STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065390	A. Building B. Wing	07/31/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on record review and interviews, the facility failed to ensure residents were kept free from significant medication errors for two (#2 and #3) of three residents reviewed for medication errors out of 15 sample residents. Specifically, the facility failed to ensure Residents #2 and #3 received medications as scheduled according to the physician's orders which resulted in significant medications errors. Findings include: I. Facility policy The 6 (six) Medication Administration Rights policy, undated, was received from the nursing home administrator (NHA) on 7/30/24 at 1:28 p.m. It read in pertinent part, Medications should be administered at the time indicated by the prescribing physician. Acceptable practice is to use a one-hour window time frame. Medications can be given one hour before or one hour after the prescribed time. II. Resident #2 A. Resident status Resident #2, age 72, was admitted to the facility on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis of one side of the body), muscle spasms, and anxiety. The 7/1/24 minimum data assessment (MDS) assessment revealed the resident was moderately cognitively impaired. A brief interview for mental status (BIMS) was not conducted as the resident was rarely or never understood. The resident was dependent for all activities of daily living (ADL). B. Record review The July 2024 CPO revealed a physician's order for Alprazolam (anti-anxiety medication) 0.25 milligrams (mg) with instructions to give one tablet via PEG-tube (percutaneous endoscopic gastrostomy feeding tube) three times a day for anxiety, ordered on 7/16/24. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/18/24 care plan, revised 7/11/24, revealed Resident #2 could experience adverse reactions from his psychotropic medications, including Alprazolam for his anxiety. Pertinent interventions included monitoring Resident #2 for mood disturbances and using non-pharmacological interventions. The 7/19/24 care plan revealed Resident #2 was at risk for adverse side effects from the use of anti-anxiety medication. Pertinent interventions included administering medications per physician's orders. Resident #2's July 2024 medication administration record (MAR) revealed the resident's Alprazolam 0.25 mg was not administered timely on the following dates: -On 7/17/24 the medication was scheduled for administration at 3:00 p.m. and administered at 4:21 p.m. (21 minutes after the allowed administration time). -On 7/18/24 the medication was scheduled for administration at 3:00 p.m. and administered at 5:24 p.m. (one hour and 24 minutes after the allowed administration time). -On 7/18/24 the medication was scheduled for administration at 9:00 p.m. and administered at 10:07 p.m. (seven minutes after the allowed administration time). -On 7/19/24 the medication was scheduled for administration at 9:00 a.m. and administered at 10:20 a.m. (20 minutes after the allowed administration time). -On 7/21/24 the medication was scheduled for administration at 3:00 p.m. and administered at 4:23 p.m. (23 minutes after the allowed administration time). -On 7/22/24 the medication was scheduled for administration at 9:00 a.m. and administered at 10:48 a.m. (48 minutes after the allowed administration time). -On 7/23/24 the medication was scheduled for administration at 3:00 p.m. and administered at 4:52 p.m. (52 minutes after the allowed administration time). -On 7/26/24 the medication was scheduled for administration at 9:00 a.m. and administered at 11:20 a.m. (one hour and 20 minutes after the allowed administration time). -On 7/28/24 the medication was scheduled for administration at 3:00 p.m. and administered at 4:46 p.m. (46 minutes after the allowed administration time). -On 7/29/24 the medication was scheduled for administration at 3:00 p.m. and administered at 4:33 p.m. (33 minutes after the allowed administration time). III. Resident #3 A. Resident status Resident #3, age 70, was admitted on [DATE] and discharged on [DATE]. According to the June 2024 CPO, diagnoses included malignant neoplasm (cancer) of the lung, lower back pain, and epigastric pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/18/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The resident required supervision to partial/moderate assistance with most activities of daily living. The resident was on a scheduled pain medication regimen and had pain almost constantly that interfered with her day-to-day activities. B. Resident interview Resident #3 was interviewed via phone on 7/31/24 at 10:39 a.m. Resident #3 said the morphine to treat her pain associated with lung cancer was administered later than it was scheduled. She said occasionally it was over two hours late. Resident #3 said the delay in administration had caused her to be in pain. Resident #3 said she had laid in bed and suffered. Resident #3 said she had used her call bell to alert the certified nurse aides (CNAs) that she was in pain but the CNAs had told her they had already alerted her nurse. C. Record review The June 2024 CPO revealed a physician's order for morphine sulfate oral solution 20 mg/milliliter (ml) with instructions to give 0.5 ml by mouth every four hours for pain management, ordered on 6/12/24. The 6/12/24 care plan, revised 6/13/24, revealed Resident #3 had acute/chronic pain risk due to her conditions, which included neoplasm of the lung, lower back pain, epigastric pain, and headaches. Pertinent interventions included administering pain medications per physician order and noting effectiveness. Review of Resident #3's June 2024 MAR revealed the resident's morphine sulfate 0.5 ml was not administered timely on the following dates: -On 6/14/24 the medication was scheduled for administration at 4:00 a.m. and administered at 5:27 a.m. (27 minutes after the allowed administration time). -On 6/15/24 the medication was scheduled for administration at 4:00 a.m. and administered at 5:12 a.m. (12 minutes after the allowed administration time). -On 6/15/24 the medication was scheduled for administration at 8:00 a.m. and administered at 10:09 a.m. (one hour and nine minutes after the allowed administration time). -On 6/21/24 the medication was scheduled for administration at 8:00 a.m. and administered at 10:15 a.m. (one hour and 15 minutes after the allowed administration time). Review of Resident #3's June 2024 pain level summary revealed the following: -On 6/14/24 at 5:23 a.m. Resident #3's pain was rated as a 6 out of 10 on a scale of 1-10; -On 6/15/24 at 10:09 a.m. Resident #3's pain was rated as an 8 out of 10; and, -On 6/21/24 at 10:15 a.m. Resident #3's pain was rated as a 6 out of 10. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 7/31/24 at 9:37 a.m. LPN #1 said medication administration was conducted each day by splitting the residents between two nurses and going down each hall, leaving about 20 residents for each nurse to administer medications to. LPN #1 said the facility's computer system notified nurses one hour before each medication cycle was due. He said, for example, for 10:00 a.m. medications, the computer system alerted them at 9:00 a.m LPN #1 said the nursing staff had a one hour window before and after a medication was due to administer the medication on time. LPN #1 said it was important to administer medications as scheduled in order to avoid interactions with other medications and to have an appropriate interval before or after meal times. LPN #1 said pain medications needed to be administered when they were scheduled to avoid over-sedating the resident. The director of nursing (DON) was interviewed on 7/31/24 at 11:11 a.m. The DON said medication administration was divided between the nurses, and that each hall had staggered medication administration schedules in order to keep the nursing staff on schedule. The DON said medications were considered to be given on-time if they were administered within an hour window before or after the medication was scheduled. The DON said most medications, especially pain medication, needed to be administered as scheduled. The DON said unforeseen circumstances could come up that could cause delays. The DON said Resident #2 may have had some delays in medication administration on the dates his medication was late due to being out of the facility for an appointment. The DON said, for Resident #3, on 6/21/24 the nurse who had administered the resident's pain medication over an hour late had been overwhelmed during the shift. The DON said the nurse in question had been counseled on timely administration of medications and later left the facility. The DON was interviewed again on 7/31/24 at 11:45 a.m. The DON said Resident #2 did not have any appointments scheduled on the days in which his medications were not administered as scheduled.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on interviews and record review, the facility failed to ensure one (#1) of three residents reviewed for accidents out of 15 sample residents received adequate supervision and services to prevent an accident. Resident #1 was admitted to the facility on [DATE] with a traumatic subdural hemorrhage with loss of consciousness (intracranial bleeding between the brain and the skull), muscle weakness, aphasia (loss of the power of speech), hemiplegia (paralysis affecting one side of the body), Parkinson's disease (a condition that affects muscle control and movement), acute pain due to trauma and a history of falling. Resident #1 was status post burr holes (small holes that a neurosurgeon makes in the skull to help relieve pressure on the brain when fluid, such as blood, builds up and compresses brain tissue) of subdural hematoma with surgical incision on the left side of his head with staples in place. On 4/15/24, certified nurse aide (CNA) #1 and CNA #2 transferred Resident #1 via the hoyer lift (mechanical lift). During the transfer, Resident #1 fell from the lift to the floor, striking his head. Resident #1 began vomiting after the fall and was immediately transferred to the hospital where he was diagnosed with a large posterior scalp hematoma (bleeding under the skin) and left ankle trauma with pain and mild soft tissue swelling. The facility failed to identify the root cause of Resident #1's fall, conduct staff re-education to prevent future falls, review transfer training techniques, or review the use of the hoyer lift procedures with CNA #1 and CNA #2, who were involved with the fall. Due to the facility's failure to transfer a dependent resident safely, Resident #1 sustained a new head injury and required hospitalization for three days. Resident #1 was discharged from the hospital to his home on hospice care due to the families concern for the resident's safety at the facility. Findings include: I. Facility policy and procedure The Mechanical Lifts policy and procedure, revised 2/1/23, was provided by the nursing home administrator (NHA) on 7/31/24 at 10:22 a.m. It read in pertinent part, (Facility name) utilizes mechanical lifts when appropriate to ensure safe patient handling during transfers and employee safety when providing patient care. Direct care staff will receive training upon hire and as needed for proper preparation of the patient, equipment, and environment during utilization of mechanical lifts. II. Mechanical lift manual (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The user manual for the Span model: F500P full body patient lift was provided by the NHA on 7/31/24 at 10:35 a.m. It read in pertinent part, Special care must be taken with users/patients who cannot themselves provide assistance while being lifted (patients who are comatose, spastic, agitated, or otherwise severely handicapped). The patient lift should be used solely for transferring a user/patient from one utility (beds, chairs, toilets) to another. The patient lift should not be used for transporting or moving any patient from one location to another location. During lifting or lowering, whenever possible, always keep the base of the lift in the widest position. The base of the lift should be closed before moving the lift. Do not roll casters over any object while the user/patient is in the sling. Do not lock casters during lifting. While being lifted in a sling, always keep the user/patient centered over the base and facing the caregiver operating the lifter. Never leave the user/patient unattended during lifting. III. Resident # 1 A. Resident status Resident #1, age 65, was admitted on [DATE] and discharged to the hospital on 4/15/24. According to the April 2024 computerized physician orders (CPO), diagnoses included traumatic subdural hemorrhage with loss of consciousness, muscle weakness, aphasia, hemiplegia Parkinson's disease, acute pain due to trauma and history of falling. The 4/15/24 minimum data set (MDS) assessment revealed the resident was unable to complete a brief interview for mental status (BIMS). The staff assessment for mental status was completed and revealed the resident had short and long-term memory problems and had severely impaired cognitive skills for daily decision making. He was dependent on staff for transfers, and required substantial/maximal assistance with bed mobility. The MDS assessment indicated the resident had one fall since admission and documented there was no injury. -However, the resident sustained a head injury with a hematoma, per the hospital records. B. Facility investigation of Resident #1's fall on 4/15/24 The fall investigation was provided by the director of nursing (DON) on 7/30/24 at 5:29 p.m. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 4/16/24 post fall investigation revealed the following in pertinent part: On 4/15/24 at 6:30 p.m. licensed practical nurse (LPN) #1 heard a loud bang and ran into the resident's room. Resident #1 was on the floor. CNA #1 and CNA #2 were using the hoyer lift to transfer the resident when Resident #1 slipped through the middle of the sling. Resident #1 hit the back of his head. The resident's vital signs were within normal limits.The physician and the resident's daughter were notified of the fall. The resident was evaluated by registered nurse (RN) #1 and she made the decision to send the resident to the emergency department (ED) as he had hit his head. The resident's vital signs were stable when the resident left the facility with emergency medical services via stretcher to the hospital ED. An undated statement was obtained from CNA #1. CNA #1 said she was sitting at the computer charting and giving a report to the next oncoming shift. She had asked CNA #2 if she would like her to help lay Resident #1 down and she replied sure. CNA #1 said the hoyer lift sling appeared to be properly in place. CNA #1 said she hooked the resident's sling up to the hoyer lift and began to lift him to the bed. She said Resident #1 suddenly began to slip out of the sling and onto the floor. An undated statement was obtained from CNA #2. CNA #2 said she worked on the night shift at (facility name). CNA #2 said she started her shift at 6:00 p.m. on 4/15/24. CNA #2 said after report was given from the day shift, one of the day shift CNAs offered to help get Resident #1 into bed before she left for the day. CNA #2 said they went to Resident #1's room and he was sitting in his wheelchair by the window side and was leaning towards his right side. CNA #2 said they adjusted Resident #1 the best they could. CNA #2 said they tucked in the hoyer lift sling and criss-crossed the sling between his legs and moved the wheelchair closer to the hoyer lift machine. CNA #2 said they then lowered the hoyer lift machine down to wheelchair level and proceeded to hook up the sling to the machine. CNA #2 said they used the first hook on all six hookups (three on left, three on right). CNA #2 said she had control of the hoyer lift and the other CNA (CNA #1) was guiding Resident #1 towards the bed. CNA #2 said the wheelchair was removed once he was high enough, then she proceeded to move towards the bed. CNA #2 said they were in position moving towards the bed when Resident #1 slipped out of the sling through the bottom. CNA #2 said Resident #1's bottom went through the sling and he landed on his bottom, and then fell backwards and hit his head. CNA #2 said at that point she was in a state of shock. CNA #2 said she had been doing that job for more than [AGE] years and that had never happened. CNA #2 said they went to Resident #1 and he was still awake, aware and trying to speak. CNA #2 said the nurse rushed in and called 911. CNA #2 said she stayed with Resident #1 until the ambulance and fire department came to help him off the floor. She said Resident #1 was then sent out to the hospital for further evaluation. An undated statement from the DON said CNA #1 and CNA #2 had both been through skills check-offs to include mechanical lifts, and both followed facility protocol for hoyer lift use. The statement said this had been an unfortunate, isolated event. The resident was evaluated at the hospital and the head computed tomography (CT) scan did not show any new bleeds. -However, according to the emergency progress note Resident #1 sustained a large posterior scalp hematoma (see record review below). C. Record review (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The baseline (admission) care plan, dated 4/13/24, revealed the resident required two person assistance with transfers, bathing, grooming, locomotion and toileting. The resident was at risk for falls related to impaired mobility secondary to weakness and debility and related to current drug regimen.The resident had acute and chronic pain. The 4/13/24 admission skin assessment revealed an actual surgical wound with dressing changes per physician orders. A review of the April 2024 CPO revealed a physician's order was set up to follow up with a neurological surgeon to remove the staples from the resident in five days, ordered on 4/14/24. The 4/16/24 nursing progress note, documented at 1:49 a.m., revealed the nurse heard a loud bang and the nurse ran into Resident #1's room. The resident was on the floor. The CNAs were using the hoyer lift and the resident slipped through the middle of the sling. The resident hit the back of his head. RN #1 came and evaluated the resident. The 4/16/24 change in condition note, documented at 2:42 a.m., revealed the resident's vital signs were within normal limits. The resident was vomiting after the fall. The note documented the physician and family were notified of the fall at 6:30 p.m. on 4/15/24. The 4/16/24 bed hold progress note, documented at 8:18 a.m., revealed the DON spoke with the resident's spouse who stated the resident would not be returning to the facility. The post fall evaluation, completed by the DON on 4/16/24, revealed the resident sustained a witnessed fall on 4/15/24. The resident hit his head and was transferred to the hospital. Neurological checks were initiated per facility protocol. A skin evaluation was not completed. The resident did not have pain from the fall and did not receive pain medication. The resident fell during a transfer in the resident's room with a hoyer lift and sling. The assessment documented the probable cause of the fall was the resident's buttocks slid through the sling onto the floor and the staff expressed that it was properly placed and the appropriate size sling was used. The IDT (interdisciplinary team) discussed the resident's fall. The resident was on the fall program with his bed in a locked and low position, received assistance from two persons at all times for hoyer lift transfers and to assure the sling fit correctly. The evaluation documented the care plan was revised on 4/16/24. It documented the physician and family were notified on 4/15/24. The 4/15/24 hospital progress note documented a [AGE] year old male with a history of Parkinson's disease and recent subdural hemorrhage status post burr holes brought in to the emergency department from a rehabilitation facility after he was accidentally dropped out of a hoyer lift and hit his head once again. He was not on an anticoagulant and was nonverbal at baseline. He was noted to have a large posterior scalp hematoma that was new since prior exam. A review of the resident revealed he had pain to his left ankle with mild soft tissue swelling. X-rays were obtained and were negative. The hospital progress note documented the plan was for the resident to return to the rehabilitation facility, however the patient's wife had serious concerns about the safety of this facility and did not wish him to go back there. The note documented the resident's spouse was going to contact hospice and palliative care services tomorrow morning as her desire was to take him home on hospice care. The resident was discharged home on hospice from the hospital on 4/17/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Following Resident #1's fall on 4/15/24 from the hoyer lift, the facility failed to identify the root cause of Resident #1's fall, conduct staff re-education to prevent future falls, review transfer training techniques, or review use of the hoyer lift procedures with CNA #1 and CNA #2, who were involved with the fall. D. Staff interviews The DON was interviewed on 7/30/24 at 5:05 p.m. The DON said Resident #1 sustained a fall on 4/15/24 at 6:30 p.m. The DON said CNA #1 and CNA #2 witnessed the fall. She said CNA #1 and CNA #2 alerted LPN #2 after the fall. The DON said CNA #1 and CNA #2 were transferring Resident #1, via a hoyer lift, from his wheelchair to the bed and had lifted the resident up in the sling and out of the wheelchair and began to lift him to the bed and that was when Resident #1 fell . The DON said she felt it was a freak accident. The DON said the hoyer lift sling was placed correctly because staff had expressed that it was properly placed and the appropriate size. She said when the CNAs started moving Resident #1 toward the bed, he slipped through the sling. The DON said since Resident #1's admission he had required two person assistance with the hoyer lift. The DON said the comprehensive care plan was still being developed on the day the resident sustained the fall. She said the resident's care plan was not updated after the fall because the resident did not return to the facility. The DON said there was a communication board in the resident's room to let the caregivers know what assistance level the resident required. The DON said no further re-education training was provided to CNA #1 and CNA #2 after the fall because they were both very competent with transfers and she did not know what further instruction or information she could have told them on how they could have corrected the situation. The DON reiterated that she had never seen this type of accident before so there had not been specific training or corrective action given to the direct care staff after the fall. The DON said CNA #1 and CNA #2 had had training on the hoyer lift in February 2024 and had completed the skills competency checklist. The DON said the facility did not do any other training for all the staff after the fall on 4/15/24 because she did not think it was needed as they had just completed the annual skills checklist and there was nothing identified in the fall incident that could have improved the situation. CNA #2 was interviewed on 7/30/24 at 5:40 p.m. CNA #2 said Resident #1 fell on [DATE] when she had just come on shift. She said Resident #1 was in his wheelchair and CNA #1 had offered to help put him into bed. CNA #2 said it was dinner time and sometimes it got busy, so she was glad for the help. CNA #2 said the hoyer lift sling was under Resident #1 and the moment she moved the hoyer lift away from the wheelchair, the resident fell and hit his head on the floor. CNA #2 said she screamed and could not believe what happened. CNA #2 said she ran and got the nurse and the resident was sent to the hospital. CNA #2 said she could not pinpoint what went wrong with the transfer since the sling was already under him. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #1 was interviewed on 7/30/24 at 5:44 p.m. CNA #1 said she and CNA #2 went in to transfer Resident #1 on 4/15/24 via a hoyer lift. She said he fell out of the sling during the transfer. CNA #1 said Resident #1 was in his wheelchair and she and CNA #2 went to hook the hoyer lift sling up and put him to bed for the evening. CNA #1 said she hooked up the sling and he slipped out of the sling. CNA #1 said she and CNA #2 had put the hoyer lift sling underneath the resident. CNA #1 said she remembered that because she had been working with Resident #1 all day on the day shift. CNA #1 said Resident #1 had just finished eating his dinner. CNA #1 said when Resident #1 was lifted up with the hoyer lift, they were turning the hoyer lift to go to the bed and that was when Resident #1 slid out of the sling and hit the floor. CNA #1 said she was completely shocked and did not know what could have gone wrong. CNA #1 said she was trying to be extra careful with the hoyer lift transfers she was now doing but said she did not receive any new training after the resident's fall. LPN #2 was interviewed on 7/30/24 at 5:55 p.m. LPN #2 said when she entered Resident #1's room on 4/15/24, he was on his back on the floor. She said the resident was conscious. LPN #2 said she checked his vital signs and went to get RN #1. LPN #2 said Resident #1 started vomiting when the emergency medical technicians (EMT) arrived. RN #1 was interviewed on 7/30/24 at 6:00 p.m. RN #1 said another RN, who had since retired, came in to assess Resident #1. RN #1 said the nurse on the floor would typically complete a fall progress note. RN #1 said a progress note was not documented by the RN in the resident's EMR. RN #1 said she decided not to move the resident until the EMT's arrived. RN #1 said she came in later to check on the situation, the resident was still on the floor and the EMTs had arrived. RN #1 said she heard the CNAs say they had hooked the hoyer lift up and they were not sure what had happened or how he fell . She said the CNAs did not say the hooks fell off but the resident fell out of the sling. The DON was interviewed again on 7/30/24 at 6:13 p.m. The DON said she had put an education book about the different types of hoyer lift slings to use, how to know which size to use as a guide and placed them at the CNAs desk stations. The DON said she was not sure if any of the CNAs had looked at it or read it. The DON said the facility had not had any further incidents of hoyer lift falls, but said she had not done any official education with staff following the fall. E. Facility follow-up On 7/30/24 at 6:04 p.m. the DON provided documentation that CNA #1 had completed a skills competency checklist on 2/13/24 and CNA #2 had completed skills competency checklist on 2/17/24. The competency nurse aide skill checklist included 53 personal care skills, including hoyer use, with a date passed by demonstration and a signature. -However, the facility did not have CNA #1 and CNA #2 complete a new skills competency checklist following Resident #1's fall from the hoyer lift on 4/15/24. On 7/31/24 at 10:30 a.m. the NHA provided documentation that the facility had conducted weekly ongoing maintenance and hoyer lift inspections from January 2024 to present. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065390	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Centennial, The	3490 Centennial Blvd Colorado Springs, CO 80907

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/31/24 at 1:09 p.m. the DON provided documentation of an audit that was performed by therapy on 7/31/24 (during the survey) to ensure residents who required hoyer lifts had the appropriate sling sizes and types and felt safe with them. The audit included five residents who were currently transferred by nursing staff using the hoyer lifts. On 8/2/24 at 9:45 a.m. the NHA sent an email which revealed in pertinent part, the NHA further reviewed the case (of the hoyer lift fall with Resident #1) with the facility medical director and the DON. The NHA said the chart reflected that when Resident #1 was returned to acute care post-fall, no significant changes from the prior studies were identified (attached were the before and after CT/neurology consult notes). The NHA said, specifically, Resident #1 had a previous history of brain injury/bleeds and that the staples identified in Resident #1's head were present upon admission to the facility. The NHA said no additional injuries or signs and symptoms of pain were noted by staff as a result of the fall. The in-services, audits sheets began and he would provide (see below). -However the hospital notes revealed after the facility fall Resident #1 sustained a new large posterior scalp hematoma (not subdural), and a new left ankle trauma with pain and mild soft tissue swelling (see record review above). In addition Resident #1 exhibited vomiting after the fall. On 8/2/24 at 2:21 p.m. the DON provided a signature page for the hoyer lift in-service. The hoyer lift in-service was dated 7/31/24 (during the survey). -However, the document revealed CNA #1 had the in-service emailed to her and CNA #2 did not participate in the in-service. -Additionally, the facility only provided the signature page, not the curriculum for the hoyer lift in-service.