STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195618	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSOLATA HOME	**2319 EAST MAIN STREET NEW IBERIA, LA 70560**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to; 1. notify the hospice physician and facility treatment nurse concerning an open skin area behind Resident #33's ear and 2. provide evidence that the physician was notified of resident #57's fall from a stand up lifter and complaints of severe pain and slight swelling to right knee in a timely manner for 2 out of 31 sampled residents. (#33, #57) Findings: 1. Resident #33. A review of Resident #33's record revealed that she was admitted to the facility on [DATE] under hospice care. [DIAGNOSES REDACTED]. A review of Resident #33's quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) cognition score of 14 out of 15, indicating that she was cognitively intact. A review of the resident's physician's orders [REDACTED].#33 was conducted. She was receiving oxygen via concentrator at 3L. Oxygen tubing was noted with the NC in place with the tubing placed behind each ear. During the observation an interview was conducted with Resident #33's sitter. She stated that about two weeks ago the resident told her that she had pain behind her right ear and that she (sitter) had found a sore that was smaller than the size of a dime behind her right ear and had told the nurse. She further stated that in the past there was padding on the oxygen tubing behind her ears, and that she did not know why, but the staff was not using it anymore. An observation of the oxygen tubing wrapped behind Resident #33's ear revealed that there was no padding and that the tube was lying in the crease behind her upper ear lobe and her head. The sitter stated that the sore was still there and that Resident #33 was still complaining of pain. Subsequent observations of Resident #33 conducted on 3/2/2020 revealed that no padding had been applied to the oxygen tubing behind the resident's ears. Observations of Resident #33 conducted on 3/3/2020 before 10:20 AM revealed that no padding had been applied to the oxygen tubing behind the resident's ears. On 3/3/2020 at 10:20 AM, an observation of Resident #33 receiving ADLs (Activities of Daily Living) from a hospice aide was conducted. The oxygen tubing remained placed behind the resident's ears with no padding noted. As the hospice aide brushed Resident #33's hair she pulled her hair away from the resident's right ear and confirmed that there was something behind under the oxygen tubing. On 3/3/2020 at 10:30 AM, an observation of S5RN entering Resident #33's room was made. S5RN was heard asking the resident what was going on with her ear. On 3/3/2020 at 3:00 PM, a review of Resident #33's March 2020 physician's orders [REDACTED]. The order read: Clean back of R (right) ear with WC (wound cleanser) and keep O2 tubing with pads at all times q d. (every day). On 3/4/2020 at 12:10 PM, an interview was conducted with S5RN. He stated that he was the wound care nurse in the facility and confirmed that on 3/3/2020 the hospice aide for Resident #33 had made him aware of an area of concern behind the resident's right ear. He stated that he had not received any alert regarding an issue with Resident #33's ears before this time. A request was made for the General Observation Notes and any nursing documentation for Resident #33 completed by the nurses from 2/21/2020 to present. S5RN presented the computerized General Observation Notes and Comprehensive Progress Notes for review. A review of Resident #33's computerized Comprehensive Progress Notes was conducted. On 2/21/2020 at 3:30 PM, S8LPN had documented the following: Resident co something bothering her behind her ear, upon assessment, resident noted with break in skin behind top of ear. Cleansed with NS/TAO applied. Cushions applied to tubing of NC. Treatment nurse made aware. Will continue to monitor. Further review of the note failed to reveal that Resident #33's physician had been made aware of the break in her skin. A review of additional computerized Comprehensive Progress Notes after 2/21/2020 through 3/1/2020 failed to reveal any evidence that Resident #33's physician had been notified about the break in skin behind her ear. On 3/4/20 at 11:30 AM, an interview was conducted with S2RN/Hospice. She stated that she was employed part time as an RN at the nursing home and was also employed with the hospice agency who provided care for Resident #33 and was the resident's hospice nurse. She presented the Visit Note Reports for the hospice visits she conducted with Resident #33 from 2/21/2020 to present. A review of hospice Visit Note Report dated 2/21/2020 completed at 9:20 PM completed by S2RN/Hospice was conducted. The narrative documentation included O2 in progress at 3 L/Min per NC continuous. No mention that the hospice physician had been made aware of the area of concern behind Resident #33's right ear related to the oxygen tubing was noted. A review of hospice Visit Note Report dated 2/24/2020 completed at 10:04 PM completed by S2RN/Hospice was conducted. The narrative documentation included O2 in progress at 3 L/Min per NC continuous. No mention that the hospice physician had been made aware of the area of concern behind Resident #33's right ear related to the oxygen tubing was noted. A review of hospice Visit Note Report dated 2/26/2020 completed at 5:37 PM completed by S2RN/Hospice was conducted. The narrative documentation included O2 in progress at 3 L/Min per NC continuous. No mention that the hospice physician had been made aware of the area of concern behind Resident #33's right ear related to the oxygen tubing was noted. On 3/4/2020 at 4:15 PM, an interview was conducted with S5RN. He reviewed the Comprehensive Progress Note entered by S8LPN dated 2/21/2020. He confirmed that the LPN had documented that he had been notified about a break in skin behind top of Resident #33's ear. S5RN stated that he had not been made aware until yesterday about the issue and if he had been made aware on 2/21/2020 as documented, an order for [REDACTED]. She stated abnormalities with the residents that she sees in the nursing home are to be reported to her and further stated that she had not been notified of the issue behind Resident #33's ears and that she should have. She stated that when she is made aware of a residents' issue, it is documented in the hospice Visit Notes accordingly. S2RN/Hospice confirmed that there was no documentation of being notified of an area of concern behind Resident #33's ear because she had not been notified of it. 2. Resident #57. The resident was admitted to the facility on [DATE]. The resident's [DIAGNOSES REDACTED]. On 3/2/2020 at 9:15 am, the resident was observed lying down in bed. The resident stated that she fell during a transfer from a stand up lifter and broke her leg. Also, the resident stated that her right leg was hurting. Review of the resident's quick notes dated 2/20/2020 at 8:00 am revealed, CNA (Certified Nursing Assistant) was assisting resident up from bed to w/c (wheelchair) with stand up lifter. Resident was standing up with lifter and knee buckled and resident began to slide out of harness and CNA assisted resident to floor . There was no evidence noted in the clinical record that the physician was notified of the incident. Review of the resident's pain control notes dated 2/21/2020 at 1:42 am revealed, Resident c/o (complain of) severe pain to right knee . right knee with sl (slight) [MEDICAL CONDITION] . There was no evidence in the clinical record the physician was notified concerning the resident's complaint of severe pain and slight swelling to right knee. On 3/4/2020 at 11:25 am, S4LPN (Licensed Practical Nurse) stated that she notified the physician concerning the incident, however no evidence was found in the resident's clinical record that the physician was notified of the incident on 2/20/2020. On 3/4/2020 at 2:25 pm, S7RN (Registered Nurse) was interviewed by telephone. S7RN stated that she did not notify the physician concerning the resident complaining of severe pain and swelling to the right knee. On 3/4/2020 at 1:05 pm, S1DON (Director of Nurses) confirmed that the physician was not notified of the incident on 2/20/2020. Review of the facility's policy and procedure for Change in Condition/Status revealed, .* Notification of MD (Medical Doctor) and RP (Responsible Party) will be made immediately in cases of condition decline, behavior, accident or injury requiring medical

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) attention .
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to conduct an investigation for an injury of unknown source for 1 out of 31 sampled residents. (#60) Finding: Resident #60 Resident #60. Review of the resident's clinical records revealed the resident's [DIAGNOSES REDACTED]. Review of the resident's quick notes dated 1/1/2020 at 12:30 pm revealed, Patient unable to eat lunch, not swallowing, holding food in her mouth, patient's right arm and right leg flaccid, MD (Medical Doctor) notified, new orders noted, to send patient to ER (emergency room) to be evaluated . The resident left the facility via ambulance at 12:40 pm. Review of the resident's Hospital A nursing notes dated 1/1/2020 at 13:08 revealed, .Description of Altered Skin Integrity: Bruising on Rt Ankle and Leg . Review of the resident's Hospital B x-ray report dated 1/1/2020 revealed, Examination: XR ankle 2 view right Clinical History: found down, concern for fracture . Findings: Acute displaced oblique fracture distal right tibial shaft with 1 shaft with lateral displacement of distal fracture fragment. Acute displaced oblique fracture distal right fibula shaft extending to the lateral malleolus with a few posterolateral displacement of distal fragment. No dislocation. Soft tissue swelling about the lower leg and ankle. Review of the resident's Hospital B Discharge Summary report dated 1/17/2020 revealed, .Closed fracture of distal end of right tibia Pt initially found down at her nursing home. Evidence of R (Right) distal tib/fib fracture seen on imaging. Per bedside nurse discussion with family, patient had been ambulatory a month prior to presentation but had a fall and had subsequently been requiring a wheelchair at least partially. Now with another fall event causing R ankle fx (fracture) . On 3/5/2020 at 2:00 pm, S10LPN (Licensed Practical Nurse) stated that he was the nurse that transferred the resident out to Hospital A when the resident had mental status changes and weakness to right arm and right leg. S10LPN stated that he does not recall the resident having a fall on that day or having any bruises or skin issues on her arms or legs at the time she was transferred to the hospital. On 3/5/2020 at 2:30 pm, S1DON (Director of Nurses) stated that the staff at Hospital B called to let them know the resident had a right distal tibial fracture. S1DON stated that she did ask the staff if the resident had a fall or if anything had happened and no one knew of any falls. S1DON stated that an investigation was not conducted. There was no evidence that an investigation was conducted for the injury of unknown source. Review of the facility's Abuse Investigations policy and procedure revealed, 1) Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the Administrator, the Director of Nurses, or the Social Services designee with the assistance of an appointed member of management will investigate the alleged incident.
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** Based on record review and interview, the facility failed to ensure resident #57's comprehensive plan of care was accurate for assistance for transfers for 1 out of 31 sampled residents. (#57) Finding: Resident #57 Resident #57. The resident was admitted to the facility on [DATE]. The resident's [DIAGNOSES REDACTED]. Review of the resident's quarterly MDS dated [DATE] revealed that the resident was coded 4/3 for total assistance with 2 plus person assist for transfers. Review of the resident's current care plan dated 2/6/2020 revealed that the resident was to be transferred with the assistance of 1 person. The care plan did not address that the resident was to be transferred with 2 person assistance. On 3/4/2020 at 12:40 pm, S11MDS (Minimum Data Set Coordinator) reviewed the resident's care plan. She stated that the resident's care plan dated 2/6/2020 was inaccurate and should have had the resident to be transferred with stand up lifter with 2 person assist.
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** Based on observation, record review, and interview, the facility failed to ensure each resident received adequate supervision of a two person assist to prevent accidents as evidenced by the CNA (Certified Nursing Assistant) transferring resident #57 with the stand up lifter using a one person assist instead of using two person assist per the facility's policy and procedure for 1 (#57) out of 5 (#29, #33, #60, #57,#118) residents with falls out of a total sample of 31 residents. Finding: Resident #57 Resident #57. The resident was admitted to the facility on [DATE]. The resident's [DIAGNOSES REDACTED]. Review of the resident's quarterly MDS (Minimum Data Set) dated 2/5/2020 revealed that the resident's BIMS (Brief Interview for Mental Status) score was 12 for moderately impaired for cognition. The resident was coded 4/3 for total assistance with 2 plus person assist for transfers. Review of the resident's Fall Risk assessment dated [DATE] revealed that the resident's score was 16, which was above 9 for being at risk for falls. Review of the resident's current care plan dated 2/6/2020 revealed that the resident was to be transferred with the assistance of 1 person. The care plan did not address if the resident was to be transferred with the use of a standing lifter. Review of the resident's quick notes dated 2/20/2020 at 8:00 am revealed, CNA was assisting resident up from bed to w/c (wheelchair) with stand up lifter. Resident was standing up with lifter and knee buckled and resident began to slide out of harness and CNA assisted resident to floor . There was no evidence noted in the clinical record that the physician or the resident's responsible party was notified of the incident. Review of the resident's pain control notes dated 2/21/2020 at 1:42 am revealed, Resident c/o (complain of) severe pain to right knee . right knee with sl (slight) [MEDICAL CONDITION] . There was no evidence the physician was notified concerning the resident's complaint of severe pain and slight swelling to right knee. Review of the resident's quick notes dated 2/21/2020 at 9:14 am revealed that the physician was notified concerning the resident complaining of pain and swelling to the right knee, which was over 24 hours after the resident was lowered to the floor from the stand up lifter by the CNA. New orders were noted for an x-ray of the right knee. Review of the resident's quick notes dated 2/21/2020 at 12:15 pm revealed, ____ gave x-ray results-Right distal femur fracture. Results called to Dr._____ -Send to Hospital A for eval and treatment . Review of the resident's hospital history and physical note dated 2/21/2020 revealed, . 86 yo (year old) WF (white female) . She apparently has been bed/chairbound for a few years. She was being transferred from bed to w/c (wheelchair) with a lifter today per CNA at NH (nursing home) and her knee buckled and she slipped from the harness to the floor (per NH report, pt does not recall exactly what occurred). She was assisted to the floor per the CNA, no injuries were noted, but she then c/o knee pain and xray showed a distal femoral fx (fracture). She was sent to ED (Emergency Department) and is admitted for medical and surgical assessment. Dr. _____ has indicated he will repair this upon medical clearance . Review of the resident's x-ray report dated 2/21/2020 revealed, .IMPRESSION: 1. Acute distal right femoral fracture . On 3/4/2020 at 9:50 am, a telephone interview was conducted with S12CNA. S12CNA stated that she was getting ready to transfer the resident from the bed to wheelchair. S12CNA stated that the resident was sitting up on the side of the bed and she put the lifter pad behind the resident's back and buckled the lifter pad around the resident's waist and then connected the straps from the lifter pad to the lifter bars of the stand up lifter. S12CNA then put the resident's feet flat on the lifter stand and made sure that both of the resident's knees were placed against the knee protector of the stand up lifter. S12CNA stated that she instructed the resident to put her hands on the bars of the stand up lifter and to hold on while she lifted her up. S12CNA stated that she pressed the button for the lifter to go up and then all of a sudden, the resident's left leg backed up off of the stand and her leg went all the way back. S12CNA stated that she tried to pick up the resident's left leg and put in back on the stand, but she could not do it. S12CNA stated that the resident's right leg had shifted and turned and then she told the resident that she had to let her down and the resident started saying, oh my leg, oh my leg. S12CNA stated that she lowered the lifter as low as it could go and disconnected the lifter pad from the stand up lifter bar so that the resident could be lowered down to the floor. S12CNA stated that she ran out of the room and called for help. S12CNA stated that she told the nurse that the resident did not fall and was lowered down to the floor. S12CNA stated that the resident did not go to the emergency room that day, but

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) went on the next day after an x-ray was done due to her right leg swelling and she was sent out to the hospital emergency room . S12CNA stated that she knows how to transfer the resident because there was a care plan on the inside of the resident's closet door letting the CNAs know how to transfer the resident. The care plan on the inside of the resident's closet door revealed that a stand up lifter was to be used to transfer the resident. S12CNA stated that she transferred the resident with one person assist with the stand up lifter all the time. On 3/4/2020 at 11:25 am, S4LPN (Licensed Practical Nurse) stated that S12CNA told her that the resident's legs buckled or gave out while being transferred with the stand up lifter. S4LPN stated that the S12CNA told her the resident was starting to slide out of the harness so she lowered the resident down on the floor. S4LPN stated that the incident occurred on 2/20/2020 at 7:30 am. S4LPN stated that she notified the physician the next day on 2/21/2020 at 9:14 am when the resident was complaining of pain and had swelling to the right knee. S4LPN stated that the stand up lifter with 2 person assist was to be used to transfer the resident. S4LPN stated that S12CNA was the only person with the resident during the transfer with the stand up lifter. S4LPN stated the use of any lifter requires 2 person assist at all times. On 3/4/2020 at 12:40 pm, S11MDS (Minimum Data Set) Coordinator stated that the resident's care plan dated 2/6/2020 was inaccurate and should have transfer with stand up lifter with 2 person assist. S11MDS Coordinator stated that all lifters are to be used with 2 person assist. On 3/4/2020 at 1:05 pm, S1DON (Director of Nurses) stated that all transfers conducted with a mechanical lifter should be assisted with 2 persons. S1DON stated that S12CNA did not follow the policy and procedure for transferring with a mechanical lifter. Review of the facility's policy and procedure for Lifting Machine, Using a Mechanical Lifting Device revealed, .1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift .
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews the facility failed to provide necessary care and services in accordance to the residents plan of care for 1 (#30) of 31 residents sampled. Findings: Resident #30 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. On 3/4/2020 at 1:20 PM, an observation was made of Resident #30's [MEDICAL CONDITION] (Bilevel Power Positive Pressure) equipment which revealed that a current date was not on the protective covering of the [MEDICAL CONDITION] mask. A review of Resident #30's physician orders [REDACTED]. That the [MEDICAL CONDITION] equipment (mask and tubing) were to be changed every 6 months in February and August. A review of Resident #30's treatment record dated 2/1/2020 to 2/29/2020 revealed that the [MEDICAL CONDITION] machine was being utilized by Resident #30. Further review revealed that the [MEDICAL CONDITION] equipment had not been changed during that month. A review of Resident #30's MAR (medication administration record) revealed that the nurse had not signed the MAR indicating that the [MEDICAL CONDITION] equipment was changed in the month of February as the physician orders [REDACTED]. S6LPN stated that she did not have the equipment to change it and she did not know how to get the appropriate equipment. S6LPN confirmed that the [MEDICAL CONDITION] equipment should have been changed in February. On 3/5/2020 at 10:00 AM, an interview was conducted with S1DON who stated that the equipment for the [MEDICAL CONDITION] machine is ordered from a company and all the nurses know where to order the equipment. S1DON confirmed that S6LPN should have known how and where to get the [MEDICAL CONDITION] equipment from and that the [MEDICAL CONDITION] mask and tubing should have been changed in February. On 03/05/20 at 5:10 PM, an interview was conducted with S5RN who is in charge of infection control for the facility, confirmed that the [MEDICAL CONDITION] equipment for Resident #30 should have been changed in February as ordered to help prevent respiratory infections for Resident #30.
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the nursing staff was competent as evidenced by the staff failing to ensure continued observations of a resident for delayed complications after sustaining a fall, for 1 (#33) of 5 (#29, #33, #57, #60, #118) resident's investigated for accidents. This deficient practice had the potential to affect the entire census of 67 residents. Findings: On 3/02/2020 at 12:36 PM, an observation of Resident #33 was conducted. An ace wrap around a splint was noted to her right arm. A concurrent interview was conducted with Resident #33's sitter, who was in the resident's room. She stated that she was notified that the resident had fallen last week, had broken her wrist, and was taken to the emergency room . A review of Resident #33's record revealed that she was admitted to the facility on [DATE] under hospice care. [DIAGNOSES REDACTED]. A review of Resident #33's quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) cognition score of 14 out of 15, indicating that she was cognitively intact. A review of Resident #33's care plan revealed: Fall risk unsteady gait/cognitive deficits impaired. Safety awareness/weakness/dizziness, impaired mobility/vision. A review of the facility fall list was reviewed and included that on 2/23/2020 at 6:27 AM, the resident fell while transferring/repositioning in her room. The list included - Type of injury: none apparent. A review of accident report titled Incident Details was reviewed and revealed that on 2/23/2020 at 6:27 AM, Resident #33 had a fall while transferring/repositioning, and that the fall assessment was completed on 2/23/20 at 1:02 PM. Type of Injury was documented with an X in the none apparent box. The assessment for pain was left blank. An area on the document included Details of the Incident. 2/23/20 632 AM-resident was going to sit in recliner and slipped out of chair due to oxygen tubing wrapped around ankle. Able to move all ext (extremities) without problems. No complaints from resident. Did not hit her head or hurt herself in any way as told by resident. A review of a mobile X-ray dated 2/24/2020 of an exam of the resident's right wrist because of pain and swelling. The impression was: [MEDICAL CONDITION] right metaphysis and right ulna. A review of the computerized nurses charting revealed the following entries: 2/23/2020 at 2:34 PM: . .voice no c/o this shift. S13LPN. 2/24/2020 at 11:41 AM: Pt (patient) c/o (complained of) pain in right wrist. Wrist is swollen, warm to touch, weak grasp. Hospice nurse notified. New order to X-ray right wrist. S6LPN and; 2/24/2020 at 12:52 PM: X-ray of right wrist done, and; 2/24/2020 at 2:26 PM: FX (fracture) of ulna + radial wrist. New Order to send to ER. Further review of Resident #33's paper charting documentation and computerized documentation was conducted. No evidence in the resident's record of continuing observations, of the absence or presence of possible delayed complications of Resident #33 were noted after the nurses note entry by S13LPN on 2/23/2020 at 2:34 PM. On 3/4/2020 at 3:45 PM, an interview was conducted with S13LPN. She confirmed that she worked on 2/23/2020 from 7AM-3PM and that Resident #33 had fallen right before her shift began. She stated that she had assessed Resident #33 throughout her shift and she had no complaints of pain. She stated that the nurses work 8 hour shifts and that another nurse worked after her on 2/23/2020 from 3PM-11PM, and another from 11PM on 2/23/2020 until 7AM on 2/24/2020. She confirmed that S6LPN worked from 7AM -3PM on 2/24/2020. S13LPN reviewed the nurse's notes and confirmed that there was no evidence that the nurses from the 2 shifts between she and S6LPN had continued to assess Resident #33's status after she had sustained the fall. S1DON presented the facility's fall policy titled Assessing Falls and Their Causes. The policy included: After a Fall-#5. Nursing staff will observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall and will document findings in the medical record, and; #6. Documentation will include any observed signs or symptoms of pain swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. It will note the presence or absence of significant findings. On 3/5/202 at 10:40 AM, an interview was conducted with S1DON. She reviewed the fall policy and procedure and confirmed that the nurses who worked with Resident #33 on the 3PM-11PM and 11PM-7AM shifts after the resident fell should have conducted continued observations and should have definitely documented their observations for possible delayed complications after the fall. She confirmed that the nurses should have documented the presence or absence possible complications as directed in the policy and procedure and they had not done so.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide current pharmaceutical services to meet the needs of each resident as evidenced by having expired medications available for resident use on 2 (Medication Cart A and C) of the 3 (Medication Cart A, B, C) medication carts in the facility. This deficient practice had the potential to affect any of the 67 residents who resided in the facility. FINDINGS: During an observation of Medication Cart A on 3/5/2020 at 1:57 p.m.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) with S3LPN (Licensed Practical Nurse), an observation was made of a bottle of Artificial Tears for Resident #10 with an expiration date of 1/2020. An interview as conducted with S3LPN at this time and she confirmed the bottle of Artificial Tears for Resident #10 had expired in January, 2020 and should have been removed from the cart. She stated the staff nurses are responsible for checking their carts for accuracy and to remove all expired medications. During an observation of Medication Cart C on 3/5/2020 at 2:42 p.m. with S4LPN an observation was made of a medication bottle, from an outside pharmacy, labeled for Resident #2 of [MEDICATION NAME] .4mg/tablet (milligrams) with an expiration date of 8/27/19. S4LPN opened the bottle and inside was a bottle of [MEDICATION NAME] .4mg/tablet with an expiration date of 2/2020. S4LPN confirmed the outer bottle of [MEDICATION NAME] contained an expiration date of 8/27/19 and the inner bottle contained an expiration date of 2/2020. She stated the medication was expired and should have been removed from the medication cart. S4LPN stated the medication was most likely brought in from home around the time of admit, placed on the cart, and never removed because it was overlooked. She stated the staff nurses check their carts for accuracy and removal all expired medications but there was no designated nurse responsible for this.