STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235482	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FENTON HEALTHCARE	512 BEACH ST FENTON, MI 48430

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Number MI 408. Based on observation, interview and record review, the facility is placed in Immediate Jeopardy due to the facility's failure to 1) Ensure adequate supervision to prevent recurring falls for one resident (Resident #3), 2) Identify the root cause of falls and implement or maintain effective interventions to reduce the risk for falls for two residents (Resident #3 and Resident #4), 3) Identify a change of condition and modify safety interventions, as necessary, to prevent falls for one resident (Resident #3), 4) Assess and treat one resident (Resident #4) in a timely manner after a fall, and 5) Investigate a fall for one resident (Resident #1) of four residents reviewed for falls, resulting in 1) hospitalization for a closed head fracture and subsequent death for Resident #3, 2) delayed identification and treatment of [REDACTED].#4 and 3) and an injury of unknown origin for Resident #1. Immediate Jeopardy The Immediate Jeopardy started on [DATE]. The Immediate Jeopardy was identified on [DATE]. The facility was notified of the Immediate Jeopardy in writing on [DATE] at 2:15 PM. The Immediate Jeopardy was removed on [DATE] Findings include: This Immediate Jeopardy began on [DATE] at 5:00 PM, when Resident #3 had an unwitnessed fall at the facility, after an unidentified change of condition, and was transferred to the hospital where he it was reported he had [MEDICATION NAME] force trauma to his head and a closed head fracture. Resident #3 was pronounced deceased at the hospital on [DATE] at 12:20 AM, 7 hours and 20 minutes later. Resident #3 fell at least five times prior to [DATE]. He fell on [DATE], [DATE], [DATE], [DATE], and [DATE]. After each fall, the facility failed to assess and identify the root cause of those falls and failed to implement effective interventions. Resident #3's progress notes on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE] all describe Resident #3's poor safety awareness, self-transferring habits, and concern for falls. During an interview with the Director of Nursing (DON) on [DATE] at 2:24 PM his risk for falls was discussed. When asked if Resident #3 would have benefited from 15-minute checks or one on one supervision the DON said, He wasn't a safety risk and said he had been having difficulty breathing. When asked if Resident #3 had any other falls during his stay the DON said she was not sure and would need to check. It was alleged via complaint on [DATE] that a resident recently passed away after a fall when staff failed to assist him and it was alleged the facility is not adequately staffed to ensure residents are provided with proper care. The complaint said, The nursing unit manager and CNA's (certified nursing assistant's) were saying the resident was getting on their nerves and they wouldn't assist him. The complainant did not leave a phone number for contact and did not respond to email. Upon review of facility residents hospitalized in [DATE] that did not return, it was noted that Resident #3 was hospitalized post fall on [DATE] at 17:00 and passed away at the hospital. Late Entry Nurses Note written by the Director of Nursing (DON) on [DATE] at 14:25 (4 days after Resident #3's death) and dated [DATE] at 14:19: (Resident) having difficulties sitting up in wheel chair today, he needs oxygen on at all times now or he gets very short of breath using all exessary mussels to breath. (Resident) assisted with lunch only at a few bits. Had to be assisted multiple times from bed to wheel chair as (Resident) was very confused and continued to attempt to self transfer. Family and physician notified of (Residents) declining health condition. Note did not include details regarding physician response or new orders. Late Entry Nurses Note written by Unit Manager D on [DATE] at 14:33 (4 days after Resident #3's death) and dated [DATE] at 15:21: Resident calling out in room for help several times this afternoon. He reported that he was not breathing well, O 2 (oxygen) was applied per nasal cannula with saturations at 93%, he appeared short of breath and stated that the belt around his waist was making it so he could not breathe and he kept attempting to stand up and remove his belt. Resident was wearing sweat pants without a belt and informed him of this many times, but resident was insistent. Physician and guardian notified, will continue to reorient resident as needed. Note did not include details regarding physician response or new orders. Total Body Skin Assessment progress note written by Unit Manager D on [DATE] at 17:00: .1 bleeding abrasion with large hematoma noted above right eye, physician notified, resident sent to ER Nurses Notes written by Unit Manager D on [DATE] at 17:00: Was notified by staff that resident had fallen in room and was bleeding. Observed resident lying on right side, face pointing towards wall and located in entryway of room. Bleeding abrasion noted above right eye as well as a large bump/hematoma. Pupils were not reactive and resident was not responding but awake appearing lethargic, unable to follow simple commands which is not his baseline. Vital Signs obtained, unable to determine pain, resident was sat up x 2 staff assist, ROM (range of motion) intact at baseline and no voiced pain while moving extremities however baseline cognition was abnormal. Physician notified of occurrence with orders to send to ER (emergency room) for further evaluation. Family/guardian notified. Resident #3's ED (emergency department) Provider's Note (dated [DATE] at 18:39) said Resident #3 arrived to the emergency room 17:36. History of Present Illness (HPI) notes said the chief complaint was fall head injury. The HPI note explained that Resident #3 was brought in by ambulance after falling forward. The note stated, Patient had an unwitnessed fall that resulted in him having [MEDICATION NAME] force trauma to his right forehead. Unknown loss of consciousness. Patient has been weak the last few days. Full history and review of systems cannot be obtained as patient has a decreased GCS (Glasgow Coma Scale). A GCS score can be indicative of how critically ill a patient is. Resident #3's GCS score was documented in the ED as 14. Resident #3's hospital Death Pronunciation Note (singed [DATE] at 00:21) said, Paged by nursing to evaluate patient for increased work of breathing, combativeness, and inability to obtain adequate vitals. Patient was recently transferred to the floor from the ED admitted for closed head fracture, PNA (pneumonia) episode of [DIAGNOSES REDACTED] (low blood sugar) .On arrival to the patient's room at 12:03, RN (registered nurse) notified house staff that patient had passed and was asystole .The patient was pronounced dead on [DATE] at 12:03 AM . Resident #3's hospital Record of Death said he expired [DATE] at 00:14 and autopsy was not requested and No was marked for, Was an infectious agent present? Resident #3's incident and accident reports for all six falls were reviewed to determine injuries, gain perspective on what he was doing when he fell , and ascertain what new interventions staff implemented to prevent future falls. It was noted for three out of six falls that Resident #3 stated he was trying to use the bathroom prior to falling. Resident #3 was incontinent at the time of three of the six falls. Two of the six falls did not assess incontinence as a contributing factor. Appropriate toileting interventions were not implemented after four of the six falls. Orthostatic blood pressures were not obtained for Resident #3 after all six falls. Resident #3 was on high-risk medications that could have caused orthostatic [MEDICAL CONDITION] and contributed to his falls. Resident #3 had the following physician orders [REDACTED].restlessness, .weight changes .orthostatic [MEDICAL CONDITION] . 2) Monitor resident for the following side effects related to antipsychotic medication use and contact practitioner if indicated Confusion . restlessness, .weight changes .orthostatic [MEDICAL CONDITION] . ([DATE]) 3) ([DATE]) and Orthostatic blood pressure three times a day on [DATE] related to [MEDICAL CONDITION]. On four out of six post fall evaluations, Blood Sugar check is required for diabetic resident). Was resident's blood sugar significant? was marked Not Applicable. Resident #3 was diabetic and on scheduled insulin at the time of all

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) six falls. Two of the six post fall evaluations did not ask/document whether blood sugar was checked. Only one blood sugar was documented ([DATE] at 00:41 a.m.) in Resident #3's electronic heath record during his entire stay at the facility. Resident #3's Incident Reports/Post-Fall evaluations indicated he was not thoroughly assessed for factors that likely contributed to his falls. At the time of Resident #3's last fall (Friday [DATE] at 17:00) Unit Manager D, Nurse E, Certified Nursing Assistants (CNA's) F, G, H, and I were working on Resident #3's floor. All staff were interviewed on [DATE]-[DATE] to determine where they were at the time Resident #3 fell . ,[DATE] staff were occupied with other residents/tasks. The 6th staff member was not available for interview and the incident report/post fall evaluation did not assess where staff were at the time of the fall. The Immediate Jeopardy was identified on [DATE]. The Nursing Home Administrator (NHA) was notified on [DATE] at 2:15 p.m. of the Immediate Jeopardy that began on [DATE] at 17:00 p.m., and the need for immediate action to ensure the facility is able to provide adequate supervision for residents, who are at risk for falls and identify, implement and monitor for effective interventions to prevent falls through thoroughly investigating and analyzing the root cause of residents' falls. Additional Findings Include: Resident #3: According to Admission Record, printed [DATE], Resident #3 was an 87-year- old male admitted to the facility on [DATE] (original admission date of [DATE]) with [DIAGNOSES REDACTED]. According to Resident #3's admission Brief Interview for Mental Status (BIMS) assessment on [DATE], his cognition was moderately impaired. According to Resident #3's most recent Minimum Data Set (MDS) Resident Assessment Tool (dated [DATE]) he did not have any indicators of [MEDICAL CONDITION] such as hallucinations and delusions and had no behavioral symptoms (Section E). The assessment said Resident #3 required limited assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weigh bearing assistance) for bed mobility, transfers, walking, dressing, toileting and personal hygiene (Section G). The assessment said Resident #3 was occasionally incontinent, defined as less than 7 episodes of incontinence (Section H). According to Section J of the MDS, Resident #3 did not have a condition or chronic disease that may result in life expectancy of less than 6 months. Section J said he did not have shortness of breath, pain, fever, vomiting, dehydration, or internal bleeding. The MDS said resident had two falls since admission/entry or reentry that resulted in injury (skin tears, abrasions, lacerations, superficial bruises, hematoma's and sprains, or pain) and no falls with major injury (bone fracture, joint dislocations, closed head injuries with altered consciousness and subdural hematoma). According to Section N of the MDS, Resident #3 was on antipsychotic, antidepressant and anticoagulant medications seven days a week. Section P of the MDS said Resident #3 did not have any physical restraints or alarms. According to Resident #3's physician orders [REDACTED]. The medications included: two anti-depressants ([MEDICATION NAME] and [MEDICATION NAME]), an antipsychotic ([MEDICATION NAME]), a blood thinner (apixaban), insulin ([MEDICATION NAME]), an anti-anxiety medication ([MEDICATION NAME]), and a medication to treat his abnormal heart rhythm ([MEDICATION NAME]). Additionally, Resident #3's as needed inhaler for shortness of breath was discontinued no [DATE] due to hospitalization and not reordered upon readmission. It was noted that Resident #3's [MEDICATION NAME] order significantly increased on [DATE]. Resident #3 was prescribed [MEDICATION NAME] 25 mg by mouth at bedtime for [MEDICAL CONDITION] (from [DATE] - [DATE]) then his dose increased to 50 mg twice daily on [DATE]. It was also noted that on [DATE] a chest x-ray and oxygen via nasal cannula at 2 liters as needed every shift for shortness of breath and low oxygen saturation was ordered. No labs were ordered according to Resident #3's order summary report. Progress Notes: According to Resident #3's progress notes he fell at least five times prior to [DATE]. He fell on [DATE], [DATE], [DATE], [DATE], and [DATE]. After each fall, the facility failed to assess and identify the root cause of those falls and failed to implement effective interventions. Resident #3's progress notes on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE] all describe Resident #3's poor safety awareness, self-transferring habits, and concern for falls. The notes did not specify whether Resident #3's plan of care was reviewed or revised with changes of condition or whether the physician had new orders when he was notified of changes of condition. Changes in Resident #3's accident risk were not clearly identified or communicated in his progress notes to include interventions attempted and whether they were successful each episode Nurses Note written [DATE] at 05:35: .a loud thud was heard from down the hall .heard the resident yell help me please! .resident in his restroom laying on the floor on his right side. In front of him was his wheelchair with the brakes unlocked a small abrasion ws found on his upper back/cervical spine area .no mental status changes noted .his neuro assessment was not significant for any abnormalities from baseline 15 minutes after the fall he complained of lower back and left shoulder pain that was sharp and ,[DATE] . Social Services Note written [DATE] at 14:58: .Resident was admitted with severe anxiety/agitation and [MEDICAL CONDITION]/delusion during evening hour, repeated calling out .resistant to care and screaming .family reported long history of psychological distress in the evening during sleep that started in his 20's following a head injury sustained during his time I the navy .had long periods of resolution of his symptoms throughout his life. Behaviors of aggression, yelling and [MEDICAL CONDITION] initiated again aprox one month prior to his admission to this facility. Non pharmacological interventions were attempted and ineffective: Anticipate resident needs and provide assist, 1:1 reassurance and supportive listening, redirection, offer drink/snack, ensure comfort of environment (light, noise, temperature). Resident was referred to (psychological services) for evaluation, medical management and psychological supportive services . Nurses Note written [DATE] at 02:39: Resident observed on floor next to bed on his back at 01:25. Stated that he got up to go to the bathroom. He used call light, but did not wait for assistance. Had regular socks on and slipped on dry floor .no injury noted. Nurses Note written on [DATE] at 02:15: Resident observed on floor in another resident room next to bed on his right side with right arm raised up beneath him, upper half of body under bedside table. Resident stated he was going to the bathroom. He had on regular sock on and one regular sock off and didn't have his wheelchair breakes locked, it was noted to be next to him and the bed. He slipped on the floor when he was attempting to self transfer from wheelchair to the bed .no injuries were noted upon initial assessment . Nurses Note written [DATE] at 14:51: .continues to make progress in PT and OT .He continues to have poor safety awareness and transfers without assistance . Nurses Note written [DATE] at 00:09: Resident had a change in neuro checks, pupils are uneven and not reactive to light, (blood pressure) is elevated ,[DATE], (elevated heart rate) 102, temp 99.1, altered mental status, unable to follow simple commands . Resident sent to the hospital at 0019. Nurses Note written [DATE] at 07:38: Resident returned from .hospital with new orders . Nurses Note written [DATE] at 10:18: Observed on the floor at 1000 by staff, writer in to assess, skin intact .no complaints of pain, range of motion within normal limits, unsure of how he got on the floor, was incontinent of bowel and bladder at the time of fall, assisted by 2 people up to bed, able to stand well, appears slightly weak . Nurses Note written [DATE] at 10:55: .new orders to send resident back to (hospital) for mental status changes, non reactive and uneven pupils, lethargy . Nurses Note written [DATE] at 15:57: Resident returned from the hospital. .very lethargic . Nurses Note written [DATE] at 21:35: Resident observed on floor between bed and wall with back up against wall/register and head leaned on right side of nightstand, resident has abrasion noted on outer right knee and lower back, no (signs or symptoms) or (complaint of) pain at this time Room rearranged for safety placing nightstand at (head of bed) and resident has scoop mattress . Nurses Note written [DATE] at 23:56: Resident laying in bed very restless, he makes sudden jerking movements and yellows out frequently and makes squeaking sounds and hums loudly, nonsensical speech and when asked if he needs anything he randomly bursts out singing loudly. Yells out hey when asked questions then says I'm sorry and flops his head down and closes his eyes. Several attempts to get out of bed and sits himself up on bedside. Singing hey baby baby. No new or revised fall prevention interventions documented. Nurses Note written [DATE] at 01:27: Resident has been laying in bed nonstop yelling out, [MEDICATION NAME], singing, and making noises. Confused per baseline and is pleasant with staff. Very restless attempting to get self out of bed requiring constant staff supervision. Nurses Note written [DATE] at 04:18: .extremely restless and fidgety .will attempt to self transfer when in room/bed and when self propels in wheelchair goes into other room and attempts to transfer to other beds . Nurses Note written [DATE] at 09:55: Resident attempting to get our of bed at this time, note easily redirected. Writer finally assisted resident into bed . Nurse Note written [DATE] at 1700: Resident in bed turning from side to side and restless .this nurse sat with him for approx 30 min . Nurses Note written [DATE] at 23:37: Resident is very restless tonight, moaning out and swinging his legs out of bed .is lethargic . Nurses Note written [DATE] at 01:21: Resident has been up through lunch and dinner yesterday, he has not napped or rested in bed .increase in agitation occurring as the night goes on, hallucinating believing his wife has fallen on the floor and is under his bed, he has pulled the fire alarm and has tried to contact 911 several times during the evening. Safety reassured to him. With each event has not been able to reorient, pupil sizes are not equal, right pupil smaller than left, they do react to light, staff have attempted to lay him down multiple times however he chooses to get himself out of bed, food and fluids provided and offered through the shift. Nurses Note written [DATE] at 06:56: Resident has been up and down all night with very small naps .some delusional thoughts noted. He was looking for his wife and trying to call her on his cell phone and would talk

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) on the phone like someone was on the other end but it wasn't on. And then few minutes later talk about how she is dead. Then talk about how she is trapped under his bed . Nurses Note written [DATE] at 16:31: .up walking in room with two photos of wife in hand. Nurse was able to intervene before falling .he stated he was cleaning up his room .fidgety with things is room watching t.v Nurses Note written [DATE] at 02:48: Up at night. Pacing from (wheelchair) to bed and back. When in bed lays across it. Wheels himself to the hallway and was in elevate twice just sitting there . Nurses Note written [DATE] at 03:48: Resident pulled fire alarm box causing alarm to sound. Nurses Note written [DATE] at 01:23: .restless and get up in just a few minutes. Nurses Note written [DATE] at 10:37: .will try and self transfer if not watched . Nurse Note written [DATE] at 07:00: Resident is extremely restless at night, only laying down for twenty minute periods, he is up and down all night long and is not sleeping .will continue to monitor. Nurses Note written [DATE] at 00:32: Resident pulled box cover off fire alarm sounding alarm several times used elevator to go downstairs and has been redirected back upstairs . Nurses Note written [DATE] at 01:15: Resident used elevator to go to first floor, he held door handle down to get into lobby sounding alarm .stated he has to go to the bathroom .assisted back to his room to toilet and wanderguard placed on right ankle due to attempting to leave thru front doors . Nurses Note written [DATE] at 05:51: Resident up all night. Pacing in hallway, dining room and getting into the elevator . Nurse Note written [DATE] at 00:08: .Alarm on elevator sounded. Resident stated he was going downstairs to get some pop . Nurses Note written [DATE] at 01:07: on [DATE] midnight resident setting in wheelchair by elevator alarm going off in elevator. Resident stated he was looking for head boss . Nurses Note written [DATE] at 03:18: Resident has been up and down from bed to wheelchair all night long. Reports being restless and unable to get comfortable in bed .Will only rest for short periods of time, less than 10 min, the gets back up .Continues to go to elevator pushing buttons to go downstairs, but alarms sounds . Nurse Note written [DATE] at 00:10: Resident .is very restless, won't stay in bed despite staff sitting with him to provide reassurance . Nurses Note written [DATE] at 01:42: Resident restless. Getting to and out of bed continuously. Complained of not being able to breath when in bed. Head of bed up. O 2 via nasal cannula applied, but resident took it off in just a few minutes . Nurses Note written [DATE] at 11:21: .complaining of runny nose .showing signs of restlessness . Nurses Note written [DATE] at 11:43: (physical therapy, occupational therapy and speech therapy) continues. He remains very confused especially at night .Ambulating with rolling walker and assist of one .Extensive assist for (activities of daily living) . Nurses Note written [DATE] at 10:00: Resident up awake all night per the staff. He was having increased anxiety and upset about things that weren't there. Point at people that weren't there. Needed one on one redirect and he calmed down but still was antsy. Unable to get him to rest. Nurses Note written [DATE] at 14:16: Resident calling for help in his room reporting he couldn't breathe, O 2 sats on room air were at 98% but he demanded oxygen, reassured him he needed to deep breathe, he had no clothes on and was sitting at the edge of his bed stated he could not breathe because his underwear were too tight. I assisted him with getting new clothes did not appear tight and they seemed to fit properly . [DATE] at 05:31: Resident was up all night. He was agitated .constantly switching from bed to wheelchair and back again .As patient continued to exert himself with repetitive behaviors, his DIB (difficulty in breathing) became more pronounced . [DATE] at 05:35: Resident was up all night. He was agitated and at times confrontational .still using O 2 .as patient continued to exert himself with repetitive behaviors, his DIB became more pronounced . [DATE] at 15:01: patient was complaining of tightness in chest and very high anxiety with breathing out his mouth (oxygen saturation) is 97 on room air placed nasal canal for comforted. Dr (doctor) ordered chest x ray . [DATE] at 06:33: Resident xray returned with no acute cardiopulmonary process . [DATE] at 20:29: Resident presented with complaints of difficulty breathing. Sitting upright on the edge of bed. SAT (saturation) 89% on)2 at 2.5 via nasal cannula. Increased to 3.5, then to 4 LPM (liters per minute) with SAT drop to 65% and resident becoming drowsy and lowing to bed with eyes closed, becoming non-responsive. Called second nurse for help, switched to tank 02, 6 LPM. SAT increased to 97%. Resident reminds drowsy. Respirations 24 . It was not documented if the physician was notified. [DATE] at 13:46: Resident participated in therapy this afternoon and while exercising O 2 was removed several times and oxygen saturation obtained while on room air and each reading was (greater than) 92% and he denied feeling short of breath . Resident stated he feel less short of breath with oxygen on while he is in his room, physician notified. [DATE] at 17:03: .He does continue to have a cough and post nasal drip . Late Entry Nurses Note written by the Director of Nursing (DON) on [DATE] at 14:25 (4 days after Resident #3's death) and dated [DATE] at 14:19: (Resident) having difficulties sitting up in wheel chair today, he needs oxygen on at all times now or he gets very short of breath using all exessary mussels to breath. (Resident) assisted with lunch only at a few bits. Had to be assisted multiple times from bed to wheel chair as (Resident) was very confused and continued to attempt to self transfer. Family and physician notified of (Residents) declining health condition. Note did not include details regarding physician response or new orders. Late Entry Nurses Note written by Unit Manager D on [DATE] at 14:33 (4 days after Resident #3's death) and dated [DATE] at 15:21: Resident calling out in room for help several times this afternoon. He reported that he was not breathing well, O 2 (oxygen) was applied per nasal cannula with saturations at 93%, he appeared short of breath and stated that the belt around his waist was making it so he could not breathe and he kept attempting to stand up and remove his belt. Resident was wearing sweat pants without a belt and informed him of this many times, but resident was insistent. Physician and guardian notified, will continue to reorient resident as needed. Note did not include details regarding physician response or new orders. Total Body Skin Assessment progress note written by Unit Manager D on [DATE] at 17:00: .1 bleeding abrasion with large hematoma noted above right eye, physician notified, resident sent to ER Nurses Notes written by Unit Manager D on [DATE] at 17:00: Was notified by staff that resident had fallen in room and was bleeding. Observed resident lying on right side, face pointing towards wall and located in entryway of room. Bleeding abrasion noted above right eye as well as a large bump/hematoma. Pupils were not reactive and resident was not responding but awake appearing lethargic, unable to follow simple commands which is not his baseline. Vital Signs obtained, unable to determine pain, resident was sat up x 2 staff assist, ROM (range of motion) intact at baseline and no voiced pain while moving extremities however baseline cognition was abnormal. Physician notified of occurrence with orders to send to ER (emergency room) for further evaluation. Family/guardian notified. Nurses Note written [DATE] at 16:12: On [DATE] at 1145 am daughters .came in to facility to collect their Dad's personal effects as he had passed away at the hospital the night before . Incident and Accident Reports: Resident #3's incident and accident reports were reviewed to determine injuries, gain perspective on what he was doing when he fell , and ascertain what new interventions staff implemented to prevent future falls. It was noted for three out of six falls that Resident #3 stated he was trying to use the bathroom prior to falling. Resident #3 was incontinent at the time of three of the six falls. Two of the six falls did not assess incontinence as a contributing factor. Appropriate toileting interventions were not implemented after four of the six falls. Orthostatic blood pressures were not obtained for Resident #3 after all six falls. Resident #3 was on multiple high-risk medications that could have caused orthostatic [MEDICAL CONDITION] and had the following physician orders: 4) Monitor resident for the following side effects related to anti-anxiety medication use and contact practitioner if indicated Confusion .restlessness, .weight changes .orthostatic [MEDICAL CONDITION] . 5) Monitor resident for the following side effects related to antipsychotic medication use and contact practitioner if indicated Confusion . restlessness, .weight changes .orthostatic [MEDICAL CONDITION] . ([DATE]) 6) ([DATE]) and Orthostatic blood pressure three times a day on [DATE] related to [MEDICAL CONDITION]. On four out of six post fall evaluations, Blood Sugar check is required for diabetic resident). Was resident's blood sugar significant? was marked Not Applicable. Resident #3 was diabetic and on scheduled insulin. Two of the six post fall evaluations did not ask/document whether blood sugar was checked. Only one blood sugar was documented ([DATE] at 00:41 a.m.) in Resident #3's electronic heath record during his stay at the facility. Resident #3's Incident Reports/Post-Fall evaluations indicated he was not thoroughly assessed for factors that likely contributed to his falls. Incident Report/ Post Fall Evaluation dated [DATE] at 05:00 a.m. said Resident #3 fell in his bathroom and obtained an abrasion to his upper back (measurements not included). Resident #3 was noted to be incontinent at the time of the fall and stated he was trying to urinate in toilet. The evaluation said it was unknown when Resident #3 last toileted. The post fall huddle asked, What was different this time?, transferring self to toilet was documented. Toileting Status was marked as a contributing factor to the fall. The intervention initiated post-fall was anti roll backs on Resident #3's wheelchair and did not address his incontinence or statement of what he was doing at the time of the fall. Under describe initial intervention to prevent future falls, a handwritten intervention was crossed out that said, Care planned no longer being able to take self to the toilet he must be assisted to the restroom. And was changed to, Anti-roll backs applied to w/c (wheelchair). Incident Report/ Post Fall Evaluation dated [DATE] at 01:25 a.m. said Resident #3 fell on the floor next to his bed. No injury was noted. The report/evaluation did not note if Resident #3 was incontinent at the time of the fall or not, or when he was last toileted. The report said Resident #3 said he got up to go to the bathroom before the fall. Toileting status was not marked as a contributing factor to the fall.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) Assessment of orthostatic blood pressure and blood sugar were not included in this report/evaluation. The fall huddle noted What was different this time?) as regular socks on . The intervention to prevent future falls was, grippy socks when in bed. Interventions to prevent future falls did not include toileting interventions. Incident Report/ Post Fall Evaluation dated [DATE] at 02:15