STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285173	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FLORENCE HOME	**7915 NORTH 30TH STREET OMAHA, NE 68112**

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on interview, record and facility policy review, the facility failed to screen prospective employees by not completing reference checks on five of ten employee files were reviewed. Findings are: A review of the facility's Abuse policy, revised on 10/05/19, documented, .Screening components It is the policy of the facility to screen employees .prior to working with residents. Screening components include verification of references . A review of the facility employee files revealed that Certified Nurse Aide (CNA)-A, CNA-B, CNA-C, CNA-D, and CNA-E did not have reference checks provided. On 08/05/20 at 1:54 PM, the Corporate Human Resource Director stated (gender) had not been doing reference checks since starting a year ago. On 08/05/20 at 3:18 PM, the Administrator stated Human Resources would complete the reference checks and was not aware they were not being completed. On 08/06/20 at 8:27 AM, the Corporate Human Resources verified there were 105 employees: 63 of the 105 (60%) were hired in the past year and had no reference checks.
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 observations, interviews and record review, it was determined the facility failed to prevent one (Resident 31) of four sampled residents from suffering a fall that resulted in a [MEDICAL CONDITION] which required stitches. Four sampled residents were investigated for falls. Findings are: Resident 31 had [DIAGNOSES REDACTED]. The resident's quarterly Minimum Data Set (MDS) assessment, dated 06/18/20, documented the resident was severely impaired in cognition, required extensive assistance for activities of daily living, and had sustained no falls since the last assessment. The resident's care plan documented the resident was at risk for falls. Interventions included: use a lift for transfers, keep bed in low position with a fall mat beside the bed, keep personal items within reach, place a body pillow beside the resident while in bed, and assist with locomotion while resident was in wheelchair. The care plan also documented the resident had a fall on 10/29/20 during a transfer and fell /rolled out of bed on 04/18/19. No injuries were incurred with the two falls. A facility incident report, dated 07/29/20, documented the nurse was called to the shower room at 10:00 AM. The nurse observed the resident on the floor, on the resident's left side; the resident was bleeding from a laceration on the forehead that measured 3.5 cm (centimeters) x 1 cm x 0.5 cm. The note documented pressure had been applied to the laceration to stop the bleeding and a dressing was applied. Range of motion and neurological checks were initiated. All were within normal limits. The resident was returned to (gender) room via wheelchair and placed in bed. The physician was notified, and a new order was issued to transfer the resident to a local emergency room for evaluation and sutures. The resident's family was also notified. The note also documented transportation arrived at 11:30 AM and the resident left the facility at 11:45 AM. A Neurological Assessment Flow Sheet, dated 07/29/20 at 10:00 AM, documented neurological checks had been initiated and the results were within normal limits. A hospital emergency room record, history and physical (H&P), dated 07/29/20, documented the resident had fallen from a wheelchair in the shower room at the nursing home. The H&P documented the resident was unable to recall the episode and the laceration to the forehead would require sutures. The report documented the resident had not suffered any additional injuries. A facility, Personal Education form, dated 07/29/20 at 5:00 PM, documented the bath aide, Certified Nurse Aide (CNA)-G, had provided a statement via telephone. The form also documented CNA-G was aware of the procedures and steps involved in providing a tub bath to a resident; however, CNA-G had just forgotten to strap the resident into the tub chair. The report also documented the CNA had been re-educated and reported to (gender) agency. On 08/03/20 at 10:28 AM, the resident was observed to have forehead sutures from a laceration. An unsuccessful attempt was made to interview the resident about the injury. Resident 31 was unable to respond appropriately. On 08/05/20 at 2:39 PM, Registered Nurse (RN)-A was asked to describe the resident's fall on 07/29/20. RN-A stated the resident had fallen out of a bath chair in the bathtub. The bath aide, CNA-G, was with the resident in the bathroom providing the resident with a bath. The nurse was called to the bathroom and upon arrival, the resident was on the floor bleeding from a laceration on the forehead. RN-A had done a full assessment, put pressure on the laceration and applied a dressing. Neurological checks were initiated, the resident was returned to the room, and the physician was notified. Arrangements were made to transfer the resident to a local emergency room . The resident's family had been notified and was going to meet the resident at the hospital. On 08/05/20 at 5:30 PM, an attempt was made to contact CNA-G. The CNA did not answer the phone. A voicemail was left, but the CNA did not return the call. On 08/06/20 at 8:30 AM, the Director of Nurses (DON) and Administrator were interviewed. They stated an investigation of the fall had been initiated. They stated CNA-G had failed to secure the resident's seat belt on the tub chair during provision of a bath, and the resident had fallen forward, striking (gender) head on the bath house floor. They stated the CNA was the only one bathing the resident; two CNAs had transferred the resident to the tub. They had counseled, in-serviced the CNA, and reported the incident to the agency. They added they were in-servicing all the staff on bath safety.

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.