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	185301	A. BUILDING _____ B. WING _____	C 08/24/2021

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REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An Abbreviated survey was initiated on 07/14/2021 and concluded on 08/24/2021. During the survey Immediate Jeopardy (IJ) was identified on two (2) separate occasions, on 07/30/2021, and on 08/24/2021. The facility abated the 07/30/2021 incident; however, the second IJ incident identified on 08/24/2021 was determined to be IJ ongoing. The facility's census was 124.

Immediate Jeopardy was identified on 07/30/2021 and was determined to exist on 06/16/2021 in the areas of 42 CFR 483.15 Admission, Transfer, and Discharge, F624 Preparation for Safe/Orderly Transfer/Discharge at scope and severity of "J", and 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F660 Discharge Planning Process at scope and severity of "J". The facility was notified of the Immediate Jeopardy on 07/30/2021.

The facility provided an acceptable Allegation of Compliance (AoC) on 08/11/2021 alleging removal of jeopardy on 08/03/2021. The State Survey Agency (SSA) validated abatement of the IJ as alleged on 08/03/2021. However, during the extended survey and abatement of the Immediate Jeopardy, the SSA investigated two (2) additional complaint intakes.

Immediate Jeopardy was identified on 08/24/2021 and was determined to exist on 05/10/2021 in the areas of 42 CFR 483.25 Quality of Care, F689 Free of Accident Hazards/Supervision/Devices at scope and severity of "J" and 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F656 Develop/Implement Comprehensive Care

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/10/2021

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Plan at scope and severity of "J" and F657 Care Plan Timing and Revision at scope and severity of "J"; 42 CFR 483.40 Behavioral Health Services, F745, at scope and severity of "J"; 42 CFR 483.70 Administration, F835 Administration at scope and severity of "J", and F837 Governing Body at scope and severity of "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care, F689 Free of Accident Hazards/Supervision/Devices at scope and severity of "J". The facility was notified of the Immediate Jeopardy on 08/24/2021, and is ongoing.

Additionally, Immediate Jeopardy and Substandard Quality of Care were identified at 42 CFR 483.40 Provision of Medically Related Social Services, at a scope and severity of "J". Immediate Jeopardy was determined to exist on 06/16/2021 and is ongoing.

F835 Administration and F837 Governing Body were previously cited on 05/22/2021, both at scope and severity of "K". A revisit was not conducted during this survey. F835 and F837 will be cited at the higher scope and severity of "K", as these tags had not been corrected.

Additional deficient practice was identified at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 Free from Abuse and Neglect at scope and severity of "D". However, F600 was previously cited on 05/22/2021 at scope and severity of "K". F600 will be cited at the higher scope and severity of "K", as this tag had not been corrected.

The State Survey Agency exited on 08/24/2021 with IJ ongoing.

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F 000	Continued From page 2 Additionally, the facility remains out of compliance from the 05/22/2021 survey as an on-site re-visit for this survey had not occurred. This enforcement cycle started with 05/22/2021 survey. The 08/24/2021 abbreviated survey investigated complaints KY00034146, KY00034148, KY00034149, KY00034150, KY00034151, KY00034156, KY00034197, KY00034198, KY00034329, and KY00034330. Complaints KY00034146, KY00034149, KY00034150, KY00034156 and KY00034198 were unsubstantiated with no deficient practice identified. Complaints KY00034148, KY00034151, KY00034197, KY00034329 and KY00034330 were substantiated with deficient practice identified.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		

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F 600	Continued From page 3 physical abuse, corporal punishment, or involuntary seclusion;	F 600		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policies it was determined the facility failed to prevent abuse or neglect for four (4) of eighteen (18) sampled residents (Residents #1, #7, #17, and #18).

Resident #1 and Resident #7 were roommates on the Memory Care Unit. On 06/19/2021, there was a verbal altercation between the residents. Resident #1 called Resident #7 a "bitch" and in return Resident #7 splashed Resident #1 with water. Resident #1 reported it to the nurse on duty.

Resident #17 and Resident #18's rooms were adjacent on the nursing unit. On 06/24/2021, at approximately 5:00 PM, Licensed Practical Nurse (LPN) #1 heard raised voices in the hall and heard Resident #17 called Resident #18 a "punk."

The findings include:

Review of the facility's policy, "Abuse Prohibition," revised 04/09/2021, revealed the facility prohibited abuse, neglect, misappropriation of resident property, and exploitation of all residents.

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Continued review revealed the policy ensured facility staff did all that was within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source and misappropriation of property for all residents.

1. Record review revealed Resident #1 entered his/her shared room and moved Resident #7's wheelchair out of the way and called him/her a "bitch". In response, Resident #7 picked up a small plastic cup of water and splashed it on Resident #1.

Record review revealed the facility admitted Resident #1 on 06/15/2016 with diagnoses that included Alzheimer's Disease, Unspecified Psychosis, Reduced Mobility, Dementia without Behaviors, Mood Disorder with Depressive Features, and Major Depressive Disorder (MDD).

Review of the Minimum Data Set (MDS), dated 05/01/2021, revealed the facility assessed Resident #1 to have no vision, hearing or speech concerns. Continued review revealed the facility assessed Resident #1 with a Brief Interview for Mental Status (BIMS) score of fourteen out of fifteen (14/15) and determined the resident was cognitively intact with no behavior concerns.

Review of the Comprehensive Care Plan (CCP), dated 12/11/2017, revealed Resident #1 could exhibit or had the potential to demonstrate verbal behaviors related to cognitive loss and dementia. Interventions included: monitoring medical conditions and medications; evaluate the need for psychiatrist services; provide consistent, trusted caregivers and structured routines; provide a calm and quiet environment; allow time for

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expression of feelings; and, divert resident by offering alternative activities such as cards.

Interview with Resident #1, on 07/14/2021 at 9:45 AM, revealed he/she could not recall the incident with Resident #7, nor did he/she recall the roommate's name.

Record review revealed the facility admitted Resident #7 on 03/17/2021 with diagnoses that included End Stage Renal Disease (ESRD), Dependent on Dialysis, Age-Related Physical disability, and Vascular Dementia without Behaviors. Continued record review revealed the facility discharged Resident #7 on 07/23/2021.

Review of the MDS, dated 06/22/2021, revealed the facility assessed Resident #7 to have no vision, hearing or speech concerns. Continued review revealed the facility assessed Resident #7 with a BIMS score of fourteen out of fifteen (14/15) and determined the resident was cognitively intact, with no behaviors.

Review of the CCP, dated 03/18/2021, revealed no care plan for behaviors for Resident #7 prior to his/her altercation with Resident #1.

Unsuccessful attempts were made on 07/19/2021 at 10:46 AM and 10:48 AM and on 07/20/2021 at 10:18 AM and 10:19 AM to contact a CNA (Certified Nurse Aide) #19 and Nurse Assistant (NA) #1 that worked on the Memory Care Unit on the day of the altercation.

Unsuccessful attempts were made on 07/19/2021 at 10:44 AM and on 07/20/2021 at 10:18 AM to contact the Transition Care Unit Unit Manager (TCU UM). The TCU UM was scheduled to work

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on the day of the altercation.

Interview with CNA #14, on 07/19/2021 at 10:50 AM, revealed she worked on the unit and was providing care in a resident's room, when the altercation between Resident #1 and Resident #7 occurred. Further interview revealed it was everyone's responsibility to supervise the residents to ensure they were safe because some residents were quick to get up and needed constant eyes on them.

Interview with Registered Nurse (RN) #2, on 07/15/2021 at 12:51 PM, revealed she was on duty when the altercation occurred between Resident #1 and Resident #7. She stated the altercation was unwitnessed and Resident #1 reported the incident to her. RN #2 stated Resident #1 approached her in the hall and reported Resident #7 threw water on him/her. Continued interview revealed RN #2 noticed a small damp spot on Resident #1's shirt. RN #2 stated she interviewed Resident #7 about the altercation and he/she reported Resident #1 called him/her a swear word because his/her wheelchair was in the way so Resident #7 picked up a small plastic cup of water and splashed it on Resident #1. RN #2 stated Resident #1 stayed out of the room and she notified her supervisors regarding the altercation. She immediately changed Resident #7's room and notified the families and physicians of both residents. RN #2 stated she received education regarding the different types of abuse along with who and when to report abuse allegations. Additionally, RN #2 stated it was everyone's responsibility to supervise the residents on the Memory Care Unit to ensure the residents were safe.

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F 600	Continued From page 7	F 600		

Interview with the Memory Care Program Director, on 07/21/2021 at 2:22 PM, revealed she was new to the position, just two (2) weeks. She stated her role included ensuring the residents were being properly supervised and their needs were met. Continued interview revealed it was the responsibility of all staff on the Memory Care Unit to supervise residents.

Interview with the Center Nurse Executive (CNE), on 07/22/2021 at 3:46 PM, revealed she expected staff to continue to supervise residents on the Memory Care Unit. She stated if behaviors were observed, interventions were to be implemented immediately and notifications made and all actions were to be documented. Continued interview with the CNE, 07/29/2021 at 3:36 PM, revealed Resident #1 nor Resident #7 were aggressive residents. She stated this altercation was not a physical one, just a disagreement.

Interview with the Center Executive Director, on 07/30/2021 at 3:04 PM, revealed he expected his staff to supervise residents. He stated everyone was expected to check on residents to ensure they were safe.

2. Review of the clinical record revealed the facility admitted Resident #17, on 02/08/2019, with diagnoses that included Chronic Kidney Disease, Right Below the Knee Amputation, and Hemiplegia Affecting the Right Side.

Review of Resident #17's Quarterly MDS, dated 05/21/2021, revealed the facility assessed a Brief Interview for Mental Status score of fifteen (15) and determined the resident was cognitively intact and no behaviors were assessed.

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F 600	Continued From page 8	F 600		

Review of Resident #17's Risk Management System (RMS) Event Summary Report, dated 06/23/2021, revealed the facility substantiated the abuse allegation and both residents identified the other as the aggressor. Further review revealed facility staff deescalated the situation, immediately separated the residents, a room move was completed, and Social Services was involved.

Review of Resident #17's Care Plan, initiated on 01/02/2021 and last revised on 04/17/2020, revealed a focus that included the resident had a history of verbal outbursts directed at others such as abusive, inappropriate language and challenging/confrontational verbal behaviors. The care plan revealed the goal was that Resident #17 would not exhibit verbal behaviors toward others.

Observation of Resident #17, on 07/23/2021 at 3:08 PM, revealed the resident was groomed, dressed and sitting in wheelchair in his/her room.

Interview with Resident #17, on 07/23/2021 at 3:08 PM, revealed he/she stated Resident #17 stood in the doorway to his/her room and called him/her a racial slur. Resident #17 stated he/she called Resident #18 the same racial slur. He/she stated the Center Executive Director was notified and Resident #18 was moved to another hall.

Review of the clinical record revealed the facility admitted Resident #18, on 04/23/2020, with diagnoses that included Bipolar Disorder, Vascular Dementia with Behavioral Disturbance, Cerebral Vascular Accident, Major Depressive Disorder, and Development Disorder of

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F 600	Continued From page 9	F 600		

Scholastic Skills.

Review of Resident #18's Physician's Orders revealed an order for behavior monitoring, dated 06/22/2021, twice daily for behaviors, which included yelling, cursing, wandering, and impulsiveness with documentation of behaviors, interventions, and response in the Progress Notes.

Review of Resident #18's Medication Administration Record (MAR), dated April through June 2021, revealed licensed nurses documented behaviors that included yelling, cursing, wandering, and impulsiveness. Further review revealed these behaviors were observed eight (8) out of thirty (30) days in April; fourteen (14) days out of thirty-one (31) days in May; and twenty-seven (27) days out of thirty (30) days in June.

Review of Resident #18's Progress Notes, revealed on 05/31/2021, Resident #18 was observed in the hallway in front of a room next door arguing with Resident #17 and upset.

Review of Resident #18's Care Plan, initiated 09/25/2020 and last revised on 05/15/2021, revealed a focus that included resident exhibited verbal behaviors of yelling, cursing, and impulsiveness. Further review revealed the goal was that Resident #18 would not exhibit verbal outburst directed at others. Continued review revealed interventions that included: staff to complete behavior documentation if behaviors were present; observe the nature of the outbursts with identification of possible triggers; staff to remove the resident from the area to allow time to calm down; and, speak in a calm, reassuring

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F 600	Continued From page 10	F 600		

voice.

Review of Resident #18's Quarterly Minimum Data Set (MDS), dated 06/28/2021, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) and determined the resident was cognitively intact.

Review of Resident #18's Risk Management System (RMS) Event Summary Report, dated 06/23/2021, revealed Resident #18 stated another resident called him/her a "punk." The RMS revealed the facility substantiated abuse and identified the root cause that both residents claimed the other called him/her names first. Further review revealed the facility made a room move for Resident #18 and the facility provided both residents with Social and Psychiatric Services.

Observation of Resident #18, on 07/29/2021 at 9:56 AM, revealed Resident #18 was dressed, groomed, had poor eye contact, and was standing in the hall by the front facility entrance.

Interview of Resident #18, on 07/29/2021 at 9:56 AM, revealed Resident #18 did not remember calling Resident #18 a name or being called a name by Resident #17.

Interview with Licensed Practical Nurse (LPN) #1, on 07/29/2021 at 8:30 AM, revealed she heard arguing in the hall and heard Resident #17 call Resident #18 a name. She stated she could not remember and said he/she was going to "do stuff" to Resident #18. She stated she separated the two (2) residents and removed Resident #18 from the area. Further interview with LPN #1 revealed

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F 600	Continued From page 11 Resident #18 yelled out a lot without a reason and he/she did not call other residents names. She stated Resident #17 had a history of aggressive verbal behaviors by cursing, and using racial slurs towards other residents. LPN #1 stated in addition to abuse education, the facility staff observed for symptoms or warning signs from residents to intervene or prevent resident to resident abuse. Interview with the Center Nurse Executive (CNE), on 07/29/2021 at 3:23 PM, revealed she substantiated the verbal abuse allegation. She stated her interview with Resident #17 revealed Resident #18 had told Resident #17 that he/she did not call him a racial slur. The CNE stated Resident #18 denied calling Resident #17 a name. Further interview revealed the CNE stated she frequently observed the resident yell out for no reason which was a symptom of his/her history of a stroke. She stated Resident #17 had previously called another resident a racial slur and it appeared the recipients were usually residents with a low BIMS score. CNE further stated staff were aware of body language, provided supervision, and intervened appropriately related to observations/situations which could become volatile if not addressed. Interview with the Center Executive Director (CED), on 07/30/2021 at 3:03 PM, revealed he was unaware of the investigation results, because he did not conduct the investigation. The CED stated the facility protected the residents from abuse with staff education about abuse and prevention, respected residents' rights, and ensured care was provided to the residents.	F 600		
F 624 SS=J	Preparation for Safe/Orderly Transfer/Dschrg	F 624		

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F 624	Continued From page 12 CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy it was determined the facility failed to provide and document sufficient preparation and orientation for one (1) of eighteen (18) sampled residents (Resident #3) to ensure a safe and orderly discharge from the facility. Review of the the Business Office (BO) notes, dated 03/30/2021, revealed the Program Director for Memory Care (former Medicaid specialist/Social Services) annotated "son is no longer wanting to be Conservator and [the facility's Social Workers (SW)] were going through the process of filing for state guardianship." Continued review revealed another note was made on 04/01/2021 by the same author that stated "the facility has filed for guardianship on this resident, Current Conservator wants nothing to do with his/her plan of care medically or financially." Further review revealed another note was completed on 05/01/2021 that stated "Guardianship has an application for this resident by the BO Manager." Additionally, on 07/02/2021 it was noted that "guardianship has been filed."	F 624		

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On 07/27/2021 at 9:20 AM, interview with Resident #3, revealed at the time of discharge from the facility he/she had been caught smoking on 06/16/2021, and the facility did speak to him/her, however, Resident #3 could not recall what was said. Continued interview revealed the facility did not give him/her any clothes or his/her medications before leaving the facility. Further interview revealed he/she did know how to administer his/her own insulin but needed someone to tell him/her how many units he needed as he/she did not have a glucose monitoring device. Additionally, Resident #3 revealed when discharged on 06/16/2021 he/she had no money and the facility failed to notify him regarding his/her money after he/she was gone.

Interview with staff revealed the facility discharged Resident #3 to an area homeless shelter via a cab transport. Interview and record review revealed no documented evidence of discharge education, education related to the resident's medications nor was equipment ordered/provided per therapy to the resident. Interview with the Homeless Shelter Director revealed the homeless shelter was not open twenty-four seven, the homeless person had to leave by 7:30 AM and could not return until 4:00 PM. In addition, they did not provide assistance, with incontinence care, transfers and or medication administration. Review of hospital records, dated 06/20/2021, revealed Resident #3 presented to the ED, four (4) days after discharge from the Long Term Care (LTC) Facility, on 06/20/2021; was admitted and received care for ten (10) days.

Immediate Jeopardy was identified on 07/30/2021 and was determined to exist on 06/16/2021 in the

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areas of 42 CFR 483.15 Admission, Transfer, and Discharge, F624 Preparation for Safe/Orderly Transfer/Discharge at scope and severity of "J", and 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F660 Discharge Planning Process at scope and severity of "J". The facility was notified of the Immediate Jeopardy on 07/30/2021.

The facility provided an acceptable Allegation of Compliance (AoC) on 08/11/2021 alleging removal of jeopardy on 08/03/2021. The State Survey Agency validated abatement of the IJ as alleged on 08/03/2021.

The findings include:

Review of facility policy, "Discharge and Transfer," revised 02/01/2019, revealed transfer and discharge included movement of a patient to a bed outside of the certified Center whether that bed is in the same physical plant or not. Continued review revealed the policy provided guidance that met state and federal regulations, to meet the resident's needs, and to facilitate a safe transition to an alternate setting. Review of the policy's "process" revealed the inter-professional care team provided sufficient preparation and orientation to the patient prior to transfer. Further review revealed if a resident was discharging to home, an assisted living center, or other community based/home alternative setting the Discharge Transition Plan was given to the resident. Additionally, a copy of the Discharge Transition Plan was placed in the resident's chart and the estimated planned discharge date was placed in the resident profile in the electronic health record (EHR) to coordinate a smooth transition.

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Review of the facility policy, "Discharge Planning Process," revised 02/01/2019, revealed all residents being discharged to home, assisted living facility or another community based setting were given a Discharge Transition Plan and Discharge Packet. The Discharge Transition Plan included a recapitulation (summary) of the resident's stay, and a final summary of the resident's status at time of discharge. Additionally the Packet included a reconciliation of all pre-discharge medications with the resident's post-discharge medications, a post-discharge plan of care, which assisted the resident to adjust to his/her new living environment and where the resident planned to reside along with any follow up care.

The facility admitted Resident #3 on 02/10/2021 with diagnoses to include Dementia without Behaviors, Type Two (2) Diabetes Mellitus (DM), Hypertension (HTN), Hyperlipidemia, Gastro-Esophageal Reflux Disease (GERD), Chronic Pain, and Tobacco Use.

Review of the Psychology notes, dated 06/07/2021 revealed Resident #3 was assessed to have Neurocognitive Disorder, Disruptive-Impulse Control and Conduct Disorder, and Personality Disorder.

Review of Resident #3's medical record revealed document titled, "Order of Appointment of Conservator," revealed Resident #3's son was appointed Conservator with a "limited Conservatorship with specific legal rights to dispose of property, execute instruments, and entering into contractual relationships" on 11/18/2020.

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Review of the the Business Office (BO) notes regarding Resident #3, dated 03/30/2021 revealed the Program Director for Memory Care (former Medicaid specialist/Social Services) annotated "son is no longer wanting to be Conservator and [the facility's Social Workers (SW)] were going through the process of filing for state guardianship." Continued review revealed another note was made on 04/01/2021 by the same author that stated "the facility has filed for guardianship on this resident, Current Conservator wants nothing to do with his/her plan of care medically or financially." Further review revealed another note was completed on 05/01/2021 that stated "Guardianship has an application for this resident by the BO Manager. Son wants no part of being conservator," all prior to discharging the resident on 06/16/2021. Additionally, on 07/02/2021 it was noted that "guardianship has been filed." However, attempts were made to contact SW on 07/16/2021 at 9:44 AM and 9:47 AM and on 07/20/2021 at 10:21 AM and 10:23 AM without success.

Review of the facility records revealed Resident #3 had a Conservator (provides supervision for a protected person), dated 11/18/2020.

Review of the most recent Comprehensive Minimum Data Set (MDS), dated 05/19/2021, revealed the facility assessed Resident #3 to have moderate cognitive impairment with a Brief Interview of Mental Status (BIMS) score of twelve of fifteen (12/15) and no concerns with hearing, speech or vision. Continued review revealed the facility assessed Resident #3 to be moderately depressed and did not exhibit behaviors. Further review revealed Resident #3 required limited

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assistance with one (1) person for transfers, extensive assist of one (1) person for dressing, toileting and completing personal hygiene. Review of the MDS revealed the facility assessed Resident #3 to be occasionally incontinent of bladder and frequently incontinent of bowel. Further review revealed Resident #3 received insulin injections, antidepressants, diuretics, and opioids. Additionally, Resident #3's plan included rehabilitation and planned to return to the community upon discharge.

Review of the Comprehensive Care Plan (CCP), dated 02/10/2021, revealed Resident #3 was at risk for decreased ability to perform Activities of Daily Living (ADLs) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfers, locomotion, and toileting with an intervention to provide him/her with a standard wheelchair with a cushion. Continued review revealed Resident #3 was at risk for cardiovascular complications related to his/her diagnosis of HTN, Hyperlipidemia, Coronary Artery Disease. Resident #3 was at risk for dehydration related to being prescribed diuretics. Further review revealed Resident #3 was insulin dependent related to his/her diagnosis of DM. Continued review revealed Resident #3 was at risk for falls related to cognitive loss, lack of safety awareness, and impaired mobility. Additionally, Resident #3 was care planned to be occasionally incontinent of urine and is unable to cognitively or physically participate in a retraining program due to cognitive loss and limited mobility. Continued review revealed no documented discharge care plan for Resident #3 per facility policy.

Review of the Nurse Practitioner (NP) notes,

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dated 04/07/2021, 05/03/2021, 05/19/2021, 05/26/2021, 06/09/2021 and 06/16/2021 revealed she documented that Resident #3 was wheelchair dependent.

Attempts were made on 07/29/2021 and 07/30/2021 at 2:25 PM and 1:15 PM, to contact the NP without success.

Review of the Occupational Therapy (OT) Discharge Summary, dated 03/05/2021, revealed Resident #3 required supervision with transfers, physical assist during ADLs using a wheeled walker and minimal assistance while seated in a wheelchair for ADLs. Continued review revealed discharge recommendations made by the Certified Occupational Therapy Assistant (COTA) included caregiver support and community reintegration services with Durable Medical Equipment (DME) of wheeled walker, wheelchair, and hospital bed and grab bars.

Interview with the Certified Occupational Therapy Assistant, on 07/28/2021 at 10:01 AM, revealed he completed therapy sessions with Resident #3 while he/she was admitted to the facility. He continued Resident #3 had issues with safety awareness due to noncompliance with safe transfer techniques. He continued caregiver support would be noted as Resident #3 needing assistance with medication management and home management (cooking, shopping, laundry, etc.)

Review of the Physical Therapy (PT) Discharge Summary, dated 03/05/2021, revealed Resident #3 had an activity tolerance of three (3) to five (5) minutes with a goal of ten (10) minutes in order to increase participation in functional tasks and

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required contact guard for sit to stand transfers and with walking with a rolling walker. Continued review revealed discharge recommendations made by the Physical Therapist (PT) included caregiver support.

Interview with the PT Assistant, on 07/28/2021 at 9:11 AM, revealed he completed PT sessions with Resident #3 while admitted. He continued Resident #3 could function appropriately with a wheelchair or at a short distance with a walker. Further interview revealed caregiver support included assistance with medications, using the restroom, and having someone near to be able to check on him/her regularly.

Review of the Physician's orders, dated 02/10/2021, revealed while admitted to the facility he/she was prescribed Insulin Glargine and Insulin Lispro (diabetes medication), Clonidine Patch (for hypertension, to be applied weekly), Depakote (for behaviors), Aricept (dementia medication), Effexor (antidepressant), Hydrochlorothiazide (antihypertensive), Imdur (antihypertensive), Linagliptin (diabetes medication), Namenda (for Dementia), Ranolazine for chest pain, and Spironolactone (a diuretic). Further review of Physician's orders revealed the Quality Assurance (QA) Nurse notified the physician on 06/16/2021 to obtain discharge orders so Resident #3 could leave the facility with his/her medications except scheduled narcotics.

Interview with LPN #2 on 07/15/2021 at 12:30 PM, RN #1 on 07/16/2021 at 11:14 AM, Quality Assurance (QA) Nurse on 07/16/2021 at 1:45 PM, Consulting Social Worker on 07/29/2021 at 10:13 AM and the Center Executive Director

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(CED) on 07/16/2021 at 11:40 AM, it was revealed Resident #3 was found to be smoking during a non-smoke period on 06/16/2021. When the facility informed him/her the facility was revoking their smoking privileges, Resident #3 became upset and wanted to leave the facility that day.

Review of the Discharge note, dated 06/16/2021, completed by the Licensed Practical Nurse (LPN) #2 revealed no documented evidence of discharge education, education related to Resident #3's medications nor any durable medical equipment (DME) that was recommended per the OT discharge summary.

Interview with Family #1, on 07/15/2021 at 9:25 AM, revealed the facility notified them of Resident #3's discharge via email on 06/16/2021. She further stated Resident #3 was incontinent of bladder and bowel at times, and would "wax and wane with Dementia" and had some previous brain damage from a motor vehicle accident thirteen (13) years ago.

Review of hospital records, dated 06/20/2021, revealed Resident #3 presented to the ED, four (4) days after discharge from the Longterm Care (LTC) Facility, on 06/20/2021. The ED determined Resident #3 was hyperglycemic with a reading of 277 (normal reading is seventy to one hundred-ten 70-110), was hypertensive, had a urinary tract infection (UTI), diarrhea, complaints of chest pain, shortness of breath, and lower extremity pain. Continued review revealed Resident #3 was diagnosed with a blood clot in the right lower leg. Additionally, Resident #3 was treated with insulin, blood pressure medications, intravenous (IV) antibiotics, and medication to

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treat blood pressure.

Interview with Resident #3, on 07/27/2021 at 9:20 AM, revealed at the time of discharge from the Long Term Care (LTC) facility he/she had been caught smoking on 06/16/2021 and the facility did speak to him/her, however, Resident #3 could not recall what was said. Continued interview revealed the facility did not give him/her any clothes or his/her medications before leaving the facility. Further interview revealed he/she did know how to administer his/her own insulin but needed someone to tell him/her how many units he/she needed as he/she did not have a glucose monitoring device. Additionally, Resident #3 revealed upon discharge from the facility he/she did not have money nor was given any and the facility failed to notify him/her regarding what was going to happen to the resident's money after leaving the facility.

Interview with Licensed Practical Nurse (LPN) #2, on 07/27/2021 at 3:34 PM, revealed she gave Resident #3 all medications except scheduled narcotics per the physician order and his/her insulin in the form of a "pen" along with a medication list. Continued interview revealed she showed Resident #3 how to use the insulin pen and he/she verbalized that he/she understood but she could not confirm this due to Resident #3 seeming to be "in a rush and was ready to leave." LPN #2 continued and stated she gave Resident #3 a couple of screw-on needle caps needed to properly administer insulin with a pen. Further interview with LPN #2 revealed Resident #3 probably didn't know how to administer his/her own medications and insulin. Additionally, LPN #2 revealed Resident #3's discharge felt rushed, therefore it was probably not safe.

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Interview with the homeless shelter's Director of Programs, on 07/27/2021 at 1:40 PM, revealed the shelter, where Resident #3 was discharged to, did not assist in any way with medications including storage or dispensing. Continued interview revealed clients at the shelter have to leave the shelter daily between 7:00-7:30 AM and check-in for the evening begins at 4:00 PM. Additionally, she stated if medications were left behind, staff collected them, placed them in a locked box and then medications were taken to a local pharmacy where they were destroyed. Further interview revealed the shelter did not have the support staff to assist clients with transfers (i.e. to and from the wheelchair), showers, and incontinence care.

Interview with the Consulting Social Worker, on 07/29/2021 at 10:13 AM, revealed she was approached by Resident #3 on 06/16/2021, in her office, desiring discharge from the facility. Continued interview revealed she helped facilitate Resident #3's discharge by contacting the homeless shelter. Further interview revealed she was not aware that Resident #3 was insulin dependent and did not inquire about medication management at the homeless shelter. Additionally, she revealed Resident #3's discharge to the homeless shelter was not unsafe due to him/her having a safe place to go. She stated her responsibility to offer options and help guide the residents but ultimately it was Resident #3's decision and he/she had the right to make bad decisions.

Interview with the Center Nurse Executive (CNE), on 07/22/2021 at 3:46 PM, revealed she was not aware if Resident #3 could self-administer insulin

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and he/she did not return demonstrate self-administration before being discharged to the homeless shelter. Continued interview revealed Resident #3 was very impulsive, screaming/yelling and cussing to staff, wanting to leave on 06/16/2021 and many staff tried to de-escalate him/her without success. Further interview revealed the CNE was not sure if someone at the homeless shelter assisted with medication management or if their staff assisted with resident needs. Additionally, the CNE revealed the facility attempted to make Resident #3's discharge as safe as possible, by calling the physician and receiving discharge orders so Resident #3 could take his/her medications with him, given Resident #3's verbal agitation at that time.

Interview with the Center Executive Director (CED), on 07/30/2021 at 3:04 PM, revealed on 06/16/2021 Resident #3 was discharged. The CED stated due to Resident #3 having a high BIMS score with no documents showing guardianship he was not going to impede on Resident #3's rights for wanting to leave the facility. Further interview revealed the facility received a physician's order for discharge so Resident #3 could have his/her medications to help make it the safest discharge for him/her at that time.

The facility alleged it implemented the following actions to remove immediacy:

1. Resident #3 was discharged from the facility on 06/16/2021.

2. The Center Nurse Executive (CNE), Rapid Response Manager, Director of Regulatory

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Compliance, or Social Services team member reviewed, on 07/31/2021, all residents with a planned discharge since 06/16/2021 to identify discharge trends.

3. The Center Executive Director (CED) and CNE completed education and a posttest after the Regional Vice President (RVP) and Clinical Quality Specialist (CQS) provided education for a safe transfer/discharge with appropriate documentation on the resident's clinical status, clinical care, and medication management instructions, on 07/31/2021.

4. On or before 08/02/2021 the Social Services team, Assistant Director of Nursing Services (ADNS), Nurse Practice Educator (NPE), Unit Managers (UM), CED, Human Resource Director (HRD) and Nurse Supervisors completed education and a posttest on the safe/orderly transfer/discharge of the resident.

5. All licensed facility and agency staff completed on or before 08/02/2021 education on a safe transfer/discharge, and education requirements to the resident. All staff were required to complete a post test.

6. The facility audited resident records daily then three (3) times a week for resident's who were planned for discharge for documented education to the resident regarding clinical care and medication education by staff. Identified areas would be corrected immediately by the team member.

7. The facility QAPI committee reviewed the CNE, ADNS and Social Services team weekly audits for appropriate transfer, discharge, and education.

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Upon review additional follow-up or re-education would occur until resolved.

The State Survey Agency (SSA) validated the removal plan by:

1. Record review revealed the facility discharged Resident #3 on 06/16/2021.

Interview, on 07/27/2021 at 3:34 PM, with Licensed Practical Nurse (LPN) #2 revealed she discharged Resident #3 on 06/16/2021.

2. Interview with the CNE, on 08/21/2021 at 3:19 PM, revealed she was involved with review of all planned discharges as alleged.

Interview with Rapid Response Manager, on 08/21/2021 at 2:56 PM, revealed she was involved with review of planned discharges as alleged.

Interview with the Director of Regulatory Compliance, on 08/21/2021 at 2:45 PM, revealed she was involved with a review of planned discharges as alleged.

Review of an audit tool, dated 07/31/2021, revealed a list of resident discharges marked as reviewed.

3. Interview with the Clinical Quality Specialist, on 08/21/2021 at 3:50 PM, revealed she provided education and posttest to the Center Executive Direction and the CNE as alleged.

Interview with the RVP, on 08/21/2021 at 4:15 PM, revealed he participated in education and posttest of the CED and the CNE as alleged.

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Interview with the CED, on 08/21/2021 at 3:54 PM, revealed he received education and completed a posttest as alleged.

Interview with the CNE, on 08/21/2021 at 3:19 PM, revealed she received education and completed a posttest as alleged.

Review of facility records revealed posttests labeled with names of the CED and CNE.

4. Interview with Social Service Specialist, on 08/20/2021 at 3:24 PM, revealed she received education and completed a posttest as alleged.

Interview with the Nurse Practice Educator, on 08/20/2021 at 4:38 PM, revealed he received education and completed a posttest as alleged.

Interview with TCU Unit Manager, on 08/20/2021 at 2:11 PM, revealed she received education and completed a posttest as alleged.

Interview with the Nurse Weekend Supervisor, on 08/20/2021 at 1:50 PM, revealed he participated in education and completed a posttest as alleged.

Record review revealed posttests labeled with the staff's names as indicated above.

5. Interview with LPN #6, on 08/18/2021 at 9:25 PM, revealed she received education and completed a posttest as alleged.

Interview with the Business Office Manager, on 08/20/2021 at 4:04 PM, revealed she received education and completed a posttest as alleged.

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F 624	Continued From page 27 Interview with Agency Registered Nurse #5, on 08/20/2021 at 5:58 AM, revealed she received education and completed a posttest as alleged. Interview with LPN #1, on 08/18/2021 at 7:48 AM, revealed she received education and completed a post test as alleged. Review of facility records revealed posttests documented for licensed nurses as alleged. 6. Interview with the CED, on 08/21/2021 at 3:54 PM, revealed he completed audits of resident records for discharge documentation as alleged. Review of facility records revealed audit sheets dated 07/31/2021 through 08/19/2021, indicating review of discharge documentation as alleged. 7. Review of facility records revealed QAPI sign-in sheets as indicated listing discharge audits in the topic. Interview with the CED, on 08/21/2021 at 3:54 PM, revealed discharge audits discussed in QAPI meetings as alleged. Interview with the RVPO, on 08/21/2021 at 4:15 PM, revealed discharge audits discussed in QAPI meetings as alleged.	F 624		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		

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§483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and facility policy review, it was determined the facility failed to develop/implement comprehensive resident specific care plans for one (1) of twenty-eight (28) sampled residents (Residents #19).

On 05/10/2021, Resident #19 was in his/her room, unassisted, when the resident stood up to get into bed. The resident stepped on his/her bedside mattress, fell and hit the wall, causing a laceration to his/her scalp. The resident was care planned to have the mattress up, while out of bed. In addition, was care planned to have staff take the resident to the common area for additional supervision.

Observation on 08/13/2021 at 1:30 PM, revealed a mattress on the floor, by Resident #19's low positioned bed. Observation of Resident #19, on 08/13/2021 at 1:45 PM, revealed the resident was seated in the common area, without his/her helmet, which was care planned to be used for fall safety. However, observation revealed the

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resident was wearing a straw hat. Interview with the resident revealed he/she did not like the helmet because it "squished" his/her head.

Observation of Resident #19 on the Homestead unit, on 08/14/2021 at 10:30 AM, revealed the resident was out of bed and seated in his/her wheelchair with no staff in view of the resident. Continued observation revealed the resident moved forward in the wheelchair and attempted to stand. State surveyor called for staff to come to assist the resident.

Immediate Jeopardy was identified on 08/24/2021 and was determined to exist on 05/10/2021 in the areas of 42 CFR 483.25 Quality of Care, F689 Free of Accident Hazards/Supervision/Devices at scope and severity of "J" and 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F656 Develop/Implement Comprehensive Care Plan at scope and severity of "J" and F657 Care Plan Timing and Revision at scope and severity of "J"; 42 CFR 483.70 Administration, F835 Administration at scope and severity of "J", and F837 Governing Body at scope and severity of "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care, F689 Free of Accident Hazards/Supervision/Devices at scope and severity of "J". The facility was notified of the Immediate Jeopardy on 08/24/2021.

F835 Administration and F837 Governing Body were previously cited on 05/22/2021, both at scope and severity of "K". As this represents continued non-compliance F835 and F837 will be cited at the higher scope and severity of "K".

Additional deficient practice was identified at 42 CFR 483.12 Freedom from Abuse, Neglect, and

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Exploitation, F600 Free from Abuse and Neglect at scope and severity of "D". However, F600 was previously cited on 05/22/2021 at scope and severity of "K" and as this represents continued non-compliance, F600 will be cited at the higher scope and severity of "K", resulting in Substandard Quality of Care at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 at a scope and severity of "K".

The State Survey Agency exited on 08/24/2021 with IJ existing on 05/10/2021 and is ongoing.

The findings include:

Review of the facility's policy, Person-Centered Care Plan, revised 07/01/2019, revealed the facility developed a comprehensive, individualized care plan within seven (7) days after completion of the comprehensive assessment. The care plan included measurable objectives and time tables that met the residents medical, nursing, nutrition, and mental and psychosocial needs. The Interdisciplinary Team (IDT) prepared the care plan and included the physician, nurse, nurse aid, food and nutrition staff, and the resident or resident representative. The facility reviewed and revised the care plan after each assessment.

Review of Resident #19's Medical Record revealed the facility admitted the resident on 07/24/2020 with diagnoses to include Unspecified Dementia with Behavioral Disturbance, Psychotic Disorder with Delusions Due to known Physiological Condition, Muscle Weakness, and Unspecified Fall, Subsequent Encounter.

The facility assessed Resident #19 with a Brief

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Interview for Mental Status (BIMS) exam score of three (3) on 04/26/2021 and determined the resident was severely cognitively impaired. Further review revealed Section G, Functional Status, noted the resident was assessed to be limited assistance with one (1) person physical assist with locomotion on the unit.

Review of Resident #19's Falls Comprehensive Care Plan, last review date 08/04/2021, revealed the focus of the care plan was resident had a history of falls related to impaired cognition, lack of safety awareness, would exit bed without staff assistance and crawl on the floor, muscle weakness as evidenced by a history of falls. The goal was for the resident to not have falls with major injury thru the next review. Some of the interventions included, bed in lowest position, fall mat to right side of bed for safety, mattress to the right side of the bed for safety due to the resident crawling out of bed every shift when in bed. Additionally, the resident was care planned to have increased supervision in the common area to decrease fall risk. Continued review of the resident's care plan revealed the resident would have a soft helmet and staff would assist to place on the resident's head. Encourage the resident to wear soft helmet and assist to place on his/her head.

Observation of Resident #19's room, on 08/13/2021 at 1:30 PM, revealed a mattress on the floor, by the resident's low positioned bed.

Observation of Resident #19, on 08/13/2021 at 1:45 PM, revealed the resident was seated in the common area, without his/her helmet, used for fall safety. Resident was wearing a straw hat. Interview with the resident revealed he/she did

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not like the helmet because it "squished" his/her head.

Observation of Resident #19 on the Homestead unit, on 08/14/2021 at 10:30 AM, revealed the resident was out of bed and seated in his/her wheelchair with no staff in view of the resident. Continued observation revealed the resident moved forward in the wheelchair and attempted to stand. State surveyor called for staff to come to assist the resident.

Interview with Registered Nurse (RN) #3, on 08/21/2021 at 12:04 PM, revealed she could not recall the details of the Resident #19's fall on 05/10/2021. She stated a written statement from CNA #16 was not obtained. RN #3 stated she recalled assessing the resident with the Attending Physician, but could not recall the environmental factors which would have caused the resident to fall. Further interview revealed that she would obtain all the information possible from the witness, but could not recall the witness mentioning anything about the mattress, adding, "I just see what was documented." She further stated the mattress being a "safety" risk would be subjective.

Interview with CNA #16, on 08/20/2021 at 7:10 AM, revealed Resident #19 would try to stand from his/her wheelchair "all the time." She further stated it would be nice if the resident remained on 1:1 supervision for the safety of the resident, adding the resident "believed" he/she could walk. CNA #16 revealed she worked the day the resident fell on 05/10/2021. She stated someone had taken the resident to his/her room, she could not recall who, but remembered entering the dining room and believed she was working with

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another resident when she noticed Resident #19 sitting in his/her wheelchair. She stated she observed the resident stand from his/her chair, step on the edge of his/her mattress that was located in his/her room, to get into bed, and fell back, hitting his/her head on the wall. CNA #16 revealed the resident had his/her helmet on, but the force of the fall made the helmet come off. CNA #16 revealed the resident's care plans should be followed for the safety of the residents.

Interview with CNA #17, on 08/21/2021 at 11:24 AM, revealed Resident #19 was care planned for the mattress because he/she liked to roll out of bed. Continued interview revealed the resident's mattress would be placed on the floor, while the resident's bed was in the lowest position. She further stated when the resident was out of his/her bed, the mattress would be moved for safety reasons.

Interview with Certified Nursing Assistant (CNA) #14, on 08/15/2021 at 10:00 AM, revealed a resident's care plan should be followed related to fall prevention. Per interview, it was important for Resident #19 to wear his/her helmet at all times because the resident was a falls risk. She further stated the resident was "quick".

Interview with LPN #7, on 08/14/2021 at 10:56 AM, revealed she had been employed by the facility for over two (2) months. Per interview, LPN #7 revealed she had worked with Resident #19. She stated the resident would get up out of his/her wheelchair, unassisted, adding, "which you saw earlier." She stated the resident liked to get up and walk. Continued interview with LPN #7 revealed she would try to keep a closer eye on the resident; however, because the resident was

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"quick" the resident needed 1:1 supervision. LPN #7 revealed this would be beneficial because of Resident #19's falls.

Interview with RN #2, on 08/19/2021 at 5:42 PM revealed she was familiar with Resident #19. Per interview, the resident would stand from his/her chair "quickly." RN #2 stated the resident needed a 1:1, but did not have the staff for a 1:1.

Interview with the Assistant Director of Nursing (ADON), on 08/19/2021 at 3:16 PM, revealed staff should not have left Resident #19 up in his/her wheelchair without staff supervision. She further stated the resident should not have been left alone in the hallway due to the resident's history of falls. She revealed the staff should have brought the resident closer to the nurses' station, to provide the supervision needed. She further revealed the resident's care plans should be followed related to supervision while in the common area.

Interview with the Program Director of Homestead, on 08/20/2021 at 4:54 PM, revealed care plans were discussed in morning meetings. She stated the nurses would normally begin the care plans and the MDS Coordinator would review and/or revise as needed. Continued interview revealed the resident's care plans should be followed.

Interview with the Center Nurse Executive (CNE), on 08/23/2021 at 11:03 AM, revealed the care plans were updated any time there were changes that were needed. Per interview, the care plans were reviewed in clinical meetings and the appropriate changes would be made. She further stated it would be her expectation the care plans

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F 656	Continued From page 36 would be followed. Interview with the Vice President of Operations, on 08/24/2021 at 2:20 PM, revealed it would be his expectation that a resident's care plans would be followed.	F 656		
F 657 SS=G	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review it was determined the facility failed to update/revise the care plan for six (6) out of twenty-eight (28) sampled residents (Resident #20, Resident #7, Resident #23, Resident #24, Resident #26, Resident #27).

On 08/07/2021, Resident #20 was observed with another resident's walker. Per interview, staff asked the resident to return the walker to the resident. Interview with staff revealed the resident became visibly upset and walked to his/her room, then walked back "at a fast pace" tripping over his/her foot causing a closed fracture of the right orbital floor. Resident #20 was care planned to have an assist of one (1) when in his/her room and/or toileting. Additionally, the resident's care plan was not revised to address the resident's "fast pace" when upset nor, was the resident care planned for his/her level of assist with ambulation. (Refer to F689)

On 08/11/2021, while returning from the beauty shop, Resident #20 walked back to his/her unit with a staff member of one (1) in a group of four (4) residents who required additional staff

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supervision when ambulating off the unit. Resident #20 fell which resulted in a Cervical Spine C2 minimally displaced base odontoid fracture. (Refer to F689)

Resident #1 and Resident #7 were roommates on the facility's memory care unit. On 06/19/2021, Resident #1 entered the shared room and had to move Resident #7's wheelchair out of his/her way. Resident #1 called Resident #7 a "Bitch" as he/she moved the wheelchair. In response to Resident #1's actions, Resident #7 picked up a small plastic cup of water and splashed it at and on Resident #1. The facility failed to update/revise Resident #7's Comprehensive Care Plan after the resident to resident altercation.

Review of the care plans for Residents #23, #24, #26, and #27 revealed no updates or revisions related to the residents' level of assistance with ambulation/locomotion off the unit.

Immediate Jeopardy was identified on 08/24/2021 and was determined to exist on 05/10/2021 in the areas of 42 CFR 483.25 Quality of Care, F689 Free of Accident Hazards/Supervision/Devices at scope and severity of "J" and 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F656 Develop/Implement Comprehensive Care Plan at scope and severity of "J" and F657 Care Plan Timing and Revision at scope and severity of "J"; 42 CFR 483.70 Administration, F835 Administration at scope and severity of "J", and F837 Governing Body at scope and severity of "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care, F689 Free of Accident Hazards/Supervision/Devices at scope and severity of "J". The facility was notified of the Immediate Jeopardy on 08/24/2021.

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F835 Administration and F837 Governing Body were previously cited on 05/22/2021, both at scope and severity of "K". As this represents continued non-compliance F835 and F837 will be cited at the higher scope and severity of "K".

Additional deficient practice was identified at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 Free from Abuse and Neglect at scope and severity of "D". However, F600 was previously cited on 05/22/2021 at scope and severity of "K" and as this represents continued non-compliance, F600 will be cited at the higher scope and severity of "K", resulting in Substandard Quality of Care at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 at a scope and severity of "K".

The SSA exited on 08/24/2021 with IJ ongoing.

The findings include:

1. Record review revaled on 08/07/2021, Resident #20 was observed with another resident's walker. Per interview, staff asked the resident to return the walker to the resident and Resident #20 stated the walker belonged to his/her mom. Interview with staff revealed the resident became visibly upset and walked to his/her room, then walked back "at a fast pace" tripping over his/her foot causing a closed fracture of the right orbital floor. Resident #20 was care planned to have an assist of one (1) when in his/her room and/or toileting. Additionally, the resident's care plan was not revised to address the resident's "fast pace" when upset nor was the resident care planned for his/her level of assist with ambulation. (Refer to

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Review of Resident #20's clinical record revealed the resident was admitted on 12/17/2019 with diagnoses to included Unspecified Dementia without Behavioral Disturbance, Muscle Weakness, and Reduced Mobility.

Review of Resident #20's Quarterly Minimum Data Set (MDS) dated 06/15/2021, revealed he/she was assessed to have a Brief Interview for Mental Status (BIMS) score of three (3), which was indicative of severe cognitive impairment. Further review revealed the resident's functional status was assessed to be supervision (oversight, encouragement or cueing) with set-up (help only), with locomotion on the unit. The resident was assessed to have "activity did not occur" with locomotion off the unit with no physical help.

Review of Resident #20's Comprehensive Care Plan related to Activities of Daily Living (ADL's), with a target date of 09/15/2021, revealed the focus of the care plan was for the resident to have assistance with ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to weakness, chronic pain, and impaired cognition, subdural hematoma, right orbital floor fracture, and C2 fracture. The goal was for the resident to improve current level of function in bathing, grooming/personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting. The resident's interventions was for the resident to provide assist with one (1) for bed mobility, provide assist of one (1) for toileting. Further review revealed no care plan for how the resident would ambulate on or off his/her unit.

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Review of the Resident #20's Falls Comprehensive Care Plan, with revision date of 08/11/2021, revealed the care plan focus was to limit the risk for falls related to weakness, history of falls, and impaired cognition. The goal of the care plan was for the resident not to have falls with injury thru the next review. Interventions included: Nursing staff to complete orthostatic blood times three (3) days related to his/her fall. Nursing staff to encourage the resident to be in common area while awake as he/she would allow, nursing staff to evaluate the resident's footwear for proper fitting, therapy rehab evaluation, and to provide assist with ambulation, initiated on 08/11/2021.

Review of Resident #20's hospital record, dated 08/07/2021, revealed the resident tripped and fell forward striking his/her right forehead against the ground. Further review revealed the resident sustained a laceration to his/her right eyebrow during the fall. Record review revealed the resident's diagnosis at discharge was "an injury of head, fall, initial encounter, facial laceration, and closed fracture of right orbital floor".

Observation and interview with Resident #20, on 08/17/2021 at 6:42 PM, revealed the resident was sitting up in his/her wheelchair, on the Transitional Care Unit (TCU), watching television with 1:1 staff. Resident #20 was observed to have the cervical collar to his/her neck.

Interview with Certified Nursing Assistant (CNA) #14, on 08/15/2021 at 10:00 AM, revealed she worked the day Resident #20 fell, on 08/07/2021. She stated the resident was observed to have another resident's walker and when asked to return the walker, the resident became upset,

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stating the walker was his/her mother's. Per interview, the resident forcibly returned the walker to CNA #14. Continued interview revealed Resident #20 was asked to have a seat in the common area while she went to retrieve a towel to wipe up liquid that was observed on the kitchen floor. When CNA #14 returned, she saw the resident on the floor and Licensed Practical Nurse (LPN) #1 and another nurse (unidentified) were assessing the resident. CNA #14 revealed she did not observe the fall and believed the resident was not at risk for falls. She stated she was not fully aware of the Resident #20's care plan.

Interview with LPN #1, on 08/18/2021 at 7:48 AM, revealed she observed Resident #20 around 6:15 PM,"walking fast". Per interview, the resident always did this when he/she became anxious. LPN #1 revealed the resident got up and walked from the common area to his/her room. LPN #1 stated she though the resident might have needed to go to the bathroom, but was not certain, adding "that was what the resident normally did, went to the bathroom and returned to the common area." Continued interview revealed that when Resident #20 came out of his/her room, the resident was observed to walk "fast" coming back to the common area and tripped on his/her own foot and fell. LPN #1 stated the resident hit his/her head, adding "he/she landed on the wooden area" of the unit. Per interview LPN #1 revealed the resident's care plan should have been revised to address the resident's "pace/gait" when he/she became anxious and/or upset.

Interview with LPN #6, on 08/18/2021 at 9:25 PM, revealed she has worked at the facility since the

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beginning of July. She further stated she was employed through agency and had only worked the Homestead Unit only twice (2), and she was not familiar with the residents. LPN #6 revealed on the day of Resident #20's fall, on 08/07/2021, she had been giving report. LPN #6 revealed the resident walked independently to and from his/her room without assistance. Per interview, LPN #6 observed Resident #20 walking in front of her, at a fast pace, and it seemed as though Resident #20 was "upset". She observed the resident's foot "kind of dragged" and he/she stumbled over his/her foot. LPN #6 revealed Resident #20 went "down". LPN #6 stated she believed the resident "hit head first" and she saw the blood coming from the resident's right eye brow. The resident was transferred to the hospital. Further interview with LPN #6 revealed she had not worked with the residents long and was unfamiliar with the resident's care plans.

Interview with the Program Director of Homestead, on 08/20/2021 at 4:54 PM, revealed care plans were discussed in morning meetings. She stated the nurses would normally begin the care plans and the MDS Coordinator would review and/or revise as needed. Continued interview revealed the residents' care plans should have been revised to show the level of assistance the residents required for care. Further, she stated the Minimum Data Set (MDS) Coordinator had developed accurate coding and thus should have been care planned. She stated this was important for the safety of the residents.

Interview with the Assistant Director of Nursing (ADON), on 08/19/2021 at 3:16 PM, revealed she and the Center Nurse Executive (CNE) had been working on updating the care plans. Per

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interview, she stated that Resident #20's care plan should have been revised to state, "If resident was upset and walk at a faster pace", the revision would be to encourage the resident to walk at a slower pace and see what upset the resident. She stated staff could try to calm the resident down by possibility telling the resident the walker was his/her mom's walker and redirect her. Continued interview revealed she would have added their intervention in the behavior section to divert the resident when he/she believed someone else had his/her mom's walker.

Interview with the Center Nurse Executive (CNE), on 08/23/2021 at 11:03 AM, revealed the care plans were updated any time there were changes that were needed. Per interview, the care plans were reviewed in clinical meetings and the appropriate changes would be made. She further stated the IDT team (IDT) would meet immediately, and would review the care plan and would put an intervention in place. Further interview with the CNE revealed she was not informed through the review of the RMS and interview with staff that Resident #20 was upset. The CNE stated this would have been important information to gather to assist with the appropriate revisions to the resident's care plan.

Interview with the Vice President of Operations, on 08/24/2021 at 2:20 PM, revealed it would be his expectation that care plans would be revised and followed.

Record review revealed on 08/11/2021, while returning from the beauty shop, Resident #20 walked back to his/her unit with a staff member of one (1) in a group of four (4) residents that required additional staff supervision when

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ambulating off the unit. Resident #20 fell which resulted in a Cervical Spine C2 minimally displaced base odontoid fracture. (Refer to F657)

Review of Resident #20's clinical record revealed the resident was admitted on 12/17/2019 with diagnoses that included Unspecified Dementia without Behavioral Disturbance, Muscle Weakness, and Reduced Mobility.

Review of Resident #20's Quarterly Minimum Data Set (MDS) dated 06/15/2021, revealed he/she was assessed to have a Brief Interview for Mental Status (BIMS) score of three (3), which was indicative of severe cognitive impairment.

Review of the Physical Therapy Discharge Summary, dated 08/08/2021 to 08/11/2021, revealed Resident #20 was seen three (3) days during the 08/08/2021 Progress Period. Continued review revealed the resident presented with diagnoses to include unspecified dementia without behavioral disturbance, difficulty in walking, not elsewhere classified, and muscle weakness. Further review revealed the short-term goal for the resident was to ambulate on level surfaces two-hundred (200) feet without an assistive device with supervision to increase independence within the facility. Record review revealed on 08/08/2021, the resident's baseline was seventy-five feet with Contact Guard (having one or two hands on the resident's body but provides no other assistance to perform the functional task, to assist with steady the resident's body or help with balance). Review of the resident's care plan revealed no documented evidence the care plan was updated to reflect the resident's level of assistance while ambulating on or off the unit, until 08/11/2021, after the

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resident's second fall.

Review of Resident #20's hospital record, dated 08/13/2021, revealed the resident was brought to the emergency room for an evaluation. The resident had significant right forehead and facial bruising. Continued review revealed the resident had a small right frontal subdural hematoma without any mass-effect or midline shift. A follow-up confirmed a C2 minimally displaced base odontoid fracture. A collar was recommended.

Interview with Certified Nursing Assistant (CNA) #15, on 08/13/2021 at 2:43 PM, revealed Resident #20 walked independently and shuffled his/her feet when he/she walked. She stated the resident was "really quick". CNA #15 revealed that on the day the resident fell, on 08/11/2021, she was assisting the Activity Assistant walk a group of residents to the beauty shop. Per interview, CNA #15 stated she recalled communicating to the resident that he/she needed to "slow down", per interview, the CNA stated the resident stated "ok" and slowed down. She stated she could not recall all the residents who went to the beauty shop, which was located off the residents' unit, but she recalled the residents required assistance with ambulation to the beauty shop. CNA #15 stated this was the first time escorting the residents to the beauty shop, so she was unaware how many staff escorted the residents off the unit and was unaware of their care plan.

Interview with the Activity Assistant, on 08/12/2021 at 12:08 PM, revealed he escorted the residents back to the unit. The Activity Assistant stated Resident #23 was observed to

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"wobble" on the way back to the unit, but did not fall. He further stated Residents #20, #24, #26, #27 were capable of walking independently, but Resident #23 required a walker. The Activity Assistant revealed the group continued to walk down the hall and the group had to go right. He revealed he walked next to Resident #23 and Resident #20 was walking behind him. He stated he positioned himself in a way he could grab the resident should anything occur. Further inteview revealed there was a place next to the Transitional Care Unit (TCU) where the nurses' station transitioned from the wood to the carpet. Continued interview revealed Resident #23 stated to Resident #20, "hurry up." Per interview, the resident was told by the Activity Assistant to "slow down" and when he turned to reach for the resident, the resident had fallen on the floor. Per interview, the Assistant Director revealed he was unaware of the level of assistance the residents required while ambulating off the unit. He stated it was important to have all aspects of the care plan completed because the residents' needs could change and it was important to keep up with the needs of the residents.

Interview with the Program Director of Homestead, on 08/20/2021 at 4:54 PM, revealed care plans were discussed in morning meetings. She stated the nurses would normally begin the care plans and the MDS Coordinator would review and/or revise as needed. Continued interview revealed the residents' care plans should have been revised to show the level of assistance the residents required for care. Further, she stated the Minimum Data Set (MDS) Coordinator had developed accurate coding and level of assistance should have been care planned. She stated this was important for the

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safety of the residents.

Interview with the Assistant Director of Nursing (ADON), on 08/19/2021 at 3:16 PM, revealed she and the Center Nurse Executive (CNE) have been working on updating the care plans. Per interview, she stated that the residents' care plan should reflect the level of assistance the resident needed. Further, she stated if the resident's were assessed to need one assist. then the care plan should have been revised. Additionally, she stated the Activity Assistance should have had additional staff members to escort the residents back to the unit.

Interview with the Center Nurse Executive (CNE), on 08/23/2021 at 11:03 AM, revealed the care plans were updated any time there were changes that were needed. Per interview, the care plans were reviewed in clinical meetings and the appropriate changes would be made. She further stated the IDT team would meet immediately, and would review the care plan and would put an intervention in place.

Interview with the Vice President of Operations, on 08/24/2021 at 2:20 PM, revealed it would be his expectation that the care plans would be revised and followed.

2. Review of the facility's policy, "Person-Centered Care Plan," revised 07/01/2019, revealed care plans were to be reviewed and revised by the facility's interdisciplinary team (IDT) after each Comprehensive Assessment, and as needed to reflect the resident's response to care and his/her changing needs and goals.

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Review of the Centers for Medicare and Medicaid Services (CMS), "Resident Assessment Instrument (RAI) Manual 3.0", dated October 2016, revealed the care plan was reviewed and revised periodically, and the services provided or arranged were to be consistent with each resident's written plan of care. The Manual stated there was a prescribed interval for Comprehensive Assessments (Quarterly, Annual, or Significant Change). Review revealed a well-developed and executed care plan was utilized to re-evaluate a resident's status. Per review, the individualized care plan was to be revised as appropriate and necessary .

Review of Resident #7's medical record revealed the resident was admitted to the facility on 03/17/2021, with diagnoses which included Vascular Dementia without Behaviors, End Stage Renal Disease (ESRD), Dependent on Dialysis, and Age-Related Physical Disability. Continued record review revealed Resident #7 had been discharged from the facility.

Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/22/2021, revealed the facility assessed Resident #7 with a Brief Interview for Mental Status (BIMS) score of fourteen out of fifteen (14/15), which indicated the resident was cognitively intact. Further review revealed the facility assessed Resident #7 to have had no exhibited behaviors.

Review of Resident #7's Comprehensive Care Plan (CCP), dated 03/18/2021, revealed the resident was not care planned for behaviors prior to his/her altercation with Resident #1. Continued review revealed no documented evidence the resident's care plan was updated/revised after the

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altercation which occurred on 06/19/2021 with Resident #1.

Interview with Registered Nurse (RN) #2, on 07/15/2021 at 12:51 PM, revealed the care plan was used to keep residents safe. Per interview, a resident's care plan explained for staff the different ways to provide care for residents, and ensured the resident received the correct care. Further interview revealed staff had access to residents' care plans via the facility's electronic health record (EHR) for each resident. In addition, she revealed the care plan was to be updated/revised when a resident experienced a significant change and the nurse, nurse manager, and social worker could all update the care plan if needed. The RN stated if staff failed to update/revise a resident's care plan the resident might not get the care they needed or required.

Interview with the Corporate MDS Coordinator, on 07/29/2021 at 2:45 PM, revealed she was not working in the facility when the resident to resident altercation occurred. Per interview, the MDS Coordinator who had been there was no longer working for the facility. She stated residents' care plans were updated annually, quarterly, or if there was a significant change and could be updated by the nurse, nurse managers, Social Services and/or the MDS Coordinator. Continued interview revealed residents' care plans needed to be followed by staff to ensure residents received the proper care. She further revealed after an altercation, the resident(s)' care plans were to be updated/revised as a resident's care needs might change. In addition, she stated nurses and Certified Nursing Assistants (CNAs) needed to be made aware of changes to a resident's care plan to ensure the necessary care

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was provided.

Interview with the Center Nurse Executive (CNE), on 07/29/2021 at 3:36 PM, revealed Resident #1 and Resident #7 were neither one aggressive residents, and the altercation between the two (2) was just a disagreement, not physical. The CNE revealed Resident #7 displayed no physical behaviors prior to the incident with Resident #1. Continued interview revealed she believed as Resident #7 had not previously exhibited behaviors, and the incident was the first time anything like that had happened, she did not feel Resident #7's care plan should have been updated.

3. Review of Resident #23's Medical Record revealed the resident was admitted on 09/08/2016, with diagnoses that included Alzheimer's Disease, Dementia, Impulsiveness, Muscle Weakness, and Altered Mental Straus. Review of the resident's Quarterly Minimum Data Set (MDS), dated 05/25/2021, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) of five (5), which was indicative of severe cognitive impairment. Review of Section G, Functional Status, revealed the resident was assessed to have one (1) person assist with locomotion off the unit. Review of Resident #23's Comprehensive Care Plan, last reviewed 06/07/2021, related to Activities of Daily Living (ADLs), revealed no documented evidence the resident's care plan was revised to show the level assistance needed, when ambulating off of the unit, as the facility assessed Resident #23 to require the assistance of one person, when off the unit.

4. Review of Resident #24's Medical Record

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revealed the resident was admitted on 06/18/2021 with diagnoses that included Alzheimer's Disease, Unspecified Dementia with Behavioral Disturbance, Psychotic Disorder with Delusions Due to know Physiological Condition,Muscle Weakness, and Anxiety Disorder.

Review of Resident #24's Quarterly MDS dated 06/24/2021, revealed the resident was assessed to have a BIMS score of two (2), indicating the resident was severely cognitively impaired. Review of Section G, Functional Status, revealed the resident was assessed to need Extensive Assistance of one (1) person for locomotion/ambulation off the unit. Review of Resident #24's Comprehensive Care Plan, last reviewed on 06/29/2021, revealed no documented evidence the resident's care plan was revised regarding level of assistance off the unit.

5. Review of Resident #26's Medical Record revealed the resident was admitted on 03/18/2021 with diagnoses that included Unspecified Dementia with Behavioral Disturbance, and Essential Hypertension. Review of the resident's Quarterly MDS, dated 06/24/2021, revealed the resident was assessed to have a BIMS score of five (5), indicating the resident was severely cognitively impaired. Review of Section G, Functional Status, revealed the resident was assessed for Supervision with no physical help from staff with locomotion/ambulation off the unit. Review of Resident #26's Comprehensive Care Plan, last reviewed on 06/29/2021, revealed no documented evidence the resident was care planned for Locomotion/Ambulation when off the

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unit.

6. Review of Resident #27's Medical Record revealed the resident was admitted on 08/28/2018 with diagnoses to include Alzheimer's Disease, Unspecified Psychosis, Muscle Weakness, and Unspecified Dementia without Behavioral Disturbance. Review of the resident's Annual MDS assessment, dated 05/01/2021, revealed the resident was assessed to have a BIMS score of fourteen (14), indicating the resident was cognitively intact. Review of Section G, Functional Status, revealed the resident was assessed to have supervision with one (1) person physical assist with locomotion/ambulation off the unit. Review of the resident's Comprehensive Care Plan, last reviewed on 05/05/2021, revealed the resident required a wheelchair with standard cushion, dycem under cushion and left leg rest for locomotion; however, there was no documented evidence the resident was care planned for the level of assistance needed for locomotion/ambulation when off the unit.

Interview with Registered Nurse (RN) #3, on 08/17/2021 at 3:01 PM, revealed that when the residents' care plan stated the residents were an assist of one (1) staff, that meant one (1) staff member would assist the resident with ambulation. Continued interview revealed one (1) staff member should not escort five (5) residents when they were assessed to be an assist of one (1). Further, RN #3 revealed she worked the Homestead Unit on the day of 08/11/2021. She revealed she did not see the residents leave the unit to attend the beauty shop. Further, she stated the staff who escorted the residents off the unit should have notified her so that she could have provided guidance on the residents' level of

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F 657	Continued From page 54 assistance when ambulating, additionally she stated the residents level of assistance should be care planned. Telephonic interview with the Minimum Data Set (MDS) Coordinator, on 08/232021 at 10:40 AM, revealed today was her first day working as MDS Coordinator at the facility, however, she has worked with MDS for over four (4) years. The MDS Coordinator revealed the MDS Assessments drives the Care Plans for the residents. Per interview, the residents who were care planned for an assist of one (1) required the assistance of one (1) staff to assist with care. Additionally, she stated when a resident was assess for two (2) staff, for transfers, then an assist of two (2) staff should be care planned to assist staff with residents' care. Lastly, the MDS Coordinator revealed that the residents, when care planned for supervision, should have supervision/oversight. Interview with the Center Executive Director (CED), on 07/30/2021 at 3:04 PM, revealed he would expect staff to update/revise a resident's care plan when it was needed. Continued interview revealed it was important to update the care plan to ensure staff were providing the "most up to date" care for all residents. Additionally, he revealed staff were to always follow the care plan. Further interview revealed the nurse, unit managers, and also social services could update the care plan. He stated the facility educated staff on behaviors and their possible triggers to help deter altercations between residents.	F 657		
F 660 SS=J	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix)	F 660		

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F 660	Continued From page 55 §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other	F 660		

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appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's policies it was determined the facility failed to develop and implement an effective

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discharge planning process to ensure the discharge needs were met for one (1) of eighteen (18) sampled residents (Resident #3).

Review of Resident #3's Comprehensive Care Plan revealed no evidence the facility developed a discharge transition plan of care, as per the facility's policy. Continued review revealed Resident #3 was at risk for decreased ability to perform Activities of Daily Living (ADLs), cardiovascular complications, dehydration, and also at risk for falls. Further review revealed Resident #3 was insulin dependent and was care planned to be occasionally incontinent of bladder and was unable to cognitively or physically participate in a retraining program due to cognitive loss and limited mobility.

Review of the Physician's Notes, dated 02/11/2021 and 06/01/2021, revealed no evidence of a plan to discharge Resident #3 from the facility. Review of the Nurse Practitioner (NP) Notes, dated 04/07/2021, 05/03/2021, 05/19/2021, 05/26/2021, 06/09/2021 and 06/16/2021 revealed no developed plan for Resident #3's safe discharge.

Resident #3 was observed smoking on 06/16/2021, during a time, smoking was not allowed. Facility staff informed Resident #3 his/her smoking privileges would be revoked, and the resident became upset and requested to leave the facility. The facility discharged Resident #3 on 06/16/2021, to a homeless shelter via a cab transport. However, the facility failed to ensure the required discharge planning, education and medication education were completed and documented prior to discharging the resident. Additionally, the facility failed to

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ensure all of Resident #3's medications were given to him/her prior to the discharge. On 06/20/2021, four (4) days after being discharged, Resident #3 was admitted to an acute care hospital setting with diagnoses which included Hyperglycemia (high blood sugar) which required insulin therapy, Urinary Tract Infection (UTI) which required intravenous antibiotic therapy, and a Deep Vein Thrombosis (DVT) which required anticoagulant therapy. Resident #3 remained in the hospital for a ten (10) day inpatient stay.

Immediate Jeopardy was identified on 07/30/2021 and was determined to exist on 06/16/2021 in the areas of 42 CFR 483.15 Admission, Transfer, and Discharge, F624 Preparation for Safe/Orderly Transfer/Discharge at scope and severity of "J", and 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F660 Discharge Planning Process at scope and severity of "J". The facility was notified of the Immediate Jeopardy on 07/30/2021.

The facility provided an acceptable Allegation of Compliance (AoC) on 08/11/2021 alleging removal of jeopardy on 08/03/2021. The SSA validated abatement of the IJ as alleged on 08/03/2021.

The findings include:

Review of the facility's policy titled, "Discharge Planning Process", revised 02/01/2019, revealed the facility developed and implemented an effective discharge planning process for all residents which focused on their discharge goals. Further review revealed upon admission all residents were assessed for discharge potential, and were to be asked about their discharge

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goals. According to the policy, discharge planning was initiated on a resident's admission and was completed as part of the facility's Person-Centered Care Plan process for residents. Per review, the discharge planning process was to assist residents in effectively transitioning to post-discharge care, and reduce factors which might cause a preventable re-admission to long term care. The policy revealed all residents who were to be discharged to a community based living setting would have a Discharge Transition Plan and a Discharge Packet. Further review revealed the Discharge (D/C) Transition Plan was to include the following: a recapitulation of the resident's stay, a final summary of the resident's status at time of discharge, reconciliation of all pre-discharge medications with the resident's post-discharge medications, a post discharge plan of care, and the resident's post-discharge residence with any follow up care required after discharge.

Record review revealed the facility admitted Resident #3 on 02/10/2021, with diagnoses which included Type 2 Diabetes Mellitus (DM), Hypertension (HTN), Hyperlipidemia (HLD), Dementia without Behaviors, and Coronary Artery Disease (CAD). Continued review revealed the facility assessed Resident #3 to have a neurocognitive disorder, limited insight/judgement, impaired memory, impaired gait and strength.

Review of the facility records revealed Resident #3 had a Conservator (provides supervision for protected person), dated 11/18/2020.

Review of the Business Office notes, dated 03/30/2021, 04/01/2021 and 07/02/2021,

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revealed the Program Director of Memory Care noted Resident #3's Conservator no longer wanted to have that responsibility and the facility's Social Workers (SW) filed for the Conservator to be removed along with Guardianship. However, attempts were made to contact both SW on 07/16/2021 at 9:44 AM and 9:47 AM and on 07/20/2021 at 10:21 AM and 10:23 AM without success.

Review of Resident #3's Physician's Orders, dated 02/10/2021, revealed the resident had medications ordered for his/her diagnoses of CAD, Type 2 D, HLD, HTN, and Dementia. Further review revealed Resident #3's medication/treatment orders included fingerstick blood glucose monitoring, long and short acting insulins and oral diabetic medication for his/her diagnosis of Type 2 DM. Continued review revealed Resident #3 also had medications ordered for diagnoses which included Bipolar Disorder, Depression, and Angina (chest pain).

Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/19/2021, revealed the facility assessed Resident #3 to have moderate cognitive impairment as indicated by the Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15) possible. Continued review revealed the facility assessed Resident #3 as moderately depressed with no behaviors exhibited. The MDS noted Resident #3 required limited assistance of one (1) person for transfers, and assessed the resident as frequently incontinent of bowel and occasionally incontinent of bladder. Per review, the facility assessed the resident to require extensive assist of one (1) person for dressing, toileting and completing personal hygiene. Further review

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revealed the facility assessed Resident #3 to require insulin injections for his/her diagnosis of Type 2 DM, and assessed the resident as receiving numerous medications to treat his/her other diagnoses. Record review revealed Resident #3 was to receive rehabilitation while a resident at the facility, and he/she would return to a community setting when discharged.

Review of Resident #3's Comprehensive Care Plan, revealed no evidence the facility developed a D/C transition plan of care, as per the facility's policy. Continued review revealed Resident #3 was at risk for decreased ability to perform Activities of Daily Living (ADLs), cardiovascular complications, dehydration, and also at risk for falls. Further review revealed Resident #3 was insulin dependent and was care planned to be occasionally incontinent of bladder and was unable to cognitively or physically participate in a retraining program due to cognitive loss and limited mobility.

Review of the Physician's Notes, dated 02/11/2021 and 06/01/2021, revealed no evidence of a plan to D/C Resident #3 from the facility, or evidence of cognitive assessments completed for the resident. Review of the Nurse Practitioner (NP) Notes, dated 04/07/2021, 05/03/2021, 05/19/2021, 05/26/2021, 06/09/2021 and 06/16/2021 revealed no documentation of a cognitive assessment by the NP's nor any documented evidence of Resident #3 requesting to be discharged from the facility. Further review of the NP Notes for the above timeframe revealed documentation noting Resident #3 was wheelchair dependent.

Interview with the Physician, on 07/21/2021 at

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4:15 PM, revealed he remembered Resident #3's name; however, he could not recall if Resident #3 had ever been under his care or if he had ever evaluated the resident. Continued interview revealed he had received a phone call from the facility 06/16/2021; however, was unable to remember why facility staff had called him.

The Surveyor attempted telephonic contact with the NP on 07/29/2021 and 07/30/2021; however the attempts were unsuccessful.

Review of the Nurse's Notes, dated 06/14/2021, revealed the Program Director of the Memory Care Unit, who previously had worked in the facility's Social Services Department, had noted Resident #3 requested to discharge from the facility to another skilled nursing facility (SNF). Continued review revealed the Program Director had sent referrals to three (3) local SNFs, and had sent referrals to three (3) SNFs close to Resident #3's home town. Further review revealed no evidence of D/C planning for Resident #3, as per the facility's policy.

Interview with the Program Director of the Memory Care Unit, on 07/27/2021 at 2:45 PM, revealed Resident #3 approached her on 06/14/2021 and stated he/she wanted to leave the facility; however, the resident did not say why he/she wanted to be discharged. Per interview, after the discussion with Resident #3, she sent referrals to several other SNFs she knew were smoking friendly facilities, as the resident was a smoker. Continued interview revealed she had not received replies from any facilities she had sent the referrals; so she assumed those facilities had not wanted to admit Resident #3. The Program Director stated she was not sure if she

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notified the Center Nurse Executive (CNE) and Center Executive Director (CED) during either a morning meeting or afternoon meeting of the lack of response from the other facilities she had contacted. Further interview revealed there was no discussion with the facility's Management staff related to beginning the D/C planning process or development of a D/C plan of care; however, there should have been and she did not start the discharge process. She stated she would have initiated the facility's D/C process if she had received return calls/messages from the other facilities she had contacted. Further interview revealed she had "updated" Resident #3 regarding the referrals she had sent, and she felt like the resident understood the facility's discharge process.

Review of the facility policy for discharge planning, revised 02/01/2019, revealed the process began at admission to the facility contrary to the Program Director's interview.

Review of a Consulting Social Worker Note, dated 06/15/2021, revealed documentation that noted Resident #3 had expressed a desire to transfer to another facility closer to his/her family. Additionally, the Note revealed "referrals had been made and staff were awaiting return calls" from the facilities contacted. Continued review revealed another Note, dated 06/16/2021 timed at 2:23 PM, which noted Resident #3 had been "found" smoking in the facility's courtyard area during a break not scheduled for smoking. Per review, when the CED "suspended" Resident #3's smoking privileges due to the infraction which occurred during the non smoking time, the resident requested to leave the facility immediately. Further review revealed Resident

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#3 chose to discharge to a Homeless Shelter and had made a "reservation" to arrive at the Shelter at 4:00 PM that day. However, review revealed no documented evidence the Consulting Social Worker had initiated the facility's discharge planning process prior to Resident #3's discharge.

Interview with the Consulting Social Worker, on 07/29/2021 at 10:13 AM, revealed a resident's discharge planning process started on admission to the facility. She revealed she was not working in the facility when Resident #3 was admitted; however, "normally" she initiated a resident's discharge care plan on admission to the facility. Per interview, when a resident expressed to return to the community when discharged from the facility, she noted that on the discharge care plan. Further interview revealed she updated the discharge care plan during the resident's stay, as their care needs changed. However, she had not had any input with Resident #3's care plan as she was not present at that time.

Review of a Nurse's Note completed by Licensed Practical Nurse (LPN) #2, dated 06/16/2021, revealed Resident #3 had been discharged from the facility at 4:23 PM on that date. Further review of the Note revealed no evidence LPN #2 gave discharge paperwork to Resident #3 prior to his/her discharge from the facility.

Interview with LPN #2, on 07/27/2021 at 3:34 PM, revealed she was the nurse on duty when Resident #3 was discharged from the facility on 06/16/2021. She stated at the time of discharge she provided Resident #3 a list of his/her medications. Additionally, LPN #2 provided Resident #3 one Lantus (long acting insulin) pen,

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and a "couple" of needle caps. Continued interview revealed she did not supply Resident #3 with any glucose monitoring equipment. Per the LPN she failed to document the medication information in the resident's record upon his/her discharge; however, she should have ensured the documentation was completed.

However, interview with Resident #3, on 07/27/2021 at 9:20 AM, revealed at the time of D/C, the facility did not give him/her any clothes, or his/her medications. Further interview revealed he/she did know how to administer his/her own insulin but needed someone to tell him/her how many units he/she needed as he/she did not have a glucose monitoring device. Additionally, Resident #3 revealed upon D/C from the facility he/she did not have money nor was given any and the facility failed to notify him/her regarding what was going to happen to the resident's money after leaving the facility.

Review of the Discharge note, dated 06/16/2021, completed by the Licensed Practical Nurse (LPN) #2 revealed no documented evidence of discharge education, education related to Resident #3's medications nor any durable medical equipment (DME) that was recommended per the OT discharge summary.

Interview with the homeless shelter's Director of Programs, on 07/27/2021 at 1:40 PM, revealed the shelter does not assist with medications including storage or dispensing. Continued interview revealed clients at the shelter have to leave the shelter daily between 7:00-7:30 AM and check-in for the evening begins at 4:00 PM. Additionally, she stated if medications were left behind, staff collected them, placed them in a

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locked box and then medications were taken to a local pharmacy where they were destroyed. Further interview revealed the shelter did not have the support staff to assist clients with transfers (i.e. to and from the wheelchair), showers, and incontinence care. Continued interview revealed if the shelter's beds were full after time of check in, they would turn clients away.

Review of hospital records, dated 06/20/2021, revealed Resident #3 presented to the Emergency Department (ED) on 06/20/2021. The ED determined Resident #3 was hyperglycemic with a reading of 277 (normal reading is seventy to one hundred-ten 70-110), which required insulin therapy. The resident was hypertensive and received blood pressure medication; also was diagnosed with a urinary tract infection (UTI) and received intravenous antibiotics. In addition, the resident had diarrhea, complaints of chest pain, shortness of breath, and lower extremity pain. Record review revealed Resident #3 was diagnosed with a blood clot in the right lower leg and received medication to treat blood clots.

Interview with the Center Nurse Executive (CNE), on 07/22/2021 at 3:46 PM, revealed the discharge process was initiated upon a resident's admission to the facility. She stated the original plan for Resident #3 was to discharge him/her back home after he/she completed his/her rehabilitation. Per interview, the Social Worker was responsible for the development of a resident's discharge care plan. Continued interview revealed the CNE's expectations regarding Resident #3's discharge was for the Social Worker to have initiated a discharge care plan for the resident when she started sending

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referrals out to other SNFs on 06/14/2021. The CNE revealed she was not aware of the facility trying to remove the Conservator and was not aware of the facility attempting to file for Guardianship. Further interview revealed the facility would not have given Resident #3 any glucose monitoring equipment; and did not send him/her with any money to obtain supplies for his/her care needs. Additionally, she stated during a resident's discharge from the facility, the resident's nurse reviewed a Discharge Summary with the resident and/or his/her family. The CNE stated the nurse provided the resident and/or family with a copy of the Discharge Summary, and also placed a copy of it in the resident's medical record. The CNE further stated Resident #3's discharge had not been "a good discharge"; however, the facility had "tried" to do the best they could for him/her given the resident's impatience and demands to leave the facility as soon as possible.

Interview with the Center Executive Director (CED), on 07/30/2021 at 3:04 PM, revealed Resident #3's discharge had not been a "normal situation" for discharge due to the resident's wanting to leave the facility as soon as possible. The CED stated the facility would not "impede" a resident's right to discharge from the facility, who had a high BIMS score indicating no cognitive impairment, and who had no documented guardian. however, the CED stated the facility had attempted to reach the state appointed Conservator. He stated the facility had called the Physician to obtain discharge orders for Resident #3 to ensure the resident's medications were provided to him/her at discharge. Additionally, the CED stated on 06/16/2021 the facility had "attempted" to provide the "best" discharge

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possible for Resident #3 at the time.

The facility alleged it implemented the following actions to remove immediacy:

1. Resident #3 was discharged from the facility on 06/16/2021.

2. The Center Nurse Executive (CNE), Rapid Response Manager, Director of Regulatory Compliance, or Social Services team member reviewed, on 07/31/2021, all residents with a planned discharge since 06/16/2021 to identify discharge trends.

3. The Center Executive Director (CED) and CNE completed education and a posttest after the Regional Vice President (RVP) and Clinical Quality Specialist (CQS) provided education for a safe transfer/discharge with appropriate documentation on the resident's clinical status, clinical care, and medication management instructions, on 07/31/2021.

4. On or before 08/02/2021 the Social Services team, Assistant Director of Nursing Services (ADNS), Nurse Practice Educator (NPE), Unit Managers (UM), CED, Human Resource Director (HRD) and Nurse Supervisors completed education and a posttest on the safe/orderly transfer/discharge of the resident.

5. All licensed facility and agency staff completed on or before 08/02/2021 education on a safe transfer/discharge, and education requirements to the resident. All staff were required to complete a post test.

6. The facility audited resident records daily then

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three (3) times a week for resident's who were planned for discharge for documented education to the resident regarding clinical care and medication education by staff. Identified areas would be corrected immediately by the team member.

7. The facility QAPI committee reviewed the CNE, ADNS and Social Services team weekly audits for appropriate transfer, discharge, and education. Upon review additional follow-up or re-education would occur until resolved.

The State Survey Agency (SSA) validated the removal plan by:

1. Record review revealed the facility discharged Resident #3 on 06/16/2021.

Interview, on 07/27/2021 at 3:34 PM, with Licensed Practical Nurse (LPN) #2 revealed she discharged Resident #3 on 06/16/2021.

2. Interview with the CNE, on 08/21/2021 at 3:19 PM, revealed she was involved with review of all planned discharges as alleged.

Interview with Rapid Response Manager, on 08/21/2021 at 2:56 PM, revealed she was involved with review of planned discharges as alleged.

Interview with the Director of Regulatory Compliance, on 08/21/2021 at 2:45 PM, revealed she was involved with a review of planned discharges as alleged.

Review of an audit tool, dated 07/31/2021, revealed a list of resident discharges marked as

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reviewed.

3. Interview with the Clinical Quality Specialist, on 08/21/2021 at 3:50 PM, revealed she provided education and posttest to the Center Executive Direction and the CNE as alleged.

Interview with the RVP, on 08/21/2021 at 4:15 PM, revealed he participated in education and posttest of the CED and the CNE as alleged.

Interview with the CED, on 08/21/2021 at 3:54 PM, revealed he received education and completed a posttest as alleged.

Interview with the CNE, on 08/21/2021 at 3:19 PM, revealed she received education and completed a posttest as alleged.

Review of facility records revealed posttests labeled with names of the CED and CNE.

4. Interview with Social Service Specialist, on 08/20/2021 at 3:24 PM, revealed she received education and completed a posttest as alleged.

Interview with the Nurse Practice Educator, on 08/20/2021 at 4:38 PM, revealed he received education and completed a posttest as alleged.

Interview with TCU Unit Manager, on 08/20/2021 at 2:11 PM, revealed she received education and completed a posttest as alleged.

Interview with the Nurse Weekend Supervisor, on 08/20/2021 at 1:50 PM, revealed he participated in education and completed a posttest as alleged.

Record review revealed posttests labeled with the

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staff's names as indicated above.

5. Interview with LPN #6 on 08/18/2021 at 9:25 PM, revealed she received education and completed a posttest as alleged.

Interview with the Business Office Manager, on 08/20/2021 at 4:04 PM, revealed she received education and completed a posttest as alleged.

Interview with Agency Registered Nurse #5, on 08/20/2021 at 5:58 AM, revealed she received education and completed a posttest as alleged.

Interview with LPN #1, on 08/18/2021 at 7:48 AM, revealed she received education and completed a post test as alleged.

Review of facility records revealed posttests documented for licensed nurses as alleged.

6. Interview with the CED, on 08/21/2021 at 3:54 PM, revealed he completed audits of resident records for discharge documentation as alleged.

Review of facility records revealed audit sheets dated 07/31/2021 through 08/19/2021, indicating review of discharge documentation as alleged.

7. Review of facility records revealed QAPI sign-in sheets as indicated listing discharge audits in the topic.

Interview with the CED, on 08/21/2021 at 3:54 PM, revealed discharge audits discussed in QAPI meetings as alleged.

Interview with the RVPO, on 08/21/2021 at 4:15 PM, revealed discharge audits discussed in

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F 660	Continued From page 72 QAPI meetings as alleged.	F 660		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to have an effective system in place to ensure each resident received adequate supervision and devices to prevent accidents for four (8) of twenty-eight (28) sampled residents (Residents #20, #19, #21, #22, #23, #24, #26, and #27). 1. On 08/07/2021, Resident #20 was observed with another resident's walker. Per interview,	F 689		

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staff asked the resident to return the walker to the resident and Resident #20 stated the walker belonged to his/her mom. Interview with staff revealed the resident became visibly upset and walked to his/her room, then walked back "at a fast pace" tripping over his/her foot causing a closed fracture of the right orbital floor. Resident #20 was care planned to have an assist of one (1) when in his/her room and/or toileting. Additionally, the resident's care plan was not revised to address the resident's "fast pace" when upset, nor was the resident care planned for his/her level of assist with ambulation. Additionally, Resident #20 had a second fall. On 08/11/2021, while returning from the beauty shop, Resident #20 walked back to his/her unit with a staff member of one (1) in a group of four (4) residents who required additional staff supervision when ambulating off the unit. Resident #20 fell which resulted in a Cervical Spine C2 minimally displaced base odontoid fracture.

2. On 05/10/2021, Resident #19 was observed seated in his/her wheelchair in his/her room. The resident stood up from his/her wheelchair, stepped on the edge of the mattress on the floor and fell forward, hitting his/her head on the back of the wall in his/her room. The resident was sent to the hospital and received a laceration to the scalp resulting in one (1) staple. The resident was care planned to have his/her mattress up while out of bed. Additionally, on 05/30/2021, Resident #19 was observed by staff to stand up out of his/her wheelchair and landed on his/her bottom when his/her name was called. Observation on 08/14/2021, revealed Resident #19 stood up from his/her chair, the State Agency Survey (SSA) Surveyor, notified staff to assist

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with the resident. Per interviews with staff, the resident was so fast, he/she required 1:1 supervision.

3. On 08/05/2021, Resident #21 was observed to have an injury of unknown source. The resident was diagnosed to have a Tibia Fracture. Review of the resident's Minimum Data Set (MDS), related to transfers was different from the resident's plan of care. The resident was assessed for two (2) assist with transfers; however, the resident was care planned for one (1) assist with transfers.

4. On 05/28/2021, Resident #22, was observed to display bruising to his/her thigh and was limping. Interviews with staff and review of the hospital record revealed the resident had a fall. The resident's care plan was up dated for the resident to wear non-skid socks when ambulating; however, observation on 08/12/2021 revealed the resident was walking without his/her left sock.

5. On 08/11/2021, Resident #23 and four (4) additional residents were escorted off his/her unit with the assistance of only one (1) staff for all five (5) residents. Resident #23 however, was assessed to have a one (person) assist when ambulating off his/her unit. The resident was escorted with four (4) other residents, of whom required the same level of supervision, increasing his/her risk for falls.

6. On 08/11/2021, Resident #24 and four (4) additional residents were escorted off his/her unit with the assistance of one (1) staff for all five (5) residents. The resident; however was assessed to have an extensive assist of one (1) person for

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locomotion/ambulation off the unit. The resident was escorted with four (4) other residents, of whom required additional and/or the same level of supervision, increasing his/her risk for falls.

7. On 08/11/2021, Resident #26 and four (4) additional residents were escorted off his/her unit with the assistance of one (1) staff for all five (5) residents. The resident was assessed for supervision with no physical help from staff with locomotion/ambulation off the unit.

8. On 08/11/2021, Resident #27 and four (4) additional residents were escorted off his/her unit with the assistance of one (1) staff for all five (5) residents. The resident was assessed to have supervision with one (1) person physical assist with locomotion/off the unit.

9. On 08/14/2021, observation of ten (10) residents sitting in the common area without staff supervision/oversight. Of the ten (10) residents observed, Residents #19, #21, and #22 were among the residents. Review of the residents' care plans revealed the residents required supervision.

Immediate Jeopardy was identified on 08/24/2021 and was determined to exist on 05/10/2021 in the areas of 42 CFR 483.25 Quality of Care, F689 Free of Accident Hazards/Supervision/Devices at scope and severity of "J" and 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F656 Develop/Implement Comprehensive Care Plan at scope and severity of "J" and F657 Care Plan Timing and Revision at scope and severity of "J"; 42 CFR 483.70 Administration, F835 Administration at scope and severity of "J", and F837 Governing Body at scope and severity of

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"J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care, F689 Free of Accident Hazards/Supervision/Devices at scope and severity of "J". The facility was notified of the Immediate Jeopardy on 08/24/2021.

F835 Administration and F837 Governing Body were previously cited on 05/22/2021, both at scope and severity of "K". As this represents continued non-compliance F835 and F837 will be cited at the higher scope and severity of "K".

Additional deficient practice was identified at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 Free from Abuse and Neglect at scope and severity of "D". However, F600 was previously cited on 05/22/2021 at scope and severity of "K" and as this represents continued non-compliance, F600 will be cited at the higher scope and severity of "K", resulting in Substandard Quality of Care at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 at a scope and severity of "K".

The State Survey Agency exited on 08/24/2021 with IJ existing on 05/10/2021 and is ongoing.

The findings include:

Review of the facility's policy titled, "Accidents/Incidents", revised 11/28/2016, revealed the facility would use the Risk Management System (RMS) to report, review, and investigate all accidents/incidents which occurred, or allegedly occurred, on Center property. Further review revealed an accident was defined as any unexpected or potential incident which may result in injury or illness to a resident/patient. Further review revealed the

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licensed nurse would utilize the RMS to report accidents/incidents and assist with completion of a timely investigation to determine the root cause. The information entered would generate notification of appropriate leadership depending on the severity level of the event; trigger specific investigation tools based on the type of event and/or injury of the patient and flow to individualized state reporting forms to assist with completing the state and federal reporting requirements, as directed. Continued review of the policy revealed a follow up investigation would be reviewed by the CNE or designee to determine if the required documentation was completed and interventions to prevent further accidents/incidents had been identified and implemented. Further, when conducting an investigation, the CED (Center's Executive Director), CNE (Center's Nurse Executive), or designee would make every effort to ascertain the cause of the accident/incident; use the RMS (Risk Management System) witness interview form to conduct witness interviews from all staff and visitors who may have knowledge of the accident/incident. Lastly, the ACED (Assistant Center Executive Director) or designee would monitor the results of the investigations/root cause analyses and forward to the Quality Assurance Performance Improvement (QAPI) Committee for follow-up.

Review of the facility's policy titled, "Falls Management", revised on 06/01/2021, revealed the residents were assessed for falls risk as part of the nursing assessment process. Continued review revealed those determined to be at risk for falls would receive appropriate interventions to reduce the risk and minimize injury. Further review revealed the residents experiencing a fall

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would receive appropriate care and investigation of the cause. The policy further revealed that the purpose was to reduce the risk for falls and minimize the actual occurrence of falls and to address injury and provide care for a fall. Continued review revealed the resident would be identified as a fall risk by reviewing the Electronic Medical Record Systems-Nursing Assessment and Non-electronic Medical Record Systems-Fall Risk Evaluation. Further review revealed the facility would communicate the resident's fall risk to the caregivers, develop individualized plans of care, and review and revise the resident's care plan regularly. Continued review revealed that if a resident falls: the incident would be documented as a new event in the Risk Management System (RMS); the care plan would be updated to reflect new interventions, an interdisciplinary team meeting would be held within seventy-two (72) hours of the fall and the Center Executive Director and Center Nurse Executive would conduct a post fall review.

Interview with the Clinical Quality Specialist, on 08/24/2021, at 2:00 PM, revealed the facility did not utilize the Non-electronic Medical Record Systems-Fall Risk Evaluation, as per the regulation. She stated staff determined a resident was at risk for falls through completing their "nursing assessments."

1. Review of Resident #20's clinical record revealed the resident was admitted on 12/17/2019 with diagnoses that included Unspecified Dementia without Behavioral Disturbance, Muscle Weakness, and Reduced Mobility.

Review of the resident's Quarterly Minimum Data

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Set (MDS), dated 06/15/2021, revealed he/she was assessed to have a Brief Interview for Mental Status (BIMS) score of three (3), which was indicative of severe cognitive impairment. Further review revealed the resident's functional status was assessed to be supervision (oversight, encouragement or cueing) with set-up (help only), with locomotion on the unit. The resident was assessed to have "activity did not occur" with locomotion off the unit with no physical help.

Review of Resident #20's Comprehensive Care Plan related to Activities of Daily Living (ADL's), with a target date of 09/15/2021, revealed the focus of the care plan was for the resident to have assistance with ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, tilting related to weakness, chronic pain, and impaired cognition, subdural hematoma, right orbital floor fracture, and C2 fracture. The goal was for the resident to improve current level of function in bathing, grooming/personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting. The resident's interventions was for the resident to have 1:1 supervision and assistance, initiated 08/14/2021, provide assist with one (1) for bed mobility, provide one on one assist for transfers, revised 08/14/2021, provide assist of one (1) for toileting. Further review revealed no care plan for how the resident would ambulate on or off his/her unit.

Review of Resident #20's first fall, dated 08/07/2021, revealed the Risk Management System (RMS) Summary Report, signed by Registered Nurse (RN) #3, under the section titled, "Describe the circumstances of the event and immediate actions taken", revealed the

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resident was walking in the hall near the nursing station and fell, striking his/her head. Further review revealed the resident sustained a laceration to the forehead. A cold compress was applied to the resident's forehead laceration. Continued review revealed Emergency Medical System was notified and the resident was transferred to the acute care Emergency Department. Continued review revealed the witnesses were Licensed Practical Nurse (LPN) #1 and LPN #2.

Further review of Resident #20's RMS Event Summary, dated 08/07/2021, revealed preventive measures that were in place prior to the fall was to have the bed against the wall, nursing staff to complete orthostatic blood times three (3) days, observe for changes in medical status, pain status, and mental status. Continued review revealed the root cause/conclusion was that the resident was walking in the hallway when he/she lost his/her balance and fell. There were no environmental factors or hazards noted. The corrective actions included: therapy to evaluate; orthostatic blood pressure for three (3) days; nursing staff to evaluate for footwear for proper footing and the resident was encouraged to be in the common area when awake as he/she would allow.

Review of Resident #20's hospital record, dated 08/07/2021, revealed the resident tripped and fell forward striking his/her right forehead against the ground. Further review revealed the resident sustained a laceration to his/her right eyebrow during the fall. Record review revealed the resident's diagnosis at discharge was an "injury of head, fall, initial encounter, facial laceration, and closed fracture of right orbital floor".

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Observation and interview with Resident #20, on 08/17/2021 at 6:42 PM, revealed the resident was sitting up in his/her wheelchair, on the Transitional Care Unit (TCU), watching television with 1:1 staff. Resident #20 was observed to have the cervical collar to his/her neck.

Interview with Certified Nursing Assistant (CNA) #14, on 08/15/2021 at 10:00 AM, revealed she had worked for the facility for over five (5) years. Per interview, CNA #14 revealed she worked the day Resident #20 fell, on 08/07/2021. She stated the resident was observed to have another resident's walker and when asked to return the walker, the resident became upset, stating the walker was his/her mother's walker. Per interview, the resident forcibly returned the walker to CNA #14. Continued interview revealed Resident #20 was asked to have a sit in the common area while she (CNA #14) went to retrieve a towel to wipe up liquid that was observed on the kitchen floor. CNA #14 stated when she returned, she saw the resident on the floor and Licensed Practical Nurse (LPN) #1 and another nurse (unidentified) were assessing the resident. The CNA stated she did not observe the fall and believed the resident was not at risk for falls. She stated she was not fully aware of the resident's care plan, but nursing staff would communicate the resident's needs to the CNAs. Additionally, she added nursing was aware of the resident's behavior, which included thinking that a walker that belonged to another resident belonged to him/her.

Interview with LPN #1, on 08/18/2021 at 7:48 AM, revealed she had been with the facility for over six (6) months and was employed through agency.

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Per interview, LPN #1 stated she worked all shifts and every unit. LPN #1 stated the residents were assessed for falls after they had a fall and it was often documented through the RMS and within the resident's change in condition. She further stated the residents were not given a score to determine if they were at high or low risk for falls. The LPN stated staff were made aware of a resident's risk for falls by reviewing the resident's care plan. Additionally, when the resident was care planned for an assist of staff, related to toileting, ambulating, dressing, and all other Activities of Daily Living (ADL), the resident would be at risk for falls.

Continued interview with LPN #1, on 08/18/2021 at 7:48 AM, revealed she worked the evening of 08/07/2021, when Resident #20 experienced his/her first fall. She stated it was around 6:15 PM, around shift change and she was counting pills with LPN #6. She stated Resident #20 normally "walks fast" when he/she becomes anxious. LPN #1 stated the resident got up and walked from the common area to his/her room. She stated she thought Resident #20 might have needed to go to the bathroom, but she was not certain, adding "that was what the resident normally did, went to the bathroom and returned to the common area." Continued interview revealed that when Resident #20 came out of his/her room, the resident was observed to walk "fast" coming back to the common area and tripped on his/her own foot and fell. LPN #1 stated the resident hit his/her head. She stated "he/she landed on the wooden area" of the unit. The LPN stated, "blood was on the floor." LPN #1 stated that when the resident landed from his/her fall, he/she rolled over into the carpet area. LPN #1 stated she recalled the staff that

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were there, she and LPN #6 were counting pills and CNA #14. She further stated she could not recall any other staff who assisted her with the resident. LPN #1 revealed the resident was assessed and was immediately transported to the hospital by the Emergency Medical System (EMS).

Interview with LPN #6, on 08/18/2021 at 9:25 PM, revealed she had worked at the facility since the beginning of July. She further stated she was employed through agency and had only worked the Homestead Unit only twice (2). She stated she was not familiar with the residents. LPN #6 stated on the day of Resident #20's fall, on 08/07/2021, she had completed her report with LPN #1. LPN #6 stated the resident walked independently to and from his/her room without assistance. Per interview, LPN #6 stated she grabbed the blood pressure cuff when she observed Resident #20 walking in front of her, walking at a fast pace. LPN #6 revealed it seemed as though Resident #20 was "upset" and "tearful". She stated she could not tell; however; if the resident was crying, as she did not get a good look at the resident's face before he/she fell. LPN #6 stated the resident fell across from the nurse's station. She stated she observed the resident's foot "kind of dragged" and he/she stumbled over his/her foot and went "down". LPN #6 stated she believed the resident "hit head first" and she saw the blood coming from the resident's right eye brow. Continued interview revealed the resident was sent out to the hospital immediately. Additionally, LPN #6 stated she was not aware of the incident that happened prior to the resident's fall, but if the resident was upset over his/her walker, it would have been important to redirect the resident so that his/her focus did not remain

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on another resident's walker.

Interview with Registered Nurse (RN) #3, on 08/17/2021 at 3:01 PM, revealed she was employed by the facility and had worked for over two (2) and a half (1/2) years. Per interview, the nurses complete the resident's fall assessment upon admission. RN #3 was unable to show the "documents" that were used to assess the residents for falls. Continued interview revealed that when a resident experienced a fall, he/she would be assessed by the nurse for injury and vital signs would be taken. She further stated that depending on the severity of the injury, the resident would be sent to the hospital. She stated the RMS and Change of Condition would be completed at that time. Per interview, RN #3 revealed Resident #20's incident occurred around 6:22 PM, on 08/07/2021. She stated it was during the change of shift and LPN #1, was coming on shift while LPN #6 was coming off shift. She stated she was on the phone at the nurses' station and rushed to find out what happened. LPN #1 stated she did not witness the fall. Continued interview revealed the resident was assessed and sent out to the hospital. RN #3 revealed she did not believe the resident was a falls risk, but was not one-hundred (100) percent sure. Further interview revealed she was not aware the resident was upset over "not having" his/her mother's walker, but the concern should have been reported.

Review of Resident #20's Physical Therapy (PT) Discharge Summary, dated 08/08/2021 to 08/11/2021, revealed the resident was seen three (3) days during the 08/08/2021 Progress Period. Continued review revealed the resident presented with diagnoses that included unspecified

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dementia without behavioral disturbance, difficulty in walking, not elsewhere classified, and muscle weakness.

Continued record review of Resident #20's PT Discharge Summary revealed the short-term goal for the resident was to ambulate on level surfaces two-hundred (200) feet without an assistive device with supervision to increase independence within the facility. Further review revealed on 08/08/2021, the resident's baseline was seventy-five (75) feet with Contact Guard (having one or two hands on the resident's body, but provides no other assistance to perform the functional task, to assist with steadying the resident's body or help with balance).

Review of Resident #20's care plan revealed no documented evidence the care plan was updated to reflect the resident's level of assistance while ambulating on or off the unit, until 08/11/2021, after the resident's second fall.

Phone interview with Physical Therapist, on 08/20/2021 at 8:29 AM, revealed Resident #20 was referred to him after his/her fall on 08/07/2021. Per interview, the Physical Therapist stated the resident showed some decline and needed assistance for ambulation, per his assessment. The Physical Therapist revealed he had not worked with the resident long before he/she fell the second time. Further interview revealed the nursing staff were responsible for ensuring the recommended intervention would be care planned.

Review of Resident #20's Risk Management System (RMS) Event Summary Report, dated 08/11/2021, signed by Registered Nurse (RN) #3,

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under the section titled, "Describe the circumstances of the event and immediate actions taken", revealed the resident was walking with the activity aide and several other residents from the beauty shop in-house. Further review revealed, the resident fell and struck his/her head, sustained head laceration, and a large bruise on the inner left wrist. A cold compress and pressure applied to the resident's head. The resident was taken to the Emergency Room (ER) per EMS. Continued review revealed witnesses were the Activity Assistant and Resident #26.

Continued review of Resident #20's RMS Event Summary, dated 08/11/2021, revealed preventive measures that were in place prior to the fall was to have the bed against the wall, nursing staff to complete orthostatic blood for three (3) days related to the fall, nursing staff to encourage Resident #20 to be in common area while awake as he/she would allow, nursing to evaluate footwear to proper fitting, observe for changes in medical status, pain status, and mental status and report to MD as indicated. Toileting offered with rounding, medication evaluation, place call light within reach while in bed or close proximity to the bed, maintain a clutter-free environment and to have therapy to evaluate. Continued review revealed the resident's care plan was updated to include, assist the resident with ambulation, provide verbal cues for safety and sequencing when needed, sent to emergency room for evaluation. Continued review of the RMS Event Summary revealed the resident was minimally unsteady with ambulation. Further review revealed the root cause was resident walking at a brisk pace in the hallway without assist.

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Review of Resident #20's hospital record, dated 08/13/2021, revealed the resident was brought to the emergency room for an evaluation. The resident had significant right forehead and facial bruising. He/She was complaining of left wrist pain. There was no wrist fracture. The resident had a small right frontal subdural hematoma without any mass-effect or midline shift. Continued review revealed the resident had a nondisplaced fracture of the right orbital floor and suspected type II noontide fracture nondisplaced. The resident was admitted for observation. A follow-up CT (computed tomography scan was a medical imaging technique) scan of the head the following day showed a mild increase in subdural hemorrhage with mild mass-effect and leftward midline shift 3 mm (millimeter). Further review revealed the cervical spine CT confirm the C2 minimally displaced base odontoid fracture which was stable alignment. A collar was recommended.

Interview with Resident #26 (identified as a witness in the facility's RMS Summary), on 08/17/2021 at 4:05 PM, revealed he/she could not recall the incident related to Resident #20's fall.

Interview with Certified Nursing Assistant (CNA) #15, on 08/13/2021 at 2:43 PM, revealed she was employed through agency and had worked with the facility for the past month. Per interview, Resident #20 walked independently and shuffled his/her feet when he/she walked. She stated the resident was "really quick". CNA #15 revealed that on the day of Resident #20's second fall, on 08/11/2021, she was assisting the Activity Assistant walk a group of residents to the beauty shop. Per interview, CNA #15 stated she recalled communicating to the resident that he/she

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needed to "slow down". Per interview, the CNA stated the resident stated "ok" and slowed down. CNA #15 stated she could not recall all the residents that went to the beauty shop, which was located off the resident's unit, but recalled the residents required assistance with ambulation to the beauty shop. The CNA revealed she was on break when the residents returned from the beauty shop. CNA #15 stated this was her first time escorting the residents to the beauty shop, so was unaware how many staff it took to escort the residents off the unit.

Interview with the Activity Assistant, on 08/12/2021 at 12:08 PM, revealed he was employed by the facility. Per interview, he worked the day of Resident #20's second fall, 08/11/2021. The Activity Assistant revealed he was assisting another CNA escort the residents to the beauty shop. He stated he could not recall the name of the CNA. Interview revealed the beautician asked the Activity Assistant to escort Residents #23, #24, #26, and #27 back to the unit, along with Resident #20. The Activity Assistant stated he did not ask staff to assist him with escorting the residents back to the unit. He stated he would grab staff on the way back to the residents' unit. He further stated all the residents resided on the Homestead Unit. The Activity Assistant revealed the group continued to walk down the hall and the group had to go right. He revealed he walked next to Resident #23 and Resident #20 was walking behind him. Continued interview revealed he positioned himself in a way he could grab the resident should anything occur. He further revealed there was a place next to the Transitional Care Unit (TCU) where the nurses station transition from the wood to the carpet. He stated Resident #23 stated to Resident #20,

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"Hurry up." Per interview, the resident was told by the Activity Assistant to "slow down" and when he turned to reach for the resident, the resident had fallen on the floor. He revealed half of the resident was on the carpet and half of his/her body was on the wood floor. He stated LPN #1 responded to the fall. Continued interview with the Activity Assistant revealed that most of the time, he and another CNA would escort the residents back to the unit. He further stated, the residents were strong walkers and could walk independently. Further, the Activity Assistant revealed he was not aware of Resident #20's level of assistance needed for ambulation, adding he was not as familiar with their care plans. Further, he stated the care plans were important to have all aspects completed because the residents' needs could change and it was important to keep up with the needs of the residents.

Interview with the Assistant Director of Nursing (ADON), on 08/19/2021 at 3:16 PM, revealed she witnessed the Activity Assistant and CNA (unidentified) escorting Resident #20 to the beauty shop. Per interview, the resident struggled to keep up with the group, but she did not notice any gait concerns. Continued interview revealed the Activity Assistant normally escorted the residents without the assistance of other staff. She further revealed that with Resident #20's first fall, he/she should have been escorted to the beauty shop in a wheelchair or had additional staff with him. The ADON revealed if the residents were assessed to be an assist of one (1), then they should have an additional staff with each resident who required that level of assistance.

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Phone Interview with the Center Nurse Executive (CNE), on 08/23/2021 at 12:49 PM, revealed she communicated with therapy (date unknown) related to Resident #20's first fall. She stated she was not informed the resident displayed an "unsteady" gait. Additionally, she was not aware the resident required additional assistance when ambulating on and/or off the unit, but should have been made aware.

2. Review of the facility's policy titled, "Enhanced Patient Supervision: Continuous 1:1, revised 06/01/2021, revealed the whereabouts and well being of the residents was part of routine nursing supervision; however, a resident may require a temporary period of enhanced supervision in order to maintain his/her safety and the safety of others. Further review revealed the residents requiring enhanced supervision may include, but were not limited to, those with: head injury/neurological problems, violent behaviors pending transfers, substance abuse/withdrawal, mental distress such as acute delirium, and sexually aggressive behaviors. Further review revealed continuous 1:1 supervision would be provided per nursing judgement or when recommended by a physician/advanced practice provider (APP).

Review of Resident #19's Medical Record revealed the resident was admitted on 07/24/2020 with diagnoses that included Unspecified Dementia with Behavioral Disturbance, Psychotic Disorder with Delusions due to known Physiological Condition, Muscle Weakness, and Unspecified Fall, Subsequent Encounter.

Review of Resident #19's Quarterly Minimum

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Data Set (MDS), dated 07/27/2021, revealed the resident's assessment for a Brief Interview for Mental Status (BIMS) was incomplete. Review of the BIMS' score for 04/26/2021 revealed a BIMS score of three (3) and the facility determined the resident was severely cognitively impaired. Further review revealed Section G, Functional Status, revealed the resident was assessed to be limited assistance with one (1) person physical assist.

Review of Resident #19's Falls Comprehensive Care Plan, last review date of 08/04/2021, revealed the focus of the care plan was the resident had a history of falls related to impaired cognition, lack of safety awareness, would exit bed without staff assistance and crawl on the floor, muscle weakness as evidenced by a history of falls. The goal was for the resident not to have falls with major injury thru the next review. Some of the interventions included: bed in lowest position, fall mat to right side of bed for safety, mattress to the right side of the bed for safety due to the resident crawling out of bed every shift when in bed. Additionally, the resident was care planned to have an extensive assist of one (1) with ambulation and when up in his/her wheelchair, and the resident would be placed in the common area to increase supervision to decrease fall risk.

Review of Resident #19's, first fall, dated 05/10/2021, revealed the Risk Management System (RMS) Event Summary Report, signed by Registered Nurse (RN) #3, revealed Certified Nursing Assistant (CNA) #16 observed the resident stand up from his/her wheelchair and fall. The resident sustained a head injury. The area was cleansed and cool compress applied. The

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attending physician assessed the resident and decided to send the resident to the Emergency Room for sutures to the scalp laceration. Continued review revealed preventative measures that were in place prior to the fall included the fall mattress at the bedside. Further review revealed the root cause was that the resident's gait was unsteady. The corrective action was that the resident "may" need 1:1 supervision to prevent attempts to walk without assistance.

Review of Resident #19's Progress Notes, dated 05/10/2021, signed by RN #3, revealed the resident fell in his/her room and sustained a head injury. The resident was assessed by the Attending Physician and the Physician requested the resident be sent to the ER for suture(s) of the wound.

Review of Resident #19's Emergency Room (ER) visit, admitted on 05/10/2021, revealed the resident was treated in the ER for a fall. Review of the record revealed the resident stated he/she was attempting to ambulate to his/her bed and got his/her feet caught up on a piece of foam causing him/her to fall hitting the back of his/her head. Further review revealed the resident sustain a small laceration to the left parietal region of the scalp. Further, the laceration was repaired with one (1) staple.

Observation of Resident #19, on 08/13/2021 at 1:45 PM, revealed the resident was seated in the common area, without his/her helmet, used for fall safety. Resident #19 stated he/she did not like the helmet because it "squished" his/her head.

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Interview with CNA #16, on 08/20/2021 at 7:10 AM, revealed she was employed by the facility. Per interview, Resident #19 was care planned to be 1:1 supervision in the past. She stated the resident would often have his/her good days and bad days. CNA #16 revealed the resident would try to stand from his/her wheelchair "all the time". She further stated it would be nice if the resident remained on 1:1 supervision for the safety of the resident, adding she believed the resident "believed" he/she could walk. CNA #16 stated she worked the day the resident fell on 05/10/2021. She stated someone had taken the resident to his/her room, she could not recall, but remembered entering the dining room and believed she was working with another resident when she noticed Resident #19 sitting in his/her wheelchair. She stated she observed the resident stand from his/her chair, step on the edge of his/her mattress that was located in his/her room, to get into bed, and fell back, hitting his/her head on the wall. CNA #16 revealed the resident had his/her helmet on, but the force of the fall made the helmet come off. The resident was bleeding and thus the ambulance was called to send the resident to the hospital. Further interview with CNA #16 revealed the resident often believed he/she could walk on his/her own. Continued interview revealed Resident #19's room was changed so that the 1:1 for Resident #25 could watch the resident while in his/her room. She further stated the resident needed 1:1 supervision.

Interview with Registered Nurse (RN) #3, on 08/21/2021 at 12:04 PM, revealed she worked the day of Resident #19's first fall, on 05/10/2021. Per interview, RN #3 revealed she could not recall the details of the incident. She stated a

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written statement from CNA #16 was not obtained. RN #3 stated she recalled assessing the resident with the Attending Physician, but could not recall the environmental factors which would have caused the resident to fall. Further interview revealed that she would obtain all the information possible from the witness, but could not recall the witness mentioning anything about the mattress, adding, "I just see what was documented." She further stated the mattress as a "safety" risk would be subjective.

Interview with the Attending Physician, on 08/23/2021 at 11:21 AM, revealed she recalled Resident #19 had a fall a couple of months ago, in which the resident had to be sent out to the hospital. Per interview, she was called into the resident's room to assess the resident. She stated she recalled asking staff if the resident had his/her helmet on when he/she fell. The Attending Physician stated staff told her the resident's helmet was on, but came off during the fall. She further revealed she recalled the resident's mattress on the floor by the resident's bed. The Attending Physician stated she ended up sending the resident out for further evaluation.

Interview with CNA #17, on 08/21/2021 at 11:24 AM, revealed she was agency and worked with the facility for over a year. She revealed she was 1:1 with Resident #25. Per interview, the CNA revealed she normally did not work the unit, but was familiar with the resident. CNA #17 stated no one stated to her she would have to watch Resident #19, but since he/she was in the room, she would keep an eye on the resident. She stated if Resident #19 needed anything, she would ensure Resident #25 was safe and if so, provide needed care to the resident if needed

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She further stated that if she was busy with Resident #25, she would put on Resident #19's call light. Continued interview revealed Resident #19 was care planned for the mattress because he/she liked to roll out of bed and had episodes where the resident crawled out of bed. Continued interview revealed the resident's mattress would be placed on the floor, while the resident's bed was in it's lowest position. She further stated that when the resident was out of his/her bed, the mattress would be moved. CNA #17 stated the mattress would be removed for safety reasons.

Phone Interview with the Center Nurse Executive (NE), on 08/23/2021 at 11:03 AM, revealed staff should ensure Resident #19's mattress was up and off the floor when up and out of bed. She further stated the care plan should be followed.

Continued review of Resident #19's Medical Record revealed the resident fell again on 05/30/2021.

Review of Resident #19's Progress Notes, dated 05/26/2021, signed by Licensed Practical Nurse (LPN) #1, revealed the resident was constantly standing up and walking around without assistance. Continued review revealed the resident was getting in and out of bed. The resident was redirected by putting the resident back in his/her wheelchair, taken out of his/her room and given a snack. Redirection was successful for a time.

Review of Resident #19's Progress Notes, dated 05/29/2021, signed by LPN #1, revealed the resident was constantly getting up out of the wheelchair. The resident was transferred back in the wheelchair. The resident was redirected by

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putting the resident back in bed and removed the wheelchair out of room, because the resident had been known to transfer to the bed to the wheelchair by himself/herself.

Review of Resident #19's RMS Event Summary Report, dated 05/30/2021, and signed by LPN #1, under the section, titled, "Describe the circumstances of the event and immediate actions taken", revealed the resident was sitting in his/her wheelchair during activities. Continued review revealed the resident stood and fell. According to the report, the Activities staff witnessed the fall. The resident was assessed and Range of Motion (ROM) was performed to the upper and lower extremities. Continued review revealed a skin assessment was completed, with no injuries noted. The resident did not hit his/her head. Per the report, the witness was the Activity Assistant. The report included preventative measures that were in place prior to the fall were the fall mat to the right side of bed, bed in the lowest position, appropriate foot wear, non-skid socks, helmet on head, when restless, get up and allow to self propel, redirect resident when attempting to get up. Interventions that were implemented immediately after the fall included redirecting the resident when he/she was restless and allow to self propel or lay down when restless if resident was already up. Continued review revealed the root cause was that the resident had poor safety related to cognition. Further review revealed the corrective action was to lay the resident down after meals and allow rest periods.

Review of Resident #19's Progress Note, dated 08/14/2021 at 6:01 PM, signed by LPN #7, revealed the resident was trying to stand and

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ambulate by himself/herself. Staff redirected the resident with a phone and magazines. Continued review revealed no further behaviors were noted and the call light was in reach.

Observation of Resident #19 on the Homestead Unit, on 08/14/2021 at 10:30 AM, revealed the resident was up and seated in his/her wheelchair. Continued observation revealed the resident moved forward and attempted to stand. The State Survey Agency (SSA) Surveyor called for staff to come to assist the resident.

Interview with the Activity Assistant, on 08/19/2021 at 5:07 PM, revealed he could not recall seeing the resident standing and falling to the floor, related to the resident's fall on 05/30/2021.

Interview with LPN #1, on 08/20/2021 at 7:55 AM, revealed she could not recall the complete details of Resident #19's second fall, on 05/30/2021, but recalled the resident was seated in the common area with the Activity Assistant. She stated the Activity Assistant was doing activities with the other residents and she was on the cart. Per interview, she stated she observed the resident stand up out of his/her wheelchair, he/she took a few steps, and then landed on the floor. She stated she was not certain if the Activity Assistant saw the fall, but it happened while he was in the room. She stated she called out for the resident, and the resident fell on his/her bottom. She stated the resident did not injure his/her head.

Interview with LPN #7, on 08/14/2021 at 10:56 AM, revealed she had been employed by the facility for over two (2) months. Per interview, LPN #7 revealed she had worked with Resident

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#19. She stated the resident would get up out of his/her wheelchair, unassisted, adding, "which you saw earlier." She stated the resident liked to get up and walk. Continued interview with LPN #7 revealed she would try to keep a closer eye on the resident; however, because the resident was "quick" the resident needed 1:1 supervision. LPN #7 revealed this would be beneficial because of the resident's falls.

Interview with the Assistant Director of Nursing (ADON), on 08/19/2021 at 3:16 PM, revealed staff should not have left Resident #19 up and in his/her wheelchair without staff supervision. She further stated the resident should not have been left alone in the hallway due to the resident's known risk of falls. She revealed the staff should have brought the resident closer to the nurses station, to provide the supervision.

Phone interview with the Center Nurse Executive (CNE), on 08/23/2021 at 12:49 PM, revealed she was not aware Resident #19 tripped over his/her mattress and stated that information was not part of the Risk Management System (RMS) investigation. The CNE stated it was important to have all the information related to the residents' falls to assist with care planning for interventions. Continued interview revealed the mattress should have been removed when the resident was out of bed. Further, the CNE revealed she could not say for certain that staff would have intervened had the SSA made them aware. She stated that it would be her expectation that staff would make round at least every two (2) hours.

3. Review of Resident #21's Medical Record revealed the resident was admitted on 12/29/2019 with diagnoses that included Vascular

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Dementia with Behavior Disturbance, Major Depressive Disorder, Age-Related Osteoporosis without current Pathological Fracture, and Muscle Weakness.

Review of Resident #21's Quarterly Minimum Data Set (MDS), dated 06/03/2021, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of three (3), indicating the resident was severely cognitively impaired. Review of Section G, Functional Status, revealed the resident was assessed to be an extensive assist with two (2) persons, with transfers. Additionally, the resident was assessed to have limited assistance with one (1) person for ambulation.

Review of Resident #21's Comprehensive Care Plan, reviewed by the facility on 06/11/2021, revealed the resident was care planned for extensive assist of one (1) staff for transfers with the rolling walker. However, the MDS assessed the resident to be an extensive assist with two (2) persons assist with transfers.

Review of Resident #21's Physical Therapy (PT) Progress Report, dates of service from 05/21/2021 to 05/27/2021, revealed the resident's goal was to complete transfers with contact guard with verbal cues in order to facilitate improved functional performance. On 05/27/2021, the resident was assessed to be "moderate" assist. Continued review revealed the resident varied from transfer ability from Contact Guard Assistance (having one or two hands on the resident's body, but provides no other assistance to perform the functional task, to assist with steadying the resident's body or help with balance), Stand By Assist (the therapist stands no

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more than several steps away to prevent a fall), to moderate assist (the assistance of one (1) to two (2) staff). Further review revealed the resident exhibited poor motor planning and had increased retropulsion when attempting to stand.

Review of Resident #21's Progress Note, dated 07/29/2021, signed by the Attending Physician, revealed a follow-up note related to the resident's complaints of pain to his/her lower extremity. Further review revealed a Venous Doppler study showed no fracture. Further review of the note revealed the Venous Doppler of the left lower extremity was negative for a Deep Vein Thrombosis (DVT), a blood clot. The resident was ordered Tylenol twice (2) a day for pain to the lower extremity.

Review of Resident #21's RMS Event Summary Report, dated 08/05/2021, signed by LPN #7, revealed under the "Describe the circumstances of the event and immediate action taken", it was reported the resident was noted to have increased edema to the left lower extremity and complaints of increase pain. Continued review revealed the resident had tenderness of the lower calf area on palpation, two (2) pitting edema noted on exam. Per the review, the Attending Physician sent the resident out for an examination.

Review of Resident #21's hospital records, dated 08/05/2021, revealed the resident was brought in by EMS for painful left lower extremity that was swollen. Per review, the facility did not report trauma but were unsure whether the resident had trauma. Further review revealed the resident was diagnosed with closed fracture of the left tibial plateau. However, per interview with the

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Orthopedic Surgeon, the cause of the injury would be from a fall.

Observation of Resident #21, on 08/13/2021 at 1:35 PM, revealed the resident was sitting at the table, in his/her wheelchair with knee immobilized. The resident stated he/she fell, but could not provide any additional information related to what happen to his/her leg.

Interview with Certified Nursing Assistant (CNA) #15, on 08/13/2021 at 2:43 PM, revealed Resident #21 could become "tearful" when getting him/her out of the bed. Per interview, CNA #15 stated she only worked with the resident a handful of times. She stated the resident wore a leg brace and did fine when getting him/her in and out of bed. CNA #15 stated about a month ago, when she first started working for the facility, she was told by staff the resident was an assist of one (1). CNA #15 stated that morning, on 07/27/2021, when she attempted to get the resident out of bed, the resident was "dead" weight, and was total assist. She stated she notified her nurse, who contacted the MD.

Interview with RN #2, on 08/18/2021 at 8:18 PM, revealed she worked day shift and was with agency. Continued interview revealed, that CNA #15 came to her to assess Resident #21. She stated the resident told her, "do not touch my leg, it hurts." RN #2 stated she assessed the resident, but there was no bruising identified. Continued interview revealed an x-ray was ordered. RN #2 stated that at that time, everything came back negative. RN #2 stated she did not know how the resident fractured his/her left tibial plateau.

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Interview with Certified Nursing Assistant (CNA) #18, on 08/13/2021 at 3:34 PM, revealed she had worked for the facility a couple for months and was employed through an agency. Per interview, CNA #18 revealed she did not work the Homestead Unit all of the time. However, she was familiar with Resident #21. Per interview, CNA #18 revealed that when she had gotten to work, the day of 08/05/2021, she reached to get the resident up and noticed a bruise on his/her leg. Continued interview revealed the resident's leg was dark, from the back of his/her legs. CNA #18 stated the resident would "scream" when she would go to touch him/her, adding the resident stated, "I don't want to fall." CNA #18 stated she went and got the nurse to assess the resident. Further, she revealed the resident was sent to the hospital. Prior to the incident, CNA #18 revealed the resident was an assist of one (1) with transfers.

Interview with Registered Nurse (RN) #4, on 08/15/2021 at 8:50 AM, revealed she had worked for the facility for three (3) months and worked part-time every other weekend. RN #4 revealed she recalled the day CNA #18 called her into Resident #21's room to assess the resident. She stated the resident had a bruise on the back of his/her leg. RN #4 stated the resident was fine when she assessed her, but would say, "don't touch me, it hurts." She stated this incident occurred on 08/052021. RN #4 further stated she called the MD as she was made aware by LPN #7 that the resident expressed some concerns about a week prior. RN #4 stated she called the Attending Physician and requested to have the resident's leg x-rayed. She further stated the resident did not express any concerns or call out in pain unless his/her leg was touched. RN #4

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revealed she had never seen the resident walk independently. She stated the resident would "drag (his/her) leg" on the floor when being pushed in the wheelchair. RN #4 stated she would; however, put the resident's foot in his/her foot rest while escorting the resident in his/her chair. She stated,"If you did not do that, the resident would attempt to stop the wheelchair from being pushed."

Interview with CNA #16, on 08/20/2021 at 7:10 AM, revealed Resident #21 was capable of using his/her walker, prior to his/her knee injury. She stated that when caring for the resident, the resident would often stiffen his/her arms, adding "it made it difficult do get the resident up in the mornings. Per interview, the resident had been doing this for the past month. She further revealed the level of assistance required to transfer the resident would be one (1) assist, prior to the resident's knee injury. She revealed the resident may become hesitant to get out of bed because he/she had a fear of falling. CNA #16 revealed that for other CNAs, the resident may be an assist of two (2). CNA #16 revealed that when assisting the resident with his/her shower, the resident would "lock up" and would not "bend" his/her leg. CNA #16 revealed that if she was uncertain with the resident's level of care, she would ask the nurse or refer to the resident's care plan. She stated that when the care plan was not followed or revised, staff could injury the resident, injury themselves, or there could be falls with injuries.

Telephone Interview with the Director of Therapy (DOT), on 08/23/2021 at 12:10 PM, revealed Resident #21 required assistance with transfers. Per interview, the resident was a one (assist) with

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toileting, dressing, and required functional assist with transfers. Continued interview revealed the resident required supervision and could only ambulate two-hundred (200) feet at the time of his/her discharge from therapy, on 05/27/2021. She further stated the resident was issued a rolling walker, as well as, a wheelchair when his/her ambulation became unsafe, adding "his/her functional level depended upon the resident's level of fatigue."

Interview with the Orthopedic Surgeon, on 08/25/2021 at 2:00 PM, revealed he saw Resident #21 once, while in the hospital. Per interview, the resident had a fractured knee and the way it was cracked on the top of the joint, the only way that could happen would be a "load" or "weight" put on all at once. He stated the resident would have had to have stumbled or had a fall for such an injury to occur. He further revealed an injury such as Resident #21 would not happen just by the resident laying in bed or standing up.

4. Review of Resident #22's clinical medical record revealed the resident was admitted on 06/27/2018 with diagnoses that included Alzheimer's Disease and Type 2 Diabetes.

Review of Resident #22's Quarterly Minimum Data Set (MDS), dated 06/04/2021, revealed the resident was assessed, under Section C, "Cognitive Skills for Daily Decision Making", to be a three (3), indicating the resident was severely "cognitively" impaired and rarely made decisions. Review of Section G, Functional Status, revealed the resident required limited assistance of one (1) person assist.

Review of Resident #22's Falls Comprehensive

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Care plan, last reviewed 06/17/2021, revealed the resident's focus was that the resident was at risk for falls related to impaired cognition, lack of safety awareness, and history of falls with fracture. The goal was to have no falls with injury. Review of the resident's interventions included provide verbal cues for safety and sequencing when needed and for non skid socks when ambulating.

Review of Resident #22's Progress Notes, dated 05/26/2021 at 3:23 PM, revealed the resident was noted to constantly wander the halls and wandered into other resident's rooms. The resident was constantly redirected and reoriented to his/her room and to the dinning room area for activities. Continued review revealed the resident was distracted for a short time from wandering during meals and activities, but would begin to wander again after a few minutes.

Review of Resident #22's Risk Management System (RMS) Event Summary Report, dated 05/28/2021, signed by LPN #1, under the section "Describe the circumstances of the event and immediate actions taken", revealed bruising was noted to the resident's left back thigh, decrease mobility, inability to bear full weight to the left lower extremity. The resident was noted walking on the Homestead Unit bare foot, non skid socks placed to bare feet upon discovery. Resident #22 was sent to the Emergency Room (ER) for evaluatuation. An X- ray of the bilateral hip was completed on 05/29/2021 with negative results received and no fracture was noted. The root cause identified was non skid socks when ambulating.

Review of Resident #22's hospital records, dated

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05/29/2021, revealed the resident presented to the Emergency Department (ED) with complaints of possible right hip fracture. The resident from the nursing home reported the resident fell. Further review revealed the x-rays of the right hip were negative for acute fracture.

Observation of Resident #22, on 08/12/2021 at 11:19 AM, revealed the resident was wandering around the unit, unassisted, with one (1) sock on and the other sock off.

Interview with LPN #1, on 08/18/2021 at 7:48 AM, revealed she cared for Resident #22. Per interview, LPN #1 stated she thought the resident fell. Per interview, the resident was observed to walk with a limp. She stated the resident would even grimace and would touch his/her side as if in pain. LPN #1 stated the resident was sent to the hospital, but when the x-rays came back, they were negative for a fracture. LPN #1 revealed the facility never determined how the resident received the bruising.

Phone Interview with the Center Nurse Executive (CNE), on 08/23/2021 at 11:03 AM, revealed that per the facility's investigation, Resident #22 did not have a fall. She stated the investigation could not determine how the resident received his/her bruising. She further stated the resident may have "bumped" into something, which may have caused the bruising. Further, the CNE revealed it was important to have a complete investigation.

On 08/11/2021, the Activity Assistant, escorted five (5) residents from the beauty shop, which was off of the residents' Homestead Unit, a locked unit. These were Residents #20, #23, #24, #26, #27. The facility failed to care plan for

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these residents' level of assistance when ambulating on and/or off the unit, creating a falls risk to the residents.

5. Record review revealed the facility admitted Resident #23 on 09/08/2016, with diagnoses that included Alzheimer's Disease, Dementia, Impulsiveness, Muscle Weakness, and Altered Mental Straus.

Review of Resident #23's Quarterly Minimum Data Set (MDS), dated 05/25/2021, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of five (5), which was indicative of severe cognitive impairment. Review of Section G, Functional Status, revealed the resident was assessed to have one (1) person assist with locomotion off the unit. Review of Resident #23's Comprehensive Care Plan, last reviewed 06/07/2021, related to Activities of Daily Living (ADLs), revealed no documented evidence the resident was care planned for Locomotion/Ambulation when off the unit.

6. Review of Resident #24's medical record revealed the resident was admitted on 06/18/2021 with diagnoses that included Alzheimer's Disease, Unspecified Dementia with Behavioral Disturbance, Psychotic Disorder with Delusions Due to know Physiological Condition,Muscle Weakness, and Anxiety Disorder.

Review of Resident #24's Quarterly MDS, dated 06/24/2021, revealed the facility assessed the resident to have a BIMS score of two (2), which indicated the resident was severely cognitively impaired. Review of Section G, Functional

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Status, revealed the resident was assessed to need extensive assistance of one (1) person for locomotion/ambulation off the unit. However; review of Resident #24's Comprehensive Care Plan, last reviewed on 06/29/2021, revealed no documented evidence the resident was care planned for Locomotion/Ambulation when off the unit

7. Review of Resident #26's medical record revealed the facility admitted the resident on 03/18/2021 with diagnoses that included Unspecified Dementia with Behavioral Disturbance, and Essential Hypertension.

Review of Resident #26's Quarterly MDS, dated 06/24/2021, revealed the resident was assessed to have a BIMS score of five (5), indicating the resident was severely cognitively impaired. Review of Section G, Functional Status, revealed the resident was assessed for Supervision with no physical help from staff with locomotion/ambulation off the unit. However; review of Resident #26's Comprehensive Care Plan, last reviewed on 06/29/2021, revealed no documented evidence the resident was care planned for Locomotion/Ambulation when off the unit.

8. Review of Resident #27's medical record revealed the resident was admitted on 08/28/2018 with diagnoses that included Alzheimer's Disease, Unspecified Psychosis, Muscle Weakness, and Unspecified Dementia without Behavioral Disturbance.

Review of Resident #27's Annual MDS assessment, dated 05/01/2021, revealed the facility assessed the resident to have a BIMS

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score of fourteen (14), indicating the resident was cognitively intact. Review of Section G, Functional Status, revealed the resident was assessed to have supervision with one (1) person physical assist with locomotion/ambulation off the unit. Review of Resident #27's Comprehensive Care Plan, last reviewed on 05/05/2021, revealed the resident required a wheelchair with standard cushion, dycem under cushion and left leg rest for locomotion; however, there was no documented evidence the resident was care planned for the level of assistance needed for locomotion/ambulation when off the unit.

Interview with the Activity Assistant, on 08/12/2021 at 12:08 PM, revealed that while escorting the residents from the beauty shop, on 08/11/2021, he observed Resident #23 to "wobble" on the way back to the unit. He stated the resident did not fall. Continued interview revealed the residents were capable of walking independently, but Resident #23 required a walker. Further, he stated he was not aware of the residents level of assistance required when ambulating, but it should be care planned to provide the residents with the needed of assistance required.

Interview with Registered Nurse (RN) #3, on 08/17/2021 at 3:01 PM, revealed that when the residents' were assessed to have an assist of one (1) staff, that meant one (1) staff member would assist the resident with ambulation. Continued interview revealed one (1) staff member should not escort five (5) residents when they were assessed to be an assist of one (1). Further, RN #3 revealed she worked the Homestead Unit on the day of 08/11/2021. She stated she did not see the residents leave the unit to attend the

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beauty shop. Further, she stated the staff who escorted the residents off the unit should have notified her so that she could have provided guidance on the residents' level of assistance when ambulating. Additionally, she stated the residents' level of assistance should be care planned.

9. On 08/13/2021, observation revealed ten (10) residents sitting in the common area without staff supervision/oversight. Of the ten (10) residents observed, Residents #19, #21, and #22 were among the residents. Review of the residents' care plans revealed the residents required supervision.

Observation of the facility's common area on 08/13/2021 at 1:32 PM to 1:48 PM, revealed ten (10) residents seated in the common area listening to music. The ten (10) residents, three (3) of which included Resident #19, Resident #21, and Resident #22.

Observation of Resident #19, 08/13/2021 at 1:45 PM, revealed the resident was seated in a chair, with his/her walker close by with a straw hat on. Resident #19 stated the helmet was "squishing" his/her head.

Observation of Resident #21, 08/13/2021 at 1:33 PM, revealed the resident was seated in the common area, in his/her wheelchair at a table. He/she was wearing his/her knee mobilizers.

Observation of Resident #22, 08/13/2021 at 1:35 PM, revealed the resident wandering the unit with one non skid sock on and one off.

Interview with the Activity Assistant, on

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08/19/2021 at 5:07 PM, revealed he left the unit at 1:30 PM and staff were to provide ADL care to the residents while he was gone. He further revealed the residents should be supervised.

Interview with RN #2, on 08/19/2021 at 5:42 PM, revealed staff were available to watch the floor/common area within the unit; however, the Activity Assistant did not communicate with staff that he was leaving the unit. Additionally, she added the residents should be supervised for there safety.

Telephone interview with the Minimum Data Set (MDS) Coordinator, on 08/232021 at 10:40 AM, revealed that though today was her first day working as MDS Coordinator at the facility, she has worked with MDS for over four (4) years. The MDS Coordinator revealed the MDS Assessments drives the Care Plans for the residents. Per interview, the residents who were care planned for an assist of one (1) required the assistance of one (1) staff to assist with care. Additionally, she stated when a resident was assess for two (2) staff to assist a resident with transfers, then an assist of two (2) staff should be care planned to assist with the residents' care. Lastly, the MDS Coordinator revealed that the residents, when care planned for supervision, should have supervision/oversight.

Interview with the Assistant Director of Nursing, (ADON) on 08/19/2021 at 3:16 PM, revealed the residents should be supervised, while in the common area, to ensure the safety of the residents. Additionally, she stated the residents' level of assistance for ambulation should have been care planned.

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Phone interview with the Center Nurse Executive (CNE), on 08/23/2021 at 12:49 PM, revealed the nursing staff had not been trained to complete the RMS. She stated she or the ADON would review the RMS to gain additional information from staff and the incident. Per interview, the CNE stated it was just an informational tool for the facility to assess the residents' falls and to have appropriate interventions in place.

Continued interview with the CNE, on 08/23/2021 at 12:49 PM, revealed she was not aware of how the Minimum Data Set (MDS) worked, but believed the care plans were generated from the MDS. The CNE reviewed the resident's care plan should be reflective of the resident's care that it would not be her expectation that the staff would supervise the residents in the common area, adding it would be 1:1 if she had. Additionally, the CNE revealed it would be her expectation that staffing would complete rounding of the residents. She stated the standard would be every two (2) hours, though it was her belief the staff supervised more often.

Phone interview with the Administrator, on 08/23/2021 at 5:18 PM, revealed it would have been his expectation that staff would look at each situation differently, related to supervision.

Interview with the Vice President of Regional Operations (VPRO), on 08/24/2021 at 2:20 PM, revealed it would have been his expectation that when the nursing staff were on the unit, they would supervise the residents. Additionally, he stated that the residents' care plans should be revised and followed.