STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105577	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Orlando	654 N Econlockhatchee Trail Orlando, FL 32825

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview and record review, the facility failed to ensure effective communication and collaboration between members of the interdisciplinary team and hospice to provide the necessary care and services to attain the highest practicable well-being before and after a fall for 1 of 5 residents reviewed for falls, of a total sample of 9 residents, (#1). The facility's failure to follow the physician's orders and treat pain and discomfort after a change in condition resulted in actual harm. Findings: Cross reference F725 and F849 Review of resident #1's medical record revealed she was originally admitted to the facility on [DATE] and readmitted on [DATE] from an acute short-term hospital. Her diagnoses included heart failure, type 2 diabetes, neuropathy, anxiety, and anemia. Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date of 8/02/24 revealed resident#1's Brief Interview for Mental Status score was 11 out of 15 which indicated moderate cognitive impairment. The MDS assessment noted no behaviors or rejection of evaluation or care necessary to obtain goals for health and well-being. The assessment showed her hearing was highly impaired and she needed set up or supervision assistance from staff for activities of daily living (ADLs). She was occasionally incontinent of bladder and was always continent of bowel. Review of the medical record revealed resident #1 had a care plan for potential for pain revised on 11/26/23. The goal read, Resident will state/demonstrate [relief] or reduction in pain intensity after receiving interventions . The interventions directed nurses to administer and monitor for effectiveness and for possible side effects of pain medication. Resident #1 also had a care plan for hospice, revised on 8/30/24, which directed nurses to collaborate with hospice regarding care, medicate for pain/discomfort as indicated within the physician orders and notify hospice, the physician, and family with changes as needed. The goal noted pain would be relieved with the aid of medications and she would be supported to promote her comfort. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of resident #1's physician's orders revealed an order for 3 liters per minute of Oxygen via nasal cannula as needed (PRN) dated 8/28/24, the anti-anxiety medication Ativan 0.5 milligrams (mg) every 6 hours (Q6H) as needed for agitation dated 9/05/24 and entered at 1:27 PM. An order for Norco 5-325 mg 4 times a day around the clock for pain management dated 9/06/24 entered at 12:34 PM. She had an additional physician order for Tylenol 325 mg 2 tablets every 8 hours PRN for moderate pain (0-3). Another order entered at 11:19 AM on 9/06/24 read, 2 view X-ray to nose s/p (status post) fall. STAT (immediately or right away). Review of a progress note effective 9/05/24 at 4:17 PM, with late entry on 9/06/24 at 12:21 AM, read, Resident was confused and agitated. Requested a onetime removal of controlled substances medication to administer Ativan 0.5 mg. Resident requested to call family and inform of her status. Called daughter and updated on event. Daughter stated she would visit her on 9/06/24. Another progress note dated 9/06/24 at 1:30 AM, revealed resident #1 was, very anxious and crying, trying to get off bed, and stating she wants to go home to her daughter. The note detailed resident #1 was assisted to her wheelchair and a Spanish speaking nurse advised her it was night time and her daughter would visit her in the morning. The nurse documented that Ativan 0.5 mg was administered at this time along with pain medication, and one-to-one monitoring was initiated. Review of a progress note dated 9/06/24, effective 5:00 AM, late entry at 8:04 AM revealed that previously administered medication for anxiety and pain were ineffective. The nurse documented resident #1 continued to be agitated and cried on and off. She indicated assigned CNA (Certified Nursing Assistant) A who was assigned to watch another resident on the 100 unit at that time was asked to take resident #1 to the 100 unit to watch her while the nurse passed medications on the 300 unit. She detailed the CNA was attending to the other resident on the 100 unit when resident #1 got up from her wheelchair and fell , sustaining a skin tear to her nose. The note described resident #1's wound was cleansed, and a dry dressing was applied. Her son and the hospice nurse were also made aware. The hospice indicated they would send a nurse to assess the resident and follow up on anxiety and pain medication frequency. Review of an eInteract SBAR (Situation, Background, Appearance, Review and Notify) Communication Form dated 9/06/24 revealed resident #1 had a fall and sustained a skin tear. The Pain Evaluation section showed resident had worsening of chronic pain, and the intensity was scored a 4 out of 10, with 10 being the worst pain. The Neurological Evaluation section was not assessed and answered, Not clinically applicable to the changes in condition being reported. The summary described the events of the fall, the CNA assigned to the resident was watching another resident at the time. The form indicated when the CNA turned to assist the other resident, resident #1 fell from the wheelchair, was observed lying on her left side with a skin tear to her nose which with bleeding. The summary continued that resident #1 was very agitated the whole night and anxiety and pain medications were given at 1:30 AM without any effectiveness, crying and agitated continued, and she tried to get of her wheelchair. The form showed communication to the Primary Care Clinician occurred at 6:42 AM and the recommendations were for the hospice nurse to be sent to evaluate and follow up on anxiety and pain medication frequency. The fall was reported to resident #1's family at 6:33 AM. Review of the hospice Pre-Admit Evaluation form dated 8/29/24 revealed Goals of Care, Avoid hospitalization s that will cause suffering for mom. Keep her in her familiar surroundings and as comfortable as possible. The evaluation showed resident #1 was, Currently more disoriented and trying to take off clothing . Intermittent confusion, Intermittent agitation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the hospice RN (Registered Nurse)-Initial Comprehensive Assessment note dated 8/30/24 revealed resident #1 suffered from chronic lower back pain and Tylenol 500 mg was given twice a day to manage that pain. The assessment showed the Care Plan Outcome was to manage pain. It listed interventions including to staff to assess pain, anticipate needs, administer medications as prescribed, and call hospice with any changes or concerns. The psychosocial section read, hospitalization = yes and hospitalization Preference = yes, discussion occurred. The note included how to contact the hospice provider and was discussed with the facility nurse. Review of a Focus Visit from the hospice nurse note dated 9/05/24 revealed a pain score of 5. The note read, Pain medication was ordered Norco 5/325 mg and restarted Gabapentin. Patient started on Ativan for agitation PRN Q6 (every 6 hours). The note included, Education for staff & PCG (patient caregiver) on care communicated with FN (facility nurse) also. The note included report was given to the facility nurse. Review of the hospice Interdisciplinary Plan of Care Revision/Physician Orders dated 9/05/24 read, Start Gabapentin 100 mg take 2 capsules TID (three times a day) for nerve pain. Ativan 0.5 mg Q6H (every 6 hours) PRN for agitation. Norco 5/325 mg was not included in the order. On 9/24/24 at 12:17 PM, during a telephone interview, resident #1's son stated the day his mother fell he had to beg the facility to send her to the hospital after her fall. He stated his mother was not supposed to be out of bed and needed oxygen. Resident #1's son stated his mother told him that the night before she fell , staff had her in the wheelchair in the hallway since 11:30 PM. He recounted his mother told him staff took her to the 100 hall, when she felt dizzy and asked to be taken back to her room, but her request was ignored. Resident #1's son shared that his mother had been diagnosed with heart failure earlier in the year, so she needed oxygen and had become weaker. He mentioned she no longer had the energy to get in the wheelchair by herself and depended more and more on staff to assist her. He recalled when he and his sister got to the facility on [DATE] they found their mother still sitting in a wheelchair with a bandage on her nose. He stated after the fall, she was not immediately taken back to her room and had not been wearing the oxygen. He described her body had, bruises all over, and he learned at the hospital she had sustained hematomas (bruises) on her face, two fractures on her nose and one fracture on her spine. Resident #1's son indicated her death certificate included blunt force trauma to her face and head. He felt if she needed more attention, Why did they not call hospice? They were probably busy or short staffed. He stated after the fall he was told the facility was waiting for an X-ray to be done. He explained, At the end, she suffered a lot. The hospital could not perform surgery, and she was in a lot of pain. He stated he called the hospice and was told the facility could have sent his mother to the hospital after the fall. He stated he felt the facility failed to provide basic standard care to his mother. He said, This did not have to happen, it was negligence. Why did she fall? Why did they not call her family? They would have come to the facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/25/24 at 11:33 AM, during a telephone interview, resident #1's daughter stated she came on 8/26/24 from out of state to spend time with her mom who had been a resident of the facility for many years. She went to the facility every day starting on 8/27/24. She noted due to her heart failure her mother needed oxygen, became weaker, and spent more time in bed. She mentioned resident #1 was pretty frail because of her age but was not in a state of dying. She recalled when she left the faciity on [DATE] at approximately 4:30 PM, her mother was in bed taking a nap. She shared the hospice nurse had visited earlier that day, and her mother was, a little restless and uncomfortable. The hospice nurse mentioned a medication would be given to help her relax, especially to sleep at night. She stated when the nurse called her later that evening, she asked if her mother had received the medication to help her relax but was told it had not arrived. She stated she did not hear from the facility again until the morning after her mother had fallen. She recalled when she arrived at the facility and saw her mom, she never expected to see what she saw, her mother was, sitting in a wheelchair by the nurses station, slumped down, and in pain, with a little blanket over her, a little band aid over the nose, with no oxygen, and the nurse working on the computer. She stated she was very shocked and asked the nurse, why her mother was still sitting in the wheelchair and not in her bed? She explained at this point resident #1 was taken to her room. She stated the nurse, and another staff member transferred her mom to her bed and then placed the nasal cannula with oxygen on over her bloody nose. She mentioned the facility called the hospice nurse, but no one did anything else. She recalled she saw, blood on the dressing and her face was all bruised. Resident #1's daughter stated her mom complained of pain, was whining and crying like it hurt. She stated at that moment her mother could not explain anything because she was in so much pain, so she asked the nurse if she had received pain medication. The nurse told her they had not given her mother anything for her pain. She stated, then the nurse gave her some Tylenol, but she noticed it did not work for her. She said, She (her mother) was still whining, complaining it still hurt, groaning, not wanting to be touched, you could see the pain in her body and her face. She stated she asked the nurse why she was not sent to the hospital and the answer was they needed to call the hospice nurse first. She stated when the hospice nurse evaluated her mom, She said that was a broken nose for sure. She stated she asked again if her mother was going to be sent to the hospital and was told no because they had ordered an X-ray. She mentioned she agreed to the X-ray but told the nurse her mother needed to be evaluated at the hospital. She indicated she waited for the X-ray to happen, but it never did. She shared resident #1 did not get any pain medication after the morning dose of Tylenol. She stated that her mother continued to sleeping on and off but would awaken with, a lot of whining and crying in pain. She recounted that her brother had left the facility for a little while and when he returned later around 4:00 PM he was surprised nothing had been done and their mom was still in a lot of pain. She stated at that time he asked several staff to explain what was going on and insisted she be sent to the hospital. She said, He had to insist a lot because they were not even cooperating to speak with him. She recalled when paramedics came, they asked staff why it took so long after the fall to be called because they could see there was damage. She explained once in the hospital, It was very traumatic to hear the news. She recounted the neurosurgeon told them her mother had two fractures on her nose, one fracture on the bone of her nose and another one on the sternum of her nose, a concussion on her forehead, two hematomas on the forehead, and a fracture of her spine. She explained the neurosurgeon told them the treatment plan would have been surgery but at her age, they could not do anything for her. She said staff at the hospital explained to her, This injury hurt her more than they could do, so they could not help her. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/24/24 at 6:09 AM, assigned CNA A explained she learned during change of shift report at 11:00 PM resident #1 had been confused. She recalled resident #1 refused to stay in bed, and Licensed Practical Nurse (LPN) C wanted to prevent a fall so she placed resident #1 in the wheelchair. She stated they had a busy night and resident #1 refused to stay in bed or the wheelchair. She recalled resident #1 tried to get up from the chair, but she could not transfer by herself. CNA A explained LPN C asked her to stay with resident #1 while she passed medications. She recounted she was doing one-to-one supervision with another resident on the 100 unit while she also took care of other residents and kept an eye on resident #1 who was in the wheelchair because there were not enough staff to watch her in her room. She indicated that even though the wheelchair was locked and would not move, she could not reach resident #1 at the wheelchair in time. CNA A conveyed when resident #1 attempted to get up and walk on her own, she fell face forward and hit her head. CNA A stated, I did my best, it's not my fault. She then stated resident #1 was left in her wheelchair because, If she was in bed they would need to keep watching her there. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/24/24 at 1:41 PM, during a telephone interview, LPN C confirmed she was assigned to resident #1 when she fell . She stated she had taken care of resident #1 before, knew she was weak, and all ADL care was performed in bed. She explained when she started her shift that night resident #1 was trying to get out of bed and CNA A called her. She indicated she was told during report resident #1 received Ativan earlier because she was, very anxious, trying to get out of bed. She stated LPN B had told her she pulled Ativan from the emergency kit, and she called to ask resident #1's daughter to come to the facility and help calm her down but she responded she would come in the next day. LPN C stated she put resident #1 in her wheelchair and kept it next to her all night. She recalled during the shift resident #1 kept talking in Spanish but there were no Spanish speaking staff on the unit, so she took resident #1 to the 200-unit and asked a Spanish speaking nurse to talk to her. LPN C indicated the nurse told her resident #1 was not making sense so she requested another Ativan from the emergency kit. She recalled in the morning, when it was time for her medication pass, resident #1's CNA was doing a one- to-one with another resident on the 100-unit, so she asked her to take resident #1 with her which she did. She explained one of the nurses from the 100-unit called her later and told her resident #1 fell . She stated she went to the 100-unit and saw resident #1 on the floor, lying on her left side, and there was blood. She indicated she assessed resident #1 and noted a small tear on her nose, and she applied pressure to it. She stated she assessed for pain but resident #1 kept on, crying, crying, and crying. She indicated resident #1 was speaking in Spanish, but I could not understand what she said, she was in pain because of the fall, and she had blood everywhere. She stated it took three staff to move her and sit her back up in the wheelchair. She stated CNA A explained to her she had resident #1 by the door of the room she was assigned one-to-one supervision with, when she saw resident #1 get out of her chair and fall but she could not reach her in time because she was not close enough to her. LPN C stated, There was nobody there to sit with the resident after she fell so she had remained next to me in the wheelchair. She stated she called hospice to report the fall and was told they would come in to follow up. She stated she did not get an order to send resident #1 to the hospital because she only saw bleeding on her nose and the bleeding stopped. She could not recall if she gave resident #1 any pain medication after the fall. When asked why she did not call hospice or the physician before resident #1 fell to report her change in condition, LPN C stated the nurse before her, had already done a change in condition and had called hospice and everybody. Being the night shift, I was waiting for the morning to report the resident's behavior. She stated LPN B wrote a progress note and mentioned during shift change report she had contacted everybody, and resident #1's family was coming in the morning. She explained resident #1 cried on and off, fidgeting throughout the night and she had never seen her behave that way before. She indicated when resident #1's family came in, they took her back to her room. In another telephone interview on 9/25/24 at 4:03 PM, LPN C stated she did not recall if resident #1 complained of pain, but said she was crying on and off. She recalled she had given her Tylenol and Ativan earlier at 1:30 AM. She stated resident #1 was fidgety in the chair and crying on and off. She said after the fall, It was not time to give Tylenol again, so I did not give her Tylenol. On 9/25/24 at 9:58 AM, CNA E stated she worked the 7 AM to 3 PM shift on 9/06/24. She recalled resident #1 was in her wheelchair in the dining area of the 300-unit and a CNA from the 11 PM to 7 AM shift was sitting next to her. She indicated she went to them to greet the resident and noticed she had a bandage on her nose. She remembered asking the CNA what happened and was told resident #1 was very anxious during the night, got up and fell . CNA E detailed resident #1's facial expression showed pain, and she was uncomfortable because she kept placing her hands on her head. She stated she asked resident #1 in Spanish if she was in pain but resident #1 would only touch her face and head and moved it side to side. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/25/24 at 1:48 PM, CNA F stated she worked a double shift on 9/05/24, from 7 AM to 11 PM and was assigned to resident #1. She noticed resident #1 was really confused and started getting agitated that day. She recalled resident #1's daughter visited, and both tied to calm resident #1 and made her comfortable in the bed. She stated later at night resident #1 tried to get out of bed, she saw her legs out of bed, and she said something in Spanish, she seemed anxious. She recalled before the daughter left the facility, she had mentioned resident #1 had a new order in case resident was anxious and she informed the nurse. She stated the nurse had a CNA sit in the room with resident #1 and she was in bed, sleeping, when she left for the night. She recalled when she returned to work at 7 AM on 9/06/24, she saw resident #1 sitting in the wheelchair with the 11 PM to 7 AM CNA in the dining area. She stated resident #1's face was bloody, and LPN D was trying to apply ice to her nose. She indicated resident #1 had a dressing or tissue on her nose, resident #1 was holding her nose, and she could see blood. She stated resident #1 was complaining of pain. CNA F said, You could hear her say, ay, ay, just ay, ay but she was not crying. She stated throughout the day she checked on the resident and she heard resident #1 say, ay, ay and make noises. She stated she knew resident #1 was in pain. On 9/25/24 at 2:43 PM, during a telephone interview, LPN B stated she worked the 3 PM to 11 PM shift on 9/05/24 and was told by resident #1's daughter she had requested, something for the anxiety because her mother was getting anxious at night. She explained later that night, resident #1 became agitated, confused, and tried to get out of bed so she implemented a staff one-to-one intervention. She stated she called the pharmacy to expedite her medication request because resident #1 was agitated, but did not document at the time she administered the medication, because so much was going on. She stated during shift change report at 11 PM, she told the oncoming nurse resident #1's next dose of Ativan should be at around 1:00 AM and to have it ready to go due to resident #1's behaviors. She clarified that the time documented in the Medication Administration Record (MAR) was not when the medication was given because, It was so hectic. LPN B recalled she called the family per resident #1's request and spoke with her daughter. She explained she did not call hospice or the physician because she did not think it was needed. She recalled resident #1 eventually fell asleep and was still sleeping when she gave report to the oncoming nurse at 11:00 PM. She indicated she returned to work the next day at 3:00 PM on 9/06/24 and resident #1's daughter was at her bedside and shared what happened that day. She recalled resident #1 had bruising to her face, on the bridge of the nose, one of her fingers was swollen and it appeared it might have been broken. She stated resident #1's family said they were waiting on an X-ray, but LPN D had not gotten report yet. LPN B shared that the previous shift was late with resident #1's medications and she did not get the medication cart keys until approximately 4:30 PM to 5 PM. LPN B stated she found out the X-ray was not done yet and asked LPN D why resident #1 was not sent to the hospital earlier but did not get a response. She indicated she asked about the X-ray and LPN D's response was she had not seen the X-ray people yet. LPN B recalled she had the same concerns as resident #1's son, who was visibly upset. She mentioned she was baffled as to why resident #1 had not been sent to the hospital. She stated the son spoke with the Director of Nursing (DON) and the decision to send resident #1 to the hospital was made. She recalled she obtained resident #1's vital signs and noted her blood pressure was a little bit elevated. She stated resident #1 had expressed pain and, you could visibly see it; you could see she was in pain which would explain why her blood pressure was elevated. She said, The family could see that as well. I would have sent the resident to the hospital. I would be upset as well. They did not want to wait anymore for the X-ray. Review of a pharmacy report for the automated dispensing machine showed Ativan 0.5 mg was removed twice for resident #1 on 9/05/24 at 9:00 PM and again on 9/06/24 at 1:21 AM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/25/24 at 3:33 PM, during a telephone interview, LPN D stated when she started her shift at 7:00 AM on 9/06/24, she noticed resident #1 was in a wheelchair in the dining area with a CNA next to her, Not herself, lethargic, just sitting there, had a bloody nose, swelling on her face. She indicated she asked what happened and inquired Are we sending her to the hospital? She stated LPN C told her she called hospice and was told not to send her to the hospital because they were coming to see her. She stated she gave resident #1 an ice pack to hold to her nose to get the swelling down. LPN D stated she did not remember if she had been given pain medication, but recalled resident #1 was in pain and gave her some Tylenol after report. She explained she was expected to perform neurological checks, currently at the half hour mark. She stated after a fall neurological checks were done every 15 minutes for one hour, every 30 minutes for two hours, every hour for four hours and every eight hours. She said she could not keep up with the needed checks due to the care needed for other residents including passing medications. She recalled the hospice nurse went over medication changes and was there for at least a couple of hours but did not send resident #1 out to the hospital. She mentioned she was going by the plan of care from hospice. She explained there was miscommunication with the DON regarding the X-ray order. She mentioned she thought the DON told her she had to enter the X-ray order in the medical record. She stated when she saw the order was already in the medical record, she thought it was taken care of. She mentioned the DON had sent her a text instructing her to call the portable diagnostic services and order the X-ray, but did not see the message until later, so it was never completed. LPN D explained she was, Just busy, trying to do everything I had to and it was not until she sat down between 3:30-4:00 PM that she realized the X-ray was never done. She indicated resident #1's son was upset and went straight to speak with the DON and requested his mother be sent to the hospital. Review of a progress note dated 9/06/24 entered at 5:46 PM, by the DON, effective 10:42 AM, revealed she spoke with resident #1's daughter who was upset the resident was out of bed and fell earlier that morning. The DON explained the reason resident #1 was up in the wheelchair was because, She was very anxious/agitated, and attempted to get out of bed. The note mentioned the DON, advised daughter that we cannot restrain a resident in a bed or chair so a fall is possible and that she may attempt to get out of bed again . Daughter asked how to prevent resident from falling and again writer advised we could not prevent her as we are not able to be right next to the resident 24/7. Writer suggested to the daughter about looking into getting a private companion to stay with resident in hopes of preventing a future fall . The daughter expressed concerns about the bruising to resident's nose and writer advised writer would obtain an order for x ray to rule out any injury. Review of the Medication Administration Record (MAR) for September 2024 revealed resident #1 received Ativan 0.5 mg on 9/05/24 at 11:58 PM. Tylenol 325 mg 2-tabs was given on 9/05/24 at 5:44 AM, for a pain level of 5 and on 9/06/24 at 1:28 AM for a pain level of 7. Norco 5-325 was not given, and the first dose was scheduled for 6:00 PM on 9/06/24. Resident #1 received 2 doses of Gabapentin on 9/06/24 at 3:49 AM and at 11:17 AM. A Lidoderm patch was administered on 9/06/24 at 8:04 AM. There was no evidence in the MAR that Tylenol or other PRN pain medication or Ativan for anxiety were administered after resident #1's fall. Review of resident #1's Weight and Vitals Summary report showed the Pain Level Summary for 9/06/24 as follows: 1:28 AM - level 7/10 1:58 AM - level 7/10 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Orlando	654 N Econlockhatchee Trail Orlando, FL 32825

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F 0684 Level of Harm - Actual harm Residents Affected - Few	3:50 AM - level 7/10 7:04 AM - level 4/10 8:04 AM - level 8/10 (PAINAD) The Pain Assessment in Advanced Dementia (PAINAD) Scale . provide a clinically relevant and easy to use pain assessment tool for individuals with advanced dementia. The tool covers five behavioral categories: breathing, negative vocalization, facial expression, body language, and consolability . The PAINAD was developed as a shorter, easier observation tool for assessing pain in nonverbal elders. (Retrieved from www.geriatricpain.org on 10/02/24). Review of a Focus Visit note by the hospice nurse dated 9/06/24 showed the visit started at 8:30 AM and ended at 11:00 AM. It revealed communication with the facility nurse, resident #1's son and daughter. It read, Patient is imminent (s/s consistent with a prognosis of 5 days or less). It showed resident #1 had a decreased response to verbal stimuli and decreased response to visual stimuli. The note documented pain was continuous, level 5 per caregiver, staff, and hospice staff, effect mobility, sleep, eating/appetite, and social activities. The vital signs were blood pressure 64/99, heart rate 100, and respirations 26. Multiple areas with ecchymosis. The note included instruction to assess patient for pain - any movement pt cries out. Norco 5/325 mg ordered Q6 around the clock, restart Gabapentin 200 mg TID. Assess patient for SOB (shortness of breath) - respirations 26, O2 at 3.5 L NC, O2 sat 98%. Assess patient for status post fall - 1 1/2 cm (centimeters) cut to nose - 0 bleeding. Left ring finger knuckle bruised, and left shin multiple bruising. Review of the hospice Interdisciplinary Plan of Care Revision/Physician Orders dated 9/06/24 revealed these interventions: discontinue Tylenol 1000 mg BID (twice a day), a new order for Norco 5/325 mg (may crush) Q6 hours around the clock. Review of Focus Visit note dated 9/06/24 by the hospice Chaplain revealed the visit started at 11:30 AM and ended at 12:45 PM. The note included Imminent: pain, respiratory distress, agitation uncontrolled, caregiver distress. The note mentioned resident #1 was unresponsive and not-verbal with uncontrolled restlessness, Facility staff not giving meds timely. The note indicated that the patient had a face down fall last night and both son and daughter were distressed. Review of the Psychosocial/Spiritual Updated Comprehensive assessment dated [DATE] by the Hospice Social Worker (SW) revealed the visit started at 12:30 PM and ended at 2:30 PM. The SW assessed resident #1's pain using the PANAID scale with a severity score of 6, rating negative vocalization, facial expression and body language at level 2 for each. The SW noted the care plan outcome was to manage pain with a goal of 1. The note indicated Norco, Gabapentin relieved the pain. The note read, Any movement pt [patient] shakes her head and states stop stop. The Psychosocial section included, Emotional Affects Behavioral Manifestations: agitated and Expression/Indications of Distress: emotional tired. The Interventions Performed section included, SW provided empathetic support and comfort touch. SW observed pt laying [sic] in bed and yelling in Spanish don't touch. SW observed pt daughter at bedside. The Response to Care section read, Pt laid [sic] in bed in agony of pain. Pt didn't want to be touched. Pt attempted to get comfortable. Pt left face around eye is bruised. Pt right leg is bruised. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/24/24 at 2:44 PM, the DON explained they reviewed the video footage and determined there was no way the fall could have been prevented. She indicated resident #1 tried to reach something on the floor and fell . The DON stated Tylenol was administered at 1:28 AM on 9/06/24 and Ativan was administered on 9/05/24 at 11:58 PM. She agreed that based on the documentation in the MAR, Ativan could have been given at 6:00 AM again. She indicated the hospice nurse spoke with resident #1's son and suggested she did not go to the hospital. She said, There was back and forth information and the son was ok with it. Later, on 9/25/24 at 8:55 AM, the DON confirmed that LPN D did not call on the X-ray because she thought the DON had called it in. The DON indicated she assumed it was called in because she entered the order for the X-ray in the medical record and asked the nurse to call it in. She stated she asked LPN D why the order was not followed up, and she could not give her a reason. On 9/26/24 at 9:34 AM, during a telephone interview, Hospice Manager G stated they re[TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview and record review, the facility failed to maintain sufficient nursing staff to provide the necessary care and services for 1 of 5 residents reviewed for falls, of a total sample of 9 residents, (#1). Findings: Cross Reference F684 Review of resident #1's medical record revealed she was originally admitted to the facility on [DATE] and readmitted on [DATE] from an acute short-term hospital. Her diagnoses included heart failure, type 2 diabetes, neuropathy, anxiety, and anemia. Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date of 8/02/24 revealed resident #1's Brief Interview for Mental Status score was 11 out of 15 which indicated moderate cognitive impairment. The MDS assessment noted no behaviors or rejection of evaluation or care necessary to obtain goals for health and well-being. The assessment showed her hearing was highly impaired and she needed set up or supervision assistance from staff for activities of daily living (ADLs). Review of a progress note dated 9/06/24 at 1:30 AM, revealed resident #1 was, very anxious and crying, trying to get off bed. The note indicated resident #1 told staff she wanted to go home to her daughter and was assisted to a wheelchair. The document detailed a Spanish speaking nurse told the resident it was night time and her daughter would visit her in the morning. The note revealed the anti-anxiety medication Ativan 0. 5 mg was administered at that time along with pain medication, and one to one supervision was initiated at that time. Review of a progress note dated 9/06/24, effective 5:00 AM, (late entry at 8:04 AM), read, Medication for anxiety and pain administered were ineffective, [resident] continues to be agitated and crying on and off. The nurse documented she needed to pass medications on the 300 unit, so she asked resident #1's assigned Certified Nursing Assistant (CNA) A to take resident #1 with her to the 100 unit to watch her and another resident that the CNA was already assigned one-to-one with. The note detailed that while the CNA watched both residents, resident #1 got out of her wheelchair and fell sustaining a skin tear to her nose. Review of a progress note dated 9/06/24 effective 10:42 AM, late entry at 5:46 PM, by the Director of Nursing (DON), revealed she spoke with resident #1's daughter who was upset the resident was out of bed and fell earlier that morning. The DON's note explained the reason resident #1 was up in the wheelchair was because, She was very anxious/agitated and continued to attempt to get out of bed. The note detailed that resident #1's daughter asked how they would prevent her mother from falling and the DON noted she advised her the facility could not prevent resident #1 from falling as staff were not able to be right next to her all the time. The DON's note indicated she suggested to the daughter to look into paying a private companion to stay with her mother to prevent a possible future fall. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 12:17 PM, during a telephone interview, resident #1's son stated his mother had reported to him when she used the call light at night, staff did not come to help her. He explained she was getting weaker and depended on staff for her ADLs. He indicated he signed up with hospice services in order to get more help for his mom. He stated he had understood she was not supposed to be out of bed due to her condition. Resident #1's son recalled when he arrived at the facility after his mother's fall, she was not in her room but was still sitting in the wheelchair until he requested she be taken back to bed. He recounted, the facility seemed short staffed but did not understand why staff did not call the family or hospice if they needed more help with his mom. He said, This did not have to happen. Why did she fall? Why did they not call us? We would have come to the facility. On 9/25/24 at 11:33 AM, during a telephone interview, resident #1's daughter shared the hospice nurse had visited her mother on 9/05/24 and noticed her mother was, a little restless and uncomfortable. She recalled the hospice nurse mentioned that staff could give her mother a medication to help her mother relax, especially to sleep at night. She indicated the facility nurse called her later that evening, between 10:00 and 10:30 PM, and said resident #1 asked her to call because she was missing her. She stated she asked the nurse if she had received the medication to help her relax and the nurse told her it had not arrived yet. She indicated she told the nurse to call her if her mother asked for her again and she could come to the facility, but she did not hear from them again until the morning after her mother fell . She recalled when she arrived at the facility, she saw her mother in a wheelchair by the nurses station, she was, slumped down, and in pain, with a little blanket over her and a little band aid over the nose, with no oxygen, and the nurse working on the computer. She stated she was very shocked and asked the nurse, why her mother was still sitting in the wheelchair by the nurse's station instead of in bed in her room. On 9/24/24 at 6:09 AM, CNA A validated she was assigned to resident #1 when she fell . She explained she learned during change of shift report that resident #1 had been confused and refused to stay in bed. Licensed Practical Nurse (LPN) C wanted to prevent a fall so she had resident #1 up out of bed and put into her wheelchair. She stated it was a busy night and resident #1 refused to stay in bed or the wheelchair. She stated LPN C asked her to supervise resident #1 while she passed medications. She explained she was already doing a one-to-one supervision with a resident in the 100 unit as well of taking care of the other residents on her assignment. She was asked to also supervise resident #1 who was in the wheelchair instead of her bed because, There was no one else who could stay with [resident #1] that night, to watch her. CNA A added, The 100 unit was short, and too many people were fall risks. There were too many people on the 100 unit refusing to stay in bed or chair, they needed staff to watch them, that is why no one else could take care of [resident #1]. She indicated that even though the wheelchair was locked, she could not get to resident #1 in time, and she fell face forward and hit her head. She stated after the fall, resident #1 was left in the wheelchair because they did not have any staff who could watch her when she was in bed. On 9/24/24 at 1:41 PM, in a telephone interview, resident #1's assigned LPN C explained she put resident #1 in her wheelchair that night so she could keep her next to her while she worked. LPN C stated, There was nobody there to sit with the resident after she fell so she had to remain next to me in the wheelchair. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 2:43 PM, during a telephone interview, LPN B stated she worked the 3 PM to 11 PM shift on 9/05/24. She indicated resident #1 became agitated, confused, and tried to get out of bed so she implemented a one-to-one supervision intervention. She explained she tried to get medication ordered by the physician for anxiety, but it was not available. She stated she called the pharmacy to expedite her request because resident #1 was agitated, but confirmed she did not document the time she actually administered the medication accurately, because so much was going on. On 9/25/24 at 3:33 PM, in a telephone interview, LPN D stated she was assigned to resident #1 on 9/06/24 from 7 AM to 3 PM. She indicated she was expected to perform neurological checks after the fall because resident #1 had hit her head. She explained neuro checks were to be performed every 15 minutes for one hour, every 30 minutes for two hours, every hour for four hours and then every eight hours. LPN D explained not all of the neurological checks were completed, I tried to keep up with her. I can honestly tell you I could not be there every hour on the hour because of other [medications] and things I had to do. I was giving some [medications], returning to see her, then went out to give other [medications]. LPN D said she was, Just busy, trying to do everything I had to, and it was not until she sat down between 3:30-4:00 PM that she realized the X-ray had not ever been done. Review of the Neurological Evaluation 72-hour Monitoring sheet dated 9/06/24 revealed only 10 of the 16 required neurological assessments were performed after resident #1's fall until she was sent to the hospital. Review of resident #1's physician's orders revealed an order for 2 view X-ray to nose s/p (status post) fall. STAT (immediately or right away) entered at 11:19 AM on 9/06/24. On 9/24/24 at 4:30 PM, during review of the video footage from the incident, the DON stated the one-to-one intervention obviously did not work. She indicated resident #1 was in the wheelchair starting around 1:30 AM. She described one-to-one supervision meant a staff member stayed with a resident to watch them and could not explain why CNA A was expected to perform one-to-one supervision with two different residents that morning. She mentioned she had not been contacted regarding the change in resident #1's condition and indicated her expectation was nurses notified her, the Risk Manager or the Unit Manager for any changes in condition. On 9/25/24 at 8:55 AM, the DON explained she entered the order for the X-ray and sent a message to the nurse to call it in. She indicated she later learned LPN D did not call to place the X-ray order. The DON stated when she asked the nurse why the order was not followed up on, the nurse could not give her a reason. Review of the Facility Assessment reviewed by the Quality Assurance and Performance Improvement Committee on 8/08/24 read, Residents' needs are constantly evaluated to ensure we have the appropriate personnel, equipment and clinical resources to provide care. At any moment, if a resident should develop a condition, disease or requires a treatment that is no part of the services we are able to provide, the resident will be transferred to the appropriate level of care. The document indicated staffing needs were evaluated at the beginning of each shift and, adjusted as needed to meet the care needs and acuity of the resident population.

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview and record review, the facility failed to communicate with the hospice provider when a change in condition was identified to provide the necessary care and services for 1 of 2 residents reviewed for hospice services, of a total sample of 9 residents, (#1). Findings: Cross Reference F684 Review of resident #1's medical record revealed she was originally admitted to the facility on [DATE] and readmitted on [DATE] from an acute short-term hospital. Her diagnoses included heart failure, type 2 diabetes, neuropathy, anxiety, and anemia. Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date of 8/02/24 revealed no behaviors or rejection of evaluation or care necessary to obtain goals for health and well-being. The assessment showed her hearing was highly impaired and she needed set up or supervision assistance from staff for activities of daily living (ADLs). She was occasionally incontinent of bladder and was always continent of bowel. Review of the medical record revealed resident #1 had a care plan for hospice revised on 8/30/24. It directed nurses to collaborate with hospice regarding care, medicate for pain and discomfort as indicated within the physician orders and notify hospice, the physician, and family with changes as needed. Review of a Hospice RN (Registered Nurse)-Initial Comprehensive Assessment note dated 8/30/24 revealed direction for nurses to anticipate needs, administer medications as prescribed and to call hospice with any changes or concerns. The note showed the hospice nurse discussed how to contact hospice with the facility nurse. Review of the Hospice Nursing - Updated Comprehensive Assessment note dated 9/02/24 revealed an order to discontinue oxygen (O2) at 2 liters per minute (LPM) and start O2 at 4 LPM via nasal cannula (NC) around the clock. Review of resident #1's physician's orders revealed an order for O2 via NC @ 4 LPM PRN (as needed) dated 9/02/24. Review of a progress note entered on 9/06/24 at 12:21 AM, effective 9/05/24 at 4:17 PM read, Resident was confused and agitated. Requested a onetime removal of controlled substances medication to administer Ativan 0.5 milligrams (mg). Resident requested to call family and inform of her status. Called daughter and updated on event. Daughter stated she would visit her on 9/6/24. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 9/06/24 at 1:30 AM, revealed resident #1 was, very anxious and crying, trying to get off bed, stating she wants to go home to her daughter. The note detailed she was assisted to a wheelchair and a Spanish speaking nurse spoke with the resident and advised her it was night time and her daughter would visit her in the morning. The nurse documented that Ativan 0.5 mg was administered at this time along with pain medication. The nurse implemented one-to-one monitoring at that time. Review of eInteract SBAR (Situation, Background, Appearance, Review and Notify) Communication Form dated 9/06/24 revealed resident #1 had a fall and sustained a skin tear. The summary read, Rt. (resident) was up all night very agitated and crying on and off, one-to-one monitoring was initiated, CNA (Certified Nursing Assistant) assigned to Rt. was watching another Rt. who was 1:1 when she turned and assisted the other Rt. and Rt. fell from chair, The SBAR indicated resident #1 was very agitated the whole night and anxiety and pain medications that were given were not effective. The document revealed resident #1 continued crying and being agitated, trying to get of the wheelchair. The form showed communication to the Primary Care Clinician occurred at 6:42 AM, after the fall. On 9/24/24 at 12:17 PM, in a telephone interview, resident #1's son stated he learned his mother needed more attention the night she fell . He recalled when he arrived at the facility after her fall, he found her still sitting in her wheelchair at the nurse's station and without the oxygen she needed. He queried why the facility staff did not call hospice for help. He explained he had signed his mother up for hospice to provide additional resources to care for her. In telephone interviews on 9/24/24 at 1:41 PM, and on 9/25/24 at 4:03 PM, resident #1's assigned Licensed Practical Nurse (LPN) C confirmed recounted resident #1 was with her all night and took her everywhere she went. She stated resident #1 was fidgety in the chair and cried on and off. She explained she decided to wait until morning to call hospice and report resident #1's behavior since it was night shift and thought the previous nurse had called them. Review of the medical record revealed no documentation that hospice was contacted regarding resident #1's change in condition on 9/05/24. On 9/25/24 at 2:43 PM, in a telephone interview, LPN B stated she worked the evening shift on 9/05/24 and was told by resident #1's daughter she had requested, something for the anxiety because her mother was getting anxious at night. She recounted she found this request odd because she had never seen resident #1 with behavior like that before. She indicated later that night, resident #1 became agitated, confused, and tried to get out of bed repeatedly, so she implemented a one-to-one supervision intervention. LPN B explained she had to contact the pharmacy three times that night to get authorization to remove Ativan and had to ask the pharmacy to expedite the request because resident #1 was agitated. She recalled she administered the anti-anxiety medication as prescribed but documented the incorrect time. She stated she never called hospice or the physician to report resident #1's change in condition because, I did not think it was needed. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/24 at 9:34 AM, during a telephone interview, the Hospice Manager G stated the hospice received a message from the telecare services on 9/06/24 at 6:43 AM that resident #1 had a witnessed fall with a skin tear on the nose. The message indicated resident #1 had a light nosebleed and had been up all night restless. The Hospice Manager explained the message indicated the facility nurse was told a hospice nurse would be sent and would call them with an estimated time of arrival. She indicated there were no other calls from the facility regarding resident #1 during that night. She explained facility nurses could have called to report resident #1's restlessness, and hospice could have checked the medications and suggest other interventions at any time. In a telephone interview on 9/26/24 at 10:14 AM, Hospice RN J explained he saw resident #1 on 9/05/24 and learned she had complained of pain and was getting anxious. He stated he obtained an order for the anti-anxiety medication Ativan as needed and Gabapentin for pain. He stated he expected the facility to inform hospice of any changes or concerns with their shared residents. He explained if a medication was not effective, the provider would consider other options to alleviate the symptoms. On 9/24/24 at 4:30 PM, the Director of Nursing (DON) acknowledged the one-to-one intervention implemented by the nurse, obviously did not work. She indicated resident #1 had been sitting in her wheelchair since 1:30 AM in order for nursing staff to watch her. She mentioned she had not been contacted regarding the change in resident #1's condition and confirmed the nurse should have notified her, the Risk Manager or the Unit Manager for guidance. On 9/25/24 at 1:16 PM, the DON explained when hospice nurses received physician orders, they documented in their notes and left a copy of those orders with facility nurses. She indicated the facility nurses were expected to enter and execute those orders in the electronic medical records accurately. She explained nurses were expected to contact the physician, herself, as well as the hospice and document any changes in condition in the medical record. Review of the Nursing - Change in a Resident's Condition or Status policy and procedure dated October 2014 read, The facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status . Review of [Hospice Agency Name] Agreement for Nursing Facility, Inpatient and Inpatient Respite Services Dated 12/20/17, read, In the provision of care to Hospice Patients the Facility shall be responsible for: Providing Services as contained in the Hospice Plan of Care. Communicating to designated [Hospice Agency Name] personnel any changes in the Hospice Patient's condition, including the Hospice Patient's reaction to treatment and recommendations for appropriate modifications to the Hospice Patient's Hospice Plan of Care.