STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505355	A. BUILDING _____ B. WING _____	**08/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED POST ACUTE	**414 - 17TH SOUTHEAST AUBURN, WA 98002**

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate falls to determine cause, identify contributing factors and implement interventions to prevent further falls for eight of eight falls identified for Resident #1, and two of two incidents for Resident #4, two of seven residents reviewed. These failures placed Resident #1 at risk for repeated falls with injury and Resident #4 at risk for injury related to skin breakdown and improper positioning, and decreased the ability to identify neglect. Findings included . Refer to CFR 483.25(b)(1)(i)(ii), F-686, Treatment/Services to Prevent Pressure Ulcers CFR 483.25(d)(1)(2), F-689, Free From Accident Hazards FACILITY POLICY According to the facility's Fall Evaluation (Morse Scale) and Management policy dated March 2018, The nurse completes the Morse Scale (a falls assessment) at admission with re-evaluation completed, with each fall and with significant change in condition. This policy indicated that Post-Fall, the licensed nurse, Completes an interdisciplinary progress note, including a brief summary of the fall, the nursing evaluation, actions taken, who was notified and the resident's condition, The nurse completes orthostatic vital signs as able, The LN (Licensed Nurse) evaluates neuro checks for 72 hours for all falls unwitnessed by staff or falls that involve the resident's head striking a surface, and The nurse completes a blood glucose reading at the time of the fall (if diagnosed diabetic). FACILITY PRACTICE In an interview on 07/14/2020 at 10:35 AM, Staff B, Director of Nursing Services, stated she expected staff to follow the facility fall evaluation policy, including obtaining blood glucose readings, for residents identified with diabetes, and orthostatic vital signs at the time of falls. Staff B indicated it was expected that nursing staff complete post fall neurological assessments as directed on the neurological evaluation form and that staff should make a progress note in the resident record regarding falls and circumstances surrounding falls. Staff B confirmed that facility staff, as part of the investigative process, should determine if Care Plan (CP) interventions were implemented at the time of falls. Staff B indicated that IDT (Interdisciplinary Team) meetings should have, but were not, consistently taking place until recently. RESIDENT #1 Resident #1 was admitted to the facility on [DATE] and according to the 01/03/2020 Admission Minimum Data Set (MDS, an assessment tool), had [DIAGNOSES REDACTED]. Staff determined, according to this MDS, this resident had no history of falls prior to admission and experienced one fall since admission. According to the 03/27/2020 and 06/16/2020 Quarterly MDSs, the resident was assessed with [REDACTED]. The 03/27/2020 MDS indicated the resident sustained [REDACTED]. FALL ON 01/03/2020 Review of facility Investigative documents showed Resident #1 sustained a fall on 01/03/2020 while attempting to ambulate to the bathroom. Interventions included, placed him on a toileting plan to assist with toileting upon rising, before and after meals and at bedtime. In an interview on 07/14/2020 at 10:40 AM, after reviewing the 01/03/2020 fall investigation, Staff B, Director of Nursing Services, confirmed staff should have, but did not attempt to obtain orthostatic vital signs or assess blood glucose monitoring at the time of the fall. Staff B confirmed the investigation should, but did not, clearly identify the resident's footwear at the time of the fall or if the resident fell from the bed or the wheelchair. Additionally, Staff B confirmed that while staff initiated neurological checks, staff did not complete the assessments over the course of 72 hours as directed on the assessment form. FALL ON 03/19/2020 According to facility investigative documents dated 03/19/2020, Resident #1's roommate comes up to the nurse station to report resident is on the floor (sic) .he saw the resident laying on the floor, so he got up to look for help. Staff documented the resident was found laying on his back head between the wall and the toilet. According to CP documents dated 03/19/2020, staff were directed to, Ensure that The resident is wearing appropriate footwear non skid socks or shoes when ambulating or mobilizing in w/c (wheelchair). Non skid socks while in bed. The investigation indicated an intervention of, Put on increased toileting program. Hourly monitoring provided. The investigation did not specify how the increased toileting program differed from the previous program implemented after the 01/03/2020 fall. In an interview on 07/14/2020 at 10:50 AM, when asked how long the resident was on the floor prior to being assisted by staff, Staff B stated, Difficult to say, it's not clearly indicated. When asked if attempts to determine how long the resident was on the floor should be made, Staff B stated, Yes. When asked the effectiveness of the previously implemented toileting program, Staff B stated, I don't see when the last time that he was toileted or provided with care. Failure to assess if care planned interventions were implemented as directed detracted from staff's ability to rule out neglect. According to the injuries report post incident portion of the investigation, staff reported the resident had a Left Elbow fracture. Record review showed no indication the resident sustained [REDACTED]. In an interview on 07/14/2020 at 10:50 AM, Staff B confirmed Resident #1 did not have a fracture on 03/19/2020 and the investigation inaccurately reflected a significant injury. In an interview on 07/14/2020 at 10:50 AM, after reviewing the 03/19/2020 fall investigation, Staff B confirmed the investigation should have, but did not, include/address the resident's blood glucose level and orthostatic vital signs at the time of the fall. Additionally, Staff B confirmed staff should have, but did not, enter a progress note into the resident's record on the day of the fall, to include Post-Fall documentation by the licensed nurse, including a brief summary of the fall, the nursing evaluation, actions taken, who was notified and the resident's condition. In an interview on 07/14/2020 at 11:05 AM, when asked if the 03/01/2020 and 03/19/2020 fall investigations were thorough, Staff A, Administrator, stated, We are clear on that now. FALL ON 03/30/2020 Facility investigative documents dated 03/30/2020 showed the resident was found on the floor, lying on his left side, on the left side of the bed. The investigation did not address the resident's footwear or if the care planned interventions regarding footwear were implemented. The investigation did not clearly indicate if the resident fell from the bed or the wheelchair. In an interview on 07/14/2020 at 11:08 AM, after reviewing the 03/30/2020 fall investigation, Staff B indicated that because staff documented the resident, was assisted back to bed . that the resident fell from bed. When asked if staff considered interventions to prevent recurrence or decrease risk of injury such as a lipped mattress or mats at bedside, Staff B replied, It doesn't appear so. When asked if those additional interventions might be something to consider, Staff B stated, Yes. In an interview on 07/14/2020 at 11:08 AM, after reviewing the 03/30/2020 fall investigation, Staff B confirmed the investigation should, but did not, include the resident's blood glucose level and orthostatic vital signs at the time of the fall. When asked if staff provided the hourly rounding as documented in the 03/19/2020 fall, Staff B indicated the investigation did not address this intervention. Despite failing to identify the efficacy of hourly rounding, staff identified the intervention of, Placed on 15 minute checks around the clock to increase supervision to decrease fall risk and help prevent future occurrence. Further review of the investigation showed no indication facility staff considered the potential impact of medications on the resident's trendable falls. The investigation failed to identify that while staff initiated neurological checks, staff did not complete the assessments over the course of 72 hours as directed on the assessment form. There was no documentation to show facility staff considered the effectiveness of the previously implemented toileting program or when the resident was last toileted or received care. Failure to determine if the resident received interventions he was assessed to require detracted from staff's ability to rule out neglect. FALL ON 04/19/2020 Facility investigative documents dated 04/19/2020 showed Resident #1 sustained an unwitnessed fall from the wheelchair. Record review showed no indication staff completed neurological

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

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) checks and no blood glucose testing at the time of the fall. The fall investigation failed to identify lack of these required post fall assessments. Record review showed the 15 minute checks were last done on 04/08/2020. There was no assessment which supported why the 15 minute checks were no longer required or why the resident no longer required increased supervision to decrease fall risk. FALL ON 04/22/2020 Subsequent investigative documents showed that on 04/22/2020 the resident sustained [REDACTED]. Per CNA resident did not have a gait belt on . According to care plan documents dated 12/30/2019, The resident required (extensive assist by (1) staff to move between surfaces as necessary using a FWW (Front Wheeled Walker) with SBA (Stand By Assist). In-service documents associated with the 04/22/2020 fall investigation summarized, When assisting a resident with ambulation (Stand By Assist) you must use a gait belt to help decrease fall risk. The investigation failed to address why nursing staff did not utilize a gait belt for a resident who was assessed to require SBA. While the CP was amended on 04/24/2020 specifying transfers with SBA should be done, with gait belt, there was no documentation to support why staff attempted the SBA transfer without the use of a gait belt. There was no witness statement from the staff member who was present at the time of the fall. Review of the investigative documents and review of the resident's records showed no assessment of orthostatic vital signs or blood glucose levels at the time of the fall. The investigation did not identify the staff's failure to follow the Fall Evaluation Policy which would have provided an opportunity to educate staff regarding failed practice. Record review showed staff did not make a timely entry regarding this fall. Documentation regarding the fall was not made until 04/23/2020, resulting in a delay in alert charting which detracted from staff's ability to timely identify injuries. The investigation did not identify the late entry, which would have provided an opportunity to educate staff regarding failed practice. The investigation indicated, Resident is mostly continent of bladder and is on a q (every) 2 hour toileting program. This appears to be an isolated incident. The investigation did not assess the last time the resident was toileted or the effectiveness of the toileting program. The investigation failed to identify the disparity between being, an isolated incident despite being the third of five falls related to the resident's toileting needs. According to the investigation, there was no witness found despite having documentation to support an unidentified staff member was present at the time of the fall. In an interview on 07/14/2020 at 11:15 AM, Staff B indicated the investigation was incorrect as there was an aide present at the time of the fall. Staff B confirmed a witness statement should have been, but was not, obtained at the time of the fall. When asked if the facilities fall investigations were thorough, Staff B replied, No. FALL ON 05/07/2020 According to facility investigative documents the resident was identified with a fall from bed on 05/07/2020, this nurse was informed by the CNA that the resident was on the floor. The facility staff did not attempt to determine when the resident last received care or how long the resident was on the floor. The resident record and investigative documents did not address whether the resident's CP was implemented regarding the use of non-skid socks while in bed. The investigation failed to identify staff did not complete neurological checks, orthostatic vital signs or blood glucose levels as required. The investigation did not address when the resident was last toileted, or if the resident's toileting program was implemented, adequate or meeting the resident's needs. Failure to determine if the resident's care planned interventions were implemented detracted from staff's ability to rule out neglect. On 07/14/2020, a full week after the fall, the investigation summary documented, therapy screen for ambulation. Review of the investigation and resident records showed no results of the therapy screen. Information was requested to support the therapy screen was performed. No information was provided. Additionally, in an interview on 07/14/2020 at 11:10 AM, Staff B indicated that facility staff did not, but should have identified repeated falls from bed and considered alternate interventions to prevent recurrence, such as a perimeter mattress or mats at bedside. FALL ON 06/13/2020 Record review showed Resident #1 sustained a fall while attempting to transfer from the wheelchair to the bed on 06/13/2020. According to the investigation, there were, No records found for the assessment portion of mental status, Predisposing environmental factors, Predisposing situational factors, or Predisposing physiological factors. Record review showed there was no post fall alert charting on 06/14/2020. In an interview on 07/14/2020 at 11:18 AM, Staff B indicated that the investigation showed, No records found, because staff did not, but should have, completed those sections of the investigation. When asked if there should have been some alert charting on 06/14/2020 related to the fall, Staff B replied, Yes. According to the investigation documents, facility staff notified the resident's family and physician of the fall on 06/16/2020, three days after the fall. The investigation did not identify this was a delayed notification. The investigation failed to identify staff did not complete neurological checks, orthostatic vital signs or blood glucose levels as required. The investigation did not address if previous interventions, including two hour toileting, were implemented. Failure to determine if the resident's care planned interventions were implemented detracted from staff's ability to rule out neglect. FALL ON 06/19/2020 According to facility investigative documents dated 06/19/2020, the resident had a witnessed fall from bed at 2:05 PM. Staff documented at the time of the fall, Resident was not wearing pants or socks . A witness statement dated 06/19/2020 indicated, while I was walking towards residents room I saw resident tried to (stand) up (at the edge of bed was dangling) and fell on his face. Record review showed the resident was subsequently identified with a fractured left upper arm. The investigation showed, resident is noted with receiving incontinence care 30 minutes prior to witnessed fall. According to a statement by the resident's care giver, the resident was put to bed, around 12:30 PM and did not specify that toileting or incontinence care took place. The investigation failed to identify how it was identified what care was provided at 1:30 PM (30 minute prior to fall) rather than the 12:30 PM (one and a half hours prior to fall) time provided by the caregiver's statement. The investigation did not address when the resident was last toileted, or if the resident's toileting program was implemented, adequate or meeting the resident's needs. Failure to determine if the resident's care planned interventions were implemented detracted from staff's ability to rule out neglect. The investigation indicated the resident had, No injuries observed post incident. This information was in conflict with the resident record that showed an x-ray post fall reflective of a fractured arm. The investigation failed to identify staff did not complete neurological checks, orthostatic vital signs or blood glucose levels as required. Failure to determine if the resident's care planned interventions were implemented detracted from staff's ability to rule out neglect. The investigation failed to identify the resident's bare feet and lack of non skid socks as potential neglect as the care plan clearly directed staff to ensure non skid socks while in bed. The investigation did not identify the care plan was not followed and did not specifically rule out abuse or neglect. In an interview on 07/14/2020 at 11:29 AM, Staff B confirmed the 06/19/2020 investigation was not thorough. In an interview on 07/14/2020 at 1:30 PM, Staff A, Administrator, indicated staff training regarding thorough investigations was being implemented. RESIDENT #4 INVESTIGATION OF 07/10/2020 Resident #4 admitted to the facility on [DATE]. According to the 12/09/2019 Significant Change MDS the resident was assessed to require Hospice services. The 03/10/2020 Quarterly MDS, showed the resident no longer required Hospice services. The 06/08/2020 Quarterly MDS showed the resident had [DIAGNOSES REDACTED]. Staff assessed the resident with severe cognitive impairment and, rarely/never understood and at risk for pressure ulcers. Review of investigative documents dated 07/10/2020 showed, Nurse noted a stage 2 pressure ulcer on the rt (right) buttocks of the resident. the ulcer is 2.5 x 1.4 mm (millimeter) in size. An investigative note dated 07/14/2020 showed, The resident was recently discharged from Hospice, however continues on comfort care. Resident has a Broda chair to allow for positioning and offloading . The investigation also showed, (resident) is on Broda chair and air mattress for support surface and will continue as helpful in reducing severity and occurrence of pressure ulcers . Record review showed the resident was discharged from Hospice services on 03/14/2020 and that Hospice staff picked up the Broda wheelchair and Specialty Pressure Reducing Air Mattress with Bolsters on 06/22/2020, leaving the resident without the identified care planned interventions. In an interview on 08/05/2020 at 3:15 PM, Staff D, Hospice Nurse Staff Manager, confirmed that all hospice Durable Medical Equipment (specialty mattress with bolsters and wheelchair) was picked up from the facility on 06/22/2020. Review of facility investigative documents showed no indication staff acknowledged hospice retrieved the air mattress and Broda chair or identified that the lack of care planned interventions may have contributed to the development of the stage 2 pressure ulcer. In an interview on 08/06/2020 at 10:15 AM, Staff B indicated the investigation should have identified the air mattress was removed on 06/22/2020. Failure to thoroughly investigate to determine the root cause of incidents detracted from staff's ability to provide timely and pertinent interventions. Failure to determine if the resident's care planned interventions were implemented detracted from staff's ability to rule out neglect. In an interview on 08/06/2020 at 10:15 AM, Staff B and C, Interim Administrator, confirmed this investigation was not thorough. INVESTIGATION OF 07/22/2020 According to facility investigative documents Resident #4 was identified on the morning of 07/22/2020 with, .a bruise purple and yellow in color on resident's left ankle foot area with noted swelling. Resident unable to give description. The resident was subsequently identified with a, fracture involving lateral malleolus (outer ankle). Immediate actions taken included, staff in-service completed to position extremities to prevent them from being injured/bumped on w/c when

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) lifted/lowered in Hoyer, and to make sure foot pedal are up prior to transferring the resident . According to a 07/30/2020 statement by Staff H, Physical Therapy Assistant, Notified on Thursday 7/23, pt (patient) requires a wc (wheelchair) replacement, talked to vendor, vendor able to bring a wc out on 7/24 tailor to needs of tilt back for positioning and comfort and LE (lower extremity) footbox, padding or covering to ensure pt's LE unable to fall . A second statement by Staff H, dated 07/30/2020, indicated, Therapy was requested for a new w/c on 7/17 r/t (related to) pt coming off of hospice on 3/12 and hospice retrieving w/c provided for pt. Review of investigative documents showed facility staff identified the resident's Broda chair, which Resident #4 was assessed to require, was removed from the facility on 07/17/2020, .the w/c provided by hospice was not retrieved until 7/17/20. at that time therapy evaluated her for a new w/c and it was placed on 7/17/20. In an interview on 08/06/2020 at 10:15 AM, Staff B was asked how the facility determined the w/c was removed from the facility on 07/17/20 when documentation from Hospice showed it was taken on 06/22/2020. Staff B indicated they concluded this based on an interview with Staff H. When asked if the 07/17/2020 date was accurate, Staff B stated, No. In an interview on 08/05/2020 at 2:25 PM, Staff B and C were asked to provide documentation Staff H assessed Resident #4 no longer required the Broda wheelchair or that an alternate wheelchair was assessed as appropriate on 06/22/2020 or 07/17/2020, per Staff H's statement. No information was provided. In an interview on 08/05/2020 at 2:25 PM, Staff B, C and E, Clinical Operations Staff, explained, Administrative staff (Staff B, C & E, Clinical Operations Staff) indicated, I believe they (CNAs) lifted and she (Resident #4) shifted and the foot got caught under (the foot pedal)and the CNA didn't see prior to lifting (the resident with the lift), I think they followed the procedure but didn't look under the blanket and we were not able to determine which CNA did it because I do not think the CNA realized they did it (caused the left ankle fracture). Care Plan documents dated 09/29/2015 showed Resident #4, requires mechanical lift/hoyer lift with two staff assistance with transfers. Review of investigative documents showed there were no interviews of direct care staff which questioned if, or which, staff provided a two person mechanical transfer as directed in the resident's care plan. The investigation made no mention of a blanket. Failure to determine if the resident's care planned interventions were implemented, or that staff demonstrated competency for mechanical transfers detracted from staff's ability to rule out neglect. In an interview on 08/06/2020 at 10:15 AM, Staff B was asked if the purpose of the second staff for mechanical transfers was to ensure safety and resident positioning, how could staff note if the resident's foot/leg slips if the resident's legs are covered with a blanket. Staff B stated, yes. When asked if any CNAs stated they did a mechanical transfer with the resident's legs covered with a blanket, Staff B stated, We didn't ask them that. When asked, in an interview on 08/06/2020 at 10:15 AM, if this investigation was thorough, Staff B and C stated, No. REFERENCE WAC: 388-97-0640(a)(b)(c). .
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (#4) of three residents reviewed for alteration in skin integrity, received necessary treatment and services, consistent with professional standards of practice, to prevent ulcers from developing. Failure to implement identified preventative measures, including a specialty air mattress and Broda wheelchair, caused Resident #4 to experience deterioration in skin condition. Findings included . Refer to CFR 483.412(c)(2)-(4), F-610, Investigate/Protect Resident During Investigation CFR 483.25(d)(1)(2), F-689, Free From Accident Hazards Resident #4 admitted to the facility on [DATE]. According to the 12/09/2029 Significant Change Minimum Data Set (MDS - an assessment tool) the resident was assessed as requiring Hospice services. The 03/10/2020 Quarterly MDS, the resident no longer required Hospice services. The 06/08/2020 Quarterly MDS showed the resident had [DIAGNOSES REDACTED]. Staff determined the resident was at risk for development of pressure ulcers but had no pressure ulcers. Staff documented the resident had interventions including pressure reducing devices for both the bed and chair. According to Care Plan (CP) documents dated 08/28/2018, the resident required a (Broda - a speciality wheelchair that prevents skin breakdown for residents that need a high level of positioning or special adaptation due to positional challenges) tilt-n-space w/c (wheelchair) for .off-loading pressure to coccyx. An additional intervention dated 10/08/2019 directed staff to Assist resident with position changes and remain on air mattress and Broda tilt in space wheelchair to avoid and excess pressure to coccyx area and Specialty Pressure Reducing Air Mattress with bolsters (a device to provide physical perimeter of mattress edge) * mattress provided by hospice. Record review showed the resident was discharged from Hospice services on 03/14/2020 and that Hospice staff picked up the Broda wheelchair and Specialty Pressure Reducing Air Mattress with Bolsters on 06/22/2020, leaving the resident without the identified care planned interventions. In an interview with Staff D, Hospice Nurse Staff Manager on 08/05/2020 at 3:15 PM confirmed that all hospice Durable Medical Equipment (specialty mattress with bolsters and wheelchair) was picked up from the facility on 06/22/2020. Review of progress notes showed no indication facility staff acknowledged hospice retrieved the air mattress. There was no indication in the record that facility staff assessed the resident required any mattress other than the air mattress, which the care plan continued to reflect the resident required. Review of investigative documents dated 07/10/2020 showed, Nurse noted a stage 2 pressure ulcer on the rt (right) buttocks of the resident. the ulcer is 2.5 x 1.4 mm (millimeter) in size. It was not until 07/16/2020 when staff documented, The air mattress got set up this evening and well functioning. In an interview on 08/05/2020 at 3:15 PM, facility Administrative Staff (Staff B, Director of Nursing, and Staff C, Interim Administrator) was asked to provide documentation to support the resident continued to receive a specialty air mattress after the 06/22/2020 Hospice removal of the air mattress. No information was provided. Failure to implement identified interventions (Broda chair, air mattress) contributed to the development of a pressure ulcer. REFERENCE WAC: 388-97-1060(3)(b). .
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure resident supervision, thorough accident investigations to determine the circumstances of resident accidents and implementation of measures to prevent reoccurrence for one (#1) of three residents reviewed for falls, for whom fall precautions were not implemented and one (#4) of four residents reviewed for injuries, for whom staff failed to provide adequate supervision to prevent injury. Failure to implement interventions, including adequate supervision and assistive devices, consistent with Resident #1's needs, goals, and care plan in order to reduce the risk of an accident, contributed to a pattern of repeated falls which caused Resident #1 to sustain a fall with a fracture, which constituted harm. Failure to provide adequate supervision during a mechanical transfer caused Resident #4 to sustain a fracture, which constituted harm. Findings included . Refer to CFR 483.412(c)(2)-(4), F-610, Investigate/Protect Resident During Investigation CFR 483.25(b)(1)(i)(ii), F-686, Treatment/Services to Prevent Pressure Ulcers RESIDENT #1 Review of facility incident logs showed Resident #1 demonstrated a pattern of eight falls starting on 01/03/2020, culminating in a fall with significant injury on 06/19/2020. Resident #1 was admitted to the facility on [DATE] and according to the 01/03/2020 Admission Minimum Data Set (MDS, an assessment tool), had [DIAGNOSES REDACTED]. Staff determined, according to this MDS, Resident #1 had no history of falls prior to admission and experienced one fall since admission. According to the 03/27/2020 and 06/16/2020 Quarterly MDSs, the resident was assessed with [REDACTED]. The 03/27/2020 MDS indicated Resident #1 sustained two or more non injury falls and the 06/16/2020 MDS reflected one non injury fall and one fall with injury. Review of facility Investigative documents showed Resident #1 sustained a fall on 01/03/2020 while attempting to ambulate to the bathroom. Record review showed no staff were present to assist or supervise the resident's ambulation. According to facility investigative documents, Resident #1 sustained a second fall on 03/19/2020 when the resident was found on the floor in the bathroom. According to Care Plan documents dated 03/19/2020, staff were directed to, Ensure that the resident is wearing appropriate footwear nonskid socks or shoes when ambulating or mobilizing in w/c (wheelchair). Nonskid socks while in bed. Facility investigative documents dated 03/30/2020 showed a third fall when the resident was found on the floor, lying on his left side, on the left side of the bed. The investigation did not address the resident's footwear or if the care planned interventions regarding footwear were implemented. Staff identified the intervention of, Placed on 15 minute checks around the clock to increase supervision to decrease fall risk and help prevent future occurrence. Facility investigative documents dated 04/19/2020 showed Resident #1 sustained a fourth fall. Record review showed the 15 minute checks were last done on 04/08/2020. There was no assessment which supported why the 15 minute checks were no longer required or why the resident no longer required increased supervision to decrease fall risk. Subsequent investigative documents showed that on 04/22/2020 the resident sustained [REDACTED]. Per CNA resident did not

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) have a gait belt on . According to care plan documents dated 12/30/2019, The resident required (extensive assist by (1) staff to move between surfaces as necessary using a FWW (Front Wheeled Walker) with SBA (Stand By Assist). In-service documents associated with the 04/22/2020 fall investigation summarized, When assisting a resident with ambulation (Stand by Assist) you must use a gait belt to help decrease fall risk. The investigation failed to address why nursing staff did not utilize a gait belt for a resident who was assessed to require SBA. While the CP was amended on 04/24/2020 specifying transfers with SBA should be done, with gait belt, there was no documentation to support why staff attempted the SBA transfer without the use of a gait belt. Failure to ensure use of a gait belt for a resident who was assessed to require SBA, did not provide a safe level of supervision or assistance. According to facility investigative documents the resident was identified with a sixth fall, from bed on 05/07/2020. Review of the resident record and investigative documents did not address whether the resident's CP was implemented regarding the use of non-skid socks while in bed. In an interview on 07/14/2020 at 11:10 AM, Staff B indicated that facility staff did not, but should have considered alternate interventions to prevent recurrence such as a perimeter mattress or mats at bedside. Record review showed Resident #1 sustained a seventh fall while attempting to transfer from the wheelchair to the bed on 06/13/2020. Review of investigative documents showed staff did not consider increased supervision to prevent further falls. Resident #1 experienced an eighth fall according to facility investigative documents dated 06/19/2020. Staff documented the resident fell from bed and, Resident was not wearing pants or socks . A witness statement dated 06/19/2020 indicated, while I was walking towards residents room I saw resident tried to stood (sic) up (at the edge of bed was dangling) and fell on his face. The resident was subsequently identified with a fractured left upper arm. Failure to implement identified measures to reduce the risk of falls, including nonskid socks, contributed to a fall with significant injury, which constituted harm. In an interview on 07/14/2020 at 10:35 AM, Staff B, Director of Nursing, indicated staff were expected to implement care plans. RESIDENT #4 Resident #4 admitted to the facility on [DATE]. According to the 12/09/2019 Significant Change MDS the resident was assessed to require Hospice services. The 03/10/2020 Quarterly MDS, showed the resident no longer required Hospice services. The 06/08/2020 Quarterly MDS showed the resident had [DIAGNOSES REDACTED]. Staff assessed the resident with severe cognitive impairment and, rarely/never understood. According to CP documents dated 08/28/2018, the resident required a (Broda - a speciality wheelchair that prevents skin breakdown for residents that need a high level of positioning or special adaptation due to positional challenges) tilt-n-space w/c (wheelchair) for trunk control, proper body alignment and off-loading pressure to coccyx. An additional intervention dated 10/08/2019 directed staff, Tilt and space/Broda chair: Specialty Pressure Reducing Air Mattress with bolsters (a device to provide physical perimeter of mattress edge) * mattress provided by hospice. Care Plan documents dated 09/29/2015 showed Resident #4, requires mechanical lift/hoyer lift with two staff assistance with transfers. Record review showed the resident was discharged from Hospice services on 03/14/2020 and that Hospice staff picked up the Broda wheelchair and Specialty Pressure Reducing Air Mattress with Bolsters on 06/22/2020. In an interview with Staff D, Hospice Nurse Staff Manager on 08/05/2020 at 3:15 PM confirmed that all hospice Durable Medical Equipment (specialty mattress with bolsters and Broda wheelchair) was picked up from the facility on 06/22/2020 and was no longer available to the resident. Record review showed no indication facility staff acknowledged hospice retrieved the Broda wheelchair or assessed the resident's wheelchair needs at that time. There was no indication in the record that facility staff re-assessed the resident required any chair other than the Broda wheelchair, which the care plan continued to reflect the resident required. In an interview on 08/06/2020 at 9:56 AM, Staff B indicated the resident was provided with a non-Broda wheelchair to replace the Broda which Hospice retrieved. Staff B stated that therapy staff provided Resident #4 with a replacement wheelchair that previously was ordered for another resident. Record review revealed no assessment that this wheelchair was appropriate for Resident #4. Staff B & C, Interim Administrator, at this time confirmed the record should, but did not contain information to show staff evaluated and analyzed potential hazards and risks associated with the replacement wheelchair. According to facility investigative documents the resident was identified on the morning of 07/22/2020 with, .a bruise purple and yellow in color on residents left ankle foot area with noted swelling. Resident unable to give description. The resident was subsequently identified with a, fracture involving lateral malleolus (outer ankle). Immediate actions taken included, staff in-service completed to position extremities to prevent them from being injured/bumped on w/c when lifted/lowered in Hoyer, and to make sure foot pedal are up prior to transferring the resident . A subsequent evaluation by the Physical Therapy Assistant dated 07/30/2020, after the fracture, showed, It was recommended that the Broda is a better and safer fit at this time d/t (due to) extended foot recliner and improved back rest that improves pt's comfort and functional fit. According to investigative documents dated 07/24/2020, The resident was evaluated while up in her w/c, and noted with her legs resting on the calf support system, however her feet were noted under the foot pedals. There was a pillow placed under the resident calves in attempt to support her legs. The foot pedal was noted to be situated directly above the point of impact of the bruising .Likely cause of the bruising is the resident's ankle bumped the foot pedal while being raised up in the hoyer (a mechanical lift). According to the CNA, Certified Nursing Aide, Mechanical lift transfer competency, Staff ensure wheelchair footplates are in the up position and, if able, swung away from the front of the chair. In an interview on 08/05/2020 at 2:25 PM, Staff A and B indicated mechanical transfers required two staff, one to operate the mechanical lift and one to help guide the resident to prevent injury. Record review showed multiple CNAs were identified as providing care for Resident #4 in the days prior to the transfer resulting in a fracture. In an interview on 08/06/2020 at 10:15 AM, Staff B confirmed that none of the CNAs identified had completed a CNA competency for a mechanical lift transfer. Facility staff failed to ensure adequate supervision, including competency and training of the staff, consistent with a resident's needs, goals, care plan in order to eliminate or reduce the risk of an accident. In an interview on 08/05/2020 at 2:25 PM, administrative staff were asked if direct care staff had performed the mechanical transfer properly, would Resident #4 have sustained the ankle fracture. Administrative staff (Staff B, C & E, Clinical Operations Staff) indicated, I believe they (CNAs) lifted and she (Resident #4) shifted and the foot got caught under (the foot pedal)and the CNA didn't see prior to lifting (the resident with the lift), I think they followed the procedure but didn't look under the blanket and we were not able to determine which CNA did it because I do not think the CNA realized they did it (caused the left ankle fracture). Administrative staff at this time confirmed that the resident's left ankle fracture was the result of a hoyer lift transfer. Failure to ensure adequate supervision during a mechanical transfer caused Resident #4, who was dependent on staff for transfers, to sustain a fracture. REFERENCE WAC 388-97-1060(3)(g). .