [DATE], the resident was attempting to get up unassisted to go to the bathroom. Further review of Resident #259's nurse's notes revealed on [DATE], Resident #259 was hollering out and staff found the resident lying on the floor again, in front of his/her bed. Interview with the DON on [DATE] at 12:15 PM revealed the IDT discussed Resident #259's falls and determined the root cause of each fall was Impaired Safety Awareness. The DON stated that after the fall on [DATE], interventions were implemented to assist the resident to a chair when he/she was restless or can't sleep and to offer snacks and fluids to the resident. According to the DON, after the fall on [DATE], the IDT determined that the resident was attempting to get up unassisted and was falling off of the right side of his/her bed. According to the DON, the left side of the bed was placed against the wall and non-skid strips were placed on the floor on the right side of the bed. Further interview with the DON revealed that after the resident fell on [DATE], the facility implemented a toileting program for the resident. Interview with Licensed Practical Nurse (LPN) #4 on [DATE] at 9:00 PM revealed she cared for Resident #259 and was aware the resident had trouble sleeping and was anxious at times. The LPN stated, You could hear the resident yelling from the hallway if the resident was in bed. Interview with LPN #2 on [DATE] at 9:10 PM revealed she cared for Resident #259 and the resident was very fidgety and didn't sleep much. The LPN stated she was not sure if the resident had sundowners or what but the resident frequently attempted to get out of bed unassisted. She stated staff assisted the resident to a wheelchair when he/she was attempting unsafe transfers from the bed. However, according to LPN #2, the resident also attempted unsafe transfers from the wheelchair and was unable to be redirected. LPN #2 stated the only way to keep the resident from falling was to keep your eyes on the resident when he/she was in the wheelchair. Interview with LPN #6 on [DATE] at 11:35 AM revealed for Resident #259 it was normal for the resident to attempt unsafe transfers from his/her wheelchair and required redirection. LPN #6 stated she was not aware of any interventions that had been implemented to prevent Resident #259 from falling when he/she was up in a wheelchair. Review of a list of residents' BIMS scores, provided by the facility, revealed Resident #56, Resident #259's former roommate, was interviewable with a BIMS score of eleven (11). Interview with Resident #56 on [DATE] at 1:50 PM revealed he/she was Resident #259's roommate

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) when he/she resided in the facility. Resident #56 stated Resident #259 didn't sleep much at all. The resident also stated Resident #259 would sleep two hours at a time if he/she slept that much. Interview with Resident #259's daughter on [DATE] at 7:30 PM revealed she visited the resident daily at the facility. She stated she had to admit the resident because he/she would stay up for two (2) or three (3) days at a time and she was no longer able to care for the resident at home. She also stated she informed staff of the resident's inability to sleep when the resident was admitted to the facility. Further review of Resident #259's care plan provided no evidence that staff developed a care plan or implemented interventions that addressed the resident's unsafe transfer attempts from the wheelchair or to address the resident's [MEDICAL CONDITION]. In addition, there was no evidence the facility identified that the care plan intervention to assist the resident to a chair when he/she was restless or can't sleep was not effective, or considered that the intervention placed the resident at increased risk for falls. Interview with State Registered Nurse Aide (SRNA) #8 on [DATE] at 6:00 PM revealed she frequently cared for Resident #259 and was assigned to care for him/her during the 6:30 PM to 6:30 AM shift on ,[DATE]-,[DATE]. The SRNA stated Resident #259 was attempting to get out of bed unassisted on [DATE] at approximately 7:15 PM and she and another SRNA assisted the resident out of bed, the resident used the restroom, and the staff assisted the resident to a wheelchair. SRNA #8 stated staff had been directed to get the resident up to a wheelchair when the resident attempted to get out of bed unassisted. The SRNA stated the resident was very confused, wild, and wiggly more than normal on [DATE]. According to the SRNA, while up in the wheelchair, Resident #259 was observed going up and down the hallways, pulled med (medication) carts around, and was attempting to stand without assistance from his/her wheelchair. She also stated the resident was hallucinating, reaching in the air for things that were not there, and bending forward to the floor in front of his/her wheelchair. The SRNA stated she reported to the nurse (LPN #3) that the resident was having a bad night and reported the ongoing behaviors the resident was exhibiting. According to SRNA #8, the nurse instructed her to leave the resident where staff could see him/her as much as possible. SRNA #8 stated she attempted toileting the resident and gave the resident something to look at, a magazine I think; however, she stated, no matter what we did the resident would not calm down. SRNA #8 stated the nurse had left the unit to get something to drink, and the medication aide and the other SRNA were in another room providing care to another resident. She stated she was charting in a small room over from the nurses' station and observed the resident in his/her wheelchair, wiggly and fidgety, at approximately 1:02 AM on [DATE]. The SRNA stated she looked out of the room to check on the resident again and observed the resident lying on the floor, in front of his/her wheelchair, at approximately 1:05 AM on [DATE]. Interview with Kentucky Medication Aide (KMA) #1 on [DATE] at 6:15 PM revealed she administered Resident #259's medications on [DATE] at 9:00 PM. She stated she thought the resident's 9:00 PM medications would help relax the resident; however, he/she was still fidgety. The KMA stated Resident #259 was up in his/her wheelchair and would not relax enough to go to sleep. She stated the resident was observed leaning forward in his/her wheelchair, reaching toward the floor in front of his/her chair, and hallucinating, attempting to pick things up that were not there. KMA #1 also stated the resident kept trying to move the medication cart, and tried to stand up unassisted from the wheelchair a few times during the shift. KMA #1 stated she did not administer [MEDICATION NAME] to the resident because she was not aware that it was ordered by the resident's physician. Interview with SRNA #9 on [DATE] at 6:55 PM revealed she assisted SRNA #8 with getting Resident #259 out of bed on [DATE] because the resident kept trying to climb out of the bed. The SRNA stated the resident was confused, hallucinating, looking for car keys and keys to his/her house, rolling up and down the hallways of the facility, and kept trying to stand up from the wheelchair. The SRNA stated she reported the resident's behaviors to the nurse and was instructed to keep the resident at the nurses' station. The SRNA stated she had been in another resident room providing care and when she came out, Resident #259 was on the floor, in front of his/her wheelchair at the nurses' station. SRNA #9 stated, Blood was coming nonstop out of the resident's head. Continued review of Resident #259's care plan revealed no evidence that interventions were developed/implemented to address the resident bending forward/reaching toward the floor while in his/her wheelchair, or the attempts to get up unassisted. Review of the resident's Medication Administration Record [REDACTED]. According to the MAR, staff had only administered the medication on one occasion, [DATE]. Interview with LPN #3 on [DATE] at 7:10 PM revealed when he arrived at the unit where Resident #259 resided on [DATE] at approximately 7:30 PM, the resident was up in a wheelchair. The LPN stated he was assigned to care for the resident for the remainder of the shift, which ended at 6:30 AM on [DATE]. The LPN stated the nurse aide that was most familiar with the resident informed him that Resident #259 had a bunch of falls and was more confused than normal. He stated the resident was disoriented, saying off the wall stuff, and was yelling out for people that wasn't there. LPN #3 stated staff had not reported to him that the resident was attempting to stand up from his/her wheelchair unassisted, but stated he was aware the resident remained up in a wheelchair for many hours due to confusion, disorientation, unrelieved anxiety and restlessness, and couldn't sleep. However, LPN #3 was unaware the resident had [MEDICATION NAME] ordered as needed for sleep. LPN #3 stated he left the unit to get something to drink and when he returned at approximately 1:05 AM on [DATE], Resident #259 was on the floor in front of the nurses' station and blood was everywhere. He stated he transferred the resident to a local hospital for further evaluation and treatment. Review of Resident #259's nurse's notes revealed LPN #3 documented that on [DATE] at 1:05 AM staff observed the resident lying on the floor on his/her left side, in the hallway in front of the nurses' station/dining room of the facility. The nurse's notes also revealed the resident had a large hematoma to the left temporal area and copious amount of bleeding also present from area. The nurse's notes indicated staff was unable to determine exact origin of bleed. According to the nurse's notes, staff contacted Emergency Medical Services (EMS) and applied a pressure dressing to the resident's left temporal area. Resident #259 was transferred to the local hospital for further evaluation and treatment, and was alert and stable when he/she left the facility. Continued interview with Resident #259's daughter on [DATE] at 7:30 PM revealed she was aware that the resident attempted to get up from the wheelchair unassisted a lot, especially when the resident was anxious/restless. The daughter stated, however, no one did anything to keep him/her from doing that. She also stated Resident #259 had fallen so many times in the facility that she could not understand why would they leave, him/her alone up in a chair at that time of night? Interview with Administrator #1 on [DATE] at 2:20 PM revealed she attended morning meetings Monday through Friday, and was a member of the IDT in the facility. She stated falls were discussed daily during the morning meetings; however, the only fall for Resident #259 that she recalled discussing was the one that occurred on [DATE]. She also stated she was not aware that Resident #259 had trouble sleeping or that he/she attempted unsafe transfers while up in a wheelchair. The Administrator also stated if staff identified that the resident had trouble sleeping, and the resident had medication ordered for sleep as needed, she would expect staff to administer and monitor the effectiveness of the medication. She also stated staff should have implemented fall interventions due to his/her unsafe transfer attempts from the wheelchair. The Administrator stated that approximately six (6) hours was a long time for a resident to be up in a wheelchair exhibiting restlessness and agitation. She stated in hind sight an increased level of supervision would have helped the resident. Review of Resident #259's hospital record revealed he/she was triaged at a local hospital on [DATE] at 1:50 AM with a stated complaint of a [MEDICAL CONDITION] to the left temporal area. Review of the resident's ED General Exam dictated by the emergency room (ER) Physician at 2:42 AM on [DATE] revealed the resident was sitting in his/her wheelchair when he/she leaned forward and fell out and hit his/her head on the floor. Review of the physician documentation also revealed the resident had a 2-centimeter (cm) laceration to the left forehead, that went to the skull, with a small arterial bleed noted that was bleeding briskly. The physician further documented that the arterial bleed was cauterized and three (3) sutures were placed to close the wound. Continued review of Resident #258's hospital record revealed a Preliminary Radiology Report for a CT scan dated [DATE] at 2:45 AM indicated Resident #1 had an acute-appearing left frontotemporal subdural hemorrhage, largest component along the left temporal lobe measuring approximately 9 millimeters (mm) in maximal thickness. Further review of the report revealed the resident also had an acute-appearing left parietal, left posterior temporal, and right posterior temporal subarachnoid hemorrhage. Continued review of the hospital record revealed Resident #259 was transferred to a larger hospital, under the care of the trauma team on [DATE] at 3:55 AM. The record also indicated the resident was alert and was able to obey commands when he/she was transferred. Review of a Coroner's Report revealed Resident #259 was pronounced deceased at 6:38 AM on [DATE]. The cause of death was a [MEDICAL CONDITION] due to a fall to the floor. 2. A review of the medical record for Resident #35 revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. A review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was severely impaired for cognition, utilized a wheelchair for mobility, and required the extensive assistance of two staff persons for transfers. A review of the plan of care developed for Resident #35 dated [DATE] revealed Resident #35 was at

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 10) risk for falls due to balance problems, weakness, and a history of falling. The care plan included fall interventions for a low bed, contour mattress, bolsters (elongated pillows), and mattress on the floor by the bed. A review of fall investigations for Resident #35 revealed on [DATE] at 6:02 AM Resident #35 sustained a fall with injury. The resident was found lying on the floor in the resident's room by the bed with a laceration noted to right side of his/her forehead/hairline. The resident had previously been up in the wheelchair. The resident was transferred to the hospital for evaluation and treatment. Continued review of the fall investigation for Resident #35 revealed no evidence of a root cause analysis conducted to identify the reason Resident #35 was falling. According to the investigation, an intervention was implemented on [DATE] for Resident #35 to be in a supervised area when up in the wheelchair. However, the facility failed to add this intervention to the resident's plan of care. Further review of fall investigations for Resident #35 revealed the resident continued to sustain falls without injury on the following dates: On [DATE] at 8:30 AM, the resident was found sitting on his/her buttocks on the mattress at the side of the bed; on [DATE] at 7:29 PM, Resident #35 attempted to get out of a chair (unclear what type of chair) to get into bed and slid to the floor; on [DATE] at 3:12 AM Resident #35 was found sitting on a mat beside the bed; on [DATE] at 6:00 PM, the resident was observed on his/her knees on the floor in his/her room; on [DATE] at 10:00 AM Resident #35 was observed sitting on his/her buttocks on the floor in the hallway (unclear if this fall was from the wheelchair); on [DATE] at 12:30 PM, the resident was observed sitting on his/her buttocks on a mat in his/her room. Interview conducted on [DATE] at 2:25 PM with SRNA #13 revealed if Resident #35 was in a wheelchair he/she would pull up to the hand rails and attempt to ambulate unassisted in the hallway. According to SRNA #13, staff had to keep an eye on the resident as the resident was unable to ambulate unassisted. Interview with SRNA #8 on [DATE] at 7:20 PM revealed Resident #35 is extremely confused and forgets he/she cannot stand. Further interview revealed if Resident #35 gets to a handrail when in his/her wheelchair, the resident pulls himself/herself up and tries to ambulate. Interview with SRNA #15 on [DATE] at 1:04 PM revealed Resident #35 was a fall risk and would try to get out of bed unassisted. According to the SRNA, once the resident was up in a wheelchair staff had to constantly watch the resident due to the resident attempting to pull himself/herself up using the handrails. The SRNA stated the resident would stand up and try to walk but the resident was unable to walk unassisted. Interview with LPN #9 on [DATE] at 10:50 AM revealed Resident #35 was confused and attempted to get up unassisted. Per the LPN, the resident was not physically able to ambulate unassisted and had a history of [REDACTED].#11 on [DATE] at 11:12 AM, revealed Resident #35 attempted to get up unassisted and had a history of [REDACTED].#10 on [DATE] at 1:41 PM revealed the LPN had taken care of Resident #35 and the resident attempted to get up unassisted. According to the LPN, the resident cannot stand on his/her own. Further review of the care plan revealed that although the resident had continued to experience falls in the facility and attempted to get up from his/her wheelchair unassisted, the facility failed to implement interventions addressing the resident's attempts to get out of the wheelchair unassisted. Further, there was no evidence the intervention of supervision while up in the wheelchair was added to the care plan even after the repeated falls mentioned above. Additional review of fall investigations for Resident #35 revealed the resident sustained [REDACTED]. Resident #35 was sitting in a wheelchair in the doorway of his/her room. Resident #35 attempted to stand, sustained a fall, and landed on the right side before staff could intervene. Resident #35 complained of right hip pain, was transferred to the hospital, and diagnosed with [REDACTED]. The resident was in the hospital at the time of the survey and had not returned to the facility. Interview with RN #2 on [DATE] at 4:30 PM revealed the RN had witnessed Resident #35 fall on [DATE]. The RN stated she was in the hallway with her medication cart administering resident medications. The RN stated the resident was in a wheelchair, attempted to stand, and fell before she could get to the resident. According to RN #2, she assessed the resident after the fall. The resident complained of right hip pain, was transferred to the hospital, was diagnosed with [REDACTED]. RN #2 stated she could not remember what the resident was doing prior to the fall, but the resident often tried to get up unassisted and had dementia. Interview with the Director of Nursing (DON) on [DATE] at 3:18 PM revealed the DON was the Minimum Data Set (MDS) Nurse in [DATE] when Resident #35 sustained a fall and was responsible for revising the resident's plan of care and was not aware why the intervention (to supervise when up in the wheelchair) was not added to the plan of care. 3. A review of the medical record for Resident #24 revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. A review of the most recent significant change MDS assessment completed for Resident #24 dated [DATE] revealed the resident had severely impaired cognition with a BIMS score of two (2) and was assessed to require the extensive assistance of two staff persons for transfers. In addition, the resident was assessed to be at risk for falls with a history of falls. A review of the plan of care initiated on [DATE] revealed Resident #24 was at risk for falls with interventions implemented to have a call light in his/her room, educate the resident to call for assistance before transferring, encourage nonskid footwear, give [MEDICAL CONDITION] medication as ordered, and to keep the environment well lit and free of clutter. Review of the fall investigations for Resident #24 revealed the resident had sustained a fall on [DATE] at 12:41 AM. The resident was found on the floor beside the bed, confused, calling for family. On [DATE] at 4:33 AM, Resident #24 sustained a fall and was found on the floor beside the bed. Per the fall investigation, the resident had been incontinent. Further review of fall investigations revealed the resident sustained [REDACTED]. The resident was found lying on the floor in his/her room by the bed. The resident stated he/she was getting out of bed. Again, the fall investigation stated the resident had been incontinent. There was no documented evidence that the facility completed a fall risk assessment as required by their policy. In addition, even though the investigations revealed the resident was incontinent with each fall, the facility documented that the root cause of the falls was weakness did not call for assist and weakness, impaired safety awareness, and there was no evidence interventions were implemented to address the resident's incontinence. Observations on [DATE] at 9:30 AM, 2:35 PM, and 3:21 PM, and on [DATE] at 10:45 AM revealed the resident had a low bed with an air mattress and fall mats on the floor. Interview with SRNA #8 on [DATE] at 7:20 PM revealed the SRNA was not sure what interventions were in place for the resident to prevent falls other than a low bed and fall mats. Interview with LPN #10 on [DATE] at 1:41 PM revealed Resident #24 could not ambulate and was at risk for falls. According to the LPN, at some point the resident's room was changed to be closer to the nurses' station to increase the resident's supervision. However, the LPN was not aware how the facility decided what interventions to implement when a resident sustained [REDACTED].#12 on [DATE] at 1:45 PM revealed the LPN could not remember the resident falling on [DATE] and [DATE], but would have assessed the resident and notified the physician and family of any changes and sent the resident to the hospital. The LPN was not aware why she did not consider the resident's incontinence or interventions for the resident to be checked and changed more often to possibly prevent falls. Interview with the MDS Nurse on [DATE] at 11:17 AM revealed she was unsure of the policy for completing fall risk assessments on residents. According to the MDS Nurse, the care plan was reviewed and revised the next day after a resident fall during the morning meeting and new interventions were developed to try to prevent further falls. The MDS Nurse stated she was not aware why toileting or checking and changing was not considered as possible interventions for Resident #24 to prevent further falls. 4. Observation of Resident #84 on [DATE] at 3:49 PM, revealed the res
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, it was determined the facility failed to ensure one (1) of thirty-nine (39) sampled residents (Resident #83) received respiratory care consistent with professional standards of practice and the comprehensive care plan. Resident #83 was observed on 02/16/2020, 02/17/2020, and 02/18/2020, to have his/her oxygen concentrator set on one and one-half (1.5) liters per minute (LPM). Review of the physician orders revealed an order dated 12/15/2019 for oxygen to be delivered via nasal cannula at two (2) LPM. The findings include: Review of the facility policy, Oxygen Administration, dated 11/04/2016, revealed oxygen should be monitored to ensure the proper flow rate setting and to assure oxygen flow from cannula or mask per physician order. Observation of Resident #83 on 02/16/2020 at approximately 10:00 AM, revealed the resident was lying in bed, receiving oxygen via nasal cannula. Observation of the oxygen concentrator revealed the setting was at 1.5 LPM. Further observation on 02/17/2020 at 8:39 AM and 02/18/2020 at 8:33 AM, revealed the oxygen concentrator continued to be set at 1.5 LPM. Review of the medical record revealed Resident #83 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) quarterly assessment, dated 01/21/2020, revealed a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated the resident had moderate cognitive impairment. The MDS further revealed the resident was on oxygen therapy. Review of the physician orders for Resident #83 revealed an order dated 12/15/2019, which stated the resident was to receive oxygen at two (2) LPM via nasal cannula for shortness of air. Review of the care plan for Resident #83 dated

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 11) 05/29/2018, revealed the facility identified that the resident had shortness of air related to [MEDICAL CONDITION], and included the intervention to administer Oxygen at two (2) LPM per nasal cannula. Review of the Treatment Administration Record (TAR), dated February 2020, revealed staff were required to check the resident's oxygen saturation every four (4) hours. Review of the TAR further revealed on 02/16/2020, 02/17/2020, and 02/18/2020, staff initialed that the task was completed every four (4) hours (8:00 AM, 12:00 PM, 4:00 PM, 8:00 PM, 12:00 AM, and 4:00 AM). Interview with Licensed Practical Nurse (LPN) #1 on 02/18/2020 at 9:00 AM, confirmed that Resident #83's oxygen concentrator was set below the two (2) LPM as ordered. She further stated she checked the oxygen setting every four (4) hours and performed oxygen saturation readings as ordered. She also stated that at times the concentrator gets bumped, which can change the settings. Interview with Assistant Director of Nursing (ADON) #1 on 02/21/2020 at 9:44 AM, and the Director of Nursing (DON) on 02/21/2020 at 12:11 PM, revealed when Nursing signed the TAR for oxygen saturation, they should also assure the oxygen was being delivered as ordered. The ADON further stated that Resident #83's oxygen concentrator should have been set at two (2) LPM.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to provide sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being for residents. Interviews with three (3) residents (Resident #87, Resident #56, and Resident #1) and six (6) staff members revealed residents often have to wait extended periods of time to have their basic care needs met and at times staff were unable to meet the needs of residents. Interviews with staff members revealed they often worked short and due to the lack of staffing were unable to always meet the needs of the residents. The findings include: Interview on 02/21/2020 at 11:00 AM with the Administrator revealed the facility did not have a staffing policy regarding the number of staff required for the facility. 1. Review of Resident #87's medical record revealed the facility admitted the resident on 09/14/2015 with [DIAGNOSES REDACTED]. Review of Resident #87's Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Further review of the MDS revealed the resident required extensive assistance of one (1) staff member for transfer and toileting. The facility also assessed the resident to be always incontinent of bladder and occasionally incontinent of bowel. Interview with Resident #87 on 02/16/2020 at 2:32 PM, revealed the resident was alert and answered questions appropriately. Resident #87 stated the facility needed more help, and that last night I ringed my call light for someone to help me go to the bathroom and they didn't get here till I used the bathroom on myself. 2. Review of the medical record for Resident #56 revealed the facility admitted the resident on 12/31/2019, with [DIAGNOSES REDACTED].#56's Admission MDS dated [DATE] revealed the resident was interviewable with a BIMS score of eleven (11) and required the assistance of two (2) staff members for transfers and toileting. The MDS also indicated Resident #56 was always incontinent of urine and frequently incontinent of bowel. Interview with Resident #56 on 02/11/2020 at 1:50 PM, revealed the resident often waited thirty minutes or longer for staff to answer the call light. The resident also stated staff told him/her that staff had called in, and they were working short when he/she would voice complaints about how long it took to receive assistance. 3. Review of the medical record for Resident #1 revealed the facility admitted the resident on 02/03/2020, with [DIAGNOSES REDACTED]. Review of Resident #1's MDS dated [DATE] revealed he/she was interviewable with a BIMS score of twelve (12) and required extensive assistance of two (2) staff members with toileting and bed mobility. The MDS also indicated Resident #1 was frequently incontinent of bowel/bladder. Interview with Resident #1 on 2/10/2020 at 11:35 AM revealed he/she often waited thirty minutes or longer for his/her call light to be answered. Interviews with State Registered Nurse Aide (SRNA) #11 on 02/10/2020 at 1:50 PM and on 02/19/2020 at 11:19 AM, revealed the facility was frequently short staffed, and residents often complained about call light wait times. The SRNA stated if a nursing assistant called in, there would be no one to cover the shift, and we have to work with two of us. SRNA #11 stated because the majority of the residents required the assistance of two staff members, it was impossible to meet the residents' needs timely, and they had to wait extended periods of time. Interviews with SRNA #8 on 02/18/2020 at 8:52 PM and 02/19/2020 at 7:10 PM revealed the SRNA stated, I do the best I can, but there is just not enough of us to go around. SRNA #8 stated usually there were two (2) nursing assistants to take care of twenty-nine (29) residents and most of the residents required total care. The SRNA stated she was not able to take care of the residents and meet all their needs when only two (2) SRNAs were assigned to provide care for the residents. Interview with SRNA #15 on 02/20/2020 at 1:04 PM revealed they had to work short at times and stated it was rough to meet resident needs. The SRNA stated when they worked short it was hard to supervise the residents to keep them from falling. Interview with Licensed Practical Nurse (LPN) #5 on 02/10/2020 at 2:50 PM revealed the facility was often short-staffed on SRNAs and residents often complained about call light wait times. The LPN stated three (3) SRNAs was the normal staffing requirement for the facility units during day shift (6:30 AM-6:30 PM) but stated usually the units were only staffed with two (2) SRNAs. Interview with LPN #9 on 02/19/2020 at 10:50 AM revealed that on some days there was not enough staff working to take care of the residents. According to LPN #9 if a crisis occurred, the staff had to stop and take care of it, resulting in other residents' needs not being met timely or not at all. Interview on 02/19/2020 with Registered Nurse (RN) #1 revealed there were not enough SRNAs assigned to the units. The RN stated, I help them all I can. The RN went on to say that she thinks there is enough licensed staff but not enough SRNAs. Interview with the Director of Nursing (DON) on 02/21/2020 at 11:45 AM revealed the facility based their staffing pattern on resident acuity. The DON stated the facility's resident acuity level had increased; however, the DON declined to answer when asked if the facility's staffing level had been increased accordingly.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure staffing information was posted on a daily basis. Observation on 02/16/2020 revealed the posted staffing was dated 02/14/2020. The findings include: A review of the facility's policy, Posting Direct Care Daily Staffing Numbers, revised July 2016, revealed the facility would post the number of nursing personnel responsible for providing direct care to residents on a daily basis. Observation of the posted staffing during the initial tour of the facility on 02/16/2020 at 9:30 AM revealed the posted staffing sheet was dated 02/14/2020, two (2) days earlier. An interview with the Dietary Manager on 02/21/2020 at 8:57 AM revealed she was the supervisor covering the facility on 02/16/2020. According to the Dietary Manager, she was responsible to ensure the facility had enough staff for Saturday, 02/15/2020 and Sunday, 02/16/2020. However, the Dietary Manager stated she was not was aware that staffing information was required to be posted daily. Interview with the Corporate Consultant on 02/21/2020 at 9:45 AM revealed staffing forms were available and stored behind the one that was posted on 02/14/2020. She stated the posting should be changed and updated daily by the manager on duty.
F 0756 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and a review of the facility policy, it was determined the facility failed to ensure the Consulting Pharmacist conducted a review of two (2) of thirty-nine (39) sampled residents' medical records (Resident #259 and Resident #2) when conducting the Drug Regimen Review (DRR) to ensure medications were not causing unwanted, uncomfortable, or dangerous effects. Resident #259 was admitted to the facility on [DATE] with physician orders for [MEDICAL CONDITION] medications. Review of Resident #259's medical record revealed the resident sustained [REDACTED]. Interviews with staff revealed the resident also had [MEDICAL CONDITION]. The licensed Pharmacist conducted a Medication Regimen Review (MRR) on [DATE], and indicated the resident's medical record listed potentially inappropriate supporting [DIAGNOSES REDACTED]. However, the pharmacist failed to review the resident's medical record in an attempt to determine whether the [MEDICAL CONDITION] medications contributed to the resident's falls. Resident #259 sustained another fall on

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F 0756 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 12) [DATE] at 9:26 PM after the pharmacy review was conducted. In addition, on [DATE] at 1:05 AM Resident #259 was found on the floor, lying on his/her left side in the hallway of the facility, and bleeding from his/her head. The resident was transferred to a local hospital on [DATE] and was diagnosed with [REDACTED]. Resident #259 expired at 6:38 AM on [DATE], due to a [MEDICAL CONDITION] from the fall to the floor. In addition, the facility failed to address a pharmacy recommendation dated [DATE], per the facility's policy for Resident #2. The facility's failure to ensure residents' medical records were reviewed to ensure medications were not causing unwanted, uncomfortable, or dangerous effects has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE] at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656), 42 CFR 483.25 Quality of Care (F689), and 42 CFR 483.45 Pharmacy Services (F756). The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Allegation of Compliance was received on [DATE], which alleged removal of the Immediate Jeopardy on [DATE]. The State Survey Agency determined the Immediate Jeopardy was removed as alleged on [DATE] prior to exit on [DATE], which lowered the scope and severity to D level at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656), 42 CFR 483.25 Quality of Care (F689), and 42 CFR 483.45 Pharmacy Services (F756) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: 1. Review of the facility's policy, Medication Regimen Review, Facility Process, dated [DATE], revealed the intent of the process was to prevent or minimize adverse consequences related to medication therapy to the extent possible by providing oversight by a licensed pharmacist, attending physician, medical director, and the Director of Nursing (DON). The policy defined adverse consequences as a broad term, which referred to unwanted, uncomfortable, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional/psychosocial status. The policy also indicated that the Medication Regimen Review would be a thorough evaluation of the resident's medication regimen with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The Medication Regimen Review would include a medical record review for the resident in order to prevent, identify, report, and resolve issues, which included medication-related problems, and collaborate with other members of the IDT, including the resident, their family, and/or the resident representative. Review of Resident #259's medical record revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #259's Minimum Data Set Assessment ((MDS) dated [DATE] revealed the resident displayed no behaviors during the assessment period. The facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated cognitive impairment, and to require extensive assistance of two (2) staff members for toileting, bed mobility, and transfers. The MDS also revealed the resident had experienced one (1) fall since admission, with no injury. Review of Resident #259's physician orders dated [DATE] and [DATE] revealed the resident received the following medications: [REDACTED]. Resident #259 also received [MEDICATION NAME] (antidepressant) 15 mg at bedtime for treatment of [REDACTED]. Review of Resident #259's record revealed the resident experienced falls on [DATE], [DATE], and [DATE], when attempting to get up unassisted. Review of Resident #259's Pharmacy Consultation Report dated [DATE] revealed the pharmacist identified concerns with the [DIAGNOSES REDACTED]. The pharmacist's report indicated the resident's medical record listed potentially inappropriate supporting [DIAGNOSES REDACTED]. The pharmacist's report also cautioned, All [MEDICAL CONDITION] need appropriate indication. Interview with the facility Pharmacist on [DATE] at 9:45 AM revealed when reviewing Resident #259's medications on [DATE], she identified that the resident was receiving [MEDICAL CONDITION] medications without appropriate [DIAGNOSES REDACTED]. The Pharmacist stated she did not usually research the resident's medical record or inquire about falls the resident had sustained, even if a medication prescribed to the resident could potentially contribute to increased falls. The Pharmacist stated she was not aware that Resident #259 had experienced three (3) falls prior to the medication review and had not discussed Resident #259's medication use with the DON or any other member of the Interdisciplinary Team (IDT). In addition, the pharmacist stated she had not observed or spoken with Resident #259 or the resident's family member/representative. Interview with the DON on [DATE] at 2:05 PM revealed the Interdisciplinary Team (IDT) reviewed all newly admitted residents' medications to ensure that residents receiving [MEDICAL CONDITION] medications had the appropriate supporting diagnoses. However, the DON was unable to remember if Resident #259's medications had been reviewed on admission. The DON also acknowledged the facility had no process in place to monitor residents for potential adverse effects of [MEDICAL CONDITION] medications, including the potential for the medication(s) to be a contributing factor for sustained falls. According to the DON, the resident's physician had not reviewed or acted upon the pharmacist's recommendations prior to the resident's transfer from the facility. Interviews on [DATE] with Licensed Practical Nurse (LPN) #5 at 3:00 PM and LPN #2 at 9:10 PM, and on [DATE] at 11:35 AM with LPN #6 revealed the staff had not been instructed to monitor residents for potential adverse effects of [MEDICAL CONDITION] medication. Interview with Physical Therapy Assistant (PTA) #1 on [DATE] at 12:45 PM revealed he provided services to Resident #259 a couple of times; however, he was unable to get the resident to participate well in therapy because the resident was lethargic during each session. Continued review of Resident #259's medical record revealed the resident sustained [REDACTED]. In addition, review of a nurse's note revealed on [DATE] at 1:05 AM staff observed the resident lying on the floor on his/her left side, in the hallway in front of the nurses' station/dining room of the facility. The nurse's notes also revealed the resident had a large hematoma to the left temporal area and copious amount of bleeding also present from area. Resident #259 was transferred to the local hospital for further evaluation and treatment. Review of Resident #259's hospital record for Resident #259 dated [DATE] revealed the resident had a laceration to the left forehead, which extended to the skull, and an arterial bleed was present and bleeding in the brain. The resident expired on [DATE] at 6:38 AM from a [MEDICAL CONDITION] sustained from a fall. 2. Review of the policy, Medication Regimen Review (MRR) Facility Process, dated [DATE], revealed the attending physician is expected to sign the resident's individual MRR and document that he/she reviewed the pharmacist's identified irregularities; document the action taken or not taken, including the rationale for why the recommendation was rejected; and return the signed form to the Director of Nursing or designee within 7 days. If preferred by the physician, instead of signing the MRR form, the physician may document a progress note in the resident's medical record that states he has reviewed the Pharmacist's recommendations and either accepts the recommendations and provides new orders or documents rationale as to why the recommendation is rejected. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of eleven (11), which indicated the resident had moderate cognitive impairment. Review of the current physician orders, per electronic medical record (EMR), revealed as of [DATE], Resident #2 had orders for [MEDICAL CONDITION] medications that included [MEDICATION NAME], Trazadone, [MEDICATION NAME], and [MEDICATION NAME]. Review of the pharmacy recommendations revealed a consultation report dated [DATE], which recommended re-evaluation of the combination of [MEDICATION NAME], and [MEDICATION NAME] and to consider dose reduction if appropriate for Resident #2. The physician checked that the recommendation was declined and did not wish to implement any changes due to reasons below. The recommendation was signed by the physician on [DATE]; however, there was no documentation as to the reason the recommendation was declined. Interview with the Director of Nursing (DON) on [DATE] at 11:19 AM, revealed the Assistant Directors of Nursing (ADONs) were responsible for ensuring pharmacy recommendations were acted upon timely. After reviewing Resident #2's pharmacy recommendation dated [DATE], she stated the ADONs and nurses knew they were required to ensure the physician's rationale was documented for declining a recommendation. Interview with ADON #1 on [DATE] at 9:55 AM, revealed she and ADON #2 audited pharmacy consultation reports/recommendations when returned from the physician to ensure they were complete and had a signature. The ADON stated she was not aware the physician had to document a rationale if a recommendation was declined. ***The facility alleged the following was implemented to remove Immediate Jeopardy effective [DATE]: 1. Resident #259 no longer resides at the facility. 2. By [DATE], the Pharmacist will complete a Medication Regimen Review for current residents, which will include psychoactive medications, to ensure there is a supporting diagnosis, and will review for necessity/indication for the medication. The Pharmacist will also review for psychoactive medications that may be contributing to falls. One hundred eleven (111) residents were reviewed. Recommendations to the Medical Director was made for sixty-three (63) residents, six (6) of which were recommendations for a gradual dose reduction of psychoactive medications. 3. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) assessed current residents for potential side effects from psychoactive medication on [DATE], and ensured resident's Medication Administration Records (MAR) reflected the need to monitor for potential side effects of psychoactive medication. 4. The facility held a meeting on [DATE] to evaluate residents receiving psychoactive medications, residents with new orders for psychoactive medications, residents that had a medication dose adjustment, and any pharmacy recommendations. The IDT (Director of Nursing, Social

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	185244	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STANFORD CARE AND REHAB, LLC	**105 HARMON HEIGHTS STANFORD, KY 40484**

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 0756 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 13) Service Director, Social Service Assistant, Activity Director, Assistant Director of Nursing, Registered Dietitian/Dietary Service Manager) was in attendance and the Medical Director attended by phone to review appropriate utilization of psychoactive medications, which includes antipsychotic medications, hypnotic medications, antianxiety medications, and mood altering medications to ensure side effects, medication changes, and overall adjustment to psychoactive is achieved. 5. The DON/ADON/Wound Nurse completed Falls Risk Assessments (utilizing the MORSE Fall Scale tool) and Pain Evaluations for current residents on [DATE]. The Nurse Consultant/DON/ADON/ Wound Nurse will also review resident falls for the past 30 days to ensure a root cause analysis has been conducted and appropriate interventions are in place. This will include a review of the care plan to ensure updates have been entered. 6. The Social Service Director, Social Service Assistant, and the Clinical Liaison will interview residents with a BIMS of eight (8) and above to identify residents with concerns related to change of condition, including but not limited to: pain, concerns related to sleep changes, requiring increased help from staff, or concerns related to increased fall risks. The interviews were completed by [DATE] and any concerns identified will be reported to the Director of Nursing (DON) and/or Executive Director immediately and addressed by the appropriate department. 7. The Wound Nurse (LPN) and Clinical Liaison (LPN) will complete resident observations by [DATE] for residents with a BIMS score of seven (7) and below to identify residents with concerns related to change of condition, including but not limited to: pain, concerns related to sleep changes, needing increased help from staff, or concerns related to increased fall risks. Concerns identified will be reported to the DON and/or Executive Director immediately and addressed by the appropriate department. 8. The Human Resource Director, ADON, Medical Records, Registered Dietician, Scheduler, Environmental Service Director, and/or the Director of Rehab will interview current staff related to any knowledge of residents with concerns related to change of condition, including but not limited to: pain, concerns related to sleep changes, needing increased help from staff, or concerns related to increased fall risks. The interviews will be completed by [DATE] and any concerns will be reported to the DON and/or Executive Director immediately and addressed by the appropriate department. 9. The DON/ADON and/or designee will review resident interviews, staff interviews, and resident observations by [DATE] to ensure the physician is notified of any change in condition. The DON/ADON/ MDS nurse will review current resident and staff interviews to ensure that appropriate interventions were placed based on falls root cause analysis. 10. On [DATE], the DON/ADON and/or designee will review fall risk evaluations and pain assessments to determine if a change of condition is indicated and will notify the resident's physician if needed. 11. By [DATE], the MDS Coordinator will review nursing notes for the past 30 days to ensure physician notification and care plan revision to reflect any change, including falls and behaviors. One resident was identified to not have a care plan related to a skin tear; however, the physician had been notified with orders for treatment. 12. By [DATE], the DON and/or the ADON will review the Twenty-Four hour reports to ensure any change in a resident's condition has been addressed appropriately to include physician notification and care plan revision. No concerns were identified. 13. The Nurse Consultant/DON/ADON/SDC/RN Charge Nurse will review care plans on current residents to ensure appropriate documentation related to change in conditions, including but not limited to: pain, concerns related to sleep, changes in behavior, fall interventions, and fall risk. The reviews were completed by [DATE]. Five resident care plans were revised. 14. By [DATE], the Nurse Consultant educated the ED/DON/ADON/SDC on utilizing Stop and Watch forms, a communication form developed by CMS to communicate changes related to change of condition. Education will include giving the completed Stop and Watch to the nurse and making a copy and leaving for the DON/ADON. The DON/ADON will review Stop and Watches and follow up on possible change of condition during the daily clinical meeting and was completed as appropriate. By [DATE], the ED/DON/ADON/SDC will educate current staff regarding utilizing Stop and Watch forms for any change in condition, giving the completed form to the nurse, and making a copy for the DON. 15. The Nurse Consultant educated the ED/DON/ADON/SDC the DON/ADON on [DATE] to review Stop and Watches forms to ensure they were acted upon appropriately to include physician notification for changes in condition, They were also educated to ensure appropriate interventions were implemented for falls based on root cause analysis of the fall, which includes the 5 Why's (a tool approved by CMS for identifying root cause analysis), to assist in determining an appropriate intervention at time of fall. The education also included the need for licensed nurses to submit the 5 Why's form for each fall to DON/ADON for review in clinical meeting. The Nurse Consultant will also re-educated the staff regarding the facility's Falls Management Policy that requires the completion of a Falls Risk Evaluation (utilizing the MORSE fall Scale tool developed for assistance in identifying fall risk residents) after each fall. The SDC/DON/ADON/ED then educated licensed staff by [DATE] regarding the utilization of the 5 Why's tool to determine the root cause of a fall to assist in determining the most appropriate intervention. In addition, current licensed nurses will be educated to notify the on-call Nurse Manager after a fall to review the root cause and the intervention for appropriateness. 16. By [DATE], the ED/DON/ADON/SDC will educate current licensed staff on appropriate documentation including, but not limited to: changes in condition, pain, concerns related to sleep changes, effectiveness of medication, notification of residents' physicians, or needing increased help from staff. 17. By [DATE], the Nurse Consultant will educate the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), and the Wound Care Nurse (LPN) on assuring that residents are assessed for potential medication side effects; to ensure a monitoring order is placed on the MAR indicated [REDACTED]. Education included reviewing residents who was newly admitted /readmitted to ensure the resident had an appropriate [DIAGNOSES REDACTED]. The review will be conducted during the daily clinical meeting and will be followed-up by the Pharmacy Consultant. Any new medication orders will be reviewed by the DON/ADON/SDC for necessity to include appropriate [DIAGNOSES REDACTED]. 18. The Nurse Consultant will educate the DON/ADON/SDC on ensuring pharmacy reviews have occurred monthly and ensuring timely follow up of recommendations per facility policy, which states the recommendations will be received by the DON within 3 days of completion of review. The recommendations will be sent to the physician and the DON will verify the physician and Medical Director has received the review within 3 days. The DON should receive a response from the physician within 7 days. If a response is not received in 7 days, the DON/ADON will notify the physician for acceptance and/or a response to the recommendations that require action. If no response is received in 14 days, the DON/ADON will notify the Medical Director for further action. The DON/ADON will also notify the Executive Director and the Nurse Consultant. This education will occur on [DATE]. The DON, ADON, or Staff Development Coordinator will then will educate current licensed staff by [DATE] on assuring that residents are assessed for potential side effects of medications, ensuring a monitoring order is placed on the MAR indicated [REDACTED]. 19. The Pharmacy Director will re-educate the Registered Pharmacist by [DATE] on accurately completing a Medication Regimen Review, which will include a supporting [DIAGNOSES REDACTED]. The Pharmacist assigned to the facility at the time of the IJ has been removed as the Pharmacy Consultant. The current Pharmacy Consultant has been educated on the concerns related to regimen reviews, appropriate [DIAGNOSES REDACTED]. 20. For all education, a post education test will be administered by the Nurse Consultant/DON/ADON/SDC following education. If a score of 100% is not obtained, re-education will be completed until proficiency is obtained and their score is 100%. Five tests will be administered daily by ED/Assistant Administrator/ DON/ADON/SDC to ensure retention of education, until IJ is removed and approved through QAPI process. Current staff who have not received education by [DATE] will be mailed a certified letter informing them to contact the Executive Director/DON/SDC prior to working the floor. Staffing Agencies currently being utilized will be mailed a certified letter on [DATE] of the need to contact the ED/DON/SDC for education prior to working. The Executive Director/SDC or designee will ensure all newly hired staff and agency staff will receive education during New Hire Orientation or prior to working the floor. 21. The IDT will review in the daily clinical meeting (Monday through Friday) each fall and nursing shift reports to ensure the following is completed for any resident who sustained a fall: Falls Risk evaluation, to include the 5 Why's; physician notification; and care plan revision. In addition, the IDT will review Stop and Watch forms, progress notes, and physician orders to ensure care plans have been updated appropriately and physicians have been notified. 22. The Executive Director/Assistant Administrator/DON will conduct daily post clinical IDT meetings Monday-Friday for two weeks to review all identified Change of Condition and the effectiveness of medication to ensure notification of residents' physician as required. In addition, the Executive Director/Assistant Administrator/DON will review five (5) random resident records to ensure proper documentation has been completed related to any change in condition, physician notification, and the care plans are appropriate. Any issues identified will be corrected immediately and reported to the QAPI Committee for 3 months for further review and recommendations. 23. The facility will conduct weekly monitoring to evaluate psychoactive medication on residents, residents new prescribed psychoactive medications, and residents that have had medication dose adjustment. This psychoactive meeting will be conducted weekly by the facility IDT, (Director of Nursing, Social Service Director, Social Service Assistant, Activity Director, Assistant Director of Nursing, Registered Dietitian or Dietary Service Manager), residents physician, facility medical director, and Pharmacist to review appropriate utilization of psychoactive

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F 0756 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 14) medications which includes antipsychotic medications, hypnotic medications, antianxiety medications, and mood altering medications to ensure side effects, medication changes and overall adjustment to psychoactive is achieved. 24. Beginning [DATE], the Nursing Consultant/ED/DON/ADON/Assistant Administrator will be on sight at facility to monitor processes related to supervision to prevent accidents, care plan development/revision, and physician notification until IJ is removed and pending QAPI Committee review. Any concerns identified will be addressed immediately and reported to QAPI weekly for review and further recommendations. An AD-HOC QAPI meeting is held at least bi-weekly and as needed to discuss issues with the Medical Director. The IDT team meets daily to discuss findings and progress. 25. Beginning [DATE], The Director of Nursing, Assistant Director of Nursing, or the Staff Development Nurse will review MAR's daily (Monday through Friday), during the Clinical Meeting, for two weeks, for documentation of side effect monitoring of [MEDICAL CONDITION] medication and appropriate [DIAGNOSES REDACTED]. The Director of Nursing will also review falls to ensure the Medication Regimen Review has been sent to the consultant pharmacist daily (Monday through Friday) during the clinical meeting. The Director of Nursing will contact the Pharmacy Director, in 72 hours, if no communication from the review is received from the consultant pharmacist. Any concerns identified will be corrected immediately, and reported to QAPI committee for further review and recommendations. 26. The Executive Director will ensure the facility has conducted weekly monitoring, month over month, for 3 months to evaluate psychoactive medication on residents newly prescribed psychoactive medications, and residents that have had medication dose adjustments. This psychoactive meeting will be conducted weekly, by the facility IDT (Director of Nursing, Social Service Director, Social Service Assistant, Activity Director, Assistant Director of Nursing, Registered Dietitian or Dietary Service Manager), residents physician, facility medical director, and the Pharmacist to review appropriate utilization of psychoactive medications, which includes; antipsychotic medications, hypnotic medications, antianxiety medications, and mood altering medications to ensure side effects, medication changes and overall adjustment to psychoactive is achieved. 27. The Nurse Consultant or Director of Nursing will be in the center daily to monitor residents with new [MEDICAL CONDITION] medication orders to ensure side effect monitoring is completed. 28. Beginning [DATE], Nursing Consultant/ED/DON/ADON/Assistant Administrator will be on sight at the facility to monitor process, related to [MEDICAL CONDITION] medications, until IJ is removed and pending QAPI Committee review. Any concerns identified will be addressed immediately and reported to QAPI weekly for review and further recommendations. AD-HOC QAPI meeting is held at least bi-weekly, and as needed, to discuss issues with the Medical Director. The IDT team meets daily to discuss findings and progress. 29. The Executive Director will review 5 random Admissions/Readmissions/Falls/New Medication Orders/ Monthly Pharmacy Reviews for timeliness, and to ensure proper documentation has occurred daily. Any issues identified will be corrected immediately, and reported to QAPI Committee for 3 months for further review and recommendations. ***The State Survey Agency determined that the facility implemented the following to remove Immediate Jeopardy on [DATE], as alleged: 1. Review of documentation revealed Resident #259 no longer resided at the facility. 2. Interview with the Administrator on [DATE] at 5:15 PM and review of documentation revealed by [DATE], the Pharmacist completed a Medication Regimen Review for current residents on psychoactive medications, to ensure there was supporting diagnosis, and necessity and indication for the use of the medication. The Pharmacist also reviewed psychoactive medications that could have contributed to falls. Further review of documentation and interview with the Administrator confirmed one-hundred and eleven (111) residents were reviewed by the Pharmacist. Review of facility documentation revealed the Pharmacist made recommendations to the Medical Director on 63 residents reviewed and six (6) of those recommendations were for gradual dose reductions of psychoactive medications. 3. Interview with the Director of Nursing (DON) on [DATE] at 3:30 PM and review of documentation revealed she and Assistant Director of Nursing (ADON) #1 assessed current residents for potential side effects from psychoactive medication on [DATE]. The DON and ADON #1 reviewed the residents' Medication Administration Records (MAR)'s to ensure it reflected monitoring for potential side effects for residents that received psychoactive medications in the facility. 4. Interview with the DON on [DATE] at 3:30 PM and review of facility documentation revealed a meeting occurred at the facility on [DATE], which evaluated residents that received psychoactive medications, residents with new orders for psychoactive medications, residents that had a medication dose adjustment, and any pharmacy recommendations. Review of documentation also revealed The IDT (Director of Nursing, Social Service Director, Social Service Assistant, Activity Director, Assistant Director of Nursing, Registered Dietitian/Dietary Service Manager) attended the meeting, as well as the Medical Director, which attended the meeting, by phone. Continued interview with the DON and further review of documentation revealed the meeting was conducted to review appropriate utilization of psychoactive medications, antipsychotic medications, hypnotic medications, antianxiety medications, and mood-altering medications to ensure side effects, medication changes, and overall adjustment to psychoactive medications was achieved. 5. Review of documentation and an Interview with ADON #1 on [DATE] at 3:15 PM revealed she and the DON as well as the Wound Nurse completed Falls Risk Assessments (utilizing the MORSE Fall Scale tool) and Pain Evaluations for current residents on [DATE]. Further interview and review of documentation also revealed The Nurse Consultant, the DON, ADON, and the Wound Nurse reviewed resident falls for the past 30 days, to ensure a root cause analysis was conducted and appropriate interventions were in place. Review of documentation and further interview with ADON #1 also revealed resident care plans were also reviewed to ensure care plan updates had been completed as required. 6. Interview with the Social Service Director on [DATE] at 5:00 PM and review of documentation revealed she and the Social Service Assistant, and the Clinical Liaison interviewed residents with a Brief Interview for Mental Status score (BIMS) of eight (8) or greater to identify residents with concerns related to change of condition, which included but not limited to; pain, concerns related to sleep changes, requiring inc
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and a review of the facility policy it was determined the facility failed to ensure behavioral interventions were implemented for two (2) of six (6) residents who utilized [MEDICAL CONDITION] medications (Resident #19 and Resident #2). Residents #19 and #2's care plans required staff to monitor the residents' mood and behavior; however, the facility failed to monitor the residents in an effort to discontinue [MEDICAL CONDITION] medications. The findings include: Review of the facility's Behavior Monitoring, effective 06/28/2017, revealed the purpose was to identify and monitor behaviors and behavior patterns and to evaluate the effectiveness of pharmacological interventions. According to the facility's process, the licensed nurse was responsible for initiating the Target Behavior/Behavior Flowsheets to monitor residents' individual Target Behaviors related to [MEDICAL CONDITION] medication use. 1. Review of Resident #19's medical record revealed the facility admitted the resident on 10/22/2018 with [DIAGNOSES REDACTED]. Review of Resident #19's Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident had severe cognitive impairment. Review of Resident #19's physician orders revealed the resident was ordered [MEDICATION NAME] 20 milligrams (mg) daily (antidepressant), [MEDICATION NAME] 250 mg twice daily (anti-[MEDICAL CONDITION]/mood stabilizer), and Trazadone 50 mg at bedtime (antidepressant). Review of Resident #19's care plan dated 11/03/2019 revealed the facility identified the potential for altered mood/behaviors related to a [DIAGNOSES REDACTED]. Continued review revealed the facility developed an intervention to monitor and record the resident's mood and behaviors. Review of Resident #19's Medication Administration Record [REDACTED]. 2. Review of the medical record for Resident #2 revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of eleven (11), which indicated the resident had moderate cognitive impairment. Review of Resident #2's current physician orders per electronic medical record (EMR) revealed the resident had orders for the following [MEDICAL CONDITION] medications: [REDACTED]. Review of Resident #2's care plan revealed the facility identified that the resident had the potential for behaviors related to

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 15) Dementia and [MEDICAL CONDITION] diagnoses. According to the care plan, the resident had behaviors of refusing baths, threatening, physical aggression, and making threatening crude remarks. Further review revealed the facility developed an intervention to notify the resident's physician if his/her mood/behavior interfered with daily function. Review of the Medication Administration Record [REDACTED]. Interview with the DON on 02/12/2020 at 2:05 PM revealed the DON acknowledged the facility had no process in place to monitor resident behaviors or potential adverse effects of [MEDICAL CONDITION] medications in the facility.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility policy, it was determined the facility failed to ensure all drugs were stored in locked compartments and failed to ensure controlled drugs were locked in a permanently affixed compartment. Observations conducted on the 300 Unit of the facility on 03/05/2020 revealed one (1) of two (2) medication carts was unlocked in the hallway of the facility, and medications were accessible to residents. Observations of the medication refrigerators on three (3) of three (3) units of the facility revealed the controlled drugs stored in the refrigerators were not in a separately locked, permanently affixed compartment. The findings include: 1. Review of the facility policy titled Medication Storage in the Facility, not dated, revealed medications and biologicals should be stored safely and securely and medications should only be accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The policy also stated medication rooms, carts, and medication supplies should be locked or attended by persons with authorized access. Observations on the 300 Unit of the facility on 03/05/2020 at 11:35 AM revealed one (1) of two (2) medication carts was unlocked and the surveyor was able to open the drawers to the medication cart and access the medications. Continued observations of the medication cart revealed the following medications were accessible to facility residents: [MEDICATION NAME] (blood thinner) 7.5-milligram (mg) tablets (box contained forty-two tablets), and one (1) [MEDICATION NAME] 10-mg tablet was also accessible to the residents. In addition, Potassium 900 milliliter (ml) bottle, 20 milliequivalents (mEq) per 15 ml with approximately 250 ml remaining in bottle; [MEDICATION NAME] (insulin) 12 ml pen, 100 units per ml; Tresiba (insulin) 3 ml pen, 200 units per ml; [MEDICATION NAME] (anti-hypertensive) 25 mg tablets (box contained ten tablets); and [MEDICATION NAME] (hormone-based [MEDICAL CONDITION]) 1 mg tablets (box contained 15 tablets). Interview with Licensed Practical Nurse (LPN) #5 on 03/05/2020 at 11:45 AM revealed she was responsible for the unlocked medication cart observed on the 300 Unit. The LPN stated she had been trained to ensure medication carts were locked when she was not within line of sight of the cart. LPN #5 also acknowledged it was a safety hazard for facility residents if medication carts were not secured as required. Interview with the Director of Nursing (DON) on 03/05/2020 at 3:30 PM revealed staff were trained to ensure medication carts were locked when the cart was not within line of sight. The DON stated staff should ensure medication carts were locked and medications secured and not accessible to residents when nurses were not supervising the medication cart. 2. Review of the facility policy titled, Medication Storage in the Facility, not dated, revealed the policy stated that Schedule II, III, IV, and V medication and other medications subject to abuse are stored under double lock (key or code) in a permanently affixed compartment separate from all other medications. Observation on 02/20/2020 at 4:00 PM of medication refrigerators on Units 100, 200, and 300 revealed the refrigerated controlled medications were stored in a locked case, which was attached to a shelf in the refrigerator; however, that shelf could be easily removed and was not permanently affixed. Interview with the Nurse Consultant on 02/25/2020 at 11:50 AM revealed the nurse was aware that the medication was affixed to the shelf but was unaware of how it should be attached to the refrigerator without damage to the refrigerator. The Administrator on 02/25/2020 at 11:50 AM revealed she was aware of a way to permanently affix the medication case to the refrigerator.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and a review of the facility policy for food preparation and storage, it was determined the facility failed to store, prepare, and serve food under sanitary conditions. Observation of the kitchen revealed a tray of desserts was stored uncovered, and not labeled/dated. Additional foods (cooked biscuits and ice cream) were stored without labels or dates; a raw, broken egg was observed stored in a tray with other eggs; and the can opener was dirty. In addition, during lunch on 02/16/2020, desserts were transported without being covered. The findings include: A review of the facility policy titled Food Preparation and Service, dated April 2019, and Food Receiving and Storage, dated October 2017, revealed raw eggs with damaged shells should be discarded. The policy further stated that appropriate measures were used to prevent cross-contamination, including cleaning and sanitizing food contact equipment between uses. According to the policy, all food stored in refrigerators and freezers would be covered, labeled, and dated with a use by date. Observation during the initial tour of the kitchen on 02/16/2020 at 9:35 AM revealed a tray of desserts containing seven (7) small bowls of pudding, one (1) bowl of fruit cocktail, two (2) bowls of Jell-O, and five (5) bowls of strawberries were stored on a shelf in the walk-in refrigerator. The desserts were not covered, labeled, or dated. In addition, a zip-lock bag of cooked biscuits was stored on a shelf, not labeled or dated. Further, a broken raw egg was observed stored with other eggs on a shelf in a refrigerator. Observation of the noon meal service on 02/16/2020 at 11:55 AM revealed facility staff brought an open cart with desserts into the dining room from the hallway. The desserts on the top shelf were covered; however, ten (10) desserts on the bottom shelf of the cart were not covered to prevent contamination of the desserts. Observation during an additional visit to the kitchen on 02/20/2020 at 3:34 PM revealed a bowl of sherbet stored in a freezer, which was not labeled or dated. Further observation revealed the can opener had a buildup of a black tar-like substance/debris on the blade and in the area of the blade-retaining slot. Interview with the Dietary Manager on 02/21/2020 at 8:57 AM revealed staff were preparing food desserts and had put the desserts back in the walk-in refrigerator to keep them cool, but should have first covered the desserts. The Dietary Manager stated the desserts that were transported in the hallway should have also been covered. According to the Dietary Manager, food stored in the refrigerator and freezers should be labeled and dated and any broken eggs should be discarded. Further interview revealed the can opener should be cleaned and sanitized after use. The Dietary Manager stated she makes rounds in the kitchen daily to identify concerns and was not aware of food being stored and served uncovered or not being labeled when stored. According to the Dietary Manager, she had checked the can opener and had not identified the buildup on the blade or the blade slot.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, record review, and facility policy review, it was determined that the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of infections for one (1) of thirty-nine (39) sampled residents (Resident #104). Observation on 02/06/2020 revealed SRNA #10 entered the room of Resident #104 without donning appropriate personal protective equipment (PPE). The findings include: Review of the facility policy titled Infection Control Program, with an implementation date of 12/27/2016, revealed the infection control program includes the prevention, surveillance, and control measures to protect residents and personnel from health care associated infections and determines when procedures, such as isolation, need to be implemented. Review of the facility policy titled, Isolation-Categories of Transmission-Based Precautions, with an implementation date of 2001 and revised date of October 2018, revealed for residents in contact precautions staff and visitors will wear gloves (clean-non-sterile) when entering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185244	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STANFORD CARE AND REHAB, LLC	**105 HARMON HEIGHTS STANFORD, KY 40484**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 16) the room and staff and visitors will wear a disposable gown upon entering the room. Record review revealed the facility admitted Resident #104 on 03/08/2013. Review of Resident #104's Annual Minimum Data Set ((MDS) dated [DATE] revealed the resident had [DIAGNOSES REDACTED]. Further review of Resident #104's Annual MDS dated [DATE] revealed the resident had a Brief Interview for Mental Status Score (BIMS) score of 11, which indicated moderate cognitive impairment. The MDS dated [DATE] also revealed Resident #104 required setup help with eating. Record review revealed a physician order dated 02/11/2020 for contact precautions for Resident #104 related to loose stools with a foul odor. A culture of the stool was received by the facility on 02/14/2020 and was positive for [MEDICAL CONDITION] (bacteria that causes diarrhea to life-threatening inflammation of the colon). Observation on 02/16/2020 at 12:32 PM revealed SRNA #10 entering Resident #104's room with the resident's food tray without donning gloves, gown, or a mask. SRNA #10 was observed to set up Resident #104's meal and touch the resident's overbed table with her bare hands. Observation further revealed SRNA #10 exited the room and utilized hand sanitizer outside the room. Interview on 02/20/2020 at 9:32 AM with SRNA #10 revealed she was aware that Resident #104 was on contact precautions for [MEDICAL CONDITION] and that prior to entering the room donning a gown, gloves, and a mask was required. She also stated that if the floor was visibly soiled, shoe protectors should be worn. The SRNA confirmed that she entered Resident 104's room on 02/16/2020 without appropriate PPE due to being nervous. SRNA #10 stated that when entering the room to provide Resident #104's meal tray the appropriate PPE should be donned. SRNA #10 stated that she washed her hands utilizing soap and water in Resident #104's room and exited without touching anything, then utilized hand sanitizer. Interview on 02/20/2020 at 10:00 AM with the Staff Development Coordinator (SDC) revealed that appropriate PPE for contact precautions related to [MEDICAL CONDITION] was to don a gown, gloves, and mask (if needed). The SDC stated that staff should don appropriate PPE prior to entering a resident room that had contact precautions. She further revealed that the handwashing with soap and water was the only acceptable method to cleanse the hands. According to the SDC, education was provided upon hire, annually, and on an as needed basis for infection control.