STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175224	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MORAN MANOR	3940 US HWY 54 MORAN, KS 66755

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 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 25 residents with 12 residents sampled. Based on interview and record review, the facility failed to complete a significant change of status Minimum Data Set, (MDS) for Resident (R)16 for two or more changes in activities of daily living in accordance with the Resident Assessment Instrument (RAI) manual, as required. Findings included: - Review of Resident (R)16's undated Physician Orders, documentation included [DIAGNOSES REDACTED]. The significant change Minimum Data Set (MDS), dated [DATE], documentation included the resident with the Brief Interview for Mental Status (BIMS) score of five which indicated severe cognitive impairment and fluctuating inattention. She required limited assistance of staff for bed mobility, transfers, walking, locomotion, personal hygiene, dressing and grooming. The quarterly MDS, dated [DATE], documentation revealed the resident required extensive assistance of staff with bed mobility, transfers, walking, locomotion, personal hygiene, dressing and grooming. On 08/18/2020 at 08:47 AM, two Certified Nurse Aides (CNA) provided extensive/weight bearing assistance with walking the resident. The CNAs used a gait belt and provided physical guidance and verbal cues while walking the resident. On 08/18/2020 at 12:31 PM, CNA P stated the resident's medications changed because she had a change of condition. On 08/19/2020 at 02:25 PM, CNA N reported the resident could not walk by herself due to the resident having a decline and needing more assistance. She stated the resident did not open her eyes and required guidance and weight bearing support. On 08/20/2020 at 10:22 AM, Administrative Nurse D stated the Resident Assessment Instrument (RAI) manual provided guidance the completion of the MDS. She verified that two or more changes in ADLs required a significant change in status MDS. Administrative Nurse D confirmed the resident's decline, going from limited to extensive assistance in six activities of daily living (ADLs), indicated a need for the initiation in a significant change in status MDS. The RAI manual, dated 10/2019, documented a significant change in status MDS is indicated when it is determined that a significant change (either improvement or decline) in a resident condition from his or her baseline has occurred as indicated by the comparison of the resident's current status to the most recent comprehensive assessment and any subsequent quarterly assessment and the resident's condition is not expected to return to baseline within two weeks. The facility failed to do a significant change in status with two or more areas for the resident from the annual MDS, dated [DATE], to the quarterly MDS dated [DATE].
F 0656 **Level of harm** - Minimal harm or potential for actual harm **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** The facility reported a census of 25 residents with 12 residents selected for review. Based on interview and record review, the facility failed to develop a comprehensive care plan for Resident (R)25 for fall prevention and failed to have the baseline care plan available for staff guidance to prevent possible falls. Findings included: - The hospital Discharge Summary, dated 06/30/20, for Resident (R)25 included [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], assessed (R)25 as having a Brief Interview of Mental Status (BIMS) score of 99, indicating the resident was unable to complete the interview. There were no behaviors, rejection of care, or wandering. She required extensive assistance of two or more staff for bed mobility and transfers. R25 walked once or twice with two or more staff assistance in her room and in the corridor. She required extensive assist of two or more staff for locomotion on and off the unit, dressing, toilet use, and personal hygiene. Her range of motion was impaired to both sides of her upper and lower extremities, her balance was not steady, and she required staff assistance for moving on and off the toilet, and for surface to surface transfers. The resident required no mobility devices. R25 fell in the last month prior to admission and had no falls since admission. She received Occupational and Physical therapy. The Falls Care Area Assessment (CAA), dated 07/16/2020, revealed R25 was an actual risk for falls related to the resident required staff assist for bed mobility. She had a previous fall at her home. She had difficulty maintaining her balance. She received an antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) daily, had [MEDICAL CONDITION], urinary incontinence, and dementia. The staff were to make sure the resident's call light was always within reach in her room and encourage her to wear some type of non-skid footwear, including nonskid socks and/or shoes when transferring and/or walking. Review of the facility's Care Plan Book M-Z lacked guidance for the resident fall prevention. Review of the electronic medical record (EMR), under the care plan tab, had a care plan initiated on 07/08/20, with a problem for safety. The care plan lacked any fall interventions. Furthermore, the care plan included a problem of self-care /ADL (activities of daily living) function but lacked instruction on what assistance R25 needed from the staff. The care plan lacked guidance for fall prevention. The Baseline Care Plan, dated 07/05/20, was unavailable for staff guidance for the resident's cares, as the baseline care plan was in the medical records department, in overflow. However, the baseline care plan included that R25 had a history of [REDACTED]. Interventions included: 1) On 07/04/20, staff should place fall mat at the resident's bed. 2) On 07/21/20, Dycem under butt in bed (Dycem is a nonslip rubber-like material). 3) On 07/31/20 the intervention was added that the staff was to check on her and assist to commons area if awake. Furthermore, for her ADL's, she required assistance of two or more for bed mobility, transfers, walking, and toileting. The Post Fall Evaluation Fall Details, under the progress notes, revealed R25 had an unwitnessed fall at 07/21/20 at 07:20 PM. Staff found the resident, on the floor, in a praying position facing the bed. Her roommate alerted staff. The Interdisciplinary Team (IDT) Review/Investigation, dated 07/21/20 at 07:20 PM, indicated the suspected cause of the fall was that she scooted out of her bed, and guided staff to place Dycem in the bed underneath her bottom (buttocks). The Post Fall Evaluation Fall Details, under the progress notes, revealed R25 had an unwitnessed fall in her room at 07/21/20 at 03:25 PM. The resident out of the bed. R25 had been assisted to the bed at 03:00 PM. The evaluation included that additional needs were an antiroll mattress, however, staff failed to care plan the antiroll mattress. On 08/18/20 at 02:16 PM, Administrative Nurse D revealed that upon admission, the facility should create a temporary care plan on paper, which should be available in the Care Plan book. On day 21, the care plan in the computer goes into effect. Staff print the care plan and the care plan should be placed in the Care Plan Book. Nurses should document changes on the paper care plan. Administrative Nurse D revealed that R25 lacked a comprehensive care plan for falls. On 08/18/20 at 02:36 PM, Consultant GG confirmed staff should have fall interventions in place for the resident's safety, a comprehensive care plan should have been completed. The Resident Assessment Instrument (RAI) manual should be followed and fall interventions should be posted on the communication board to make staff aware of the resident's fall interventions. On 08/18/20 at 02:40 PM, Administrative Staff A confirmed she would expect that the care plan be completed timely. On 08/18/20 at 02:55 PM, Administrative Nurse D confirmed that the Care Plan Book lacked the temporary care plan and that it was found in the overflow, where staff was unable to access the resident's fall interventions. On 08/20/20 at 10:40 AM, Licensed Nurse (LN) H reported when a resident has a fall, staff try to look at the care plan to see the current interventions, and new fall interventions should be placed on the care plan. The facility's' policy Care Plans,

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Comprehensive Person-Centered, dated 12/2016, directed that a comprehensive, person-centered care plan including measurable objectives and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident and developed within seven days of completion of the required comprehensive MDS assessment. The facility failed to ensure the development of a comprehensive care plan that included interventions for this resident's falls or have the baseline care plan available to staff to prevent possible further falls.
F 0657 **Level of harm -** Minimal harm or potential for 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** The facility reported a census of 25 residents with 12 selected for review, including six residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to review and revise the care plan with interventions following falls to prevent further falls for two dependent Residents (R)17 and R 16, that experienced multiple falls and the facility failed to follow care planned interventions to prevent further falls for one dependent R 25. Findings included: - Review of Resident (R)17's Physician Orders, dated 08/10/2020, documentation included [DIAGNOSES REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE], documentation included the resident admitted on [DATE], with the Brief Interview for Mental Status (BIMS) score of 13, which indicated cognitively intact. The resident required limited assistance of staff with bed mobility, transfers, walking and locomotion, toilet use, personal hygiene, dressing and grooming. Her balance with transition was not steady but she was able to stabilize without staff assistance. She had no functional limitation in range of motion (ROM) and was always continent of bowel and bladder. The resident had a fall in the last month prior to admission, and the assessor was unable to determine if she fell in the previous 2-6 months of admission. The resident experienced two or more falls since admission. The Falls, ADL Functional/Rehabilitation Potential, and Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 06/19/2020, documented respectively the resident was a potential fall risk related to impaired gait/mobility. Staff should make sure the resident's call light was within her reach in her room. Staff should monitor to ensure non-skid fall strips were in the room and replace the strips when necessary. She was at risk for impaired mobility. Staff assist with activities of daily living (ADL's), staff assist with her balance. Staff should keep frequently used objects near the resident, assistive device within her reach, and provide the resident with frequent reminders to use her assistive device. She was at risk for urinary incontinence related to her need for staff to assist her, as needed, with toileting. Staff were to encourage elder(resident) to toilet following the toileting program and provide the elder with appropriate incontinent products if necessary. The resident's base line care plan, dated 06/08/2020, documented safety elopement risk with the intervention of hourly checks and application of a wander guard bracelet (an alarm device that activates when the resident approaches the exit doors). History of falls entry included shoes while walking, call light in reach and therapy screens. Additional interventions included: 1. On 06/12/2020, for non-skid strips (lacked specific location). 2. On 06/15/2020, for toileting plan, However, the care plan lacked specific times or a toileting plan. 3. On 06/21/2020, resident should keep her shoes within her reach. 4. On 06/22/2020, staff should place dycem (non-skid sheet) in the recliner. There were no additional care plan interventions entered after 06/22/2020. The comprehensive care plan (CP), dated 06/18/2020 and revised 07/08/2020, directed staff to 1. Ensure all clothes were properly fitting in order to prevent falls. 2. Staff to provide limited assistance to get into and out of bed as well as get positioned in the bed. 3. Staff to provide limited assistance for dressing and undressing. The resident preferred to wear a shirt, pants, and boots. 4. Staff to provide the resident with a front wheeled walker. She required limited assistance of one staff for locomotion. 5. Staff should provide supervision for personal hygiene. 6. Staff should provide limited assist to get to the toilet; transfer on/off toilet, clothing manipulation, disposable undergarment and peri care. 7. Staff to provide limited assistance of one staff to transfer from one seat to another while using a gait belt. Additionally, a fall intervention, dated 07/18/2020, included the resident should wear non-skid footwear while awake. Review of the facility fall log since the resident admitted on [DATE] revealed the resident experienced 13 falls. The falls occurred on 06/12/2020 at 06:32 AM, 06/15/2020 at 10:50 PM, 06/21/2020 at 04:10 PM, 06/22/2020 at 10:45 PM, 07/04/2020 at 12:00 PM, 07/18/2020 at 06:06 PM, 07/28/2020 at 07:45 AM, 07/29/2020 at 01:30 AM, 07/31/2020 at 5:00 PM, 08/01/2020 10:30 AM, 08/14/2020 at 05:00 PM, 08/17/2020 at 02:10 PM, and 08/18/2020 at 04:50 PM. The care plan lacked any fall interventions for the seven falls that occurred on 07/28/2020 at 07:45 AM, 07/29/2020 at 01:30 AM, 07/31/2020 at 5:00 PM, 08/01/2020 10:30 AM, 08/14/2020 at 05:00 PM, 08/17/2020 at 02:10 PM, and 08/18/2020 at 04:50 PM. Additionally, the facility lacked specific times for a toileting plan initiated on 06/15/2020. On 08/19/2019 at 02:01 PM, Certified Nurse Aide (CNA) O, reported the nurse should put the fall intervention in place immediately to prevent the resident from further falls. The resident has a toileting program. I do not know the specific times; we ask her if she wants to go to the bathroom. The resident is in therapy. The resident is a fall risk because she walks by herself. She will turn on the light at times, staff make rounds at shift change and check everybody's location every hour. We do not have any specific assignment responsibilities for who we monitor for falls. On 08/19/2020 at 2:25 PM, CNA N, reported the care plan should provide guidance for the resident's individual preferences and needs. The care plans should be located in the electronic medical records (EMR). Fall interventions for the resident included signs in the resident's room, prompt her to toilet so she would not try to toilet herself without calling staff for help. The resident forgets to use her call light. CNA N was unaware of specific times for toileting, because staff just ask her if she needs to go through out the shift. The resident has boots she should wear when she walks, and should wear nonskid socks, and staff should keep her walker next to her bed. On 08/19/2020 at 11:31 AM, consultant staff HH stated therapy worked on the resident's balance and attempted to get the resident to slow down. She falls out of bed and falls going to the bathroom. The resident needs to slow down to do transfers and requires contact guard assistance with use of a gait belt. The resident wore boots with a non-skid surface. On 08/19/2020 at 04:38 PM, Licensed Nurse H reported she looked on the care plan in the computer for changes in fall interventions. She tried to put immediate interventions in place when residents fall, however it was difficult at times to find an immediate intervention. LN H stated the resident fell so many times she could not remember the details. LN H reported she tried to remind the resident several times a day to use the call light and ask for staff assistance. Some days it worked and some days the reminders did not. The resident's interventions to prevent further falls should include specific toileting times around the time she had a tendency to fall. Staff should not peek in her room walk away. She stated she would expect the care plan in the EMR to have the specific times to offer toileting assistance. On 08/19/2020 at 01:30 PM, Administrative Staff A, stated the staff should review care plan for new fall interventions. The communication board in the electronic medical record had new instructions they could review when staff report on duty. The communication board maintained the instructions for seven days. She verified the CNA's kiosk (electronic medical record) lacked documentation of care plan interventions for fall that occurred 07/18/2020 and thereafter. Additionally, she verified the toileting plan lacked specific times for toileting the resident. On 08/19/2020 at 03:31 PM, Administrative Nurse D stated she would expect staff to have immediate interventions documented in the care plan to guide staff in the needed care for the resident to prevent further falls. She verified the facility staff failed to provide interventions for the resident's falls after 07/18/2020 and failed to specify the resident's toileting schedule to prevent further falls. The facility policy for Accident/Incident Committee, dated 01/20/2019, documentation included the purpose was to review post incident documentation to ensure that staff placed adequate interventions reduce the risk of future occurrences, that included falls. The IDT meeting should include discussion, review and/or revision of the following: 1. Review the resident's chart of the documentation pertaining to the incident. 2. Review the Care Plan to ensure immediate interventions were placed after the incident. 3. The bladder assessment should be reviewed to ensure that the resident's toileting plan was adequate. The facility failed to review and revise the care plan with interventions following falls to prevent further falls for the dependent resident that experienced multiple falls. - Review of Resident (R)16's undated Physician Orders, documentation included [DIAGNOSES REDACTED]. The significant change Minimum Data Set (MDS), dated [DATE], documentation included the resident with the Brief Interview for Mental Status (BIMS) score of five which indicated severe cognitive impairment and fluctuating inattention. She required limited assistance of staff for bed mobility, transfers, walking, locomotion, personal hygiene, dressing and grooming. The resident required extensive assistance of staff for toileting. Her balance during transition was not steady and she was only able to stabilize with staff assistance. The resident had no functional limitation in range of motion (ROM) in the upper or lower extremities. She was frequently incontinent of bowel and bladder The resident used a walker as an assistive mobility device. She experienced two non-injury falls and one fall with no major

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) injury. The resident received antidepressants for five days of the look back period and antibiotic for three days of the look back period. She received restorative nursing program for active range of motion (AROM), dressing, and grooming for five days of the look back period. The quarterly MDS, dated [DATE], revealed changes which included a BIMS score of 99, she was not able to complete the interview for BIMS. The resident required extensive assistance of staff with bed mobility, transfers, walking, locomotion, personal hygiene, dressing and grooming. She received antidepressants, anticoagulant, and antibiotic for seven days of the look back period. The ADL Functional/Rehabilitation Potential and Falls Care Area Assessment (CAA), dated 11/21/2019, documentation revealed the resident with a [DIAGNOSES REDACTED]. She had self-care deficit related to muscle weakness and repeated falls. The resident experienced a decline in cognition and memory impairment. She required more assistance with activities of daily living (ADLs) and communication. Her impaired vision increased impairment of the resident's safety awareness. Staff should monitor her closely and provide increased assistance. Her incontinence increased and staff should continue to provide her with incontinent products as needed and assist her with peri care. She had history of falls related to muscle weakness and impaired balance. The care plan (CP), dated 6/22/2020 directed staff to: 1. Assist the resident to the toilet at 08:00 PM, initiated on 04/05/2020. 2. Occupational and Physical therapy to evaluate and treat, initiated on 06/01/2020. 3. Provide extensive assistance of one staff for toileting needs with toileting program for prompted toileting: 05:00 AM, 11:00 AM, 04:00 PM, 07:00 PM, 2100 PM, initiated on 06/22/2020. Review of the resident's clinical record revealed the resident had fallen four times in the past 90 days. She fell on [DATE], 05/31/2020, 06/02/2020, and 07/18/2020. Review of the resident's care plan revealed the following concerns: 1. The resident's care plan lacked an immediate intervention following the fall on 05/30/2020, 2. The resident's care plan lacked a revision for the toileting schedule to include 02:00 PM, following the fall on 05/31/2020. 3. The resident's care plan lacked an intervention to address the resident falling due to getting up without assistance on 06/02/2020 at 06:00 AM. 4. The resident's care plan lacked a new immediate intervention following the fall that occurred on 07/18/2020 at 02:20 PM. The investigation identified the root cause of the problem was the resident got up without assistance and fell . The immediate intervention noted in the progress note was getting the resident off the floor and treating the wound. The documentation lacked immediate intervention to prevent further falls. Getting the resident off the floor following a fall and treating a wound that resulted from the fall and is not an immediate intervention to prevent further falls. On 08/19/2020 at 02:25 PM, CNA N reported the resident's interventions to prevent falls should be in the resident's care plan. She confirmed the resident was unable to walk by herself and stated the resident did not open her eyes, required guidance and weight bearing support. She stated she was not aware of a specific toileting program; however, staff should offer to toilet the resident at least every two hours. On 08/19/2020 at 04:38 PM, Licensed Nurse H reported she looked on the care plan in the computer for changes in interventions She stated she tried to put an immediate intervention in place when residents fall to try and prevent another fall, but was difficult sometimes to find an immediate intervention. On 08/19/2020 at 03:31 PM, Administrative Nurse D stated she would expect staff to have immediate interventions documented in the care plan to guide staff in the needed care for the resident to prevent further falls. She verified the facility staff failed to care plan interventions for the resident's falls. The facility policy for Accident/Incident Committee, dated 01/20/2019, documentation included the purpose was to review post incident documentation to ensure that adequate interventions were placed to reduce the risk of future occurrences, that included falls. The IDT meeting should include discussion, review and/or revision of the following: 1. Review the resident's chart of the documentation pertaining to the incident. 2. Review the Care Plan to ensure immediate interventions were placed after the incident. 3. The bladder assessment should be reviewed to ensure that the resident's toileting plan was adequate. The facility failed to review and revise the care plan with interventions following falls to prevent further falls for the dependent resident that experienced multiple falls.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 25 residents with 12 selected for review, including three residents reviewed for skin conditions. Based on observation, interview, and record review, the facility failed to provide appropriate treatment to Resident (R)8's wound, failed to report change to the skin condition surrounding the wound, and failed to complete and document a weekly wound assessment. Findings included: - The Order Summary Report, dated 07/01/20, for Resident (R)8 included [DIAGNOSES REDACTED]., or the body cannot respond to the insulin), and muscle weakness. The significant change Minimum Data Set (MDS), dated [DATE], assessed R8 of having a Brief Interview of Mental Status Score (BIMS) of 15, indicating cognitively intact, and she did not reject care. She required extensive assistance of two or more staff for bed mobility, dressing, and hygiene. She was totally dependent of two or more staff for transfers and had no impairment to her range of motion. R8 was at risk for developing pressure ulcers and had two stage two pressure areas that was not present on admission. She also had moisture associated skin damage (MASD). Furthermore, she had a pressure reducing device for her chair and bed, was on a turning/repositioning program, and received nutrition or hydration to manage skin problems. The staff provided pressure ulcer/injury care, application of nonsurgical dressing other than to her feet, and application of ointment/medications other than to her feet. The quarterly MDS, dated [DATE], assessed R8 of having a BIMS score of 15 and she did not reject care. She required extensive assistance of two or more staff for bed mobility, transfers, and hygiene, and had no range of motion impairment. She was at risk for pressure ulcers, but there was not any present. She did have open [MEDICAL CONDITION] other than ulcers, rashes, or cuts, and MASD. Furthermore, she had pressure reducing device for her chair and bed, was on a turning/repositioning program, and received nutrition or hydration intervention to manage her skin problems. Staff applied ointments/medications other than to her feet. The Pressure Ulcer/Injury Care Area Assessment (CAA), dated 02/27/20, included that R8 was on a low air loss mattress, received wound protocol medications, and hourly repositioning offered. She needed daily assistance with her activities of daily living (ADL's), and that she had multiple co-morbidities (multiple chronic conditions) that had the potential to increase her skin risk. The care plan, dated 06/01/20, revealed that R8 had impaired skin integrity related to impaired mobility and incontinence, and guided staff to continue skin treatments as ordered by the physician, and a license nurse should assess and document skin (condition of) weekly. The Non-Pressure Sore Assessment, under the assessment tab in the electronic medical record (EMR), revealed R8 presented with four abdominal wounds on 04/27/20, three of them had developed on that date. The Non- Pressure Sore Assessment, dated 05/26/20, revealed the resident's abdominal wound, as identified as wound number four, had pink skin surrounding the wound. The following assessments for wound number four, as follows: The Non -Pressure Sore Assessment, dated 06/02/20, revealed the abdominal wound had bright red skin surrounding the wound. Review of the EMR lacked Non -Pressure Sore Assessments for the following dates: 06/09/20, 06/16/20, 06/23/20, 06/30/20, and 07/07/20. The Non -Pressure Sore Assessment, dated 07/15/20, revealed the abdominal wound had bright red skin surrounding the wound. The Non -Pressure Sore Assessment, dated 07/21/20, revealed the abdominal wound had bright red skin surrounding the wound. Review of the EMR lacked Non -Pressure Sore Assessments for the following dates: 07/28/20, 08/04/20, 08/11/20, and 08/18/20. The physician notification for all of the above Non-Pressure Sore Assessments had a date for physician notification of 04/27/20. The documentation indicated that the physician was not notified when there was a change in the skin condition. On 08/19/20 at 10:41 AM, Licensed Nurse (LN) H, reported that R8's dressing to her abdomen was saturated with serosanguinous (semi-thick reddish drainage) drainage, so she had removed the dressing. On 08/19/20 at 10:45 AM, observation of the treatment to R8's abdominal wound by LN H revealed a bright red rectangle area approximately three by five inches around the approximately one centimeter circular open wound. There were two light purple areas in the red rectangle area that were closed and another area to the right of the red rectangular area. LN H cleaned the open wound with gauze that had been soaked in a soap and water solution, however, LN H failed to rinse the soap off the resident's abdomen wound before patting the area dry and applying a new dressing. The new dressing was applied directly over the bright red rectangle discoloration of the skin. The discoloration of the resident's abdomen matched the size of the dressing area. On 08/19/20 at 10:59 AM, LN H revealed that the light purple areas were previously opened areas, and had used another dressing type before when the skin was red. Furthermore, she was unaware the wound and surrounding skin needed to be rinsed with water after she cleansed the area with the soap, related to the treatment order did not specify to do that, it says to clean with soap and water and pat dry. LN H revealed that the Director of Nursing (DON) conducted wound rounds with the physician via telehealth (electronic communication) and she believed the DON notified the physician related to the resident's reddened area of skin surrounding

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) her open wound. The Treatment Administration Record, dated 08/2020, included an order to cleanse the medial (middle)(open area to R8's abdomen with soap and water, pat dry, apply collagen powder (a powder used to promote wound healing), cover with a non-adherent pad, and secure with tape, every day shift, for skin impairment. On 08/19/20 at 11:05 AM, Administrative Nurse D, confirmed that during R8's treatment to her abdominal wound, the soap should be rinsed off with water after cleansing. Furthermore, she revealed the physician seen her last week via Facetime (video call) and thought the physician made changes to her treatment. On 08/20/20 at 10:36 AM, LN H confirmed that wounds should be assessed weekly by the DON. On 08/20/20 at 11:07 AM, Administrative Nurse D, revealed that wound assessments should be completed weekly. The Non -Pressure Sore Assessment should be completed for wounds other than pressure wounds. She printed the assessments and would document assessment information on the paper assessments. She verified she lacked documentation on the EMR. Furthermore, she revealed the physician should be notified when there was a major change of increase in the wound size, and if no changes in the wound in two weeks, she should notify the physician. Administrative Nurse D revealed the physician notification date of the Non- Pressure Sore Assessment was the original notification date and interpreted the assessment of that it how it was to be answered. On 08/20/20 at 02:00 PM, Administrative Nurse D confirmed staff failed to adequately assess the wounds weekly for lack of improvement or deterioration of the abdominal wound, for possible changes needed in the treatment. The facility's policy for Dressing Changes, dated 09/2015, indicated during a dressing change to assess the resident's wound, clean the wound with a four by four (gauze) as ordered, and repeat step with a clean four by four if necessary. The facility's policy for Pressure Injury Prevention Policy, dated 05/2016, directed that all non-pressure injuries would be assessed and documented weekly, on the Weekly Non- Pressure Ulcer Assessment. The facility failed to rinse the resident's abdominal wound with soap during the resident's wound treatment, failed to notify the physician timely when there was a change in the surrounding skin color, and failed to complete and document weekly wound assessments, to ensure the resident's wound from possible further break-down.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 25 residents with 12 selected for review, including six residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to thoroughly investigate to determine contributing factors and causes of falls and/or initiate appropriate immediate interventions for two dependent Residents (R)17 and R 16, that experienced multiple falls, to prevent further falls. The facility failed to follow fall interventions for one dependent R 25. Findings included: - Review of Resident (R)17's Physician Orders, dated 08/10/2020, documentation included [DIAGNOSES REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE], documentation included the resident admitted on [DATE], with the Brief Interview for Mental Status (BIMS) score of 13, which indicated cognitively intact. The resident required limited assistance of staff with bed mobility, transfers, walking and locomotion, toilet use, personal hygiene, dressing and grooming. Her balance with transition was not steady but she was able to stabilize without staff assistance. She had no functional limitation in range of motion (ROM) and was always continent of bowel and bladder. The resident had a fall in the last month prior to admission, and the assessor was unable to determine if she fell in the previous 2-6 months of admission. The resident experienced two or more falls since admission. The Falls, ADL Functional/Rehabilitation Potential, and Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 06/19/2020, documented respectively the resident was a potential fall risk related to impaired gait/mobility. Staff should make sure the resident's call light was within her reach in her room. Staff should monitor to ensure non-skid fall strips were in the room and replace the strips when necessary. She was at risk for impaired mobility. Staff assist with activities of daily living (ADL's), staff assist with her balance. Staff should keep frequently used objects near the resident, assistive device within her reach, and provide the resident with frequent reminders to use her assistive device. She was at risk for urinary incontinence related to her need for staff to assist her, as needed, with toileting. Staff were to encourage elder(resident) to toilet following the toileting program and provide the elder with appropriate incontinent products if necessary. The resident's base line care plan, dated 06/08/2020, documented safety elopement risk with the intervention of hourly checks and application of a wander guard bracelet (an alarm device that activates when the resident approaches the exit doors). History of falls entry included shoes while walking, call light in reach and therapy screens. Additional interventions included: 1. On 06/12/2020, for non-skid strips (lacked specific location). 2. On 06/15/2020, for toileting plan, However, the care plan lacked specific times or a toileting plan. 3. On 06/21/2020, resident should keep her shoes within her reach. 4. On 06/22/2020, staff should place dycem (non-skid sheet) in the recliner. There were no additional care plan interventions entered after 06/22/2020. The comprehensive care plan (CP), dated 06/18/2020 and revised 07/08/2020, directed staff to 1. Ensure all clothes were properly fitting in order to prevent falls. 2. Staff to provide limited assistance to get into and out of bed as well as get positioned in the bed. 3. Staff to provide limited assistance for dressing and undressing. The resident preferred to wear a shirt, pants, and boots. 4. Staff to provide the resident with a front wheeled walker. She required limited assistance of one staff for locomotion. 5. Staff should provide supervision for personal hygiene. 6. Staff should provide limited assist to get to the toilet; transfer on/off toilet, clothing manipulation, disposable undergarment and peri care. 7. Staff to provide limited assistance of one staff to transfer from one seat to another while using a gait belt. Additionally, a fall intervention, dated 07/18/2020, included the resident should wear non-skid footwear while awake. On 06/08/2020 at 04:28 PM, the Progress Note (PN), documented the resident arrived at 04:00 PM, via facility van. She ambulated (walked) with one person assist. The resident had poor balance and gait. The resident's skin assessment noted the following: small bruises at left upper arm, right cheek, right outer thigh, and mid back and a small abrasion noted to left knee. Review of the facility fall log since the resident admitted on [DATE] revealed the resident experienced 13 falls. The falls occurred on 06/12/2020 at 06:32 AM, 06/15/2020 at 10:50 PM, 06/21/2020 at 04:10 PM, 06/22/2020 at 10:45 PM, 07/04/2020 at 12:00 PM, 07/18/2020 at 06:06 PM, 07/28/2020 at 07:45 AM, 07/29/2020 at 01:30 AM, 07/31/2020 at 5:00 PM, 08/01/2020 10:30 AM, 08/14/2020 at 05:00 PM, 08/17/2020 at 02:10 PM, and 08/18/2020 at 04:50 PM. Review of the resident's clinical record related to falls revealed the following concerns: On 06/15/2020 at 10:50 PM, PN documentation included the CNA called the nurse to the resident's room by certified nurse aide (CNA). Upon entering the room, the nurse noted the resident lying on her back in the middle of the floor, between the bed and bathroom with her feet towards the door. Her walker was approximately three feet from the resident facing the bathroom. The resident attempted to get up when the nurse entered the room. The resident stated she fell while going to the bathroom. Following her assessment, the staff assisted the resident to the bathroom using a gait belt and a walker. She was continent of bowel and bladder. She was then assisted back to bed. The nurse documented the call light was on at the time of the fall. The electronic medical record (EMR) lacked documentation of an immediate intervention to prevent the resident from further falls. The IDT Investigation and Incident Note indicated a toileting plan as an intervention to prevent further falls and failed to specify the times. The root cause analysis failed to address the call light being on at the time of the fall in the investigation. On 06/21/2020 at 4:10 PM, PN documented the nurse heard a noise from the resident's room. The resident yelled for help when staff entered the room. She was sitting on the floor in front of her chair. The resident stated she was trying to put on her shoe. The walker laying on the floor near the resident. The assessment revealed she had a blood pressure (BP) of 177/89 and had a scalp laceration just above her left eye measuring 2.0 centimeters (cm) by 1.0 cm. with large amount of sanguineous (fluid with blood) drainage and a superficial abrasion to left knee. She complained of pain rated at eight of ten at the left side of her face/scalp. Following the completed assessment, the staff assisted her off the floor to the chair using a gait belt. Wound care provided to the laceration with wound cleanser, two steri- strips, and applied ice pack for comfort/swelling. No immediate intervention to prevent further falls. The IDT investigation report lacked a thorough investigation and root cause analysis prevent further falls. The new intervention included staff to ensure her shoes were in reach. The investigation failed to address the reason the resident had difficulty in putting on her shoes, or where they were located at the time of the fall. On 06/22/2020 at 10:45 PM, PN, documentation noted the CNA alerted the nurse that the resident was on the floor in her room. The nurse entered the room and noted the resident sat with her back to the recliner with her feet facing southeast. was on the left side of her recliner. The immediate intervention was staff placed dycem to her recliner. The post fall evaluation documentation noted the resident attempted to self-toilet at the time of the fall. The IDT Investigation and Incident Report failed to address the resident's attempt to self-toilet as a contributing factor to the fall and staff lacked revision to the toileting plan,

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	175224	A. BUILDING _____ B. WING _____	08/20/2020

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MORAN MANOR	3940 US HWY 54 MORAN, KS 66755

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) which lacked specific times and/or guidance to the staff. On 07/18/2020 at 06:14 PM, PN documentation included at 05:45 PM, a CNA told the nurse that the resident was on the floor. When the nurse entered the resident's room, she noted the resident was sitting on her buttocks, at end of bed. She had a red area on her right shoulder and the right side of her head in the hairline. The resident feet were out in front of her and she was bare footed. The resident's walker was placed by her recliner. The resident stated she was going to the bathroom. The nurse assessed the resident and findings included BP of 171/114. The PN lacked documentation of an immediate intervention. The Post Fall Evaluation, documented the reason for the fall as she had no shoes on at the time of the fall and was not using walker. The documentation included the resident with impaired balance, [MEDICAL CONDITION], and dementia. The IDT Investigation and Incident Report documentation lacked address of the resident's elevated BP, toileting pattern, using the walker without assistance as a component of contributing factors to the fall. The facility failed to conduct a thorough investigation to include a root cause analysis to provide an appropriate intervention to prevent further falls. On 07/28/2020 08:08 AM, PN documentation included at 07:45 AM, a CNA reported to the nurse that the resident was on the floor. The nurse entered the room and noted the resident was on the floor between the bed and the recliner with her legs crossed in front of her, she was without clothing. The resident stated, she was trying to get dressed. The nurse told the CNA reported she came in the room, and the resident was on on her bed, naked. The CNA reported when he/she stepped out to tell another CNA where he/she would be, she re-entered the resident's room, and the resident had fallen to the floor. The documentation lacked evidence of an immediate intervention to prevent the resident from further falls. The Post Fall Evaluation Fall Details, documented the reason for the resident's fall was due to the resident not waiting for staff assistance. The resident lacked foot covering was not using her cane/walker. She was not wearing her oxygen at the time of the fall. The resident was incontinent at the time of her fall. The IDT Investigation and Incident Report lacked contributing factors and causes of the fall such as the need to wait for staff assistance, dressing, incontinence, and bare feet to determine an appropriate intervention to prevent the resident from further falls. Staff placed a sign in the resident's room to direct the resident to call for assistance, however the toileting plan lacked specific times and was not addressed. On 07/29/2020 at 01:30 AM, PN documentation revealed the resident fell in her room. The resident reported she ambulated herself to the toilet, lost her balance, and fell . She reported she thought she had put her call light on, as she waited for staff to come and assist her to the bathroom, she walked to the bathroom with her walker when no staff arrived, however, the call light was not activated. The immediate intervention was to have the resident demonstrate use of call light properly, and to re-educate on importance of its use. The immediate intervention was not a new appropriate intervention to prevent further falls. The Post Fall Evaluation Fall Details, the resident was using the walker as instructed and was not wearing oxygen as prescribed at the time of the fall. The IDT Investigative and Incident Report, failed to analyses the resident's contributing factors and/or causes contributing to the fall. The facility failed to revise the toileting plan with specific times, to complete a thorough investigation to determine a new and/or appropriate intervention to prevent further falls for the resident. On 07/31/2020 at 05:06 PM, PN documented the CNA's reported the resident fell in her room by the bathroom. The documentation revealed a lack of immediate and /or new intervention to prevent further falls. The Post Fall Evaluation Fall Details documented the reason the resident fell was she left the restroom without her walker or without staff assistance. She was unable to remember to use the call light or wait for staff assistance. The IDT Investigation and Incident Notes, failed to address the lack of specific times for a toileting plan and lacked a thorough investigation to determine a new and/or appropriate intervention to prevent further falls. On 08/01/2020 at 03:47 PM, PN documented the resident experienced an unwitnessed fall which occurred in the bathroom. The resident attempted to self-toilet at time of the fall. The reason for the fall was not evident. The resident was found in the bathroom, unassisted, in front of her toilet. She did not have her cane/walker, lacked her oxygen, and she was incontinent at the time of the fall. Staff reported the resident's bathroom call light was on. The IDT Investigation and Incident Report, documentation included resident found sitting on the bathroom floor, stated she missed the toilet. The root cause was identified as the resident was transferring without staff assistance. Therapy was to evaluate the resident for toilet transfers and to toilet the resident daily at 03:30 PM. However, the care plan lacked any revision related to schedule for toileting. The medical record lacked evidence of staff providing toileting at 03:30 PM. On 08/14/2020 at 05:00 PM, PN documentation included the resident had an unwitnessed fall in the resident's room, while she attempted to self-toilet. The reason for the fall was her shoes tangled on her feet and the resident not waiting for staff assistance. The documentation identified the resident possibly required new footwear, however no immediate intervention placed to prevent further falls. The IDT Investigative and Incident Report lacked a thorough investigation to analysis of findings to determine the causes and contributing factors of the fall. The report lacked address of the resident's continued attempts at toileting without assistance and/or identifying a toileting pattern for the resident. On 08/19/2020 at 08:09 AM, observation revealed the resident was on her bed on her left side. The bed was against the wall on the right side and non-slip strips were on the floor on the left side of the bed towards the bathroom and in the bathroom. On 08/19/2020 at 04:21 PM, the resident sat up in her bed. The resident had slip on boots with nonskid rubberized soles at her bedside, within reach. Her call light was in reach. Her walker was out of reach in front of her recliner. There was a pink sign on the walker with slow down call for help, written on it. The resident stated she slid out of bed putting on her shoes and recited what was written on the sign from memory. On 08/19/2019 at 02:01 PM, Certified Nurse Aide (CNA) O, reported the nurse should put the fall intervention in place immediately to prevent the resident from further falls. The resident has a toileting program. I do not know the specific times, we ask her if she wants to go to the bathroom. The resident is in therapy. The resident is a fall risk because she walks by herself. She will turn on the light at times, staff make rounds at shift change and check everybody's location every hour. We do not have any specific assignment responsibilities for who we monitor for falls. On 08/19/2020 at 2:25 PM, CNA N, reported the care plan should provide guidance for the resident's individual preferences and needs. The care plans should be located in the electronic medical records (EMR). Fall interventions for the resident included signs in the resident's room, prompt her to toilet so she would not try to toilet herself without calling staff for help, . The resident forgets to use her call light. CNA N was unaware of specific times for toileting, because staff just ask her if she needs to go through out the shift. The resident has boots she should wear when she walks, and should wear nonskid socks, and staff should keep her walker next to her bed. On 08/19/2020 at 11:31 AM, consultant staff HH stated therapy was worked on the resident's balance and attempted to get the resident to slow down. She falls out of bed and falls going to the bathroom. The resident needs to slow down to do transfers and requires contact guard assistance with use of a gait belt. The resident wears boots with a non-skid surface. On 08/19/2020 at 02:25 PM, CNA N reported the resident was unable to walk by herself. She stated the resident did not open her eyes and required guidance and weight bearing support. She stated she was not aware of a specific toileting program; however, staff should offer to toilet the resident at least every two hours. On 08/19/2020 at 04:38 PM, Licensed Nurse H reported she looked on the care plan in the computer for changes in fall interventions. She tried to put immediate interventions in place when residents fall, however it was difficult at times to find an immediate intervention. LN H stated the resident fell so many times she could not remember the details. LN H reported she tried to remind the resident several times a day to use the call light and ask for staff assistance. Some days it worked and some days the reminders did not. The resident's interventions to prevent further falls should include specific toileting times around the time she had a tendency to fall. Staff should not peek in her room walk away. She stated she would expect the care plan in the EMR to have the specific times to offer toileting assistance. On 08/19/2020 at 03:31 PM, Administrative Nurse D stated she would expect staff to have immediate interventions documented in the post fall assessment and/or progress notes. She verified staff failed to complete a thorough investigation of the resident's repeated falls since 07/18/2020, and failed to provide adequate interventions for the resident's falls. She verified staff failed to to specify the resident's toileting schedule to prevent further falls. The facility policy for Accident/Incident Committee, dated 01/20/2019, documentation included the purpose was to review post incident documentation to ensure that staff placed adequate interventions reduce the risk of future occurrences, that included falls. The IDT meeting should include discussion, review and/or revision of the following: 1. Review the resident's chart of the documentation pertaining to the incident. 2. Review the Care Plan to ensure immediate interventions were placed after the incident. 3. The bladder assessment should be reviewed to ensure that the resident's toileting plan was adequate. The facility failed to thoroughly investigate the resident's repeated falls to determine the contributing factors and causes of her falls and/or initiate the appropriate immediate interventions for this dependent resident that experienced multiple falls, to prevent further falls. - Review of Resident (R)16's undated Physician Orders, documentation included [DIAGNOSES REDACTED]. The significant change Minimum Data Set (MDS), dated [DATE], documentation included the resident with the Brief Interview for Mental Status (BIMS) score of five which indicated severe

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) cognitive impairment and fluctuating inattention. She required limited assistance of staff for bed mobility, transfers, walking, locomotion, personal hygiene, dressing and grooming. The resident required extensive assistance of staff for toileting. Her balance during transition was not steady and she was only able to stabilize with staff assistance. The resident had no functional limitation in range of motion (ROM) in the upper or lower extremities. She was frequently incontinent of bowel and bladder The resident used a walker as an assistive mobility device. She experienced two non-injury falls and one fall with no major injury. The resident received antidepressants for five days of the look back period and antibiotic for three days of the look back period. She received restorative nursing program for active range of motion (AROM), dressing, and grooming for five days of the look back period. The quarterly MDS, dated [DATE], revealed changes which included a BIMS score of 99, she was not able to complete the interview for BIMS. The resident required extensive assistance of staff with bed mobility, transfers, walking, locomotion, personal hygiene, dressing and grooming. She received antidepressants, anticoagulant, and antibiotic for seven days of the look back period. The ADL Functional/Rehabilitation Potential and Falls Care Area Assessment (CAA), dated 11/21/2019, documentation revealed the resident with a [DIAGNOSES REDACTED]. She had self-care deficit related to muscle weakness and repeated falls. The resident experienced a decline in cognition and memory impairment. She required more assistance with activities of daily living (ADLs) and communication. Her impaired vision increased impairment of the resident's safety awareness. Staff should monitor her closely and provide increased assistance. Her incontinence increased and staff should continue to provide her with incontinent products as needed and assist her with peri care. She had history of falls related to muscle weakness and impaired balance. The care plan (CP), dated 6/22/2020 directed staff to: 1. Assist the resident to the toilet at 08:00 PM, initiated on 04/05/2020. 2. Occupational and Physical therapy to evaluate and treat, initiated on 06/01/2020. 3. Provide extensive assistance of one staff for toileting needs with toileting program for prompted toileting: 05:00 AM, 11:00 AM, 04:00 PM, 07:00 PM, 2100 PM, initiated on 06/22/2020. Review of the resident's clinical record revealed the resident had fallen four times in the past 90 days. She fell on [DATE], 05/31/2020, 06/02/2020, and 07/18/2020. Review of the Interdisciplinary Team (IDT) notes, following the resident's falls revealed the following concerns: On 05/30/2020 at 10:10 PM, staff found the resident on the floor. She was tearful. The immediate intervention of PRN (as needed) Tylenol administered. The suspected root cause was the resident transferred without assistance. Intervention included her Toileting schedule adjusted to toilet at 09:00 PM. The documentation lacked an analysis of findings that would indicate toileting at 09:00 PM and was an appropriate intervention for a fall that occurred at 10:10 PM. The intervention failed to address the resident getting up without staff assistance. On 05/31/2020 at 1:55 PM, staff found the resident on the floor in front of her recliner. The floor was dry, clear of clutter, nonskid socks were on and her walker was close by. The resident was unable to give a description of her fall. A urinalysis (UA- screening of urine to detect infection) with C&S (culture and sensitivity-a test to grow the bacteria that exist in the urine and determine effective antibiotic to treat the bacteria in 48 hours) if indicated, suspected a Urinary tract infection [MEDICAL CONDITION]. The resident was not symptomatic of a UTI. The documentation lacked an immediate intervention to prevent the resident from further falls pending any urine lab results. There was not an analysis of findings demonstration of a root cause analysis to determine the causes or contributing factors of the fall. The additional intervention included to toilet the resident at 02:00 PM, however, staff failed to revise the care plan. On 06/02/2020 at 06:00 AM, staff found the elder on the floor with her legs extended, leaning against left side of bed. Resident was alert and oriented to person only. The resident wore a night gown, an incontinent brief, and gripper socks. Neurological checks were within normal limits (WNL). Resident assisted to standing position with maximum assistance of two staff and ambulated with assistance of two staff to the bathroom. The resident was continent of bowel and bladder. The immediate intervention revealed staff toileted the elder. The Interdisciplinary Team (IDT) recommended the resident's toilet time changed to 0500 AM. The documentation lacked an analysis of findings that would indicate toileting at 05:00 AM, which was an appropriate intervention for a fall that occurred at 06:00 AM, however, The intervention failed to address the resident getting up without staff assistance. On 07/18/2020 at 02:20 PM, staff found the resident on the floor. The resident received a skin tear during the fall. The immediate intervention included staff obtained the resident's neurological assessment, wound care to the skin tear, and staff assisted the resident to the recliner. Staff determined the suspected root cause of the fall was related to the resident attempted to transfer without staff assistance. The documentation lacked immediate intervention to prevent further falls. Treating a wound that resulted from a fall and getting the resident off the floor is not an immediate intervention to prevent further falls. The fall investigation lacked a analysis of findings regarding the resident getting up without assistance. Review of the POS [REDACTED]. The facility failed to complete a thorough investigation related to a root cause analysis to determine causes and contributing factors to the resident's repeated falls and communicate changes in the interventions to staff to prevent further falls. On 08/18/2020 at 08:47 AM, two Certified Nurse Aides (CNA) provided extensive/weight bearing assistance with walking the resident. The CNAs used a gait belt and provided physical guidance and verbal cues while walking the resident. On 08/18/2020 at 01:24 PM, CNA P applied a gait belt on the resident, placed a walker in front of her, and provided verbal cues and physical guidance to use the walker. Staff assisted the resident from the chair as the resident leaned towards the right. The resident ambulated with her walker, however the resident walked on her tip toes. On 08/19/2020 at 10:58 AM, the resident sat in a chair in the lobby. Certified Medication Aide (CMA) R asked the resident if she wanted to go to the bathroom, and the resident nodded her head yes. The resident's eyes remained closed while staff ambulated the resident down the hall. The resident ambulated with a shuffled gait. On 08/19/2020 at 02:25 PM, CNA N reported the resident was unable to walk by herself. She stated the resident did not open her eyes and required guidance and weight bearing support. She stated she was not aware of a specific toileting program; however staff should offer to toilet the resident at least every two hours. On 08/19/2020 at 04:38 PM, Licensed Nurse H reported she looked on the care plan in the computer for changes in interventions She stated she tried to put an immediate intervention in place when residents fall to try and prevent another fall, but was difficult sometimes to find an immediate intervention. On 08/19/2020 at 12:10 PM, Administrative Nurse D stated she would expect to have immediate interventions documented in the post fall assessment and/or progress notes. She verified the post fall assessment lacked interventions following the resident's falls as noted above. On 08/19/2020 at 01:30 PM, Administrative Staff A, stated the staff should review care plan for new fall interventions. The communication board in the electronic medical record had new instructions they could review when staff report on duty. The communication board maintained the instructions for 7 days. She stated the IDT notes identified the root cause analysis and fall interventions. Administrative Staff A verified the facility failed to complete a thorough investigations following a fall. The facility policy for Accident/Incident Committee, dated 01/20/2019, documentation included the purpose was to review post incident documentation to ensure that adequate interventions were placed to reduce the risk of future occurrences, that included falls. The IDT meeting should include discussion, review and/or revision of the following: 1. Review the resident's chart of the documentation pertaining to the incident. 2. Review the Care Plan to ensure immediate interventions were placed after the incident. 3. The bladder assessment should be reviewed to ensure that the resident's toileting plan was adequate. The facility failed to thoroughly investigate the resident's repeated falls to determine the contributing factors and causes of her falls and/or initiate the appropriate immediate interventions for this dependent resident that experienced multiple falls, to prevent further falls. - The hospital Discharge Summary, dated 06/30/20, for Resident (R)25 included [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], assessed (R)25 as having a Brief Interview of Mental Status (BIMS) score of 99, indicating the resident was unable to complete the interview. There were no behaviors, rejection of care, or wandering. She required extensive assistance of two or more staff for bed mobility and transfers. R25 walked once or twice with two or more staff assistance in her room and in the corridor. She required extensive assist of two or more staff for locomotion on and off the unit, dressing, toilet use, and personal hygiene. Her range of motion was impaired to both sides of her upper and lower extremities, her balance was not steady, and she required staff assistance for moving on and off the toilet, and for surface to surface transfers. The resident required no mobility devices. R25 fell in the last month prior to admission and had no falls since admission. She received Occupational and Physical therapy. The Falls Care Area Assessment (CAA), dated 07/16/2020, revealed R25 was an actual risk for falls related to the resident required staff assist for bed mobility. She had a previous fall at her home. She had difficulty maintaining her balance. She received an antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) daily, had [MEDICAL CONDITION], urinary incontinence, and dementia. The staff were to make sure the resident's call light was always within reach in her room and encourage her to wear some type of non-skid footwear, including nonskid socks and/or shoes when transferring and/or

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(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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) walking. Review of the facility's Care Plan Book M-Z lacked guidance for the resident fall prevention. Review of the electronic medical record (EMR), under the care plan tab, had a care plan initiated on 07/08/20, with a problem for safety. The care plan lacked any fall interventions. Furthermore, the care plan included a problem of self-care /ADL (activities of daily living) function but lacked instruction on what assistance R25 needed from the staff. The care plan lacked guidance for fall prevention. The Baseline Care Plan, dated 07/05/20, was unavailable for staff guidance for the resident's cares, as the baseline care plan was located in medical records department, in overflow. However, the baseline care plan included that R25 had a history of [REDACTED].
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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** The facility reported a census of 25 residents. The facility identified nine residents who required insulin. Based on observation and interview, the facility failed to provide appropriate labeling and storage of injectable medications for eight of the nine Residents (R) 24, R20, R8, R1, R14, R4, R15, and R21, that required insulin, to ensure safe medication administration Findings include: - Observation of the nurses' medication cart, on 08/17/2020 at 03:16 PM revealed eight insulin syringes lacked open dates. This included: 1. An injectable pen of Tresiba (a long-acting insulin that controls blood sugar for 24 hours) for R24. 2. An injectable pen of [MEDICATION NAME] (a long-acting insulin that controls blood sugar for 24 hours) for R20. 3. An injectable pen of [MEDICATION NAME] (a long-acting insulin that controls blood sugar for 24 hours) for R8. 4. An injectable pen of [MEDICATION NAME] for R1. 5. An injectable pen of [MEDICATION NAME] for R14. 6. An injectable pen of [MEDICATION NAME] for R 4. 7. An injectable pen of [MEDICATION NAME] (a fast-acting injectable medication to control blood sugars) for R15. 8. An injectable pen of [MEDICATION NAME] for R21. On 08/17/2020 at 03:16 PM, Licensed Nurse G, confirmed the injectable pens lacked a date the medications were opened. She also confirmed staff should date the injectable pens when opened. On 08/20/2020 at 08:22 AM, Administrative Nurse D, confirmed the injectable pens should be labeled with a date of opening. The facility policy Administering Medication, dated December 2012, documented when opening a multi-dose container, the date opened shall be recorded on the container. The facility failed to provide appropriate labeling and storage of injectable medications for R1, R4, R8, R14, R15, R20, R21, and R24, to ensure safe medication administration.