STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165185	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Oak Rehab and Care Center	1600 Summit Street Red Oak, IA 51566

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37074 Based on clinical record review, resident interviews, staff interviews, and facility policy review the facility failed to ensure 2 of 3 (Resident #3 and #10) residents were treated with dignity and respect. The facility reported a census of 28 residents. Findings include: 1. According to the quarterly Minimum Data Set (MDS) assessment Resident #3 had a Brief Interview of Mental Status (BIMS) score of 13. A BIMS score of 13 suggested no cognitive impairment. The MDS listed the following diagnoses: cancer, anemia, hypertension, neurogenic bladder, obstructive uropathy, septicemia, diabetes mellitus, depression, and insomnia. The Care Plan focus area with an initiation date of 2/20/24 documented Resident #3 exhibits the following behaviors: being non-compliant with the use of her call light, asking for assistance and walking without staff assistance. On 6/11/24 at 1:51 PM Resident #3 stated she could not recall staff telling another staff member to shove whipped cream in her face and if they did it was probably a joke. When asked how staff treat her, she stated they are great. Staff will laugh and joke with her and she will do the same with them. Resident #3 stated Staff B Certified Nursing Assistant (CNA) is good with her, she even braids her hair after her baths. Resident #3 added she has had no issues with the care provided by Staff B. On 6/11/24 at 2:16 PM Staff E Activity Director/CNA stated she was assisting with passing out lunch trays. They had desserts to pass out so she asked Staff B to pass them out. The dessert was blueberry cobbler and Resident #3 needed one. The resident asked for extra whipped cream and Staff B said to rub it in the resident's face. Staff E told Staff B that comment was not appropriate and should not say those things. Staff E stated Staff B said it jokingly and Resident #3 heard it because she smiled. Staff E indicated she has heard Staff B say off the wall comments before, she means them jokingly but those comments were not always taken that way. On 6/11/24 at 3:17 PM the Corporate Nurse Consultant stated he was in the building doing a mock survey when he heard Staff B say to shove the whipped cream in Resident #3's face. He overheard the comment, it sounded like a fly by, sarcastic comment. Judging by her demeanor it was just a sarcastic comment. He indicated it was not ok to say even if it was a sarcastic comment and he reported it to the Administrator right away. Since this he has learned this is Staff B's sarcastic mannerism. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 3:10 PM Staff B stated she got written up for making the comment to Resident #3 about shoving whipped cream in her face. She added it was a joke, but now knows she should not be joking about this. Since then she has watched videos on abuse, neglect, and resident rights. On 6/13/24 at 12:53 PM the Director of Nursing (DON) stated Staff B can be mouthy and rude, not sure how else to describe it. She did not witness Staff B make the comment to Resident #3 about shoving whipped cream in her face. Even if she was joking she should not have said that to the resident. When Staff B jokes, it's hard to interpret if she is joking or not. Residents with cognitive issues could take it differently so we need to be careful on what is being joked about. On 6/13/24 at 2:05 PM the Administrator stated it was no okay for Staff B to tell staff to shove whipped cream in Resident #3's face, even if she was joking, we don't joke like that here. On 6/13/24 at 2:24 PM the MDS Coordinator/Assistant Director of Nursing (ADON) stated Staff B can be hot headed and does not take well to changes that are made. When she is joking in her comments, you don't know other people well enough to say certain things. When she was made aware of Staff B stating to shove the whipped cream in Resident #3's face, she went to approach Staff B about it she threw her hands up in the air and said she did not want to talk to the MDS Coordinator/ADON about it. The Corporate Nurse Consultant was here at the time and took over the situation. 2. According to the quarterly MDS assessment tool with a reference date of 5/22/24 Resident #10 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented the following diagnoses: type 2 diabetes mellitus, amnesia, and pain in left lower leg. The Care Plan focus area with an initiation date of 8/28/23 documented Resident #10 is able to communicate and can understand what is said to her and able to make her needs known. On 6/11/24 at 9:47 AM Resident #10 stated she was kind of tired of Staff A CNA calling her brat. She would come in her room and say good morning brat, how are you brat. She does not think Staff A is doing it to be mean but it's very unprofessional, she says it a lot. On 6/13/24 at 11:22 AM Staff A was asked if she assists Resident #10 with her needs and she indicated she does. When asked if she calls the resident brat while speaking with her, she acknowledged she does and now calls her lovebug. She indicated brat is not very professional and only says it as a joke. Staff A indicated she asked Resident #10 if she liked it and she does. But she thought calling her lovebug would give the resident more spunk. She now sees that calling her brat was not very nice, it may be fun for some residents but not for others, that's why she changed it. On 6/13/24 at 12:53 PM the DON stated even if Staff A is joking she should not be calling a resident brat. She does not think that is appropriate. On 6/13/24 at 2:05 PM the Administrator indicated it is not ok for Staff A to call Resident #10 brat, even if she's joking it is not ok. She calls Resident #4 nanny. In this day an age you need to be careful on what you say. It's not appropriate to call anyone brat or nanny; staff can use their names. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided a document titled Resident Rights Policy with a revision date of 11/2019 indicated the facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Resident Rights 1. Resident rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 2. Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. 5. Respect and dignity. The resident has a right to be treated with respect and dignity.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 37074 Based on clinical record review, employee timecard review, resident interview, staff interviews, and facility policy review the facility failed to ensure 2 of 3 resident (Resident #4 and #5) were free from exploitation. Staff signed out Resident #4's Tramadol on the medication count sheet at 12:00 AM but her timecard documented she clocked out at 11:09 PM. Staff had signed out Resident #5's Hydrocodone (narcotic pain medication) as being given. When staff spoke with Resident #5 during his comprehensive assessment he stated he had not received his Hydrocodone for 2-3 weeks. The facility reported a census of 28 residents. Findings include: 1. The quarterly Minimum Data Set (MDS) assessment tool with a reference date of 4/3/24 documented Resident #4 had severely impaired cognitive skills for daily decision making. The MDS documented Resident #4 received scheduled pain medications and received an opioid while a resident in the facility. The MDS documented the following diagnoses: autistic disorder, anemia, dementia, seizure disorder, respiratory failure, COVID-19, and hypoxemia. The Care Plan focus area with an initiation date of 12/18/23 documented the resident had chronic pain related to abnormal posture. The Care Plan directed staff to anticipate the resident's need for pain relief and respond immediately to any complaint of pain. The Medication Administration Record (MAR) for May 2024 revealed Resident #4 had an order for Tramadol (treatment of severe pain) 50 milligrams (mg) every 8 hours for pain control. Review of the April and May 2024 MAR revealed Resident #4's Tramadol was scheduled to be administered at 12:00 AM, 8:00 AM and 4:00 PM. Review of a document titled Controlled Medication Utilization Record for Resident #4's Tramadol 50 mg every 8 hours revealed Staff C Licensed Practical Nurse (LPN) signed out that she administered the medication at 12:00 AM on 5/31/24. Review of the May 2024 MAR revealed Staff D Agency LPN documented 9 (see nurse notes) on 5/31/24 at 12:00 AM for Resident #4's Tramadol 50 mg every 8 hours order. Staff C failed to sign the order out as being given. Review of Resident #4's Progress Note titled, orders-administration notes, revealed Staff D documented the resident's Tramadol 50 mg scheduled for 12:00 AM had been signed out by Staff C as given already. On 6/11/24 at 3:06 PM Staff C acknowledged she did not sign out Resident #4's Tramadol order on the MAR because the facility had let her go without giving her time to catch up on her charting before she left the building. When asked why she signed it out at 12:00 AM on 5/31/24 but her time card shows she clocked out at 11:09 PM on 5/30/24, she stated she gave Resident #4 her Tramadol before she left at 11:00 PM. Staff C denied taking the Tramadol after signing it out as being given. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 10:39 AM Staff D stated on 5/31/24 Resident #4's Tramadol was signed out as being given by Staff C on the count sheet but she did not sign it out as being given on the MAR. She acknowledged the medication had been removed from the medication card. The night Staff C had quit, the Administrator asked her to come to her office because Staff C had quit and they needed a nurse to finish her shift. Her and Staff C completed a narcotic count then left the building. When Staff D looked at the MAR to see what needed done, Resident #4's Tramadol order needed to be carried out. She went to the narcotic book but the medication had been signed out as being given by Staff C. Staff D indicated this was a little after 11:00 PM because the Administrator texted her at 11:00 PM to come to her office. She arrived to her office about 2 minutes after that. Staff D indicated when she arrived to the Administrator's office Staff C was staying right outside of her office. When she noticed the medication had been signed out by Staff C at 12:00 AM on 5/31/24 and the medication was removed from the medication card. Staff D did not know if Staff C actually gave Resident #4 her medication because the order on the MAR was not signed out as being given either. Staff D stated Staff C was standing by the Administrator's office door when she arrived, they immediately did a narcotic count and Staff C left. There would no way Staff C could have signed out and gave Resident #4 her Tramadol as she documented. When asked if Staff D noticed if Resident #4 was in any pain that night, she stated she did not observe any changes in the resident that night. On 6/13/24 at 12:53 PM the Director of Nursing (DON) stated her thoughts on Staff C signing out Resident #4's Tramadol at 12:00 AM on 5/31/24; she either gave it at 9:00 PM and did not want to sign it out early or she took it. Review of Staff C's timecard revealed on 5/30/24 she clocked in at 6:00 PM and clocked out at 11:09 PM. 2. The annual MDS assessment tool with a reference date of 5/26/24 documented Resident #5 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented he received a PRN (as needed) medication or was offered and declined. The MDS documented he took an opioid medication. The MDS documented the following diagnoses for Resident #5: atrial fibrillation, diabetes mellitus, seizure disorder, anxiety, depression, bipolar, respiratory failure with hypercapnia, and obesity. The Care Plan focus area with an initiation date of 5/29/24 documented Resident #5 had chronic pain related to morbid obesity and immobility. Review of March 2024 Medication Administration Records (MARs) revealed Staff C signed out Resident #5's PRN Hydrocodone (treatment of pain) 5-325 milligram (mg) every 8 hours PRN on: a. 3/1 with a pain rating of 7 out of 10 b. 3/2 with a pain rating of 7 out of 10 c. 3/3 with a pain rating of 7 out of 10 d. 3/6 with a pain rating of 7 out of 10 e. 3/7 with a pain rating of 8 out of 10 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. 3/12 with a pain rating of 7 out of 10 g. 3/15 with a pain rating of 7 out of 10 h. 3/16 with a pain rating of 7 out of 10 i. 3/17 with a pain rating of 7 out of 10 j. 3/18 with a pain rating of 7 out of 10 k. 3/20 with a pain rating of 7 out of 10 l. 3/21 with a pain rating of 7 out of 10 m. 3/25 with a pain rating of 7 out of 10 n. 3/29 with a pain rating of 7 out of 10 o. 3/30 with a pain rating of 7 out of 10 p. 3/31 with a pain rating of 8 out of 10 Review of April 2024 Medication Administration Records (MARs) revealed Staff C signed out Resident #5's PRN Hydrocodone 5-325 mg every 8 hours PRN on: a. 4/4 with a pain rating of 7 out of 10 b. 4/8 with a pain rating of 8 out of 10 c. 4/26 with a pain rating of 7 out of 10 d. 4/27 with a pain rating of 7 out of 10 e. 4/28 with a pain rating of 7 out of 10 Review of May 2024 Medication Administration Records (MARs) revealed Staff C signed out Resident #5's PRN Hydrocodone 5-325 mg every 8 hours PRN on: a. 5/2 with a pain rating of 7 out of 10 b. 5/6 with a pain rating of 7 out of 10 c. 5/10 with a pain rating of 8 out of 10 d. 5/11 with a pain rating of 7 out of 10 e. 5/12 with a pain rating of 7 out of 10 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. 5/20 with a pain rating of 7 out of 10 g. 5/24 with a pain rating of 6 out of 10 h. 5/25 with a pain rating of 7 out of 10 i. 5/26 with a pain rating of 6 out of 10 On 6/11/24 at 1:41 PM Resident #5 stated he really has not had any pain when asked how his pain has been the last few months. If he did have pain, it's in his tailbone but staying in bed alleviates that pain. When asked when he last had his PRN Hydrocodone he stated he could not recall since it's been so long ago. He denied asking Staff C for anything for pain in the last month or so. On 6/11/24 at 10:13 AM Staff G Agency LPN stated Resident #5 does not ask for his PRN Hydrocodone nor does he ask for his PRN Tylenol. She added he may have asked for his PRN Tylenol when she first started working at the facility in April 2024. When she would get report, the off going nurse never reported he had received his PRN Hydrocodone on the previous shift. When they looked at the MARs they saw that Staff C had signed his PRN Hydrocodone out a lot. The narcotic counts were never off and the order was signed off as being give, so it looked like he was asking for it. On 6/11/24 at 3:06 PM Staff C when asked why she was the only staff member giving Resident #5 his PRN Hydrocodone, she stated he would ask for it when she would do medication pass. In April and May he would have right shoulder pain, rating it from a 6-8 out of 10. He also had pain everywhere. Staff C stated she only worked two nights a week, maybe three nights. She added the last time she worked he rated his pain a 2 so she did not give him anything. She denied taking the Hydrocodone herself after she signed his order out. The facility had suspected her of taking resident's medications, they suspended her but she quit. She added, she has been a nurse since 1993 and has never taken any resident's medications. When asked about the day she came to work acting out of her norm according to the facility, she stated when she got home that day, her mom checked her blood sugar and it was low at 41. On 6/13/24 at 10:39 AM Staff D stated Staff D stated Resident #5 was never in pain nor did he ask for his PRN pain medication while she worked. She recalled giving him a PRN once time at the end of February, but nothing since then. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 12:53 PM the Director of Nursing (DON) stated Staff C had previously worked as an agency nurse then came back full time. She always thought Staff C was doing her job when she was there at the facility. In the middle of May there was an episode where Staff C showed up for her shift unfit for work. She was banging on the main entrance, disheveled, and display erratic behavior. Staff C told them she had a headache, then she picked up the narcotic cards to do a count, stated she can't count these, threw them in the narcotic lock box and said I trust you. The DON asked her to go to her office while a replacement was found for her. Staff C indicated she thought her Zoloft was causing this behavior, then stated she thought she had cancer and needed to see the doctor but did not have health insurance. The DON wanted to give Staff C a ride home that day, when she went to get her stuff, Staff C had left the building. When the Assistant Director of Nursing (ADON) completed Resident #5's MDS assessment, she had completed the pain medication portion of the assessment and Resident #5 had stated he had no pain during the 5-day review period. When the ADON reviewed the resident's MAR, she noticed his PRN Hydrocodone was being given only by Staff C, this was a pattern. Staff C documented Resident #5's pain 7 out of 10 and 8 out of 10 but he had chronic pain of 3 out of 10. When staff spoke to Resident #5 he indicated he had not asked for his PRN Hydrocodone for 2-3 weeks prior to this ordeal. The Administrator was going to suspend Staff C while they continued to complete the investigation but Staff C ended up quitting. On 6/13/24 at 2:05 PM the Administrator stated between May 16-18th, she could not remember specifically what day, the DON called her about an incident with Staff C. She indicated Staff C came to the front entrance, when staff usually come through the west door. Staff C started pounding on the door with both her fists, stating she could not get in. The DON opened the front entrance doors and Staff C stated her key was not working. Staff C wore a t-shirt, hair was disheveled, no bra on, she did not look like she was ready to work. Staff C went to the medication cart, threw the medication cards in the narcotic lock box and said I can't count these, I trust you. She took an otoscope and put it in her mouth. When staff asked Staff C what she was doing, she told them she was getting a drink. The DON indicated she would take Staff C, so she went to put her things away and get her keys. When she returned staff had let Staff C out the front door. This kind of behavior prompted them to start looking in to their narcotic log to see if there were any patterns. When they reviewed Resident #5's Hydrocodone PRN order they noticed Staff C was the only staff member that had signed the medication as being given. When those spoke to Resident #5 about him needing his PRN Hydrocodone, he told them he had not taken it for two weeks. Once they called their corporate office, they decided the Administrator would come in at 10:30 PM during Staff C's next scheduled shift to talk with her about what was going on with Resident #5's PRN Hydrocodone order. She also wanted to address her attendance issues. When the Administrator arrived at 10:30 PM, she had Staff C come in to her office as well to talk about the behaviors staff observed a few weeks prior, along with their look in to Resident #5's PRN Hydrocodone order only being signed out by her. The Administrator informed her they were going to suspended her while they look further in to these issues. Staff C told the Administrator that she started taking metformin and was having a reaction. The Administrator indicated then we can clear this all up if you can get a doctor's note for them. That's when Staff C filled out a note that indicated she quit right then. Staff C waited in her office until 11:30 PM until Staff D came in to replace her. After Staff C left the building Staff D noticed Resident #4's 12:00 AM Tramadol order was signed out as being given at 12:00 AM by Staff C. Staff C was not in the building at that time and was with the Administrator from 10:30 PM until 11:30 PM so there was no way she could have given the medication during that time. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 2:24 PM the MDS Coordinator/ADON stated while she was completing Resident #5's MDS assessment she interviewed the resident and she stated he did not have any pain during the review period. While she was reviewing the MAR she noticed a lot of staff put he was not having any pain but there were nights where his Hydrocodone was being given consistently. Staff C had been the only administering his PRN Hydrocodone for pain. She went back to talk to Resident #5 about this and he stated he was having pain before his hospitalization but not since then. She let the Administrator know what she had found out. The facility provided a document titled Abuse Prevention Plan-Iowa Policy with a revision date of March 2019 documented in accordance with the Vulnerable Adult Law of the State and the Centers of Medicare and Medicaid (CMS), it is our policy that all residents resident in the facility will be protected from abuse, neglect, misappropriation of funds/property, exploitation or involuntary seclusion, mistreatment/maltreatment and that interventions are implemented to provide the vulnerable adult with a safe living environment. Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion. Misappropriation of resident property/financial exploitation means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on clinical record review, hospital documents review, staff interviews and facility policy review the facility failed to update 1 of 10 resident (Resident #1) care plans after she sustained a fractured humerus. The facility reported a census of 28 residents. Findings include: According to the Admission Minimum Data Set (MDS) assessment tool with a reference date of 2/13/24 documented Resident #1 had a Brief Interview of Mental Score of 3. A BIMS score of 3 suggested severe cognitive impairment. The MDS documented she used a walker and wheelchair and dependent on staff for toilet transfers. The MDS listed the following diagnoses for Resident #1: fractures and other multiple trauma, coronary artery disease, thyroid disorder, hip fracture, anxiety, and depression. The facility provided a report titled Fall dated 2/25/24 at 1:05 PM. The report documented staff was called to Resident #1's room for a witnessed fall. An assessment was completed, resident complained of pain in her right shoulder. She was sent to the local emergency room (ER) to be evaluated. Review of a document titled Diagnostic Radiology with an admit and discharge date of [DATE] documented a right shoulder x-ray completed. The following findings documented: age-indeterminate but suspect acute mildly displaced humeral neck fracture, with suspect involvement of at least the surgical neck. The humeral shaft is superiorly displaced approximately 1.6 centimeter (cm) from the head. The Care Plan focus area with an initiation date of 2/7/24 documented the resident had limited physical mobility related to a fracture of her left hip with nailing. The care plan failed to include her humerus fracture and interventions for staff to follow while caring for Resident #1 while her fracture healed. On 6/13/24 at 12:53 PM the Director of Nursing (DON) stated Resident #1's fall with fracture took place prior to her taking the DON position and prior to the new MDS Coordinator/Assistant Director of Nursing (ADON) starting. She acknowledged the humerus fracture should have been on Resident #1's care plan. The facility provided a policy titled Care Plan Revisions Upon Status Change Policy with an effective date of 4/23/19. The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. PROCEDURE Policy Explanation and Compliance Guidelines 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experience a status change. 2. Procedure for reviewing and revising the care plan when a resident experience a status change: (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. c. The team meeting discussion will be documented in the nursing progress notes. d. The care plan will be updated with the new or modified interventions. e. Staff involved in the care of the resident will report resident response to new or modified interventions. f. Care plans will be modified as needed by the MDS Coordinator or another designated staff member. g. The Charge Nurse or other designated staff member will communicate care plan interventions to all staff involved in the resident's care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165185	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** 37074 Based on observations, clinical record review, facility investigative file review, staff interviews and facility policy review the facility failed to transfer 1 of 3 resident (Resident #1) safely to prevent her from falling. Staff failed to obtain a gait belt prior to assisting Resident #1 from the toilet to the sink to wash her hands. Instead staff held on to the resident's pants during the transfer. As Resident #1 turned away from the sink, she lost balance, staff lost grip and the resident fell on her right shoulder. The resident was sent to the emergency room (ER) to be evaluated and was found to have a right proximal humerus fracture. The resident returned to the facility the same day with her right arm in a sling and recommendations to follow up with orthopedics. The facility reported a census of 28 residents. Findings include: According to the Admission Minimum Data Set (MDS) assessment tool with a reference date of 2/13/24 Resident #1 had a Brief Interview of Mental Score of 3. A BIMS score of 3 suggested severe cognitive impairment. The MDS indicated Resident #1 utilized a walker and wheelchair for mobility. The MDS documented she used a walker and wheelchair and dependent on staff for toilet transfers. The MDS documented she had a fall in the last month prior to admission. She did have a fracture related to the fall in the 6 months prior to admission. Resident #1 had one fall with injury since admission. The MDS listed the following diagnoses for Resident #1: fractures and other multiple trauma, coronary artery disease, thyroid disorder, hip fracture, anxiety, and depression. The Care Plan focus area with an initiation date of 2/7/24 documented Resident #1 had a walk to dine program. The Care Plan indicated the resident was to use a hemi-walker with assistance of one staff, gait belt and wheelchair to follow, 2-3 times per day. A second Care Plan focus area with an initiation date of 2/7/24 documented she required assistance with her transfers, bed mobility and ambulation. The Care Plan indicated she required extensive assistance of one staff person with bed mobility, transfers, and ambulation. The Progress Notes documented the following notes: a. 2/10/24 at 2:57 PM skilled status note: resident's weight bearing tolerance has decreased since fall this morning. The need for assistance with a gait belt and walker has become more reliant on the assistance of one person than on herself. b. 2/25/24 at 3:32 PM this nurse was called to Resident #1's room for a witnessed fall. Observed resident lying on floor, supine with her knees bent. Bilateral forearms resting on resident's abdomen. This nurse sent Certified Nursing Assistance (CNA) to call for non-emergent transport to the emergency room at 1:08 PM. Resident complained of pain at 10/10 at right shoulder. She was able to move her fingers and bend at the elbow without discomfort or additional pain. Radial pulses equal bilaterally. Update received from the emergency department, resident was ready for transport back to facility. Resident had sustained a right humerus fracture and was stabilized with a sling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	c. 2/25/24 at 4:08 PM Resident #1 returned to the facility at 3:49 PM in a shoulder/arm sling without a waist band. She stated her shoulder only hurts when she tried to use it or move it. The facility provided a hand-written statement from Staff E Activities Director/CNA. The statement documented the following: staff went to help Resident #1 off the toilet. She stood up by herself. Staff walked with Resident #1 holding the back of her pants, as there was no gait belt in sight. Staff walked with her to the sink where she washed her hands. As she turned around, Resident #1 lost balance. Staff's right hand was on Resident #1's right shoulder at the time she began to fall. Staff lowered her to the floor but lost grip. Resident #1 fell hitting her right shoulder on the floor. Staff E went to get the nurse who took vitals and instructed staff to call the nonemergency line to come take Resident #1 to the emergency room . Staff E signed the statement. The facility provided a report titled Fall dated 2/25/24 at 1:05 PM. Staff was called to Resident #1's room for a witnessed fall. An assessment was completed, resident complained of pain in her right shoulder. She was sent to the local emergency room (ER) to be evaluated. Review of a document titled Diagnostic Radiology with an admit and discharge date of [DATE] documented a right shoulder x-ray was completed. The following findings were documented: age-indeterminate but suspect acute mildly displaced humeral neck fracture, with suspect involvement of at least the surgical neck. The humeral shaft is superiorly displaced approximately 1.6 centimeter (cm) from the head. On 6/11/24 at 2:11 PM Staff E stated the day Resident #1 fell , she went in to assist her. The resident started to stand up before she could get a gait belt on her. They walked to the sink in her room, Resident #1 washed her hands, she turned around and she lost her balance as she picked up the walker instead of turning with the walker, and fell on her right side. Staff E stated she was holding Resident #1's pants and her hands slipped off her Resident #1's pants as she was falling and could not catch her, which resulted in her falling to the floor. When asked if Resident #1 had complained of pain after the fall, she indicated the resident said ow and that her shoulder was hurting, so she went and got the nurse. She acknowledged a gait belt is usually used when assisting Resident #1 with ambulation. She added the gait belts are occasionally on the back of the doors in the resident's rooms but sometimes they are not there. The day she fell , there were no gait belts on the back of her room door. Staff E stated at the time of the fall, Resident #1 required assistance of one staff, her walker and a gait belt with transfers and ambulation. When asked what she should have done if a gait belt was not in the resident's room, she stated she would make sure to ask the resident to sit back until she returned with a gait belt. She acknowledged she should have used a gait belt that day when she had assistance Resident #1. On 6/12/24 at 3:10 PM Staff B CNA indicated if a resident was to get up prior to applying a gait belt, she would find the nearest chair, ask the resident to sit back down, and to hold on while she goes to get one then assist the resident. When asked who requires the use of a gait belt is stated as far as she knew everyone that was ambulatory with staff assistance. On 6/13/24 at 11:22 AM Staff A CNA stated that if she could not find a gait belt prior to assisting a resident with a transfer, she would ask the resident to sit back down until she could get a gait belt. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/13/24 at 12:53 PM the Director of Nursing (DON) was asked if staff are assisting a resident and there is no gait belt in the resident's room what are staff supposed to do? She stated staff need to go find a gait belt, they have plenty in the facility. They should ask the resident to remain seated where they are until they find a gait belt. The DON indicated the gait belts are to be on the back of the doors in the resident's rooms, at times they get moved and are in the resident's closets. The facility provided a documented titled Transfer-Ambulation with Transfer Belt Policy with a revision date of March 2019. It is the policy of this facility that all associates utilize a transfer (gait) belt with residents during transfers, ambulation and gait training. The gait belt provides a firm grasping surface for the staff person and protects the resident from accidental trauma to the skin. It gives the resident a sense of security as it is tightened. The belt also allows the staff person to gradually lower a resident to the floor (if necessary) without injuring self or resident. Procedure: 4. If from chair, ensure resident's feet are flat on floor 5. Standing in front of resident, brace resident's lower extremities to prevent slipping. Staff person's knees bent, feet apart, back straight. 6. Place transfer (gait) belt low around resident's waist. Properly tighten belt to comfortably tight level. To bring the resident to standing position, keep your back relatively straight and pull on the gait belt. 8. Failure to use transfer belt with an assisted transfer is ground for disciplinary action and termination. 9. Grasp the belt on the resident's side, while assisting him/her to stand. 11. If ambulation, walk slightly behind and to one side of resident while holding on to the belt. 12. If resident begins to fall, draw the resident close to your body using the gait belt, and slowly lower the resident to the floor.