STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maunalani Nursing and Rehabilitation Center	5113 Maunalani Circle Honolulu, HI 96816

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interview, document and medical record review (RR), the facility failed to ensure appropriate discharge summaries were completed for two out of a sample size of three residents (R). R1 and R2 were transferred to the Hospital for a higher level of care, but when the Resident's families informed the facility the resident would not be returning to the facility, the discharge summaries are required to include a recapitulation of the resident's stay and treatment in the facility. R2's discharge summary was not accurate or complete, and R1's had not been completed prior to survey. As a result of these deficiencies, the provider did not have all the necessary information regarding the resident's clinical status. This deficient practice could affect all discharged resident's. Findings include: 1) R1 is a [AGE] year old female with significant past medical history that included, but not limited to Cerebral Vascular Accident (CVA/stroke) resulting in right lower extremity weakness, hypertension (high blood pressure), atrial fibrillation (irregular heart rate), urinary tract infection (UTI), muscle weakness, difficulty walking, dysphasia (swallowing difficulty), and mild dementia. Her medications included Eliquis (blood thinner) to reduce risk of stroke. R1 requires 2-person assist with transfers, feeds self after meal setup, and is incontinent of bowel and bladder. R1 is often up in a wheelchair (w/c). She was able to walk with a front wheel walker, gait belt and requires full contact-guard. R1 is sometimes resistive to care. At baseline, she is alert, responsive with forgetfulness, and unable to speak clearly due to her stroke. R1 has had multiple skin tears on her lower legs. On 09/12/2024, she was transferred to the hospital for a change in her mental status. While R1 was in the hospital, her family notified the facility she would not be returning to the facility. On 10/17/2024, RR revealed there was no discharge summary in the Electronic Medical Record. On 10/18/24, the facility provided a discharge summary for R1 which was signed by the attending physician (MD)1, but did not have a date. When inquired, the Director of Nursing investigated, and reported MD1 had completed the discharge summary after meeting with surveyor on 10/17/2024 regarding another resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) R2 was a [AGE] year old male with past pertinent history of diabetes, hypertension, and end stage renal disease. He was incontinent of urine, had a urostomy (urinary bladder removed and opening in belly created to drain urine), and had dialysis three times a week. R2 has some memory issues at baseline and prior to hospitalization was dependant on his daughter for care. He was hospitalized on [DATE], for sepsis due to cellulitis (bacterial infection) of the right lower extremity. His hospitalization was complicated by multiple debridements and necrotizing fasciitis (flesh-eating disease) and delirium. On 09/05/2024, R2 had a amputation above the right knee. He was discharged to the skilled nursing facility for dressing care of surgical site and rehabilitation, with the discharge goal to return home with his daughter. On 09/21/2024, R2 fell at the facility, had a change in level of consciousness and was transferred to the hospital for a higher level of care. The daughter informed the facility R2 would not be returning to the facility. RR of R2's medical records revealed a discharge summary by MD1, dated 09/24/2024. The discharge summary was a paper preprinted form and included the following: Original Admission Problem (preprinted on form): Physical and Occupational Therapy Management and Treatment Procedures to date (preprinted on form): Physical and Occupational Therapy Progress Mentally and physically (preprinted on form): Developed change in condition and sent to er.Current problem in care (preprinted on form): Dementia Immediate Cause of Discharge (preprinted on form): To ER Anticipated goals of Improvement (preprinted on form): N/a (not applicable) discharge date : 09/21/24 The discharge summary was not adequate for an emergency transfer, as it did not include why R2 needed the PT/OT, and he did not have a diagnosis of dementia. When the facility was notified he would not be returning, there was no additional discharge summary completed. On 10/17/2024 at 10:40 AM conducted an interview with MD1. At that time, he stated I could have done better with content and details.

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F 0684 Level of Harm - Minimal harm or potential for 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** 39853 Based on interviews, document and record review, the facility failed to recognize the seriousness of one Resident's (R)1 condition, of a sample size of three. Specifically, R1 exhibited a change in level of consciousness on two consecutive days, and on day two, the nursing staff determined her condition not serious enough to transport to the hospital by Emergency Medical Services (EMS/911). In addition, the facity failed to develop a comprehensive care plan for R1's multiple skin tears. As result of these deficiencies, R1 was 1) hospitalized for sepsis due to urinary tract infection (UTI), and 2) continued to get skin tears. These deficiencies may affect any resident, and has potential to delay transport to a higher level of care. Findings include: 1) Reviewed the facility grievance log, which included a complaint made by R1's daughter. The Complaint Report Form was dated 09/12/2024, and included Dtr (daughter) expressed concerns that staff did not contact EMS (Emergency Medical Services/011) timely to address resident's needs & family's concern for stroke. R1 is a [AGE] year old female with significant past medical history that included, but not limited to Cerebral Vascular Accident (CVA/stroke) resulting in right lower extremity weakness, hypertension (high blood pressure), atrial fibrillation (irregular heart rate), urinary tract infection (UTI), muscle weakness, difficulty walking, dysphasia (swallowing difficulty), and mild dementia. Her medications included Eliquis (blood thinner) to reduce risk of stroke. After her stroke on March 31, 2024, she was an inpatient at a Rehabilitation Center, and then transferred to the facility at SNF (skilled nursing facility) level of care on 05/15/2024. R1 required 2-person assist with transfers, often up in wheelchair (w/c), feeds self after meal setup, and incontinent of bowel and bladder. R1 is able to walk with front wheel walker, gait belt and requires full contact-guar (person assisting had one or two hands on body). She is sometimes resistive to care. R1's baseline is alert, responsive with forgetfulness, and unable to speak clearly due to her stroke. She has had multiple skin tears on her lower legs. 2) Review of Nursing Notes included the following: 09/11/2024 12:52 PM Subject: Increased confusion and unsteady gait. Data: Family notified this writer (Registered Nurse (RN)1) that while working with therapy this shift, resident's (R1) gait was more unsteady than usual. She was also noted to have increased confusion. Action: MD notified. Response: N.O. (new orders) CBC (complete blood count) with diff and BMP (basic metabolic panel) for Thurs 9/12 and cranberry supplement 300 mg BID (twice a day) for UTI prevention. Resident is now resting comfortably with call light within reach. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/11/2024 at 02:47 PM Subject: Orthostatic hypotension (low blood pressure (BP)) Data: BP 101/59 after working with therapy (family employed) Action: Resident was safely assisted back into bed and legs elevated. Pushed 120 cc (cubic centimeters) of fluid Response: BP increased to 130/54. Resident is now coherent, talking and smiling at baseline. 09/12/2024 11:08 AM: Subject: Labs Data: labs done last evening due to episode of lethargy (weak,sleepy,unable to do anything), and low bp. Awake and alert this morning. Labs wnl (within normal limits) No significant findings. Action: MD to review labs. Informed daughter of lab results and current condition. Response: Daughter appreciative of call. 09/12/2024 at 03:27 PM Subject: Episode of increased confusion/incoherence Date: Resident was eating lunch on lanai with family when this writer (Unit Manager /UM1)) was notified that resident was unresponsive. This writer found resident in w/c with eyes open, difficulty swallowing, lethargic and slow to respond. resident was making incoherent sentences and noted to be confused. Vitals stable. Both daughters with resident at time of incident. Family expressed concern and called 911 for resident to be seen quickly at Hospital. Action: Resident was transferred to .Hospital at 1250 pm via ambulance. Resident was alert with confusion at time of transfer Reviewed the SNF/NF to Hospital transfer form completed on 09/12/2024, which included: BP 140/85 at 12:43 PM Reason(s) for transfer: two episodes of unresponsiveness, increased confusion, increased incoherence. Physician orders included: - 05/26/2024 Metroprolol Tartrate Oral Tablet 50 mg (milligrams). Give 0.5 mg tablet by mouth two times a day for HTN (hypertension/high blood pressure) Hold for SBP (systolic blood pressure) less than 120 and HR (heart rate) less than 55. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Monitor for Orthostatic Hypotension (low blood pressure that happens when standing after sitting or lying). On 09/12/2024, the RN documented the chart code 9, which is Other/See Nursing Notes (MAR nursing note). Review of the Medication Administration Record (MAR) revealed the following: - R1's BP had been stable and the metroprolol was documented to be administered every day in September except on 09/12/2024. On 09/12/2024, the RN did not administer the 8:30 AM dose, and entered the code 12 (Vitals outside parameter). The MAR nursing note documented at 09:45 AM, R1's BP was 108/76. On 09/12/2024, there was no documentation that a repeat blood pressure was taken after the one documented in MAR note (108/76), which required the blood pressure medication to be held. In this circumstance, it is the standard of care to repeat the blood pressure. Reviewed P1's Care Plan (CP), which included Risk for UTI d/t (due to) Hx (History) of UTI. Interventions included Monitor and document PRN (as needed) for s/s (signs and symptoms) of UTI: strong smelling urine, blood in urine, .fever, chills, confusion, change in mental status. On 10/17/2024 at 11:39 AM, interviewed RN1, who had been assigned R1 on 09/11/2024 and 09/12/2024. She said on 09/11/2024, R1's daughter informed her that her mother's gait had changed and was noticed after physical therapy. She went on to say at baseline, R1 was confused, but more so, and very lethargic. RN1 said she checked vitals, raised her legs and gave her something to drink. She said she thought R1 might have been alittle dehydrated, or had a UTI. RN1 said the daughter wanted her mother to go to the hospital, but informed her they could do things at the facility, so contacted the physician and he ordered blood tests. RN1 was assigned R1 again the next day, 09/12/2024 and R1 was more tired that day. She said CNA (certified nurse assistant)1 got her up and took her to the lanai before lunch time. Later, CNA1 told her something was going on with R1, and she was having difficulty swallowing, very lethargic not as responsive, not as coherent by baseline. She was taken back to bed from the lanai. RN1 said R1's family was with her at the time, and wanted us to call 911. RN1 said she told them they could do some more things at the facility, as felt is was not super critical. She said the family really wanted her to be seen at the hospital. RN1 said she spoke with the Unit Manager (UM)1 and because R1 was not super critical they could call AMR (non emergency transport ambulance service). She said when she told the family they could call AMR, rather than 911, they asked about the response time. RN1 said when she informed them it could be an hour or more, they were not happy, and the daughter called 911 herself. She said EMS arrived in approximately 10 minutes. Inquired who makes the decision to transport by 911 or AMR, and she said it was situational, and the physician would make the decision, but they hadn't yet called him. She said that day, the UM1 said R1 was not supercritical, and felt AMR was fine. She went on to say, R1 was alert, and speaking, but the family was concerned maybe she was having a stroke. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/2024 at 12:04 PM, interviewed the UM1. She said the first day after R1 had an episode, they did labs, which didn't show anything significant. UM1 went on to say, the next day about lunch time, the daughters were with R1 in the lanai, and one came to get her because R1 wasn't acting normal When she responded, she said R1 wasn't talking, eating, and had a blank stare. She said she directed staff to take her back to the room and do a head to toe assessment. The UM1 said R1 was not in critical condition. She said the daughter's were worried, so they did send her out (to the emergency room). On 10/17/2024 at 12:25 PM, interviewed CNA1, who worked with R1 09/11/2024 and 09/12/2024. She said on 09/12/2024, R1 was different from other days, and she didn't want to get up. CNA1 said she was going to get her up, and RN1 said not to, because her blood pressure was low when she took it in the morning, so she left the BP machine in the room. CNA1 said later, when she went to tell the nurse R1 was not feeling good, and she was told the family called, and wanted R1 up in the lanai, because they were coming to visit. CNA1 said she got her up, but could tell she was not normal, she was slumped (CNA demonstrated position leaning to the side with head down) over in the chair. CNA1 said the day before, the daughter wanted her to walk R1, and had to stop because she was having difficulty walking.That's why we felt that maybe she had a stroke. Review of R1's Emergency Department Provider note dated 09/12/2024 revealed the following entry: .Patient called as a code stroke (team response to facilitate time sensitive treatment if stroke). CT head and CTA brain and neck negative for any new strokes, suspect at this time is metabolic encephalopathy (brain dysfunction caused by underlying condition).Workup was notable for infected urine, likely causing sepsis and UTI. Patient was given IV antibiotics, fluids and admitted to the hospital.The patient was seen immediately upon arrival due to life/limb threatening illness.There was a high probability of imminent or infiltrating deterioration in the patients condition due to sepsis (serious condition in which the body responds improperly to an infection), UTI, and severely altered mental status. 3) Reviewed R1's nursing notes, and identified the following references to skin tears: 05/15/2024, 01:47 PM: Admission Note identified 1) Skin tear right shin, 1.5 cm x 2 cm, and 2) Skin tear left shin, 5 cm x x 0.75 cm. 06/16/2024, 01:17 AM: Resident noted with new skin tear to RLE.C-shaped measuring 2.0 cm. 07/08/2024, 10:21 AM: .sustained skin tear to left shin old discoloration, Measures 0.65 cm x 0.2 cm. 07/25/2024, 02:03 PM: 1. Skin tear to RLE (right lower extremity).2. Skin tear to RLE . 08/22/2024, 10:32 PM: Skin tears to R shin. 09/08/2024, 10:56 PM: Patients family notified nurse of skin tear to left lower extremity 1 cm x 3 mm. 09/12/2024, 11:55 AM: Skin tear to RLE. Reviewed R1's care plan (CP), which revealed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/08/2024, the following CP was initiated Focus: I sustained skin tear to my left shin. Goal: I will resolve in 14 days without any complication . Interventions: - I agree to receive topical treatment as ordered by my physician. Monitor for signs and symptoms of infection every shift: bleeding, pain, swelling, bleeding [sic], drainage, color, pus and notify physician. - Monitor for treatment adverse effects and effectiveness and notify physician. On 08/08/2024 this focus was documented as Resolved. The CP for left shin skin tear was not initiated after identified on admission assessment 05/15/2024, or updated with the 09/08/24 skin tear. The CP was not revised to include new interventions. On 08/08/2024, the following CP was initiated Focus: skin tear to right shin and right lower leg (reopen on 8/21/23). Goal: I want to resolve skin tear without infection within 14 days. Interventions: - Apply treatment as ordered (See TAR (treatment administration record)) Monitor healing progress daily. Notify MD if no improvement or s/s (signs/symptoms) of infection noted. - Check my fingernails as needed and trim when indicated. - I get combative and resistive with care in the evenings due to my dementia. Please provide 2 assist. When I am combative or resistive, stop care and allow me to calm down before resuming care. - May use long pants daily On 09/02/2024, this focus was documented as Resolved. The CP for right shin skin tear was not initiated after identified on admission assessment 05/15/2024, or when tear occurred on the right shin 06/16/2024. Reviewed the facility policy titled Care Plans: Baseline and Comprehensive, revised 03/27/2024. The policy included: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The purpose of the Comprehensive Care Plan policy is so that each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. Comprehensive assessments, care planning, and care delivery process involve gathering and analyzing information, selecting and initiating interventions, and then monitoring results and adjusting interventions accordantly [sic]. - 6. License nurse will develop the baseline care plan to include conditions and risks affecting resident's health and safety. Examples include, but are not limited to .e. Alterations in skin integrity Reviewed the facility policy titled Skin tears and Bruising dated 06/21/2024. The policy included: - Policy: To provide preventative skin care to all residents especially those vulnerable to skin tear trauma. - B. A resident's care plan shall be initiated with the following interventions, as appropriate, to prevent and promote healing of skin tears and bruising.b). Upon moving or transferring the resident, look and ensure that the resident's extremities are safe. Be especially careful when using the mechanical lift. c). Be careful in the care of the resident to prevent shearing of skin with clothing and bed linen.e) Apply lotion to the forearms and lower legs to retain moisture, lubricate skin and prevent further breakdown. f) Trim the resident's fingernails. g.) Develop and implement a behavioral management care plan if appropriate. h) Encourage family to bring long pants for the resident to ear, .i) Encourage good nutrition and hydration. On 10/17/2024, at 12:45 PM, accompanied CNA1 to unit where R1 resided. At that time asked CNA1 about the skin tears and if she had any thoughts of how R1 kept getting the tears so frequently. CNA pointed out a resident in a wheel chair, and pointed out the metal on the side of the wheelchair (leg lift), and demonstrated how the tears could have occurred by moving her legs against the sharp edged metal. She also said R1 use to need the hover lift for transfers, which may have caused friction.

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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** 39853 Based on interviews, observation, record review, the facility failed to provide adequate supervision to one Resident (R)2. On 09/21/2024, R2 fell while in the Physical Therapy gym which resulted in harm. He was hospitalized with a subdural hematoma (bleeding near the brain) which required immediate surgical intervention. In addition, the facility failed to conduct a thorough investigation, document findings, and interventions taken to reduce the likelihood of a similar event. This deficient practice could affect any resident if the appropriate level of supervision is not provided. Findings include: 1) On 09/23/2024, the Office of Healthcare Assurance (OHCA) received an facility reported incident (ACTs # 11218) regarding a witnessed fall with injury. The report included: Resident is a [AGE] year-old-male who was admitted . on 09/12/2024 for PT/OT (physical/occupational services) after being hospitalized . following right foot necrotizing fasciitis status post angiogram and balloon angioplasty on 8/29/24, then right knee above amputation on 9/5/24. He is A&Ox4 to person, time, place, and situation. He is on hemodialysis three times a week, mostly incontinent to bowel and bladder. He is only able to walk 10 feet with use of parallel bars with contact guard assistance from therapist. On 09/21/2024 at approximately 10:15 AM, resident had a witnessed fall in therapy gym. Resident was receiving physical therapy service with PTA (physical therapy assistant). He propelled himself to the parallel bars, quickly attempted to go up the ramp to parallel bars. Resident's wheelchair tipped and he slid backwards out of it and fell to the ground. Resident was assisted to lying on the floor with comfortable position and a pillow was placed under his head. No changes of level of consciousness or visible injuries were noted. The therapist called a licensed nurse immediately. Resident verbalized that he moved too quickly to attempt standing in parallel bars. Head to toe assessment performed after the fall. Resident was able to answer questions appropriately. He reported pain to the back of head. No bump or lump on his head was noted. Pupil reactions were equal and brisk to light. He was able to move both upper and lower extremities. Resident remained alert with no loss of consciousness or change in mental status. VS 174/71, 68, SPO2 99% on RA. Resident was assisted back to wheelchair via mechanical lift with two staff transfer. Neurocheck were initiated every 15 min. for 1hr., every 30 min. for 2 hrs. per facility protocol. Resident reported pain level 5/10 to back of his head when he transferred to his bed around 10:45 am. Physician (MD)1 was notified and he ordered to send resident to emergency room for further evaluation. POA1(power of attorney/daughter) was notified. Note: Emergency Medical Service (EMS) responded that it would take proximately 20 minutes because they had a lot of calls, and if resident ' s condition changes to call back. While awaiting arrival of EMS the licensed nurse noted resident ' s change of mental status and increased pain. The nurse immediately re-alerted 911 to respond immediately. Resident left with EMS at approximately 11:57 AM . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Completed report was dated and received on 09/23/2024. The report included R2 would not be returning to the facility, and will be discharge to the community. 2) Request made for the investigation notes. Reviewed the notes provided by the Director of Nursing (DON), which included: DON notes dated 09/25/2024: Resident is baseline A&O x3. However, occasional episodes of confusion and disorientation noted since SNF admission. The therapy reports stated that resident was displaying anxiety, disorientation, suspicions, and depression, and SLUMS scored 11/30 (questionnaire that measures cognitive function. Higher scores indicate better cognitive function) Verbal and tactile cues required for safe transfer technique during therapy sessions. Cognitive deficit, complex medical conditions with easy fatigue, impaired physical function with recent right AKA ambulation also increased risk of fall and injury. This fall happened due to resident moved too quickly to get to the parallel bars before therapist could provide verbal cue for safety. Due to right above knee amputation, he might not be able to hold himself without sliding from the wc. Unit Manager (UM)2 notes dated 9/30/2024: Per interview with therapist who worked with resident at the time of incident, they were working on wheelchair propulsion up to parallel bars for next activity to attempt ambulate in parallel bars. Resident self propelled to therapist on the left side. Resident propelled too fast to ramp and posteriorly tipped out of wheelchair. Therapist attempted to catch the resident but was too late and bumped occipital area of head. Reviewed the Corporation Resident/patient Incident Report completed by PTA1 dated 09/22/2024. The report included, but not limited to the following: On 21 [DATE] at 1015 with daughter and grandson present, R2 and PTA were working on wheelchair propulsion to parallel bars for next activity to attempt to ambulation in parallel bars. Resident self-propelled to parallel bars, with Therapist 6 ft. to the left side. Resident propelled to [sic] fast to ramp and posteriorly tipped out of the chair. Therapist attempted to catch resident however to [sic] late and resident bumped occipital region of head. BP documented to be 174/74. 3) Review of R2's medical records revealed R2 had a past pertinent history of diabetes, hypertension, and end stage renal disease. He was incontinent of urine, had a urostomy (urinary bladder removed and opening in belly created to drain urine), and had dialysis three times a week. R2 has some memory issues at baseline and prior to hospitalization was dependant on his daughter for care. He was hospitalized on [DATE], for sepsis due to cellulitis (bacterial infection) of the right lower extremity. His hospitalization was complicated by delirium. The goal was for R2 to return home. Reviewed R2's Fall Risk Evaluation completed on admission, which deemed R2 to be a high risk with a score of 18. Score 10 or higher indicates the resident is at high risk of fall. Reviewed Physical Therapy Treatment Encounter Note date of Service 09/21/2024 by PTA1. The note included, but not limited to the following: .Pt (R2) is able to stand with CGA (contact guard assist-the therapist is close and not more than several steps away in case resident loses their balance, strength, etc) performed x1 with gait belt (safety device used to help someone move or walk) for assistance for 2 mins (minutes). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	.Wheelchair navigation and transfer training in and out of wheelchair x2 from mat table to wheelchair with CGA/SBA (standby assist-both require no immediate assistance from the therapist, however, the therapist would intervene as needed) with gait belt for safety. Wheelchair management training self propelling in therapy gym education to address [sic] STG (short term goal) of wheelchair mobility tolerance and to improve independence with mobility and ensure safety within home. Other Status Update Report: Patient had minor fall in therapy gym while attempting to navigate parallel bars. Transfers .Sit to stand = CGA Safety Awareness = impaired Response to Session Interventions: Patient was responsive to therapeutic [sic] interventions, completed all strengthening, transfer training, and mobility training well, however while working on STG of self propelling in wheelchair patient moved too quickly up to parallel bars. Once patient hit the ramp with wheelchair his wheelchair tipped and he fell backwards, therapist jumped to try to assist descent however patient fell back to quickly hit back side of head, patient was assessed rapidly, given pillow underneath head . Reviewed the Fall Nursing Note, dated 9/21/2024 at 04:43 PM, which included, but not limited to: - pt (R2) wasn't on the unit until after 10:44 am. - Between 10:45 am and 11:15 am MD and 911 called due to pt complaining of headache MD gave instructions to call 911. - Called 911 immediately and they said that because of pt's LOC (level of consciousness (Showed no signs of confusion)) they would come in approximately 20 minutes because they had a lot of calls today; they said to call back if pt (R2) condition changes; pt was showing no signs of confusion initially - after reassessing pt he had some confusion (could not remember where he was, who the nurse was, etc) I immediately called 911 again to report the update in pt condition and they said that they would be there in a few minutes. - continued to monitor pt until EMT [sic] arrived sometime between 11:30 am to 11:45 am. - Left for hospital around 11:57 am. Reviewed the Neurological Assessment form, that included the following documentation following after P2's fall 09/21/2024 at approximately 10: : 10:15 AM (in PT gym: Blood pressure (BP) 174/71, oriented, speech clear, headache 10:30 AM: Not taken. (Arrive on unit after 10:44 AM). 10:45 AM: (Back on unit) BP 172/72, oriented, speech clear, headache (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	10:49 AM: BP 169/80, oriented, speech clear, headache 11:00 AM: BP 171/70, oriented, speech clear, headache 11:30 AM: BP 184/83, disoriented, drowsiness, speech garbled 11:51 AM: Pt (patient/R2) sent to ER (emergency room) with EMT' Review of R2's vitals summary revealed is BP baseline was lower prior to the fall, and recorded as: 09/21/2024 at 08:27 AM: 138/67 09/20/2024 at 06:32 PM: 139/71 09/20/2024 at 02:26 PM: 145/78 09/19/2024 at 07:28 PM: 138/75 09/19/2024 at 0:542 PM: 166/66 09/19/2024 at 09:21 AM: 165/72 09/19 2024 at 00:32 AM: 135/69 Review of R2's Medication Administration Record (MAR) for behavioral monitoring every shift, revealed the following behaviors: 09/14/2024 1st shift - 3 (key agitation) 09/15/2024 2nd shift - 3 09/19/2024 3rd shift - 2 (keyRestless, attempting to get out of bed) Reviewed R2's MDS (Minimum Data Set-clinical assessment) dated 09/19/2024, documented his Functional Status (Section G) for transfers was total dependence. Reviewed R2's active care plan, which included: -Risk for fall, due to recent right above the knee amputation. Intervention 09/13/2024 Provide me safety reminder as needed. -I need assist during ADL (activities of daily living) daily due to right above the knee amputation .I am here for short term rehabilitation to improve ADL function . Interventions 09/13/2024: Provide me simple verbal or physical cues as needed for my maximum participation and safety, .I need 1 or 2 staff substantial/maximum assist to dependent assist during sit to stand .I am not walking with nursing at this time. PT will direct nursing staff when is appropriate. Reviewed EMS Patient Care Record) dated 09/21/2024, which included .The pt. opened his eyes briefly to painful stimuli and moaned in response to verbal commands, with no purposeful movements of his arms. Clinical impression: Closed head injury, Intracranial Bleed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Reviewed R2's Emergency Department (ER) Provider (MD)2 notes 09/21/2024 that revealed the following: - Full trauma team activation (team page for immediate response to ER) on arrival. -EMS reports fall backwards out of wheelchair .Patient experienced head strike and then sudden onset of worst headache of life. Reviewed the Trauma History and Physical by (MD)3, dated 09/21/2024 included .patient found to have large acute on chronic SDH (Subdural hematoma-dangerous bleeding that puts pressure on the brain) with midline shift, neurosurgery to take for emergent craniotomy (surgery to relieve pressure on the brain). On 09/25/2024, R2 had a complication of a large rebleed and required a second surgery. 3) On 10/16/2024 at 12:45 PM, interviewed RN3. She said R2 had some hospital delirium with some residual behaviors. RN3 went to the PT gym to assist the day R2 fell . She said the PTA relayed R2 quickly rolled his wheelchair toward the parallel bars and when he reached the incline the w/c flipped backwards and he struck his head. She said daughter had been present at the time of the fall but had her back turned as she was watching her son. On 10/16/2024 at 12:00 PM, conducted telephone interview with R2's Power of Attorney (POA/daughter). She shared that she was present with her young son when her dad was getting PT. The POA said she heard the tech ask Are you OK? The whole wheelchair fell backward. She felt there was a delay getting additional help, approximately 15-20 minutes. The POA said she heard the therapist say, I should have been behind him instead of next to him. She said it was then over an hour before EMS was called. The POA felt the therapist should have known R2 was a high risk, and not able to stand on own. She went on to say R2 had neuropathy (nerve damage) in his good leg, and can't feel it all the time. The POA said R2 he is not able to walk on his own, and totally dependent. On 10/16/2024 at 02:30 PM, interviewed the UM2. She said when there is a fall, nursing does a root cause analysis (RCA), that includes looking at how the fall happened, identify contributing factors, and interview staff. Inquired if there were opportunities identified during this RCA, and she said the only question that came up was why the therapist was at R2's side, instead of behind the w/c. UM2 said [NAME] from PT participated in these, and she did not discuss the concern with the PT Director She said she was not aware of any changes that had been implemented as a result of the incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/16/2024 at 03:00 PM, interviewed the Director of Rehab (DPT). She said from what she had been told, PTA1 and R2 went up to the gym, and the daughter and young son were present. She went on to say they were doing exercises and w/c mobility, then going to work on the bars (parallel) for standing. When transitioning, R2 went up to the bar, pulled up to bars, got into bars. guess too forceful and went back. The DPT said there is a very small incline, little ramp to get into bars. She said it was PTA1's first time with R2, and it was on a Saturday, so he was alone. Inquired if the incident was analyzed for any opportunities, and she replied to make sure precautions are in place, specific to the resident and to follow current levels of supervision, and weight bearing. Asked if anything specific related to positioning of the PTA1 to Resident, and she said she didn't really identify anything. PTD said she called PTA1 the next day, but it was difficult to understand him at the time. She said he was very sad and upset the fall occurred. Inquired specifically if PTA1 talked about any opportunities or ideas to prevent similar fall, and she said no. On 10/16/2024. at 03:30 PM, toured the rehab room with the PTD, and observed the parallel bar equipment. At each end of the bars is a small ramp with a skid strip to enter the bars to the level plane. The PTD did not know any specifics of the fall. such as which end of the ramp the fall occurred, placement of the wheelchair, position of therapist, and had not reenacted the event to identify opportunities. On 10/17/2024, at 09:45 AM, interviewed the DON. She said she became aware of the incident that Saturday, and had a conversation with the PTD and there needed to be investigation and inservices to the rehab team. She went on to say on Monday (09/23/2024), she went to a meeting with the therapists, and they briefly went over what happened on Saturday. Inquired if any opportunities were identified or changes made based on review of the incident, and she said just how to prevent incidents and need to know each resident and follow PT recommendations. She went on to say they identified a need to be able to obtain assistance quicker, and that staff need to always stay with the resident. The DON said it was agreed therapists shouldn't use the rehab gym unless there is another staff present. She did not think there were minutes to the meeting or attendance recorded. The DON stated I should have written more in my summary. On 10/17/2024 at 02:00 PM, interviewed the Physical Therapy Assistant Director (PTAD). He explained they are a contracted group. The PTAD confirmed they discussed the fall that Monday, and that PTA was alone in the gym at the time. There was further discussion in the future, they want to have other staff around. He said the meeting emphasis was on fall prevention, to be attentive and present. On 10/18/2024 at:915 AM, conducted a phone interview with the VP of Operations for the PT vendor. She said the corporate office provides operational and clinical support to the staff working at the different facilities. The RVP was notified of the incident by the onsite PTD. She went on to say she was on site at the facility October 1, 2024, the week after the incident for follow up education with staff. As a result of that, they determined and put in action plan as follows: 1) there will be two people in the space at all times 2) to expedite response and assist staff were trained to use the 500 page, and 3) emphasize staff will review the chart to familiarize self with resident and adhere to functional recommendations. The VPO said she did not interview or speak with PTA1, but reviewed the records and conclusion was that R1 was not doing a transfer from sit to stand, and R2 propelled himself to the ramp. She went on to say the facility does the investigation after the report is made. Request was made regarding the documentation of the incident review, recommendations and action plan. At the time of exit, this documentation was not provided. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/18/2024 at 10:30 AM conducted a second interview with PTD by phone. At that time the RTD said the staff meet every morning, and that Monday after the incident, the DON was present to discuss what could be done to prevent another incident. She said about a week later, the RVP met with them. Inquired if there were any changes or actions taken as a result of the two meetings, and she said they would call Code 500 if assistance was needed, for quicker response. She said they emphasized knowing what level of assistance the resident needs for fall prevention. The RTD said there were no minutes to the meeting. Inquired if there would be any policy changes, and she said we don't want any therapist alone in the gym. Inquired if that policy had been implemented, and she said yes. The RTD said she usually gets information to the on call staff by texting them. She said not all of the on call staff had been notified of the changes. Inquired why she did not mention the action plans during the initial interview, and she said she misunderstood the question. When inquired if PTA1 had received an orientation, she said she did a phone orientation with him the Friday before he worked, but did not have any documentation regarding the orientation or content. On 10/18/2024 at approximately 10:30 AM, interviewed PTA2, who works part time. She said they discussed the fall at one of their meetings Asked it she had any ideas how to prevent this type of fall and she said some of the wheelchairs have stoppers, but did not know if the w/c used that day had them or not. PTA2 went on to say, its all about staying close to the patient, always contact guard. always use safety belt, hold the wheel chair and gotta be behind. She said most of the residents are high risk. On 10/18/2024 11:56 AM, conducted a phone interview with PTA1. He said it had been his first time at the facility and confirmed the orientation he received was on the phone. RTA1 said after the fall occurred, he assessed R2, checked neuro signs and he was alert and oriented. He said R2's daughter was there, so he ran downstairs to get help. PTA1 said they did some exercises on the unit before going upstairs (to the PT gym). He went on to say he reviewed R2's chart and noted he needed work with wheelchair mobility, standing and a few steps in the parallel bars. He said he instructed R2 to wheel over to the parallel bars, and turned to pick up some equipment. He said R2 wheeled too quickly, and he witnessed the fall, but could not get to him. Inquired if anyone had discussed the specifics of the fall with him, and he said he was asked to write a statement, about [NAME] had discussed details, or reenacted the event. Inquired if he had any suggestions to prevent a similar fall, and he said after the incident, he looked at the w/c with nursing, and it was noted that w/c did not have the longer antitip bars. He went on to say the antitip bars on the chair used that day were the short ones, and would buffer a fall, but not stop it. He said R2 had been following directions well and trusted him to be safe with the w/c mobility. PTA1 said it was his first time at the facility and was not oriented to the gym, layout of the facility, or how to summons help. 4) Reviewed the facility policy titled Fall Management, revised date 08/04/2024. The purpose of the policy read The fall management program are interventions developed to prevent falls and injury. The procedure included 2. When a fall occurs, an incident report investigation will be initiated immediately, including .A root cause analysis as to the reason a fell occurred and strategies to minimize reoccurrence 5) Requested documentation of PTA1's orientation, and was provided validation that PTA1 completed the required training from the contracted vendor, but there was no orientation specific to the facility documented.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interview and medical record review (RR), one physician's (MD)1 documentation of one Resident's (R)2 visit, did not meet regulatory requirements. MD1's visit note did not accurately reflect R2's total program of care, and included an inaccurate statement. Findings include: R2 was a [AGE] year old male with past pertinent history of diabetes (on insulin), hypertension, anemia of chronic renal failure, and end stage renal disease. He was incontinent of urine, had a urostomy (urinary bladder removed and opening in belly created to drain urine), and received dialysis three times a week. R2 has some memory issues at baseline and prior to hospitalization was dependant on daughter for care. He was hospitalized on [DATE], for sepsis due to cellulitis (bacterial infection) of the right lower extremity. His hospitalization was complicated by multiple debridements and necrotizing fasciitis (flesh-eating disease) and delirium. On 09/05/2024, R2 had an amputation above the right knee. On 09/12/2024, he was admitted to the skilled nursing facility for short term care, which included daily dressing changes of the surgical site, physical and occupational therapy. The discharge goal was to return home with his daughter as caregiver. Reviewed R2's medical records, which included revealed the following: 09/13/2024, R2's care plan included:initiated a plan for his insomnia. Interventions included monitoring and recording his hours of sleep nightly. 09/13/2024 09:18 PM Nursing Notes: Subject: Behavior/AGITATED/Restless, Refused care Data: .Resident noted trying to get out of chair every so often, there were times able to redirect, there were times, unable to redirect. At one point, resident noted tried to get out of geri-chair, and this writer tried to help him not falling on the floor, resident pushed this writer on the chest, .During MD round at the beginning of shift, MD assessed resident, however resident pointed finger at MD and said you get out of here. do not touch me.Staff reported last night he did not sleep . This morning, he woke up and said Where's my knife.At one point resident said I want Army hotel. Resident kept removing his dressing to right leg amputation . Action: MD1 order Ativan 0.5 mg Q6 hr for mild to moderate agitation, and Valium 5 mg injection Q 12 hr for severe agitated for 2 weeks, . 09/20/2024 MD1 Progress note: (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Denies having a cough, No fever, No wheezing or orthopnea. Denies hemoptysis or pleurisy. Review of systems performed. As noted in the history. Ten systems reviewed Vital signs stable. General: lying comfortably in bed in no apparent distress. Responding to commands. HEENT (head, ear, eyes, nose, throat). Eyes, pupils reactive to light,. Dentition fair. Oropharynx is clear. Neck: no lymadenopathy. Normal carotid pulses. Cardiovascular. No murmurs, rubs or [NAME]. Respiratory: Fair respiratory effort. Clear to auscultation. Abdomen. Positive bowel sounds. Soft and nontender. No masses palpated. Extremities: Dorsalis pedis (pulse that can be palpated over the midfoot) and radial pulses 2+ (strong and easily palpable pulse, which suggests good blood circulation). No edema. Assessment and Plan: pvd (peripheral vascular disease). Supportive care, Constipation. Bowel movements moving regularly on current regimen. Plan of care. Here for long term care. Medications and orders reviewed in the EMR (electronic medical record). The MD visit note dated 09/20/2024 included two entries that were not accurate: 1. Dorsalis pedis pulses 2+: R2 had an above the knee amputation of his right leg, so there would not be a pedal pulse. 2. Here for long term care: R2 was at the facility for short term care and the current plan for discharge was home with the assistance of his daughter. The MD note dated 09/20/2024 did not reflect R2's condition and total plan of care. It did not include documentation of progress and problems in maintaining or improving highest practical physical, mental and psychosocial well-being. There was no documentation regarding the problem identified with his behavior, cognitive status, or if his sleep had improved.