STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065221	A. BUILDING _____ B. WING _____	08/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPRING CREEK HEALTH CARE CENTER	1000 E STUART ST FORT COLLINS, CO 80525

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to protect one (#2) of three residents reviewed out of six sample residents from abuse and neglect. The facility failed to transfer Resident #2 in an appropriate manner consistent with physical therapy evaluation which determined the safest way to transfer Resident #2 was by utilizing a hoyer lift. Resident #2, was admitted to the facility on [DATE] with a history of [MEDICAL CONDITION] (stroke) that resulted in one sided weakness on her left side. In early morning of 8/1/2020 Resident #2 was transferred by two certified nurse aides (CNAs) without using the Hoyer lift, and by using an arm to arm method. The staff members failure to use a hoyer lift when transferring, contributed to the harm of Resident #2 sustaining a left hand fractured. Cross-reference to F609, (reporting of allegations of abuse and neglect), failure to timely report allegations of abuse and neglect. Cross-reference to F610, (investigation of allegations of abuse and neglect), failure to timely investigate allegations of abuse and neglect. Cross-reference to F637, failure to assess the resident after a change of condition. Cross-reference to F684, failure to monitor resident's cast after hand fracture. Findings include: A. Facility policy and procedure The Abuse and Neglect prohibition policy and procedure, with revision date July 2018, was provided by the nursing home administrator (NHA) on 8/25/2020. The policy read in part, Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin. Any observations of allegations of abuse, neglect or mistreatment must be immediately reported to the administrator. The facility will timely conduct an investigation of any alleged abuse/neglect in accordance with state law. B. Resident #2 status Resident #2, age [AGE] years old, was admitted [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 8/7/2020 minimum data set (MDS) assessment documented the resident was moderately cognitively impaired with the brief interview for mental status score (BIMS) of 13 out of 15. The staff assessment indicated the resident had no symptoms of [MEDICAL CONDITION] or difficulty concentrating on activities, no disorganized thinking and rejected care. She required extensive assistance from two staff for transfers, she had functional limitation in range of motion (ROM) on both sides and used an electric wheelchair for mobility. C. Record review The resident's care plan, initiate on 11/16/19 and revised on 11/29/19, documented resident had an activities of daily living (ADL) self-care performance deficit due to decreased physical mobility secondary [MEDICAL CONDITION] and [MEDICAL CONDITION] from the stroke. Resident required a total staff assistance of two staff for all ADL's. Interventions included to use mechanical lift for transfers with the assistance of two staff members. The resident's care plan, initiated on 8/18/2020 (after the incident on 8/1/2020), documented resident had a history of [REDACTED]. Interventions included to encourage recommended method of transferring and provide means of completing transfer safely, when resident declines to use the mechanical lift for transfers, provide education regarding the risk of making this choice. If she continues to decline, inform the director of nursing (DON) prior to transfer. Interdisciplinary progress notes and behavior notes were reviewed between June and August 2020. There were no documented notes that resident refused the recommended method of transfer. The late entry progress note, created on 8/2/2020 (one day after the incident), with effective date of 8/1/2020 documented by RN #1 read: Resident requesting rising per usual at 400 a.m. Aids reported bed making a noise, that the resident thought was her (left) arm. Resident riding (wheelchair) to nurses' station, asking for a sling. Inquiring of need, resident stated, my arm got caught. Able to move (left upper extremity) at paralysis baseline, while already in tears (about) the delivery of Retinol cream alternative. While inquiring of further concerns, resident returned to room, never mind!. -There was no thorough nursing assessment, Situation- Background-Assessment-Recommendation (SBAR) note, or further investigation of the resident's arm and her overall condition after she reported that her hand got caught. The progress note documented by RN #2 on 8/1/2020 at 3:56 p.m., read: Patient complaining of pain of the left hand. Unable to move (left hand), patient refusing passive range of motion. Arm wrapped with (curlex) unable to visualize. Patient states her arm was caught while getting (out of bed) this (morning). XRAY stat (immediate) ordered. Will continue to monitor. -There were no thorough nursing assessment, SBAR note, or further investigation of the resident's arm and her overall condition after she reported to the second nurse that her hand got caught. The progress note documented by RN #2 on 8/1/2020 at 10:00 p.m. (18 hours after the incident) read that x-ray results demonstrated an acute [MEDICAL CONDITION] hand. Physician was notified and the resident was transferred to the emergency room (ER) for evaluation. The SBAR note completed on 8/1/2020 at 10:20 p.m. documented resident's vital signs, and the same note as in the above progress note. The note stated that the resident experienced pain with movement of the left hand, the level of pain was not recorded. According to the admission note dated 8/1/ from the ER, resident was admitted on [DATE] with the following clinical impression: closed fracture of distal end of left radius. D. Resident interview Resident #2 was interviewed on 8/24/2020 around 11:00 a.m. She said during the transfer on 8/1/2020 she was transferred by two CNAs, she said it was done that way because it was faster. She said after the incident, on 8/1/2020 when her papralyzed left hand hit the frame of the bed, from now on she was transferred only by mechanical lift. Resident did not answer the question if she refused to be transferred by mechanical lift on the day of the incident or before that. E. Facility investigation On 8/24/2020, during the survey, facility investigation provided by NHA. The root cause analysis read: (Resident #2) got a fractured wrist because she chose for CNAs to transfer her without a lift. CNAs transferred resident without recommended lift. Interventions implemented: Staff and resident education, ad hoc (when necessary) regarding transfer, briefing sheets for CNAs, and transfer sheets. IDT recommendations: continue education for staff, including at orientation. Ad hoc QAPI meeting summary read: Staff are frequently unclear of transfer orders for residents related to safety. Need method for staff to know transfer techniques for residents needing to use mechanical lift assistance especially. Systemic changes were listed as: update care plans, update white boards for residents in rooms with proper transfer technique, and develop briefing sheets for CNAs where resident's transfer status will be indicated. F. Staff interviews Physical therapy director was interviewed on 8/25/2020 around 2 p.m. He said the most recent evaluation for the resident was completed on 1/15/2020. At that time it was recommended to use a mechanical lift for residents for all transfers. He said in general, mechanical lift was recommended for individuals who are not able to bear weight, and Resident #2 was not able to bear weight on her legs due to paralysis on one side of the body. He said arm to arm transfer would only be appropriate for residents who are able to bear weight on their legs, rotate and make few steps. He said resident #2 was not able to do any of the above and should have been transferred only by mechanical lift. DON was interviewed on 8/25/2020 around 1:00 p.m. She said she was notified about the incident on 8/1/2020, she said the investigation was done by the administrator and the education part to staff was done by staff development coordinator (SDC). She said she was not aware of any delayed education to the staff on proper transfers. SDC was interviewed on 8/31/2020 around 2 p.m. She said she was notified about the need for education to staff by NHA around 8/14/2020. She said that was the time when she started her education on proper transfer status for residents who used mechanical lifts. NHA was

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 0600 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) interviewed on 8/25/2020 at 2:06 p.m. He said after the investigation the allegations were substantiated as a neglect. He said two involved CNAs were re-educated on proper transfers at the time of the investigation 8/14/2020. He said the delay in the investigation was due to the confusion that it was the resident's choice to be transferred without lift and he needed to clarify the specifics with the corporate team. After it was clarified on 8/14/2020, he reported it to the state department, police and started the investigation and education to staff.
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.** Based on record review and interview, the facility failed to report alleged violations of potential neglect to the state survey and certification agency in accordance with state law involving one (#2) of three residents reviewed for abuse out of six sample residents. Cross-reference F600 failed to protect resident from abuse and F610 (investigation of allegations of abuse and neglect), failure to timely investigate allegations of abuse and neglect. Findings include: I. Facility policy and procedure The Abuse and Neglect prohibition policy and procedure, with revision date July 2018 was provided by the nursing home administrator (NHA) on 8/25/2020. The policy read in part, Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin. Any observations of allegations of abuse, neglect or mistreatment must be immediately reported to the administrator. The facility will timely conduct an investigation of any alleged abuse/neglect in accordance with state law. II. Failure to report alleged violations of potential neglect to the state survey and certification agency involving Resident #2. A. Incident report and investigation summary On 8/24/2020 facility investigation provided by NHA. On 8/24/2020, during the survey, facility investigation provided by NHA. The root cause analysis read: (Resident #2) got a fractured wrist because she chose for CNAs to transfer her without a lift. CNAs transferred resident without recommended lift. Interventions implemented: Staff and resident education, ad hoc (when necessary) regarding transfer, briefing sheets for CNAs, and transfer sheets. IDT recommendations: continue education for staff, including at orientation. Ad hoc QAPI meeting summary read: Staff are frequently unclear of transfer orders for residents related to safety. Need method for staff to know transfer techniques for residents needing to use mechanical lift assistance especially. Systemic changes were listed as: update care plans, update white boards for residents in rooms with proper transfer technique, and develop briefing sheets for CNAs where resident's transfer status will be indicated. B. Failure to report There was no evidence to indicate the 8/1/2020 incident was reported to the state licensing and certification agency or law enforcement officials before 8/13/2020. III. Staff interviews DON was interviewed on 8/25/2020 around 1:00 p.m. She said she was notified about the incident on 8/1/2020, she said the investigation was done by the administrator and the education part to staff was done by staff development coordinator (SDC). She said she was not aware of any delayed education to the staff on proper transfers. SDC was interviewed on 8/31/2020 around 2 p.m. She said she was notified about the need for education to staff by NHA around 8/14/2020. She said that was the time when she started her education on proper transfer status for residents who used mechanical lifts. NHA was interviewed on 8/25/2020 at 2:06 p.m. He said after the investigation the allegations were substantiated as a neglect. He said two involved CNAs were re-educated on proper transfers at the time of the investigation 8/14/2020. He said the delay in the investigation was due to the confusion that it was the resident's choice to be transferred without lift and he needed to clarify the specifics with the corporate team. After it was clarified on 8/14/2020, he reported it to the state department, police and started the investigation and education to staff.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** Based on record review and interview, the facility failed to have evidence incident of neglect or potential neglect involving one (#2) of three residents out of six sample residents, was thoroughly investigated and steps were taken to prevent further neglect. Cross-reference F600-failed to protect resident from abuse and F609 (reporting of allegations of abuse and neglect), failure to timely report allegations of abuse and neglect. Findings include: I. Facility policy and procedure The Abuse and Neglect prohibition policy and procedure, with revision date July 2018, was provided by the nursing home administrator (NHA) on 8/25/2020. The policy read in part, Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin. Any observations of allegations of abuse, neglect or mistreatment must be immediately reported to the administrator. The facility will timely conduct an investigation of any alleged abuse/neglect in accordance with state law. II. Failure to report alleged violations of potential neglect to the state survey and certification agency involving Resident #2. A. Incident report and investigation summary On 8/24/2020, during the survey, facility investigation provided by NHA. The root cause analysis read: (Resident #2) got a fractured wrist because she chose for CNAs to transfer her without a lift. CNAs transferred resident without recommended lift. Interventions implemented: Staff and resident education, ad hoc (when necessary) regarding transfer, briefing sheets for CNAs, and transfer sheets. IDT recommendations: continue education for staff, including at orientation. Ad hoc QAPI meeting summary read: Staff are frequently unclear of transfer orders for residents related to safety. Need method for staff to know transfer techniques for residents needing to use mechanical lift assistance especially. Systemic changes were listed as: update care plans, update white boards for residents in rooms with proper transfer technique, and develop briefing sheets for CNAs where resident's transfer status will be indicated. B. Failure to investigate There was no evidence to indicate the 8/1/2020 incident was investigated at the time it was discovered that Resident #2 sustained a hand fracture on 8/1/2020. III. Staff interviews DON was interviewed on 8/25/2020 around 1:00 p.m. She said she was notified about the incident on 8/1/2020, she said the investigation was done by the administrator and the education part to staff was done by staff development coordinator (SDC). She said she was not aware of any delayed education to the staff on proper transfers. SDC was interviewed on 8/31/2020 around 2 p.m. She said she was notified about the need for education to staff by NHA around 8/14/2020. She said that was the time when she started her education on proper transfer status for residents who used mechanical lifts. NHA was interviewed on 8/25/2020 at 2:06 p.m. He said after the investigation the allegations were substantiated as a neglect. He said two involved CNAs were re-educated on proper transfers at the time of the investigation 8/14/2020. He said the delay in the investigation was due to the confusion that it was the resident's choice to be transferred without lift and he needed to clarify the specifics with the corporate team. After it was clarified on 8/14/2020, he reported it to the state department, police and started the investigation and education to staff.
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** Based on record review and interviews, the facility failed to develop and revise comprehensive care plans for each resident that included the instructions needed to provide effective and person-centered care for three (#2, #4, and #6) residents out of six sample residents. Specifically, the facility failed to: -Ensure the comprehensive care plan was revised and updated for Resident #2 with care assistance with cast and sling; and, -Ensure the comprehensive care plan was revised and updated with hospice care services for Resident #4 and #6. Cross-reference: F684: the facility failed to ensure Resident #2 received care and assistance with cast and sling care after her hand was fractured. Findings include: I. Failure to revise and update the care plan for resident ' s cast and sling care after the fracture A. Resident #2 status Resident #2, age [AGE] years old, was admitted [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 8/7/2020 minimum data set (MDS) assessment documented the resident was moderately cognitively impaired with the brief interview for mental status score (BIMS) of 13 out of 15. The staff assessment indicated the resident had no symptoms of [MEDICAL CONDITION] or difficulty concentrating on activities, no disorganized thinking and rejected care. She required extensive assistance from two staff for transfers, she had functional limitations in range of motion (ROM) on both sides and used an electric wheelchair for mobility. B. Resident interview and observations Resident #2 was interviewed on 8/24/2020 around 11:00 a.m. Resident observed sitting in her room in an electric wheelchair in front of the TV. She had a blue sling on her left hand that was in a cast. Resident #2 said during the transfer on 8/1/2020 her hand hit the side of the bed and she sustained a fracture. When asked about her hand in cast, she said nurses don ' t need to check on her casted hand because she is a nurse herself and knows what she needs to watch for. C. Record review The progress note documented by RN #2 on

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) 8/1/2020 at 10:00 p.m., read that x-ray results demonstrated an acute [MEDICAL CONDITION] hand. Physician was notified and the resident was transferred to the emergency room (ER) for evaluation. According to the admission note dated 8/1/ from the ER, resident was admitted on [DATE] with the following clinical impression: closed fracture of distal end of left radius. The resident ' s care plan was reviewed on 8/24/2020. It did not reveal the comprehensive care plan was revised to indicate the resident ' s fractured arm, sling and cast that resident had. II. Failure to revise and update the care plan with hospice services A. Resident #4 status Resident #4, age 94, was admitted on [DATE]. According to the August 2020 CPO, the [DIAGNOSES REDACTED]. The 8/26/2020 MDS assessment revealed the resident ' s cognition was severely impaired, she was rarely understood, had memory problems and her brief interview for mental status score was not conducted. She required extensive assistance of one person with bed mobility, transfers, dressing and toileting. The MDS section for special treatment revealed that the resident did not participate in hospice services. 1. Record review According to the physician's order [REDACTED]. The resident ' s care plan initiated on 10/30/2017 and lastly revised on 9/30/2019, revealed that resident have chosen to maintain a (do not resuscitate) status at this time, and her and her family made a decision to move forward with hospice services. Interventions included to indicate hospice referral, and to provide comfort measures when end of life is eminent. Resident ' s care plan was not updated since 2019 and did not include specific person-centered interventions that the resident was receiving through hospice services. B. Resident #6 status Resident #6, age 80, was admitted on [DATE]. According to the February 2020 CPO, the [DIAGNOSES REDACTED]. The 8/6/2020 MDS assessment revealed the resident ' s cognition was moderately impaired with the brief interview for mental status score (BIMS) of nine out of 15. She had difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was said, and such behavior fluctuated in severity. She required minimal assistance of one person with bed mobility, transfers, dressing and toileting. The MDS section for special treatment revealed that the resident participated in hospice services. 1. Record review According to the physician's order [REDACTED]. The resident ' s care plan initiated on 3/11/19 and lastly revised on 10/24/2019, revealed that the resident has chosen to maintain a (do not resuscitate) status at this time, and her and her family made a decision to move forward with hospice services. Interventions included to call hospice with any updates, and to see social services conference notes. The resident ' s care plan was reviewed on 8/24/2020 at 11:00 a.m. The care plan was not revised since 2019 to include specific person-centered interventions that the resident was receiving through hospice services. On 8/26/2020 after it was brought to the attention of the SSD, the care plan was updated with the following interventions: Visit frequency: (nurse once a week) , (social services worker twice a month). Notably: Visits via phone and video call per COVID 19 precautions. Nursing may be allowed in the facility if there is a significant change or if death is imminent. C. Staff interviews Hospice Registered nurse (RN) #1 was interviewed over the phone on 8/25/2020 around 9:00 a.m. She said, both, Resident #4 and #6 were receiving hospice services and she was the nurse who worked with residents. She said due to the COVID policy, nurses were no longer allowed in the building and most communication occured over the phone or video conferences with the social services director (SSD). She said telehealth conferences were done weekley every Wednesday, and on as needed basis if a resident had a change in condition. RN #2 was interviewed on 8/31/2020 around 1:30 p.m. She said nurses generally did not have time to update care plans and all care plans were updated by unit managers. RN#3 was interviewed on 8/31/2020, she said all care plans were updated by the MDS coordinator. All changes in resident ' s status were discussed in the morning meeting and after that MDS coordinator would make changes to the plans. She said the care plan should be updated to reflect the resident ' s current status, and should be done as soon as change of status became known. RN #4/MDS coordinator was interviewed on 8/31/200 around 2:00 p.m. She said she did participate in care plan updates, but not all of them. She said she just made sure they were updated with all new changes that were discussed in the morning meeting. She said care plans regarding medical needs such as casts and slings were updated by unit managers, hospice services were updated by the social services department and activities by activities department. Regarding Resident #4 ' s MDS section, she said Resident #4 participated in hospice services and her MDS was marked incorrectly. She said she will correct the error immediately. RN# 5/unit manager was interviewed on 8/31/2020 around 2:00 p.m. She said all sections of the care plans were updated by the MDS coordinator and after it was done by her, she would provide a printed report for unit managers to review what was updated and what was missing. SSD was interviewed on 8/31/2020 around 2:00 p.m. He said he was in charge of updating care plans that related to psy-social well being of residents. He said he was updating all care plans related to hospice services as well. Regarding Resident #4 he said he wasn ' t sure how it got missed, and regarding Resident #6 he said he made the updates on 8/26/2020. The Director of nursing (DON) was interviewed on 8/24/2020 around 3:00 p.m. She said unit managers were in charge to make sure all care plans were up to date and reflect the most curren resident ' s condition. She said the hospice care plan was usually listed under the resident's other sections of care plan such as code status. She said usually it was not a separate section of the care plan.
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** Based on observations, record review and interview, the facility failed to ensure that the resident received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (#2) of three residents reviewed for quality of care of six sample residents. Specifically, the facility failed: -To identify signs and symptoms of a hand fracture after inappropriate transfer in order to provide timely intervention and hospitalization for Resident #2, which resulted in the delayed care for the resident; -To add physician's orders [REDACTED]. hand after it was placed in a cast. Cross-reference to: Cross-reference to F600 failed to prevent neglect, resident was transferred in inappropropriate manner and sustained hand fracture. Cross-reference to F637, failure to assess Resident #2 after she reported to two nurses that her hand got caught during the transfer. Findings include: I. Failure to identify hand fracture and timely transport resident to the emergency department for evaluation. A.Resident #2's status Resident #2, age [AGE] years old, was admitted [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 8/7/2020 minimum data set (MDS) assessment documented the resident was moderately cognitively impaired with the brief interview for mental status score (BIMS) of 13 out of 15. The staff assessment indicated the resident had no symptoms of [MEDICAL CONDITION] or difficulty concentrating on activities, no disorganized thinking and rejected care. She required extensive assistance from two staff for transfers, she had functional limitations in range of motion (ROM) on both sides and used an electric wheelchair for mobility. The resident's care plan, initiate on 11/16/19 and revised on 11/29/19, documented resident had an activities of daily living (ADL) self-care performance deficit due to decreased physical mobility secondary [MEDICAL CONDITION] and [MEDICAL CONDITION] from the stroke. Resident required a total staff assistance of two staff for all ADL's. Interventions included to use mechanical lift for transfers with the assistance of two staff members. The resident's care plan, initiated on 8/18/2020 (after the incident on 8/1/2020), documented resident had a history of [REDACTED]. Interventions included to encourage recommended method of transferring and provide means of completing transfer safely, when resident declines to use the mechanical lift for transfers, provide education regarding the risk of making this choice. If she continues to decline, inform the director of nursing (DON) prior to transfer. Interdisciplinary progress notes and behavior notes were reviewed between June and August 2020. There were no documented notes the resident refused the recommended method of transfer. 3. Resident interview Resident #2 was interviewed on 8/24/2020 around 11:00 a.m. She said during the transfer on 8/1/2020 she was transferred by two CNAs, she said it was done that way because it was faster. She said after the incident, on 8/1/2020 when her papralyzed left hand hit the frame of the bed, from now on she was transferred only by mechanical lift. Resident did not answer the question if she refused to be transferred by mechanical lift on the day of the incident or before that. 4. Record review The late entry progress note, created on 8/2/2020 (one day after the incident), with effective date of 8/1/2020 documented by RN #1 read: Resident requesting rising per usual at 400 a.m. Aids reported bed making a noise, that the resident thought was her (left) arm. Resident riding (wheelchair) to nurses' station, asking for a sling. Inquiring of need, resident stated, my arm got caught. Able to move (left upper extremity) at paralysis baseline, while already in tears (about) the delivery of Retinol cream alternative. While inquiring of further concerns, resident returned to room, never mind!. There was no thorough nursing assessment, Situation-Background-Assessment-Recommendation (SBAR) note, or further investigation of the resident's arm and her overall condition after she reported that her hand got caught. The progress note documented by RN #2 on 8/1/2020 at 3:56 p.m., read: Patient complaining of pain of the left hand. Unable to move (left hand), patient refusing passive range of motion.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) Arm wrapped with (curlex) unable to visualize. Patient states her arm was caught while getting (out of bed) this (morning). XRAY stat (immediate) ordered. Will continue to monitor. -There were no thorough nursing assessment, SBAR note, or further investigation of the resident's arm and her overall condition after she reported to the second nurse that her hand got caught. The progress note documented by RN #2 on 8/1/2020 at 10:00 p.m. (18 hours after the incident) read that x-ray results demonstrated an acute [MEDICAL CONDITION] hand. Physician was notified and the resident was transferred to the emergency room (ER) for evaluation. The SBAR note completed on 8/1/2020 at 10:20 p.m. documented resident's vital signs, and the same note as in the above progress note. The note stated that the resident experienced pain with movement of the left hand, the level of pain was not recorded. According to the admission note dated 8/1/ from the ER, the resident was admitted on [DATE] with the following clinical impression: closed fracture of distal end of left radius. II. Failure to add physician's orders [REDACTED]. hand after it was placed in the cast. 1. Resident interview Resident #2 was interviewed on 8/24/2020 around 11:00 a.m. Resident observed sitting in her room in an electric wheelchair in front of the TV. She had a blue sling on her left hand that was in a cast. Resident #2 said during the transfer on 8/1/2020 she was transferred by two CNAs, she said it was done that way because it was faster. She said after the incident, on 8/1/2020 when her papralyzed left hand hit the frame of the bed, from now on she was transferred only by mechanical lift. Resident did not answer the question if she refused to be transferred by mechanical lift on the day of the incident or before that. When asked about her hand in cast, she said nurses don't need to check on her casted hand because she is a nurse herself and knows what she needs to watch for. 2. Record review The Resident #2's comprehensive care plan was reviewed on 8/24/2020, it did not mention that the resident had a fractured hand and there was no mention that the resident was wearing a sling on her left hand and had a cast. The medical administration (MAR) and treatment records (TAR) were reviewed for August 2020, there was no mention for monitoring resident's hand due to the fracture. There was no mention that the resident had a sling and a cast on her left hand. On 8/24/2020 after the interview with LPN #1, the following order was added to the MAR: Waterproof cast to right wrist for 6 weeks. Weight bearing as tolerated, monitor cast to right wrist for any numbness, swelling, pain or irritation and report any findings to MD. Every shift for right wrist fracture for 6 weeks. III. Staff interviews CNAs who assisted resident with transfer in the morning of 8/1/2020 were not available for an interview. CNA #1 was interviewed on 8/24/2020 around 2 p.m. She said the resident required two person assistance and was transferred with the Hoyer lift. She said the resident was paralized on the left side and not able to move her left hand and left leg. She said recently the resident sustained [REDACTED]. She said residents required assistance with placing the sling and with other activities of daily living. Licensed practical nurse (LPN) #1 was interviewed on 8/24/2020 around noon. She said she was working on the unit on 8/1/2020, but she was not the primary nurse for the resident that night. She said she was working with the resident today and the resident was wearing a cast and a sling, she believed the fracture was related to having hardwear in her arm from a previous fracture. She said the resident was wearing a cast and a sling. She said the waterproof cast was applied on 8/11/2020. She said she checked the resident's hand for swelling and pain during her shift. She said she would document any abnormal signs in progress notes. She reviewed the resident's MAR and TAR and said she could not locate an order to monitor the resident's hand. She reviewed the resident's paper chart and located an order from the physician dated 8/11/2020. The order read Waterproof cast to right wrist x 6 weeks. Weight bearing as tolerated monitor cast to right wrist for any numbness, swelling, pain or irritation and report any findings to the physician. She said nursing assessment should be completed immediately when the resident reported that her hand got hurt. She said nursing assessment included completing SBAR form that included vital signs section and the description of what is being observed. RN #3 was interviewed on 8/25/2020 around 3 p.m. She said sling and cast care should be recorded on the TAR and monitored and signed every shift by nurses. She said SBAR form should have been completed at the time when the resident reported her hand got hurt. She said she read the note by the night nurse and said it was not investigated thoroughly and not all questions were asked by the nurse to form a complete understanding of what happened to her arm. The DON was not available for an interview on 8/31/2020. SDC was interviewed on 8/31/2020 around 2 p.m. She said SBAR form should be completed immediately after change of condition becomes known. She said it was expected from the nurses to complete the form (not only progress notes) because the form included more steps and instructions for actions such as to notify physician and family. Physical therapy director was interviewed on 8/25/2020 around 2 p.m. He said the most recent evaluation for the resident was completed on 1/15/2020. At that time it was recommended to use a mechanical lift for residents for all transfers. He said in general, mechanical lift was recommended for individuals who are not able to bear weight, and Resident #2 was not able to bear weight on her legs due to paralysis on one side of the body. He said arm to arm transfer would only be appropriate for residents who are able to bear weight on their legs, rotate and make a few steps. He said resident #2 was not able to do any of the above and should have been transferred only by mechanical lift.