| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056288 | A. Building<br>B. Wing | 04/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hanford Post Acute | 1007 West Lacey Blvd<br>Hanford, CA 93230 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123<br><br>Based on interview and record review, the facility failed to ensure a comprehensive, person-centered care plan was developed and implemented to meet the identified needs for one of six sampled residents (Resident 4) when Resident 4 was assessed as being a fall risk, had known behaviors of standing up without staff supervision and the facility did not put a fall risk care plan with effective interventions into place to prevent falls.<br><br>This failure resulted in Resident 4 falling eight times, on 1/19/25, 1/23/25, 1/28/25 at 8:45 a.m., 1/28/25 at 3:17 p.m., 2/2/25, 2/4/25, 2/10/25 and 2/14/25 placing the resident at risk for significant injuries. (Cross reference F689)<br><br>Findings:<br><br>During a review of Resident 4 ' s Admission Record, undated, the admission record indicated, Resident 4 was admitted to the facility on [DATE] with diagnoses which included fracture (break in bone) of the skull, muscle weakness, abnormalities of gait (pattern of walking) and mobility (ability to move freely), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), cognitive (relating to the mental process involved in knowing, learning, and understanding) communication deficit (communication difficulty caused by cognitive impairment), cerebral infarction (condition where blood flow to the brain is blocked, causing brain tissue damage), nontraumatic intracerebral hemorrhage (bleeding occurs within the brain tissue), traumatic subdural hemorrhage (collection of blood between the brain and inner layer of skull) and traumatic subarachnoid hemorrhage (type of stroke) with loss of consciousness (state of being awake).<br><br>During a review of Residents 4 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 4 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 09 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 4 ' s cognition was moderately impaired.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/3/25 at 2:56 p.m. with CNA 6, CNA 6 stated she was familiar with Resident 4 and had taken care of him prior to his discharge. CNA 6 stated Resident 4 was very confused, difficult to communicate with and impulsive. CNA 6 stated Resident 4 was very weak and unable to stand safely by himself but had behaviors of standing up suddenly and falling. CNA 6 stated Resident 4 was very confused and did not realize how weak he was and that it was not safe for him to stand on his own. CNA 6 stated at Resident 4 was on every 15-minute checks but still had falls. CNA 6 stated Resident 4 would have required one on one (1:1) supervision (constant staff supervision) to prevent him from falling.<br><br>During a concurrent interview and record review on 4/3/25 at 3:29 p.m. with LVN 2 Resident 4 ' s falls were reviewed. The falls were as follows:<br><br>1/19/25-Resident fell trying to get off bed<br><br>1/23/25-Resident fell getting out of wheelchair<br><br>1/28/25-8:45 a.m. Resident found on floor<br><br>1/28/25-3:17 p.m. Resident found on floor<br><br>2/2/25-Resident on floor, dragging self out of room asking staff to put him into wheelchair<br><br>2/4/25-Resident fell getting up from wheelchair across from nurses ' station<br><br>2/10/25-Resident fell in dining room<br><br>2/14/25-Resident fell across from nurses ' station<br><br>LVN 2 stated Resident 4 was at high risk for falls because he had non-compliant behaviors, was constantly trying to get up unsupervised, had weak legs and poor balance. LVN 2 stated Resident 4 ' s primary language was not English which caused some communication issues. LVN 2 stated she thought he could understand the reminders to call for help but could not retain it due to cognition. LVN 2 stated Resident 4 was stubborn and would continue to do what he wanted to do even if it was not safe. LVN 2 stated Resident 4 was never placed on 1:1 supervision, and the only way to prevent falls would have been for staff to always stay with the resident. LVN 2 stated she would keep the resident close to the nurse ' s station when she was sitting there, and he did not fall when she had him under constant supervision because she could redirect him quickly. Resident 4 ' s fall risk scores (0-8 low risk, 9-15 moderate risk, 16-42 high risk) were reviewed. Resident 4 ' s fall risk scores were reviewed as follows:<br><br>1/17/25 score 10, moderate risk for falls<br><br>1/23/25 score 14, moderate risk for falls<br><br>1/28/25 score 22, high risk for falls<br><br>1/28/25 score 20, high risk for falls<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2/4/25 score 20, high risk for falls<br><br>2/10/25 score 20, high risk for falls<br><br>2/14/25 score 22, high risk for falls<br><br>LVN 2 stated Resident 4 was a moderate risk for falls when he was admitted but his fall risk increased as he continued to have falls. Resident 4 ' s care plans were reviewed, LVN 2 stated she was unable to locate any fall risk care plan interventions before his first fall on 1/19/25. LVN 2 stated there were no fall prevention interventions in the care plan until his fall on 2/4/25. LVN 2 stated Resident 4 was on hourly checks, but it was not documented on the care plan and should have been. LVN 2 stated care plans were important because they direct the resident ' s care. LVN 2 stated care plans were used to involve the residents in their care, indicate what interventions are needed to meet their needs, included details about the resident ' s life including the treatments provided and physician ordered interventions.<br><br>During a telephone interview on 4/4/25 at 7:50 a.m., with Family Member (FM) 2, FM 2 stated he was Resident 4 ' s responsible party. FM 2 stated Resident 4 had frequent falls while at the facility and he did not feel like the facility did enough to prevent the resident ' s falls. FM 2 stated Resident 4 was agitated which caused him to stand up frequently and then he would fall, but he did not feel like the facility addressed the issue and the resident kept falling.<br><br>During a concurrent interview and record review on 4/4/25 at 9:12 a.m. with the Assistant Director of Nursing (ADON), the ADON stated Resident 4 was a resident at the facility for one month. The ADON stated, he had a few falls. I ' m not sure how many. Resident 4 ' s fall risk care plan was reviewed. The care plan indicated, . Resident is at risk for falls with or without injury . unwitnessed fall on 1-19-25 . witnessed fall on 1-23-25 . witnessed fall 2/4/25 . Unwitnessed fall 2/10/25 . Unwitnessed fall 2/14/25 . Date initiated 1/17/2025 . Will minimize risk for falls to extent possible . Date initiated: 2/4/25 . Add sensor pad [a device used to monitor patients to ensure they do not rise from the bed or chair on their own to reduce falls] to bed and wheelchair . Date initiated: 2/04/25 . Add to B&B [bowel and bladder program-scheduled toileting] Q [every] 2 hours . Anticipate and meet needs . falling star program . Keep bed in low position with brakes locked . Keep call light within reach . Keep personal items frequently used within reach . Non skid material [flexible material used to prevent slipping] to w/c [wheelchair] . The ADON stated she was unable to find a fall risk care plan with interventions before 2/4/25. The ADON stated Resident 4 did not have a fall risk care plan started on admission. The ADON stated it was her expectation for a fall risk care plan to be implemented on admission to prevent resident falls. The ADON stated care plans were used to provide person-centered care for each resident and should have measurable objectives and the interventions reflecting the residents ' abilities to perform ADLs and transfers. The ADON stated the cause of Resident 4 ' s falls was his need to get up. The ADON stated Resident 4 ' s need for supervision was not addressed on the fall risk care plan. The ADON stated Resident 4 was not safe to stand up without assistance.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility ' s policy and procedure (P&P) titled Care plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, . A comprehensive, person-centered care plan should include measurable objectives and timetables to meet a resident ' s physical, psychosocial and functional needs . A comprehensive, person-centered care plan should be developed within the seven (7) days of the completion of the required MDS assessment . Describe the services that are to be furnished in an attempt to assist the resident attain or maintain that level of physical, mental, and psychosocial wellbeing . When possible, interventions should address the underlying source(s) of the problem . The interdisciplinary team should review and updates the care plan .<br><br>The facility ' s policy and procedure (P&P) titled Falls and Fall Risk, Managing, dated 2/2018 was reviewed. The P&P indicated, . the staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling . Environmental factors that contribute to the risk of falls . footwear that is unsafe or absent . Resident conditions that may contribute to the risk of falls . cognitive impairment . lower extremity weakness . functional impairments . Medical factors that contribute to the risk of falls . neurological disorders . balance and gait disorders . implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls . If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant . If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling . or until the reason for the continuation of the falling is identified as unavoidable . staff will monitor and document each resident ' s response to interventions intended to reduce falling . If the resident continues to fall, staff will re-evaluate the situation .<br><br>The facility ' s P&P titled Care Planning-Interdisciplinary Team, dated 3/2022, the P&P indicated, . interdisciplinary team is responsible for the development of resident care plans . Resident care plans are developed according to the timeframes and criteria established . Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team .<br><br>The facility ' s P&P titled Falls and Fall Risk, Managing, dated 2/2018 was reviewed. The P&P indicated, . the staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling . Environmental factors that contribute to the risk of falls . footwear that is unsafe or absent . Resident conditions that may contribute to the risk of falls . cognitive impairment . lower extremity weakness . functional impairments . Medical factors that contribute to the risk of falls . neurological disorders . balance and gait disorders . implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls . If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant . If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling . or until the reason for the continuation of the falling is identified as unavoidable . staff will monitor and document each resident ' s response to interventions intended to reduce falling . If the resident continues to fall, staff will re-evaluate the situation . |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38961<br><br>Based on interview and record review, the facility failed to ensure residents receive necessary treatment and care in accordance with facility's policies and procedures and professional standards of practice for one of thirteen residents (Resident 12) when Resident 12 who had a known history of constipation, with infrequent bowel movements and refusing continence care for several days and nursing staff did not notify the doctor and implement interventions to prevent complications.<br><br>This failure resulted in Resident 12 experiencing avoidable impaction of stool, life-threatening symptoms of altered mentals status and low blood pressure that required transfer to higher level of care to an acute care hospital where the emergency department (ED- is the part of the hospital where patients get treated for serious or sudden health problems) physician digitally removed 2.205 pounds of hardened stool. Resident 12 was treated for acute septic shock (is a severe, life-threatening form of sepsis characterized by dangerously low blood pressure and organ dysfunction due to an infection),admitted to the intensive care unit 3/6/25 and later the same day passed away.<br><br>Findings:<br><br>During a review of Resident 12's Admission Record (AR- a document containing resident medical and personal information), undated, the AR indicated, Resident 12 was admitted to the facility on [DATE] with diagnoses which included Parkinsonism (a brain disorder that makes it hard to control body movements), Adult Failure to Thrive (a medical condition characterized by a decline in physical and cognitive function, often including weight loss, decreased appetite, and a general lack of vigor), abnormalities of gait (a condition characterized by walking in an unusual or unsteady way), Osteoarthritis (is a condition when the cushion between the bones breaks down and the bones rub together and the joints hurts and become stiff) and constipation (fewer bowel movements (BM) or the stool is hard, dry and painful).<br><br>During a review of Resident 12's Minimum Data Set (MDS- a standardized assessment tool used in nursing homes) assessment dated [DATE], The MDS Section GG (focuses on assessing a resident's functional abilities, particular in areas of self-care and, mobility) indicated Resident 12 was not capable of going to the toilet and was dependent with staff with activities of daily living (ADLs). The MDS Section H (focuses on Bladder and Bowel health- This section is crucial for assessing resident's continence status) indicated Resident 12 could not control her Bladder (the part of the body that holds urine) and Bowel (the part of the body responsible for storing and eliminating stool) and was not on an incontinent program (it's a plan to help residents go to he bathroom more regularly or with assistance).<br><br>During a review of Resident 12's Brief Interview of Mental status assessment (BIMS - a test used in the nursing homes to check how well a resident is thinking and remembering things) dated 2/16/25, Resident 12's BIMS score was 13 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 12 was cognitively intact (thinking, memory, and understanding are normal).<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 12's Progress Notes (PN), dated 3/6/25 the PN indicated, .upon med pass [medication administration] writer noted to be unresponsive and lethargic resident [Resident 12] unable to verbalize what was wrong writer obtained vitals [BP] 89/50, [HR] 60, [RR] 17, [Temperature] 97.3 writer notified [name of doctor] via phone new order to be sent out to [name of acute hospital] for further evaluation for AMS [altered mental status] orders noted and carried out care plan updated RP [Responsible Party] notified.<br><br>During a review of Resident 12's Acute Care Hospital (ACH) document titled, ED [Emergency Department-is a part of the hospital where people go when they need urgent medical help] Physicians Notes (EDPN), dated 3/6/25, at 1:25 a.m. The EDPN indicated .patient is a 78 y.o. [year old] female . presents to the ED with altered mental status and Hypotension (Low Blood Pressure) . During the initial triage vital signs taken at the ED, resident was noted with a Blood Pressure (BP-how hard your blood is pushing inside your body when it moves through your veins and arteries) 62/50, Heart Rate (HR-how fast of slow the heart is beating) 139, Respirations Rate (RR-how fast you're breathing) 26, and Oxygen Saturation (how much oxygen your blood is carrying to your body) of 93% . During an evaluation by the ED physician, he noted resident had a high probability of imminent (likely to happen soon) or life-threatening deterioration due to the low B/P . CT (Computed tomography- medical device that takes picture of the inside of the body, like brain, lungs, or bones, so the doctor can see of anything is wrong) was performed and indicated the lung bases were poorly seen due to severe distention (swelling ) with abundant fecal material (stool) in the left colon (part of the large intestine) .a massive digital (using fingers) removal of feces [stool] procedure on this patient after giving 4 mg [milligrams-unit of measurement] morphine (a drug used to treat moderate to severe pain) IV [intravenous - when medicine or fluids are given through a needle or tube directly into a vein] .massive amounts of stool was coming up the vagina and out of the rectum[IL7] (It is where the body stores stool before a person is ready to have a bowel movement) .physician noted to have removed 1000 g (grams) (unit of measure) 2.205 pounds of hard rocky poop [stool] .Patient [Resident 12] is s/p [status post] fecal disimpaction (removing hard, stuck stool) 1 kg [kilogram- unit of measurement] [2.205 pounds] of fecal [stool] matter evacuated . While initially responsive to 1.5L [liters-unit of measurement] bolus (a quick large dose of medication or fluids directly into a vein through an IV) patient quickly decompensated (the body or an organ is no longer able to cope of function properly after trying to manage a problem for a while) . These findings suggest poor prognosis (low chances of recovery) . after speaking with patient's son, [name of son] and daughter, explaining the patient's current prognosis along with her status, family would like to change the patient's code status (tells healthcare worker what to do if a patient's heart stops or they stop breathing) to DNR/DNI [Do not Resuscitate -do not try to bring them back if a the heart stops beating or they stop breathing]/ [Do not intubate - if a person has trouble breathing, they don't wasn't a breathing tube] . on 3/6/25 at 12:55 p.m. resident passed away under comfort care (keeping a patient comfortable at end of life) .Cause of Death, Septic Shock and colitis[IL8] (inflammation of the colon) .<br><br>During a concurrent interview and record review on 3/24 /25 at 11:40 a.m. with the Assistant Director of Nursing (ADON), Resident 12's Bowel Continence (BC), dated 2/2025 and 3/2025 was reviewed. The BC indicated,<br><br>On 2/23/25 at 1:59 p.m. and 9:34 p.m. Resident 12 refused care.<br><br>On 2/24/25 Resident 12 refused care.<br><br>On 2/25/25 at 9:59 p.m. and 10:58 p.m. Resident 12 had no BM.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 2/26/25, 2/27/25, 2/28/25, 3/1/2025, 3/2/25 Resident 12 refused care. The ADON stated stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>On 3/3/25 at 5:20 a.m. Resident 12 had no BM, and at 1:52 p.m. and 9:59 p.m. Resident 12 refused care. The ADON stated stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>On 3/4/25 at 3:52 a.m. Resident12 had incontinence [urine and bowel], and at 1:51 p.m. and 9:59 p.m. Resident 12 refused care. The ADON stated stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>The ADON stated, they did not know how often or how much Resident 12 was having BM.<br><br>The ADON stated they could not accurately track Resident 12's BM because she often refused brief changes. The ADON stated Resident 12 did not have regular BM that staff could track by shift or daily, which put Resident 12 at risk for constipation and impaction. The ADON stated the staff did not inform the doctor about Resident 12's repeated refusals or the lack of BM. The ADON stated Resident 12 was not put on a bowel protocol (a standardized guidelines designed to prevent and manage constipation and promote regular bowel movement). The ADON stated we did not know Resident 12 was constipated. The ADON stated constipation, and impaction could cause serious health problems, like confusion, low BP, and severe infection. The ADON stated these conditions were life-threatening and may lead to death.<br><br>During a concurrent interview and record review on 4/21/25 at 12:05 p.m. with License Vocational Nurse (LVN) 2, Resident 12's Bowel Continence (BC), dated 2/2025 and 3/2025 was reviewed. The BC indicated:<br><br>On 2/23/25 at 1:59 p.m. and 9:34 p.m. Resident 12 refused care. LVN 2 stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>On 2/24/25 Resident 12 refused care. LVN 2 stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>On 2/25/25 at 9:59 p.m. and 10:58 p.m. Resident 12 had no BM. LVN 2 stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>On 2/26/25, 2/27/25, 2/28/25, 3/1/2025, 3/2/25 Resident 12 refused care. LVN 2 stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 3/3/25 at 5:20 a.m. Resident 12 had no BM, and at 1:52 p.m. and 9:59 p.m. Resident 12 refused care. LVN 2 stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>On 3/4/25 at 3:52 a.m. Resident12 had incontinence [urine and bowel], and at 1:51 p.m. and 9:59 p.m. Resident 12 refused care. LVN 2 stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>LVN 2 stated Bowel Continence section was where the Certified Nursing Assistant would document Resident 12's bladder and bowel movement and incontinent care. LVN 2 stated she was the License Nurse assigned to care for Resident 12 on 2/28/24, 3/1/24, and 3/2/25. LVN 2 stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth. LVN 2 stated Resident 12 was on a stool softener medication that could be given as needed, she did not give it because she could not confirm if Resident 12 had a BM. LVN 2 stated Resident 12 was alert, knew what was going on, and could make her own decisions. LVN 2 stated they respect Resident 12's right to refused care. LVN 2 stated she tried three times to get Resident 12 to accept care, but the Resident 12 kept on refusing. LVN 2 stated she told the Physician, but she did not document that she has done so. LVN 2 stated she should have documented. LVN 2 stated it was important to notify the physician and document to keep Resident 12 safe. LVN 2 stated unfortunately, Resident 12 chose not to receive care and refused to be checked for a BM. LVN 2 stated the physician knew about Resident 12's refusal and did not give any new orders.<br><br>During an interview on 4/21/25 at 1:50 p.m. with CNA 12, CNA 12 stated she was the CNA assigned to Resident 12 the day she was sent out to the hospital on 3/6/25. CNA 12 stated she checked on Resident 12 every two hours and encouraged her to accept care but Resident 12 still refused. CNA 12 stated it was difficult to know if Resident 12 had a bad BM because Resident 12 did not allow anyone to touch her. CNA 12 stated she told the nurse, and the nurse would talk to Resident 12, but Resident 12 still refused care. CNA 12 stated Resident 12 refused to be checked for toileting, hygiene, and bowel movement. CNA 12 stated no assessment was conducted to check if Resident 12 had bowel movements or is she had abdominal distention.<br><br>During an interview on 4/21/25 at 2 p.m. with the Physician, the Physician stated Resident 12 was alert, aware, and able to make her own decision. The Physician stated Resident 12 refused care, and the license nurse did inform him and did not give any new orders. The Physician stated if a resident refuses care, there was nothing he could do. The Physician stated Resident 12 refused care and had the right to refuse essential care. The Physician stated forcing care could lead to a lawsuit for assault. The Physician stated there was no meeting held with Resident 12, family, and the facility to talk about Resident 12's goals of care. The Physician stated the facility did not arrange goals of care meeting because no one asked for one, and Resident 12 sometimes accepted care. The Physician stated it was hard to prevent the impaction because Resident 12 kept on refusing care.<br><br>During a concurrent interview and record review on 4/21/25 at 2:15 p.m. with Certified Nursing Assistant (CNA) 10, Resident 12's Bowel Continence (BC), dated 2/2025 and 3/2025 was reviewed. The BC indicated:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 2/23/25 at 1:59 p.m. and 9:34 p.m. Resident 12 refused care. CNA 10 stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>On 2/24/25 Resident 12 refused care. CNA 10 stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>On 2/25/25 at 9:59 p.m. and 10:58 p.m. Resident 12 had no BM. CNA 10 stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>On 2/26/25, 2/27/25, 2/28/25, 3/1/2025, 3/2/25 Resident 12 refused care. CNA 10 stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>On 3/3/25 at 5:20 a.m. Resident 12 had no BM, and at 1:52 p.m. and 9:59 p.m. Resident 12 refused care. CNA 10 stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>On 3/4/25 at 3:52 a.m. Resident12 had incontinence [urine and bowel], and at 1:51 p.m. and 9:59 p.m. Resident 12 refused care. CNA 10 stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>CNA 10 stated she had worked at the facility for three years. CNA 10 stated she was assigned to care for Resident 12 on 2/28/25 and 3/1/25. CNA 10 stated on those days, Resident 12 refused to be checked for BM and refused to be changed. CNA 10 stated she told the nurse about Resident 12's refusal. CNA 10 stated the nurse spoke to Resident 12, but Resident 12 still refused. CNA 10 stated she did not know if Resident 12 had a BM on those dates because staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>During an interview on 4/21/25 at 2:30 p.m. with CNA 13, CNA 13 stated she had worked at the facility for [AGE] years. CNA 12 stated she was familiar with Resident 13. CNA 13 stated Resident 13 often refused diaper changes, getting dressed, and taking showers. CNA 13 stated Resident 13 had been like that since she was admitted to the facility. CNA 13 stated Resident 13 was alert and aware of what is going on. CNA 13 stated Resident 13 needed staff help with all her daily activities. CNA 13 stated nurses would talk to Resident 13, but she would still refuse care. CNA 13 stated it was hard to know if Resident 13 had a BM because she refused to be checked. CNA 13 stated it was the first time she heard Resident 13 had a stool impaction.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 4/23/25 on 3:13 p.m. with the Director of Nursing (DON), the DON stated she started working as the DON in February 2025. The DON stated she was aware of Resident 12's refusal with care. The DON stated Resident 12 was alert and oriented, and the facility respects her right to refuse essential care. The DON stated they tried to contact the family and have a meeting, but the family declined. The DON stated when residents refuse care, staff talk to them and explain the benefits of care. The DON stated they also notify the doctor about the resident's refusal. The DON stated she believes there was an Interdisciplinary Team Meeting (IDT- a group of healthcare professional from different disciplines who work together to plan and coordinate care for resident). The DON stated staff did not check if Resident 12 had bowel movements, abdominal distention and did not check her abdominal girth.<br><br>During a review of the facility document titled, IDT CONFERENCE NOTES (ICN), dated 6/12/22, the ICN indicated, . Quarterly . List of risk factors . Impaired mobility, B&B [bladder and Bowel] incontinence, . impaired cognition . Activities . Refuses group participation and individual activities . present in today's CC [conference call] via phone DPOA [durable power of Attorney- a person who is legally chosen to make decisions on behalf of someone else, if the person becomes unable to make decisions on their own] [name] and [name]. Topics discuss or residence refusal of care and non-compliance with bathing, and refusals to get out of bed. [Name] stated his mother has always had a great hygiene and does not understand why such a change in behavior. [name] stated he had been estranged from resident for almost [AGE] years. [name] and [name] are new DPOA . SSD visits resident often to encourage her to allow staff to assist her with her ADL's and to bathing regularly .<br><br>During a review of the facility's Policy and Procedure titled Refusal of Treatment dated, 05/2013, the P&P indicated, Our facility shall honor a resident's request not to receive medical treatment as prescribed by his or her physician, as well as care routines outlined on the resident's assessment and plan of care . Policy Interpretation and Implementation The resident is not forced to accept any medical treatment and may refuse specific treatment even though is prescribed by a physician . Treatment is defined as care provided for purposes of maintaining/restoring health, improving functional level, or relieving symptoms . If a resident refuses treatment, the Unit Manager, Charge Nurse, or Director of Nursing Services will interview the resident to determine what and why the resident is refusing in order to try to address the resident's concerns and explain the consequences .The Care Plan Team will assess the resident's needs and offer the resident alternative treatments, if available and pertinent, while continuing to provide other services outlined in the care plan . If the resident's refusal brings about a significant change, a reassessment will be made, and such information will be incorporated into the resident's care plan . Should the resident refuse to accept treatment, detailed information relating to the refusal must be entered into the resident's medical record .Documentation pertaining to a resident's refusal of treatment shall include at least the following:<br><br>a. The date and time the staff tried to give a medication or treatment was attempted.<br><br>b. The medication or treatment refused.<br><br>c. The resident's response and reason(s) for refusal;<br><br>d. The name of the person attempting to administer the treatment;<br><br>e. That the resident was informed (to the extent of their ability to understand) of the purpose of the treatment and the consequences of not receiving the medication/or treatment;<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | f. The resident's condition and any adverse effects due to such refusal;<br><br>g. The date and time the physician was notified as well as the physician's response;<br><br>h. All other pertinent observations; and<br><br>i. The signature and title of the person recording the data .<br><br>The Attending Physician must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the refusal .<br><br>During a review of the professional reference titled The Refusing Resident: Risk Management Principles from https://www.caringfortheages.com/article/S1526-4114(17)30261-5/fulltext, dated 7/2017 the Professional reference indicated, The Right to Refuse. Residents in a SNF (Skilled Nursing Facility) have the right to consent to or to refuse any treatment or procedure, even to the detriment of their health. This right to refuse is juxtaposed (placing two or more things side by side, often to compare or contrast them and highlight their differences or similarities) with the facility's duty to help each resident attain or maintain the highest practicable physical, mental, and psychosocial well-being and to ensure that the resident's condition does not decline unless it is medically unavoidable . If the resident refuses specific treatments, the attending physician and facility staff should document all steps that were taken to address the resident's concerns and alternatives that were offered. The facility also needs to assess the resident for decision-making capacity. Once capacity is assessed, the facility is expected to determine and document what the resident is refusing, to assess the reasons for the resident's refusal, to advise the resident about the consequences of refusal, to offer pertinent alternative treatments, and to continue to provide all other appropriate services . It is generally the attending physician's determination as to whether a resident has decision-making capacity. In complex or ambiguous cases, a mental health professional (psychiatrist or psychologist) may be asked to weigh in . In the case of a refusing resident, the facility should not only document every incident of a refusal (or noncompliance/nonadherence), but also take the extra steps to conduct a timely interdisciplinary team (IDT) meeting; communicate with the attending physician and conduct a care conference with the family, documenting all the efforts made by the facility and the care team to try to render care; and encourage compliance and consider alternatives - in addition to explicitly stating the risks of continued refusals . Best Practices . Documentation is key when caring for a resident who is refusing treatment and that refusal leads to a deterioration in condition. The facility should document the following:<br><br>The resident's capacity to make decisions.<br><br>What the resident is refusing<br><br>The reasons for refusal, if known.<br><br>Advising the resident/responsible party about consequences of refusal.<br><br>Offering pertinent alternative treatments.<br><br>Continuing to provide all other appropriate services.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Attention to documentation may not prevent a lawsuit, but it will provide the facility with the best defense possible, with the goal of minimizing the risk involved .<br><br>During a review of the professional reference titled, Fecal Impaction, dated 7/2023, indicated, Fecal impaction occurs because of hardened fecal matter retained in the large bowel which cannot be evacuated by regular peristaltic activity. If this is not recognized and treated early, it can give rise to the formation of fecoliths, or stone-like feces. Fecal impaction is a cause for increased morbidity (the condition of suffering from a disease or medical condition) and a significant cause of a decrease in quality of life among the elderly. This activity reviews the causes, pathophysiology [is the study of how the disease starts] and presentation of fecal impaction and highlights the role of the interprofessional team in its management.<br><br>Objectives:<br><br>Review the causes of fecal impaction.<br><br>Describe the evaluation of a patient with fecal impaction.<br><br>Summarize the treatment options for fecal impaction.<br><br>Explain modalities to improve care coordination among interprofessional team members in order to improve outcomes for patients affected by fecal impaction[IL36] .<br><br>. Fecal impaction commonly occurs among elderly individuals, rarely presenting as an acute emergency to a hospital. Severe constipation is a significant problem that affects almost 70% of elderly people who are under care in nursing homes. Among those affected, about 7% will have the condition detected during a digital rectal examination. Fecal impaction is more common among older women who are in institutional care and have associated neuropsychiatric disorders. It is a cause for increased morbidity among the elderly, and if allowed to progress, this can lead to complications causing mortality (death) in the older age group . Physical examination findings often reveal a distended abdomen. In thinly built or emaciated individuals, hard fecal mass masses may be palpable along the colon. Occasionally, patients may also present with a spurious or overflow diarrhea. The diagnosis of fecal impaction is primarily based on clinical signs. A detailed history of bowel habits and a full physical examination which includes a digital rectal exam is mandatory . Prognosis Fecal impaction is a significant but preventable problem in the elderly population within hospitals and other institutions. The best way to treat it is to prevent it from developing in the first place. The cause of constipation should be identified early and managed appropriately. The patient should be educated about lifestyle measures and dietary habits to prevent fecal impaction. Unfortunately, recurrent fecal impaction is very common in elderly and institutionalized patients. Often these patients present to the emergency department because the presenting symptoms can mimic other sinister intestinal pathology . The key to successful management of fecal impaction is a preventive and active management strategy with early recognition of severe constipation and prompt intervention to prevent the occurrence of fecal impaction. This proactive approach will prevent morbidity as well as increase the quality of life among the elderly and hospitalized patients .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of the professional reference titled, Significant morbidity and mortality associated with fecal impaction in patients who present to the emergency department from https://pmc.ncbi.nlm.nih.gov/articles/PMC6499648/#:~:text=A%20systematic%20review%20of%20FI,of%20case%20reports%20(10) titled, dated 12/2018 indicated, .Fecal impaction (FI) is defined by a large mass of stool in the rectum and/or colon that is unable to be evacuated . FIs are most common in the elderly population and become more prevalent with increasing age (3,4). In 2011, there were over 42,000 emergency department (ED) visits for FI, with 85+ and 65-[AGE] year age groups having the highest and second highest visit rates, respectively, relative to all ED visits in each age group (5). FIs are particularly prevalent in the institutionalized [a person living in a structured setting] elderly . A high rate of mortality has been linked with FI, often due to the complications occurring in elderly and chronically ill patients (11). A systematic review of FI reported that death occurred secondary to FI complications in 29% of cases (10) . Treatment for FI includes use of digital disimpaction, enemas, suppositories, and oral laxative regimens (3,11). For at-risk or refractory patients, preventative strategies like use of stool softeners or reduction in use of constipating medications are known to reduce FI incidence (11) .<br><br>[ |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38961<br><br>Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistance to prevent falls for two of six sampled residents (Residents 1 and 4) when:<br><br>1. Nursing staff were aware of Resident 1's cognitive impairment (difficulties with mental processes such as memory, attention, reasoning, and decision making), poor safety awareness, impulsive behaviors of getting up from bed without using the call light, history of falls, and did not implement effective interventions to prevent falls.<br><br>These failures resulted in Resident 1 suffering avoidable falls on the following dates: 9/30/24, 11/5/24, 12/9/24, 12/16/24, 12/18/24, and 2/1/25. and placed the resident at risk for injury, pain. and suffering. These failures resulted in Resident 1's experiencing five unwitnessed falls prior to the avoidable fall on 2/1/25 with injury, sustaining a (laceration (cut in the skin caused by an injury) above the left eyebrow requiring transportation to the emergency department (ED) for sutures (a row of stitches holding together edges of a wound) and avoidable pain and suffering. Resident 1 had two additional avoidable falls. Resident 1 had a unwitnessed fall in his room on 3/11/25 sustaining a laceration to the forehead which required transportation to the emergency department for evaluation and a additional fall in his room on 3/12/25 opening the same area to his forehead and required transportation back to the emergency department for repair. Resident 1 was diagnosed with a subdural hematoma (pool of blood between the brain and its outermost covering) measuring up to 11 mm (millimeters) (unit of measure) in thickness. Resident 1 passed away on 3/17/25 at ACH from his injuries related to the fall on 3/12/25.<br><br>2. Resident 4 was assessed as being a fall risk, had poor safety awareness, impulsive behaviors of standing while unattended and multiple falls and the facility did not implement effective interventions to prevent falls, including adequate supervision consistent with the resident's needs, goals and care.<br><br>This failure resulted in Resident 4 falling eight times in 30 days, placing him at risk for significant injuries and/or death.<br><br>Findings:<br><br>1. During an observation on 2/13/25 at 8:15 a.m., in Resident 1's room, Resident 1 was lying in bed with eyes closed. Resident 1 had a sutured laceration above his left eye. Resident 1's bed was in low position, fall mat on the floor next to bed on left side, no fall mat on right side. Call light within reach. No staff present in the room.<br><br>During a review of Resident 1's Admission Record (AR- a document containing resident medical and personal information), undated, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia[CE2] (a group of symptoms that affect memory, thinking, and social abilities), abnormalities of gait and mobility, and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Residents 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 10 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1's cognition was moderately impaired.<br><br>During a review of the Acute Care Hospital (ACH) document titled, Emergency Department Report, dated 2/1/25, the note indicated . patient is a 93 y.o. [year old] male . presents to the ED [emergency department] after fall. Per skilled nursing facility, patient had an unwitnessed ground level fall in his room between his bed and bathroom door .3-centimeter (unit of measure) (cm) linear (straight line) wound located on the face . Left eyebrow laceration was repaired . follow up for wound check and suture removal .<br><br>During an interview on 2/13/25 at 9:35 a.m. with Certified Nurse Assistant, (CNA) 1 CNA 1 stated she had provided care for Resident 1 before and was familiar with him. CNA 1 stated Resident 1 was a high fall risk because he would get out of bed and stand without assistance. CNA 1 stated attempts to redirect Resident 1 or remind him to use the call light were not successful because the resident was disoriented and did not remember. CNA 1 stated, Resident 1 does not use his call light when getting out of bed and was not safe to get out of bed by himself. CNA 1 stated, Resident 1 was unsteady on his feet and needed supervision when standing.<br><br>During an interview on 2/13/25 at 9:50 a.m. with CNA 2, CNA 2 stated she knew Resident 1 and had provided care for him before. CNA 2 stated, Resident 1 would wake up and try to get up out of bed without using the call light to ask for help. CNA 2 stated, Resident 1 was unsteady on his feet and needed supervision when walking.<br><br>During an interview on 2/13/25 at 10 a.m., with Licensed Vocational Nurse (LVN), LVN stated, Resident 1 was confused and a high risk for falls. LVN stated, Resident 1 does not follow commands and would try to get out of bed without help all the time. LVN stated, Resident 1 would get out of bed without using his call light, stands and tries to walk without supervision or assistance. LVN stated, Resident 1 did not have supervision on 2/1/25 when he got out of bed and fell in his room. LVN stated, Resident 1 needs supervision and continuous monitoring for his safety and was not provided.<br><br>During an interview on 2/13/25 at 10:20 a.m., with CNA 3, CNA 3 stated, she had provided care to Resident 1 before and was familiar with him. CNA 3 stated, Resident 1 did not use his call light to ask for help. CNA 3 stated, Resident 1 was wobbly and unsteady when standing up. CNA 3 stated Resident 1 was not safe to get out of bed on his own and needed supervision because he was unsteady on his feet. CNA 3 stated, Resident 1 was impulsive and needed one-on-one monitoring (refers to providing residents, focused attention and monitoring, ensuring their safety and wellbeing) to keep him safe and prevent falls. CNA 3 stated one-on one supervision was not provided.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 2/13/25 at 10:40 a.m., with Minimum Data Set Coordinator (MDSC), Resident 1's Minimum Data Set (MDS- a standardized assessment tool used for all residents in a skilled in nursing home) dated 2/5/25 was reviewed. The MDS Section C indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool that identifies cognitive impairment levels (0-7 Severe cognitive impairment, 8-12 Mild cognitive impairment and 13-15 Cognitive intact) score of 10, indicating Resident 1 had moderate cognitive impairment. The MDSC stated, Resident 1 would not remember to use the call light to ask for help. The MDSC stated, Resident 1 needed supervision when getting out of bed and when moving from sitting to standing. The MDSC stated, she knew Resident 1 fell in his room while getting out of bed and walking, and that no supervision was provided at the time of the fall on 2/1/25. The MDSC stated, Resident 1 needed supervision due to his cognitive impairment, impulsive behavior, and mobility issues. Resident 1 MDS Section GG (GG-focuses on residents' functional abilities), was reviewed. The MDS section GG indicated Resident 1 needed supervision for getting out of bed, standing, and walking. The MDSC stated, Resident 1's fall on 2/1/25 which resulted to a wound on his face and left eyebrow laceration which required a sutured could have been prevented had he been supervised when getting out of bed, moving from a sitting position to standing, and walking. The MDSC stated, it was the facility's responsibility to keep residents safe from falls resulting in injuries. The MSDC stated, Resident 1 was known to be impulsive, cognitively impaired, and had poor safety awareness.<br><br>During an interview on 2/13/25 at 11:15 a.m. with CNA 4, CNA 4 stated, he was the CNA assigned to Resident 1 on 2/1/25. CNA 4 stated, Resident 1 was unsteady on his feet, impulsive, cognitively impaired, and had poor safety awareness. CNA 4 stated, Resident 1 would stand up and starts walking without asking for help. CNA 4 stated Resident 1 was wobbly and unstable when walking and was not safe on his own. CNA 4 stated Resident 1 does not recognize the risk of getting out of bed without help. Resident CNA 4 stated, he would walk by Resident 1's room and see him getting out of bed on his own, so he had to quickly enter the room to stop Resident 1 from falling. CNA 4 stated Resident 1 was a high fall risk and does not use his call light. CNA 4 stated, he had reminded Resident 1 to use his call light, but Resident 1 would still stand up and walk without assistance.<br><br>During a concurrent interview and record review on 2/13/25 at 11:30 a.m. with the Assistant Director of Nursing (ADON), Resident 1's Medical Records (MR) was reviewed. The MR indicated Resident 1 had a fall on 2/1/25 in his room and suffered a laceration to his left brow with bleeding and bruising. The ADON stated, she knew Resident 1 was impulsive, cognitively impaired, and had poor safety awareness. The ADON stated Resident 1's fall on 2/1/25 could have been prevented if a one-on-one monitoring intervention had been put in place to keep him safe from falls.<br><br>During an interview on 2/13/25 at 12 p.m. with Administrator (ADM), the ADM stated, we need to have the correct interventions in place to keep residents safe. The ADM stated it was our responsibility to keep residents safe. The ADM stated, we did not do enough fall interventions to keep Resident 1 safe from harm.<br><br>During a concurrent interview and record review on 3/11/25 at 8:30 a.m. with the ADON, Resident 1's falls since 9/25/24 were reviewed. The falls were as follows:<br><br>9/30/24 at 12 a.m. Found on the floor next to bed<br><br>11/05/24 at 7:04 p.m. Found on the floor next to bed<br><br>(continued on next page) |

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|---|---|---|---|
| | 056288 | A. Building<br>B. Wing | 04/04/2025 |

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| Hanford Post Acute | 1007 West Lacey Blvd<br>Hanford, CA 93230 |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 12/09/24 at 4:00 p.m. Found on the floor next to bed<br><br>12/16/24 at 10:00 p.m. Found on the floor next to bed<br><br>12/18/24 at 9:09 a.m. Found on the floor next to bed<br><br>2/1/25 at 4:12 p.m. Found on the floor next to bed<br><br>ADON stated, Resident 1's falls occurred while Resident 1 was in his room. ADON reviewed Resident 1's care plan dated 2/10/25, the care plan indicated, . resident is (high) risk for falls with injury r/t [related to] unsteady gait, poor balance . history of falls, poor safety awareness d/t [due to] DX [diagnosis] Dementia (a group of symptoms characterized by a decline in memory, thinking, and social abilities), hx [history of] multiple falls, non-compliance, impulsive behaviors . Interventions . Toileting scheduled . Anticipate and meet needs . Keep call light within reach . Educate remind resident to call for assistance with all transfers . encourage room change closer to the nurses station . Encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility .Falling Star Program [a program in nursing homes uses a visual cue, like a falling star graphic on resident's door, to flag high-risk fall residents] . Keep personal items frequently used within reach .Landing mat to left side of bed . IDT [Interdisciplinary Team- a group of healthcare professionals who collaborate to provide comprehensive, individualized care for residents] Recommends . Non-skid strips to left side of bed .Bowel and Bladder Program (a structured plan designed to help individual manage their bowel and bladder functions) every 2 hours .Room change closer to nurses station .Fall mats to both sides of bed .Falling Star Program .Educate remind resident to call for assistance with all transfers . The ADON stated Resident 1's falls occurred while he was in his room and the interventions of keeping call light within reach, and encouraging to use would not address the cause of the falls, which occurred when he was unsupervised in his room.<br><br>During a concurrent observation and interview on 3/24/25 at 9:30 a.m. with LVN 2 in the hallway by Resident 1's room, the name tag listing name of residents in the room by the doorway was missing a name for Resident 1. LVN 2 stated, Resident 1 had a fall on 3/11/25 and 3/12/25. LVN stated, Resident 1 was sent to ACH on 3/12/25 and had not returned.<br><br>During a telephone interview on 3/26/25 at 11:08 a.m. with CNA 5, CNA 5 stated, she was assigned to Resident 1on 3/12/25 at the time of his fall. CNA 5 stated, Resident 1 was confused and would get out of bed by himself to go to the bathroom. CNA 5 stated, we tried to keep an eye on him when passing by his room. CNA 5 stated, she walked by his room and saw Resident 1 lying on the floor at the foot of his bed and partially in the open bathroom door. CNA 5 stated, she did not witness the fall and found him on the floor. CNA 5 stated she ran into his room and saw a small puddle of blood by his head. CNA 5 stated, Resident 1 was groaning while on the floor. CNA 5 stated, Resident 1 was bleeding from his forehead and blood was running down his face when CNA 5 and LVN assisted him to a sitting position on the side of his bed. CNA 5 stated, staff member came into the room to assist her in changing Resident 1's shirt and jacket due to blood on his clothing. CNA 5 stated, she stayed with Resident 1 and assisted him back into bed. CNA 1 stated, Resident 1 vomited and she alerted the LVN. CNA 5 stated, she was not in the room at the time of the fall providing care to other residents in the room.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a telephone interview on 3/27 /25 at 10:27 a.m. with ADON, ADON stated, Resident 1 had an unwitnessed fall on 3/11/25 at 7:24 p.m. in his room. ADON stated, Resident 1 was found on the floor by his bed. ADON stated, Resident 1 was bleeding from his forehead and was sent to ACH. ADON stated, Resident 1 returned from ACH on 3/12/25 at 1:22 a.m.<br><br>During a telephone interview on 3/27/25 at 1:00 p.m. with ADON, ADON stated, Resident 1 had a fall in his room on 3/12/25 at 7:03 p.m. ADON stated, Resident 1 was found lying on the floor and assisted back to bed by staff. ADON stated, Resident 1 was sent to ACH on 3/12/25 and has not returned. ADON stated, Resident 1 was taking [name of medication] to thin his blood which could cause excessive bleeding with any injuries from a fall. ADON stated, Resident 1 was a high fall risk due to the history of his falls and had the potential for life threatening outcomes.<br><br>During a record review of the Resident 1's falls since 9/25/24 were reviewed. The falls were as follows:<br><br>9/30/24 at 12 a.m. Found on the floor next to bed<br><br>11/05/24 at 7:04 p.m. Found on the floor next to bed<br><br>12/09/24 at 4:00 p.m. Found on the floor next to bed<br><br>12/16/24 at 10:00 p.m. Found on the floor next to bed<br><br>12/18/24 at 9:09 a.m. Found on the floor next to bed<br><br>2/1/25 at 4:12 p.m. Found on the floor next to bed<br><br>3/11/25 at 7:24 p.m. Found on floor next to bed<br><br>3/12/25 at 7:03 p.m. Found on floor next to bed<br><br>During a review of the Acute Care Hospital (ACH) document titled, ED Physicians Notes, dated 3/11/25, at 9:08 p.m. the note indicated ( . patient is a 93 y.o. [year old] male . presents to the ED [emergency department] after a fall out of bed and hit his forehead .2 cm (centimeter) (unit of measure) mid forehead superficial (occurring on the skin or immediately beneath it) abrasion (a area damaged by scrapping) . Diagnosis, Mechanical Fall, forehead abrasion, severe dementia .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of the Acute Care Hospital (ACH) document titled, ED Physicians Notes, dated 3/12/25, at 8:10 p.m. the note indicated ( . patient is a 93 y.o. [year old] male . presents to the ED [emergency department] after a fall out of bed and hit his forehead .CT scan of head was performed indicating Intracranial hemorrhage (life threatening medical emergency when blood leaks inside or between the brain and skull) of left frontal , subdural hematoma ( pool of blood between the brain and its outermost covering) measuring up to 11 mm (millimeters) (unit of measure) in thickness and small volume left parietal subarachnoid hemorrhage (a type of stroke where bleeding occurs in the space between the brain and the tissues covering it) . Patient presents after a fall with head trauma while on blood thinner medication placing him at high risk for intracranial hemorrhage .Intensive Care Unit (ICU) physician was consulted, who requested to transfer the patient to neuro [neurological] ICU .[Name of ACH] [Name of Neurosurgeon] was consulted who then spoke to family in regards to potential management for this patient .Eventually family decided that they do not want to pursue any neurological intervention and did not want him transferred to another facility .Prefer that the patient stays here at this hospital .Resident 1 passed away on 3/17/25 .<br><br>During a record review of the Death Certificate for Resident 1, indicated . Cause of Death as Cardiopulmonary Arrest (Cardiac arrest-sudden loss of heart function) and Subdural Hematoma w/loc (loss of consciousness-unresponsive to stimuli) status .<br><br>During a review of the facility's Policy and Procedure titled Falls and Fall Risk Managing, dated 3/2018, the P&P indicated, .Based on previous evaluations and current data, staff may identify interventions related to the resident's specific risks and causes in the attempt to reduce falls and minimize complications from falling . Resident centered fall prevention plans should be reviewed and revised as appropriate .If the resident continues to fall, the situation should be reevaluated to determine whether it would be appropriate to continue or change current interventions.<br><br>During a review of the facility's P&P titled Safety and Supervision of Residents, dated 7/2017, the P&P indicated, . Our facility strives to make the environment as free from accident hazards as possible . Safety risks and environmental hazards are identified on an ongoing basis . When accident hazards are identified, the QAPI [Quality Assurance and Performance Improvement- is a data driven, proactive approach to improve the quality of care in nursing homes]/safety committee shall evaluate and analyze the cause(s) . Employees shall be trained on potential accident hazards and demonstrate competency . and try to prevent avoidable accidents . Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents . care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices . `<br><br>During a review of the facility's P&P titled Fall Prevention Program/Falling Star, updated 2/3/25, the P & P indicated .Staff to assist resident to the bathroom before meals, after meals, at bedtime and as needed . Resident not to be left alone in room while out of bed .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of a professional reference located at https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/facilities/ltc/mod3sess2.html titled Module 3: Falls Prevention and Management, dated 10/2014, the reference indicated, . An important job for licensed nurses is to assess residents' risk of falling. This is best done using a protocol or instrument that asks the licensed nurse to look at or test several features about the residents . Implement an individualized care plan . nursing should add an individualized approach for falls to the resident's care plan . An individualized care plan for falls is not a one-time solution. Licensed nurses and other staff must revisit the plan to make sure it is effective in preventing additional falls and injuries from falls .<br><br>42123<br><br>2. During a review of Resident 4's Admission Record, undated, the admission record indicated, Resident 4 was admitted to the facility on [DATE] with diagnoses which included fracture (break in bone) of the skull, muscle weakness, abnormalities of gait (pattern of walking) and mobility (ability to move freely), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), cognitive (relating to the mental process involved in knowing, learning, and understanding) communication deficit (communication difficulty caused by cognitive impairment), cerebral infarction (condition where blood flow to the brain is blocked, causing brain tissue damage), nontraumatic intracerebral hemorrhage (bleeding occurs within the brain tissue), traumatic subdural hemorrhage (collection of blood between the brain and inner layer of skull) and traumatic subarachnoid hemorrhage (type of stroke) with loss of consciousness (state of being awake).<br><br>During a review of Residents 4's MDS assessment dated [DATE], indicated Resident 4's BIMS scored 09 of 15. The BIMS assessment indicated Resident 4's cognition was moderately impaired.<br><br>During an interview on 4/3/25 at 2:56 p.m. with CNA 6, CNA 6 stated she was familiar with Resident 4 and had taken care of him prior to his discharge. CNA 6 stated Resident 4 was very confused, difficult to communicate with and impulsive. CNA 6 stated Resident 4 was very weak and unable to stand safely by himself but had behaviors of standing up suddenly and falling. CNA 6 stated Resident 4 was very confused and did not realize how weak he was and that it was not safe for him to stand on his own. CNA 6 stated at Resident 4 was on every 15-minute checks but still had falls. CNA 6 stated Resident 4 would have required one on one (1:1) supervision (constant staff supervision) to prevent him from falling.<br><br>During a concurrent interview and record review on 4/3/25 at 3:29 p.m. with LVN 2 Resident 4's falls were reviewed. The falls were as follows:<br><br>1/19/25-Resident fell trying to get off bed<br><br>1/23/25-Resident fell getting out of wheelchair<br><br>1/28/25-8:45 a.m. Resident found on floor<br><br>1/28/25-3:17 p.m. Resident found on floor<br><br>2/2/25-Resident on floor, dragging self out of room asking staff to put him into wheelchair<br><br>2/4/25-Resident fell getting up from wheelchair across from nurses' station<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 2/10/25-Resident fell in dining room<br><br>2/14/25-Resident fell across from nurses' station<br><br>LVN 2 stated Resident 4 was at high risk for falls because he had non-compliant behaviors, was constantly trying to get up unsupervised, had weak legs and poor balance. LVN 2 stated Resident 4's primary language was not English which caused some communication issues. LVN 2 stated she thought he could understand the reminders to call for help but could not retain it due to cognition. LVN 2 stated Resident 4 was stubborn and would continue to do what he wanted to do even if it was not safe. LVN 2 stated Resident 4 was never placed on 1:1 supervision, and the only way to prevent falls would have been for staff to always stay with the resident. LVN 2 stated she would keep the resident close to the nurse's station when she was sitting there, and he did not fall when she had him under constant supervision because she could redirect him quickly. Resident 4's fall risk scores (0-8 low risk, 9-15 moderate risk, 16-42 high risk) were reviewed. Resident 4's fall risk scores were reviewed as follows:<br><br>1/17/25 score 10, moderate risk for falls<br><br>1/23/25 score 14, moderate risk for falls<br><br>1/28/25 score 22, high risk for falls<br><br>1/28/25 score 20, high risk for falls<br><br>2/4/25 score 20, high risk for falls<br><br>2/10/25 score 20, high risk for falls<br><br>2/14/25 score 22, high risk for falls<br><br>LVN 2 stated Resident 4 was a moderate risk for falls when he was admitted but his fall risk increased as he continued to have falls. Resident 4's care plans were reviewed, LVN 2 stated she was unable to locate any fall risk care plan interventions before his first fall on 1/19/25. LVN 2 stated there were no fall prevention interventions in the care plan until his fall on 2/4/25. LVN 2 stated Resident 4 was on hourly checks, but it was not documented on the care plan and should have been. LVN 2 stated care plans were important because they direct the resident's care. LVN 2 stated care plans were used to involve the residents in their care, indicate what interventions are needed to meet their needs, included details about the resident's life including the treatments provided and physician ordered interventions.<br><br>During a telephone interview on 4/4/25 at 7:50 a.m., with Family Member (FM) 2, FM 2 stated he was Resident 4's responsible party. FM 2 stated Resident 4 had frequent falls while at the facility and he did not feel like the facility did enough to prevent the resident's falls. FM 2 stated Resident 4 was agitated which caused him to stand up frequently and then he would fall, but he did not feel like the facility addressed the issue and the resident kept falling.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 4's Nurse's Note, dated 1/19/25, the note indicated, . At around 0120 [1:20 a.m.], writer was sitting at nurses station charting . notified by resident roommate, that roommate had fell trying to get off bed . Upon entering the room, the resident was found on the floor on right side of his bed, facedown with head facility the head of the bed . resident stated was trying to go to the restroom. Resident stated to have a headache .<br><br>During a review of Resident 4's Interdisciplinary Team (IDT-Interdisciplinary Team- involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities for the best interest of the resident) note dated 1/29/25 at 10:21 a.m., the IDT note indicated, . IDT met on 01/20/25 to discuss resident's fall on 01/19/25 . IDT intervention: Resident added to B&B program X4 hours .<br><br>During a review of Resident 4's SBAR, dated 1/23/25, the SBAR indicated, . change in condition, symptoms, or signs observed and evaluated is/are: Falls . 01/23/25 .<br><br>During a review of Resident 4's Alert Charting, dated 1/23/25 at 9:10 p.m., the note indicated, . Approximately 2110 [9:10 p.m.] . notified by staff member, resident fell trying to get out of wheelchair . resident was found on the floor on left side, face down . resident stated was trying to get to bed .<br><br>During a review of Resident 4's IDT Note, dated 1/24/25, the note indicated, . IDT met to discuss resident's fall on 01/23/25 . IDT intervention: Non-skid material to wheelchair & Resident will be added to falling star program. Resident's last fall was 01/19/2025 .<br><br>During a review of Resident 4's SBAR, dated 1/28/25 at 8:50 a.m., the SBAR indicated, . writer was called into resident room by residents roommate. Upon entering room, resident found on the floor on his bottom, his head against roommates' foot board .<br><br>During a review of Resident 4's Nurses Notes, dated 1/28/25 at 3:25 p.m., the note indicated, . called into resident room by CNA and activity director stating that resident was on floor kneeling with back to bed and him facing the table. Writer went to go observe and noted resident was on floor on both knees with back to bed and him facing the table. Resident wheelchair was next to him .<br><br>During a review of Resident 4's Nurse's Note, dated 2/4/25 at 2:00 p.m., the note indicated, . resident sitting across from nurses station, resident [resident] stood up and was very unsteady and week [weak] . This writer attempted to reach resident to sit him back in wheelchair and resident fell on to floor, fall witnessed and resident assisted back onto his feet and placed back in wheelchair .<br><br>During a review of Resident 4's IDT Note, dated 2/5/25 at 9:54 a.m., the note indicated, . IDT met to discuss resident's fall on 02/04/2025 . IDT intervention: Resident placed on 1 hour checks. SSD [Social Services Director] scheduled a care conference for 02/14/2025 to discuss POC [plan of care] with family .<br><br>During a review of Resident 4's Nurse's Note, dated 2/10/25 at 7:50 a.m., the note indicated, . On 2/10/25 at approx. [approximately] 0655 [6:55 a.m.] CNA called writer to dining room due to resident having unwitnessed fall. Upon entering dining room resident noted to be laying on floor on his bottom his wheelchair behind him . Resident was noted with no socks .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 4's IDT Note, dated 2/11/25 at 9:36 a.m., the note indicated, . IDT met to discuss [discuss] resident's fall on 02/10/2025 . IDT recommendations: Sensory pad to bed & wheel chair. Nursing to obtain consent .<br><br>During a review of Resident 4's SBAR, dated 2/14/25, the SBAR indicated, . change in condition . Falls . 02/14/2025 . Writer approaching nurses station and CNA states resident had fallen. Resident noted to be sitting in wheelchair. CNA x2 had assisted resident back to chair without waiting for writer to asses resident . Resident continued to stand up being non compliant . Resident unable to give description .<br><br>During a review of Resident 4's IDT note, dated 2/17/25 at 4:47 p.m., the IDT note indicated, . IDT met to discuss resident's fall on 02/14/2025 . Resident is currently out at acute care hospital. Upon his readmission resident will be placed on Q2 [every two] hour checks .<br><br>During a concurrent interview and record review on 4/4/25 at 9:12 a.m. with the Assistant Director of Nursing (ADON), the ADON stated Resident 4 was a resident at the facility for one month. The ADON stated, he had a few falls. I'm not sure how many. Resident 4's fall risk care plan was reviewed. The care plan indicated, . Resident is at risk for falls with or without injury . unwitnessed fall on 1-19-25 . witnessed fall on 1-23-25 . witnessed fall 2/4/25 . Unwitnessed fall 2/10/25 . Unwitnessed fall 2/14/25 . Date initiated 1/17/2025 . Will minimize risk for falls to extent possible . Date initiated: 2/4/25 . Add sensor pad [a device used to monitor patients to ensure they do not rise from the bed or chair on their own to reduce falls] to bed and wheelchair . Date initiated: 2/04/25 . Add to B&B [bowel and bladder program-scheduled toileting] Q [every] 2 hours . Anticipate and meet needs . falling star program . Keep bed in low position with brakes locked . Keep call light within reach . Keep personal items frequently used within reach . Non skid material [flexible material used to prevent slipping] to w/c [wheelchair] . The ADON stated she was unable to find a fall risk care plan with interventions before 2/4/25. The ADON stated care plans were used to provide person-centered care for each resident and should have measurable objectives and the interventions reflecting the residents abilities to perform ADLs and transfers. The ADON stated the cause of Resident 4's falls was his need to get up. The ADON stated the facility did not place Resident 4 on 1:1 supervision, but he was placed on every hour checks. The ADON stated Resident 4 did continue to have falls while on every hour supervision. The ADON stated Resident 4 should not have stood up without staff assistance because he needed supervision for safety. Resident 4's Nurse's Note, dated 2/2/25 at 7:57 p.m. was reviewed. The note indicated, . Upon shift change, resident on the floor on his bottom dragging himself out of room asking staff to put him in his wheelchair . staff transferred resident from floor to w/c. Resident noncompliant with use of call light, and wheelchair . The ADON stated the note did not specify the resident fell and she was unsure what dragging himself out of room referred to. Resident 4's SBAR, dated 2/2/25 was reviewed and indicated, . lump to left forehead, No changes observed . This started on 2/2/25 . during staff PM report, staff member came to writer and notified resident noted to have lump to his forehead . Resident was asked what happened and resident denies falling or hitting self . The ADON stated she was unable to clarify the note and whether Resident 4 fell on [DATE], because the nurse no longer worked at the facility. The facility's P&P titled Falls and Fall Risk, [NAME] [TRUNCATED] |

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| | 056288 | A. Building<br>B. Wing | 04/04/2025 |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123<br><br>Based on interview and record review, the Administrator (ADM) failed to provide consistent administrative oversight and resources to ensure residents received adequate supervision and care planning when the administrator was aware of multiple falls for one of six sampled residents (Resident 1) and did not ensure the Interdisciplinary Team implemented effective fall prevention interventions.<br><br>These failures resulted in Resident 1 suffering avoidable falls on the following dates: 9/30/24, 11/5/24, 12/9/24, 12/16/24, 12/18/24, and 2/1/25. and placed the resident at risk for injury, pain. and suffering. These failures resulted in Resident 1 ' s experiencing five unwitnessed falls prior to the avoidable fall on 2/1/25 with injury, sustaining a (laceration (cut in the skin caused by an injury) above the left eyebrow requiring transportation to the emergency department (ED) for sutures (a row of stitches holding together edges of a wound) and avoidable pain and suffering. Resident 1 had two additional avoidable falls. Resident 1 had a unwitnessed fall in his room on 3/11/25 sustaining a laceration to the forehead which required transportation to the emergency department for evaluation and a additional fall in his room on 3/12/25 opening the same area to his forehead and required transportation back to the emergency department for repair. Resident 1 was diagnosed with a subdural hematoma (pool of blood between the brain and its outermost covering) measuring up to 11 mm (millimeters) (unit of measure) in thickness. Resident 1 passed away on 3/17/25 at ACH from his injuries related to the fall on 3/12/25. (Cross reference F689 and F865)<br><br>Findings:<br><br>During an observation on 2/13/25 at 8:15 a.m., in Resident 1 ' s room, Resident 1 was lying in bed with eyes closed. Resident 1 had a sutured laceration above his left eye. Resident 1 ' s bed was in low position, fall mat on the floor next to bed on left side, no fall mat on right side. Call light within reach. No staff present in the room.<br><br>During a review of Resident 1 ' s Admission Record (AR- a document containing resident medical and personal information), undated, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia (a group of symptoms that affect memory, thinking, and social abilities), abnormalities of gait and mobility, and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage).<br><br>During a review of Residents 1 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 10 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 ' s cognition was moderately impaired.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the Acute Care Hospital (ACH) document titled, Emergency Department Report, dated 2/1/25, the note indicated . patient is a 93 y.o. [year old] male . presents to the ED [emergency department] after fall. Per skilled nursing facility, patient had an unwitnessed ground level fall in his room between his bed and bathroom door .3-centimeter (unit of measure) (cm) linear (straight line) wound located on the face . Left eyebrow laceration was repaired . follow up for wound check and suture removal .<br><br>During an interview on 2/13/25 at 10 a.m., with Licensed Vocational Nurse (LVN), LVN stated, Resident 1 was confused and a high risk for falls. LVN stated, Resident 1 does not follow commands and would try to get out of bed without help all the time. LVN stated, Resident 1 would get out of bed without using his call light, stands and tries to walk without supervision or assistance. LVN stated, Resident 1 did not have supervision on 2/1/25 when he got out of bed and fell in his room. LVN stated, Resident 1 needs supervision and continuous monitoring for his safety and was not provided<br><br>During an interview on 2/13/25 at 10:20 a.m., with CNA 3, CNA 3 stated, she had provided care to Resident 1 before and was familiar with him. CNA 3 stated, Resident 1 did not use his call light to ask for help. CNA 3 stated, Resident 1 was wobbly and unsteady when standing up. CNA 3 stated Resident 1 was not safe to get out of bed on his own and needed supervision because he was unsteady on his feet. CNA 3 stated, Resident 1 was impulsive and needed one-on-one monitoring (refers to providing residents, focused attention and monitoring, ensuring their safety and wellbeing) to keep him safe and prevent falls. CNA 3 stated one-on one supervision was not provided.<br><br>During an interview on 2/13/25 at 12 p.m. with Administrator (ADM), the ADM stated, we need to have the correct interventions in place to keep residents safe. The ADM stated it was our responsibility to keep residents safe. The ADM stated, we did not do enough fall interventions to keep Resident 1 safe from harm.<br><br>During a concurrent interview and record review on 3/11/25 at 8:30 a.m. with the ADON, Resident 1 ' s falls since 9/25/24 were reviewed. The falls were as follows:<br><br>9/30/24 at 12 a.m. Found on the floor next to bed<br><br>11/05/24 at 7:04 p.m. Found on the floor next to bed<br><br>12/09/24 at 4:00 p.m. Found on the floor next to bed<br><br>12/16/24 at 10:00 p.m. Found on the floor next to bed<br><br>12/18/24 at 9:09 a.m. Found on the floor next to bed<br><br>2/1/25 at 4:12 p.m. Found on the floor next to bed<br><br>The ADON stated Resident 1 ' s falls occurred while he was in his room and the interventions of keeping call light within reach, and encouraging to use would not address the cause of the falls, which occurred when he was unsupervised in his room.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent observation and interview on 3/24/25 at 9:30 a.m. with LVN 2 in the hallway by Resident 1 ' s room, the name tag listing name of residents in the room by the doorway was missing a name for Resident 1. LVN 2 stated, Resident 1 had a fall on 3/11/25 and 3/12/25. LVN stated, Resident 1 was sent to ACH on 3/12/25 and had not returned.<br><br>During a telephone interview on 3/27/25 at 10:27 a.m. with ADON, ADON stated, Resident 1 had an unwitnessed fall on 3/11/25 at 7:24 p.m. in his room. ADON stated, Resident 1 was found on the floor by his bed. ADON stated, Resident 1 was bleeding from his forehead and was sent to ACH. ADON stated, Resident 1 returned from ACH on 3/12/25 at 1:22 a.m.<br><br>During a telephone interview on 3/27/25 at 1:00 p.m. with ADON, ADON stated, Resident 1 had a fall in his room on 3/12/25 at 7:03 p.m. ADON stated, Resident 1 was found lying on the floor and assisted back to bed by staff. ADON stated, Resident 1 was sent to ACH on 3/12/25 and has not returned. ADON stated, Resident 1 was taking [name of medication] to thin his blood which could cause excessive bleeding with any injuries from a fall. ADON stated, Resident 1 was a high fall risk due to the history of his falls and had the potential for life threatening outcomes.<br><br>During a review of the Acute Care Hospital (ACH) document titled, ED Physicians Notes, dated 3/11/25, at 9:08 p.m. the note indicated ( . patient is a 93 y.o. [year old] male . presents to the ED [emergency department] after a fall out of bed and hit his forehead .2 cm (centimeter) (unit of measure) mid forehead superficial (occurring on the skin or immediately beneath it) abrasion (an area damaged by scrapping) . Diagnosis, Mechanical Fall, forehead abrasion, severe dementia .<br><br>During a review of the Acute Care Hospital (ACH) document titled, ED Physicians Notes, dated 3/12/25, at 8:10 p.m. the note indicated ( . patient is a 93 y.o. [year old] male . presents to the ED [emergency department] after a fall out of bed and hit his forehead .CT scan of head was performed indicating Intracranial hemorrhage (life threatening medical emergency when blood leaks inside or between the brain and skull) of left frontal , subdural hematoma ( pool of blood between the brain and its outermost covering) measuring up to 11 mm (millimeters) (unit of measure) in thickness and small volume left parietal subarachnoid hemorrhage (a type of stroke where bleeding occurs in the space between the brain and the tissues covering it) . Patient presents after a fall with head trauma while on blood thinner medication placing him at high risk for intracranial hemorrhage .Intensive Care Unit (ICU) physician was consulted, who requested to transfer the patient to neuro [neurological] ICU .[Name of ACH] [Name of Neurosurgeon] was consulted who then spoke to family in regards to potential management for this patient .Eventually family decided that they do not want to pursue any neurological intervention and did not want him transferred to another facility .Prefer that the patient stays here at this hospital .Resident 1 passed away on 3/17/25 .<br><br>During a record review of the Death Certificate for Resident 1, indicated . Cause of Death as Cardiopulmonary Arrest (Cardiac arrest-sudden loss of heart function) and Subdural Hematoma w/loc (loss of consciousness-unresponsive to stimuli) status .<br><br>During a review of the facility ' s Policy and Procedure titled Falls and Fall Risk Managing, dated 3/2018, the P&P indicated, .Based on previous evaluations and current data, staff may identify interventions related to the resident ' s specific risks and causes in the attempt to reduce falls and minimize complications from falling .Resident centered fall prevention plans should be reviewed and revised as appropriate .If the resident continues to fall, the situation should be reevaluated to determine whether it would be appropriate to continue or change current interventions.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility ' s job description titled Job Description: Administrator, undated, . Position Title . Administrator . primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times . Oversees Quality care and analyzes the entire operation of the nursing facility . Plan, develop, organize, implement, evaluate, and direct the facility ' s programs and activities in accordance with guidelines issued by the governing board . Supports Clinical efforts by understanding QA measures . Understand and reviews Quality Measures on a regular basis . |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>42123<br><br>Based on interview and record review the facility failed to identify and develop an effective QAPI (Quality Assurance and Performance Improvement-a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving) program when the facility ' s QAPI failed to utilize resident fall data to establish an effective safety plan for fall prevention for one of six sampled residents (Residents 1).<br><br>These failures resulted in Resident 1 suffering avoidable falls on the following dates: 9/30/24, 11/5/24, 12/9/24, 12/16/24, 12/18/24, and 2/1/25. and placed the resident at risk for injury, pain. and suffering. These failures resulted in Resident 1 ' s experiencing five unwitnessed falls prior to the avoidable fall on 2/1/25 with injury, sustaining a (laceration (cut in the skin caused by an injury) above the left eyebrow requiring transportation to the emergency department (ED) for sutures (a row of stitches holding together edges of a wound) and avoidable pain and suffering. Resident 1 had two additional avoidable falls. Resident 1 had a unwitnessed fall in his room on 3/11/25 sustaining a laceration to the forehead which required transportation to the emergency department for evaluation and a additional fall in his room on 3/12/25 opening the same area to his forehead and required transportation back to the emergency department for repair. Resident 1 was diagnosed with a subdural hematoma (pool of blood between the brain and its outermost covering) measuring up to 11 mm (millimeters) (unit of measure) in thickness. Resident 1 passed away on 3/17/25 at ACH from his injuries related to the fall on 3/12/25. (Cross reference F689 and F835)<br><br>Findings:<br><br>During an interview on 4/4/25 at 1:28 p.m. with the Administrator (ADM) and Administrator Consultant (ADMC), the ADM stated the facility held their last QAPI meeting on 3/25/25. The ADM stated the facility utilized the fall data to give the staff incentives to prevent falls. The ADM stated, We started doing a pizza party for staff if they go 7 days without resident falls. We have seen success [at decreasing falls]. The ADM stated the QAPI tracks the number of falls, and he used the information to present at the QAPI meeting but was unable to verbalize how the data was used to ensure the facility had an effective fall prevention program in place.<br><br>During a review of the facility ' s job description titled Job Description: Administrator, undated, . Position Title . Administrator . primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times . Oversees Quality care and analyzes the entire operation of the nursing facility . Plan, develop, organize, implement, evaluate, and direct the facility ' s programs and activities in accordance with guidelines issued by the governing board . Supports Clinical efforts by understanding QA measures . Understand and reviews Quality Measures on a regular basis .<br><br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility ' s policy and procedure (P&P) titled Quality Assurance and Performance Improvement (QAPI) Plan, dated 4/2014, The P&P indicated, . facility shall develop, implement and maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care . objectives of the QAPI Plan are to . Provide a means to identify and resolve present and potential negative outcomes related to resident care and services . Provide structure and processes to correct identified quality and/or safety deficiencies . Establish and implement plans to correct deficiencies . committee shall meet monthly to review reports, evaluate the significance of data, and monitor quality-related activities . |