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| S 000 | Initial Comments<br><br>Annual Licensure and Certification Survey | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210b)<br>300.1210 b)4<br>300.1210c)<br>300.1210d)2)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br>4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:<br>2) All treatments and procedures shall be administered as ordered by the physician.<br>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.<br><br>These requirements were Not Met as evidenced by:<br><br>Based on observation interview and record review, the facility failed to ensure fall interventions were put in place after a resident | S9999 | | |

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| S9999 | Continued From page 2<br>(R11) at risk for falls fell. This failure resulted in R11 sustaining a right hip fracture requiring surgical intervention. The facility failed to ensure a cervical collar was applied during transfer, the facility failed to ensure a gait belt was used to transfer a resident safely, and the facility failed to ensure a resident received nectar-thick liquids as ordered. This applies to 4 of 35 residents (R11, R600, R188, R452) reviewed for falls and safety in the sample of 35.<br><br>The findings include:<br><br>1. R11's Physician Order Sheet dated 8/22 show R11 has diagnoses that include seizure, hypothyroidism and bipolar disorder.<br><br>R11's facility assessment dated 12/22/22 show R11 is moderately cognitively impaired and needs extensive assist of 2 person assist with all transfers.<br><br>R11's Fall Risk Assessment dated 12/17/22 show R11 was at risk for falls.<br><br>A Facility Reported Incident (FRI) dated 12/13/22 sent to the state agency show as initial and final, "12/12/22 at 10:30 AM, resident called out and was attended to in the room. The resident was observed lying on the floor by the bed, with call light within easy not activated by resident. When asked by the nurse what happened, resident verbalized, "I stood up trying to look for my mask and lost balance". Nurse immediately initiated assessment. Head to toe assessment performed, noted with skin tear to right elbow, resident denies hitting his head noted pain in right hip ...MD notified of incident and resident c/o of pain, STAT X-ray of the right hip was ordered ... Results came back with Acute displaced right | S9999 | | |

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| S9999 | Continued From page 3<br>femoral neck fracture. MD notified of results with order to send patient out to the hospital for evaluation and treatment ... (R11) was transported to ER via 911. Resident admitted for right hip fracture. Surgery planned 12/14/22 ...Injury acute displaced right femoral neck fracture."<br><br>R11's Emergency notes (ER) dated 12/12/22, show "80 y/o sig (significant) for developmental delay, seizure disorder CAD s/p CABG bipolar hypothyroidism who presented to ED with complaints of mechanical fall unto his right side ...He was in a wheelchair when he dropped his mask onto the floor. He bent down from the wheelchair to pick up his mask, lost his balance and fell onto his R side ..."<br><br>R11's radiology report dated 12/12/22 show R11 sustained Fracture of the right femoral neck (Right hip fracture)<br><br>R11's surgical consultation dated 12/13/22 show " the patient presents with observed fall... living in nursing home...who has pain and dysfunction in his right hip region. He was seen in the ER...X-rays taken in the ER consistent with right femoral neck fracture...He has pain with movement of the right hip ...the right hip is short and externally rotated. It was difficult to get the history, he has some developmental delay which have been life long. Plan: We will take the patient to the operating room where he was medically optimized."<br>R11 underwent surgical procedure: hemiarthroplasty of right hip.<br><br>On 1/23/23 at 1pm, R11 was sitting in his wheelchair in his room. When asked how he was doing, he said "Ok." When asked about his | S9999 | | |

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| S9999 | Continued From page 4<br>recent fall, he said he did not remember falling.<br><br>On 1/24/23 at 8:34 am, V12 (Registered Nurse/RN) said she was the nurse when R11 fell. V12 (RN) said on 12/12/22 she was at the nurses' station when she heard R11 screaming. V12 said she ran to R11's room and found R11 on the floor on his right side. V12 said R11 said he was reaching for his mask and fell. V12 said R11 had discomfort to his right hip. R11 was sent to the ER via 911. R11 fractured his right hip. V12 said R11 had surgery to fix R11's right hip. V12 said R11 has history of falling due to unassisted transfers. V12 said R11 tends to forget frequent reminders. R11 has poor safety awareness and does not ask for assistance. V12 said R11 needs frequent monitoring. V12 said R11's room is far from the nurses' station.<br><br>On 1/24/23 at 8:38 AM, V13 (Certified Nursing Assistant/CNA) said he was one of the CNAs working on 12/12/22. V13 said he heard R11 yelling for help. V13 said he went to R11's room and saw R11 on the floor. R11 said he stood up and tried to reach for something on the floor and fell. V13 said R11 has history of getting up from wheelchair without asking for assistance. R11 does not remember reminders. V13 said staff tries to make sure R11 was not transferring himself without assistance. V13 said there was no device to alarm staff when R11 was attempting to transfer.<br><br>On 1/24/23 at 8:47 am, V14 (Certified Nursing Assistant/CNA) said R11 fell trying to reach for his mask. R11 was sent to the hospital. V14 said R11 had done this in the past, trying to transfer himself without waiting for assistance. V14 said staff do their best to check and monitor R11, but staff gets busy. | S9999 | | |

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| S9999 | Continued From page 5<br><br>A fall incident dated 9/30/22 show "per resident had a fall ... his head and c/o of back pain. Resident description: I slid from the chair."<br><br>A fall incident dated 8/7/22 show "writer heard a call from resident's room, went to resident's room and noted resident lying on his left side on the floor. Resident description: Per resident he was trying to go to bed by himself lost balance and fell to the floor. "<br><br>R11's fall care plan did not show any fall interventions or necessary precautions after R11's previous falls of 9/30/22 and 8/7/22.<br><br>R11's latest care plan with revision date of 12/28/22 (only updated after R11 already had the fall with injury.) show R11 has history of falls r/t poor balance, unsteady gait, recent fall with right hip fracture with intervention to include remind resident to call for help and not to get up unassisted.<br><br>On 1/24/23 at 11:30 AM, V3 (Assistant Director of Nursing/ADON) said "reminders" do not work for R11 since R11 has developmental delay. V3 said R11 does not retain "reminders." V3 (ADON) said R11 is a fall risk due to history of unassisted transfers. V3 said unfortunately R11's care plan did not show any new evaluation and new fall interventions after R11's repeated falls due to unassisted transfers. V3 said there should be interventions for each fall that works for R11. R11's room is not visible from the nurses' stations. V3 said R11 will be moved closer to the nurses' stations, and more effective intervention has to be put into place to prevent falls and falls with injury.<br>R11's progress notes, dated 12/28/22, by V48 | S9999 | | |

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| S9999 | Continued From page 6<br>(R11's physician), confirms R11's diagnosis of having developmental delay.<br><br>The facility policy entitled Fall Risk Assessment and Prevention with revised date of 10/11/22 shows, " Purpose: to guide management of falls within (name of the facility) according to regulation and best practices for fall management to assist the IDT in reducing the risks of resident falls in the community as well as managing post fall interventions."<br><br>2. R600's Progress Note dated September 28, 2022, showed R600 sustained a "C2 (second cervical (neck) vertebrae (spine) fracture) with severe cervical stenosis and (spinal) cord edema" after a fall."<br><br>R600's Restorative Progress note dated January 23, 2023, showed R600 "wears Aspen collar (cervical collar) on at all times except for eating and bathing time for spinal precautions ..."<br><br>R600's physician order dated January 23, 2023, showed, "Precautions: Fall Risk, cervical collar on at all times except eating and drinking: spinal precautions."<br><br>On January 23, 2023, at 9:22 AM, R600 was lying in bed with no cervical collar around her neck. A cervical collar was noted on R600's bedside table. At 9:40 AM, V6 (Certified Nursing Assistant/CNA) and V7 (Certified Nursing Assistant/CNA) transferred R600, from her bed to a chair, without a cervical collar in place. At 12:20 PM, R600 was seated in her room with no cervical collar on.<br><br>On January 24, 2023, at 9:24 AM, R600 was alone in her room with no cervical collar on. | S9999 | | |

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| S9999 | Continued From page 7<br><br>On January 23, 2023, at 10:15 AM, V6 (CNA) stated, "I don't know why exactly she (R600) needs to wear that collar. I know she doesn't wear it when she eats. She is a new resident to us. She just got admitted last week."<br><br>On January 25, 2023, at 9:10 AM, V3 (Assistant Director of Nursing/ADON) stated, "R600 is to have her cervical collar on at all times except when eating or drinking. She needs it to keep her cervical spine fracture stable. She is at risk for falls. If she were to fall again, without the collar on, it could make her spine fracture worse or cause another spinal fracture."<br><br>3. R188's current care plan showed R188 was at high risk for falls due to her diagnosis of dementia and problems with her balance/gait. The care plan showed R188 required the assistance of one staff, with the use of a gait belt and walker, for all transfers.<br><br>On January 23, 2023, at 9:10 AM, V7 (CNA) transferred R188 from a wheelchair to a recliner without the use of a gait belt. V7 placed her hand on the waistband of R188's pants to assist her with the transfer.<br><br>On January 24, 2023, at 11:20 AM, V3 (ADON) stated, "A gait belt should be used for all transfers. R188 had a fall about a month ago so a gait belt should be used when transferring her."<br><br>The facility's Gait Belt/Transfers policy dated May 10, 2021, showed, "Gait belt must be used with any assisted transfer or ambulating procedure."<br><br>4. R452's electronic medical record (EMR) shows, she was admitted to the facility on | S9999 | | |

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| S9999 | Continued From page 8<br>January 20, 2023.<br><br>On January 23, 2023, at 9:34 AM, R452 was lying in bed. Her breakfast tray was on her bedside table, pushed up against the wall. She was served a regular diet of french toast, breakfast sausage, oatmeal and regular thin orange juice. There were 4 cups of water on her bedside dresser. 2 of them were regular water and the other 2 were thickened water. She had not eaten breakfast yet.<br><br>On January 23, 2023, at 10:56 AM, V49 (Occupational Therapist/OT) asked V29 (CNA) to please warm up R452's breakfast so she could eat breakfast. (lunch being served at 11:30 AM)<br><br>On January 23, 2023, at 11:15, V33 (R452's sister) was at the facility visiting her. She stated, they served her a regular diet for breakfast that morning. She had a feeding tube until Thursday last week (January 19, 2023). She was on a special diet when she left the hospital on Friday (January 20, 2023). We told them that on Friday when she was admitted. She can't eat a regular diet.<br><br>On January 23, 2023, at 11:50 AM, V29 (CNA) stated, she did not know what R452's diet order was. V29 did not have a meal ticket for R452. She had given her a regular diet this morning even though she didn't know what her diet was. She stated, she asked the nurse, but the nurse did not have "time" to look at R452's diet order. V29 felt she couldn't wait for the nurse to look so she served her a regular tray.<br><br>On January 23, 2023, at 12:03 PM, V30 (Licensed Practical Nurse/LPN) stated, she didn't know what R452's dietary orders were because | S9999 | | |

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| S9999 | Continued From page 9<br>she "didn't see anything" in the computer.<br><br>R452's order summary report provided on January 24, 2023 shows, no dietary orders were entered into the computer until Monday, January 23, 2023 (3 days after she was admitted to the facility). "Regular diet, mechanical soft texture, nectar/mildly thick consistency, seen by ST (speech therapy)."<br><br>R452's ST daily treatment note provided on January 25, 2023, shows, "Reason for referral: Dysphagia (difficulty swallowing), The patient (R452) is a 68 year old female who was admitted to the facility following hospitalization with diagnosis of CVA (cerebral vascular accident). During hospitalization, patient with increased lethargy and recommendations of NPO (nothing by mouth) with NG tube (nasogastric tube) for immediate nutrition. Increased levels of alertness noted, and video swallow study completed on 1/19/23 with diet recommendations of NTL (nectar thick liquids)/mechanical soft solids. Upon admission to the facility, no diet orders were placed in patient's chart, with staff requesting immediate SLP (speech language pathologist) evaluation to determine safest least restrictive diet..." ST was not requested to see patient until January 23, 2023 (3 days after admission and no diet orders).<br><br>On January 25, 2023, at 10:25 AM, V31 (Speech Therapist) stated that there were no orders from the hospital, but they should have still verified what her diet order was. She definitely is recommending nectar thick liquids because she is a silent aspirator (swallows liquids into her lungs) which was shown on the video swallow study. There were no orders for speech therapy either. If they would have entered orders for ST, | S9999 | | |

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| S9999 | Continued From page 10<br>we would have seen her over the weekend.<br><br>R452's hospital admission paperwork dated January 20, 2023, shows, "SLP recommendations: Compensatory swallowing strategies: Upright 90 degrees for all oral intake; remain upright for 10-30 minutes after meals; eat/feed slowly; small bites/sips; alternate solids and liquids. Recommended form of medications with puree. SLP skilled therapy needed at next level of care, YES." No ST orders were placed until January 23, 2023 (3 days after admission).<br><br>(A) | S9999 | | |